Chapter Five: Working-age Adults

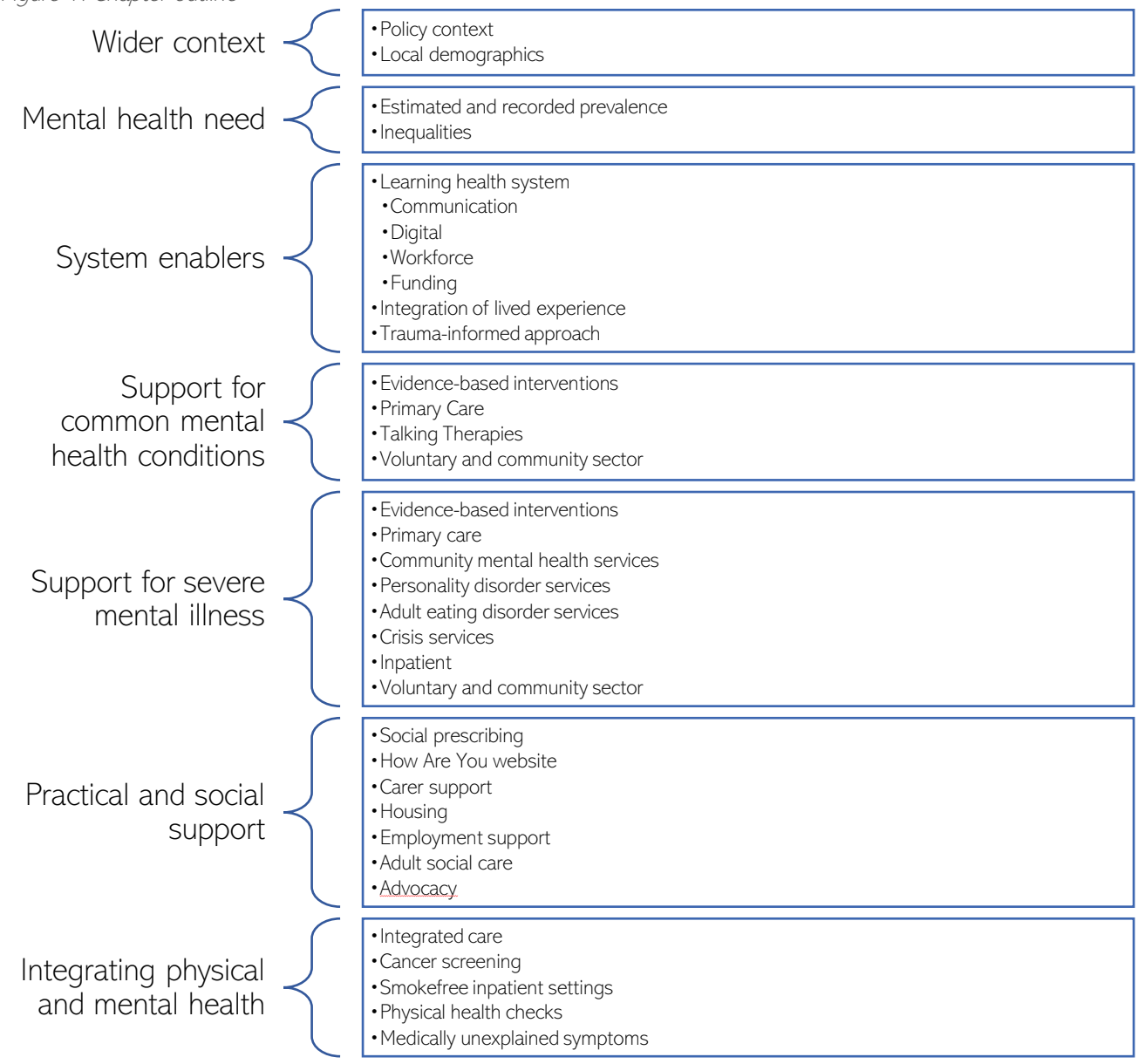
Summary

Scope

This chapter of the Cambridgeshire and Peterborough Mental Health Needs Assessment covers the mental health needs of working age adults. We have defined this group as all adults aged between 17 and 64, regardless of employment status. We have used this definition as it is widely used within the NHS and social care and 17 is the cut off for some children and young people's mental health services. However, many of the services covered here will also cover older adults (aged 65 and above). We also recognise that people may work outside of this age range, particularly as the state pension age is increasing.

There are seven main sections of this chapter:

Figure 1: Chapter outline



This chapter of the mental health needs assessments does not cover the following services:

- Secure mental health services (also known as forensic services). These provide accommodation, treatment and support for people with severe mental illness who pose a risk to themselves and at times, the public (Public Health England, 2019). They predominantly support people who have been imprisoned, or those who have been admitted to hospital through the Mental Health Act following a criminal offence (Durcan, 2011).
- Learning disability services, which are covered in the Health of Adults with a Learning Disability JSNA (2023)

Key findings

Table 1: Key findings of the working-age adults chapter of the Cambridgeshire and Peterborough Mental Health Needs Assessment

	Summary
Wider context	• 65% of people living in Cambridgeshire and Peterborough are adults aged between 16 and 64 (working-age adults). It is predicted there will be a 15.6% increase in the number of working-age adults in our local area from 2021 – 41. • Mental health services across England are under increasing pressures, including workforce shortages, increased demand and the wider impacts of the COVID-19 pandemic (Department of Health & Social Care, 2023).
Mental health need	• National data shows that mental illness is the largest cause of disability amongst working-age adults (Kirk-Wade, 2022). An estimated 1 in 6 adults (18%) experiencing depression and/or an anxiety disorder within any given week (NHS Digital, 2014), though this may have increased due to wider pressures from the COVID-19 pandemic (O'Shea, 2021). • It is estimated that more than 123,500 working-age adults experienced a common mental health condition within the past week in Cambridgeshire and Peterborough. • In 2022/23, GP registers showed that around 95,000 adults (12%) in Cambridgeshire and Peterborough were known to have depression and 8,695 (0.8%) a severe mental illness (NHS Digital, 2023c).
System enablers	• Engagement with local people highlights there is a gap in terms of people's understanding of what support is available to them. • For the past 5 years, per head spend on mental health services in Cambridgeshire and Peterborough has been below the national average. • There is ongoing work in our local system to better understand and share good practice of trauma-informed approaches. • There are national pressures on the NHS workforce, which are reflected in our local system and are a major constraint in the system.
Support for common mental health conditions	• 1 in 8 GP patients in Cambridgeshire and Peterborough report having long-term mental health conditions (NHS England, 2023a). General practice is a first-point of contact for many people with common mental health conditions. • Talking Therapies (previously known as IAPT and locally the Psychological Wellbeing Service) provides a range of treatment offers. In 2021/22, 8 in 10 people in Cambridgeshire and Peterborough who were referred to Talking Therapies began treatment. Around half of this group completed treatment.

Support for severe mental illness, including crisis care	• The Community Mental Health Transformation has addressed gaps in the mental health system and strengthened links between primary and secondary care services. • There are increasing numbers of referrals to the Primary Care Mental Health Service (PCMHS), which responds to GP requests for mental health assessment and recommends mental health interventions. • A range of factors are likely to have contributed to increased pressures on local inpatient services in the past year. • For people attending Accident and Emergency for mental health related reasons between August 2022 and July 2023 almost half (47%) of spent over 6 hours in this department.
Social support and connection	• There is a range of voluntary and community sector support within Cambridgeshire and Peterborough, as well as services providing practical support for people with mental health conditions and those who carer for them. • The newly formed Integrated Neighbourhoods bring together community initiatives that boost social support. • Adult social care plays a key role in supporting people with mental health conditions
Integrating physical and mental health	• International data shows that people with mental illness face physical health inequalities, including in terms of risk factors, early detection (such as cancer screening (National Institute for Health and Care Excellence, 2023)) and health outcomes. • An initial evaluation of the local Talking Therapies service found that there was a 75% reduction in hospital admissions in people who accessed the support pathway for long-term physical health conditions (NHS England, 2023c). • Cambridgeshire and Peterborough is one of the top performers for annual physical health checks, 63% of people on the SMI register receiving all six physical checks by the first quarter of 2023/24. However, completion of a health check does not yet show a sustained improvement in health outcomes.

Contents

Wider context

- Around 1 in 6 adults in England have a common mental health condition (NHS Digital, 2014). It is estimated that around a third of people with mental health needs access NHS mental health services (Department of Health & Social Care, 2023).
- National Institute for Health and Care Excellence (NCIE) standards and guidelines stress that early recognition and rapid access to biopsychosocial and effective care provides the best outcomes for people with mental illnesses (Public Health England, 2019).
- National evidence shows the commissioning and implementation of mental health services is more variable than for physical health conditions, in terms of funding, the length of period mental health problems often go untreated, and full, rather than partial, access to effective interventions(Public Health England, 2019).
- Mental health services across England are under increasing pressures, including increased demand, the wider impacts of the COVID-19 pandemic (Department of Health & Social Care, 2023) and staff recruitment and retention (Care Quality Commission, 2023).

Policy context

National policy

The Five Year Forward View for Mental Health (2016) set out recommendations for parity of esteem between physical and mental health across all age groups; tackling inequalities; and for cross-Governmental actions on the wider determinants of health, including housing and social inclusion. This strategy was built on in the NHS Long Term Plan and NHS Mental Health Implementation Plan 2019/20 – 2023/24, which set out new integrated models of community mental health care. The key ambitions for 2023/24 are summarised below:

Table 2: Summary of core Long Term Plan ambitions relating to the mental health of working-age adults. Adapted from: NHS Mental Health Implementation Plan (2019/20 – 2023/24)

Programme	NHS Long Term Plan ambition for 2023/24
Talking Therapies (previously IAPT)	• Access to Talking Therapies services will be expanded to cover a total of 1.9 million adults and older adults across England. • All areas will maintain the existing Talking Therapies referral to treatment time and recovery standards (50% recovery rate; 75% of people accessing treatment within 6 weeks; and 95% of people accessing treatment within 18 weeks.) • All areas will maintain the existing requirement to commission Long Term Conditions Talking Therapies services.
Severe mental illnesses community care	• New integrated community models for adults with severe mental illness (including care for people with eating disorders, mental health rehabilitation needs and a 'personality disorder' diagnosis) spanning both core community provision. • Dedicated services will ensure at least 370,000 adults and older adults per year have greater choice and control over their care, and are supported to live well in their communities. • A total of 390,000 people with severe mental illness will receive a physical health check. • A total of 55,000 people with severe mental illness a year will have access to Individual Placement and Support (IPS) services. • The 60% Early Intervention in Psychosis access standard will be maintained and 95% of services will achieve Level 3 NICE concordance.
Mental health crisis care and liaison	• There will be 100% coverage of 24/7 age-appropriate crisis care, via NHS 111, including: o 24/7 crisis resolution and home treatment functions for adults, operating in line with best practice by 2020/21 and maintaining coverage to 2023/24.

	○ 24/7 provision for children and young people that combines crisis assessment, brief response and intensive home treatment functions. ○ A range of complementary and alternative crisis services to A&E and admission (including in voluntary sector/local authority-provided services) within all local mental health crisis pathways. ○ Mental health professionals working in ambulance control rooms, Integrated Urgent Care services, and providing on-the-scene response in line with clinical quality indicators. • All general hospitals will have mental health liaison services, with 70% meeting the 'core 24' standard for adults and older adults.
Therapeutic acute mental health inpatient care	• The therapeutic offer from inpatient mental health services will be improved by increased investment in interventions and activities, resulting in better patient outcomes and experience in hospital. This will contribute to a reduction in length of stay for all services to the current national average of 32 days (or fewer) in adult acute inpatient mental health settings.

Alongside the Long Term Plan, the advancing mental health equalities strategy (2020) had three key focus areas: supporting local health systems to address inequalities in mental health, improving data flow and quality to better inform decision making, and working with partners to promote a representative workforce across all levels of the mental health system.

The Major Conditions Strategy will be released in 2024 and will include a focus on mental illness. This replaces the planned Mental Health and Wellbeing Plan. This national strategy will focus on integrated healthcare, and will have five main focus areas:

- Moving towards a personalised approach to prevention.
- Early diagnosis and treatment in the community.
- The effective management of multiple conditions.
- Closer integration and alignment between physical and mental health services.
- Person-centred services and support, which gives individuals greater choice about their care.

Community mental health framework

The Community Mental Health Framework for Adults and Older Adults sets out the Long Term Plan's vision to expand and transform community mental health services for adults and older adults with severe mental illnesses. This programme has been co-designed with service users and carers. It sets out that people with mental health conditions will be enabled as active participants rather than passive recipients of disjointed, inconsistent and episodic care. The overall goal of delivering good mental health support, care and treatment in the community is underpinned by the following six aims (NHS England, 2019):

1) 'Promote mental and physical health, and prevent ill health.
2) Treat mental health problems effectively through evidence-based psychological and/or pharmacological approaches that maximise benefits and minimise the likelihood of inflicting harm, and use a collaborative approach that: builds on strengths and supports choice; and is underpinned by a single care plan accessible to all involved in the person's care.
3) Improve quality of life, including supporting individuals to contribute to and participate in their communities as fully as possible, connect with meaningful activities, and create or fulfil hopes and aspirations in line with their individual wishes.
4) Maximise continuity of care and ensure no "cliff-edge" of lost care and support by moving away from a system based on referrals, arbitrary thresholds, unsupported transitions and discharge to little or no support. Instead, move towards a flexible system that proactively responds to ongoing care needs.
5) Work collaboratively across statutory and non-statutory commissioners and providers within a local health and care system to address health inequalities and social determinants of mental ill health.

6) Build a model of care based on inclusivity, particularly for people with coexisting needs, with the highest levels of complexity and who experience marginalisation'.

The Community Mental Health Framework replaces the Care Programme Approach (CPA) for community mental health services. It aims to move away from 'an inequitable, rigid and arbitrary CPA classification' and replace this with a universal standard of community mental healthcare (NHS England, n.d.).

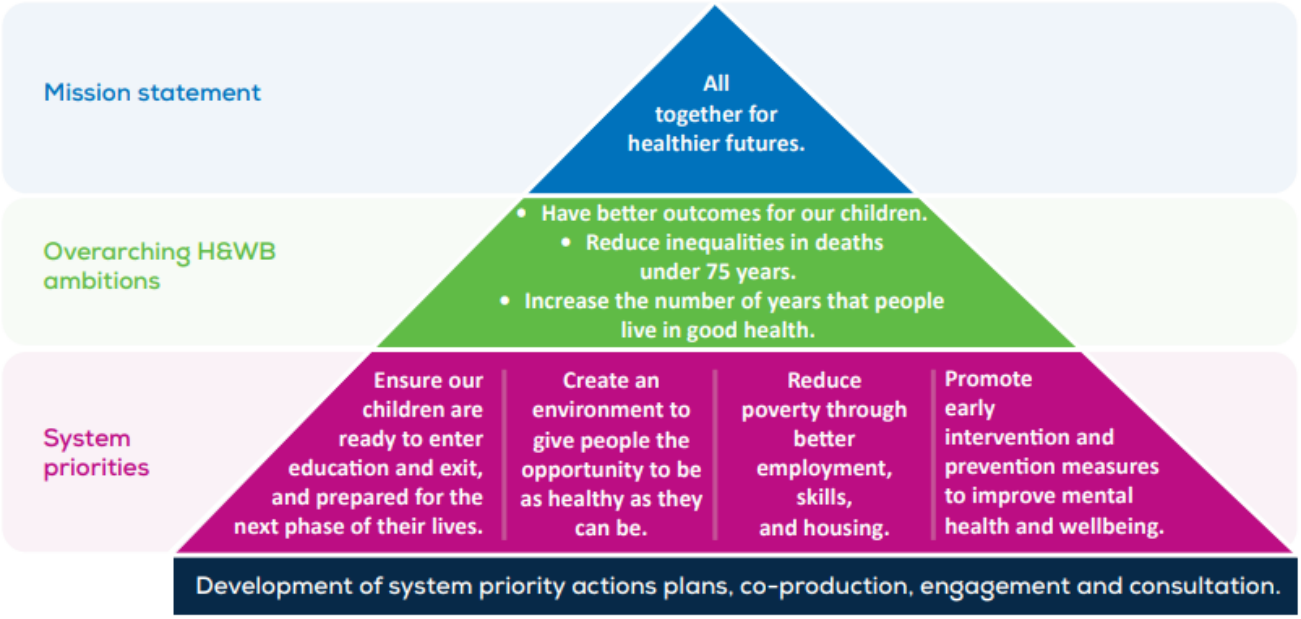
The COVID-19 Mental Health and Wellbeing Recovery Action Plan (2021) set out additional investment to speed up the roll out of the Community Mental Health Framework.

Local policy

The main local strategy relating to the mental health of working-age adults is the Joint Health and Wellbeing Strategy (2022 – 2030), which was created by Cambridgeshire County Council, Peterborough City County and the Cambridgeshire and Peterborough Integrated Care System. This strategy:

- Set out three overarching ambitions: increasing the number of years people spend in good health; reducing inequalities in preventable deaths before age 75; and achieving better outcomes for children.
- Named four system priorities, including 'promoting early intervention and prevention measures to improve mental health and wellbeing'.
- Set 'ensuring health checks for 60% of people living with severe mental illness' as a specific target to reduce health inequalities.

Figure 2: Ambitions of the Joint Health and Wellbeing Strategy. Image source: Joint Health and Wellbeing Integrated Care Strategy



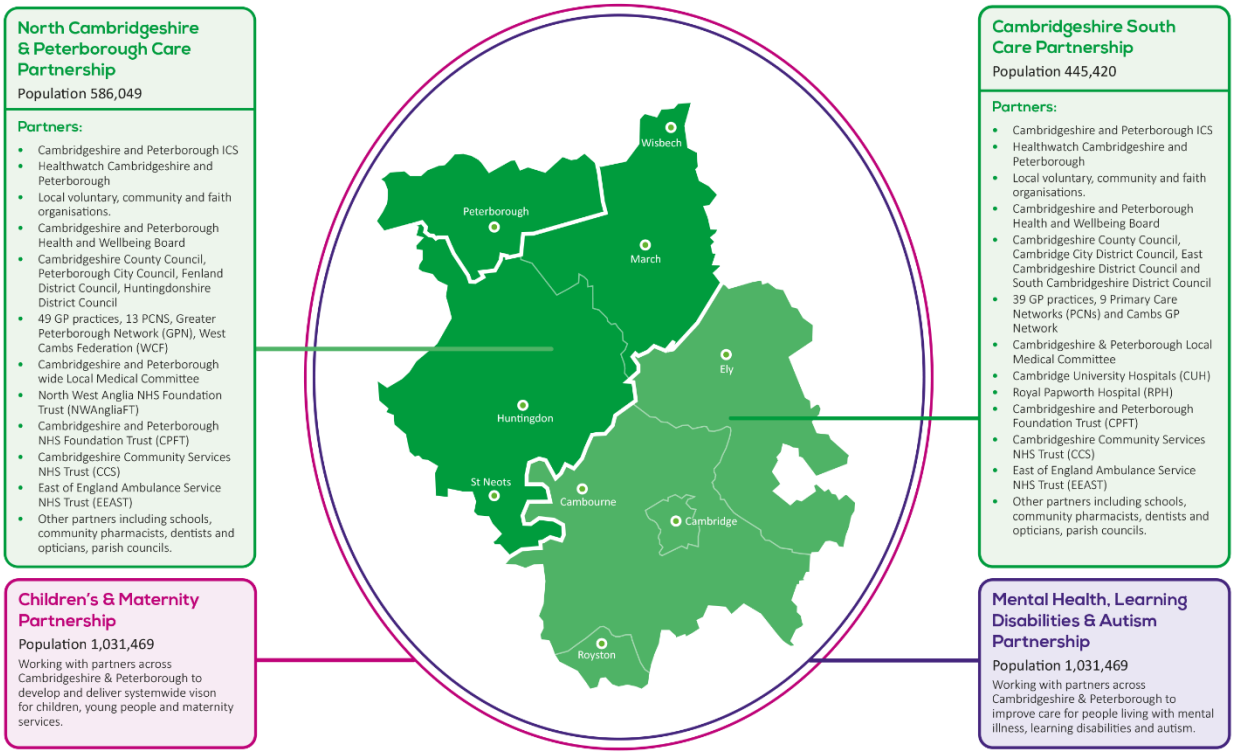
Other relevant strategies include the:

- The Crisis Care Concordat, published in 2014, recognises many of the issues related to the crossover of work by health, social care and emergency services.
- As part of the clinically-led review of NHS access standards, Cambridgeshire and Peterborough received additional funding in 2020/21 to test new models of integrated care and four-week waiting times for community-based mental health services
- All Age Carers Strategy (2018 – 2022)
- Joint Cambridgeshire and Peterborough Suicide Prevention Strategy 2022-2025
- CPFT Strategy (2023 – 2026)

North and South Care Partnerships and Integrated Neighbourhoods

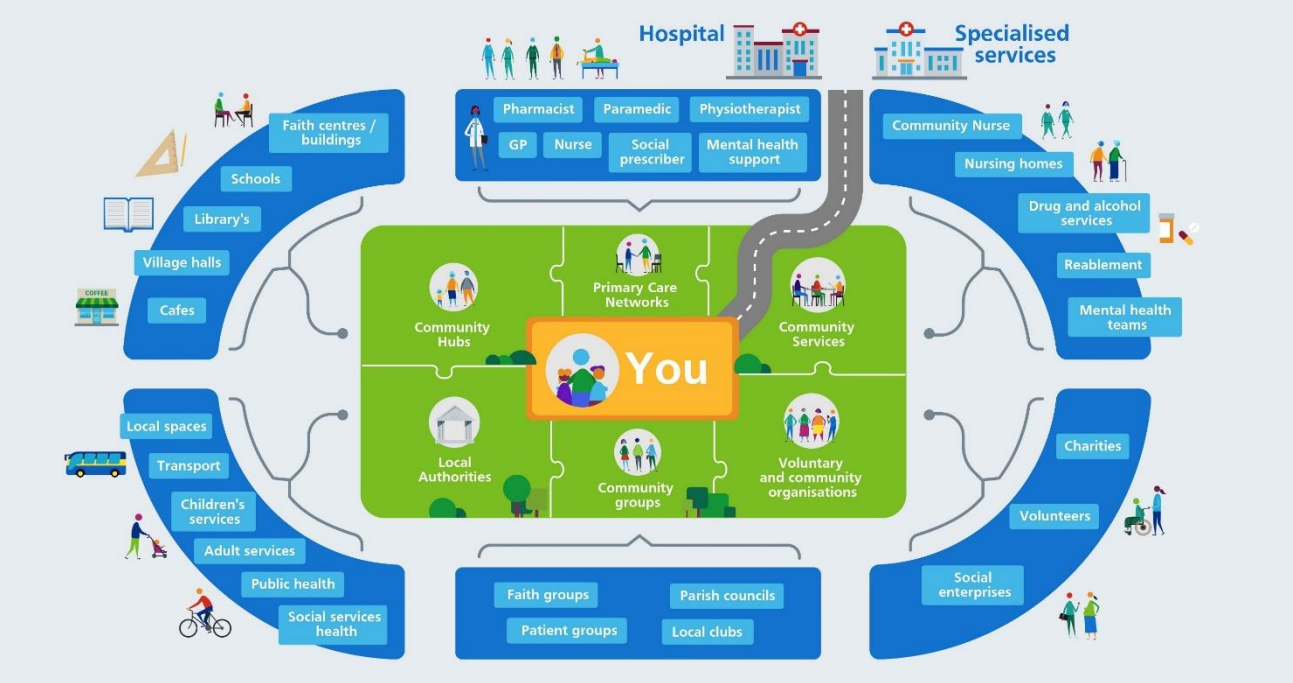
The Cambridgeshire and Peterborough Integrated Care System (ICS) works across the health system, local authorities, voluntary and community sector organisations and the wider community. Within this, there are two 'Place' partnerships, covering the North and South of our local areas. Each of these places covers a population of around 575,000 people.

Figure 3: Cambridgeshire and Peterborough Integrated Care System North and South Partnerships



Within the North and South Partnerships, most people's needs will be delivered through Integrated Neighbourhoods. These are communities of between 30,000 and 50,000 people based around Primary Care Networks (PCNs). The aim for Integrated Neighbourhoods is that 'local care provision should be proactive, in the right place, and make a difference for the local population, by addressing health inequalities and improving outcomes for our patients' (Cambridgeshire and Peterborough Integrated Care System, 2023).

Figure 4: Model of Integrated Neighbourhoods.



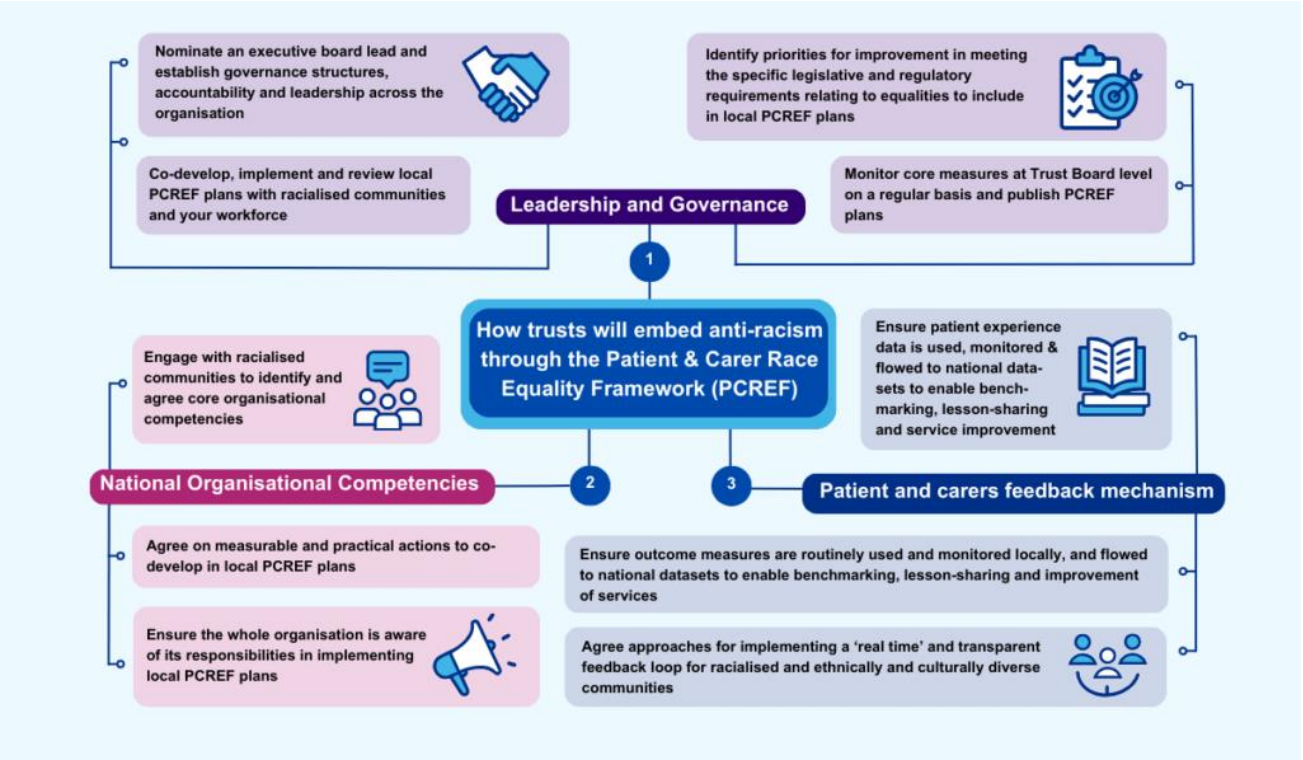
Patient and Carer Race Equality Framework

The Patient and Carer Race Equality Framework (PCREF) is one of the key recommendations of the Mental Health Act independent review (NHS England, 2023g). It is community-driven Organisational Competence Framework which should enable trusts to understand what practical steps they need to take to meet the needs of diverse ethnic backgrounds. PCREF is governed by NHS England and is mandatory for NHS trusts from 2023/24.

There are three strands to what PCREF will enable NHS trusts to do:

1) Leadership and Governance: ensure that all NHS Mental Health Trusts are fulfilling their statutory duties under core pieces of legislation, such as the Health and Social Care Act 2012 and the Equality Act 2010.
2) National Organisational Competencies: guidance on the competencies trusts should develop and ideas on how to do so, in line with local priorities.
3) The Patient and Carers Feedback Mechanism: ensure that the patient and carer voice is at the heart of the planning, implementation and learning cycle.

Figure 5: How NHS trusts will embed anti-racism through PCREF. Image source: NHS England



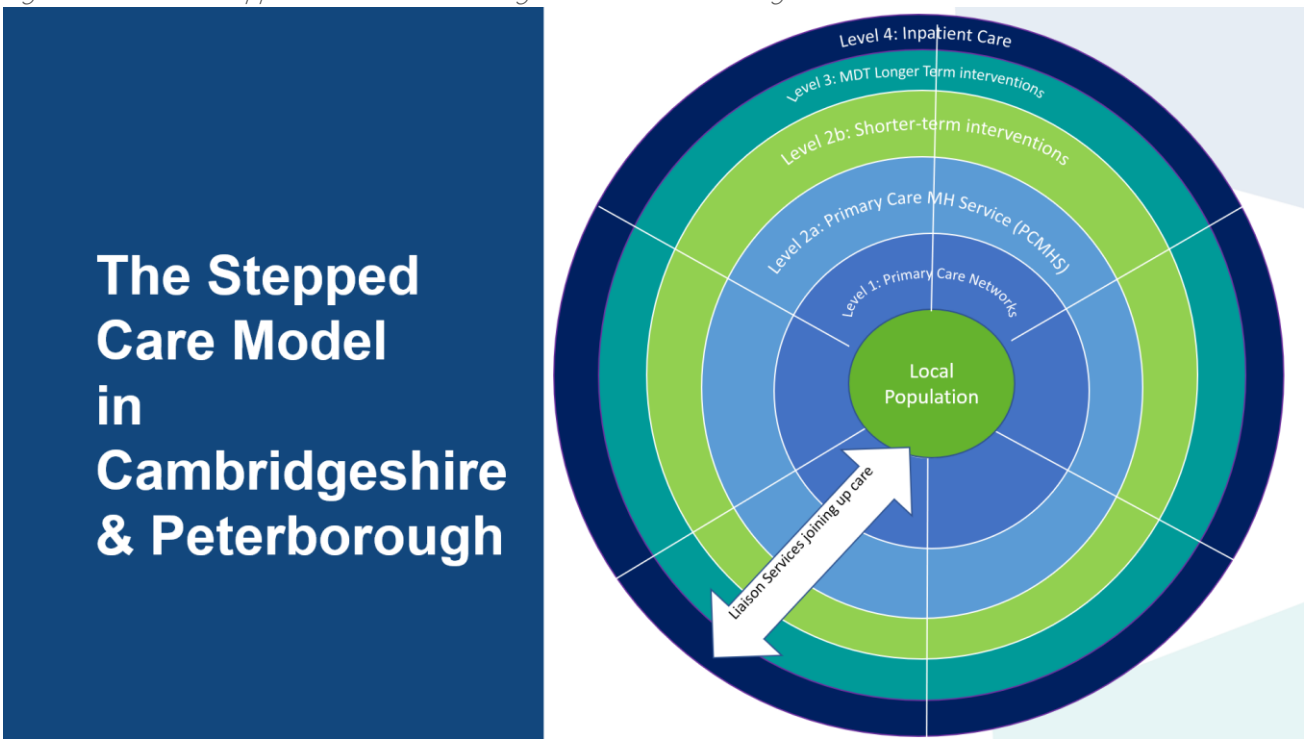
Work to implement PCREF is underway at Cambridgeshire and Peterborough NHS Foundation Trust (CPFT). Current activities include:

- Mapping out what work is already taking place within CPFT that aligns to PCREF guidance.
- Engaging with teams across CPFT about PCREF.
- Work towards a 'recommendations' paper for developing a local PCREF plan.
- Starting to review the quality of patient ethnicity data.

Stepped model of care

- The community mental health transformation project of 2019 – 2022 led to a shift from mental health care being provided either within primary care or secondary care, to a stepped model of care.
- With the person firmly at the centre of the model, stepped care is then wrapped around them in increasing levels of intensity and joined together by senior liaison practitioners working across different levels of care, where the most effective yet least resource intensive form of support is provided initially (Public Health England, 2019).
- In Cambridgeshire and Peterborough, this is a place-based stepped care model:
    - Community mental health services are wrapped around Primary Care Networks (PCNs) and Integrated Neighbourhoods, so individuals are initially supported by their GP in combination with community-based support, and then in collaboration with the Primary Care Mental Health Service (PCMHS) where further assessment is deemed necessary by their GP.
    - Newly formed Neighbourhood Mental Health Hubs bring together practitioners across the system to connect secondary care clinical expertise to the wealth of community assets. Roles such as social prescribing link workers combine these offers.

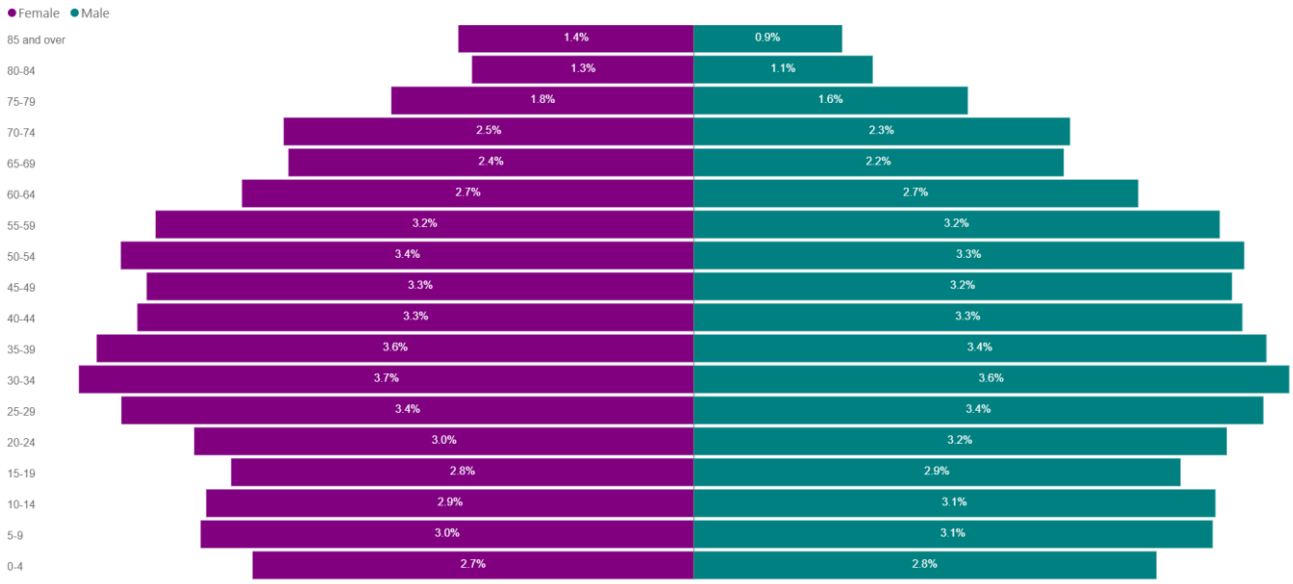
Figure 6: Model of stepped care for in Cambridgeshire and Peterborough.



Population demographics

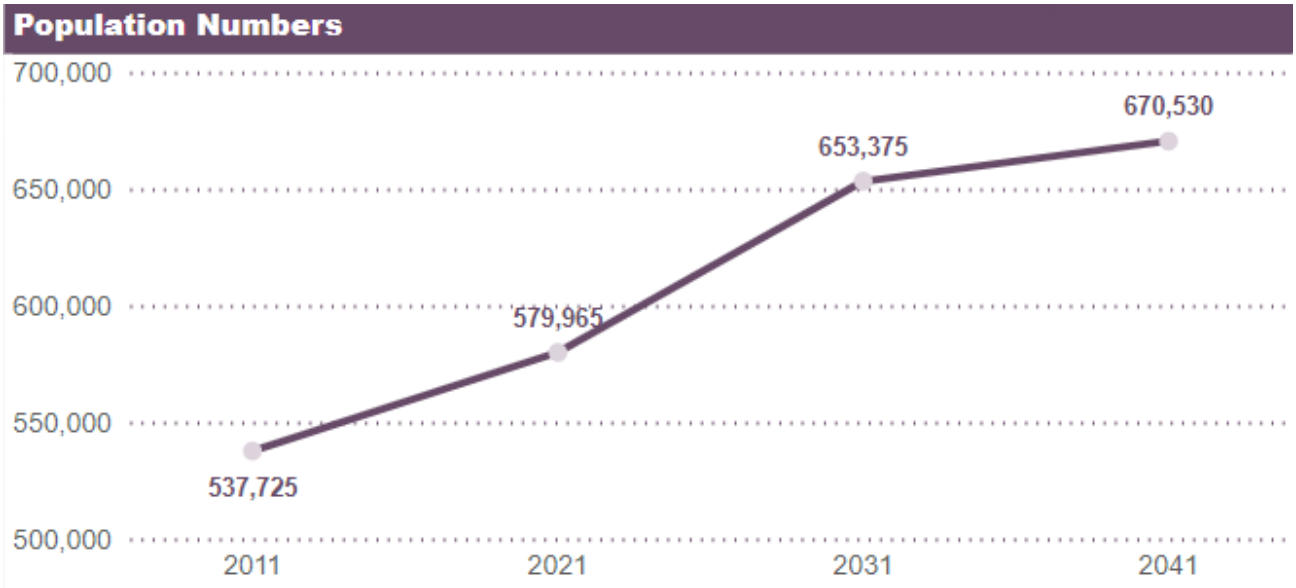
- According to the 2021 Census, Cambridgeshire and Peterborough makes up 1.5% of the total population of England.
- There were 579,963 working-age adults in Cambridgeshire and Peterborough in 2021, 64.8% of the total population. Cambridge has a higher proportion of working-age adults (75.1%), compared to other districts in Cambridgeshire (below 62%).
- There was a 7.9% increase in the number of working-age adults in Cambridgeshire and Peterborough from 2011 to 2021. The greatest increases were in Cambridge (18.3%) and Peterborough (14.4%)
- A detailed breakdown of age profiles by district is included in the JSNA 2023.

Figure 7: Percentage population pyramid for Cambridgeshire and Peterborough, Census 2021. Image source: JSNA 2023



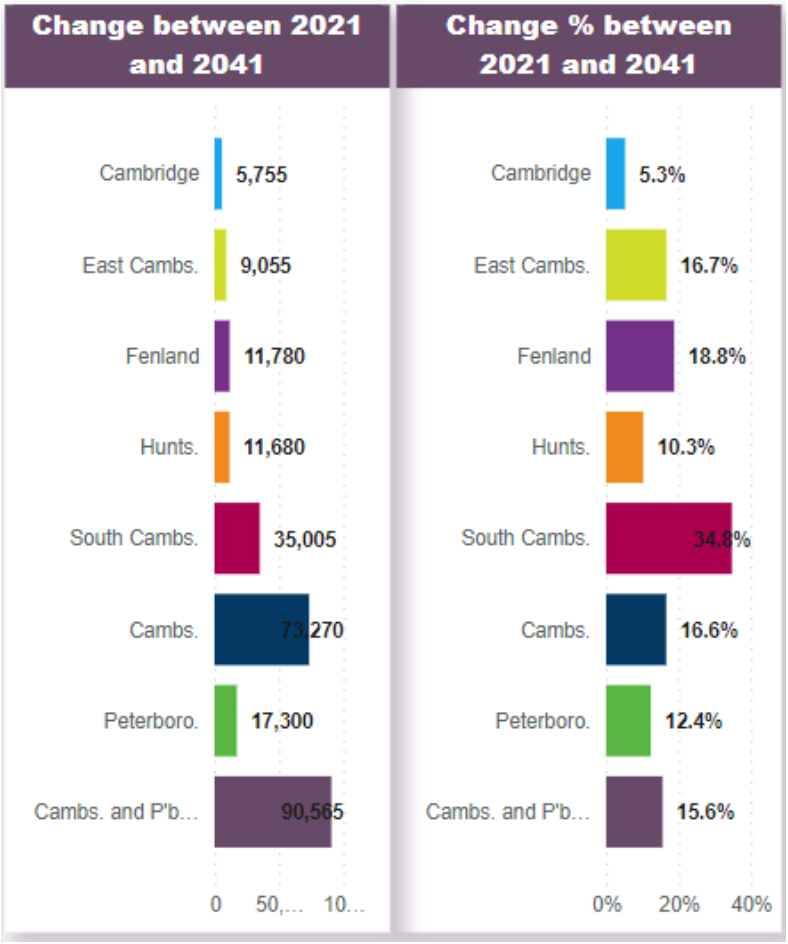
It is estimated that there will be a 15.6% increase in the number of working-age adults in Cambridgeshire and Peterborough from 2021 to 2041.

Figure 8: Forecast change in population aged 15 – 64 years, Cambridgeshire and Peterborough, 2021 – 2041. Image source: JSNA 2023



It is estimated that South Cambridgeshire will experience the greatest percentage increase in working-age adults.

Figure 9: Forecast change in population aged 15 – 64 years, Cambridgeshire and Peterborough districts, 2021 – 2041. Image source: JSNA 2023



It is also important to consider local population demographics to better understand mental health need. Due to factors such as varying levels of poverty across districts, actual mental health need may differ from estimates made from national data.

- Chapter one of the mental health needs assessment covers environmental factors which are important to mental health.
- Wellbeing Acorn is a tool used to understand health and wellbeing. It provides geodemographic segmentation of Cambridgeshire and Peterborough, segmenting the population into 4 groups (Health Challenges; At Risk; Caution; Healthy) and 25 types, which describe health and wellbeing attributes.
- In Cambridge City, there is a significant transitory population associated with the universities that can impact services.

Additional Resources

- Mental Health Policy in England
- The Community Mental Health Framework for Adults and Older Adults
- Progress in improving mental health services in England
- The Health and Social Care Committee's Expert Panel: Evaluation of the Government's progress against its policy commitments in the area of mental health services in England
- For further information about PCREF: NHS England » Advancing mental health equalities and Patient and carer race equality framework: making decisions with communities, not for them
- JSNA 2023

Mental health need

- Mental illness is the largest cause of disability amongst working-age adults in England (Kirk-Wade, 2022)
- In any given week, one in six adults (17%) experiences depression and/or an anxiety, a greater proportion than in the 1990s (NHS Digital, 2014). Using this figure, we estimate that there are around 123,500 working-age adults in Cambridgeshire and Peterborough with a common mental health condition.
- In 2022/23, 95,137 adults (12% of those registered at general practices) in Cambridgeshire and Peterborough were recorded as having depression and 8,695 adults (0.8%) were on the severe mental illness register (NHS Digital, 2023c).

Definitions

Common mental health conditions are defined as depression and anxiety disorders, including generalised anxiety disorder (GAD), phobias, social anxiety, obsessive-compulsive disorder (OCD) and post-traumatic stress disorder (PTSD) (NICE, 2011). They are 'common' as they impact around one in six adults (over 16s) in any given week (NHS Digital, 2014).

- Common mental health problems cause distress and interfere with everyday life. The large numbers of people experiencing these conditions at any one time mean that they have a significant cost to society (Public Health England, 2019).

Severe mental illnesses are long-term health conditions that have a substantial impact on multiple aspects of people's lives (Swinson et al., 2016). This term is commonly used to describe diagnoses of bipolar disorder and psychotic disorders, but can also include conditions such as anxiety, depression, and eating disorders when the impact is severe (Swinson et al., 2016).

- *Note that in NHS guidance around physical health checks, severe mental illness (SMI) is defined as a recorded diagnosis of bipolar affective disorder, schizophrenia or any long-term psychotic illness* (NHS England, 2018). *This definition is because of the cardiometabolic risks associated with antipsychotics,*

rather than implying that other mental health conditions are not 'serious' or 'severe', or do not have physical health risks (NHS England, 2018).

Many of these conditions have specific National Institute for Health and Care Excellence (NICE) guidelines covering their treatment and management. There are also NICE guidelines on the transition between inpatient mental health settings and community or care home settings.

Table 3: Definitions of mental health conditions. Adapted from: NHS Mental Health Conditions

Condition	Definition	NICE Guidelines
Agoraphobia	Characterised by fear or avoidance of specific situations or activities that the person fears will trigger panic-like symptoms, or be difficult or embarrassing to escape from, or where help may not be available. Specific feared situations can include leaving the house, being in crowded places, or using public transport.	Generalised anxiety disorder and panic disorder in adults: management
Bipolar disorder	Bipolar disorder (bipolar affective disorder) is a mental health condition that impacts people's mood, which can swing from extreme highs (mania or hypomania) to extreme lows (depressive episodes).	Bipolar disorder: assessment and management
Depression	A mental health condition characterised by persistent low mood and a loss of interest and enjoyment in day-to-day activities. A range of emotional, physical and behavioural symptoms are likely, such as disrupted sleep, change in appetite, loss of energy, low feelings of self-worth and suicidal thoughts. Persistent depressive disorder (also called dysthymia or chronic depression) is continuous depression that lasts for 2 or more years.	Depression in adults: treatment and management
Eating disorders	Eating disorders are mental health conditions where the control of food is used to cope with feelings and other situations. The most common types of eating disorder are anorexia nervosa, bulimia nervosa, binge eating disorder and 'other specified feeding and eating disorder' (OSFED), which is used to describe symptoms which do not fit into the criteria for specific eating disorders.	Eating disorders: recognition and treatment
Generalised anxiety disorder (GAD)	An anxiety disorder characterised by excessive worry about many different things and difficulty controlling that worry. This is often accompanied by restlessness, difficulties with concentration, irritability, muscular tension and disturbed sleep.	Generalised anxiety disorder and panic disorder in adults: management
Health anxiety	A central feature is a persistent preoccupation with the possibility that the person has, or will have, a serious physical health problem. Normal or commonplace physical symptoms are often interpreted as abnormal and distressing, or as indicators of serious illness.	
Hoarding disorder	Hoarding disorder is defined as 'persistent difficulty discarding or parting with possessions, regardless of their actual value', which leads to an accumulation of possessions that compromises the use or safety of living spaces (American Psychiatric Association, 2022)	
Obsessive-compulsive disorder (OCD)	An anxiety condition characterised by the presence of obsessions (repetitive, intrusive and unwanted thoughts, images or urges) and/or compulsions (repetitive behaviours or mental acts that a person feels driven to perform).	Obsessive-compulsive disorder and body dysmorphic disorder: treatment
Panic disorder	People with panic disorder experience repeated and unexpected attacks of intense anxiety. There is a marked fear of future attacks which can result in avoidance of situations that may provoke a panic attack. Symptoms include overwhelming feelings of fear and apprehension, which are often accompanied by physical symptoms.	Generalised anxiety disorder and panic disorder in adults: management

Personality disorders	'Personality disorders' are a term used to describe mental health conditions that impact how people think, perceive, and relate to others. This term is controversial, with many people being given this diagnosis preferring not to use it as it can add to the challenges they experience ("Shining Lights in Dark Corners of People's Lives" The Consensus Statement for People with Complex Mental Health Difficulties Who Are Diagnosed with a Personality Disorder, 2018). The latest version of the International Classification of Diseases (ICD-11) defines personality disorder as a single condition, instead of separate types of disorder. NICE is currently exploring whether existing recommendations can be amended in line with this or whether these guidelines should be withdrawn.	Borderline personality disorder: recognition and management and Antisocial personality disorder: prevention and management
Post-traumatic stress disorder (PTSD)	A set of psychological and physical problems that can develop in response to threatening or distressing events, such as physical, sexual or emotional abuse, severe accidents, disasters and military experiences. Typical features of PTSD include repeated and intrusive distressing memories that can cause a feeling of 'reliving or re-experiencing' the trauma and hypervigilance (being 'on edge' much of the time).	Post-traumatic stress disorder
Premenstrual dysphoric disorder (PMDD)	Premenstrual dysphoric disorder (PMDD) is a very severe form of premenstrual syndrome (PMS). It causes a range of emotional and physical symptoms every month during the week or two before someone has their menstrual period.	
Psychosis	Psychosis is when people lose some contact with reality. This may involve hallucinations or delusions (firmly held false beliefs).	Psychosis and schizophrenia in adults: prevention and management
Schizoaffective disorder	Schizoaffective disorder is a mental health condition where people experience psychosis as well as symptoms of mood disorders (such as manic symptoms or depressive symptoms) (Mind, 2023).	
Schizophrenia	Schizophrenia is a type of psychosis. The symptoms of this long-term mental health condition are usually classified into 'positive' symptoms (changes in behaviour or thoughts, such as hallucinations and delusions) and 'negative' symptoms (where people withdraw from the world around them).	Psychosis and schizophrenia in adults: prevention and management
Social anxiety disorder (social phobia)	A persistent and overwhelming fear of a social situation, such as speaking on the phone, which impacts a person's ability to function effectively in aspects of their daily life. People with social anxiety will fear doing or saying something that will lead to being judged by others and being embarrassed or humiliated. Feared situations are avoided or endured with intense distress	Social anxiety disorder: recognition, assessment and treatment

Estimated prevalence

- It is estimated that around 123,500 people experienced a common mental health condition within the past week in Cambridgeshire and Peterborough.
- Chapter two of this mental health needs assessment covers population groups at higher risk of poor mental health.
- The estimated prevalence of adverse childhood experiences is covered in chapter four of the mental health needs assessment.

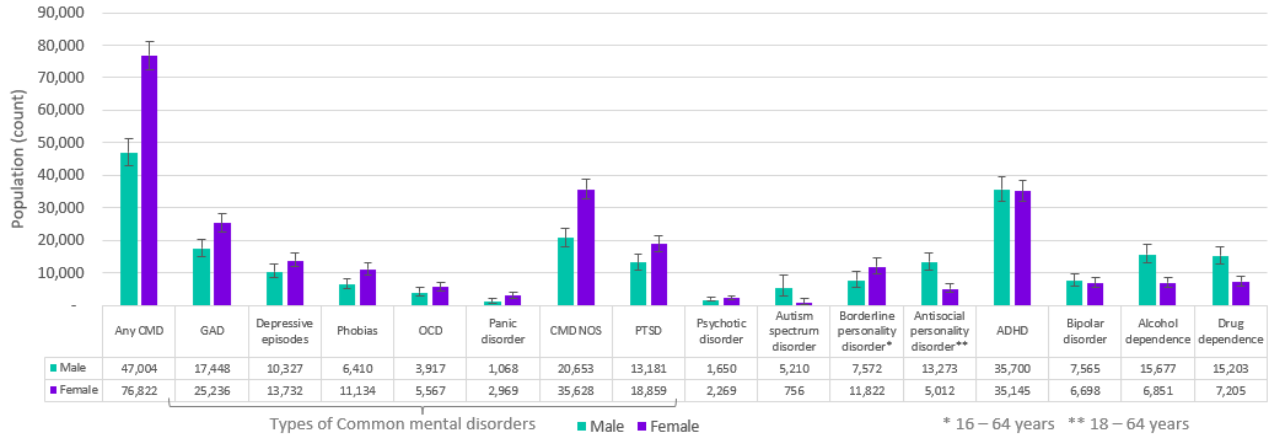
Common mental health conditions

- The estimated prevalence of mental illness in Cambridgeshire and Peterborough were calculated using the Adult Psychiatric Morbidity Survey (APMS). This survey provides data on the prevalence of both treated

and untreated psychiatric disorders in the English adult population (aged 16) using actual diagnostic criteria for a range of conditions.

- The national prevalence data from the APMS carried out in 2014 has been applied to the Census 2021 population for Cambridgeshire, Peterborough and the five districts to calculate the local estimated population size with different mental illnesses by age and sex. The actual prevalence will be affected by random variation and also by local variations in risk factors such as deprivation.
- It is estimated that around 123,500 people experienced a common mental health condition within the past week in Cambridgeshire and Peterborough. About 43,000 are estimated to have experiences some form of anxiety disorder and 24,000 to have experienced depression.

Figure 10: Estimated number of people with common mental health conditions, substance dependence, ADHD and autism in the Cambridgeshire and Peterborough (aged 16+). Data sources: Adult Psychiatric Morbidity Survey (2014), Census 2021



Estimates have also been calculated by district, which show that Peterborough and Huntingdonshire have the highest estimated numbers of adults (aged 16+) with common mental health conditions. These estimates are based on national surveys so do not adjust for local factors such as differences in deprivation between areas.

Table 4: Estimated prevalence of any common mental health condition in Cambridgeshire and Peterborough districts, by age group. Data sources: APMS and Census 2021

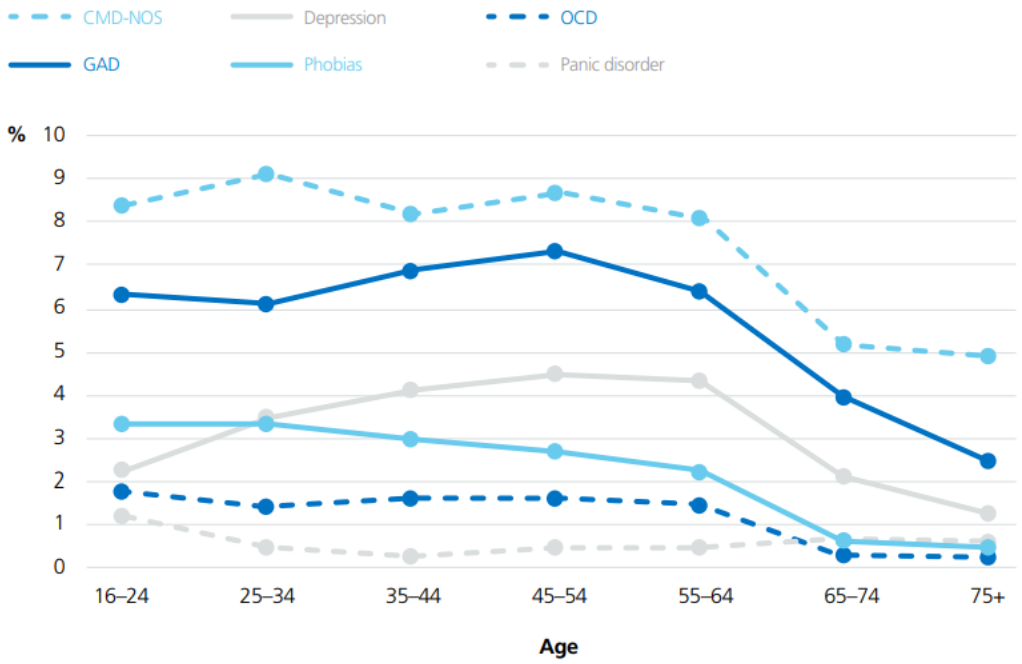
	Age group (prevalence)							
Area Name	16-24 (18.9%)	25-34 (19.0%)	35-44 (19.3%)	45-54 (19.1%)	55-64 (18.0%)	65-74 (11.5%)	75+ (8.8%)	16+ (17.0%)
Cambridge	5,788	5,666	3,792	3,018	2,206	1,000	697	21,211
East Cambridgeshire	1,341	1,932	2,265	2,427	2,071	1,115	750	12,144
Fenland	1,710	2,414	2,297	2,606	2,544	1,435	961	14,422
Huntingdonshire	2,918	4,339	4,567	4,855	4,386	2,279	1,472	25,204
South Cambridgeshire	2,459	3,501	4,423	4,532	3,684	1,907	1,339	22,160
Cambridgeshire	14,216	17,852	17,345	17,439	14,889	7,737	5,218	95,140
Peterborough	4,066	6,198	6,280	5,262	4,096	1,925	1,219	28,487
Total	18,282	24,051	23,625	22,701	18,985	9,662	6,437	123,626

It is important to consider that many people meet criteria for more than one mental health condition (NHS Digital, 2014), and may have other co-occurring needs. For example, people who experience psychosis are more likely than the general population to have a have a history of trauma, poor physical health and social issues (National Institute for Health and Care Excellence et al., 2016). Around 40% of people with first-episode psychosis will misuse substances at some point in their lifetime (National Institute for Health and Care Excellence et al., 2016).

Prevalence by age

The Adult Psychiatric Morbidity Survey (2014) showed that working-age adults (aged 16 to 64) were around twice as likely to have symptoms of common mental health conditions that adults over 65. Anxiety disorders were more common in young women aged 16 to 24, compared to other groups.

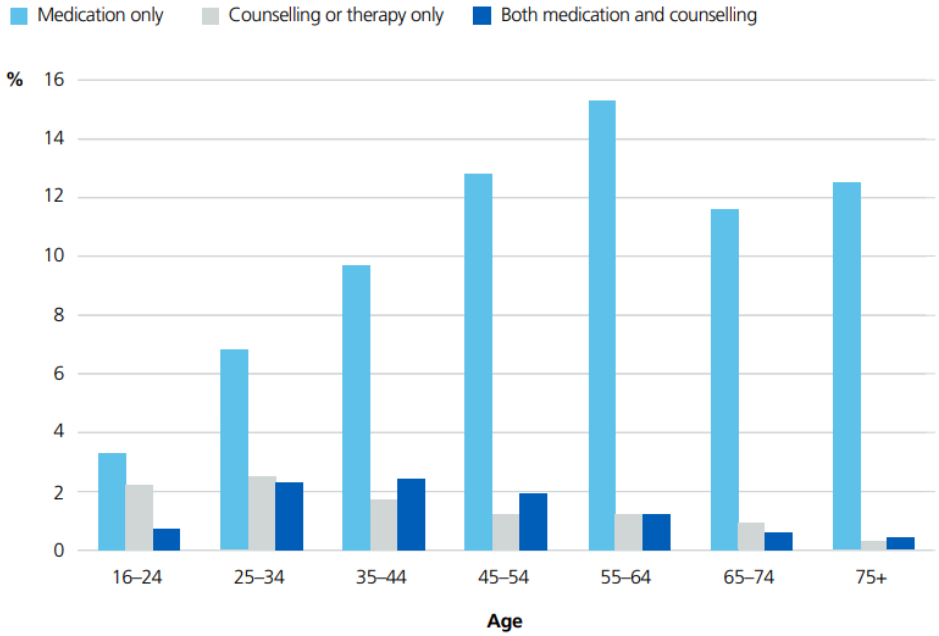
Figure 11: Prevalence of common mental disorders (CMDs), by age. Image source: [Adult Psychiatric Morbidity Survey 2014]



Note: CMD-NOS is 'common mental disorder – not otherwise specified', indicating where people had a CIS-R (clinical interview) score of 12+ but did not meet criteria for any specific condition. OCD is obsessive-compulsive disorder, and GAD is generalised anxiety disorder.

The Adult Psychiatric Morbidity Survey also showed that adults aged between 35 and 54 were most likely to receive treatment for a mental health condition, after controlling for the severity of symptoms; whilst young adults (aged 16 to 25) and adults aged 75 or over were the least likely to receive treatment. Young adults (16 – 24) were the least likely to use psychotropic medication. Adults aged 75 or over were 10 times more likely to receive medication than psychological therapy, despite being at greater risk of medication side effects.

Figure 12: Proportion of adults receiving treatment for a mental health condition, by age. Image source: [Adult Psychiatric Morbidity Survey 2014]



Who is most likely to experience common mental health conditions?

- The prevalence of common mental health problems is influenced by the wider determinants of health. For example, people living in poverty are more likely they are to have some form of mental health problem. Poor mental health can also lead to reduced income and employment, which entrenches poverty and increases the risk of mental health problems (Public Health England, 2019).
- Data from the national Adult Psychiatric Morbidity Survey (2014) found that Black women, adults under the age of 60 who lived alone, women living in large households, adults who smoke and adults in receipt of benefits were most likely to have common mental health conditions (NHS Digital, 2014).
- Chapter two of this mental health needs assessment covers population groups at higher risk of poor mental health.

Psychosis

PsyMaptic is a population-level prediction model that predicts the number of people experiencing first-episode psychosis; and those referred, assessed and treated by Early Intervention in Psychosis (EIP) services, based on epidemiological evidence and demographic predictions (McDonald et al., 2021). The local EIP service is CAMEO.

Using this tool, we can estimate that there were 371 people (95% confidence interval: 343 – 401) who would meet the threshold to be referred to CAMEO in 2023 for suspected psychosis, and 137 people (95% confidence interval: 127 – 148) who we would expect to meet the full ICD-10 criteria for a first-episode of a psychotic disorder in 2023.

Table 5: Estimated and number of people experiencing first-episode psychosis; and those referred, assessed and treated by Early Intervention in Psychosis services in Cambridgeshire and Peterborough, 2023. Data source: [PsyMaptic]

	Estimates (95% CI)
Referred	371 (343, 401)
Assessed	333 (308, 361)
Treated	159 (147, 172)
Probable cases	137 (127, 148)

COVID-19 pandemic and the cost of living crisis

The impact that the COVID-19 pandemic will have on mental health is not fully understood. Considerations should be made for direct impacts on arising from COVID-19 infection, alongside indirect effects arising from lockdown and social isolation, disruptions to normal patterns and routines, and economic pressures (Davidson, 2021).

- The Centre for Mental Health estimates that 8.5 million additional adults in England will require mental health support from 2021 to 2026, as a direct result of the COVID-19 pandemic (O'Shea, 2021).
- National surveys show that there were increases in poor mental health over the pandemic, particularly during periods of national lockdowns and high rates of COVID-19 cases, including anxiety, depressive symptoms and stress (Office for Health Improvement and Disparities, 2022a). Groups most at risk of poor mental health during the early stages of the pandemic included 'young adults, women, those with pre-existing mental health conditions, those from minority ethnic communities, and people experiencing socio-economic disadvantage' (Bunn & Dias, 2021).
- Data suggests that although adults with pre-existing mental health conditions reported poorer mental health and wellbeing in the earlier stages of the pandemic than those without, this gap did not widen over this time (Office for Health Improvement and Disparities, 2021).
- There is some evidence suggesting that rural communities may have faced specific pressures on mental health as a result of the COVID-19 pandemic, alongside other impacts such as from Brexit (Environment Food and Rural Affairs Committee, 2023).

Evidence shows that the cost of living crisis may be impacting the nation's mental health:

- 1 in 6 adults experienced moderate to severe depressive symptoms in autumn 2022, similar to rates in summer 2021 but higher than pre-pandemic levels (Office for National Statistics, 2022).
- Although there is not enough evidence to provide levels of depressive symptoms were higher due to the rising cost of living, rates of people with depressive symptoms were almost 3 times higher amongst people who reported finding it 'difficult' to pay their energy bills, compared to those who found it 'easy' (Office for National Statistics, 2022).

Understanding prevalence data

There are different ways of diagnosing and measuring mental illnesses, although many are underreported (Edwards et al., 2016). This can make it difficult to estimate the prevalence of mental health conditions. The table below highlights the strengths and limitations of different data sources which can be used to estimate mental health prevalence:

Table 6: Strengths and limitations data sources used to estimate the prevalence of mental health and neurodiverse conditions

Source	Covers	How collected	Limitations

Adult Psychiatric Morbidity Survey (APMS)	• Common mental disorders • Bipolar disorder • Psychotic disorders • Personality disorders • Suicidal thoughts, suicide attempts and self-harm • Comorbidity in mental and physical illness • Drug and alcohol dependence • ADHD • Autism	People aged 16 or above living in England are selected at random by their home address. The survey is carried out once every 7 years, with the data from the next survey being due to be released in 2024. A full profile of this data source can be found here.	Methodology undercounts the most serious mental health problems where people are currently homeless, resident in an institution or less likely to take part in the survey due to their mental health.
Global Burden of Disease	• Anxiety • Depression • Dysthymia • Bipolar • Schizophrenia • Anorexia and bulimia • Autism • ADHD • Conduct Disorder	Estimates are based on systematic reviews and meta-analyses, including of survey data. Bias in the studies is accounted for. Data includes DALYs (disability-adjusted life years).	Some estimates are based on limited or poor-quality data sources ("Global, Regional, and National Burden of 12 Mental Disorders in 204 Countries and Territories, 1990–2019: A Systematic Analysis for the Global Burden of Disease Study 2019," 2022).
GP Patient Survey	• Self-reported long-term mental health conditions	GP patients are asked if they have any long-term mental health condition, as part of NHS England's annual GP patient survey. Results are weighted.	Data is self-reported.
Projecting Adult Needs and Service Information System (PANSI)	• Depression • Personality disorders • Psychotic disorders • Suicide • Alcohol use • Autism	Population projections up to 2035, using ONS data	Based on the Adult Psychiatric Morbidity Survey (APMS), see above.
Quality and Outcomes Framework (QOF)	• Depression prevalence and incidence • SMI register	Extracted from general practice data. Can be broken down nationally and regionally, as well as by integrated care system and individual general practice.	Underestimates true prevalence because this only includes people diagnosed by their GP.

Understanding depression prevalence

The Adult Psychiatric Morbidity Survey (APMS) estimated that the prevalence of depression in England was between 2 to 6% in 2014 (NHS Digital, 2014). Other UK studies have estimated the prevalence as between 5 to 15% (Ayuso-Mateos et al., 2001). These estimates may vary due to differences in the populations sampled and the changes in prevalence over time, as well as differences in depression severity. To illustrate the complexities of estimating how many people are likely to have a mental illness within our local population, depression is used as an example below:

Defining depression

Studies may assess depression levels by looking at how often depression is recorded within health records, or by surveying the population group (using screening tools and/or diagnostic interviews).

- Recorded depression diagnoses are the easiest and cheapest information to collect, but this may miss people who have limited access to healthcare or those who are unlikely to seek out mental health support.
- Screening tools are brief measures that identify depression based on symptoms. They typically use a cutoff score to indicate depression. Although this allows for relatively quick and low-cost data collection, it has been argued that some tools may overestimate prevalence (Levis et al., 2019, 2020).
- Diagnostic interviews carried out by trained professionals are higher cost option which takes longer, but are considered the 'gold standard' for identifying mental health conditions.

Within estimates the prevalence, there can be variations relating to:

- Severity: different research may use different thresholds for defining depression. In some cases, it may be relevant to understand the prevalence of 'subthreshold' or subclinical depression, when people experience less severe symptoms. This has a greater impact on some health services than major depression, due to being more common in the population (Zhang et al., 2023).
- Co-morbidity: a high proportion of people with depression have co-occurring conditions (particularly anxiety) ("Global, Regional, and National Burden of 12 Mental Disorders in 204 Countries and Territories, 1990–2019: A Systematic Analysis for the Global Burden of Disease Study 2019," 2022), which is not captured in all research.
- Timings: for example, the Adult Psychiatric Morbidity Survey (APMS) measures the proportion of adults experiencing a common mental health condition 'within the last week' (NHS Digital, 2014). This may be less useful for commissioners who are estimating the number of people likely to access services over a year.

Sample

- For the research to be generalisable to the relevant population (e.g. adults in Cambridgeshire), it should be representative. This may be achieved by weighted sampling.
- Samples should ideally be random and free of bias. For example, people who decide to take part in surveys around mental health (self-selected respondents) may be more likely to experience poor mental health. Equally, people with severe health conditions may be less able to partake in these surveys.
- Large samples may be required for subgroup analysis (understanding differences between groups and inequalities).

Additional Resources

- Time for united action on depression: a Lancet–World Psychiatric Association Commission
- Depression and Other Common Mental Disorders: Global Health Estimates
- Covid-19 and the nation's mental health, Mental health impacts of the COVID-19 pandemic on adults and COVID-19 mental health and wellbeing surveillance: report
- Mental Health and the Cost-of-living Crisis: Another pandemic in the making?
- A significant proportion of mental health conditions begin in childhood (50% by age 14) and the majority by young adulthood (75% by age 25). There are close links to the chapter on children and young people's mental health, which includes a focus on the transition between children and young people's services.
- Whilst there will also be a chapter on this needs assessment focusing on the mental health needs of older adults, it is important to consider the all-age adult aspects for this population.

Recorded prevalence

It can be interesting to compare estimated levels of mental health need (i.e. how many people we expect to experience different mental health conditions) to the number of people presenting to services. This may help to identify unmet needs within our population.

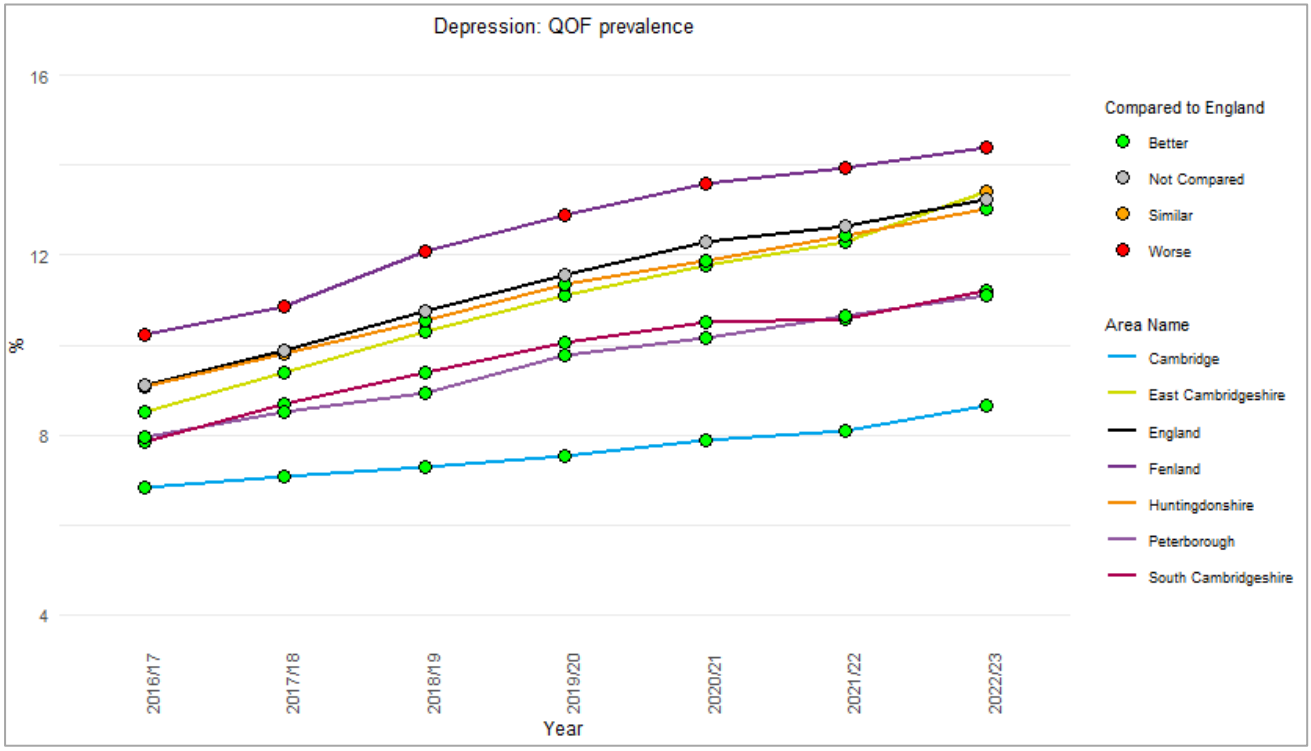
Depression

- In 2022/23, 95,137 adults aged 18+ (11.5% of those registered at general practices) in Cambridgeshire and Peterborough were recorded as having depression.
- Recorded depression prevalence has been significantly higher than the national average in Fenland since 2016/17.

Prevalence

- 95,137 (11.5%) of adults registered at general practices in Cambridgeshire and Peterborough were recorded as having depression (aged 18+) in 2022/23, compared to the national average of 13.3%.
- Depression prevalence has increased across all districts since 2016/17, following the national trend.
- Recorded depression prevalence is significantly higher than the national average in Fenland since 2016/17; but is currently below the national average in Cambridge, Huntingdonshire, Peterborough and South Cambridgeshire.

Figure 5: Depression prevalence in adults as recorded by primary care, Cambridgeshire and Peterborough, 2016/17 – 2022/23. Data source: NHS Digital



Treatment-resistant depression

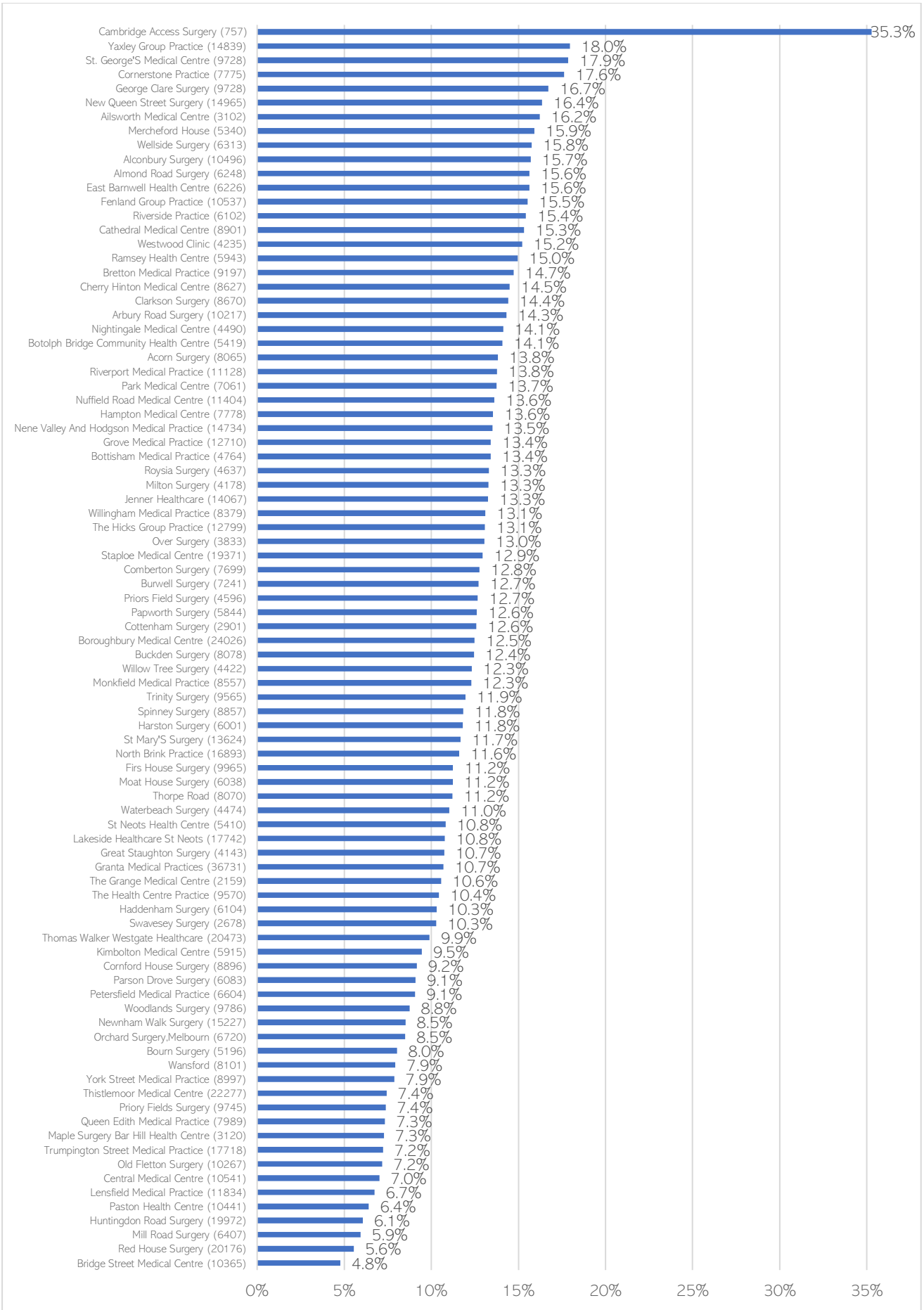
- The i-VALiD study (Informing VALues-based practice in persistent Depression), based in Cambridgeshire and Peterborough, is collecting evidence to improve mental health services for treatment-resistant depression (ARC East of England, 2023).
- People with treatment-resistant depression (depression which has not responded to two or more antidepressants at an adequate dose and duration) should be referred to a specialist service delivered by a specialist multi-professional team (Cummergen et al., 2022).
- This project has taken a values-based approach, drawing together evidence, the priorities of patients and carers, and clinical expertise (ARC East of England, 2023).
- It has resulted to two publications so far: a literature review exploring what outcomes matter to people reviewing treatment for treatment-resistant depression (Cummergen et al., 2022); the other reviewing the strength of economic evidence for different therapies (Hannah et al., 2023). Another piece of work

will use focus groups to investigate what patients and clinicians would like to see change about the treatment pathway (ARC East of England, 2023).

How does depression prevalence vary across general practices?

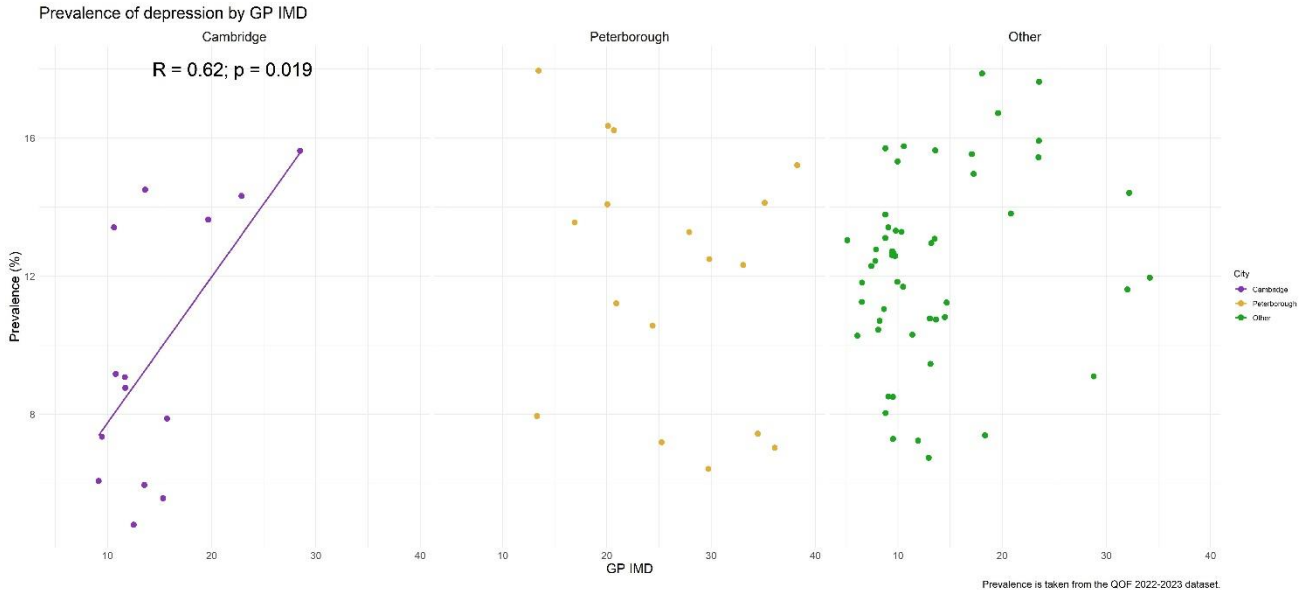
- There is substantial variation in the recorded prevalence of depression across different general practices, across Cambridgeshire and Peterborough, ranging from 4.8% to 35.3%. Some of this variation may be due to differences in how practices record depression.
- The highest recorded prevalence was in the Cambridge Access Surgery (35.3%), which provides specialist GP services to people experiencing homelessness, at risk of homelessness or living in supported housing.

Figure 13: Prevalence of depression by GP practice in Cambridgeshire and Peterborough, recorded by primary care and shown as a percentage of GP practice population. Brackets show practice size (adults aged 18+). Data source: Quality and Outcomes Framework, 2022-23


Cambridge Access Surgery (757) 35.3%
Yaxley Group Practice (14839) 18.0%
St. George'S Medical Centre (9728) 17.9%
Cornerstone Practice (7775) 17.6%
George Clare Surgery (9728) 16.7%
New Queen Street Surgery (14965) 16.4%
Ailsworth Medical Centre (3102) 16.2%
Mercheford House (5340) 15.9%
Wellside Surgery (6313) 15.8%
Alconbury Surgery (10496) 15.7%
Almond Road Surgery (6248) 15.6%
East Barnwell Health Centre (6226) 15.6%
Fenland Group Practice (10537) 15.5%
Riverside Practice (6102) 15.4%
Cathedral Medical Centre (8901) 15.3%
Westwood Clinic (4235) 15.2%
Ramsey Health Centre (5943) 15.0%
Bretton Medical Practice (9197) 14.7%
Cherry Hinton Medical Centre (8627) 14.5%
Clarkson Surgery (8670) 14.4%
Arbury Road Surgery (10217) 14.3%
Nightingale Medical Centre (4490) 14.1%
Botolph Bridge Community Health Centre (5419) 14.1%
Acorn Surgery (8065) 13.8%
Riverport Medical Practice (11128) 13.8%
Park Medical Centre (7061) 13.7%
Nuffield Road Medical Centre (11404) 13.6%
Hampton Medical Centre (7778) 13.6%
Nene Valley And Hodgson Medical Practice (14734) 13.5%
Grove Medical Practice (12710) 13.4%
Bottisham Medical Practice (4764) 13.4%
Roysia Surgery (4637) 13.3%
Milton Surgery (4178) 13.3%
Jenner Healthcare (14067) 13.3%
Willingham Medical Practice (8379) 13.1%
The Hicks Group Practice (12799) 13.1%
Over Surgery (3833) 13.0%
Staploe Medical Centre (19371) 12.9%
Comberton Surgery (7699) 12.8%
Burwell Surgery (7241) 12.7%
Priors Field Surgery (4596) 12.7%
Papworth Surgery (5844) 12.6%
Cottenham Surgery (2901) 12.6%
Boroughbury Medical Centre (24026) 12.5%
Buckden Surgery (8078) 12.4%
Willow Tree Surgery (4422) 12.3%
Monkfield Medical Practice (8557) 12.3%
Trinity Surgery (9565) 11.9%
Spinney Surgery (8857) 11.8%
Harston Surgery (6001) 11.8%
St Mary'S Surgery (13624) 11.7%
North Brink Practice (16893) 11.6%
Firs House Surgery (9965) 11.2%
Moat House Surgery (6038) 11.2%
Thorpe Road (8070) 11.2%
Waterbeach Surgery (4474) 11.0%
St Neots Health Centre (5410) 10.8%
Lakeside Healthcare St Neots (17742) 10.8%
Great Staughton Surgery (4143) 10.7%
Granta Medical Practices (36731) 10.7%
The Grange Medical Centre (2159) 10.6%
The Health Centre Practice (9570) 10.4%
Haddenham Surgery (6104) 10.3%
Swavesey Surgery (2678) 10.3%
Thomas Walker Westgate Healthcare (20473) 9.9%
Kimbolton Medical Centre (5915) 9.5%
Cornford House Surgery (8896) 9.2%
Parson Drove Surgery (6083) 9.1%
Petersfield Medical Practice (6604) 9.1%
Woodlands Surgery (9786) 8.8%
Newnham Walk Surgery (15227) 8.5%
Orchard Surgery,Melbourn (6720) 8.5%
Bourn Surgery (5196) 8.0%
Wansford (8101) 7.9%
York Street Medical Practice (8997) 7.9%
Thistlemoor Medical Centre (22277) 7.4%
Priory Fields Surgery (9745) 7.4%
Queen Edith Medical Practice (7989) 7.3%
Maple Surgery Bar Hill Health Centre (3120) 7.3%
Trumpington Street Medical Practice (17718) 7.2%
Old Fletton Surgery (10267) 7.2%
Central Medical Centre (10541) 7.0%
Lensfield Medical Practice (11834) 6.7%
Paston Health Centre (10441) 6.4%
Huntingdon Road Surgery (19972) 6.1%
Mill Road Surgery (6407) 5.9%
Red House Surgery (20176) 5.6%
Bridge Street Medical Centre (10365) 4.8%
0%
5%
10%
15%
20%
25%
30%
35%

There is a significant association between general practices deprivation and the number of patients on recorded as having depression in Cambridge, but not in Peterborough or other districts. As national data shows that depression prevalence is higher in more deprived areas (Hodgson et al., 2020; Remes et al., 2019), this may suggest that depression is underreported in some local areas.

Figure 14: Prevalence of depression by general practice index of multiple deprivation (IMD). Data sources: QOF depression prevalence 2022/23, IMD scores 2019.



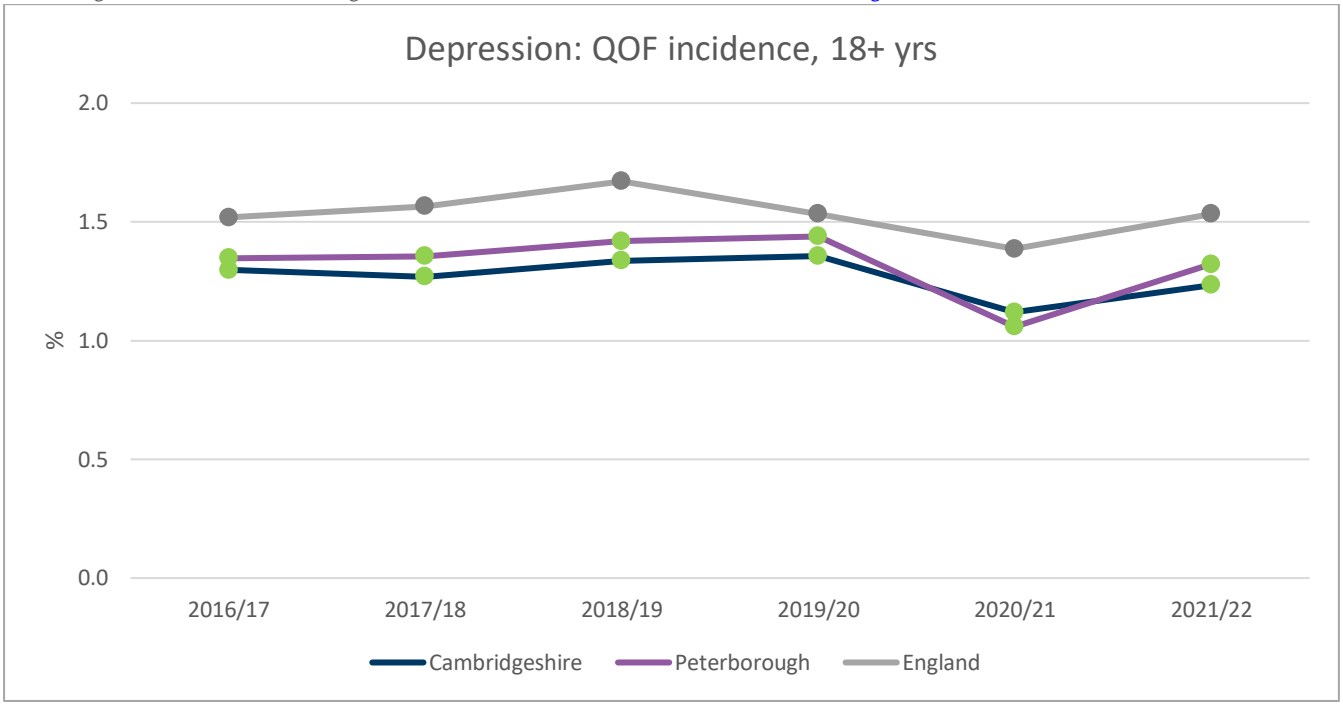
The following caveats apply to this analysis:

1. The calculation of GP IMD is based on the location of the practice rather than a measure of their patient register. As such, a practice in a deprived area may not have a patient register from a similar deprivation, but instead a more mixed population.
2. Given that there is a sizeable student population in Cambridge, it is worth considering that the Cambridge analysis may reflect two separate groups; a group of practices that cater to the student population that tends to be in less deprived areas of Cambridge (close to the colleges), and a group of practices that deal with the residential population. As the student population may be more homogeneous than their residential counterparts, they might not be comparable and should be considered separately.

Incidence

- From 2016/17 to 2021/22, the percentage of new diagnoses of depression was significantly lower than the national rates in Cambridgeshire and in Peterborough.
- In 2021/22, the percentage of patients aged 18+ with depression recorded for the first time in the year shows an increase in Cambridgeshire, Peterborough and England, compared to the previous year.

Figure 15: Depression incidence (recorded for the first time within the year) in adults as measured by primary care, Cambridgeshire and Peterborough, 2016/17 – 2021/22. Data source: NHS Digital



Hoarding

- The DSM defines hoarding disorder as 'persistent difficulty discarding or parting with possessions, regardless of their actual value', which leads to an accumulation of possessions that compromises the use or safety of living spaces (American Psychiatric Association, 2022). This was recognised as a mental health condition in 2013 (and 2017 in the World Health Organisation's International Classification of Diseases (ICD-11)).
- Hoarding can be a symptom of other physical and mental health problems, such as those relating to drug and alcohol use, dementia, depression and physical illness (Haighton et al., 2023; Samuels et al., 2008). It is also recognised within the Care Act 2014 as a manifestation of self-neglect (Cambridgeshire and Peterborough Safeguarding Partnership Board, n.d.).
- Severe hoarding can create serious risks to individuals, including risks to safety from falls and impeded fire escape routes (Postlethwaite et al., 2019). This can impact other members of the household, and in some cases neighbours.
- Hoarding contributes to a substantial economic cost to housing providers and Fire Services, although estimates for this cost varies (Neave et al., 2017).
- Stakeholders across the UK working with people with hoarding disorder highlight the need for multiagency approaches to intervention, often across health, housing, emergency services and social care (Haighton et al., 2023). For example, the local protocol for working with people with hoarding behaviours highlights that local authorities, NHS services, community sector organisations, social landlords and the fire service all work to reduce the risks associated with hoarding and to promote health and wellbeing.
- Early identification and support when hoarding issues may be seen as 'clutter' is important to reducing the impact this has on individuals. Evidence suggests that treatment of the underlying mental health need needs to take place before or alongside support with the decluttering process (Morein-Zamir & Ahluwalia, 2023).

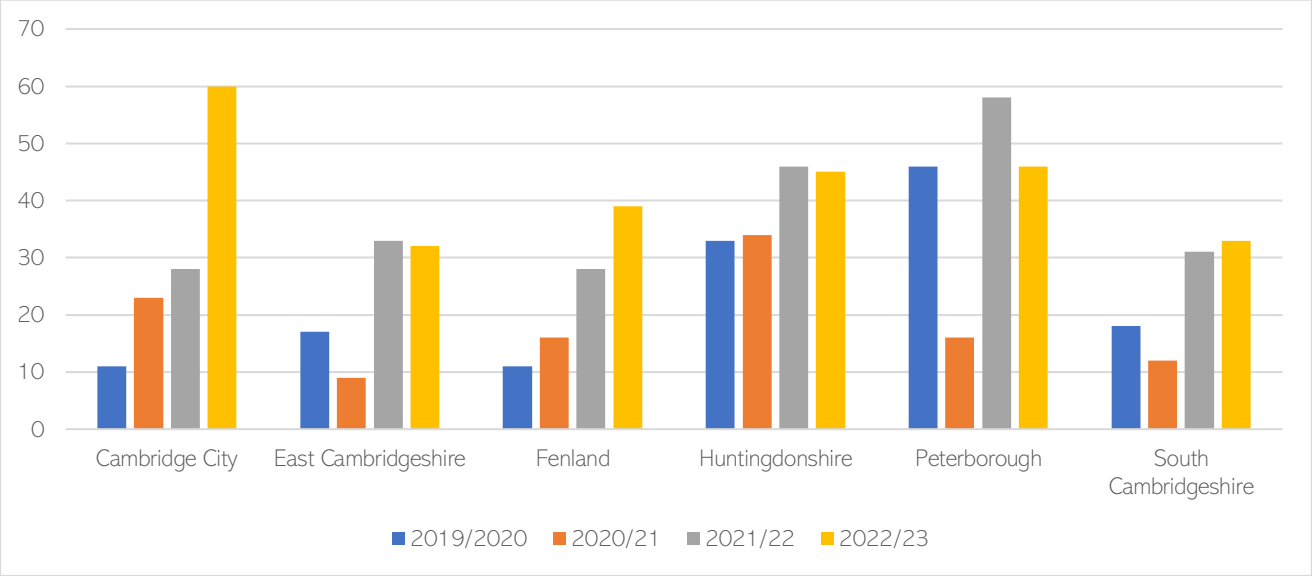
Prevalence

- International research suggests that between 1.7 to 3.6% working-age adults may have hoarding disorder (Postlethwaite et al., 2019). Combining this estimate with data from the 2021 Census, this suggests there

could be between 9,900 to 20,900 working-age adults in Cambridgeshire and Peterborough with hoarding disorder. This is similar or perhaps greater than the prevalence of obsessive-compulsive disorder (OCD) (National Institute for Health and Care Excellence, 2023).

- However, hoarding most often goes unrecognised:
    - People who hoard do not tend to identify has as having hoarding issues. They may have varying levels of insight into their behaviour, but this can be compounded if they feel that they cannot trust people due to previous negative or judgemental responses.
    - Hoarding behaviours often begin in early adulthood but may not be disclosed until decades later, or even at all (Morein-Zamir & Ahluwalia, 2023). Support services (including mental health services) may not identify someone has having hoarding issues until they visit their house.
- In Cambridgeshire and Peterborough, there was a 188% increase in the number of households identified as a hoarding risk by Fire and Rescue Service from 2019/20 to 2022/23. There was a sharp increase in 2021/22 and 2022/23, compared to before the pandemic.
    - A lower number of households were identified in 2020/21 compared to other years, which is likely due to the impact of the COVID-19 pandemic and lockdowns.
    - The number of households identified as a hoarding risk varies by district, although Huntingdonshire is consistently one of the highest areas.

Figure 16: Total number of households identified as a hoarding risk by district, 2019/20 – 2022/23. Data source: CFRMIS



Note that this data only includes households where a hoarding referral was made, or a hoarding risk was identified during a visit. These are distinct households and may have one or more hoarding job associated with them.

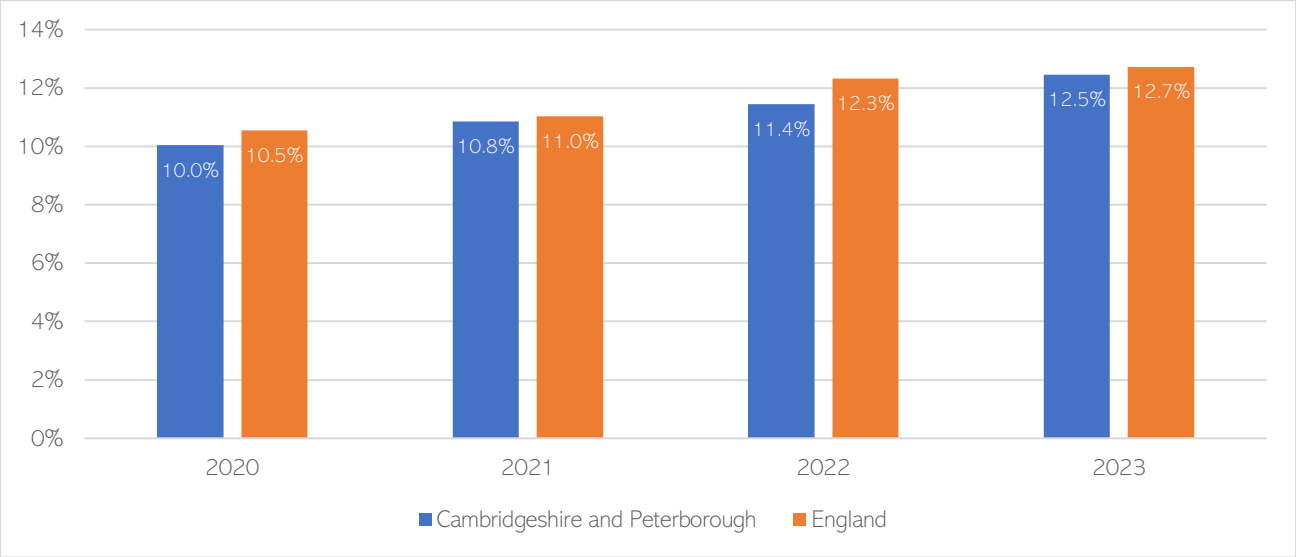
Additional Resources

- Cambridgeshire guidance on hoarding
- Cambridgeshire and Peterborough Multi-agency Protocol for Working with People with Hoarding Behaviours
- Hoarding: Key considerations and examples of best practice
- Centre for Collaborative Research on Hoarding
- A Psychological Perspective on Hoarding: DCP Good Practice Guidelines

Self-reported mental illness

1 in 8 (12.5%) of people within Cambridgeshire and Peterborough ICS reported having a long-term mental health condition in the 2023 GP Patient Survey. There has been a steady increase in the proportion of people self-reporting a mental health condition from 2020, in line with national trends.

Figure 17: Weighted proportion of GP Patient respondents who self-reported having a 'long-term mental health condition', 2020 – 2023. Data source: GP Patient Survey



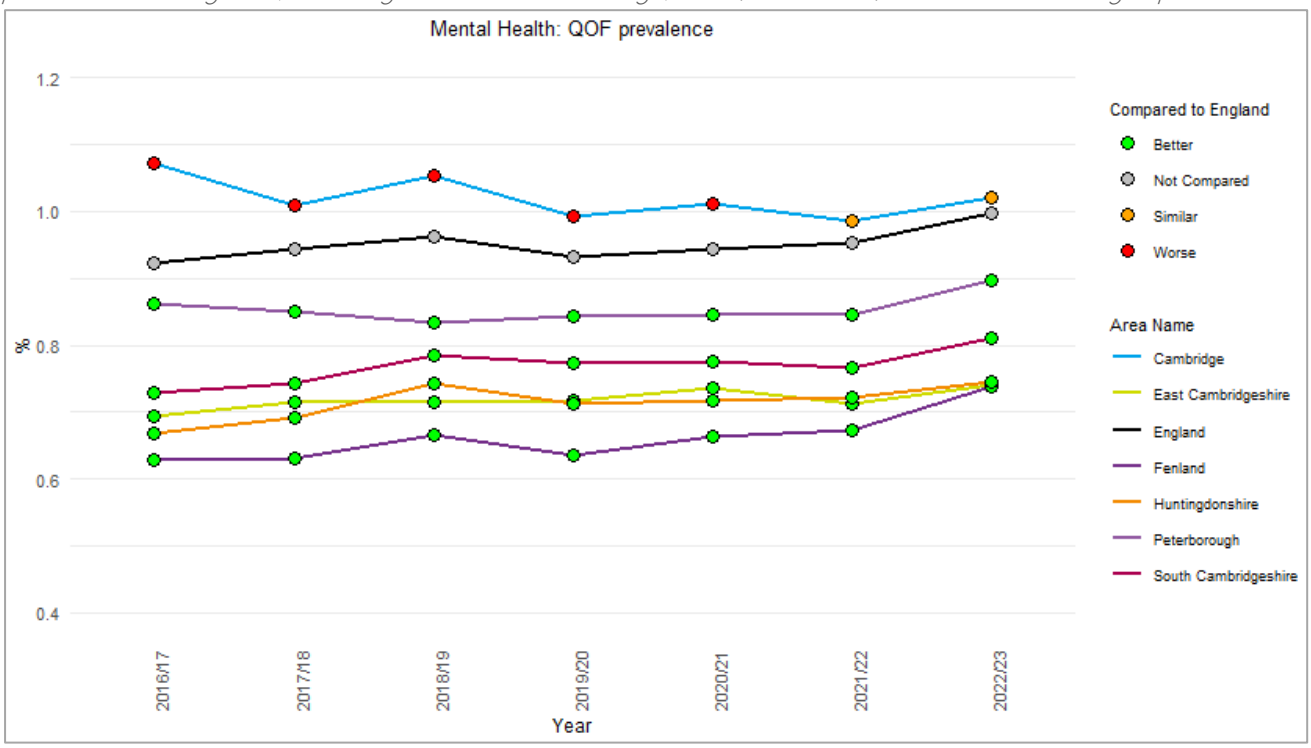
Severe mental illness

In Cambridgeshire and Peterborough, there were 8,695 adults on the SMI register in 2022/23, which is equivalent to 0.84% of the adult population (age 18+) who are registered with GPs (NHS Digital, 2023c). Comparatively, 1.00% of adults in England are on the SMI register (NHS Digital, 2023c).

Prevalence

- The proportion of people on the SMI register has been significantly lower than the national average since 2016/17 in all districts apart from Cambridge.
- The prevalence in Cambridge has declined in recent years and is now statistically similar to the national rate.

Figure 18: % of patients with schizophrenia, bipolar affective disorder and other psychoses as recorded on general practice disease registers, Cambridgeshire and Peterborough, 2016/17 – 2022/23. Data source: Fingertips



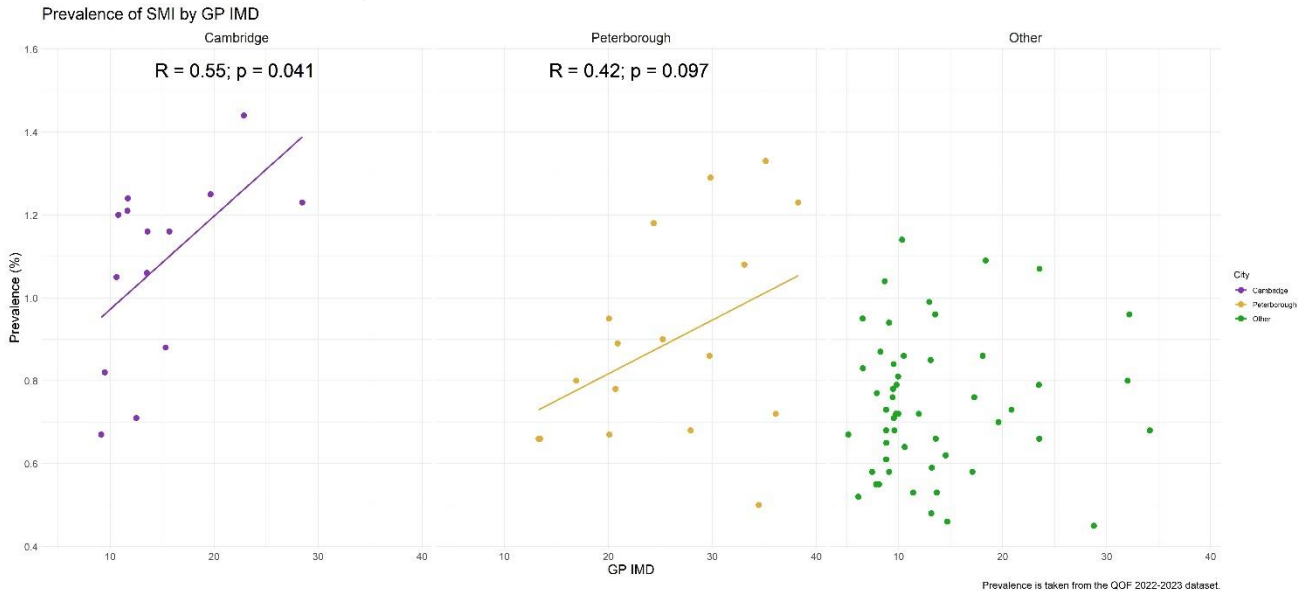
How accurate is the SMI register?

- In Cambridgeshire and Peterborough, it is estimated that the register covers 85.5% of people we would expect to see with severe mental illness in our local population (NHS England, 2023d).
- In comparison, nationally the SMI register covers 89.5% of people we would expect to have SMI (NHS England, 2023d).

Is there a link between deprivation and the prevalence of severe mental illness?

National research shows that there are higher levels of severe mental illness in more deprived areas (Grigoroglou et al., 2019). In Cambridge and Peterborough, there is a non-significant association between deprivation and number of people on GP practices severe mental illness (SMI) registers.

Figure 19: Prevalence of severe mental illness by general practice index of multiple deprivation (IMD). Data sources: QOF SMI prevalence 2022/23, IMD scores 2019.



The following caveats apply to this analysis:

1. The calculation of GP IMD is based on the location of the practice rather than a measure of their patient register. As such, a practice in a deprived area may not have a patient register from a similar deprivation, but instead a more mixed population.
2. Given that there is a sizeable student population in Cambridge, it is worth considering that the Cambridge analysis may reflect two separate groups; a group of practices that cater to the student population that tends to be in less deprived areas of Cambridge (close to the colleges), and a group of practices that deal with the residential population. As the student population may be more homogeneous than their residential counterparts, they might not be comparable and should be considered separately.
3. Peterborough may demonstrate a degree of heteroscedasticity as there appears to more variance in the higher deprivation areas than in the low deprivation areas. However, Bartlett test is non-significant when grouping IMD into high and low categories, though a median split may not be the most sensitive method of conducting this analysis.

Inequalities

Research has consistently shown that there is a strong relationship between social disadvantage and poor mental health (Lancet, 2021). This was detailed in chapter two of the mental health needs assessment. There are also links between unhealthy relationships and loneliness, and poor mental health: hence relationships are a key priority in the local Health and Wellbeing Integrated Care Strategy.

- It is well recognised nationally that some groups are more likely to experience serious mental illness, and that many of these groups also face barriers preventing timely access to care (Davidson, 2021). This can be seen in terms of the unequal use of crisis care in the local pathway.
- Getting It Right First Time (GIRFT (add link)) has documented that across the country while the ethnic breakdown of those accessing core services may be similar to the overall population mix, the proportion of people from Black, Asian and other minority ethnic backgrounds is disproportionately high among in higher-intensity forms of community and inpatient services (Davidson, 2021).
- GIRFT states that both the inpatient admission and community caseload data related to ethnicity provide a stark illustration of the fact that if services do not get things right at the beginning, people will disproportionately end up in longer-term and/or more restrictive settings owing to avoidable extra acuity and the accumulation of preventable secondary and tertiary problems (Davidson, 2021).

One way of assessing inequalities in terms of access to mental health services is to compare who is accessing mental health support compared to our local population. Understanding barriers is important to addressing

inequalities and is linked to the local Health and Wellbeing Strategy priority around 'motivation' and removing barriers to accessing services. These graphs give a broad overview of inequalities in access to mental health services. However, it is also important to note that some variations may be due to differences in mental health need. Different groups are more likely to experience mental illness (NHS Digital, 2014), due to a complex range of biological, social and economic factors.

Data sources and caveats

Data covering Cambridgeshire and Peterborough was analysed from a range of sources:

Data type	Data source	Time period
Total population	https://cambridgeshireinsight.org.uk/jsna-2023/demography/age-structure-and-population-change/	Collected as part of the 2021 Census
Talking Therapies	https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-annual-reports-on-the-use-of-iapt-services/annual-report-2021-22	Referrals accessing services in 2021/22
Primary care mental health service (PCMHS)	Chapter Five of the Mental Health Needs Assessment	Analysis of unique referrals accessing PCMHS, January 2019 – July 2023
First Response Service (FRS)	Chapter Five of the Mental Health Needs Assessment	Analysis of unique referrals accessing FRS, August 2021 – March 2023
Detained under the Mental Health Act	MHA Dashboard - Mental Health, Learning Disability and Autism Resource Hub - FutureNHS Collaboration Platform	Detentions under all sections of the Mental Health Act, July 2022 – June 2023

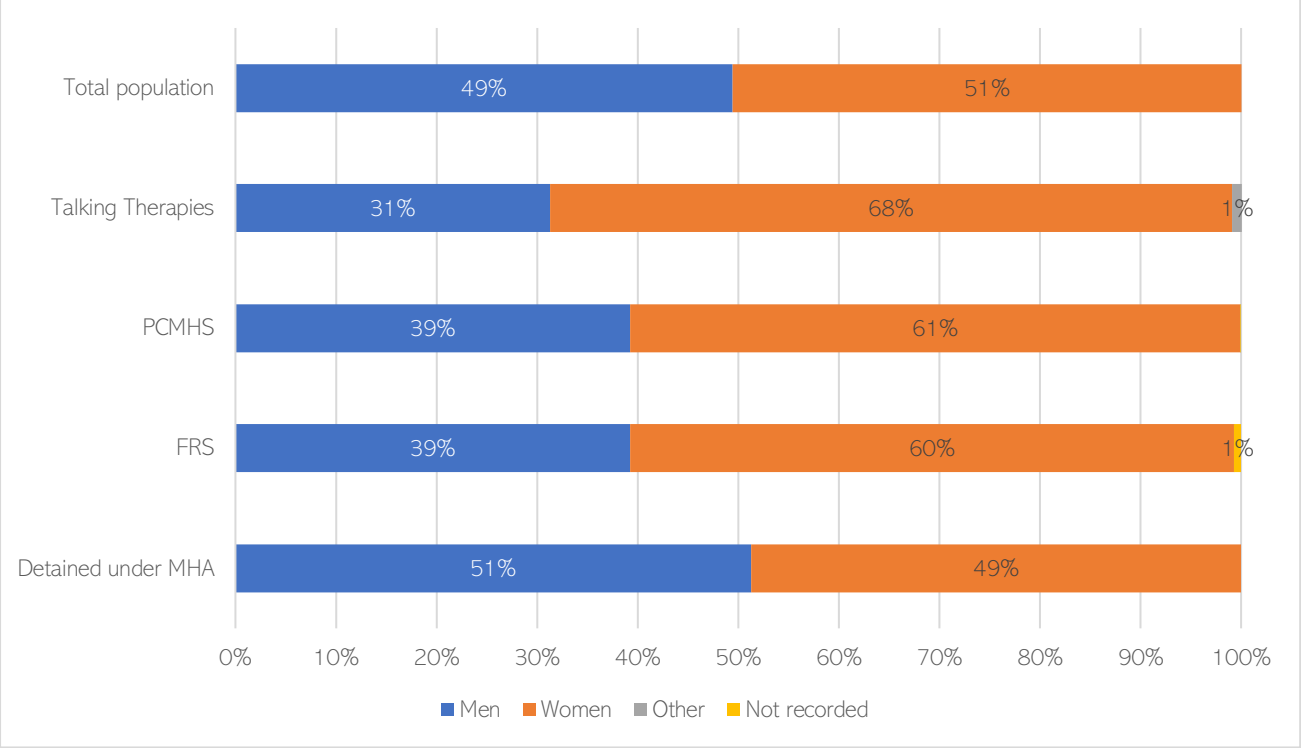
Caveats to this analysis include:

- Data was collected over different time periods, which may have distorted the findings.
- There is a lack of intersectional analysis, which considers the impact of multiple demographic factors on access to services, such as the interaction of age, gender and ethnicity. Some factors, such a deprivation, may underlie differences between groups.
- Some data, particularly for ethnicity, is missing from the datasets analysed. This prevents a full understanding of service use.

Gender

A greater proportion of women than men access Talking Therapies, CPFT's Primary Care Mental Health Service (PCMHS) and the First Response Service (FRS). Men are substantially more likely to be detained under the Mental Health Act via the criminal justice system than women.

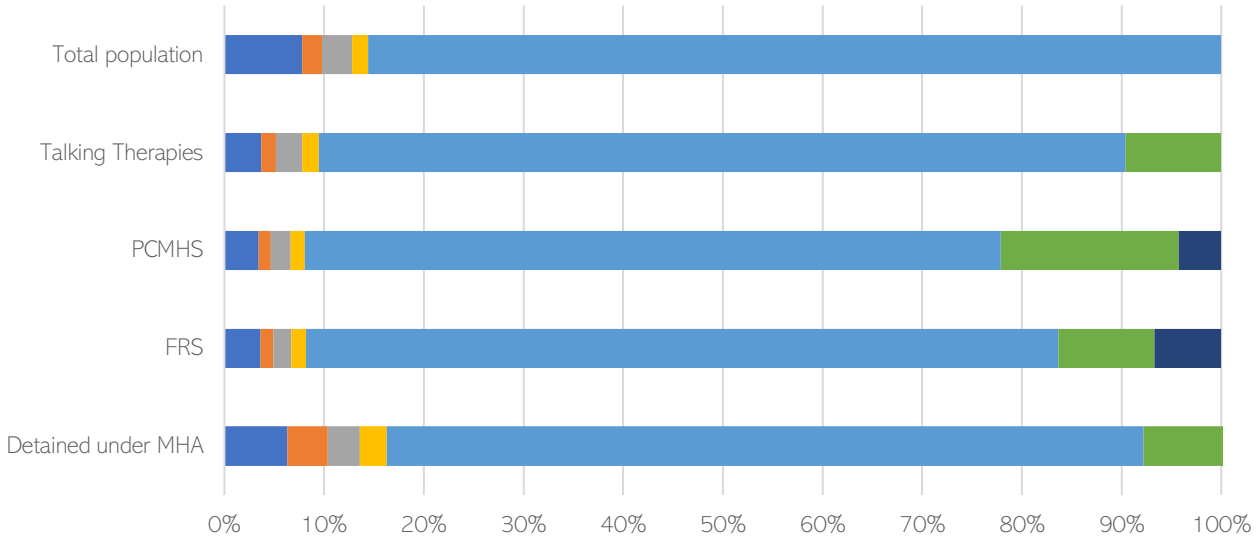
Figure 20: Access to mental health services in Cambridgeshire and Peterborough by gender. Data sources listed above.



Ethnicity

From this analysis, it seems that people from Black, and Asian ethnic groups are more likely to be detained under the Mental Health Act than their White counterparts. This would reflect national data trends (Weich et al., 2017); however, it is difficult to draw conclusions from local data due to missing or unrecorded ethnicity data. The use of broad categories for ethnicity will have masked differences within groups. For example, national analyses highlight people from 'Bangladeshi' ethnic groups are the least likely to receive treatment from NHS Talking Therapies (Collaborating Centre for Mental Health, 2023).

Figure 21: Caseload of mental health services in Cambridgeshire and Peterborough ICS, by ethnicity. Data sources listed above

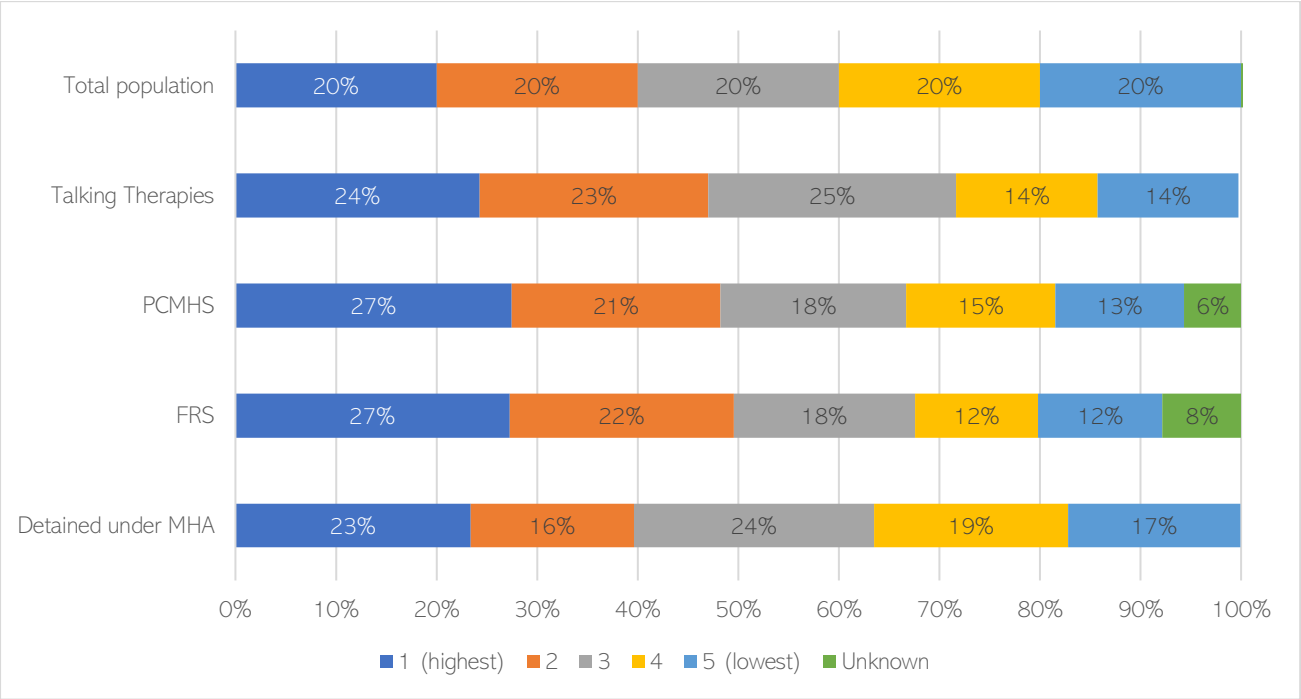


	Detained under MHA	FRS	PCMHS	Talking Therapies	Total population
Asian	6%	4%	3%	4%	8%
Black	4%	1%	1%	1%	2%
Mixed	3%	2%	2%	3%	3%
Other	3%	2%	1%	2%	2%
White	76%	75%	70%	81%	86%
Missing/invalid	8%	10%	18%	10%	0%
Not stated		7%	4%		

Deprivation

People living in the most deprived areas of Cambridgeshire and Peterborough are more likely to present to mental health services, particularly the Primary Care Mental Health Service (PCMHS) and the First Response Service (FRS).

Figure 22: Caseload of mental health services in Cambridgeshire and Peterborough ICS, by local deprivation quintile. Data sources listed above



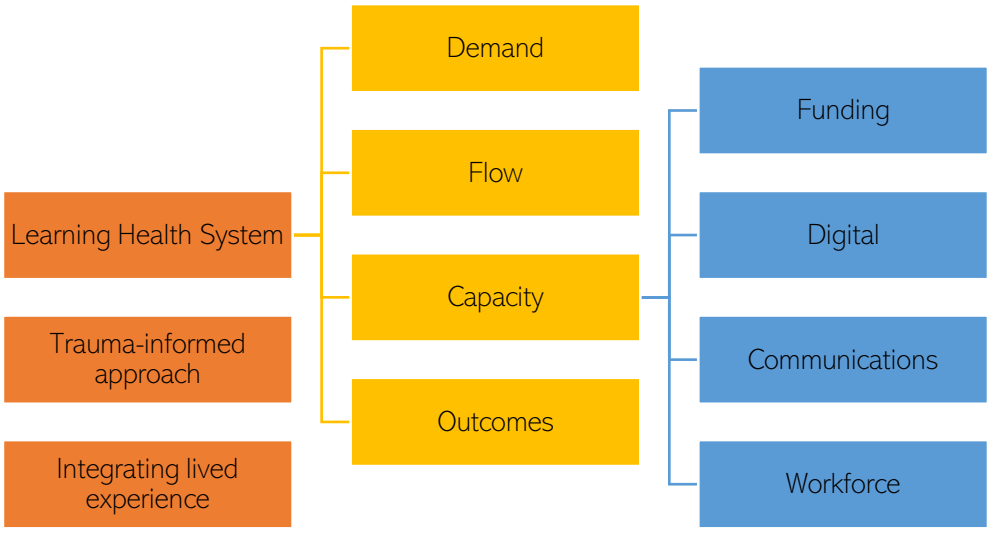
Additional Resources

- Chapter two of this mental health needs assessment covers inequalities in mental health services in more detail, covering access, experience and outcomes

System enablers

This mental health needs assessment gives a whole system overview of the services that support people experiencing poor mental health, including those with diagnoseable mental illnesses, in Cambridgeshire and Peterborough.

Figure 23: System enablers covered in this section of the mental health needs assessment



Learning Health System

A learning health system (LHS) is a 'team, provider or group of providers that, working with a community of stakeholders, has developed the ability to learn from the routine care it delivers and improve as a result' (Hardie et al., 2022). This is a systematic approach to iterative, data-driven improvement embedded in standard healthcare delivery (Hardie et al., 2022). Providing teams with the opportunity to become LHSs can help to improve the quality and effectiveness of health and care services (Hardie et al., 2022).

There are 8 priority areas that have been identified needing action to support the development of LHSs:

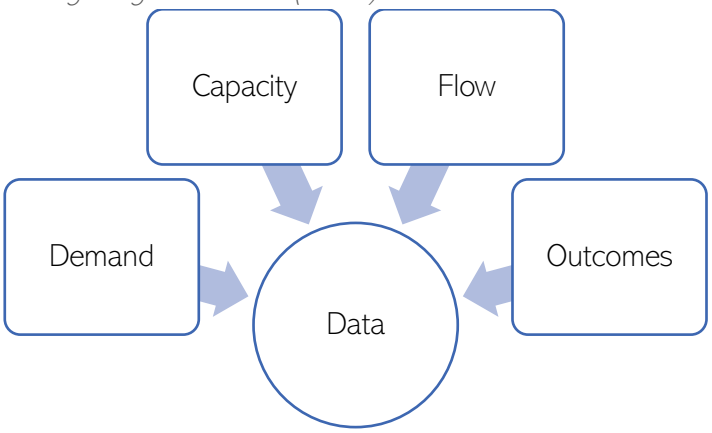
Table 7: Eight priority areas for action for learning health systems. Source: Developing learning health systems in the UK: Priorities for action

Areas for action		Recommendations
For policymakers	Clear narrative	• Build on this report to set out a clear vision and set of principles for developing LHSs • Build the evidence base – on both the impact of LHSs and overcoming barriers to adopting LHS approaches • Align related policy areas to support LHS approaches • Support the sharing of expertise and learning across LHSs
	Digital maturity	• Provide longer term funding to help the least mature organisations and systems • Spread best practice for procuring and implementing digital tools • Embed digital skills and knowledge in maturity assessments • Support the development of new analytics and data tools
	Data analytical expertise	• Support the professionalisation of the data analytics workforce • Promote open-source data tools for all analysts to use • Develop digital skills across the wider health care workforce
	System interoperability	• Further develop interoperability standards and support services to meet them • Provide guidance on where interoperability can add most value • Make sure that lessons from previous efforts to achieve interoperability are learned
	Implementation and improvement capacity	• Develop a system-readiness framework for applying LHS approaches • Provide funding to help organisations build their improvement capability • Consider implementation support within centrally led transformation initiatives • Develop training for implementing and using LHSs • Collate and promote helpful tools, such as the LHS Toolkit
For system leaders	Learning culture	• Create responsibility for LHSs at board level • Embed improvement in organisational strategy • Develop wider organisational leadership
	Frontline implementation capacity	• Protect staff time for LHS work • Provide access to training and coaching
	Organisational improvement capacity	• Develop in-house expertise • Support the convening of learning communities

Getting It Right First Time

Getting It Right First Time (GIRFT) is a national programme designed to improve NHS care by reducing unwanted variations in the way services are delivered. The national GIRFT report for adult crisis and acute care has 17 recommendations to improve services and ensure people receive the right treatment at the time, which should reduce number of people reaching crisis point (Getting It Right First Time, 2022). The key recommendations are structured around four domains, with an overarching focus on data reporting and use.

Figure 24: Key elements of Getting It Right First Time (GIRFT)



This mental health needs assessment supports the first recommendation of GIRFT, which states that Trusts should 'review local population needs assessments such as JSNA and to take into account factors known to increase mental health needs and demand, including but not limited to the vulnerable groups highlighted in the report to help drive their strategic plans between 2022-2025' and to 'ensure data is segmented to take account of variation in local area needs'.

Adult Crisis GIRFT looks at what can be done to improve access before people reached crisis point, as well as what could be done for people in crisis. The key messages are:

1) Trusts need to be routinely analysing and reporting data especially outcome data
2) Trusts need to 'get it right first time' by ensuring equitable access to timely and effective core mental health community care and treatment before people reach emergency need level
3) Trusts need to routinely use proven flow tools, in both community and inpatients, to maximise effective use of capacity; creating 'easy in, easy out' services to prevent people getting stranded in the wrong part of the pathway

Flow

Timely access to mental health care is important. As GIRFT highlights, the more time that passes before treatment is accessed, the greater the likelihood that a condition will become more chronic and difficult to treat. Delays to access also make crisis presentations more likely. Presentation in crisis often reduces available options and may lead to a breakdown in community support, making recovery harder to achieve. Timely, equitable access to care must lead to timely effective interventions; otherwise, people can end up in sub-optimal care pathways (Davidson, 2021).

- The key issue is that patients must be able to step the intensity of their care up or down as and when is necessary; in essence, people should receive the lowest intensity of service that meets their need. When people do need more intense care, they should have timely access to the appropriate interventions.
- National data shows that when people's healthcare moves between teams, over 20% do not reach the new team (Healthwatch, 2023b; NHS England, 2019). This may be because their referral was rejected (Healthwatch, 2023b), complex referral process and transition between services (NHS England, 2019), or a lack of support to meet multiple needs (NHS England, 2019).

- People report this is frustrating, anxiety inducing and can cause harm in some circumstances (Healthwatch, 2023b). It may also lead increased demand in other areas of the healthcare system, such as crisis services (Healthwatch, 2023b).
- When multiple services provide care, people may have to go through multiple assessments, which can be distressing for the individual. It increases the chance they will drop out of services, delays their access to treatment and is a poor use of resources.
- Some groups are more likely to 'bounce around' services. For example, people with co-occurring substance use and mental health needs can often experience difficulties accessing continuous care and may fall through the gap between services

Outcomes

- In broad terms, 'outcomes' refers to the results of any care or treatment provided. In mental health, the outcomes of support, care and treatment might be that a person is able to lead a more fulfilling life, have reduced or no symptoms, volunteer in the community or return to a job that they love.
- There are a range of frameworks and tools to measure mental health and wellbeing, including those that measure symptoms of mental illness, quality of life, and functioning (The King's Fund, 2019).
- The NHS Long Term Plan (NHS, 2019) commits to improving the quality of care and outcomes for patients, and the use of patient reported outcome measures (PROMs) in community mental health services (Royal College of Psychiatrists, 2023).
- Service users and staff highlight that there any many challenges in using standardised health outcomes in mental health services (The King's Fund, 2019). For example, individuals have different ways of conceptualising their mental health (ranging from biological causes of illness to social factors), which are not always captured in measurement tools (The King's Fund, 2019). Patient reported outcome measures can help to measure the effectiveness of care, support patients to feel understood and progress towards their personal goals, and to help services understand if they are meeting patients' needs (Royal College of Psychiatrists, 2023).
- Different services use different types of outcomes:
    - Three PROMS have been selected by NHS England for use in NHS commissioned community MH Services: DIALOG scale, Goal-Based Outcomes tool (GBO) and the Recovery Quality of Life 10-item scale (ReQoL-10).
    - MYCaW, an individualised tool for understanding people's concerns, often used within Personalised Care roles.
    - The Centre for Mental Health has carried out research into how local authorities can understand how well mental health services meet people's needs, starting with 'what good mental health care feels like' (Centre for Mental Health, 2022).

Capacity

There are many factors that impact capacity in a geographical area, including historical and current levels of spending (in terms of revenue, capital and infrastructure), and the recruitment, retention and deployment of staff. Wider health system capacity will also impact on the ability of services to make the best use of capacity (Davidson, 2021).

GIRFT states that paying close attention to the linkages and dependencies that exist between different levels of care and the individual part of the wider health and social care system is essential to ensuring that trusts have the capacity to provide all patients with timely and appropriate access (Davidson, 2021). Patients must also be able to move between different levels of care intensity (in both directions), as well as being able to enter and exit the service with minimum difficulty. If all the constituent parts are operating efficiently and in concert with each other, patients will access appropriate care and not become stranded, thus maximising total capacity (Davidson, 2021).

Core elements of capacity in mental health systems are funding and workforce.

Additional Resources

- Improving mental health services in systems of integrated and accountable care: emerging lessons and priorities
- Learning Healthcare Systems - The Learning Healthcare Project
- Realising the potential of learning health systems
- Overview: GIRFT national report for mental health crisis and acute care focuses on reducing barriers to access
- Mental Health – Adult Crisis and Acute Care GIRFT Programme National Specialty Report
- Getting the most out of GIRFT: A practical toolkit for embedding GIRFT within a trust
- 'It feels like being seen': how can local authorities know if their mental health services are working well?
- Add link to outcomes powerpoint

Communications

Engagement with people across Cambridgeshire and Peterborough in the 2022 Public Mental Health Survey highlighted that there is a gap in terms of individuals' understanding of what support is available to them and how to access it; or what they can do to support their mental wellbeing. Pressures on the mental health system mean that there is a particularly urgent need for support and information while waiting for treatment services. This highlights the importance of communications around support services, including community-based activities and organisations.

What is the most effective way to communicate messages around mental health?

An evidence review carried out in 2023 looked at national guidance and research around communicating mental health and wellbeing information. This review also included evidence from neighbouring local authorities.

Key findings

Most of the literature found was of low strength due to being from small studies (rather than systematic reviews), not easily generalisable and often lacking a comparison group or control for other factors. Several national guidelines were identified which give practical frameworks for designing, implementing, and evaluating communications work, although not specific to mental health communications. Findings were also informed by examples from neighbouring local authorities:

- Print media is generally less effective (has a narrow audience and often requires higher literacy rates) than other forms of more interactive media, video and online resources.
- Evidence on social media is mixed, but some forms may be particularly effective with specific target audiences (e.g., one study found that Instagram generated a lot more engagement than Facebook and Twitter for physical activity trackers).
- There is some evidence that television programmes such as mental health documentaries can increase intention to seek help, but it is not clear how long this effect lasts and for which population groups this is most effective.
- One study highlights the need for trauma-informed and empathy-based approaches, especially when communicating mental health to children and young people, families and schools.
- The importance of evaluation of communications work is repeatedly mentioned both in literature and practise examples, but in reality is very limited. Most local authorities largely rely on websites and newsletters for their mental health communications for which evaluation of outcomes are very limited.

How to ensure effective communication

1) Engage your target audience for the development of successful communications. From gaining insight about ways they find information, communication needs, interests, identifying barriers, coproduction and inclusion of personal stories, testing of the materials, to evaluating the impact of the campaign.
2) Use evidence-based approaches to guide communication development, such as:
    a. Effective communications checklist by the Centre for Applied Behavioural Science
    b. RESPONSE checklist
    c. OASIS campaign planning framework
3) Keep communications and messaging simple and readable. This is covered in evidence-based checklists mentioned above, and key elements include:
    a. Check readability level, use short sentences, avoid abbreviations and use colloquial terms.
    b. Check accessibility requirements of your target audience (languages, sign language, braille, easy read etc.)
4) Consider framing around wider determinants. It may be helpful to shift the tone from individualistic perspective that can lead to shame and blame (e.g., food we eat and level of exercise) to one that recognises and addresses the wider determinants of health (e.g., homes, jobs, access to education, experience of poverty and discrimination).
5) Consider the role of messengers. Rather than running a campaign directly, it may be more effective to engage community leaders and organisations working directly with your target audience (e.g., from a charity to a football club). Work with partners to use existing communication routes to engage with underserved populations.
6) Where relevant, link to national campaigns and review OHID Campaign Resource Centre

Digital

Digital technologies and platforms, such as apps and online cognitive behaviour therapy (CBT), have become a key part of mental health services across England. Digital approaches can help to improve access to care, provide early intervention and help to reduce inequalities in mental health, but are not always being used to their full potential (Mental Health Network NHS Confederation, 2023). Effective implementation of evidence based digital health technologies is critical to delivery of priorities. Digital health technology (DHT) can support people at different points of their journey:

- Treating and diagnosing mental health conditions, or guiding care choices
- Helping citizens and patients to manage their own mental health
- Save costs or release staff time

The NHS Confederation has worked with leaders across the mental health sector and experts by experience to identify key themes for utilising digital approaches to mental health (Mental Health Network NHS Confederation, 2023):

1) Developing a compelling narrative around how digital approaches can meet the needs of the population.
2) Lived experience should be a core part of service development and delivery.
3) Working with partners across integrated care systems to deliver joined-up support.
4) Focusing on inclusion and aiming to reduce inequalities rather than exacerbate them through digital exclusion.
5) Creating learning opportunities to develop and share insights.
6) Supporting innovation, research and development.
7) Focusing on regulation, standards, quality and safety.

There are benefits and risks to using digital tools in healthcare as digital exclusion (lacking the access, skills and confidence to use the internet and benefit fully from digital technology in everyday life) can exacerbate health inequalities. The NHS has recently published a framework on digital inclusion which highlights 5 areas of action (NHS England, 2023b):

1) 'Access to devices and data so that everyone can access digital healthcare if they choose to and experience the benefits
2) Accessibility and ease of using technology, so that user-centred digital content and products are co-designed and deliver excellent patient outcomes
3) Skills and capability so that everyone has the skills to use digital approaches and health services respond to the capabilities of all
4) Beliefs and trust so that people understand and feel confident using digital health approaches
5) Leadership and partnerships so that digital inclusion efforts are co-ordinated and help to reduce health inequalities'.

Additional Resources

- Maximising the potential of digital in mental health
- Work underway in the digital mental health landscape
- Digital exclusion & health inequalities
- Unlocking The Digital Front Door: Keys to inclusive healthcare

Workforce

Partners from across the health and social care system must come together to plan and develop a workforce which can meet the needs of our local population (NHS Employers, 2022a).

NHS workforce

There is national acknowledgement that staff shortages remain the main constraint to improving and expanding mental health services. From 2016/17 to 2021/22, the NHS mental health workforce increased by 22%. Over the same time, referrals increased by 44%, meaning that the increase in staff was outpaced by the rise in demand for services (House of Commons Committee of Public Accounts, 2023).

- The Health and Social Care Committee's Expert panel reported in 2021 that 'lack of appropriate growth in the mental health workforce has led to negative impacts on both staff and services users', with staff saying that unmanageable workloads meant that they were more likely to become exhausted or demoralised, or experience burnout (Health and Social Care Committee's Expert Panel, 2021). These challenges were reiterated in the 2020 State of Care report (Care Quality Commission, 2023).
- The NHS Long Term Workforce Plan, published in 2023, predicts that demand for mental health services will grow faster than for other NHS services and confirms the particular challenge of expanding the mental health workforce.
- The National Audit Office surveyed mental health trusts in 2022 and found that the top reasons for workforce shortages are problems with staff recruitment and retention, high staff turnover and competition for staff from other healthcare providers.

Figure 25: NHS mental health trust survey respondents' views on reasons for workforce shortages. Image source: [Progress in improving mental health services in England]

Notes

1 Mental health trusts comprise trusts solely providing mental health services, as well as combined trusts providing mental health services alongside community or acute health services.

2 Data were collected between September 2022 and October 2022. The overall response rate to the trust survey was 74%, The survey question asked: "You said that workforce shortages were a very or quite significant barrier to improving mental health services. Below is a list of possible reasons for staff shortages – please indicate the extent to which each applies for your trust." 31 trusts answered the question.

Source: National Audit Office survey of NHS mental health trusts

In the East of England, in the first quarter of 2023/24 there was a (NHS Digital, 2023b):

- 10.6% vacancy rate in all mental health posts
- 19.4% vacancy rate in mental health nursing posts
- 10.0% vacancy rate in medical mental health posts
- Note that this data does not capture how vacancy rates are filled by temporary staff. Full caveats for this data source are available here.

Local strategy

Workforce is one of the 4 priorities of the 2022 – 2025 Trust Strategy in Cambridgeshire and Peterborough NHS Foundation Trust. This strategy aims to achieve:

- Happy, healthy and appreciated staff provide better care for patients and carers.
- Staff will feel valued, have career opportunities, offered new ways of working and develop new skills to achieve their full potential.
- Staff will have access to a variety of resources to support their health and wellbeing.

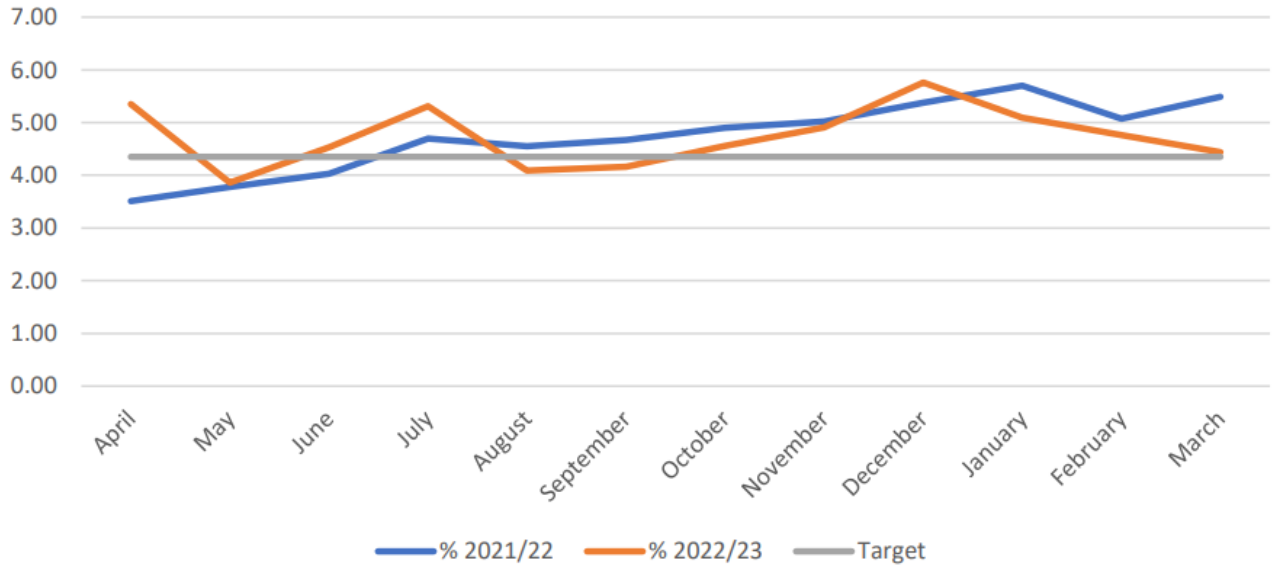
The goals for 2025 are to:

- Reduce turnover to <10% and vacancy rates to be <7.5%.
- Achieve 75% of staff recommending the Trust.
- Increase nursing and AHP apprenticeships to achieve the national public sector apprenticeship target (2.3% of workforce) and exceed it by a further 1.75%.
- Increase the diversity of our senior workforce aligned to race disparity ratio measures.

Local picture

The average percentage staff sickness rate for CPFT was 4.74% in 2022/23, which was above the set target of 4.35%.

Figure 26: % staff sickness rates in CPFT, 2021/22 – 2022/23. Image source: CPFT Annual Report and Accounts 2022-23



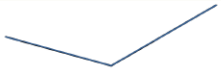
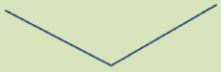
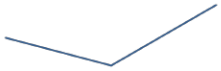
The 12-month average turnover in 2022/23 was 15.75%, which is also above the Trust target of 10.50%.

Table 8: Staff turnover rates in CPFT, 2022/23. Data source: CPFT Annual Report and Accounts 2022-23

	Monthly	12-month rolling average
April	1.3%	14.6%
May	1.3%	15.1%
June	1.1%	15.2%
July	1.6%	15.8%
August	1.9%	16.3%
September	1.4%	16.2%
October	1.3%	15.9%
November	1.0%	15.9%
December	1.2%	16.0%
January	1.3%	16.0%
February	0.9%	16.1%
March	1.3%	15.9%
2022/23 Average	1.29%	15.75%

National benchmarking reports from 2022/23 show that the community mental health workforce in Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) was better than regional and national comparators, with low vacancy rates and relatively high staffing levels; and low absence rates, turnover and spend on banking staff.

Figure 27: Community Mental Health Team (CMHT) staffing levels in Cambridgeshire and Peterborough Foundation Trust (CPFT), 2022/23. Image source: (Benchmarking Network, 2023)

	MH063	Mean	Median	National trend
Community total WTE per 100,000 resident population (age 16+)	134.9	100.4	98.4	
Generic CMHT staff sickness / absence %	4.6%	7.1%	5.7%	
Generic CMHT staff turnover %	1.3%	13.2%	12.3%	
Generic CMHT staff vacancies as % of staff in post	6.4%	13.6%	12.7%	
Generic CMHT spend on Bank and Agency (as a % of total spend on staffing)	2.2%	12.0%	10.4%	

However, the vacancy rates in adult acute care (inpatient mental health wards) is substantially higher in Cambridgeshire and Peterborough compared to other areas. National benchmarking data shows that the local vacancy is 29%, compared to a national average of 18%.

- This places Cambridgeshire and Peterborough ICS within the highest quartile of adult acute vacancies in 2022/23, compared to other areas (Benchmarking Network, 2023).
- The effect of these staffing shortages led to the closure of an inpatient ward in May 2022. This had knock-on impacts across the system and contributed to increased use of out of area placements and problems with flow across the pathways.

Wider mental health workforce

The introduction of Integrated Care Systems (ICSs) provides an opportunity to embed integrated workforce planning (NHS Employers, 2022b).

Mental health support to non-specialised professionals

There has been growth in the number and types of way that mental health professionals support professionals in other sectors, who are not trained in mental health. The model of clinical supervision has been proposed as one method to support worker wellbeing, lessen compassion fatigue and create space for workers to think creatively, manage risk and develop trauma-informed and reflective practice.

- This approach has been used in particular to provide support to non-mental health professionals working with people with severe multiple disadvantage including repeat street homelessness, mental and physical health problems, drug and/ or alcohol misuse, and offending behaviour (Fulfilling Lives, 2022).
- New Neighbourhood Mental Health Hubs in Cambridgeshire and Peterborough offer clinical expertise alongside community experts to people working or volunteering to support others with mental health needs.

Compassionate care

- Providing compassionate care requires 'requires time, capacity for reflection, and an environment that values emotional as much as physical safety' (Liberati et al., 2023).
- National organisations, service users, carers and healthcare professionals have all highlighted issues around low levels of compassion and respect for patients in mental health services (Mind, 2017). The most extreme end of this includes exposures of abuse in mental health services in some areas of England in 2022 (Wells, 2022).
- The Care Quality Commission has highlighted that workforce issues (including vacancies, and high turnover and sickness rates) can make it difficult for staff and patients to build and maintain relationships (Care Quality Commission, 2021).

- In a system where demand for mental health support is greater than capacity, some systems can become 'designed to exclude' individuals – for reasons such as 'complexity', diagnosis and co-morbidity (Beale, 2022)
- It is the responsibility of the system to create the conditions in which compassion can flourish.

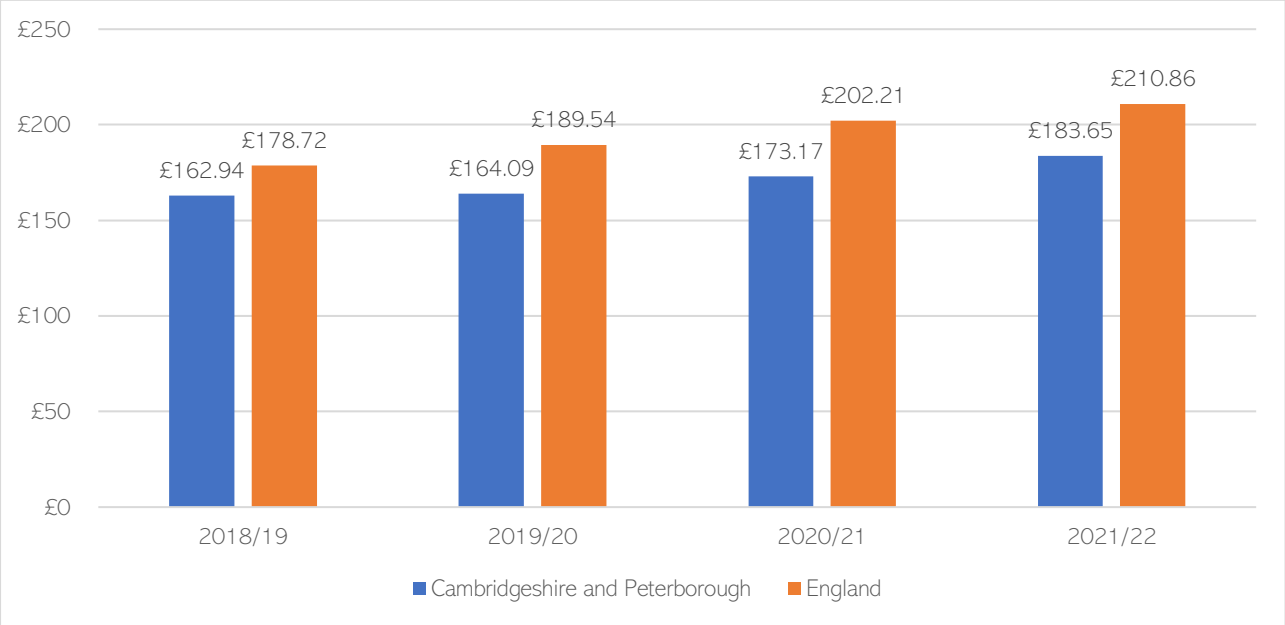
Additional Resources

- Integrated workforce thinking across systems: practical solutions to support integrated care systems (ICSs)
- Waste not, want not: Strategies to improve the supply of clinical staff to the NHS
- Untapped? Understanding the mental health clinical support workforce | Nuffield Trust
- Mental health workforce report (bma.org.uk)
- Safe, sustainable and productive staffing: An improvement resource for mental health
- Developing workforce safeguards: Supporting providers to deliver high quality care through safe and effective staffing
- Working together to prevent suicide in the NHS workforce
- Local strategies: Combined Authority Employment Skills Strategy (2022), Integrated workforce strategy (2017), HEE Cambridgeshire and Peterborough Workforce Partnership

Funding

For the past five years, per head spend on across all mental health services (adjusted for mental health need) has been below the national average in Cambridgeshire and Peterborough. These figures include spending on all-age mental health services, as well as learning disability and dementia services.

Figure 28: Per head spending on mental health services in Cambridgeshire and Peterborough, adjusted for mental health need. Data source: Royal College of Psychiatrists



Note: this data is standardised to take account of mental health need using NHS England needs-based population data for 2018/19 – 2021/22.

Getting It Right First Time (GIRFT) recommends that trusts work with system partners to ensure that the Mental Health Investment Standard is met, and that they have nominated finance/transformation leads at senior level with

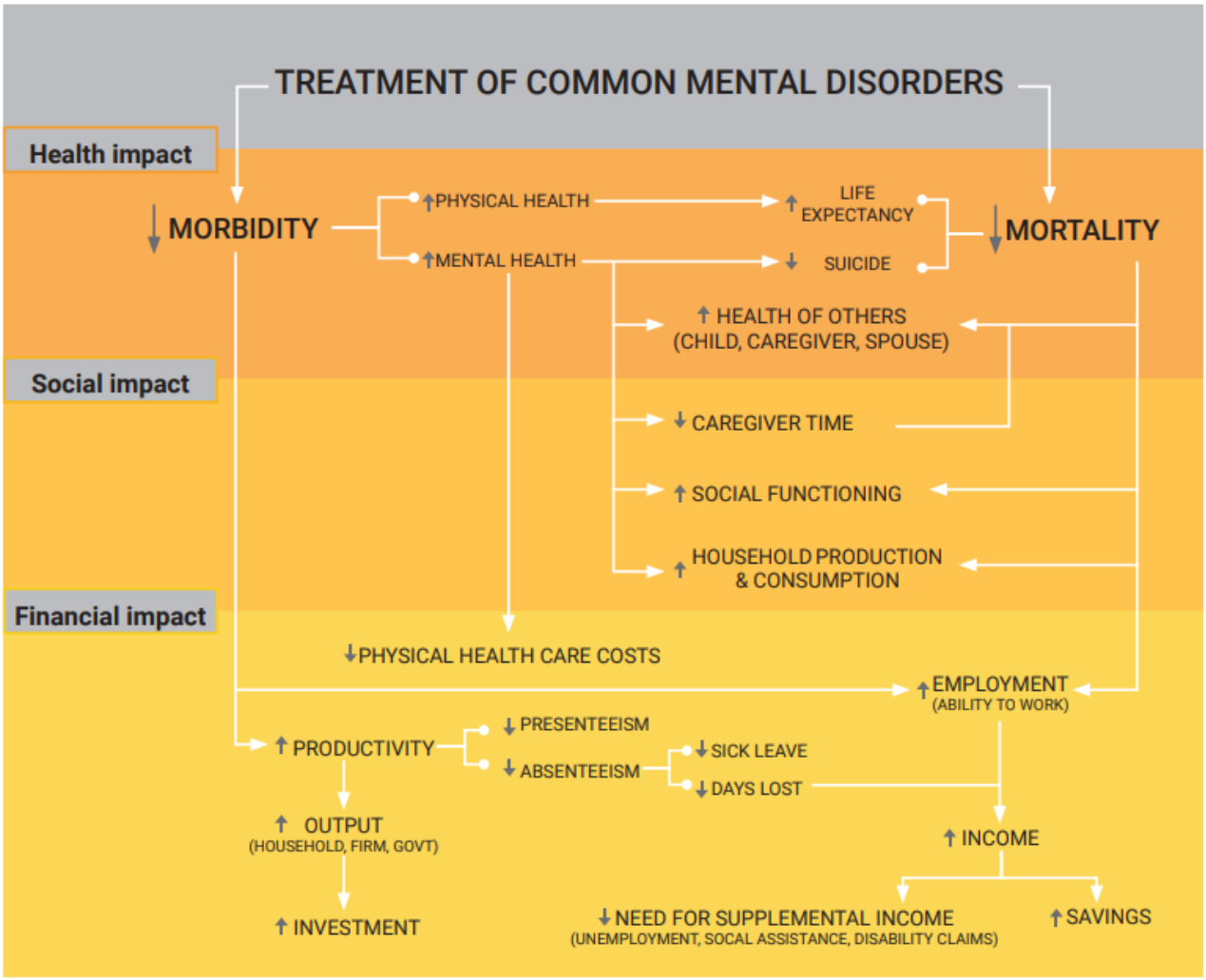
a thorough understanding of the Standard and can specifically identify the growth in investment expected in each service area (Davidson, 2021)

Health economics

- Although health economics is used to inform decision making across healthcare systems, this has historically been underused within mental health (Lathe et al., 2023).
- Some argue that economic estimates of the impact of mental health conditions often underestimates their true costs. Mental ill health may have a range of impacts on society, including on interpersonal relationships, education, employment and benefits, social services, other areas of the healthcare system and the criminal justice system (Lathe et al., 2023; Watson, n.d.).
- In a 2023 review of mental health services in England, the National Audit Office highlighted that 'understanding of costs of services is still poor for many areas, including in primary and community services' (House of Commons Committee of Public Accounts, 2023).

The World Health Organisation has proposed that frameworks analysing the impacts of investing in mental health services should consider health impacts (e.g. on both physical and mental health), social impacts (e.g. on social functioning and carers) and financial impacts (e.g. on employment and physical health care costs) (World Health Organisation, 2021). However, the scope of analyses and the availability of data varies across these domains.

Figure 29: Analytical framework for identifying potential impacts of mental health investment. Image source: World Health Organisation



Cost of mental illness

- Mental health is an 'indispensable part of health' (World Health Organisation, 2021), with poor mental health impacting individual's quality of life and life span.
- It has been estimated that mental health problems cost the UK economy at least £118 billion each year, appropriately 5% of the UK GDP in 2019 (McDaid et al., 2022). The majority of these costs are due to the lost productivity of people with mental illnesses and costs incurred by unpaid carers (McDaid et al., 2022).
    - This figure is likely to be underestimate as it does not include impacts of presenteeism or absenteeism in the workplace, or the links with physical health conditions (McDaid et al., 2022).
    - Comparatively, the NHS spent £16.8 billion on mental health services in 2023/23, including spend on learning disability, autism and dementia services (NHS England, 2023e).
- Mental illness has a substantial impact on the national workforce: mental illness is consistently one of the top five reasons for sickness absence in the UK (Office for National Statistics, 2023) and 'presenteeism' due to mental ill-health (in which people still attend work but are less productive) is estimated to account for 1.5 times as much working time lost to absenteeism and to have a significant cost to employers (The Sainsbury Centre for Mental Health, 2007).
- There are close links between poor mental health and physical health conditions, with co-morbid mental health conditions raising total health care costs by an estimated 45% for each person with a long-term physical health condition. It has been estimated that between 12 to 18% of NHS spending on long-term conditions is linked to poor mental health and wellbeing (Naylor et al., 2012).
- The 2010 Marmot review highlighted that health inequalities directly cost the NHS at least £5.5 billion per year. Productivity losses associated with inequalities are thought to be between £31 to £33 billion per year (Marmot, 2010).

Economic case for prevention

The Mental Health Foundation carried out a rapid review of cost-effective interventions to prevent the development of mental health conditions, drawing on systematic reviews as well as individual studies published between 2019 and 2021. This review identified a range of research highlighting the economic benefits of prevention, although the majority of these interventions were aimed at children and young people.

Figure 30: Examples of interventions with a strong evidence base for preventing mental health conditions across the life course. Image source: Mental Health Foundation

Other useful resources include:

- Public Health England's health economics evidence resource summaries economic evidence for public health interventions.
- The Health Financial Management Association report sets out the steps for NHS finance staff to make the case to address health inequalities
- Public Health England produced a guide for Commissioning Cost-Effective Services for Promotion of Mental Health and Wellbeing and Prevention of Mental Ill-Health

Cost-effectiveness of early intervention and treatment

A 2011 report estimated the savings associated with 15 types of mental health promotion and prevention programmes, looking at savings across the NHS, public sector and wider impacts, across the short, medium and long-term (Knapp et al., 2011). The table below highlights total savings across each of these sectors:

Figure 31: Total returns on investment (economic payoffs per £1 expenditure). Image source: Mental health promotion and mental illness prevention: The economic case

	NHS	Other public sector	Non-public sector	Total
Early identification and intervention as soon as mental disorder arises				
Early intervention for conduct disorder	1.08	1.78	5.03	7.89
Health visitor interventions to reduce postnatal depression	0.40	–	0.40	0.80
Early intervention for depression in diabetes	0.19	0	0.14	0.33
Early intervention for medically unexplained symptoms [b]	1.01	0	0.74	1.75
Early diagnosis and treatment of depression at work	0.51	–	4.52	5.03
Early detection of psychosis	2.62	0.79	6.85	10.27
Early intervention in psychosis	9.68	0.27	8.02	17.97
Screening for alcohol misuse	2.24	0.93	8.57	11.75
Suicide training courses provided to all GPs	0.08	0.05	43.86	43.99
Suicide prevention through bridge safety barriers	1.75	1.31	51.39	54.45
Promotion of mental health and prevention of mental disorder				
Prevention of conduct disorder through social and emotional learning programmes	9.42	17.02	57.29	83.73
School-based interventions to reduce bullying	0	0	14.35	14.35
Workplace health promotion programmes	–	–	9.69	9.69
Addressing social determinants and consequences of mental disorder				
Debt advice services	0.34	0.58	2.63	3.55
Befriending for older adults	0.44	–	–	0.44

As highlighted above, there are significant short and longer-term economic benefits of early intervention in psychosis (EIP) services. The net cost savings per person after the first four years is £7,972, with a further £6,780 saving per person in the next four to 10 years if full EIP provisions are provided. Over a 10-year period this would result in £15 of costs saved for every £1 invested (Public Health England, 2019): The majority of these savings are due to:

- the reduction in use of crisis and inpatient services.
- improved employment outcomes.

- the reduction in risk of future hospitalisation as a result of improved management and reduced risk of relapse.

Financial opportunities

The GIRFT report has identified financial opportunities linked to MH crisis and acute services relating to:

Table 9: Areas for improvement and opportunities identified in the national GIRFT report. Adapted from: (Davidson, 2021)

Improvement	Opportunity
Improve community-based care and local inpatient capacity	Reduce out of area placements
Ensure existing staff capacity is efficiently utilised and train sufficient numbers of professionally qualified staff	Reduce bank and agency costs
Reduction in patients that present to Accident and Emergency 24 hours or less, prior to admission	Reduce Accident and Emergency attendances
Reduce unexplained variation in admissions under the Mental Health Act	Reduce admissions under the Mental Health Act
Most short-stay hospital cases could and should receive better care in the community	Reduce proportion of short stay hospital admissions (0-3 days length of stay)
Ensure people do not become stranded in community teams or inpatient services	Reduce length of stay of patients staying over 60 days

The experience of people with lived experience and local staff may provide opportunities to better understand these areas for improvement.

Additional Resources

- Oxford Mental Health Economics and Policy
- Mental Health Investment Standard (MHIS) categories
- The economic case for investing in the prevention of mental health conditions in the UK
- Mental health promotion and mental illness prevention: The economic case
- Better Mental Health For All
- Mental health investment case: a guidance note
- Public mental health: Evidence, practice and commissioning (see pages 109 – 114)

Integration of lived experience

This report uses the term 'lived experience' to describe the range of approaches that can be used by healthcare systems involve, listen to and work with the people and communities they serve. These include patient engagement, feedback and co-production (Wellings & Thorstensen-Woll, 2022). Integrating the voices of local people and communities is a central feature of integrated care systems (ICSs) and is crucial to building a learning health system. However, a 2023 report from the King's Fund highlights that across England (Wellings & Tiratelli, 2023):

- Patient experience is not always prioritised within ICSs, including a lack of consideration of insights provided from patient experience compared to other types of data.
- There is not always enough capacity to ensure that patient experience 'everyone's business'.
- There is a need for clarity within ICSs for who has responsibility for different aspects of lived experience.

Where possible, data about the experiences and outcomes of people who have used the services of local mental health services has been included in this needs assessment. However, it is nationally recognised that there is a gap in the collection of outcome data from mental health services (Department of Health & Social Care, 2023)

Where is lived experience collected?

- There are many ways to record and collect lived experience insights, including focus groups, surveys and personal blogs. The table below lists some of the key sources of lived experience insights that are collected.
- It is important to consider how well these approaches capture everyone's voices: for example, national surveys may not be accessible or engaging to all groups.
- Integrated care systems need to understand the experience of individuals (who may have multiple needs and complicated routes to accessing care), rather than just experiences of people within individual services (Wellings & Thorstensen-Woll, 2022).

Table 10: Sources of lived experience insights

Type of data	Where collected?
National surveys	• State of Care survey (covering health and adult social care) • Community Mental Health Survey • GP Patient Survey • Survey of Adult Carers • Adult Social Care User Survey
Local authority	• Resident surveys (e.g. Cambridgeshire County Council Quality of Life Survey) • Regular forums (e.g. adult social care forums)
Healthcare services	• Friends and Family Test (FFT) • GP patient groups • Complaints procedures (via PALS) • Individual services may have their own processes for service users and family members to give feedback
Local organisations	• Co-production collaborative • Healthwatch • SUN (Service User Network) • How Are You (HAY) • Voiceability • Community groups • Carer support groups (e.g. Rethink Carers, Pinpoint, Making Space) • Individual organisations have their own feedback and co-production processes (e.g. CPSL Mind has their own co-production group)
Ad-hoc work	• From services and commissioners (e.g. consultation around new service design) • Government consultations • From national organisations (e.g. report from Rethink Mental Illness) • From local organisations (e.g. surveys conducted by Healthwatch) • Academic research

Why is lived experience vital?

Lived experience is a vital part of integrated care systems is key:

- To address power imbalances in the mental health system.
- To ensuring services and strategies will make a difference to local communities.
- To quality improvement (Ezaydi et al., 2023)
- To understanding inequalities.
- NHS trusts and local authorities also have legal duties to consult or involve the public when proposing changes to service provision.

GIRFT notes that engagement activities are important for challenging the system; sampling of individual personal experiences provides different perspectives to those of care providers, but the subjects of such samples typically only represent a very small percentage of people accessing services. Although limited in numbers, however, all such feedback remains valuable, so it is essential that it is reviewed and disseminated to teams in a timely manner. To more accurately gauge impacts and effectiveness, routine generation and use of patient outcome data for all people in contact with a service is essential. This will not replace other activities such as engagement events or external sampling; instead, they will together contribute to a more robust and comprehensive picture (Davidson, 2021).

What does 'good' look like ?

Each integrated care board (ICB) is expected to have a system-wide strategy for engaging with people and communities. NHS England has defined 10 principles for how ICSs should work with people and communities:

1) 'Put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS.
2) Start engagement early when developing plans and feed back to people and communities how their engagement has influenced activities and decisions.
3) Understand your community's needs, experience and aspirations for health and care, using engagement to find out if change is having the desired effect.
4) Build relationships with excluded groups, especially those affected by inequalities.
5) Work with Healthwatch and the voluntary, community and social enterprise (VCSE) sector as key partners.
6) Provide clear and accessible public information about vision, plans and progress, to build understanding and trust.
7) Use community development approaches that empower people and communities, making connections to social action.
8) Use co-production, insight and engagement to achieve accountable health and care services.
9) Co-produce and redesign services and tackle system priorities in partnership with people and communities.
10) Learn from what works and build on the assets of all ICS partners – networks, relationships, activity in local places.'

Ensuring people and communities are central to decision-making

There are many different frameworks for integrating lived experience, which may be useful for different projects (such as setting priorities or writing reports) (Greenhalgh et al., 2019). There are also multiple reports setting out best practice:

- The involvement of people with lived experience can be evaluated using the four patient involvement (4Pi) standards, which were developed by people with lived experience
- Co-production:
    - The SUN (Service User Network) report on Co-Production and Involvement Best Practice Guidance
    - Social Care Institute for Excellence's report Co-production: what it is and how to do it
    - Nesta's report Co-production: Right here, Right now
    - Rethink Mental Illness's Model for Coproduction: a guide for Integrated Care Systems
- Building meaningful partnerships:
    - National Voices has set out 6 key features which 'support meaningful partnership between lived and learned experience'.
    - The King's Fund report on how to listen to and learn from people and communities
    - What Works Centre for Wellbeing has reviewed the evidence around community power and the impact on community wellbeing, including the enablers and barriers which can impact community agency
- NHS England has set out frameworks for the patient and public participation in commissioning:
    - Framework for patient and public participation in public health commissioning
    - Framework for patient and public participation in primary care commissioning

Integrating patient feedback

Patient feedback, including positive and negative feedback and informal comments, should be collected, analysed and interpreted. These findings should be accessible for staff, so they can utilise this feedback as a key 'driver of quality improvement' alongside other types of data to help understand what is happening within services (Kumah et al., 2017; Weich et al., 2020). However, too often:

- Patient feedback is not used to drive quality improvement (NHS Confederation, 2023).
- The data collected focuses on a single service or aspect of care, rather than looking at the experiences of individuals as a whole (NHS Confederation, 2023).
- The processes for embedding patient feedback vary both between and within NHS trusts, with national research highlighting that there is often insufficient use of patient experience data in inpatient mental health services (Weich et al., 2020).

What are local people's experiences of the mental health system?

The Service User Network is the service user network in Cambridgeshire and Peterborough. The majority of feedback received about mental health or drug and alcohol service is positive. However, feedback from 310 people across the county from the first quarter of 2023/24 raised the following issues (Sidney, 2023):

- People do not know what support is available other than their GP. This is a particular issue for people who have been discharged from clinical services, with reports of people 'feeling like they have been dropped' and CPFT staff not knowing which other services are available.
- People can find it difficult to get an appointment at their GP.
- There are long waiting lists and people are not sure if they are even still on a waiting list or not as they are not hearing anything. There are extremely long waiting times (around 2 years) for ADHD and autism assessments.
- People really appreciative of the service and support they have received when they have been able to access support – particularly from third sector and grassroots organisations.
- Older people feel that mental health support is disjointed and focuses mainly on dementia, and there is not enough focus on other conditions such as depression, anxiety, and personality disorder. Discharge from hospital to home/care home was also raised as an issue, due to unrealistic expectations of carers both in terms of finances and capability.
- People with PTSD or complex trauma report that they cannot find support.
- People with co-occurring mental health needs and substance use are still not finding joined up support with substance misuse and mental health services.

What does national research tell us about people's experiences of the mental health system?

National research by Healthwatch, who analysed the experiences of over 4,000 people in 2022, highlighted several issues with mental health support (Healthwatch, 2022):

- Variations in how well-equipped GP teams are to deal with mental health issues, and people can struggle to get their GP to refer them for specialist mental health support.
- Long waiting times for services, across all stages of the mental health system.
- Mental health assessments can feel hasty and often do not lead to the outcome people want.
- Poor communication between services and patients, and between different services.
- Many people felt that their treatment ended before they felt are ready, with a lack of follow-up support.
- People who need to restart treatment after relapsing often have to completely restart the whole process of getting help.
- In terms of specific services, people raised that:
    - Crisis services can be over-subscribed and therefore often inaccessible.
    - Community-based treatment is patchy and can be unhelpful at times.
    - Inpatient treatment is an unpleasant experience.

Healthwatch also highlighted that some groups face greater difficulties when accessing care, including (Healthwatch, 2022):

- Some services are inaccessible for autistic people and people with learning disabilities.
- Lack of specialist support for LGBTQ+ people.
- Some people face communication barriers, particularly people with sensory impairments and/or people who do not speak English as a first language.
- Services do not always meet the needs of people from ethnic minority backgrounds.
- Services are not always equipped to support people with 'complex needs', such as people experiencing homelessness.

People report that delays to receiving care and limited choice of support can mean that their mental health deteriorates. This can also have a significant impact on their family, who may take provide day-to-day support for their loved one (Healthwatch, 2023a).

Additional Resources

- Health Innovation East Midlands have collated a range of Patient and Public Involvement Resources

Trauma-informed approach

What is trauma?

There is growing research around trauma, including how trauma and adverse childhood experiences can make someone more likely to develop, or directly cause, a mental health condition. Different organisations use different definitions of trauma, with the Office for Health Improvement and Disparities (OHID) stating that:

> *'Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as harmful or life threatening. While unique to the individual, generally the experience of trauma can cause lasting adverse effects, limiting the ability to function and achieve mental, physical, social, emotional or spiritual well-being'* (Office for Health Improvement and Disparities, 2022b)

What is a 'trauma-informed' approach or service?

OHID has adopted (Office for Health Improvement and Disparities, 2022b) the definition developed by the United States Substance Abuse and Mental Health Services Administration, which states that systems or organisations are trauma-informed if they:

> *'realize[s] the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization'* (Huang et al., 2014)

These approaches are not about treating people who have experienced trauma, but taking a whole-systems approach to allow people who have experienced trauma to access the support they need, whether that be mental healthcare or other support services (Sweeney & Taggart, 2018).

There has been an increased focus in recent years on services taking a 'trauma-informed approach', including within the NHS Long Term Plan (NHS, 2019), and nationally in Wales (ACE Hub Wales, 2022) and Scotland (Scottish Government, 2021). Some research focuses on trauma-informed approaches for specific groups, including for

women (Bear et al., 2019) and people experiencing severe multiple disadvantage (Department for Levelling Up, 2023).

There is some evidence showing that trauma-informed interventions have a positive impact (Scottish Government, 2021):

- Trauma-informed interventions can increase engagement with treatment and reduce trauma-related symptoms, such as for women with co-occurring mental health needs and substance use.
- Trauma-informed alternatives to seclusion are associated with reductions in the use of restraint against young people in secure psychiatric care.

Trauma-informed approaches in Cambridgeshire and Peterborough

To improve system-wide understanding of trauma-informed approaches in Cambridgeshire and Peterborough, cross-sector workshops took place in 2023. This was led by Changing Futures and included people with lived experience, organisations providing support around domestic violence and healthcare staff.

Additional Resources

- Trauma-Informed Wales: A Societal Approach to Understanding, Preventing and Supporting the Impacts of Trauma and Adversity
- Scottish Government's Trauma-informed practice: toolkit
- A sense of safety: trauma-informed approaches for women
- Trauma-informed approaches to supporting people experiencing multiple disadvantage: A Rapid Evidence Assessment
- Training: Scotland National Trauma Training Programme, NHS England All Our Health: Vulnerabilities and trauma-informed practice and Trauma-Informed Care programme

Support for common mental health conditions

Evidence-based interventions

The Adult Psychiatric Morbidity Survey (2014) found that 10.4% of all adults in England were receiving medication as treatment for common mental illness. This was the most common form of treatment, with 3% of adults receiving psychological therapy and 1.3% receiving both therapy and medication (NHS Digital, 2014). These figures may be out of date, due to substantial investments in Talking Therapies services since 2014.

- The following interventions should be available to support people experiencing mild-to-moderate anxiety and depression (Public Health England, 2019):
  - individual facilitated self-help based on the principles of cognitive behavioural therapy (CBT)
  - computerised CBT
  - structured group physical activity programmes
  - group-based peer support programmes (for those who also have a chronic physical health problem)
- People who present with more severe common mental health conditions, or who fail to respond to the above treatments, should be offered one of a range of more intense psychological therapies (such as face-to-face CBT or couples therapy), or a suitable medication, or both (Public Health England, 2019).
- Social factors contributing to the depression should also be addressed (Public Health England, 2019).
- Although depression and anxiety disorders respond well to evidence-based interventions, there are high levels of relapse. Services should therefore ensure that relapse prevention approaches are included in treatment episodes, as detailed in relevant NICE guidance (Public Health England, 2019).

Antidepressants

- Antidepressants are a type of medication used to treat depression. They can also be used to treat other conditions, such as generalised anxiety disorder and long-term chronic pain (NHS, 2021).
- Nationally, antidepressants prescriptions have increased since SSRIs (selective serotonin reuptake inhibitors) were introduced as a treatment for depression in the 1980s (Kendrick, 2021). Research suggests that this increase has been driven by both greater numbers of people receiving antidepressant treatment and prescriptions lasting for a longer time (Kendrick, 2021).
- In the UK, the median duration of antidepressant use is over 2 years (Kendrick, 2021). For some people, a long-term antidepressant prescription may be the best form of treatment and help to prevent relapse of depression symptoms.
- However, around 30 to 50% of patients on long-term antidepressants had no clear clinical reasons for continuing to take them (Kendrick, 2021). Long-term antidepressant use is associated with increased risk of side effects and withdrawal symptoms (Kendrick, 2021).
- It is estimated that around half of people who stop taking antidepressants experience discontinuation/ withdrawal symptoms, although there is not comprehensive data on this issue (Davies & Read, 2019). Patient-led groups have highlighted that these symptoms can be severe and/or long-lasting (LEAP for Prescribed Drug Dependence, 2023).

What do the guidelines say?

- NICE guidelines highlight that antidepressant treatment 'might need to be taken for at least 6 months after the remission of symptoms, but should be reviewed regularly' (NICE, 2022).
- British Association for Psychopharmacology guidelines state that 'medication-responsive patients should have their medication continued at the acute treatment dose after remission with the duration determined by risk of relapse' and that for patients at lower risk of relapse 'the duration should be at least 6 – 9 months after full remission' (Cleare et al., 2015).
- The Royal College of Psychiatrists state that 'evidence does suggest the need for improved monitoring of patients' long-term antidepressant use' but that GPs will require better resources to undertake regular antidepressant reviews (Royal College of Psychiatrists, 2019).

Additional Resources

- Optimising personalised care for adults prescribed medicines associated with dependence or withdrawal symptoms: Framework for action for integrated care boards (ICBs) and primary care
- Lived Experience Advisory Panel for Prescribed Drug Dependence, a group that have drafted a model for an integrated primary care service for prescribed drug dependence

Primary care

'Primary care is in a unique position to deliver mental health care, being most people's first port of call-in times of health care need or the development of symptoms. It is the only part of our health service that offers 'cradle to grave' family orientated, person-centred care, often seeing and supporting patients through significant life events such as pregnancy and bereavement.' – Royal College of General Practitioners (Royal College of General Practitioners, 2017)

- It is estimated that 1 in 4 people using primary care services will require treatment for a mental health condition at some point in their life (Care Quality Commission, 2015).
- 90% of adults with mental health conditions (excluding those with serious and enduring mental illness) are supported in primary care (Independent Mental Health Taskforce, 2016).

- It has been estimated that 30 – 40% of people seeing their GP have a mental health component to their consultation (Mind, 2018; Royal College of General Practitioners, 2017).
- 12% of GP patients in Cambridgeshire and Peterborough report having a long-term mental health condition (NHS England, 2023a).

What support is provided?

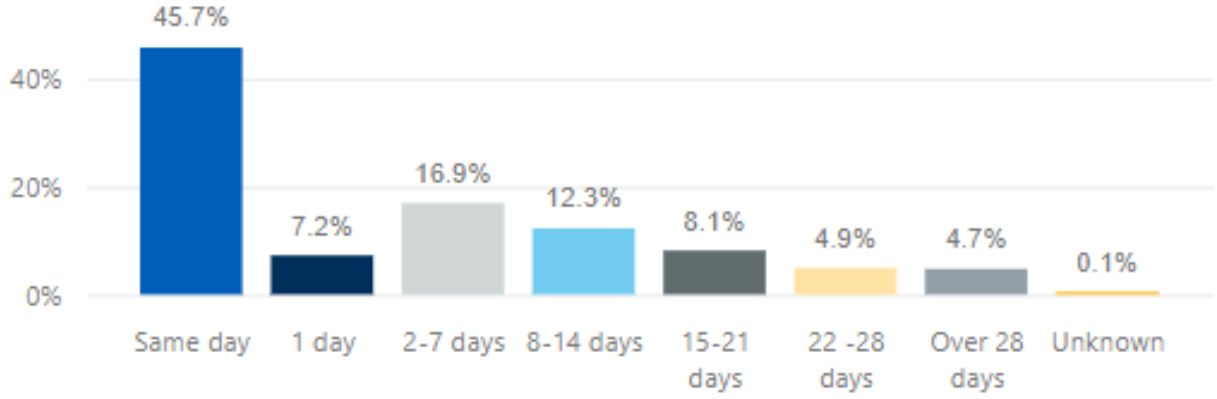
- At the initial stages of the stepped care model, healthcare professionals in primary care should be alert to the symptoms of common mental health conditions and have a good understanding of the best practice protocols they can put in place and the onward referral routes available (Public Health England, 2019).
- Onward referral options include social prescribing (add link) to community resources such as community support groups (such as CPSL Mind), volunteering opportunities, physical activity programmes and befriending services. This is likely to increase confidence, build social networks and develop self-efficacy (Public Health England, 2019).
- Medication should not routinely be prescribed at the lower steps for recent onset mild common mental health conditions (Public Health England, 2019). NICE guidelines are clear about when they should be prescribed (NICE, 2022).

Appointments

In May 2023, there were around 429,000 appointments in general practice in Cambridgeshire and Peterborough ICS (NHS Digital, 2023a) (note that these appointments were made for any reason, not specifically mental health).

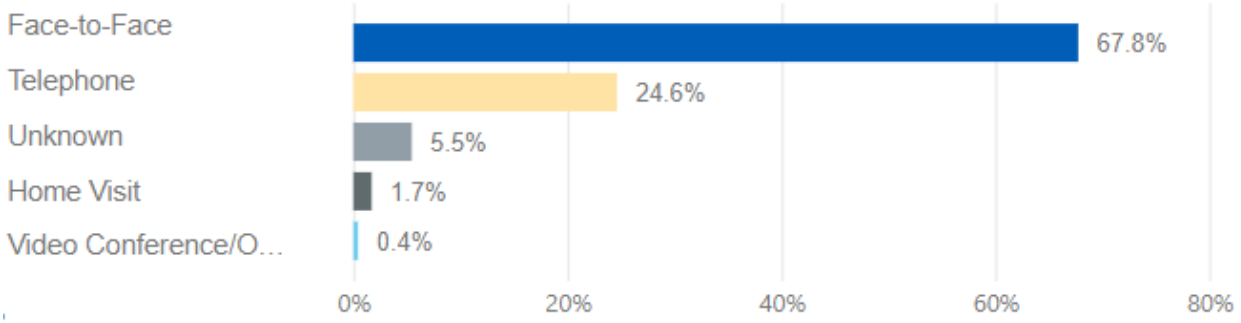
- Around half of these appointments took place within 48 hours of being booked and almost 70% within a week of booking (NHS Digital, 2023a).
- This data does not capture the full picture as some people may find it difficult to book a GP appointment initially, and not end up making an appointment. People with poor mental health may face additional barriers to accessing appointments.
- It is also important to be aware that many people want to book ahead for GP appointments (Paddison, 2023).

Figure 32: Waiting time between booking and getting an appointment in general practice in Cambridgeshire and Peterborough ICS, May 2023. Image source: NHS Digital



68% of general practice appointments in May 2023 were delivered face-to-face, which is similar to the national average. Almost a quarter were on the telephone.

Figure 33: General practice appointment mode in Cambridgeshire and Peterborough ICS, May 2023. Image source: NHS Digital



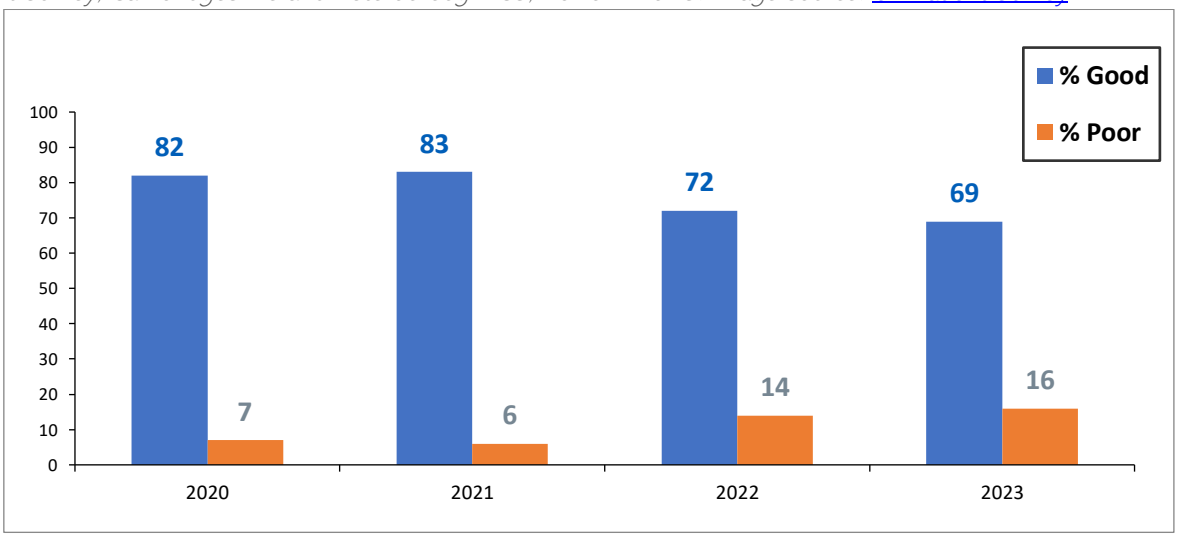
The majority of appointments in May 2023 were with 'other practice staff' (56%) and general practitioners (39%), with the rest of appointments being carried out by 'unknown' healthcare professionals (NHS Digital, 2023a).

Experience of general practice

GP Patient Survey is sent to adult patients (aged 16+) registered with GP practices in England. In 2023, the response rate in Cambridgeshire and Peterborough was 34% (10,993 responses). Several questions in this survey relate to mental health.

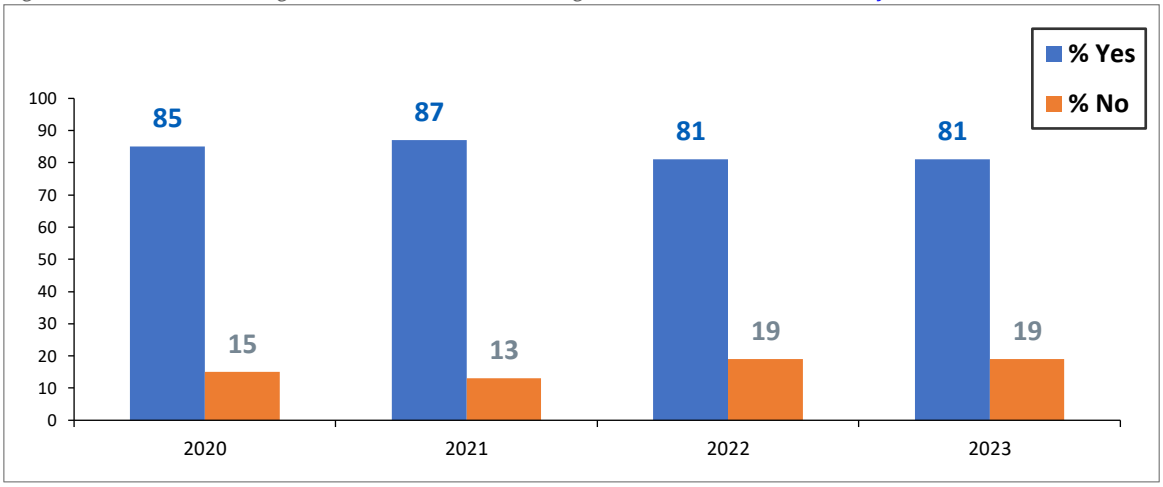
In 2023, 69% of local respondents described their overall experience at their GP practice as good. This is similar to the national average (71%), which has also declined in recent years. There is substantial variation between primary care networks (PCNs) in Cambridgeshire and Peterborough, from 87% to 43% reporting that their overall experience was good.

Figure 34: Responses to the question 'overall, how would you describe your experience of your GP practice?' in the GP Patient Survey, Cambridgeshire and Peterborough ICS, 2020 – 2023. Image source: GP Patient Survey



The vast majority of local people (81%) reported that healthcare professionals recognised and/or understood their mental health needs at their last appointment. This has remained consistent over recent years and is similar to the national average (81%). The range within PCNs is from 90% to 66%.

Figure 35: Responses to the question 'During your last general practice appointment, did you feel that the healthcare professional recognised and/or understood any mental health needs that you might have had?' in the GP Patient Survey, Cambridgeshire and Peterborough ICS, 2020 – 2023. Image source: GP Patient Survey



On average, 83% of all GP patients in Cambridgeshire and Peterborough felt that healthcare professionals were good at treating them with care and concern at their last general practice appointment. This was slightly lower (76%) amongst patients who reported having a long-term mental health condition.

Additional Resources

- Mental health and primary care networks: Understanding the opportunities

Talking Therapies

Talking Therapies (previously known as Improving Access to Psychological Therapies (IAPT) and later locally as the CPFT Psychological Wellbeing Service) provides treatment for common mental health conditions at the higher levels of the stepped care model (Public Health England, 2019). It was first introduced in 2008 and has grown to support over 1.2 million people across England in 2021/22 (NHS England, 2023f).

In Cambridgeshire and Peterborough, Talking Therapies can be accessed by anyone aged 17 or over, without the need for a mental health diagnosis. People can self-refer into this service or be referred in by CPFT professionals. Treatment offered includes:

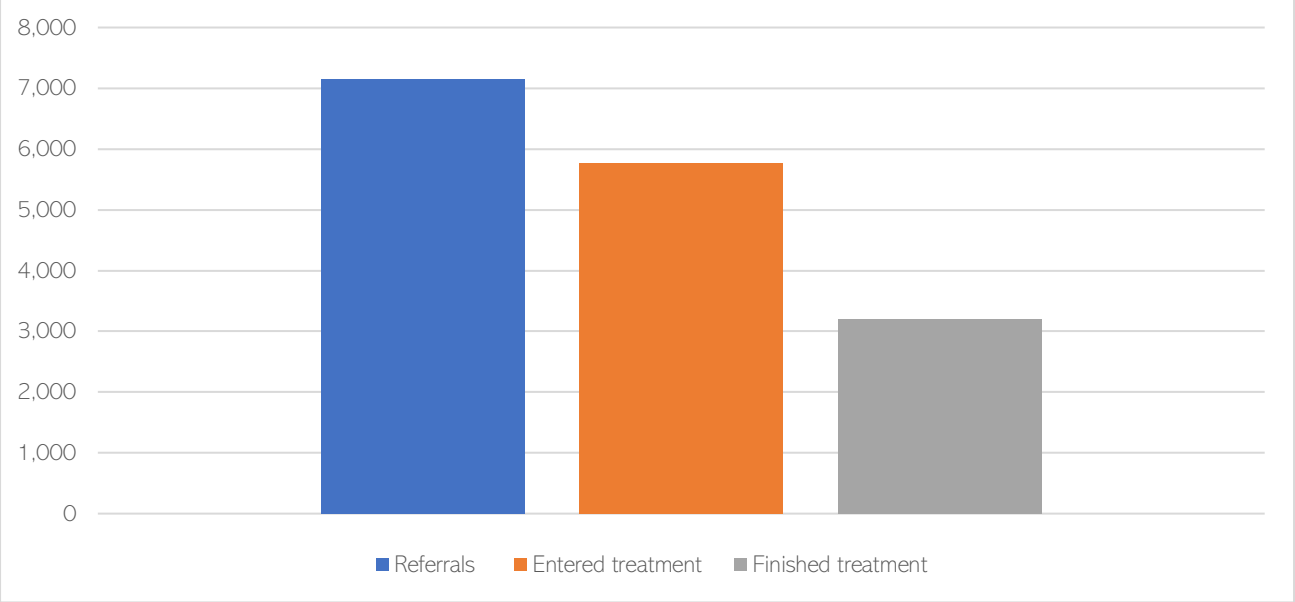
- Low intensity interventions
- Cognitive behavioural therapy (CBT)
- Computerised cognitive behavioural therapy (cCBT)
- Virtual reality-based therapy
- Interpersonal therapy (IPT)
- Eye Movement Desensitisation Reprocessing (EMDR)
- Wellbeing workshops and group treatments
- Specialist support for people who are unemployed.

The introduction of the Psychological Skills Service (PSS) meets the needs of people whose mental health needs are too complex for Talking Therapies (add link).

Who is accessing Talking Therapies?

In the final quarter of 2022/23, over 7,100 people in Cambridgeshire and Peterborough were referred to Talking Therapies. 8 in 10 people who were referred to Talking Therapies began treatment (5,770). Over half (55%) of this group went on to complete treatment (3,195).

Figure 36: Number of people who were referred to, started treatment and finished treatment at Talking Therapies in Cambridgeshire and Peterborough Integrated Care System, Q4 2022/23. Data source: NHS Digital



How does Cambridgeshire and Peterborough compare to national targets?

- An increasing number of people have entered treatment in Talking Therapies in Cambridgeshire and Peterborough over the past two years.
- In the final quarter of 2022/23, 6% of referrals into this service were for adults over the age of 65.
- In the final quarter of 2022/23, almost everyone (99%) received their first treatment appointment within 18 weeks of referral, and a very high proportion (93%) received their first appointment within 6 weeks of referral, meaning that Cambridgeshire and Peterborough performed better than the national standard in terms of waiting times.
- However, the recovery rate for this service in the final quarter of 2022/23 was 48%, below the national target (50%). The recovery rate was also below the national target for people from Black, Asian or minority ethnic groups.

Figure 37: Performance overview of NHS Cambridgeshire and Peterborough ICS Talking Therapies, Q4 2022/23. Source: NHS Mental Health Dashboard

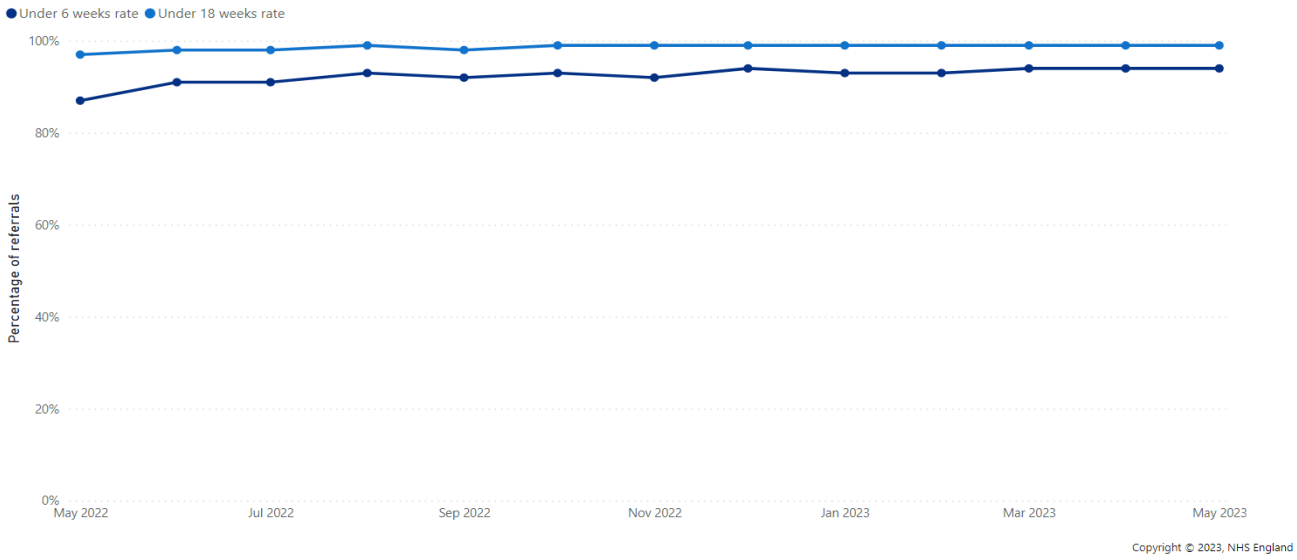
Indicator	Reporting period	Indicator value	Standard met	Trend	Better is...	12 Month % change*	24 Month % change*
NHS Talking Therapies access: number of people entering NHS funded treatment during reporting period	***Q4 2022/23***	5,770	●		▲	-0.3%	24.2%
NHS Talking Therapies % of all referrals that are for older people 65+	***Q4 2022/23***	6.0%	N/A		▲	1.6%	2.8%
NHS Talking Therapies recovery rate: % of people that attended at least 2 treatment contacts and are moving to recovery	***Q4 2022/23***	48.0%	●		▲	-1.0%	-1.0%
NHS Talking Therapies recovery rate for Black, Asian or Minority Ethnic groups	***Q4 2022/23***	47.0%	●		▲	-7.0%	-1.0%
NHS Talking Therapies % of people receiving first treatment appointment within 6 weeks of referral	***Q4 2022/23***	93.0%	●		▲	10.0%	3.0%
NHS Talking Therapies % of people receiving first treatment appointment within 18 weeks of referral	***Q4 2022/23***	99.0%	●		▲	1.0%	0.0%
NHS Talking Therapies % of in-treatment pathway waits over 90 days	***Q4 2022/23***	17.3%	N/A		▼	-1.7%	3.1%
NHS Talking Therapies ICB spend	***2022/23***	£10.7m	N/A		N/A	83.8%	71.5%

*Note that these indicators should be interpreted with caution as some data is experimental and changes could be due to fluctuations in data quality. * green figures indicate a positive change for the indicator (the 'better is…' column shows whether this is a positive or negative change) and red figures indicate a negative change. A green circle in the 'standard met' column indicates that performance is better than the national standard where applicable, and a red circle indicates that performance is worse.*

What are the waiting times for this service?

In May 2023, almost everyone (94%) referred to Talking Therapies in Cambridgeshire and Peterborough began treatment within 6 weeks; and 99% within 18 weeks. Waiting times for this service decreased slightly from May 2022 to May 2023.

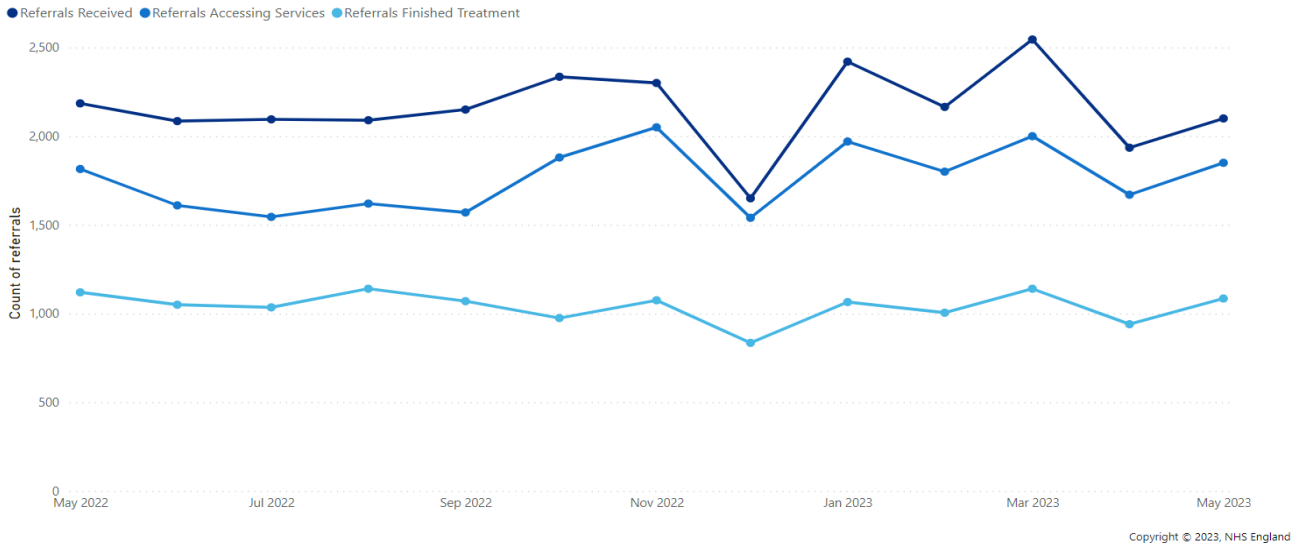
Figure 38: NHS Talking Therapy waiting times, Cambridgeshire and Peterborough ICB, May 2022 – May 2023



How many people access this service?

The number of people referred to Talking Therapies dropped substantially in December 2022 and has shown a fluctuating trend since then. However, the number of referrals finishing treatment has stayed relatively stable at around 1,000 people per month.

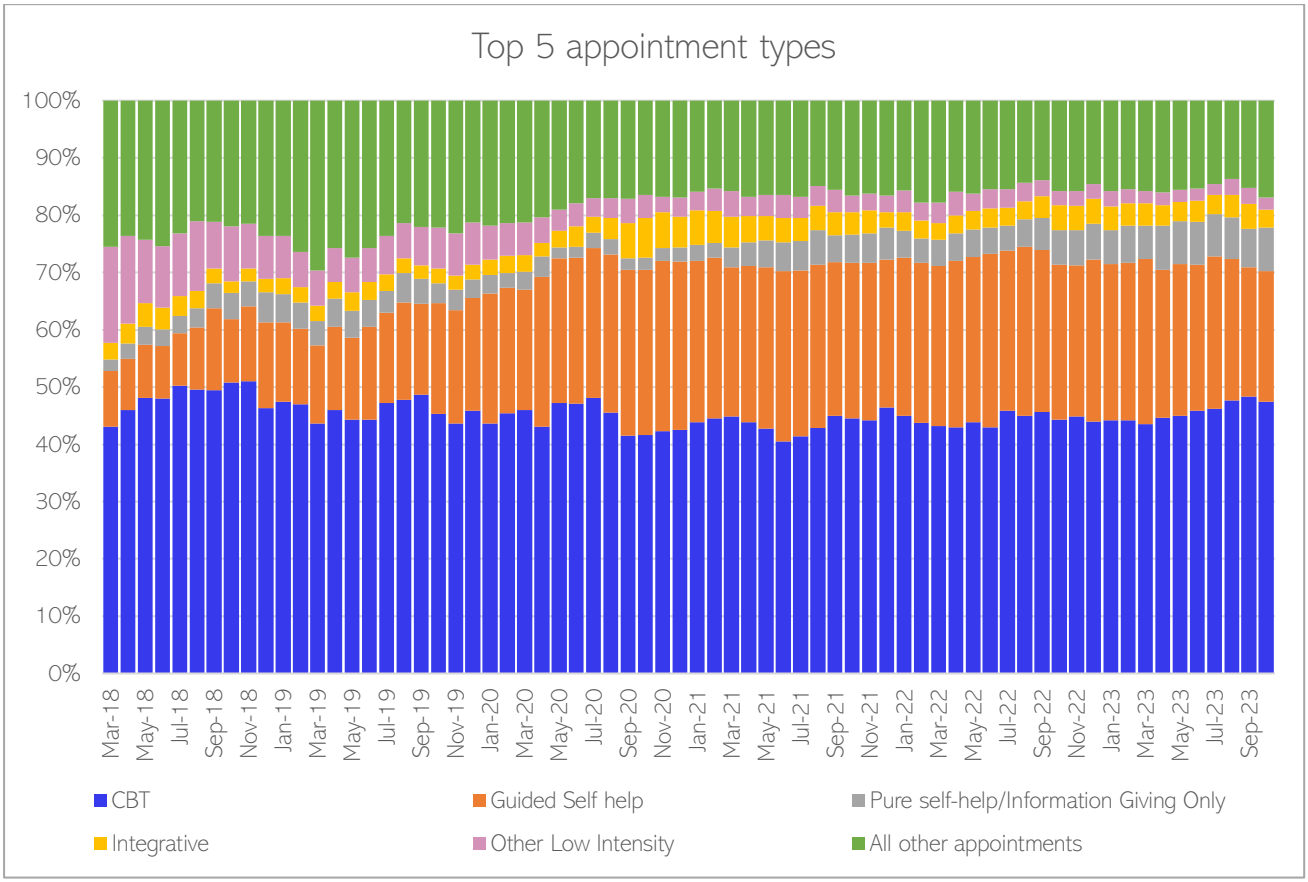
Figure 39: NHS Talking Therapy referrals received, accessing services and finishing treatment, Cambridgeshire and Peterborough ICB, May 2022 – May 2023



What type of support do people access?

Since May 2020, more than 80% of all the appointments in the Talking Therapies service were CBT (cognitive behavioural therapy), guided self-help, pure self-help/information-giving only, integrative, and other low-intensity appointments.

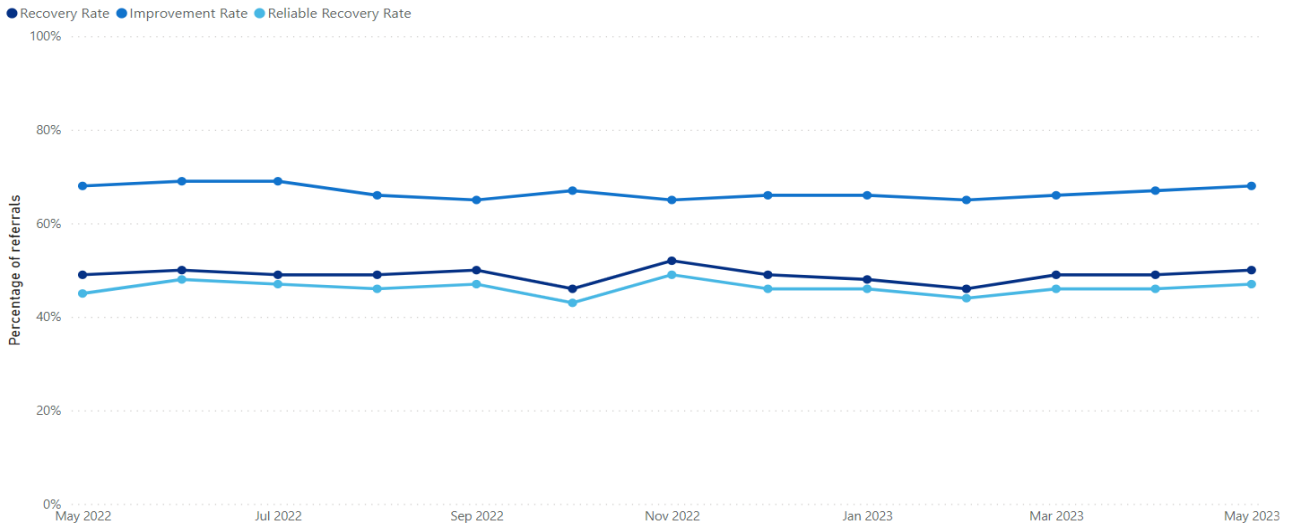
Figure 40: Top 5 most common appointment types at CPFT Talking Therapies, March 2018 – September 2023. Data source: CPFT



What are the outcomes?

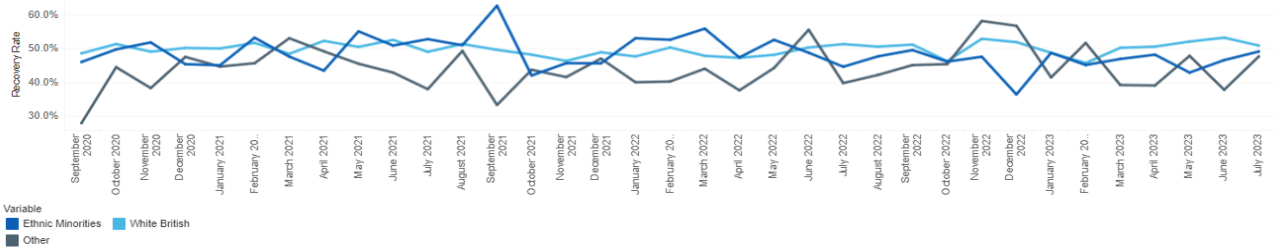
- The majority of people completing a course of treatment in Cambridgeshire and Peterborough Talking Therapies show 'improvement' in their symptoms. Around half enter 'recovery', which is recorded using range of clinical measures which monitor symptom frequency and severity.
- The rate of recovery, improvement, and reliable recovery has shown a fairly stable trend since May 2022.

Figure 41: NHS Talking Therapy outcomes, Cambridgeshire and Peterborough ICB, May 2022 – May 2023. Data source: Source: [Workbook: TTAD_ProtectedCharacteristics (england.nhs.uk)]



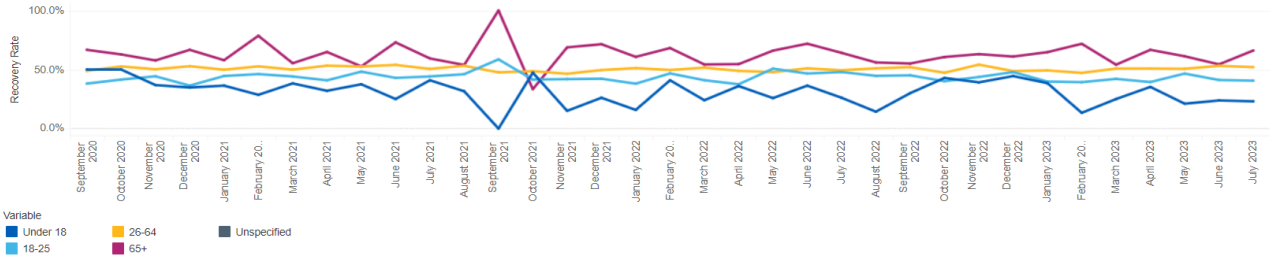
Recovery rates show fluctuations for White British and ethnic minority groups. The recovery rates for people from ethnic minority groups have been constantly lower than 50% since June 2022. Similarly, national research shows that people from minoritized ethnic groups experience poorer outcomes from Talking Therapies, although this gap has narrowed in recent years (Collaborating Centre for Mental Health, 2023).

Figure 42: Talking Therapy recovery rates by ethnic group, Cambridgeshire and Peterborough ICB, May 2022 – May 2023. Source: Workbook: TTAD_ProtectedCharacteristics (england.nhs.uk)



The recovery rate for under 18-year-olds has been substantially lower compared to all other age groups. The recovery rate for 18-25 has been below 50% for most of the reporting periods.

Figure 43: Talking Therapy recovery rate by age group, Cambridgeshire and Peterborough ICB, May 2022 – May 2023. Source: Workbook: TTAD_ProtectedCharacteristics (england.nhs.uk)

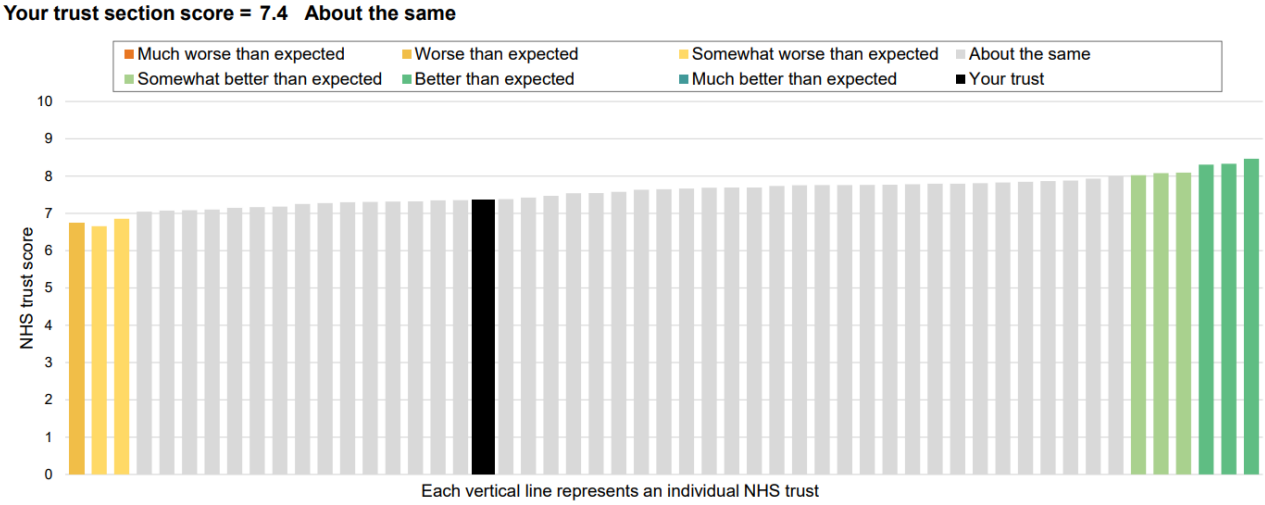


Nationally, people living in more deprived areas are less likely to recover through Talking Therapies, compared to people living in less deprived areas. This may be due to wider factors, such as financial insecurity, that exacerbate poor mental health (Nuffield Trust, 2023).

What do people say about this service?

In Cambridgeshire and Peterborough, most people who have used NHS Talking Therapies report that this service was explained to them in a way that they understand; and that they were involved as much as they wanted in deciding which talking therapies to use. The score given to this service in the NHS Community Mental Health Survey (7.4 out of 10) was similar to the national average and did not change significantly between 2021 and 2022.

Figure 44: Score of Cambridgeshire and Peterborough NHS Trust on NHS Talking Therapies, compared to all NHS Trusts. Image source: [NHS Community Mental Health Survey Benchmark Report 2022]



Additional Resources

- NHS Talking Therapies, for anxiety and depression
- The NHS Talking Therapies manual
- Ethnic Inequalities in Improving Access to Psychological Therapies (IAPT)

Voluntary and community sector support

There is a range of voluntary and community organisations offering support for people with common mental conditions, as well as those offering social support. Many of these organisations are included on the How Are You (H.A.Y) Website.

This section gives an overview of the support provided by some of the largest voluntary sector organisations in Cambridgeshire and Peterborough, such as CPSL Mind, but is not comprehensive.

CPSL Mind

CPSL Mind (Cambridgeshire, Peterborough and South Lincolnshire Mind) provides a range of support that promote good mental wellbeing through the Good Life service. This includes:

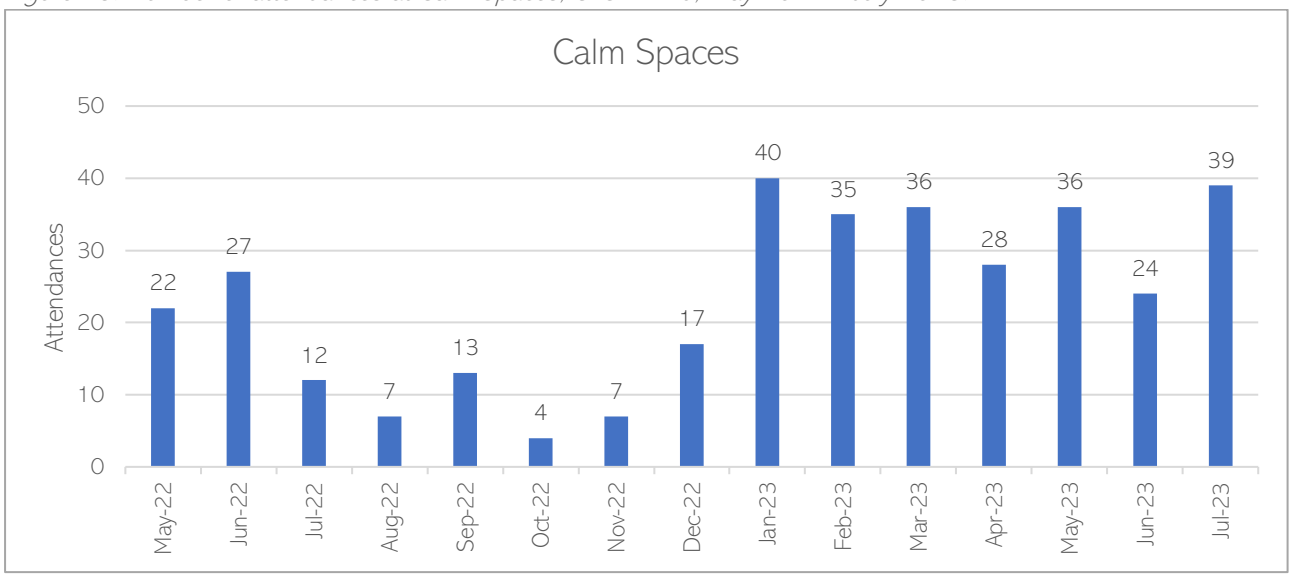
- Good Mood Café: an opportunity to meet new people, to share interests and wellbeing tips in an informal space. Cafes are held in local cafes, outdoors and online.
- Calm Spaces: offer places to find guidance on self-help techniques which can help people to ground themselves and feel better, both in that moment and in the future. Calm Spaces are held in local community spaces and online.
- Good Life Fund: offers grants of up to £500 to people in our local community to help set up groups that connect people, such as book clubs, craft classes, or activities that encourage people to learn new skills.
- Qwell: online support and wellbeing community, which includes self-help resources and chat-based counselling.

CPSL Mind also offers Changing Lives Talking Therapies: counselling and cognitive behavioural therapy (CBT) for people experiencing difficulties with their mental health, including group therapy.

Calm Spaces

There was an average of 34 attendances for at Calm Spaces from January to July 2023. The increase in 2023 was due to the inclusion of the Rural Good Life team into the Service and an increase in staff members.

Figure 45: Number of attendances at Calm Spaces, CPSL Mind, May 2022 – July 2023.



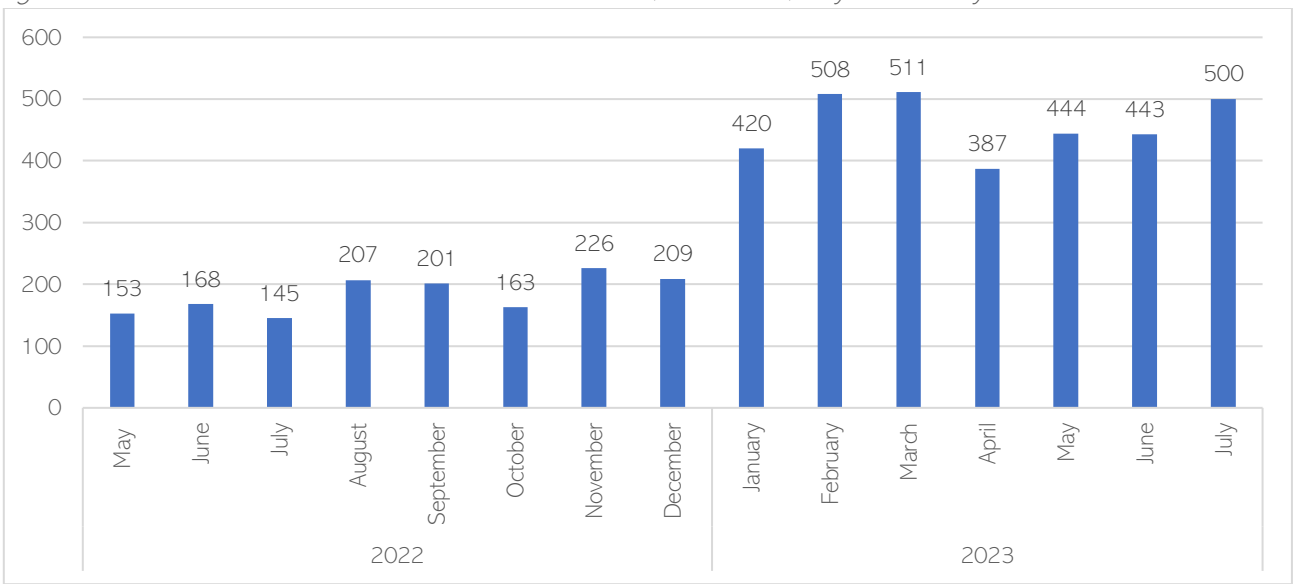
Good Life Fund

From August 2022 to July 2023, the co-production team at CPSL Mind approved 32 applications to the Good Life Fund for presentation to the Good Life board.

Good Mood Cafés

The number of attendances at Good Mood Cafés rose substantially from an average of 189 attendances per month in the 2022, to an average of 459 per month from January to July 2023. This increase was due to the inclusion of the Rural Good Life team into the Service and an increase in staff members.

Figure 46: Number of attendances at the Good Mood Cafés, CPSL Mind, May 2022 – July 2023.



There is ongoing work to evaluate this service and collect outcomes from people who have attended Good Life Cafés.

Money Matters Service

From August 2022 to July 2023, the Money Matters Service protected/generated £68,064 for people accessing this service, through welfare benefits, tax credits or grants. This is an average of over £17,000 per quarter.

Qwell

In May to July 2023, 252 people used the online Qwell service.

- There were 202 new registrations in this time period. 18% were from men, suggesting that men were much less likely to use this service compared to the general population.
- On average, each individual logged in to Qwell on 6 separate occasions. 18% of logins were from people from Black or other ethnic minority groups, a relatively high proportion compared to other mental health services aimed at people with common mental health conditions.
- Around two thirds (65%) of logins were made out of hours, suggesting that this service provides an important form of support for at this time.
- The most common types of support accessed were messaging and chat-based counselling sessions. Only 4% of people accessed peer support forums.
- The feedback was overwhelmingly positive, with 98% of people saying that they would recommend this service.

CRUSE

Cruse is a national charity providing bereavement support for people of all ages, including by phone, online and one-to-one in person support. There are branches in Peterborough and Cambridge (covering Fenland and Uttlesford Area).

In 2011/22, 296 people self-referred to this service and 295 were referred by health care professionals. 407 people completed treatment.

CHOICES

CHOICES provides trauma-informed counselling throughout Cambridgeshire and Peterborough, for people who have experienced sexual abuse in childhood. This includes specialist counselling, peer support groups and psychoeducation symptoms management sessions.

- 131 people received counselling in 2021/22. Almost half (95 out of 204) of people seen by this service had been referred from mental health services.
- People attending counselling reported reduction in trauma symptoms (flashbacks, panic attacks, nightmares, self-harm, and dissociation) and improved relationships with their immediate family, friends, and work colleagues. Out of people who had previously used drugs, two thirds had stopped drug use completely after attending counselling.
- 9 in 10 (91%) of people attending individual symptoms management sessions developed positive coping mechanisms and 74% felt better able to make everyday decisions.

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