Support for severe mental illness

- Severe mental illnesses are long-term mental health conditions that have a substantial impact over multiple aspects of people's lives (Swinson et al., 2016). This term is commonly used to describe bipolar disorder and psychotic disorders, but can also include other mental health conditions when the impact is severe such as anxiety, depression, and eating disorders (Swinson et al., 2016).
    - In NHS guidance on 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, 2018b), although people in 'remission' are excluded from this register. This definition is used 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 their own physical health risks (NHS England, 2018b).
- Community mental health services are 'secondary care services designed for those with severe mental health conditions (inclusive of psychosis, eating disorders, and bipolar mood disorder), enabling people to access specialised care as close to their home as possible' (Bagri, 2023).

Evidence-based interventions

- Community based mental health services support people with mental health conditions in their journey from referral to longer term recovery (Public Health England, 2019). Services should be commissioned to consistently provide rapid access to a full NICE-recommended package of care, delivered in a person-centred and values-based way.
- This includes (National Institute for Health and Care Excellence, 2011; NHS England, 2023d; NICE, 2014):
    - person-centred and co-produced approaches to care planning.
    - psychosocial and psychological therapy interventions for individuals and their families.
    - optimisation of medication and regular medication review.
    - physical health assessments and required interventions, including dental and ophthalmologic and healthy lifestyle promotion.
    - effective recovery and rehabilitation in home and community settings including support with finding and maintaining stable housing, employment, financial wellbeing and social networks.
- Services should help people achieve and maintain recovery by (Public Health England, 2019):
    - providing rapid referral for assessment and secondary care treatment and support where required.
    - providing enhanced primary care step-down support to maintain recovery following discharge from secondary mental health services.
    - Providing rapid access to care to enable service users to step-up their care as required or self-refer for reassessment.
    - routinely recording and publishing patient and carer experience and outcome measures.

Antipsychotics

- Antipsychotics are medications used to reduce and control psychotic symptoms, such as delusions and hallucinations.
- The different types of antipsychotics are sometimes categorised as 'first-generation' and 'second-generation'. Their side effects vary, so the choice of medication is related to an individual's particular needs.
- Clozapine is a second-generation antipsychotic that is unusually effective but also has particular side effects, so is considered separately below (NICE, 2014).

Clozapine

- NICE guidelines state that clozapine is the only medication known to reduce symptoms and risk of relapse for adults whose schizophrenia has not responded to conventional antipsychotic drugs (National

Collaborating Centre for Mental Health, 2014). Around half of people with treatment-resistant schizophrenia respond to clozapine (53).

- Research suggests that fewer than 1 in 3 patients with treatment-resistant schizophrenia receive clozapine in the UK (Whiskey et al., 2021), highlighting unmet need.
- The Clozapine Clinic is a service run by CPFT (Cambridgeshire and Peterborough NHS Foundation Trust) which monitors the effects of clozapine. This includes mandatory blood monitoring (carried out weekly, fortnightly or monthly) and biannual physical health checks.
- The table below demonstrates the potential gap for the use of clozapine within our local area, with a total of 277 people living with treatment-resistant schizophrenia who may benefit from clozapine initiation.

Table 1: Estimated level of unmet need in clozapine treatment in Cambridgeshire and Peterborough, December 2023

	Estimated prevalence of schizophrenia (0.45%)[1]	Estimated prevalence of treatment-resistant schizophrenia (33%)[2]	Number of patients who would respond to clozapine (50%)[3]	Current Caseload	Potential Gap
Cambridge	656	219	109	219 *(Cambridge Clinic)*	78
East Cambridgeshire	395	132	66		
South Cambridgeshire	729	243	122		
Huntingdonshire	814	271	136	67 *(Huntingdon Clinic)*	69
Peterborough	971	324	162	105 *(Peterborough Clinic)*	57
Fenland	461	154	77	8 *(Fenland Clinic)*	69
Total	4026	1342	671	399	272

Note that crude estimates for the prevalence of schizophrenia used 2021 Census data and did not account for age, deprivation or rurality. Data sources for estimates:

1) *Census 2021 and NICE Guidelines (2014) (https://www.nice.org.uk/guidance/cg178/evidence/full-guideline-490503565) [point prevalence]*
2) *Clinical Guidance on the Identification and Management of treatment-resistant schizophrenia (2019) (https://www.psychiatrist.com/jcp/psychiatry/clinical-guidance-on-treatment-resistant-schizophrenia/#:~:text=Treatment%2Dresistant%20schizophrenia%20(TRS),inconsistent%20and%20not%20evidence%20based)*
3) *Mizuno Y, McCutcheon RA, Brugger SP, Howes OD. Heterogeneity and efficacy of antipsychotic treatment for schizophrenia with or without treatment resistance: a meta-analysis. Neuropsychopharmacology 2020; 45: 622–31.*

Who is prescribed antipsychotics?

- The majority of people prescribed antipsychotics have been diagnosed with a psychotic illness, bipolar disorder or schizophrenia (Marston et al., 2014). This group meet criteria for the general practice severe mental illness (SMI) register and therefore are offered annual physical health checks, to monitor potential cardiometabolic side effects associated with antipsychotics (add link).
- NICE guidelines also recommend that certain antipsychotics can be used to augment therapy for depression (NICE, 2022a) or to manage delirium in some people receiving palliative care (National Institute for Health and Care Excellence, 2015).

- There is also a cohort of people prescribed antipsychotics who do not meet these criteria. In 2021/22, across England (46):
    - 0.5% of people without a learning disability, who did not have a SMI diagnosis or require palliative care, were treated with antipsychotics.
    - 9.1% of people with a learning disability, who did not have a SMI diagnosis or require palliative care, were treated with antipsychotics.
- National research highlights that people with dementia make up a substantial proportion of this group (Marston et al., 2014), and that a quarter of people with a 'personality disorder' diagnosis, with no recorded SMI diagnosis, are prescribed antipsychotics (Hardoon et al., 2022).
- Local guidance in Cambridgeshire and Peterborough highlights that all patients prescribed antipsychotics, including those not on the SMI register, should also receive physical health checks.

Additional Resources

- Evidence-based interventions offered in Cambridgeshire and Peterborough (link powerpoint)

Primary care

Primary care works in partnership with secondary care community mental health provision to provide long-term support for people with enduring mental health conditions. The aspiration is that local people can access the right level of care, from the right place, at the right time.

- The Stepped Care Model of Community Mental Health aims to move away from mental health support being delivered either by primary or by secondary care, into a model built around Integrated Neighbourhoods and Primary Care Networks (PCNs). Investment has been made into liaison roles that join primary care, secondary care, voluntary and community sector organisations, as well as in filling gaps in support between Talking Therapies and community mental health services.
- Primary care also provides physical healthcare for people with severe and enduring mental illness, including physical health checks (Royal College of General Practitioners, 2017) (add link)

Peterborough Exemplar (2019 – 2022)

- Peterborough was chosen as the site of a two-year NHS England-funded pilot to transform the delivery of mental health support. Prior to the this, feedback to the SUN (Service User Network) highlighted that people felt that they were 'bounced around' different services and that often help was only available when they became 'unwell enough to hit… threshold'
- The Peterborough Exemplar aimed to provide a sustainable, person-centred system of mental health care for Peterborough, which would deliver a better access to a broader range of care options, reduce demand for high-level interventions, give greater service efficiency, and improve patient experience and outcomes.
- Changes introduced as part of the Exemplar include: increasing the number of clinicians and multi-disciplinary staff within CPFT's Primary Care Mental Health Services (PCMHS), specific mental health clinical leads for each primary care network (PCN), the introduction of a new group programme for people identifying with traits of personality disorder and the dual diagnosis outreach team (DDOT) and the creation of a digital and community engagement team connecting community assets with clinical care.
- Improvements as a result of the Peterborough Exemplar include:
    - Enhanced professional relationships and partnership working between primary care, mental health specialists, local authorities and the voluntary and community sector.
    - Reduced waiting times and increased attended contacts, compared to comparator sites.
    - Two new psychology-driven services accessed directly from primary care. These services fill gaps and enhance access for those that had not previously reached specialist mental health service thresholds.
    - Support to address social factors through new workers and better use of community assets.

- Increased focus on underserved populations from diverse ethnic groups.
- Focus on prevention and mental wellbeing using a digital approach, supported by a community engagement team.

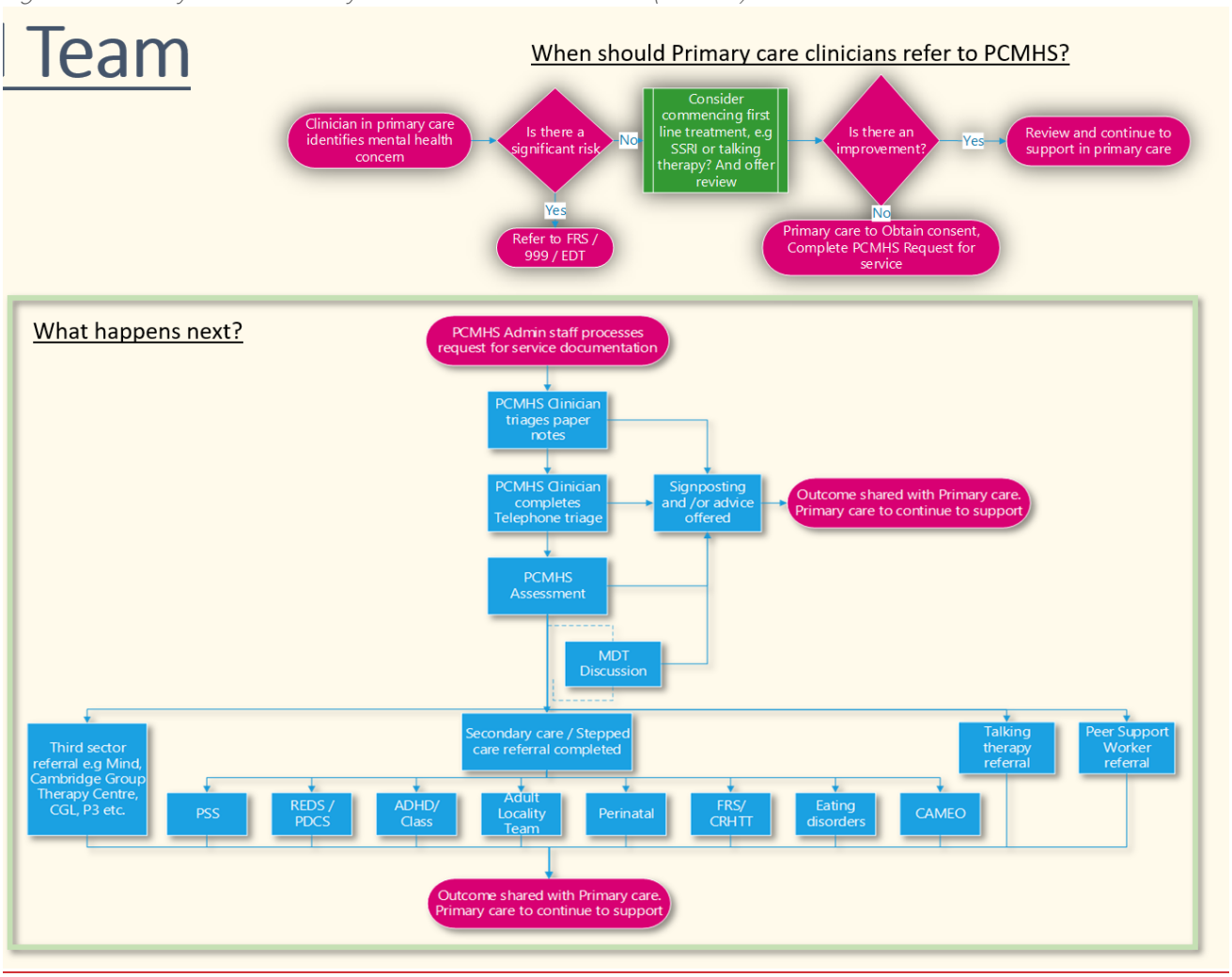
The Peterborough model has not simply been replicated across the county as each neighbourhood is has unique local needs. However, each neighbourhood across the county now benefits from:

- A dedicated Mental Health Liaison Practitioner within CPFT's Primary Care Mental Health Service (PCMHS), the support of an Advanced Nurse Practitioner and the offer of a Primary Care Network (PCN) Mental Health Lead GP role, to directly support the PCN Clinical Director and become the key link between primary and secondary care for that set of general practices.
- PCN Mental Health Leads are brought together for a quarterly networking and training session, allowing them to share expertise with peers.
- The How Are You Digital and Community Engagement team work closely alongside Integrated Neighbourhood colleagues, supporting both voluntary and community sector organisations and statutory teams with knowledge of local assets and a website resource that proactively seeks to remove barriers to accessing support.
- Community and clinical expertise being brough together in new Neighbourhood Mental Health Hubs, which provide a space for professionals to reflect, share case studies and exchange information and updates with everyone supporting those with mental health challenges across the neighbourhood, whatever organisation they work or volunteer with.

Primary care mental health service

- CPFT's Primary Care Mental Health Service (PCMHS, previously known as PRISM) provides specialist mental health support for anyone between age 17 and 65 in Cambridgeshire and Peterborough.
- The PCMHS supports GPs in the provision of person-centred care that considers mental health, physical health and social care needs (Cambridgeshire and Peterborough NHS Foundation Trust, 2023b):
    - If a GP identifies a mental health concern, and there is not significant risk that would indicate a crisis pathway needed, they would initially consider a first line treatment as per NICE guidelines, such as Talking Therapies.
    - If no improvement is seen and the patient is felt to need support beyond the primary care team (including personalised care roles such as social prescribers), the GP requests service from PCMHS.
    - The PCMHS team then triages the patient notes, pulling together a detailed history and complete a telephone triage with the patient if appropriate. This is used to determine if an assessment is in the patient's best interest, and next steps are then decided, often as part of an multidisciplinary team discussion.
    - Supported offered by PCMHS includes mental health assessments, brief interventions, advice on treatment and referrals or signposting to community support (Cambridgeshire and Peterborough NHS Foundation Trust, 2023b). Peer support workers, who have lived or living experiences of mental health challenges, can provide a supportive relationship for people accessing this service (Cambridgeshire and Peterborough NHS Foundation Trust, 2023b).
- PCMHS consists of three teams: a north team covering the Peterborough PCNs, the central team supporting Huntingdonshire and Fenland PCNs, and the south team who cover East Cambridgeshire, South Cambridgeshire and Cambridge City PCNs.

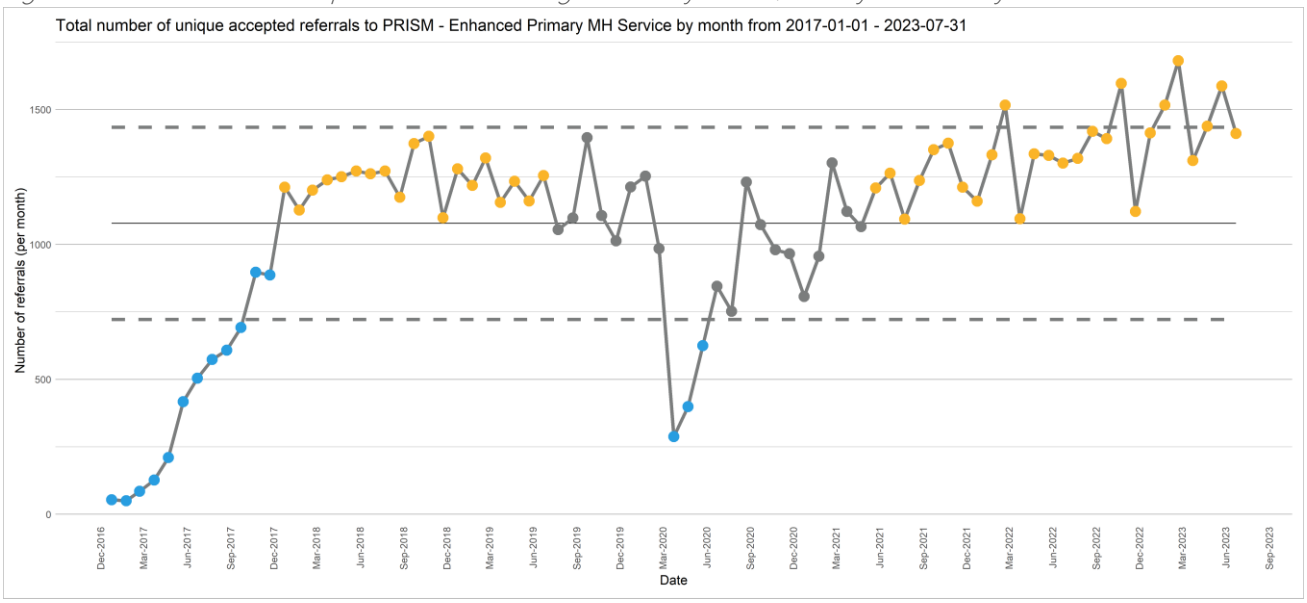
Figure 1: Pathway into the Primary Care Mental Health Service (PCMHS)



Who uses this service?

The number of referrals to the PCMHS has been increasing steadily since June 2020. Before this time period, the COVID-19 pandemic meant that there was a substantial drop in referral numbers.

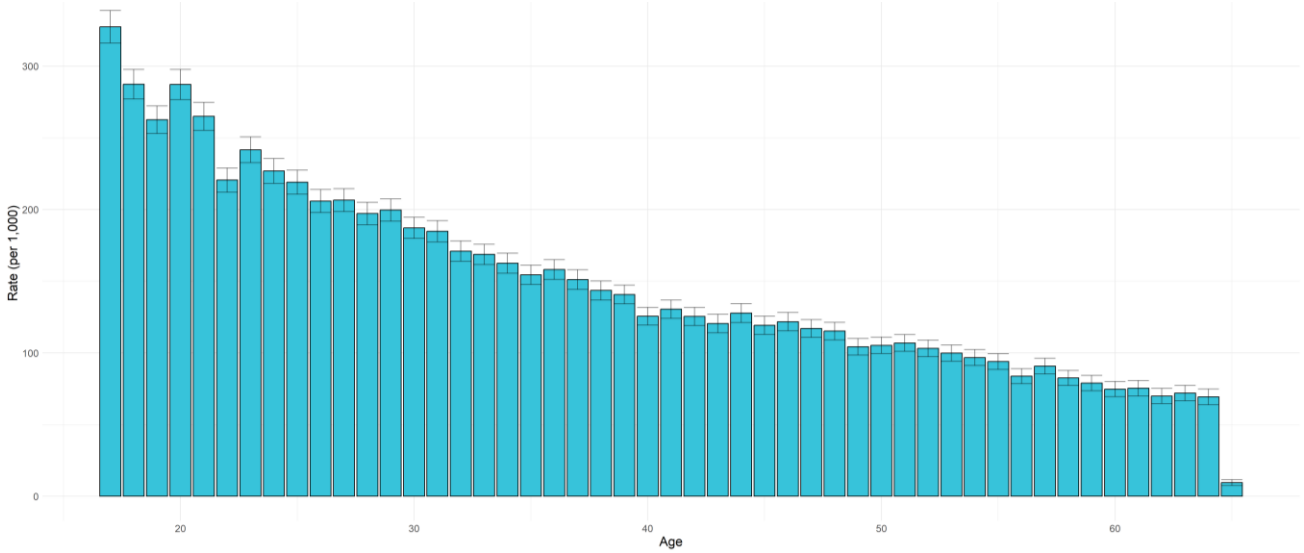
Figure 2: Total number of unique referrals accessing PCMHS by month, January 2019 – July 2023.



Note that unique referrals are not unique service users: a single individual may be referred to the same service multiple times.

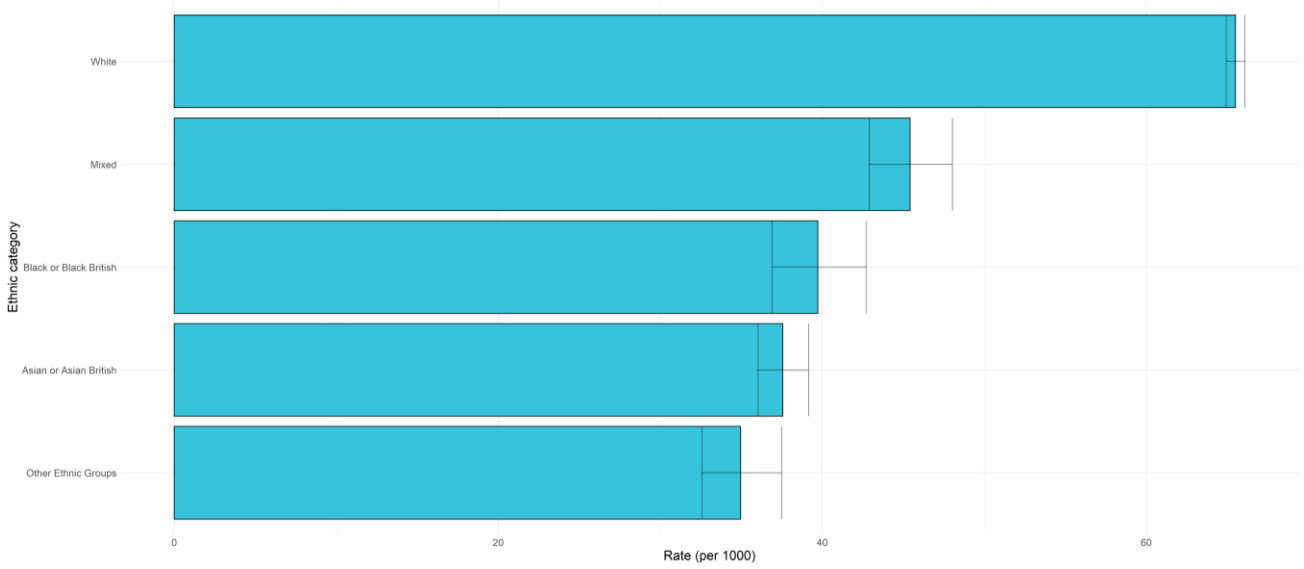
Access rates to the PCMHS decreases by age, with young adults aged between 17 and 21 being most likely to access this service. No adults over the age of 65 were referred to this service from January 2019 – July 2023.

Figure 3: Rate of unique referrals accessing PCMHS by age per 1,000 in the general population, January 2019 – July 2023.



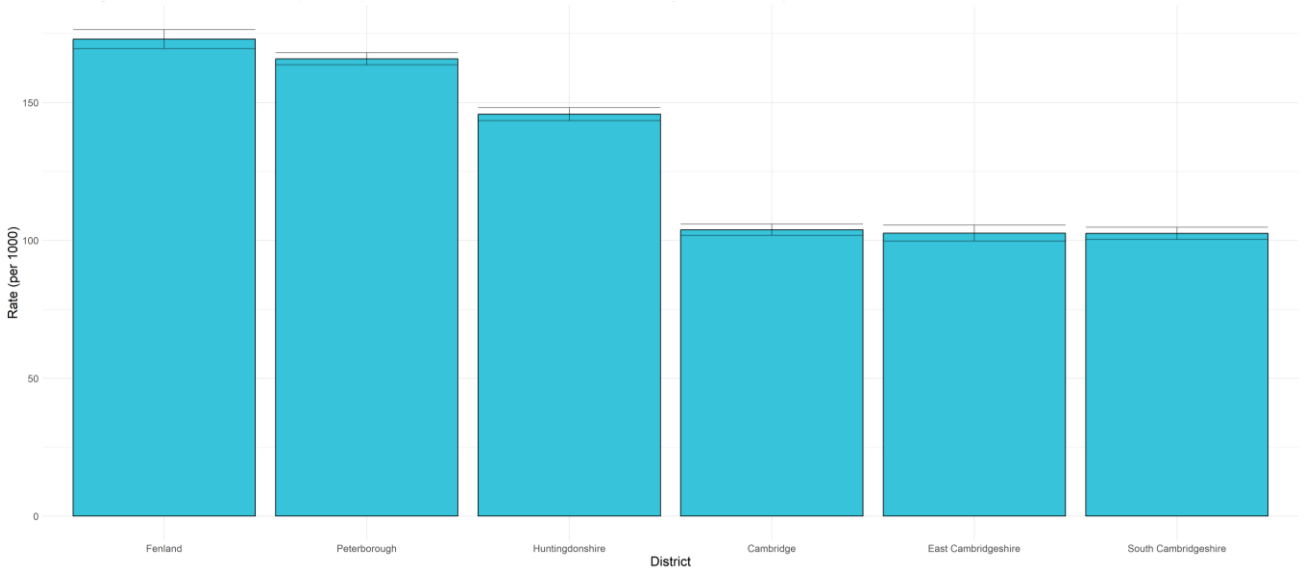
- Women are significantly more likely to access the PCMHS than men.
- Across all age groups, people from more deprived areas are significantly more likely to be referred to and be accepted by the PCMHS.
- People from 'white' ethnic groups are significantly more likely to access this service than those from other ethnic groups. There does not seem to significant different in the rate of referrals for people from 'Black or Black British', 'Asian or Asian British' and 'Other' ethnic groups, though these figures may mask differences within these diverse groups.

Figure 4: Rate of unique referrals accessing PCMHS by ethnic group per 1,000 in the general population, January 2019 – July 2023.



There is a higher rate of referrals accessing the PCMHS from Fenland and Peterborough, compared to other districts. Huntingdonshire also has a high level of referrals, when compared to Cambridge City, East Cambridgeshire and South Cambridgeshire.

Figure 5: Rate of unique referrals accessing PCMHS by district, January 2019 – July 2023.



How effective is this service?

An independent evaluation of the PCMHS in 2018 estimated that this service resulted in an annual saving of at least £650,000, due to a reduction in secondary care referrals and re-referrals to PCMHS (Elliot & Allan, 2018). The evaluation found that (Elliot & Allan, 2018):

- There were strong levels of support for the introduction of this service amongst practitioners and patients.
- Practitioners had positive experiences of working within the PCMHS team. They reported that the 'buy-in' to this service from GPs was mixed, although this is improving as the service becomes better established.
- Patients were very positive about their experiences of and outcomes from the service, and particularly appreciated being able to access appointments at their GP surgery.
- Initial feedback from practitioners, patients and GPs suggested that this service is helping to support patient wellbeing and the management of mental health conditions.

Since this evaluation there have been additional developments to the PCMHS team to improve the working partnership with primary care initially as part of the Peterborough Exemplar and in the roll out of the county-wide Stepped Care model.

Community Connector Mental Health Service

Mental Health Community Connectors (MHCCs) were introduced to work with patients with mental health needs, who do not currently need support from specialist community mental health services (Tiffin, 2023). They provide a specialist social prescribing service focussing on mental health need.

- Each community connector works with around 150 individuals per year who:
    - are not suitable for Talking Therapies and do not reach thresholds for secondary mental health services.
    - currently rely on regular GP appointments for sustained wellbeing, and for whom isolation is a key issue, or their mental health issues are exacerbated by other social issues (such as housing, relationship, physical health, finance/benefits, drugs and alcohol).
- They provide mental health support within primary care, often within the community rather than the practices themselves, and offer longer appointments than GPs. They have a flexible role that aims to meet the needs of individual primary care networks (PCNs) (Tiffin, 2023), including:

- Flexible strengths-based and goal-oriented support within a familiar setting of patient's general practice.
- Support with accessing and navigating with mental health services, community support and preventative physical health services.
- Coaching and encouragement based on the 'Five Ways to Wellbeing'.
- A dedicated in-house mental health resource for GPs with expert knowledge and access to further services to ensure patients are navigated to the right place at the right time.

- This role was added to PCNs as part of the NHS England Additional Roles Reimbursement Scheme in 2021, to enable PCNs and mental health providers to work together and place professionals with mental health expertise within primary care.

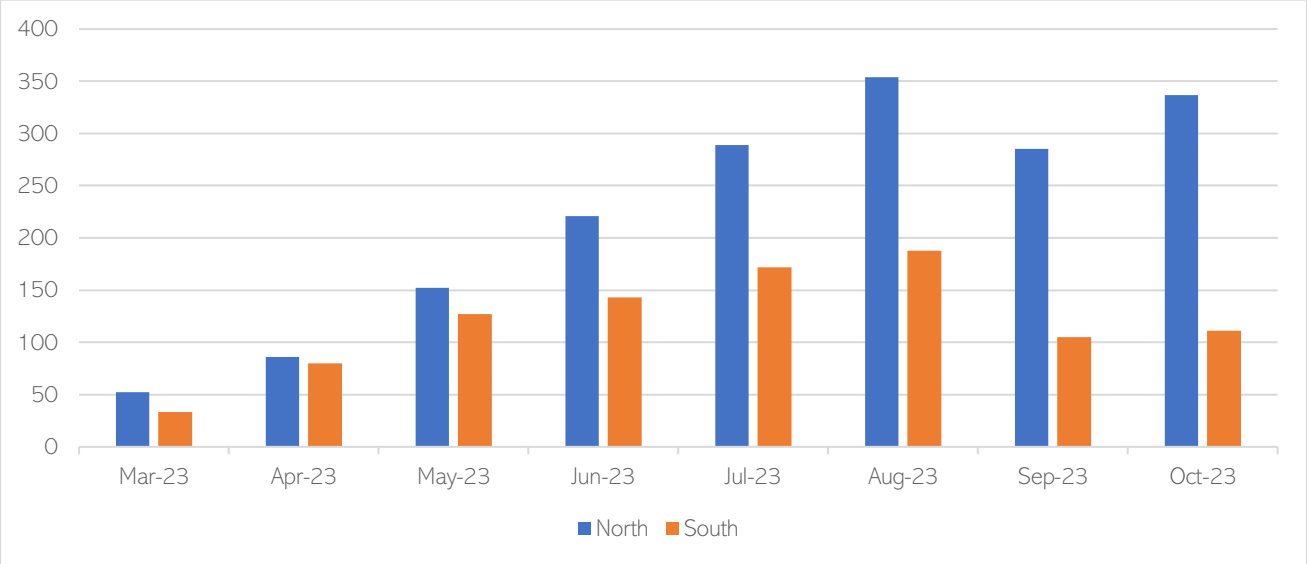
How many people use this service?

PCNs in Cambridgeshire and Peterborough range in size from around 30,000 to 90,000 people (*Primary Care Networks - Overview*, 2019). In October 2023, there were:

- 7 mental health community connectors in the North (covering 58% of the 12 PCNs).
- 6 mental health community connectors in the South (covering 67% of the 9 PCNs).

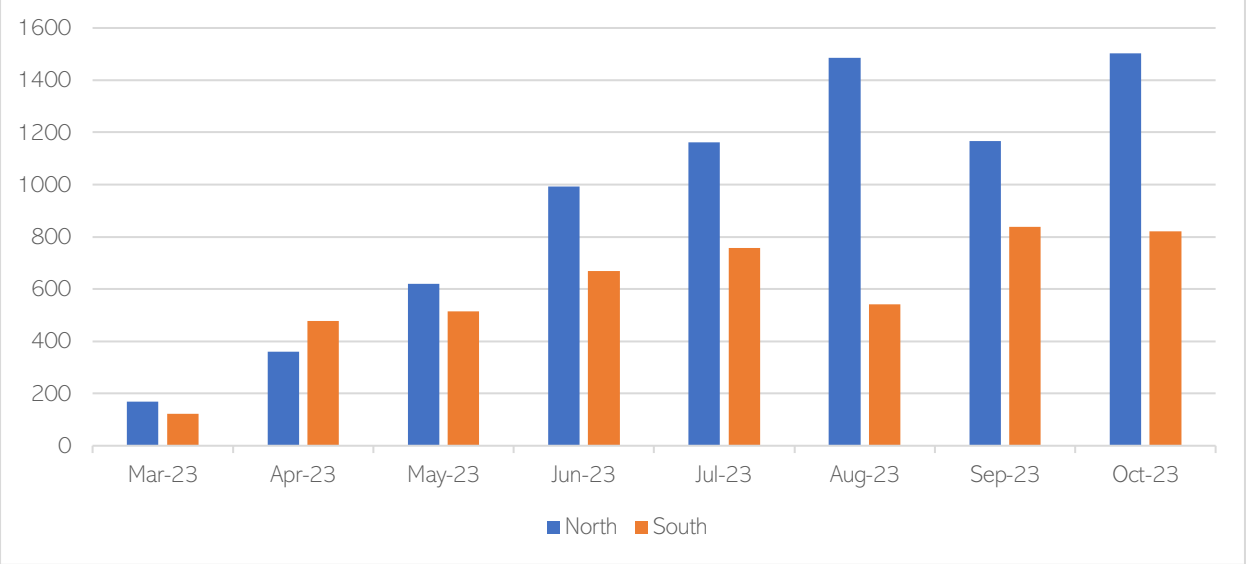
990 people have been referred to Mental Health Community Connectors from February to October 2023, with 281 onward referrals made to relevant mental health organisations. Patients on the service caseload each month for services in the North and South increased steadily from March to August 2023, with a slight decrease after this point.

Figure 6: Active patients on the community connectors caseload each month in North and South, March – October 2023.



Each patient using this service is likely to receive 7 or 8 activity contacts. The number of patient contacts delivered each month has increased over time, although the average number of patient contacts per month varied somewhat (from 2 to 13) as these services became established. Overall, there have been 12,200 activity contacts across both services from February to October 2023.

Figure 7: Patient contacts from community connectors each month in North and South, March – October 2023.



What do people say about this service?

In October 2023 90% of patients in the North, and 80% in the South, were 'likely' or 'extremely likely' to recommend the service. Patient satisfaction scores continue to rise each month.

Additional Resources

- Peterborough Exemplar
- Improving access for all: reducing inequalities in access to general practice services
- Data packs for primary care networks in Cambridgeshire and Peterborough, produced in November 2019
- Mental health and primary care networks: Understanding the opportunities
-

Community mental health services

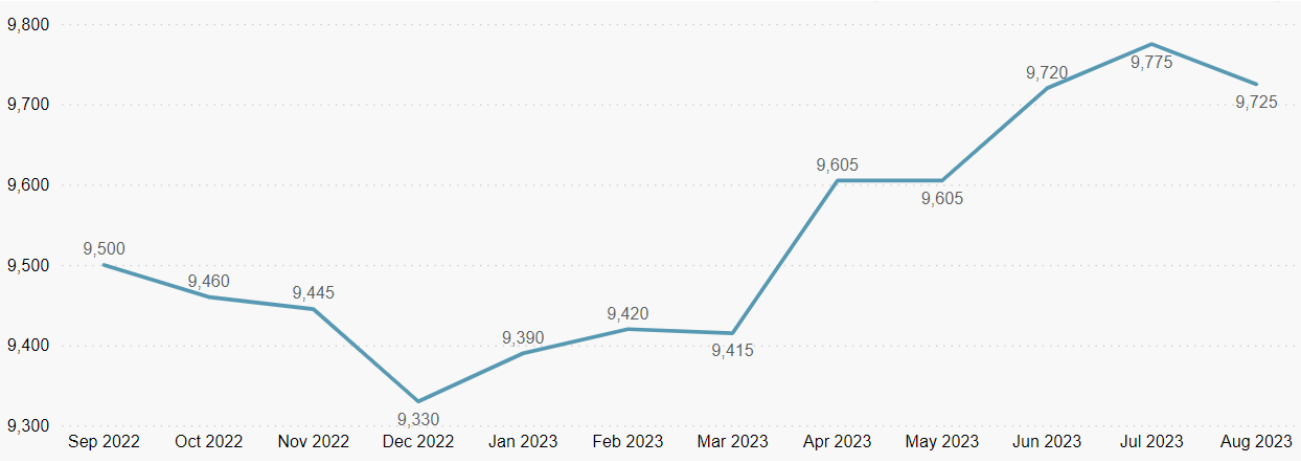
- Community mental health teams (CMHTs) support people living in the community who have complex or serious mental health problems. Patients are able to step down to primary care as their circumstances improve.
- CMHTs are multidisciplinary; staff can include psychiatrists, social workers, nurses, allied health professionals, psychologists, pharmacists and peer workers (Davidson, 2021).
- Since 2020, the number of people referred to core community mental health services has increased in Cambridgeshire and Peterborough. This is matched by an increase in waiting times: in July 2023, 43% of people referred to core community mental health services were waiting for 4 weeks or more since their last contact.

Increasing demand

The number of people accessing community mental health services with serious mental illness who received two or more care contacts in the rolling 12-month period increased from December 2022 to July 2023.

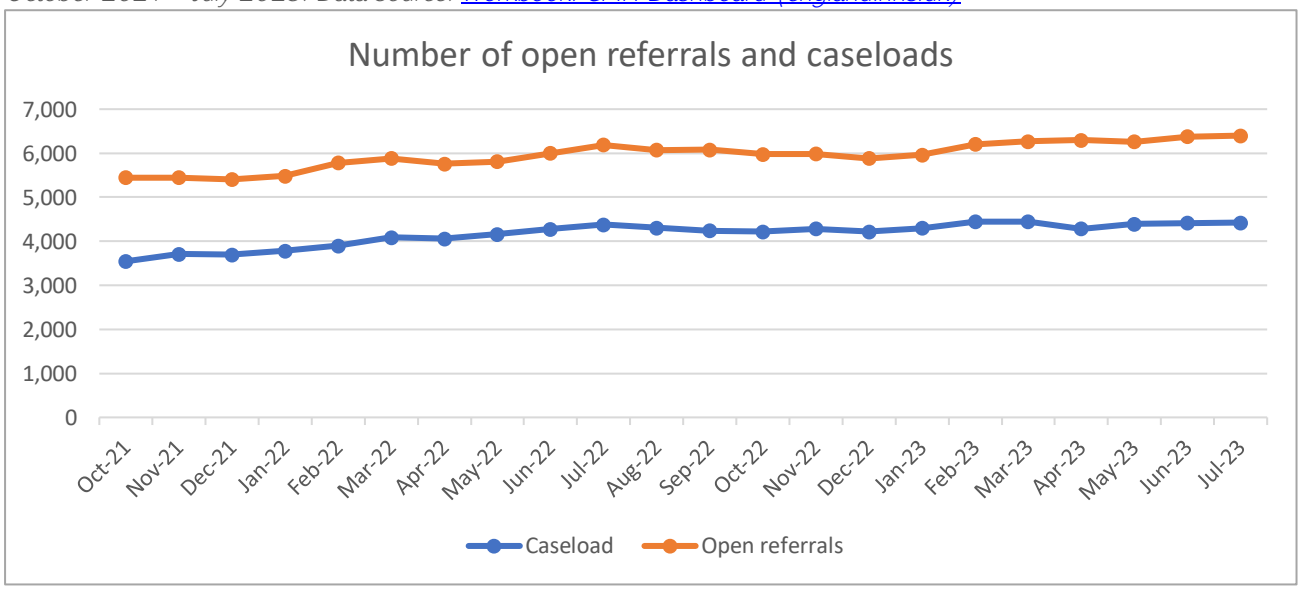
Figure 8: Number of people accessing community mental health services for adults and older adults with serious mental illness who received 2 or more care contacts (any contacts that were clinically meaningful or to support the mental

health of the person referred) within the 12 month rolling reporting period, September 2022 to June 2023. Image source: [Mental Health Services Monthly Statistics Dashboard]



Core community mental health teams include mental health experts from the NHS, social care and voluntary sectors. Core teams deliver and coordinate care for adults with mental health problems, including those with co-existing conditions. This involves assessment, specific psychological and pharmacological interventions, and support to access community assets. The number of open referrals and caseload of core community services increased from October 2021 to July 2023.

Figure 9: Open referrals and caseload of core community mental health services, Cambridgeshire and Peterborough ICS, October 2021 – July 2023. Data source: [Workbook: CMH Dashboard (england.nhs.uk)]



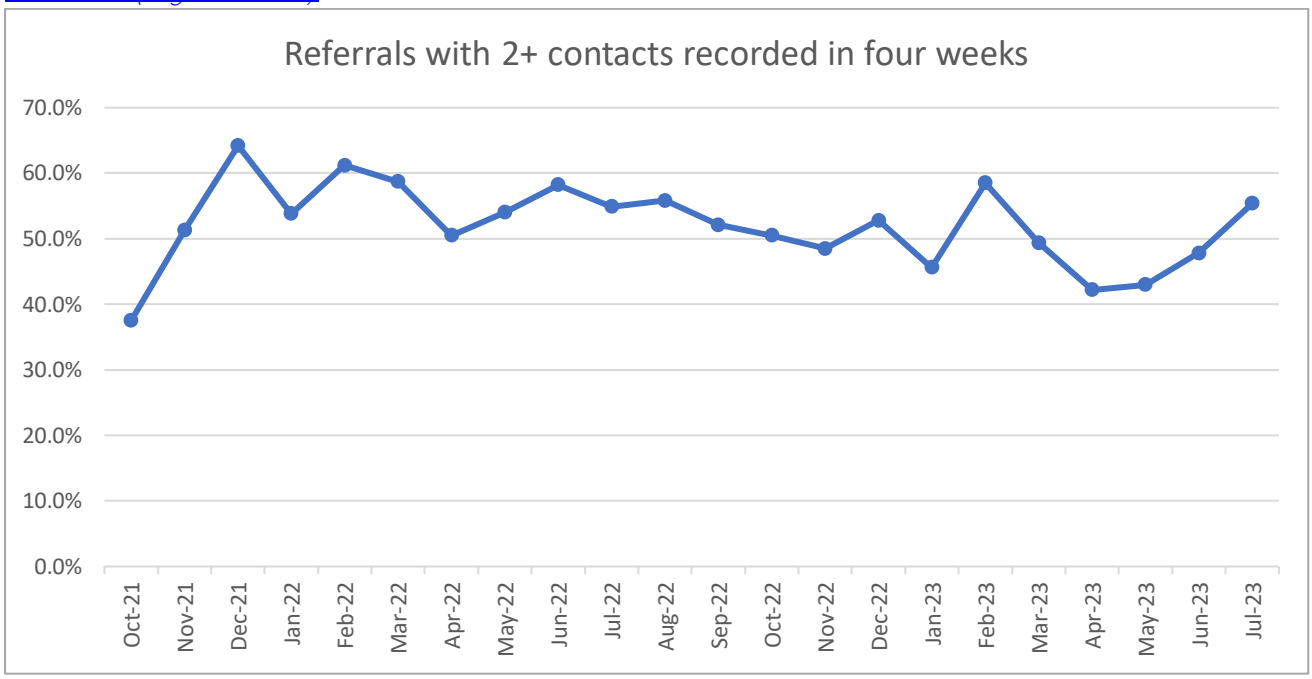
Note that 'caseload' is a measure of referrals that have had at least one attended contact and are still open at the end of the month whilst 'open referrals' is a count of all referrals, including those yet to be seen.

The proportion of contacts that were not attended (DNA or 'did not attend') declined overall from October 2021 (17%) to July 2023 (12%).

Waiting times

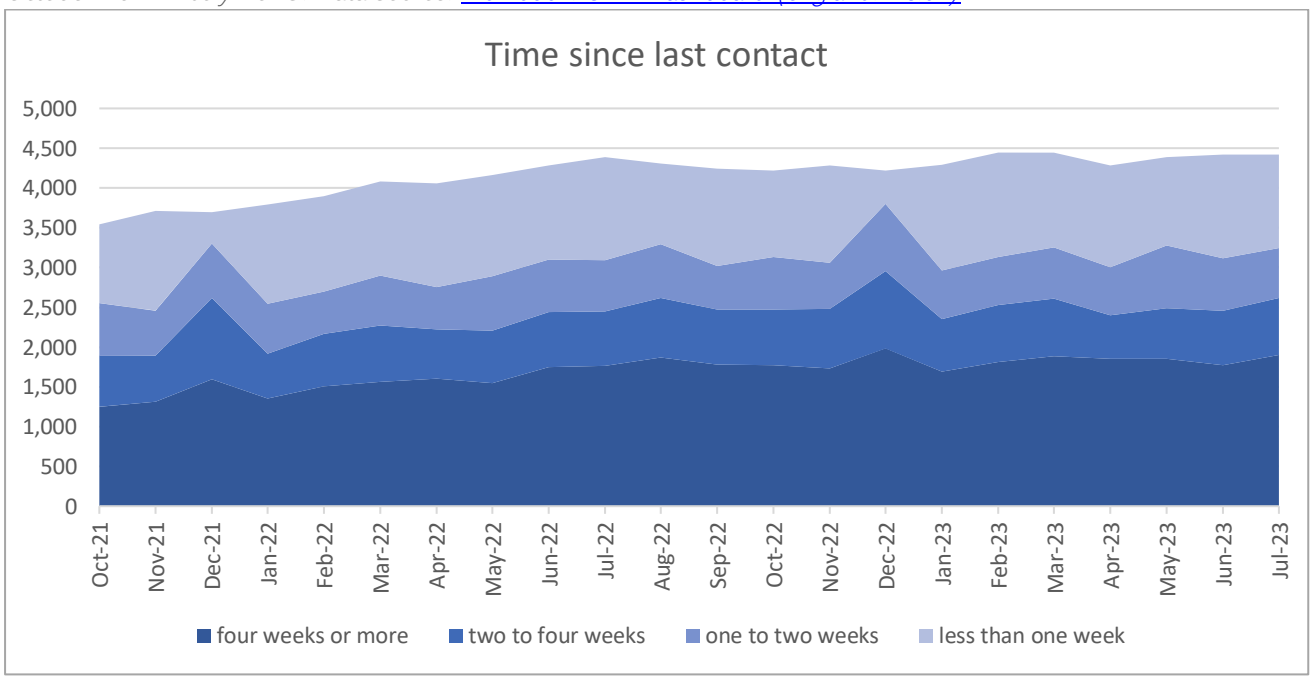
In July 2023, over half (55%) of people referred to community mental health services had 2 or more contacts (defined as any contacts with this service that were clinically meaningful or to support the mental health of the person referred) within the past 4 weeks; similar to 52% from August 2022 to July 2023.

Figure 10: Proportion of people referred to core community mental health services with two or more contacts recorded in the past 4 weeks, Cambridgeshire and Peterborough ICS, October 2021 – July 2023. Data source: Workbook: CMH Dashboard (england.nhs.uk)



The proportion of referrals waiting four weeks or more shows an increasing trend since October 2021. In July 2023, a high proportion (43%) of referrals were waiting for 4 weeks or more since the last contact. The proportion of referrals waiting less than one week also shows a slight increase over time: in July 2023, about 27% of referrals had been waiting less than one week since the last contact.

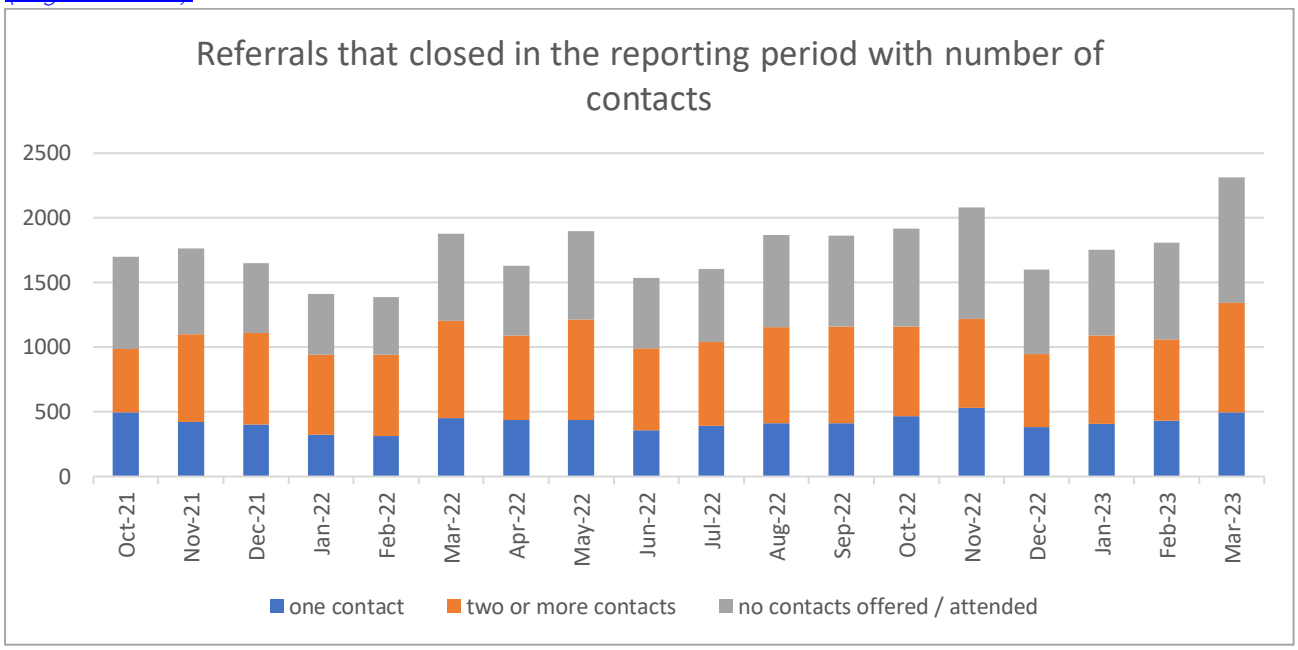
Figure 11: Time since last contact in core community mental health services, Cambridgeshire and Peterborough ICS, October 2021 – July 2023. Data source: Workbook: CMH Dashboard (england.nhs.uk)



Duration of contacts

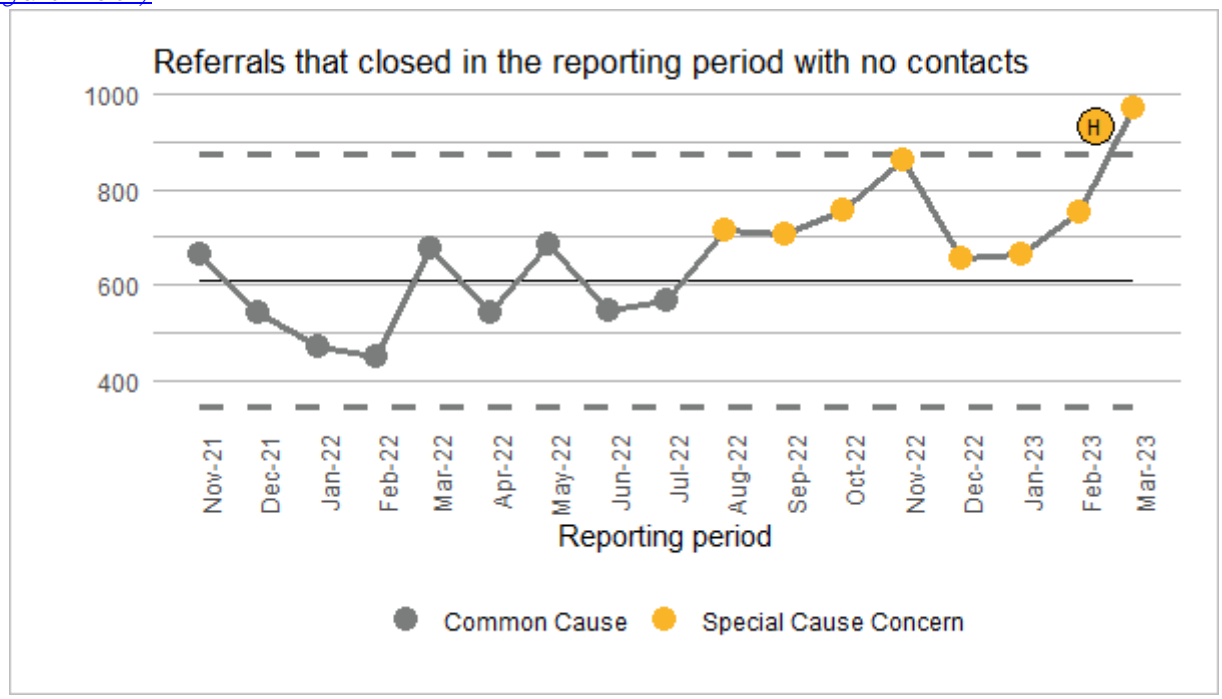
In March 2023, 41% of referrals closed without any contacts being offered or attended. The proportion of referrals that closed with one contact shows a decrease from 29% in October 2021 to 21% in March 2023.

Figure 12: Referrals to core community mental health services that closed within the time period, by number of contacts, Cambridgeshire and Peterborough ICS, October 2021 – March 2023. Data source: [Workbook: CMH Dashboard (england.nhs.uk)]



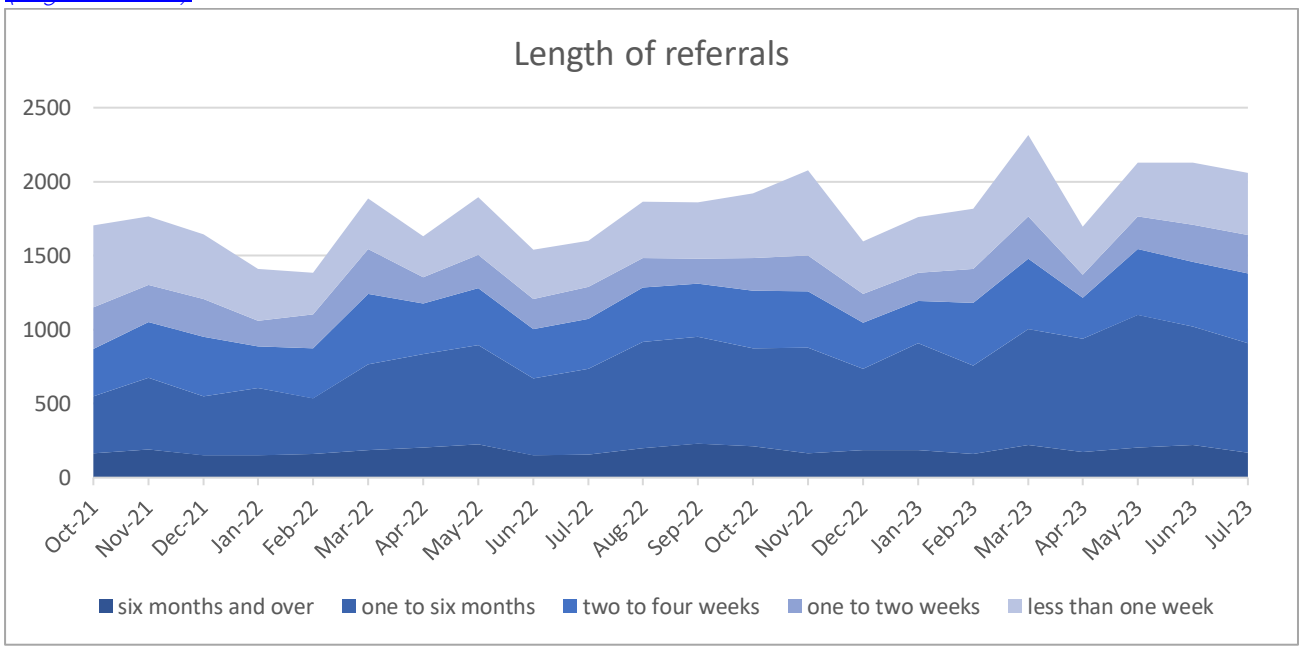
The number of referrals that closed in the reporting period with no contacts shows a shift (a run of 7 consecutive data points falling above the mean).

Figure 13: Referrals to core community mental health services that closed within the time period with no contacts, Cambridgeshire and Peterborough ICS, October 2021 – Ma 2023. Data source: [Workbook: CMH Dashboard (england.nhs.uk)]



Over a third of (36%) of closed referrals in July 2023 had a referral length (time between the start and end of the referral) between 1 and 6 months. A declining trend is seen in the proportion of referrals with lengths less than a week and 1-2 weeks, while the length of referrals ranging from 2 weeks to 6 months shows an increasing trend.

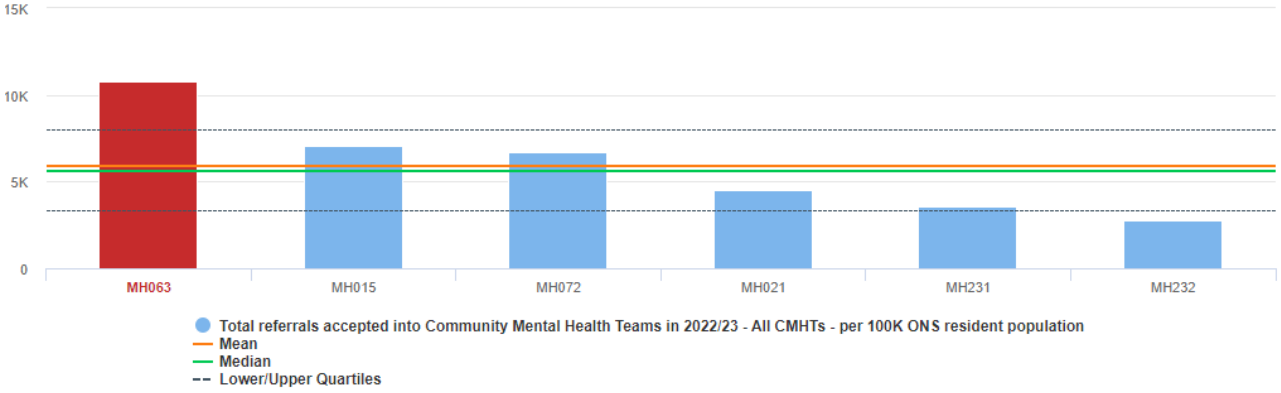
Figure 14: Length of referral to core community mental health services (lighter colours indicate shorter referrals), Cambridgeshire and Peterborough ICS, October 2021 – July 2023. Data source: [Workbook: CMH Dashboard (england.nhs.uk)]



How many people are referred to these services?

Referrals to community mental health teams may be 'stepped up' or 'stepped down' care, such as from crisis teams, inpatient wards, liaison psychiatry, or the Primary Care Mental Health Service (PCMHS) (CPFT, 2023a). The number of referrals accepted by local community mental health services per 100,000 of the total population in Cambridgeshire and Peterborough is substantially higher than other areas in the East of England.

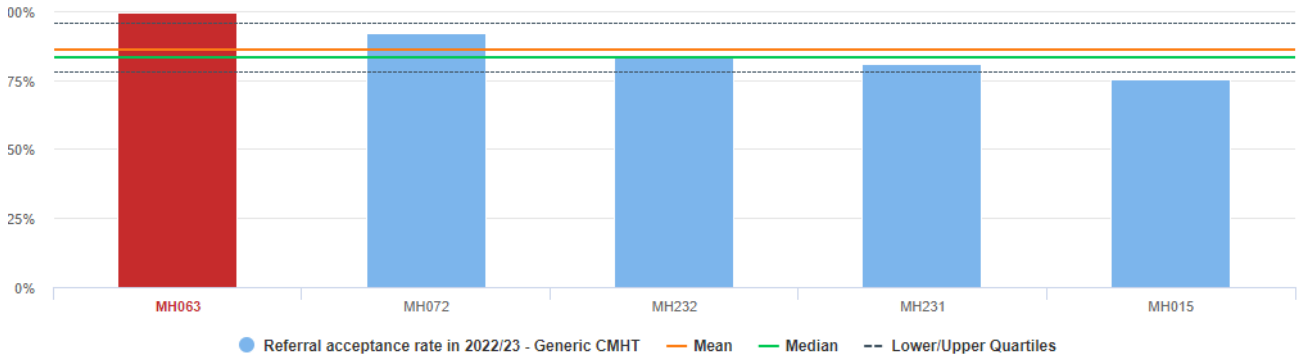
Figure 15: Total referrals accepted into community mental health teams per 100,000 resident population, East of England, 2022/23. Image source: NHS Benchmarking report 2022/23



Note: Cambridgeshire and Peterborough ICS is shown in red (MH063).

Almost everyone who was referred to the generic community mental health teams in Cambridgeshire and Peterborough in 2022/23 were accepted.

Figure 16: Percentage acceptance rates for referrals into generic community mental health teams, East of England, 2022/23. Image source: NHS Benchmarking report 2022/23



Sample Information

	Lower Quartile	Mean	Median	Upper Quartile
All Organisations	78.12	86.15	83.22	95.65

Note: Cambridgeshire and Peterborough ICS is shown in red (MH063).

Adult locality teams

Adult Locality Teams support people aged 17 and over who are 'experiencing symptoms of moderate to severe mental illness'. These community mental health teams accept referrals from the Primary Care Mental Health Service (PCMHS), First Response Service (FRS), crisis team, inpatient wards, liaison psychiatry, other mental health teams or other health professionals (CPFT, 2023a).

This service introduced brief psychological interventions (BPI) for anxiety and depression, initial evaluations of which suggested they had a positive impact on patients in terms of wellbeing, anxiety and mood (Roberts et al., 2021).

Arts Therapy

CPFT Arts Therapy connects and engages people by offering groups and one-to-one sessions with art, music and dramatherapy practitioners (CPFT, 2023b).

Early intervention in psychosis

Early intervention in psychosis (EIP) services are multidisciplinary community mental health services that provide treatment and support to people experiencing or at high risk of developing psychosis, typically over three years (Public Health England, 2019).

CAMEO (Cambridgeshire and Peterborough Assessing, Managing and Enhancing Outcomes) provides support for people who are experiencing their first episode of psychosis or those at risk of developing psychosis. This service is open to people aged 14 to 65. Support is provided by:

- CAMEO North, which covers Peterborough, Huntingdon and Fenland.
- CAMEO South, which covers East Cambridgeshire, South Cambridgeshire and Cambridge City.

Evidence base

There is a wide range of international evidence of highlighting the importance of early intervention in psychosis (EIP) services, including:

- Impact on individuals: cognitive behavioural therapy for psychosis (CBTp) has been shown to reduce rehospitalisation rates, length of hospital stay and symptom severity; and to improve social functioning (NHS England, 2023e).
- Early intervention: people experience improved outcomes when receiving care from an EIP service, compared to standard care (NHS England, 2023e).

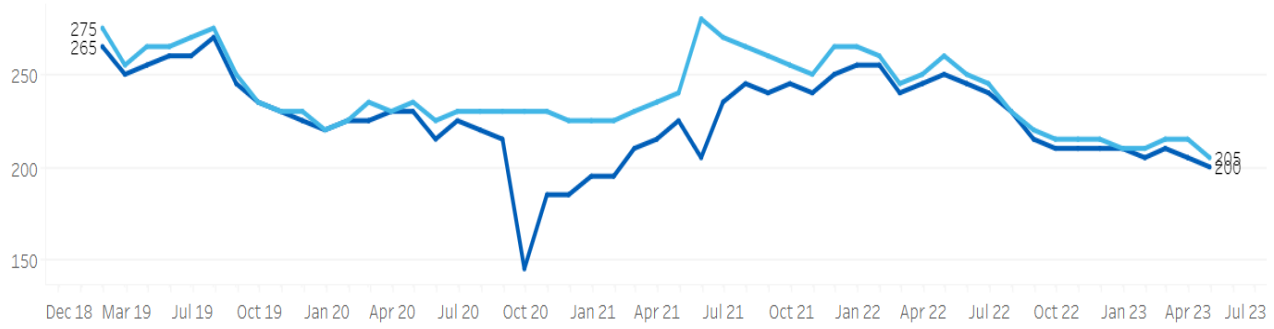
- Economic benefits: the reduction in crisis and inpatient services associated with EIP services, as well as improved employment outcomes, leads to estimated net cost savings of £7,972 per person after the first four years of starting treatment (NHS England, 2023e).

An evaluation of CAMEO, carried out between 2013 and 2019, found that 60% of patients had a 'good outcome' and were discharged to primary care. The remaining 40% required follow-up in secondary mental health services, which may suggest they had a poorer outcome (Osimo et al., 2021).

Referrals

The number of open referrals and caseload of CAMEO declined by 25% in July 2023, compared to March 2019.

Figure 17: Open referrals (light blue) and caseload (dark blue) in EIP services, Cambridgeshire and Peterborough ICS, March 2019 – May 2023. Image source: EIP Triangulation Tool - Mental Health, Learning Disability and Autism Resource Hub - FutureNHS Collaboration Platform

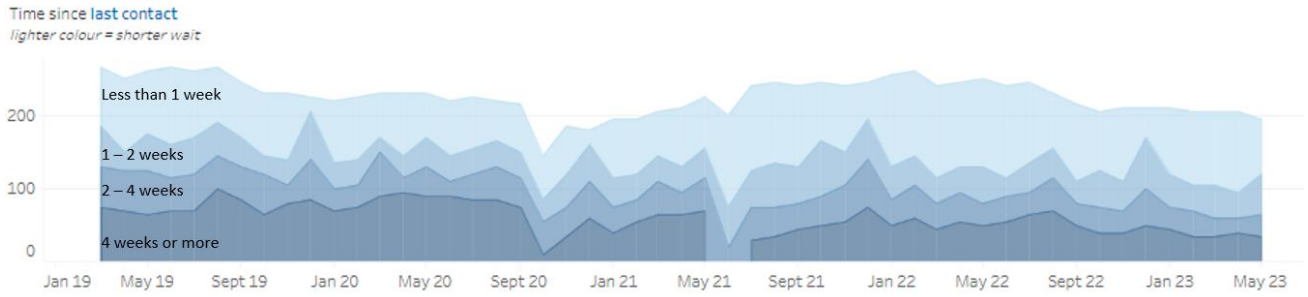


Waiting times

The NHS Long Term plan continued the ambition from the Five Year Forward View for Mental Health that at least 60% of all people with first episode psychosis should be accepted into a specialist EIP service and start a NICE-recommended package of care within 2 weeks from referral (National Institute for Health and Care Excellence et al., 2016). By 2023/24, this should increase to 95%.

Waiting times are decreasing in CAMEO. The proportion of referrals waiting for more than 4 weeks since the last contact has decreased since March 2019, while wait times of less than 1 week show an increasing trend.

Figure 18: Time since last contact in EIP services, Cambridgeshire and Peterborough ICS, March 2019 – May 2023. Image source: EIP Triangulation Tool - Mental Health, Learning Disability and Autism Resource Hub - FutureNHS Collaboration Platform



Bed days

The average 'in month' bed days for people in the EIP caseload was 26.3 in May 2023, similar to May 2019 (26.9).

Figure 19: In month bed days for people on CAMEO caseload, May 2019 to May 2023. Image source: EIP Triangulation Tool - Mental Health, Learning Disability and Autism Resource Hub - FutureNHS Collaboration Platform

How does this service compare to national guidelines?

- NICE guidelines have seven key quality statements for EIP services, which are used to inform the national annual EIP self-assessment.
- In 2022/23, CAMEO was graded level 2 overall in this assessment (Early Intervention In Psychosis Scoring Matrix), which indicates that this service 'needs improvement'. However, as shown below, CAMEO is top performing (level 3) is many areas.
- The reason this service does not meet level 3 is due to a relatively low proportion of service users with first episode psychosis (FEP) being recorded as having a physical health checks and interventions. This may reflect data issues rather than the true proportion of patients accessing physical health checks.

Table 2: National Clinical Audit of Psychosis scoring matrix for CAMEO, 2022/23

Timely access		Top performing
% of service users with FEP that were allocated to, and engaged with, an EIP care coordinator within 2 weeks of receipt of referral	84.6%	
Effective treatment		Needs improvement
% of service users with FEP taking up CBTp	69%	Top performing
% of service users with FEP talking up supported employment and education programmes	45.2%	Top performing
% of service users with FEP and their families taking up family interventions	50%	Top performing
% of carers that took up carer-focussed education and support programmes	71.8%	Performing well
% of service users with FEP that have had a physical health review and relevant interventions in the last year	60%	Greatest need for improvement
Recording outcome measures		Performing well
% of service users for whom 2+ outcome measures were recorded at least twice (assessment and another time point)	53%	
Overall score		Needs improvement

Additional Resources

- Implementing the early intervention in psychosis access and waiting time standard
- Report from the National Clinical Audit of Psychosis (NCAP) Service User Reference Group workshop 2022

Recovery services

The Recovery Coach Team provides coaching and peer support sessions for people transitioning from secondary community mental health services back to their GP (93).

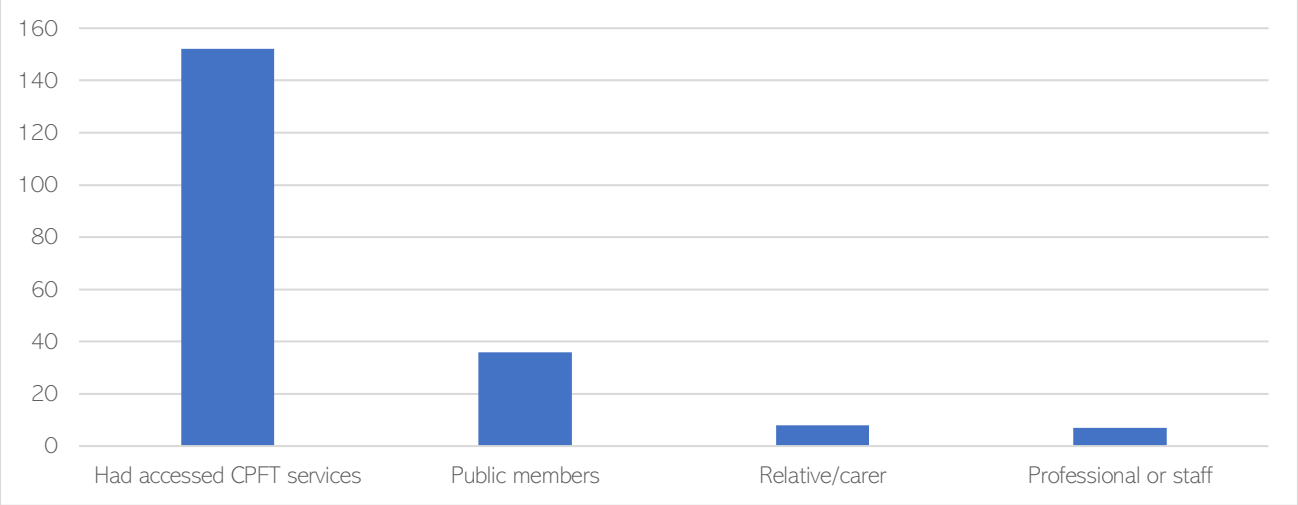
The RCE Wellbeing Hub (formerly known as Recovery College East) offers short courses to support people's wellbeing and the wellbeing of those around them. It is based on the key principles of hope in recovery, empowering people to be in control of their wellbeing and supporting them to find opportunities to 'live well'. Courses are open to anyone over the age of 17.

How many people use this service?

From September 2022 to July 2023 in the RCE Wellbeing Hub:

- There were 283 unique student registrations and 733 student attendances.
- There were 2946 hours of teaching delivery.
- On average, there were 4.5 students per session and 86% of student registrations were attended.
- The majority of students had previously accessed CPFT services; and had heard about services from a CPFT staff member or the CPFT website.

Figure 20: Groups accessing the RCE Wellbeing Hub, September 2022 to July 2023



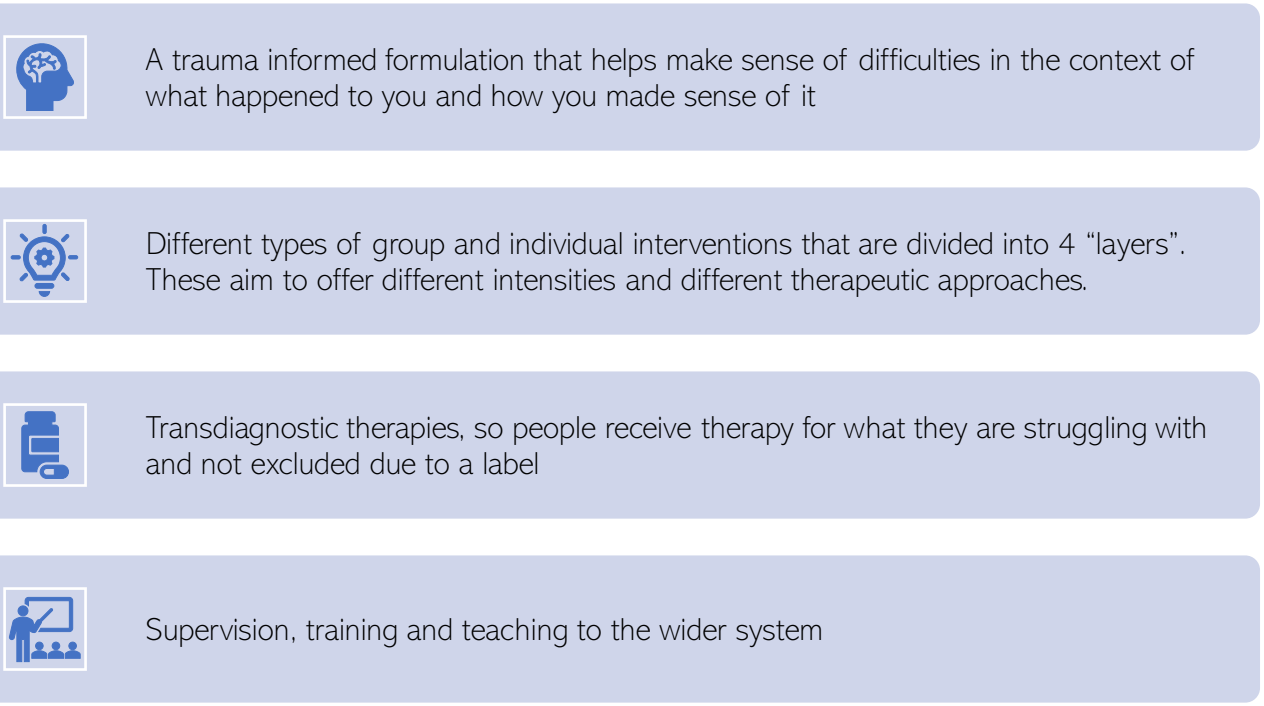
What do people say about this service?

97% people who used this service would recommend it to others. One individual stated that: '*what I like about the RCE Wellbeing Hub is that it's reminded me that I love to learn. I feel this strange thing now that I think might be happiness creeping in. This has really been quite life changing. The tutors are amazing, and they make the courses. The Hub has really helped me get a hold of my life again*'.

Psychological Skills Service

The Psychological Skills Service was introduced as part of the Exemplar. This service offers group interventions, brief psychological interventions, psychological support work and advanced individual therapy for people who previously fell between the gap of Talking Therapies and secondary care. People can be referred in from a range of services, including Primary Care Mental Health Services (PCMHS) and Talking Therapies.

Figure 21: Services provided by the Psychological Skills Service (PSS). Image source: [Psychological Skills Service (PSS) September 2023]



Additional Resources

- Standards for Community-Based Mental Health Services

Personality disorder services

National research highlights that people with 'complex emotional needs' associated with a diagnosis of a 'personality disorder' experience poor quality treatment, including fragmented and stigmatising care; or are turned away from mental health services (Pettitt et al., 2013; Trevillion et al., 2022). National research shows that people with this diagnosis feel that specialist services can be helpful, although it is often difficult to find long-term support (Pettitt et al., 2013).

In Cambridgeshire and Peterborough, the Personality Disorder Community Service and the Relational & Emotional Difficulties Service offer two separate pathways to help people manage emotional dysregulation, to control unhelpful coping behaviours and improve their ability to sustain meaningful relationship.

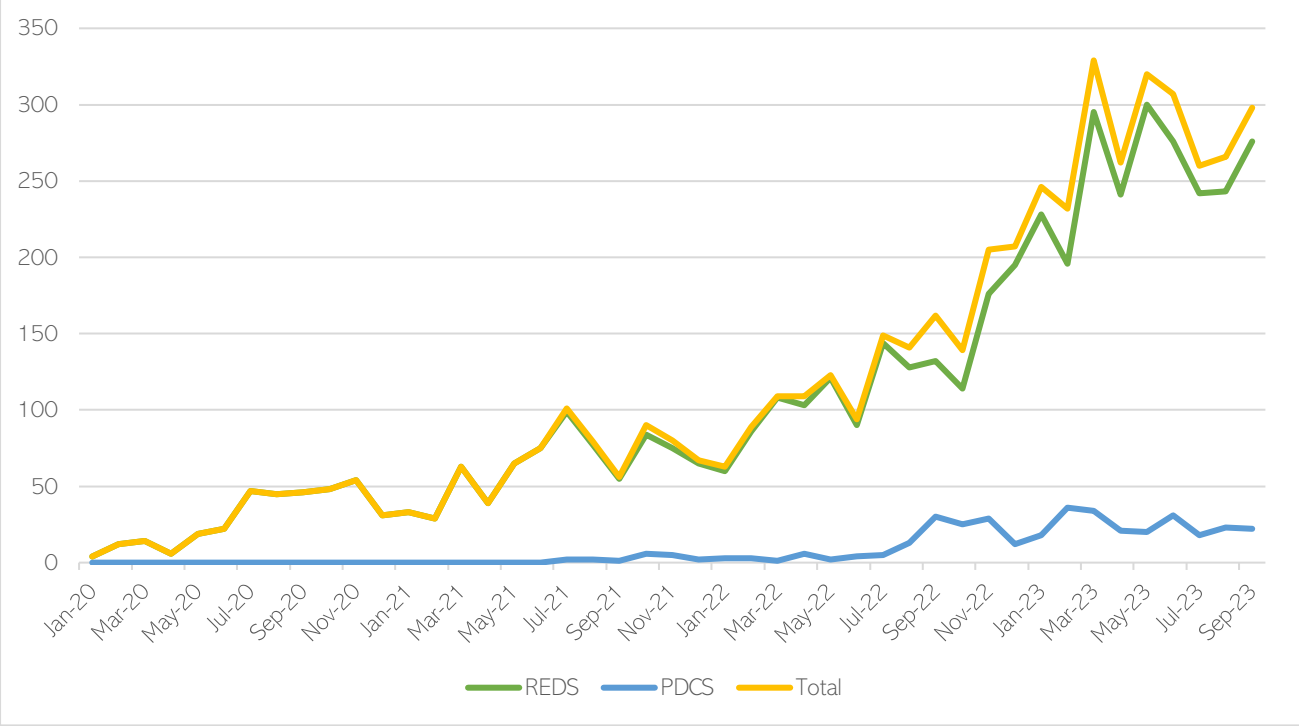
- Personality Disorder Community Service (PDCS) is a secondary care service provided by a multi-disciplinary team. This service supports people who meet the threshold for severe personality disorder over a 6-month pathway, with progression to REDS, group therapy, or REDS with wrap around 1:1 support.
- Relational & Emotional Difficulties Service (REDS) is a new psychological treatment service for people who have a range of difficulties associated with regulating emotions and who may struggle to negotiate relationships. They offer a DBT skills group and a peer support group programme.

Springbank is a 12-bed recovery unit for women with a diagnosis of emotionally unstable personality disorder (borderline personality disorder or BPD in US terminology) who are struggling to cope with the demands of life outside of hospital, despite the input from community psychiatric services.

How many people are referred to PDCS and REDS?

There has been a sharp increase in the number of referrals to PDCS and REDS from 2020. There was an over 200% increase in the total number of referrals to both services from October 2022 to September 2023.

Figure 22: Referrals to Personality Disorder Community Services (PDCS) and Relational & Emotional Difficulties Service (REDS), January 2020 – September 2023

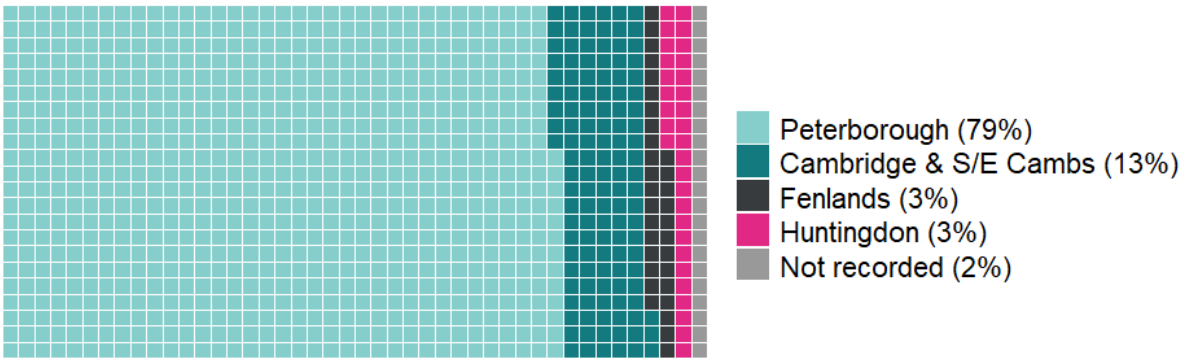


Note that data was only recorded on this system from January 2020

Who is referred to this service?

These graphs are based on anonymised data from 968 service users who accessed PDCS and REDS between June 2020 and April 2023. This showed that the majority of service users (79%) were from Peterborough, which is because this is where the service was initially piloted.

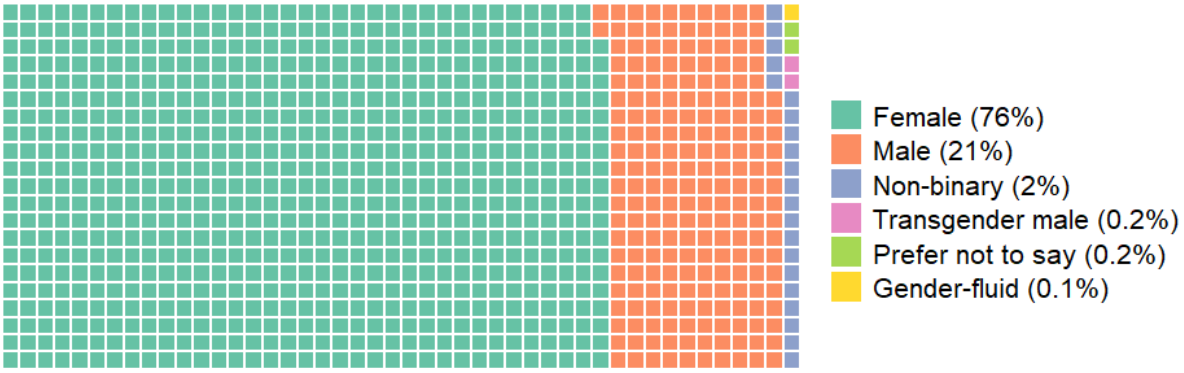
Figure 23: Proportion of PDCS and REDS service users by locality, June 2020 – April 2023



Note that locality was based on registered GP address rather than the addresses of individual service users.

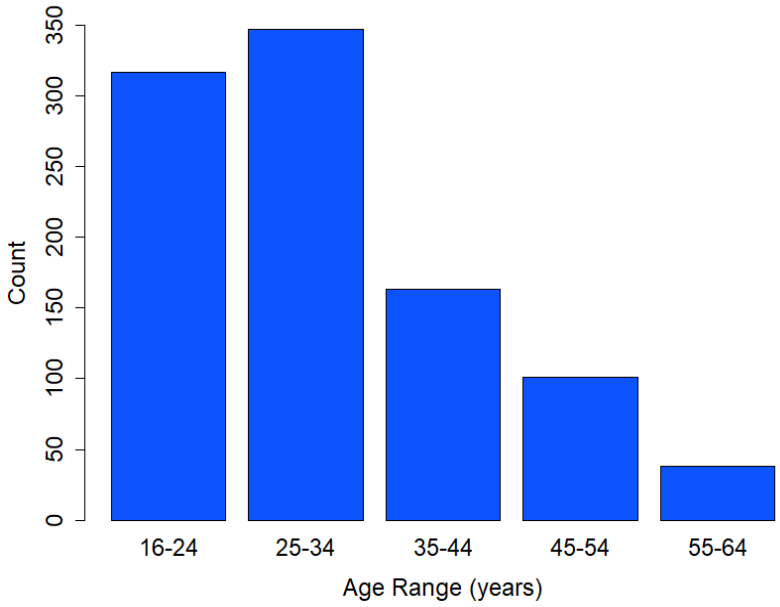
Around three quarters of people using these services were women (76%).

Figure 24: Proportion of PDCS and REDS service users, June 2020 – April 2023.



People using this service ranged in age from 16 to 63 years old. The mean age was 31 years.

Figure 25: Number of people using PDCS and REDS by age group, June 2020 – April 2023.



This analysis suggested that that people from minority ethnic backgrounds are underrepresented in personality disorder services in Peterborough, but not Cambridgeshire:

- Ethnicity data were compared to the 2021 Census data for Peterborough and Cambridgeshire using chi-square goodness of fit test or Fisher's exact test for smaller sample size.
- All ethnic minority groups except for "mixed or multiple ethnicity" were underrepresented among Peterborough service users. People who identified as "Asian, Asian British or Asian Welsh" were most underrepresented, followed by people who identified as "Black, Black British, Black Welsh, Caribbean or African". People who identified as "white" were overrepresented.
- The ethnicity of service users in Cambridgeshire was reflective of the general population; however, people from Cambridgeshire comprise only 19% of service users.
- This reflects previous research showing lower referral rates for ethnic minorities to UK personality disorder services (Garrett et al., 2011).

What do people say about this service?

Feedback from the Personality Disorder Community Service is highly positive:

Figure 26: Feedback from people who have used the Personality Disorder Community Service

Further experiences, stories and advice from people who have used this service are recorded by CPFT.

Testimonials from women who have stayed on the Springbank ward can be found here.

Additional Resources

- A Guidance on Complex Emotional Needs Carers: Involving CEN Carers as Partners in Care
- Royal College of Psychiatrists Guidelines on Services for people diagnosable with personality disorder
- Add link to poster

Adult eating disorder services

Eating disorder services should be multidisciplinary and include care in the community as well as intensive day patient or inpatient treatment for people with a high level of risk. They should provide effective evidence-based treatment that meets the needs of people across the full range of eating disorder diagnoses (NHS & National Collaborating Centre for Mental Health, 2019).

There are two main services supporting people with eating disorders in Cambridgeshire and Peterborough:

- Personalised Eating Disorder Support (PEDS) offers support for people with anorexia, bulimia, and binge eating disorder where they do not meet the criteria for the NHS secondary care eating disorder team. They also support people at risk of these eating disorders, who experience symptoms affecting their quality of life (Personalised Eating Disorder Support, 2023).
- Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) adult eating disorder services provide assessment and support to adults (over 18s) with moderate to severe eating disorders across the local region (including Cambridgeshire, Peterborough and Norfolk). They provide support to people within the community and have 14 inpatient beds (Ward S3).

The Exemplar (approved by the Clinical Commissioning Group in 2019) aimed to produce a seamless system delivering accessible evidence-based eating disorder services, removing referrals and thresholds, ensuring early

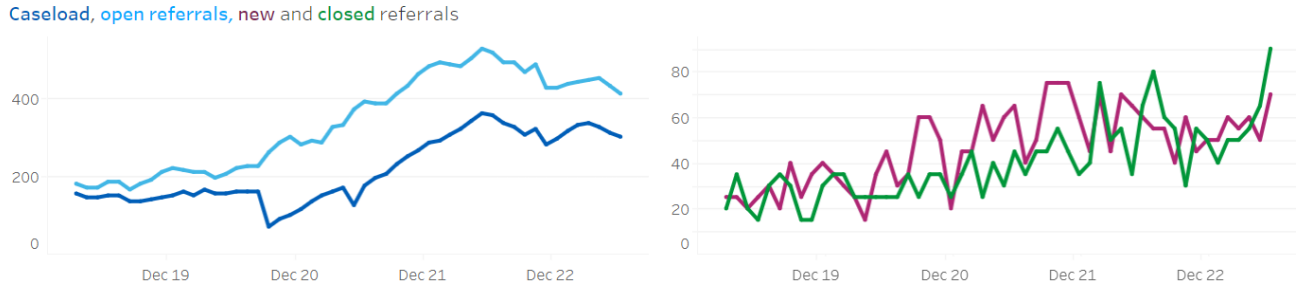
intervention, integrated working and robust physical heath monitoring. This is delivered via three pathways (link powerpoint);

1. Community
2. Stability and support
3. Medical Monitoring: Specialist Health Care Assistants (SHACs) based within GP practices in Cambridgeshire and Peterborough carry out medical monitoring of people with mild-to-moderate eating disorders.

Referrals and caseload

The number of open referrals and caseload of adult eating disorder services have substantially increased since April 2019. In July 2023, the 76% of the caseload was made up of open referrals, compared to 86% in April 2019.

Figure 27: Caseload and referrals to eating disorder services (age 18 to 64), Cambridgeshire and Peterborough ICS, April 2019 to April 2023. Image source: Workbook: Eating Disorders Services (england.nhs.uk)



Note: Caseload is a measure of referrals that have had at least one attended contact and are still open at the end of the month. Open referrals is a count of all referrals, including those yet to be seen.

During the period August 2021 to July 2023, the majority of new referrals to eating disorder services were from general practice.

Contacts

The proportion of people referred to adult eating disorder services who have 2+ contacts recorded within the past four weeks shows an increasing trend since January 2022, with over a third having 2+ contacts ('contacts' are defined as anything clinically meaningful or to support the mental health of the person referred) in July 2023.

Figure 28: Proportion of referrals to eating disorder services (age 18 to 64) with two or more contacts recorded within the past 4 weeks, Cambridgeshire and Peterborough ICS, August 2019 – July 2023. Image source: Workbook: Eating Disorders Services (england.nhs.uk)

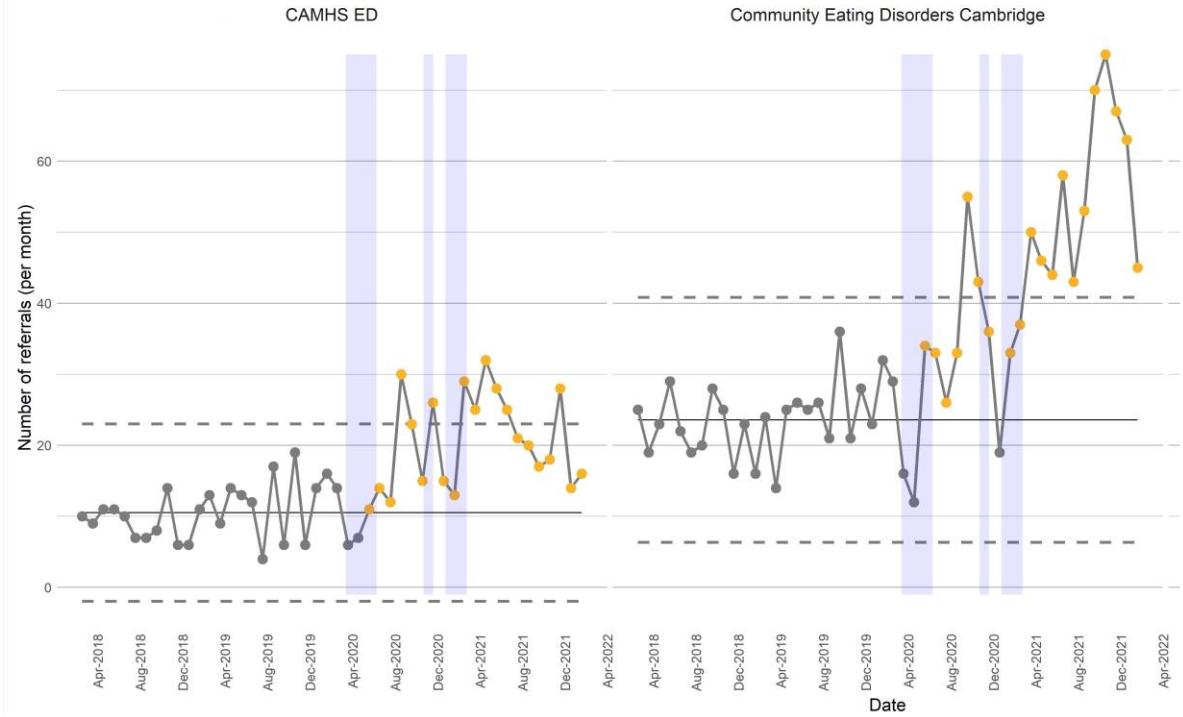
In July 2023, 42% of all consultations in adult eating disorder services were done via video consultation. Since September 2021 there has been a substantial increase is seen in the number of telephone and video consultations, alongside a large decrease in the number of face-to-face consultations.

Figure 29: Consultation types in adult eating disorder services (age 18 to 64), Cambridgeshire and Peterborough ICS, April 2019 – July 2023. Image source: [Workbook: Eating Disorders Services (england.nhs.uk)]

Impact of the COVID-19 pandemic on services

All eating disorder services saw an increase in referral rates since the start of the COVID-19 pandemic, but the largest increase was in adult community eating disorder services.

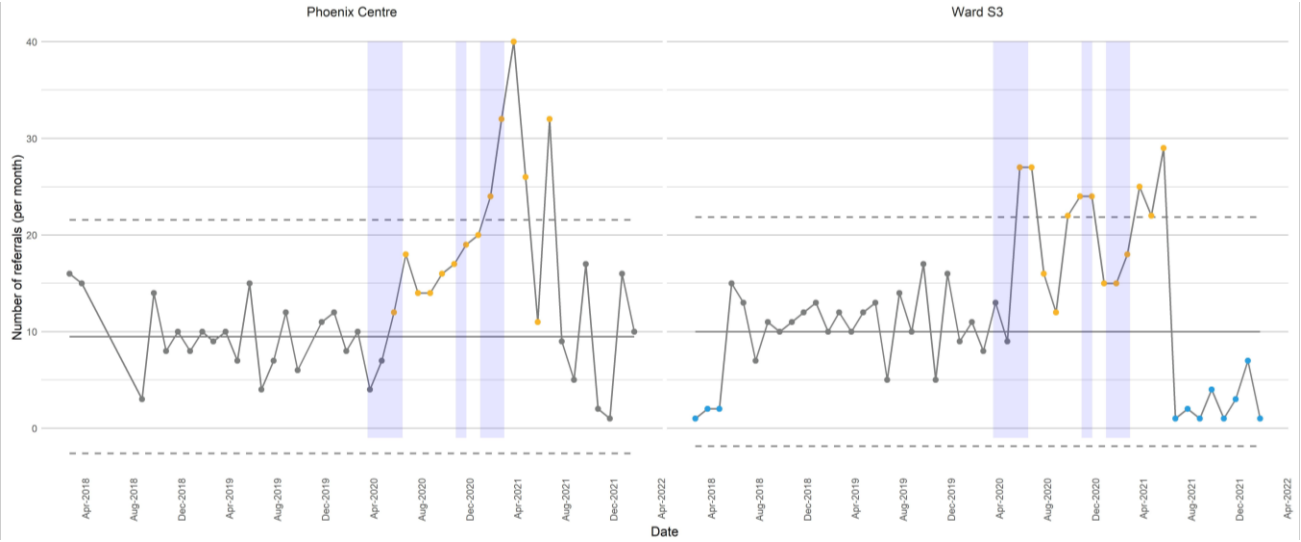
Figure 30: New referrals (all ages) to community eating disorder services. March 2018 – February 2022.



Note: blue windows represent periods of national lockdown due to COVID-19. This is a statistical processes control (SPC) chart, where the horizontal black line represents the mean over the baseline period, and the dotted lines on either side of the mean are the control limits (the threshold between normal variation in the data and variation that is beyond the range that we would expect). CAMHS ED stands for Child and Adolescent Mental Health Services Eating Disorder services (which support children and young people up to the age of 18).

Increases in referrals to inpatient services were seen towards the end of the first national lockdown. Referrals remained higher than the pre-pandemic baseline until July 2021, after which referrals to Ward S3 were below baseline.

Figure 31: New referrals to inpatient eating disorder services. March 2018 – February 2022.



Note: blue windows represent periods of national lockdown due to COVID-19. This is a statistical processes control (SPC) chart, where the horizontal black line represents the mean over the baseline period, and the dotted lines on either side of the mean are the control limits (the threshold between normal variation in the data and variation that is beyond the range that we would expect). The Phoenix provides support to children and young people aged 13 to 18, whilst Ward S3 (adult services) supports over 18s. Referrals into inpatient services include those from outside the local area and represent a different population to the Cambridgeshire and Peterborough.

A detailed analysis of referrals to community and inpatient eating disorder services in Cambridgeshire and Peterborough comparing the 2 years prior to the pandemic (March 2018 – February 2020) to the earlier stages of the pandemic (March 2020 – February 2022) found that:

- Since the start of the COVID-19 pandemic, there was an increase in referrals to community and inpatient eating disorder services. The increase in referrals was greatest in less deprived areas for children and adults.
- By Spring 2022, inpatient services had returned to pre-pandemic levels of referrals, whilst community services were still seeing a higher rates of referrals. This has continued into 2023.
    - Increases in the number of referrals to children's services occurred in all districts, which has continued into 2023.
    - Increases in the number of referrals to adult services occurred across all districts, with the greatest increases seen in Cambridge and East Cambridgeshire.
- For children and young people, there were increased referrals across all ages (from 11+) during the early stages of the pandemic, though this increase was greatest across the late teenage years.
- Increases in adult referrals during the early stages of the pandemic were primarily from young adults aged 19 to 25.

What do local people think?

A survey of 37 local professionals (from acute services, primary care and eating disorder services) suggested that reasons behind the increase in referrals included a loss of control during lockdowns, greater isolation and people's routines being restricted. However, several people felt that the rise in referrals was accelerated, rather than caused by, the pandemic.

A survey of 6 local people (1 with lived experience of an eating disorder, 5 of whom were carers/loved ones of someone with an eating disorder) about what could be done to support people with an eating disorder and their loved ones highlighted the importance of:

- Early education around eating disorders and potential warning signs, including in schools and targeted at parents/carers.
- Better education for medical professionals.
- Rapid referrals into eating disorder services.

- Early support for families around how to support their loved ones, such as support groups for carers.
- Community support post-discharge.
- Screening for autism in people diagnosed with eating disorders.

Education around eating disorders for professionals and parents/carers is currently being provided locally by Personalised Eating Disorder Support (PEDS).

Additional Resources

- Adult Eating Disorders: Community, Inpatient and Intensive Day Patient Care Guidance for commissioners and providers
- Royal College of Psychiatrists reports and resources on eating disorders
- MindEd adult eating disorders hub
- Best practice in managing services transitions for eating disorder services

Crisis services

The mental health charity Mind has defined a mental health crisis as when some is in a 'mental or emotional state where they need urgent help' (Mind, 2011). Urgent, emergency and acute mental health care is provided by a range of teams and services (Public Health England, 2019), some of which may be used as part of planned care. This includes:

- Urgent metal health helplines: these services can be accessed by anyone and are open 24/7. They can assess people's mental health and help people to access support.
- Crisis response and home treatment teams: these community-based services aim to assess and manage all patients in a mental health crisis and people also being considered for psychiatric hospital admission. They offer intensive home treatment rather than hospital admission, if this is safe and feasible.
- Mental health liaison services: situated in general hospitals, for example in the emergency department or inpatient wards, these services aim to provide psychiatric assessment and treatment to patients who may be experiencing mental health conditions whilst in hospital.
- Acute inpatient services: provide treatment when a person's mental health condition cannot be managed in the community, and where the situation is so severe that specialist care in a safe and therapeutic space is required.

The NHS Long Term Plan set aims for significant expansion to crisis services, which should allow faster access for people experiencing mental health crisis (NHS, 2019).

Getting It Right First Time

The GIRFT vision is that people accessing services will:

- be treated as equals and as partners in their assessment, care and treatment.
- given copies of their assessments, so that they can check and correct them if necessary, and see that they have not only been listened to but heard correctly.
- get information on the current known outcomes and potential benefits and harms of any proposed intervention.
- not be repeatedly asked to give their history unless there is a clear and specific need to clarify something in the assessment or therapy.
- routinely be asked their opinion on aims and desired outcomes of accessing the service, and whether the interventions were beneficial to them, taking into account any harms from the intervention (i.e. was there a net positive benefit for them).

- Sometimes the treating team and person accessing the service may disagree on issues identified or desired aims and outcomes. Such disagreements should be routinely noted and where feasible agreed compromises reached.

In Cambridgeshire and Peterborough, nationally monitored indicators suggest there are particular pressures on inpatient services. There are likely to be a range of factors contributing to this, such as workforce pressures which led to the closure of the Mulberry Ward 3. Greater acuity of mental health need at the point of admission and delays to discharge may also contribute.

Table 3: Nationally monitored indicators for the effectiveness of adult acute mental health pathways. Based on NHS England interpretations

Measure	Local picture	Interpretation
Number of inappropriate out of area placements (OAPs)	There was a 20-times increase in the number of OAPs from April 2022 to 2023. The number of inappropriate OAPs is starting to decline as of Summer 2023.	This is likely to reflect pressures on the acute mental health pathway, with around half of this increase being due to a ward closure (which happened due to workforce pressures). Other contributing factors may be increasing complexity of mental health need, resulting in longer stays, and delayed discharges.
% admissions involving people not known to mental health services	Around 7% of people admitted from August 2022 – July 2023 had not been in contact with core community mental health services within the period 6 months prior to admission. This is comparable to other areas in the East of England.	It is a positive sign that people are known to mental health services before admission, as this may reflect that their needs were already being recognised by services.
Number of mental health related Accident and Emergency (A&E) attendances	Mental health related A&E attendances are at a similar rate in Cambridgeshire and Peterborough to other areas in the East of England, but attendances due to self-harm are higher than other areas.	It is difficult to interpret higher rates of self-harm attendance compared to other areas, as this may be due to differences in coding and as Addenbrooke's is a regional trauma centre.
% of mental health related A&E waits lasting 12+ hours	From August 2022 to July 2023, 17% of people attending A&E due to mental health reasons spent over 12 hours in A&E. This is higher than most other areas in the East of England.	Long waits in A&E may reflect difficulties accessing assessment under the Mental Health Act and/or inpatient mental health provision.
% of admissions involving detention under the Mental Health Act	The number of new monthly admissions where the person is detained under the MHA in the 24 hours pre-admissions or post-admissions shows a relatively stable trend.	Many factors can contribute to detention status, including acuity of mental health need and uptake of voluntary admission.
% of available adult acute beds that are occupied at any one time	In June 2023, 91% of adult acute beds were occupied. This is above recommended occupancy levels (85%) but similar to national occupancy rates for psychiatric beds (90.5%).	This indicates significant pressures on inpatient services.
Occupied adult bed days per 100,000 weighted mental health population	From August 2022 to July 2023, the rate of admissions to acute inpatient mental healthcare per 100,000 of the population was lowest in Cambridgeshire and Peterborough, compared to other areas in the East of England.	This could be a positive measure, as it suggests that Cambridgeshire and Peterborough is not over-reliant on inpatient care compared to other areas. However, it may also reflect problems with flow into inpatient beds.

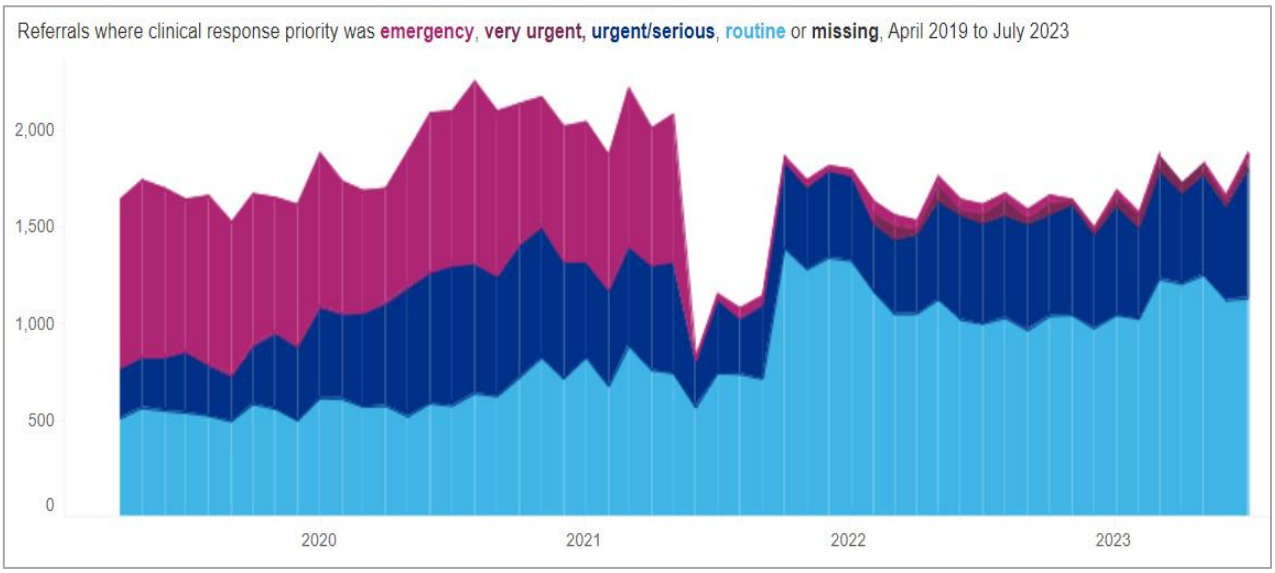
Average acute mental health length of hospital stay and rate of admissions per 100,000 weighted population lasting 60+ days	From August 2022 to July 2023, the mean length of stay for discharged hospital spells in Cambridgeshire and Peterborough higher than the East of England average. Cambridgeshire and Peterborough ranked highest for the proportion of discharged hospital spells lasting over 60 days (26%) and 90 days (15%).	Contributing factors to increasing lengths of stays over 60 days may include a greater use of out of area placements, greater acuity of mental health need at the point of admission, staffing pressures and delays to discharge.
% of 72 hour follow-ups completed for people leaving acute inpatient care	In Cambridgeshire and Peterborough, 60% of discharges were followed up within 72 hours in July 2023. The national target is that 80% of adults are followed up within this stime period, but this target has not been met nationally since data became available in June 2020.	Like other areas, Cambridgeshire and Peterborough is not meeting the national target for timely follow ups following discharge.

Overview of community crisis services

Note that there was a change in data systems in adult and specialist mental health services on 14th June 2021, hence some national dashboards show a substantial spike around these dates.

There has been a substantial decline in the number of referrals to community crisis services which are classified as 'emergency' since 2021. There were 215 'emergency' referrals in the 12 month period ending July 2023, 59% lower than the previous 12 months (520).

Figure 32: Referrals to community crisis services, 18-64 years, Cambridgeshire and Peterborough ICS, April 2019 – July 2023. Data source: Urgent and Emergency Mental Health Dashboard - Mental Health, Learning Disability and Autism Resource Hub - FutureNHS Collaboration Platform



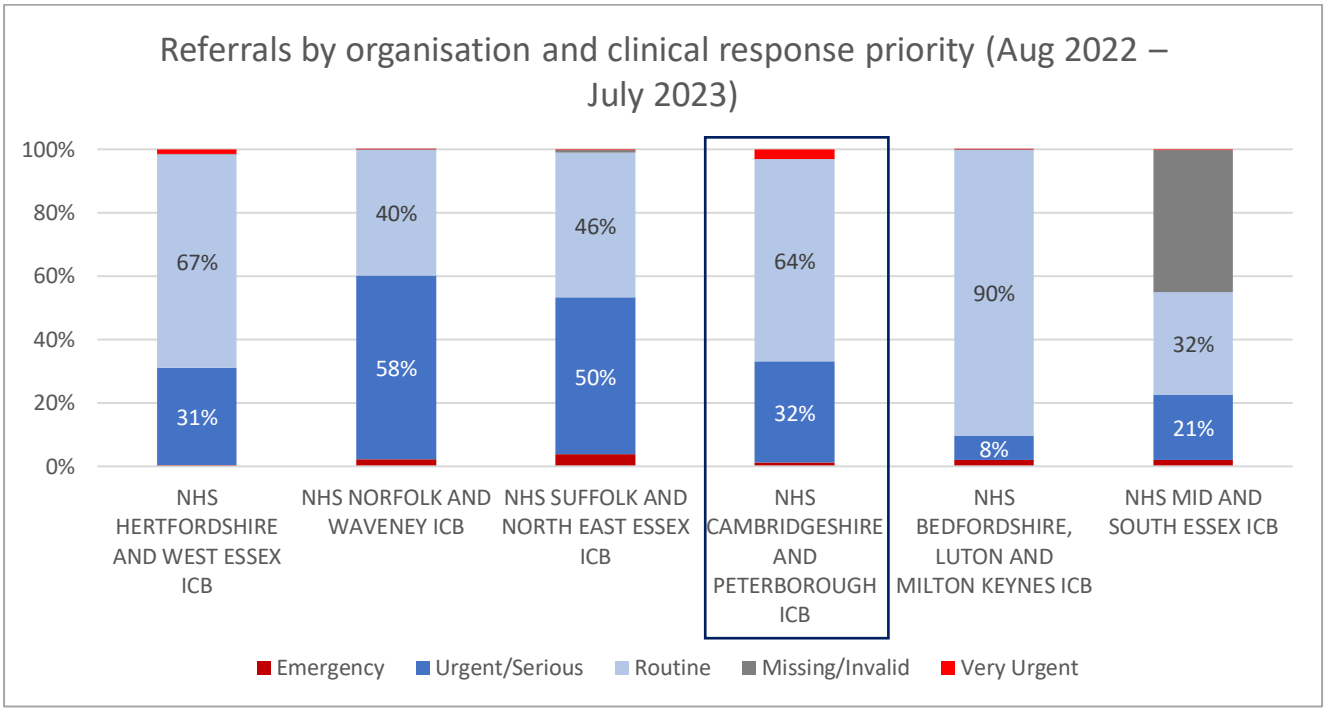
Referrals are classified using the following criteria:

- *Emergency: emergency situations in which there is imminent risk to life or serious harm to themselves or others and will require a "999" response, potentially within minutes. This would require a response from the police or an ambulance, but may also require rapid support or a joint response from a mental health crisis service.*
- *Very urgent: people who present a risk of harm to themselves or others; present acute suicidal ideation with clear plan and intent; have a rapidly worsening mental state; do not require immediate physical health medical intervention; are not threatening violence to others. These referrals require a very urgent face-to-face assessment with a specialist mental health crisis practitioner within 4 hours.*

- *Urgent: typical presentations in this category include high risk behaviour due to mental health symptoms; new or increasing psychiatric symptoms that require timely face-to-face intervention to prevent full relapse; significantly impaired ability for completing activities of daily living; vulnerability due to mental illness; expressing suicidal ideation but no plan or clear intent. These referrals require an urgent face-to-face assessment with a specialist mental health crisis practitioner within 24 hours.*
- *Routine/non-urgent: in the context of crisis care, this term covers all responses that do not require an urgent face-to-face intervention from a specialist NHS mental health crisis service.*

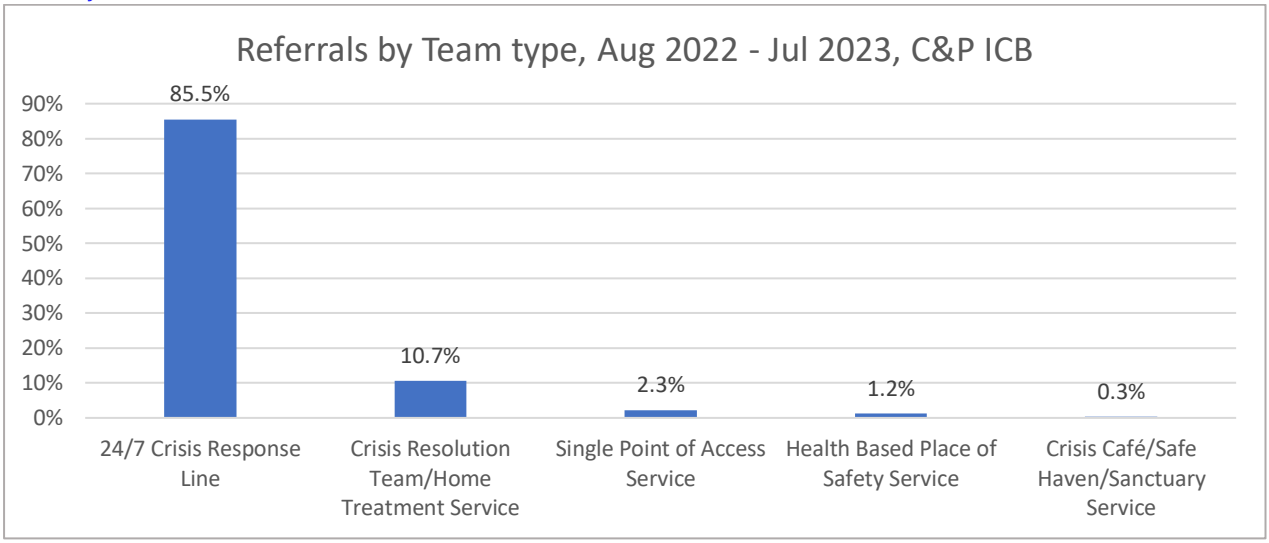
For the year ending July 2023, Cambridgeshire and Peterborough had 64% routine, 32% urgent or serious, 3% very urgent and 1% emergency referrals. There is substantial range in the types of referral across the East of England.

Figure 33: Referrals to community crisis services by clinical response priority, 18-64 years, East of England, August 2022 – July 2023. Data source: Urgent and Emergency Mental Health Dashboard - Mental Health, Learning Disability and Autism Resource Hub - FutureNHS Collaboration Platform



Local data shows that the First Response Service (FRS, a 24/7 crisis response line) is a well-established part of the crisis pathway in Cambridgeshire and Peterborough. From August 2022 to July 2023, FRS received 86% of referrals into community mental health crisis services.

Figure 34: Referrals to Community Crisis Services by team type, 18-64 years, Cambridgeshire and Peterborough ICS, August 2022 – July 2023. Data source: [Urgent and Emergency Mental Health Dashboard - Mental Health, Learning Disability and Autism Resource Hub - FutureNHS Collaboration Platform]

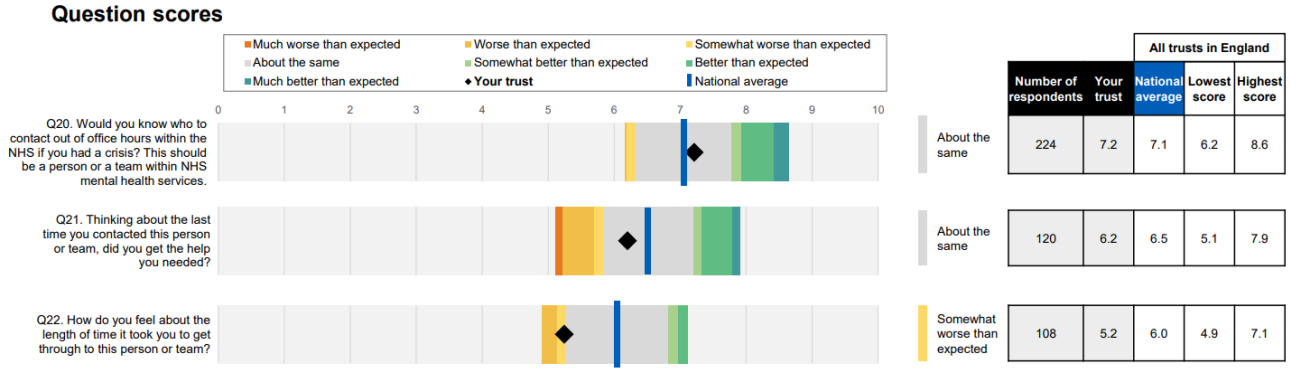


Experience of crisis services

The NHS Community Mental Health Survey (2022) included three questions around crisis care:

- There was a significant decrease in the scores for each of these questions in Cambridgeshire and Peterborough from 2021 to 2022, showing that people had poorer experiences.
- People's feelings on the 'length of time it took to get through to the person or team providing support' was scored 5.2 out of 10 and was highlighted as a key area for improvement. This score was somewhat lower than other areas in England.

Figure 35: Experiences of crisis services as reported in the NHS Community Mental Health Survey. Image source: [NHS Community Mental Health Survey Benchmark Report 2022]



First response service

The First Response Service (FRS) provides support for people experiencing a mental health crisis and is available 24/7. Support offered can include telephone support, a face-to-face assessment and referrals to other CPFT services. A detailed analysis of FRS service use from August 2021 and March 2023 found that:

- There is annual variation in FRS rates of referrals, with between 1,600 to 1,900 people being referred each month.
- The greatest rates of referrals were from people in their late teens to early thirties.
- More women than men accessed this service.
- There were higher referral rates amongst 'White' ethnic groups than other ethnic groups.

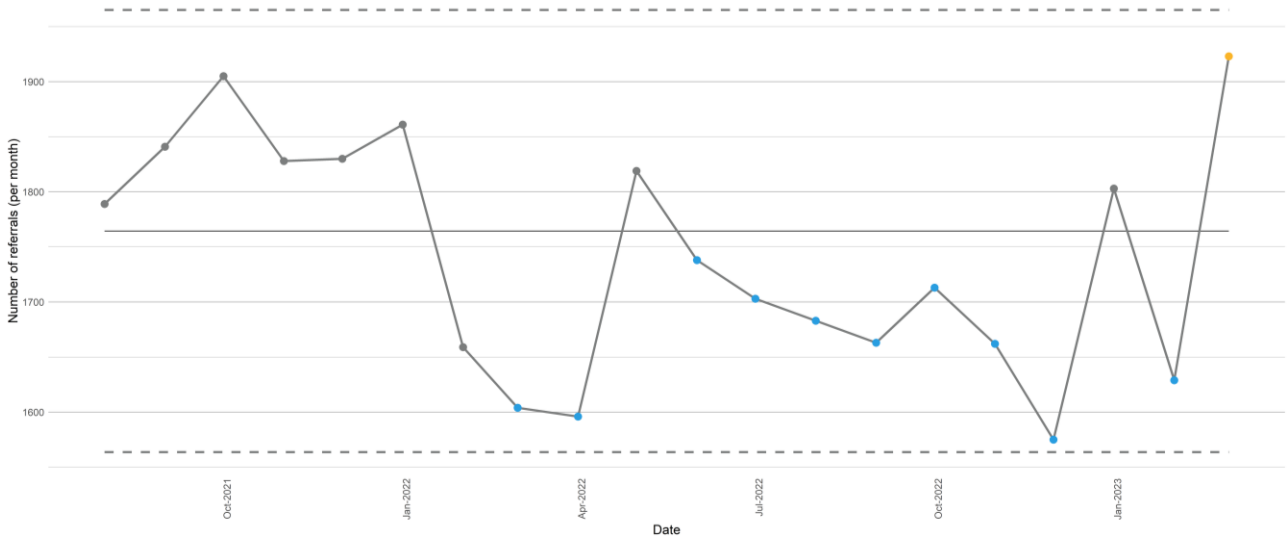
- Referrals to FRS were higher in Cambridge and Peterborough compared to other districts. Referral rates were also higher in more deprived areas.

Full results of this analysis are summarised below.

How many people are referred to FRS?

The number of unique referrals accessing FRS each month ranged from over 1,900 in October 2021, to below 1,600 in April 2022. There was a trend towards lower number of referrals from August 2021 to December 2023, although there was a spike in March 2023.

Figure 36: Total number of referrals accessing FRS by month, August 2021 – March 2023. Data source: FRS analysis



Note: this is a statistical processes control (SPC) chart. The horizontal black line represents the mean over the baseline period. The dotted lines on either side of the mean are the control limits, which represent the threshold between normal variation in the data and variation that is beyond the range that we would expect.

- *The mean and control limits are calculated based on the first 12 points of time plotted.*
- *The yellow dots represent data points of concern, either due to the distance from the norm or because the performance has been worse for a substantial amount of time (7 measurements in a row); whilst blue dots represent data points where performance is considerably better than then norm, or performance has been better for a substantial amount of time (7 measurements in a row).*

Who is referred to FRS?

- The greatest rates of referrals come from people in their late teens to early thirties.
- There are more referrals for women than men; and higher referral rates amongst 'White' ethnic groups than other ethnic groups.
- In terms of geographic variation, referrals are higher in Cambridge and Peterborough compared to other districts, and also higher in more deprived areas.
- Some general practices and primary care networks have above or below average referral rates to FRS, but the reasons behind this are unclear.

Where are referrals from?

The vast majority of referrals to FRS are self-referrals; followed by from GPs, internal referrals (where referrals are labelled as coming from 111, 'First Response Service' or 'Internal Referral') and relatives or carers. For these more common pathways, between 1% to 6% of referrals lead to a face-to-face contact.

What happens after people are referred to FRS?

The triage category refers to the time they need to be assessed by a member of the clinical team. Approximately 86% of referrals to FRS are for advice; after this most people are triaged within 24 hours.

Referrals for advice from 'Asian or Asian British' service users are lower than all other groups; whilst referrals for advice from service users from 'white' ethnic groups are higher. For other triage categories, referral numbers are too low to draw any conclusions about potential inequalities by ethnicity.

What is the profile of high service users?

There is a small number of people accessed this service multiple times from August 2021 to March 2023. This analysis looked at the 1112 people who were in the 90th to 98th percentile of referrals, individuals who had between 4 to 11 referrals between this period. This group is more likely to be female and from younger age groups, compared to all people who have used FRS. The rate of high service users is comparable across most ethnic groups; but some GPs have higher numbers of high service users.

There is a small number of people who have a very high level of service use. This analysis looked at the 278 people who were in the 99th to 100th percentile of referrals, individuals who had between 12 to 580 referrals between August 2021 and March 2023. Similar to the high service use group, this group of individuals was more likely to be female and most ethnic groups have similar rates to the total group of people using FRS. A few GPs have higher numbers of individuals with very high levels of service use. There was a relatively even distribution by ages.

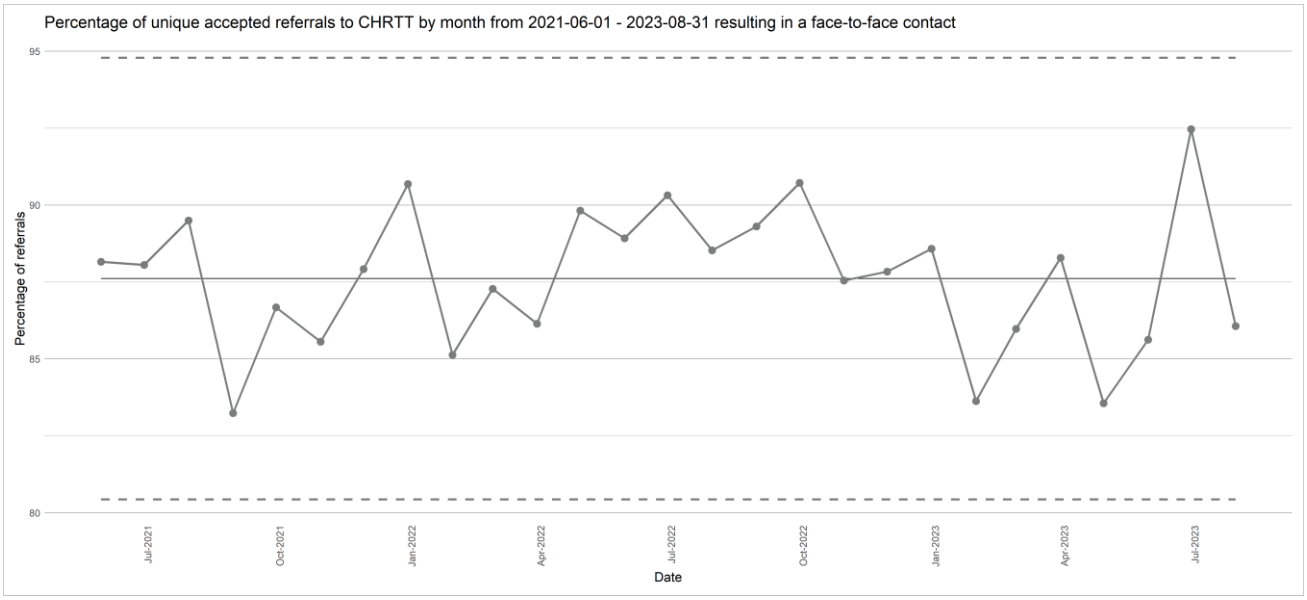
Crisis response and home treatment teams

The crisis resolution and home treatment team (CRHTT) is a 24/7 service that provides intensive support to people experiencing mental health crisis. They offer intensive home treatment rather than hospital admission, if this is safe and feasible. They also work to facilitate early discharge from hospital where possible and appropriate (Public Health England, 2019).

Where are people referred from?

- Referrals to this service are made from other mental health services, including the First Response Service (FRS). Most referrals are from Accident and Emergency (through Liaison Psychiatry), the community mental health team (adult locality teams) and adult inpatient mental health services.
- Around 87% of referrals to CRHTT lead to a face-to-face contact, a rate that has remained relatively stable since June 2021.
- The rate of referrals resulting in a face-to-face contact is higher for referrals from inpatient adult mental health services and First Response Service (over 75%), and lower for referrals from Accident and Emergency (around 50%).

Figure 37: Percentage of unique referrals accessing CHRTT resulting in a face-to-face contact, June 2021 – August 2023.



Who is referred to this service?

From June 2021 to August 2023:

- A similar rate of men and women were referred to CRHTT.
- People from the most deprived were more likely to be referred to this service, compared to those from less deprived areas.
- There was a particularly high rate of referrals to the CRHTT for people in their early twenties in Cambridgeshire and Peterborough. There was also a low rate of referrals for people over 65.
- A higher rate of people were referred to the CRHTT from Cambridge City and Peterborough, and lower from East Cambridgeshire, compared to other districts.
- People from 'Black or Black British' ethnic groups were substantially more likely to be referred to the CRHTT than people from other ethnic backgrounds.

Ambulance

Ambulances respond to people in serious medical emergencies, including those experiencing a mental health crisis and people who have self-harmed.

A mental health response car was introduced across Cambridgeshire and Peterborough in 2021. This service is for people who call 999 when experiencing a mental health crisis and is staffed by a paramedic and specialist mental health practitioner. This was introduced as a joint initiative between Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) and East of England Ambulance Service (EEAST) (99).

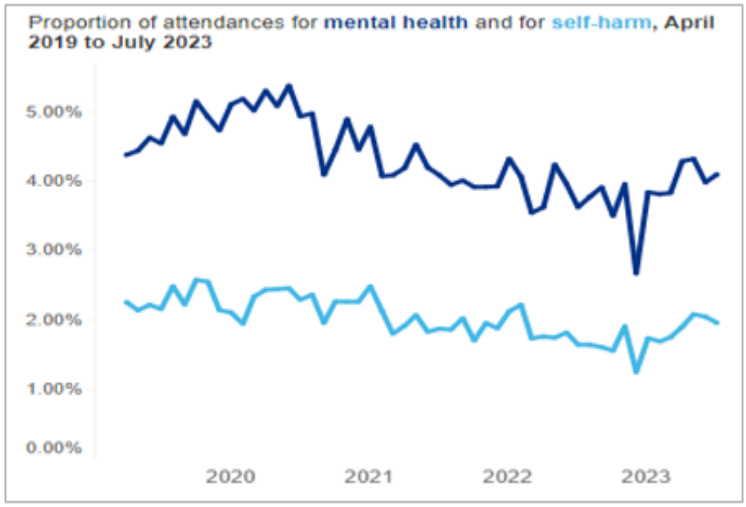
Accident and Emergency

Accident & Emergency departments (A&E or Emergency Departments) support people facing serious or life-threatening medical emergencies, including those experiencing a mental health crisis and people who have self-harmed.

How many people attend Accident and Emergency for mental health reasons?

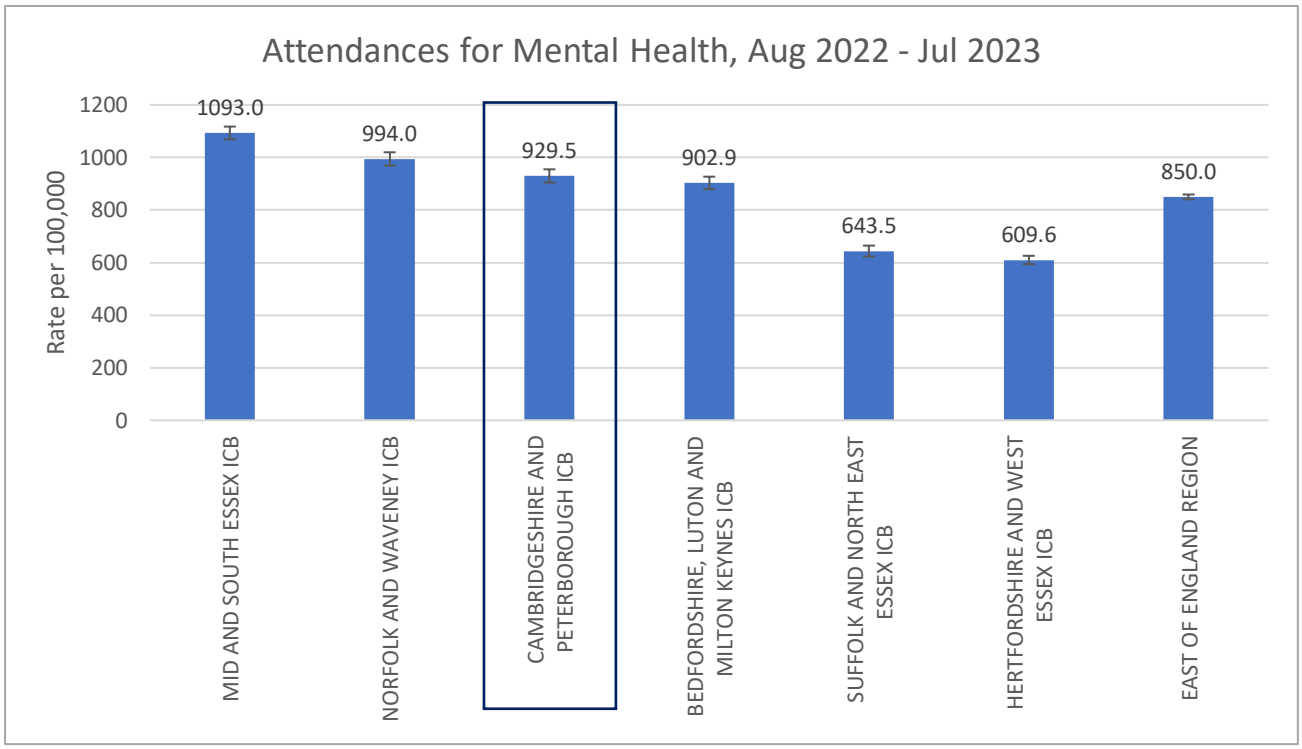
In Cambridgeshire and Peterborough ICS, the proportion of Accident and Emergency attendances for mental health and for self-harm have increased since December 2022.

Figure 38: Proportion of Accident and Emergency attendances for mental health and self-harm, Cambridgeshire and Peterborough ICS, April 2019 – July 2023. Image source: Urgent and Emergency Mental Health Dashboard - Mental Health, Learning Disability and Autism Resource Hub - FutureNHS Collaboration Platform



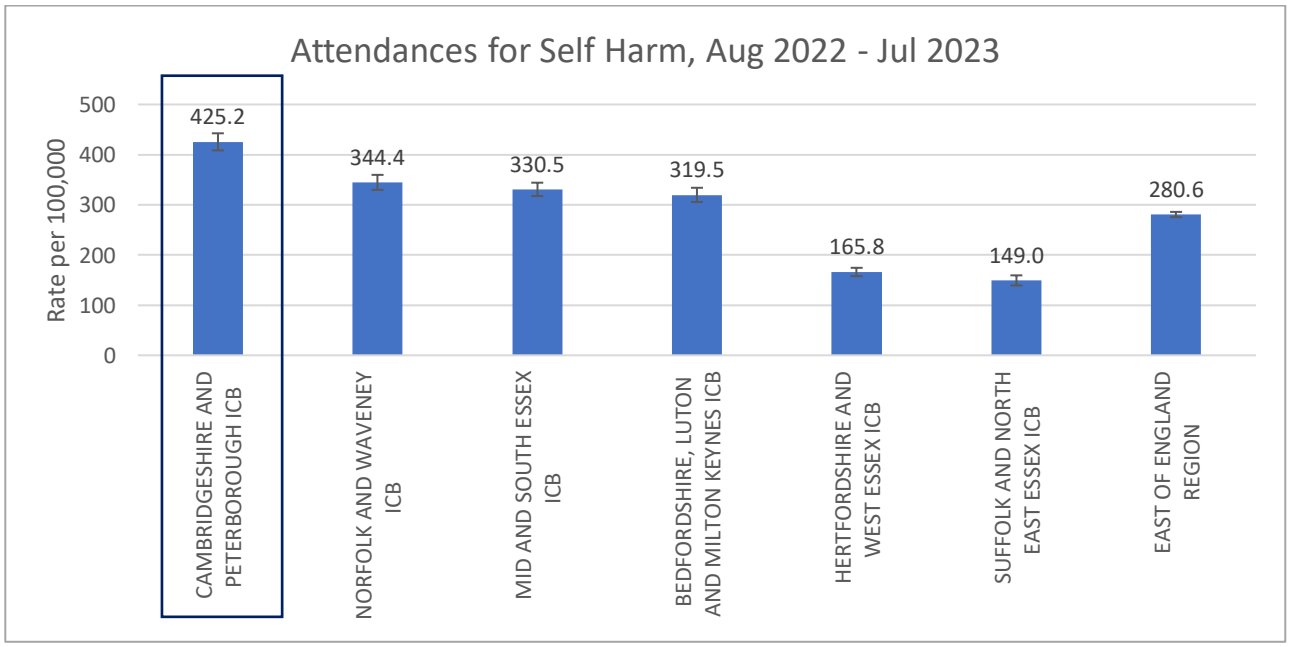
Rates of attendances to Accident and Emergency where the primary complaint was mental health-related (including self-harm) in Cambridgeshire and Peterborough are similar to other areas in the East of England.

Figure 39: Accident and Emergency attendances for mental health, Cambridgeshire and Peterborough ICS, August 2022 to July 2023. Source: Urgent and Emergency Mental Health Dashboard - Mental Health, Learning Disability and Autism Resource Hub - FutureNHS Collaboration Platform



However, attendances for self-harm appear to be higher in Cambridgeshire and Peterborough than other areas. This may be due to the coding practices of hospitals for self-harm, as highlighted by a recent report by Fullscope, which focused on self-harm amongst children and young people in Cambridgeshire and Peterborough. Another potential contributing factor is that Cambridge University Hospitals NHS Foundation Trust (Addenbrooke's Hospital) is the trauma centre for the East of England, so receives people from across the region for trauma care.

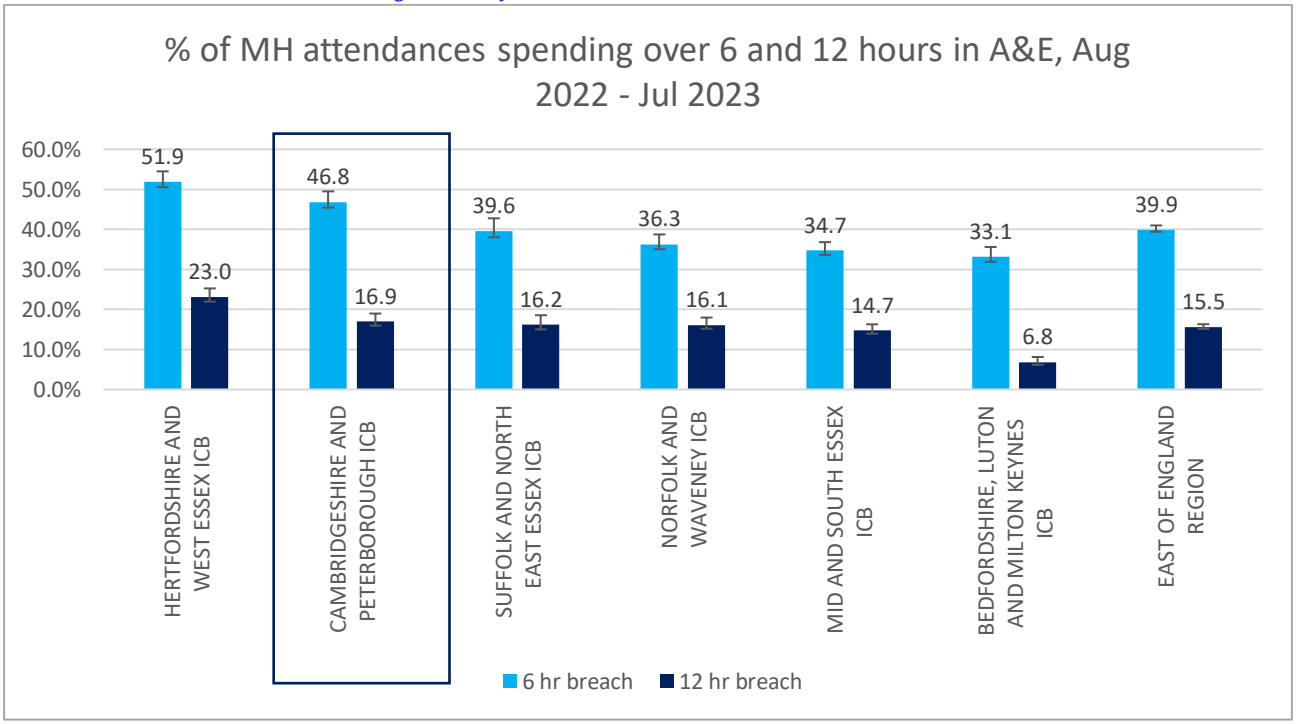
Figure 40: Accident and Emergency attendances for self-harm, Cambridgeshire and Peterborough ICS, August 2022 – July 2023. Source: Urgent and Emergency Mental Health Dashboard - Mental Health, Learning Disability and Autism Resource Hub - FutureNHS Collaboration Platform



How long do people spend in Accident and Emergency?

- Over the past couple of years, an increasing proportion of people attending Accident and Emergency for reasons relating to mental health in Cambridgeshire and Peterborough have ended up spending over 6 or 12 hours in this department.
- 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.
    - Around 1 in 8 (17%) spent over 12 hours in Accident and Emergency. This is higher than most areas in the East of England.
- This is also higher than the length of time people spent in Accident and Emergency when their chief complaint related to their physical health. 30.9% of all people attending this service spent more than 4 hours in the Accident and Emergency department in Cambridgeshire and Peterborough in June 2023 (NHS England, 2023c).

Figure 41: Proportion of mental health attendances spending over 6 and 12 hours in Accident and Emergency, Cambridgeshire and Peterborough ICS, August 2022 – July 2023. Data source: Urgent and Emergency Mental Health Dashboard - Mental Health, Learning Disability and Autism Resource Hub - FutureNHS Collaboration Platform



What do people say about this service?

- A national survey carried out in 2014 found that Accident and Emergency departments were felt to be the worst for service user experience, compared to other options in a mental health crisis such as voluntary sector organisations, GPs and community mental health teams (Care Quality Commission, 2015). Fewer than 1 in 3 people reported that the advice and support they got was 'right for them' (Care Quality Commission, 2015).
- International studies highlight that people attending Accident and Emergency in mental health crisis often have poor and stressful experiences, due to staff attitudes, waiting times and the environment of this setting, which can be distressing in itself (Sacre et al., 2022).

Liaison psychiatry services

Liaison psychiatry services provide psychiatric assessment and treatment to patients who may be experiencing mental ill health whilst in general hospital wards (such as Emergency Departments and inpatient wards) (Public

Health England, 2019). They provide support for people who present with both physical and mental health symptoms. National studies show that these services improve quality of care, reduce the length of time people stay in hospital and reduce the risk of adverse events linked to mental health (Royal College of Psychiatrists, 2013).

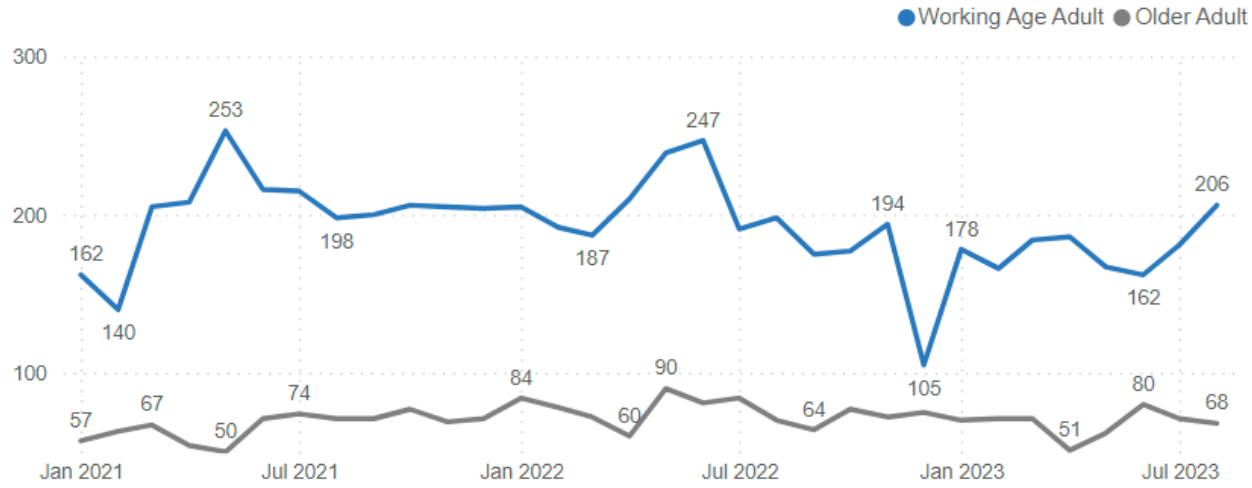
The key trends in referrals to liaison psychiatry for working-age adults (aged between 18 and 65) are:

- Addenbrooke's: referrals to liaison psychiatry have increased steadily since 2016.
- Hinchingbrooke Hospital: referrals to liaison psychiatry seem relatively stable since 2021.
- Peterborough Hospital: referrals to liaison psychiatry seem relatively stable since 2021.

How many people are referred to this service?

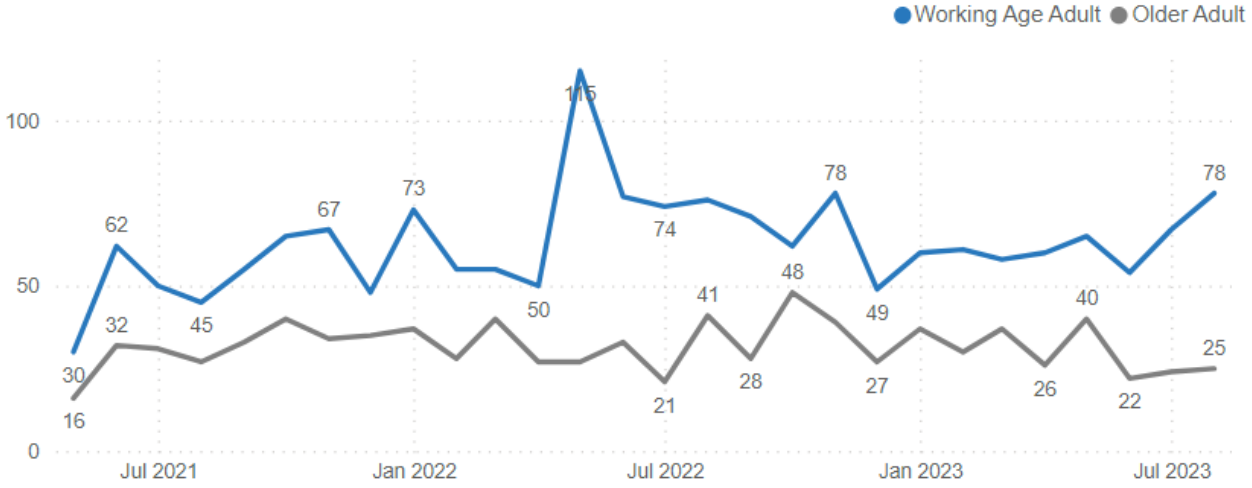
Referrals to liaison psychiatry in Peterborough City Hospital seem relatively stable since 2021. Data was not collected on this system before then.

Figure 42: Referrals to Liaison psychiatry in Peterborough City Hospital, January 2021 – July 2023.



Referrals to liaison psychiatry in Hinchingbrooke Hospital peaked in May 2022, but have otherwise remained relatively stable since 2021.

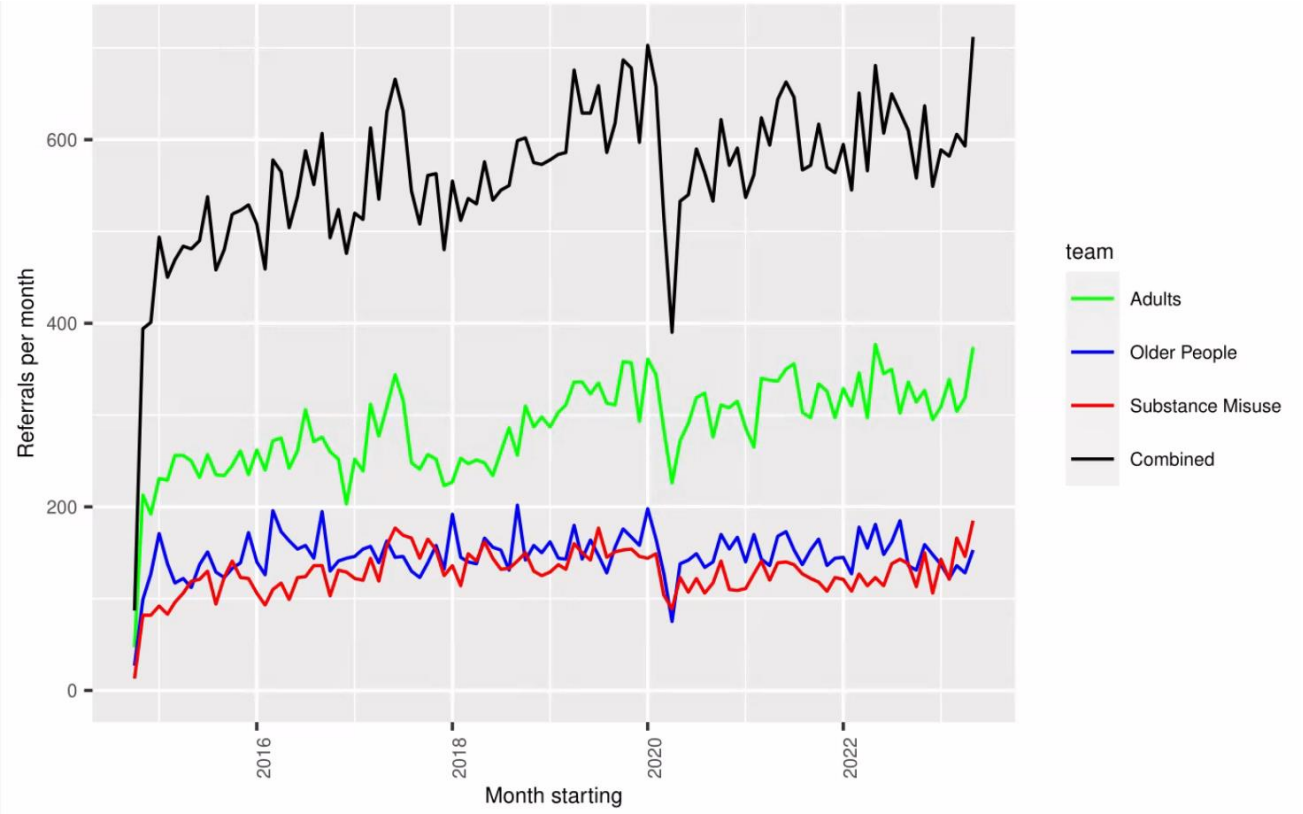
Figure 43: Referrals to Liaison psychiatry in Hinchingbrooke Hospital, May 2021 – August 2023.



Referrals to liaison psychiatry in Cambridgeshire South have increased steadily since 2016. There was a noticeable decrease in referrals in 2020, when NHS Trusts were asked to urgently discharge any hospital inpatients who were medically fit to leave hospital to increase capacity in response to the COVID-19 pandemic (Nuffield Trust, 2023).

Note that data is divided differently on this system, with a separate category for referrals relating to substance misuse.

Figure 44: Referrals to liaison psychiatry, Cambridgeshire South (Addenbrooke's and the Rosie Hospital), 2014 - 2022. Data source: Epic

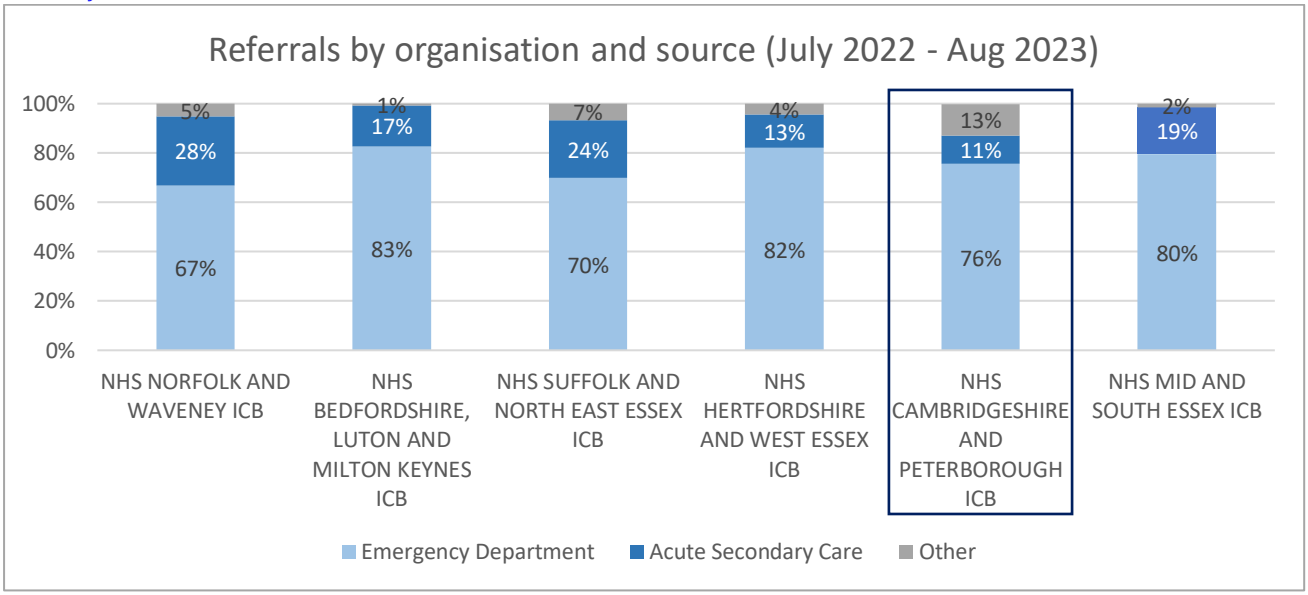


Note: the initial low figures in 2014 are an artefact of moving from paper to electronic systems.

Where are people referred from?

Over the past year (July 2022 to August 2023), three quarters (76%) of referrals to liaison psychiatry teams in Cambridgeshire and Peterborough have been from the Accident and Emergency (Emergency Department). Compared to recent years, there were increasing levels of referrals from the Accident and Emergency, but lower levels of referrals from acute wards.

Figure 45: Referrals to Liaison Psychiatry by organisation and source, 18 – 64 years, Cambridgeshire and Peterborough ICS, July 2022 – August 2023. Data source: Urgent and Emergency Mental Health Dashboard - Mental Health, Learning Disability and Autism Resource Hub - FutureNHS Collaboration Platform



What is the response time for this service?

In Cambridgeshire and Peterborough ICS, the proportion of liaison referrals with any contact and face-to-face contact has shown relatively stable trends since October 2021.

Figure 46: Referrals to Liaison Psychiatry with any contact and with a face-to-face (F2F) contact, 18 – 64 years, Cambridgeshire and Peterborough ICS, October 2021 – August 2023. Data source: Urgent and Emergency Mental Health Dashboard - Mental Health, Learning Disability and Autism Resource Hub - FutureNHS Collaboration Platform

How do local services compare to national standards?

In 2022/23 (NHS England, 2023h):

- 2 out of 3 local acute hospitals met the 'core 24' service standard, which sets out a range of support and responses on a 24 hour basis (such as the availability of consultant psychiatrists).
- 2 out of 3 mental health liaison teams were open 24/7.

Police

Some people experiencing mental health crisis come into contact with police. There are a range of local strategies and approaches aiming that this group receives the most appropriate mental health support.

Integrated Mental Health Team

- The Integrated Mental Health Team (IMHT) are specialist mental health staff based at the police force control room in Hinchingbrooke. They work to ensure the most appropriate pathways are taken for individuals in mental health crisis.
- This team supports people in mental health crisis; gives support to the police whilst liaising with mental health teams in relation to police matters; supports police on help with missing persons and domestic abuse cases; and advises operations and gives clarity to officers over the Mental Health Act.

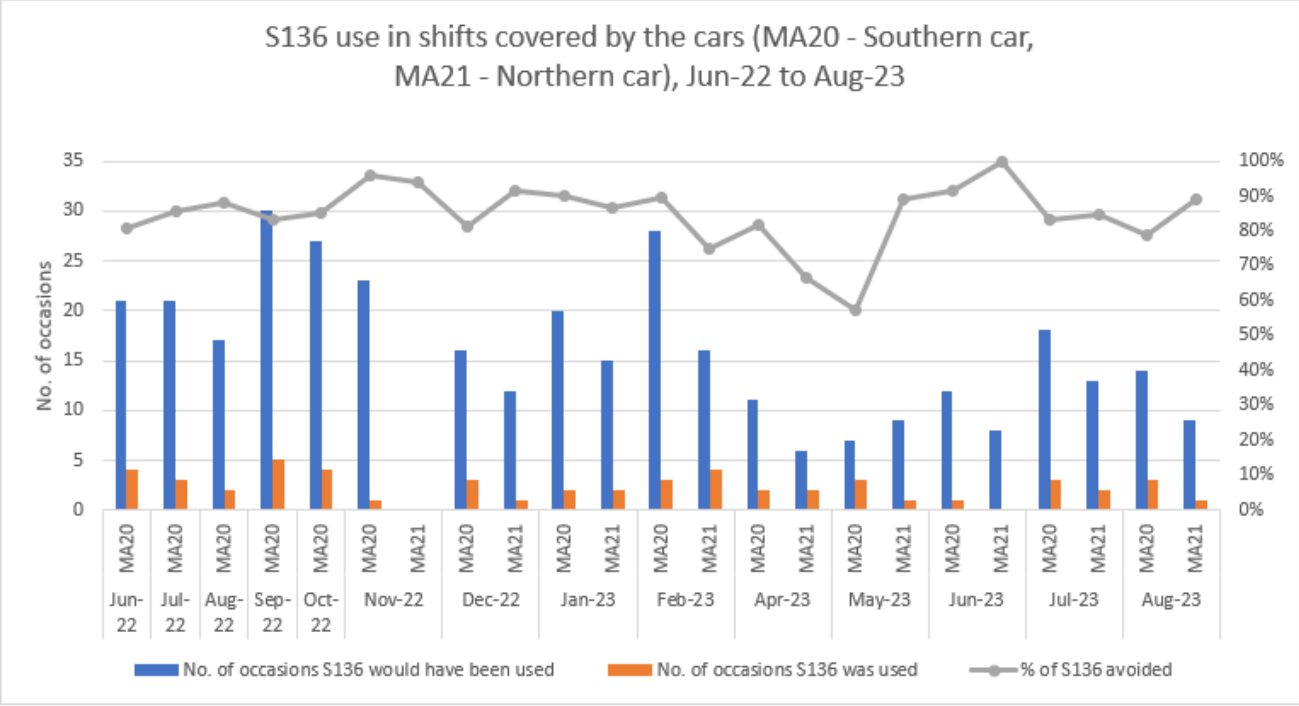
Police and Mental Health Response Car

The Police and Mental Health Joint Response Cars (PMHJRC) aim to improve support for patients in mental health crisis, by exploring options of care within the community. These cars are staffed by two police constable and one Band 7 mental health practitioner; and respond mental health crisis and concern for person calls. The aims of this service are:

- To provide patients in a mental health crisis with a specialist resource that meets their presenting needs.
- To reduce the number of detentions under Section 136 of the Mental Health Act, by identifying and implementing other, more appropriate plans for care.
- To improve the patient and staff experience regarding community-based mental health presentations.
- To improve and promote system working for the benefit of all partners within the locality.
- To reduce the amount of hours police are engaged dealing with mental health crisis.
- To improve the skills police services when dealing with mental health crisis.

There are two mental response cars, one based in the North (MA21) and the other in the South (MA20). From June 2022 to August 2023, the use of Section 136 was avoided on between 60 to 100% of occasions.

Figure 47: Section 136 use in shifts covered by Joint Mental Health Response Cars, June 2022 – August 2023.



Note that this data only covers the car shifts, not the total number of Section 136 detentions.

Operation Farmington

- Operation Farmington is a project across Cambridgeshire and Peterborough in which multi-agency information sharing is used to aid police decision making when responding to calls for service from those

who are "high demand" (either by repeated calls to the Police Service Centre and Force Control Room, Custody or for police attendance in the community)

- It recognises that many people in contact with the criminal justice system (victims, suspects and witnesses) have unmet mental health and/or substance use needs and aims to provide the 'right care at the right time from the right service',

Right Care, Right Person

Right Care, Right Person (RCRP) is a national programme 'designed to ensure that people of all ages, who have health and/or social care needs, are responded to by the right person, with the right skills, training, and experience to best meet their needs' (96). All police forces are moving towards police officers only attending mental health calls when there is an immediate risk to life or serious harm, or where a crime is involved.

In Cambridgeshire and Peterborough, 'Concern for Welfare' calls have been handled under RCRP since the 13th of November 2023.

Mental Health Act

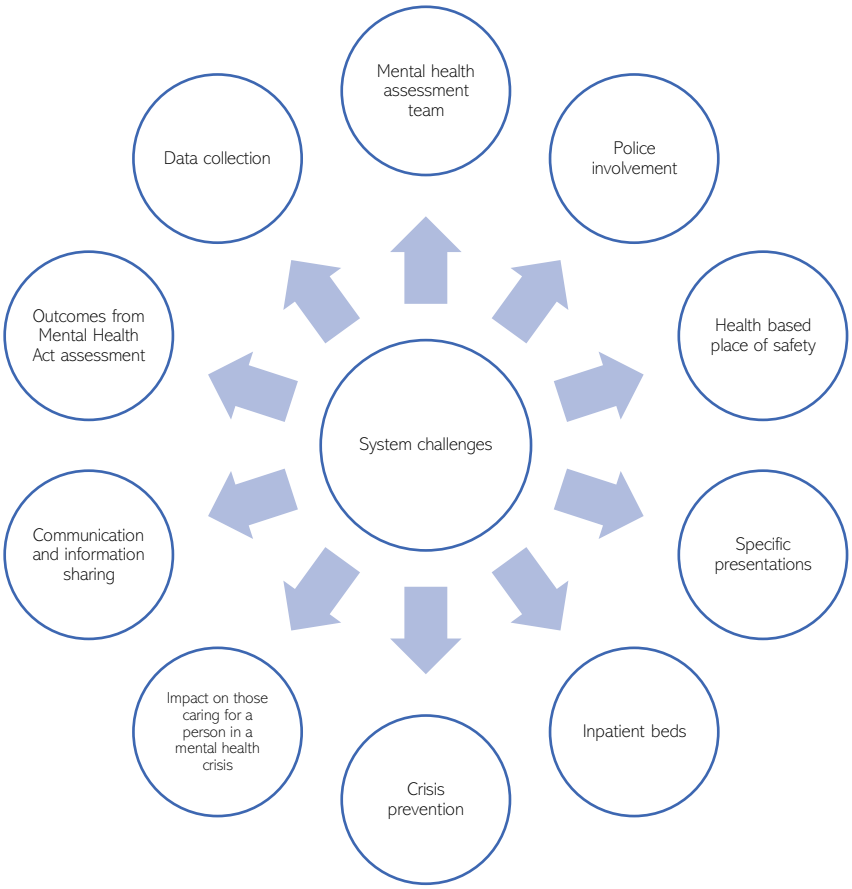
The Mental Health Act is a law that allows people to be sectioned (detained in hospital) if they have a mental health condition and need treatment, and certain conditions are met. There are different types of sections, which have different rules about how long people can be detained (Mind, 2023).

Mental Health Act Assessment Pathway Review 2023

In 2018, reforms were proposed to the Mental Health Act with the aim to better empower patients to make decisions about their care, to improve the experiences of patients from ethnic minority groups and to reduce the use of the Mental Health Act for people with a learning disability and autistic people (Garratt, 2023).

Due to these planned legislative changes, and reports of issues in the Cambridgeshire and Peterborough Mental Health Act 'pathway', the system has invested in a multiagency review of the Mental Health Act pathway. This review began with 3 workshops, held between April and June 2023, in which over 60 stakeholders helped to identify system challenges and potential solutions. Workshop participants, including people with lived experience, identified potential solutions which would help resolve these challenges, the prioritised options of which will be developed as a business care.

Figure 48: System challenges identified in the Cambridgeshire and Peterborough Mental Health Act Assessment Pathway Review 2023



A detailed summary of the findings of this pathway review are listed below:

Table 4: Specific challenges identified in the Cambridgeshire and Peterborough Mental Health Act Assessment Pathway Review 2023

Pathway area	Specific challenges	
Mental health assessment team	Approved Mental Health Professionals	• Two services provide AMHPs, which have different thresholds. These thresholds can be influenced by system issues • Timeliness of assessment • Availability of AMHPs and resource to their roles
	Section 12 doctors	• Section 12 doctor availability • Doctor retains responsibility until bed is identified • Payment of Section 12 doctor fee
	Specialist Section 12 approved and second doctor	• Specialist doctors to assess children and young people • Specialist doctors to assess people with a learning disability or autistic people
Police involvement	Section 135 and 136	• S135 is rarely used because of the time needed to complete the application, attend court and gather team • Increase in S136 due to: police 'holding' responsibility; alternatives not always being offered; officers feeling that there is a lack of 'options', increase in people with multiple S136 detentions in short space of time
	Conveyance	• Reports that police are thought of a 'default' option • Concerns over use of private ambulance services

	Safety and security	• Reports that police used as default, instead of multiagency response
Health based place of safety	• Only one S136 suite • Emergency departments are not ideal location for people experiencing a mental health crisis	
Specific presentations	• Children and young people: assessment process is more complex in situations where there are breakdowns in 'placements' due to issues around finding safe accommodation • Learning disability and autism: assessment process is more complex in situations where there are breakdowns in 'placements' due to issues around finding safe accommodation; lack of specialist staff; lack of knowledge, understanding and confidence around learning disabilities and autism, including reasonable adjustments • Substance use: challenges around completing assessments in timely manner	
Inpatient beds	• High level of occupancy in local beds	
Crisis prevention	• Workforce pressures in community mental health teams • Gaps in some specific areas of crisis prevention, such as an alternative to hospital admission (e.g. crisis house or acute day centre)	
Impact on those caring for a person in a mental health crisis	• Lack of specific support for people caring for those experiencing a mental health crisis	
Communication and information sharing	• Communication across organisations	
Outcomes from Mental Health Act assessment	• Concerns around the support given to people who are assessed under the Mental Health Act, but not admitted	
Data collection	• Poor data collection across the system contributes to poor understanding of the 'pathway'	

What do people say?

A review of international research into the experiences of people assessed and detained under mental health legislation found that (Akther et al., 2019):

- In most studies, a proportion of patients reported that their involuntary admission had helped avert risk and protect them from harm, but some felt that greater provision of timely and appropriate information could help patients feel safer.
- Many people reported that they were not given basic information about this what happened to them and why. When people were provided with clear information, this appeared to reduce fear and the impact of coercion, improve relationships with staff and result in patients feeling less disempowered.
- In the great majority of studies, patients described wanting to be involved in decisions about their care. Good relationships with staff could facilitate involvement in decision making. Carers' input to decisions was appreciated particularly when patients were too distressed to engage, but this could also leave patients feeling excluded from decision-making.

As part of the Cambridgeshire and Peterborough Mental Health Act Assessment Pathway Review (2023), people with lived experience of the pathway (including as carers) highlighted that:

- Local practice is that requests for planned Mental Health Act assessments are not completed if a bed has not been identified. This leads to delays which may increase distress and anxiety for the individual and their carers, and may also increase the use of Section 136 detentions as people reach 'crisis point'.

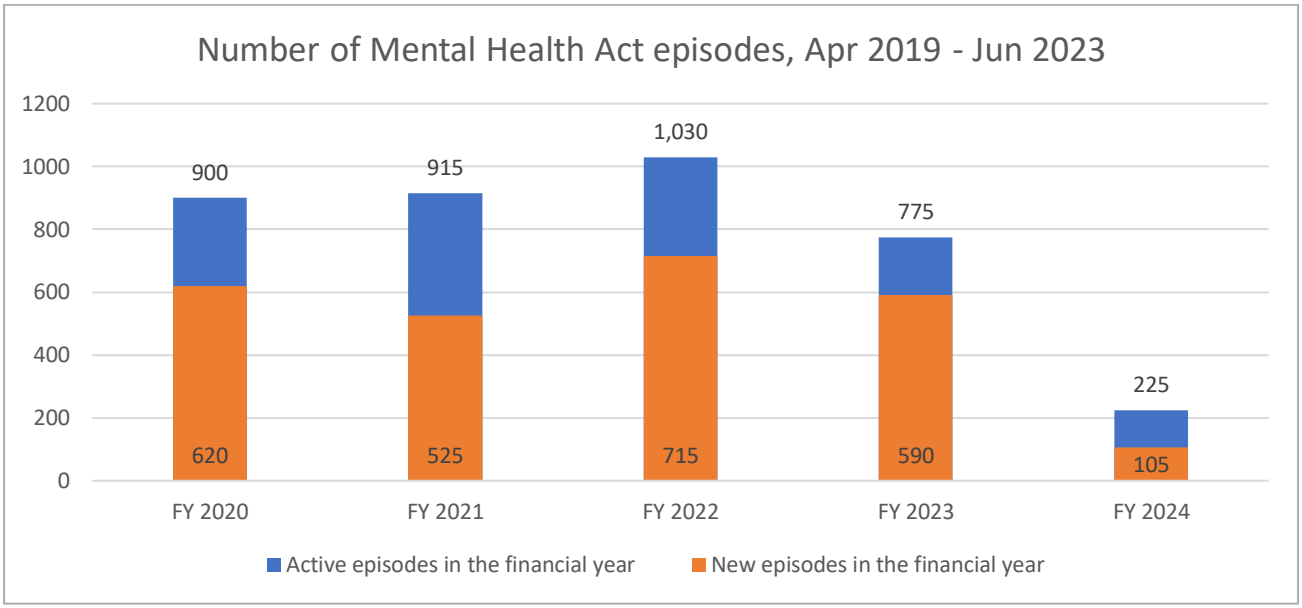
- The process of carrying out Section 135, which requires a warrant application, takes long time. This can cause considerable distress and trauma to both the individual and those that they live, due to having to maintain the safety of the individual whilst the process is completed.
- The use of restraint to maintain the safety of the individual and others as part of the assessment process was raised as a concern, due the long-term impacts this can have on the individual and their loved ones.
- As the only Section 136 Suite in the county is based in Fulbourn, people living in the North of the county do not have equitable access to services and find it difficult to be supported by friends and family.
- In 2022/23 64% of those detained under Section 136 of the Mental Health Act were initially conveyed for assessment to their local Accident and Emergency department. People identified concerns that this is not the 'best' place for a person to be assessed and this related to:
    - Limited or no private space for the assessment to be conducted, thus impacting on the dignity and privacy of the individual.
    - That maintaining the individual's and other safety in this environment was more complex and would often mean that either police or security staff would be seen to be 'on guard', stigmatising the individual by 'criminalising' the assessment process.
    - That staff attitudes towards people in mental health crisis could occasionally be unhelpful and led to both the individual being assessed and the staff conducting the assessment feeling unwelcome or discriminated against.
- Specific challenges relating people caring for someone experiencing a mental health crisis were identified:
    - Additional sense of responsibility and potential resulting distress and anxiety when supporting a person whilst a Mental Health Act assessment is arranged and/or the delay in the assessment being completed.
    - Sense of holding the risk and responsibility for the individual who may present at significant risk to self or others.
    - Feeling abandoned and unsupported at the end of the assessment process when the person is not admitted or offered additional help and support.
    - Lack of specific carer support prior to, during and after the assessment process.

How many people are detained?

The data below covers uses of the Mental Health Act in CPFT (Cambridgeshire and Peterborough Foundation Trust). It does not over NWAFT (North West Anglia Foundation Trust) or CUH (Cambridge University Hospital).

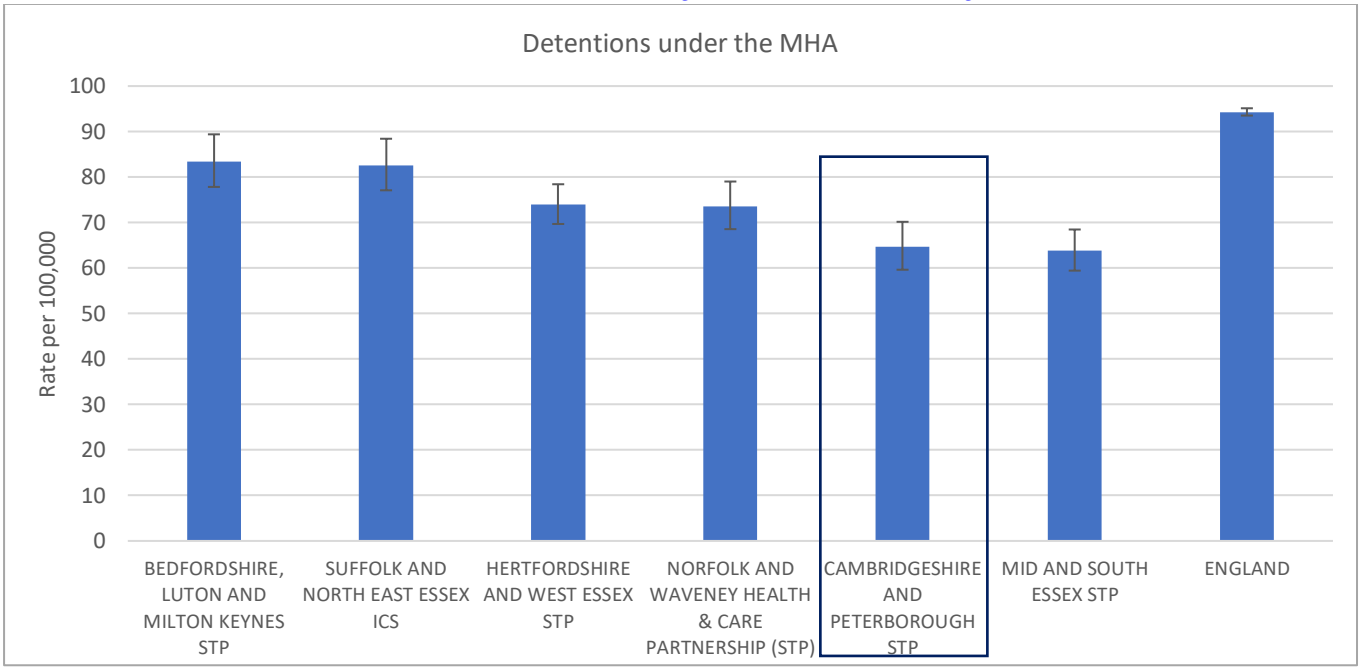
In Cambridgeshire and Peterborough, there was a 25% decline in in the number of Mental Health Act episodes in 2023/24, compared to the previous financial year.

Figure 49: Number of Mental Health Act episodes in Cambridgeshire and Peterborough, April 2019 – June 2023. Data source: [MHA Dashboard - Mental Health, Learning Disability and Autism Resource Hub - FutureNHS Collaboration Platform]



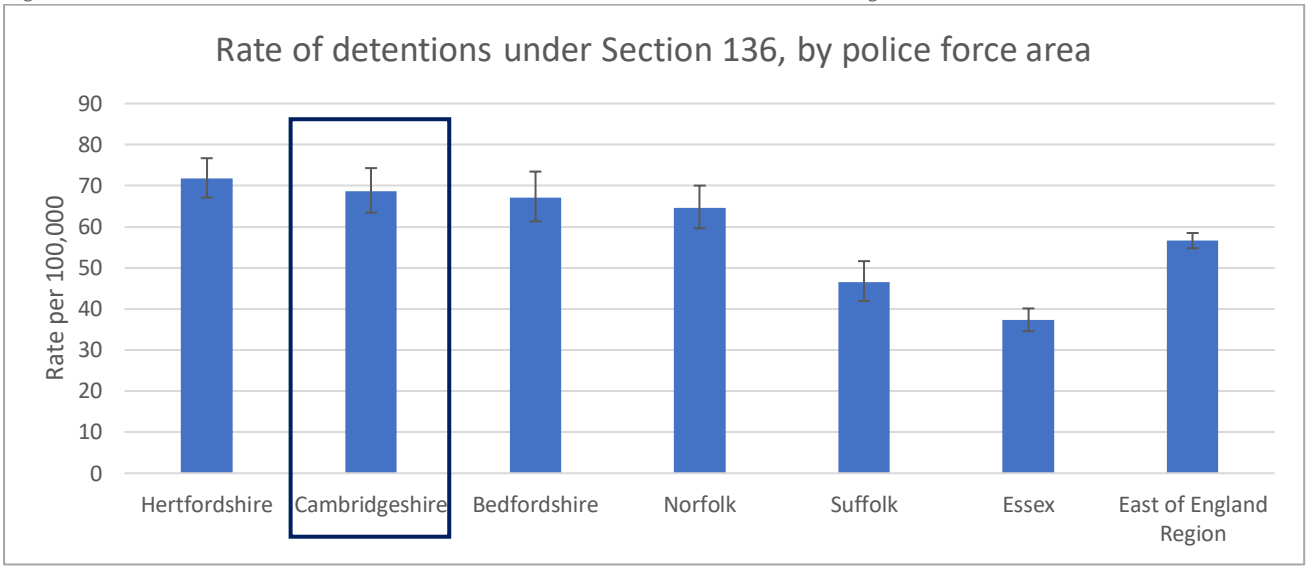
In 2021/22, the rate of detentions under the Mental Health Act was lower in Cambridgeshire and Peterborough compared to most other areas in the East of England.

Figure 50: Rate of detentions under the Mental Health Act per 100,000 of the total population by STP, East of England, 2021-22. Data source: [Mental Health Act Statistics, Annual Figures, 2021-22 - NHS Digital]



In 2021/22, the rate of detentions under Section 136 per 100,000 population in Cambridgeshire Constabulary (69 per 100,000) was the second highest in the East of England region. It was significantly higher than the regional average of 57 per 100,000.

Figure 51: Rate of Mental Health Act detentions under Section 136, East of England, 2021/22. Data source: Gov.uk



How long are people detained?

The average length of Section 2 detentions in Cambridgeshire and Peterborough increased from April 2019 to May 2023, from around 15 to 20 days. Contrastingly, a declining trend is seen Section 3 detentions, from an average of 300 to below 100 days.

Figure 52: Average length of MHA episodes (section 2) for adults aged 18 – 64, Cambridgeshire and Peterborough ICS, April 2019 – May 2023. Data source: MHA Dashboard - Mental Health, Learning Disability and Autism Resource Hub - FutureNHS Collaboration Platform

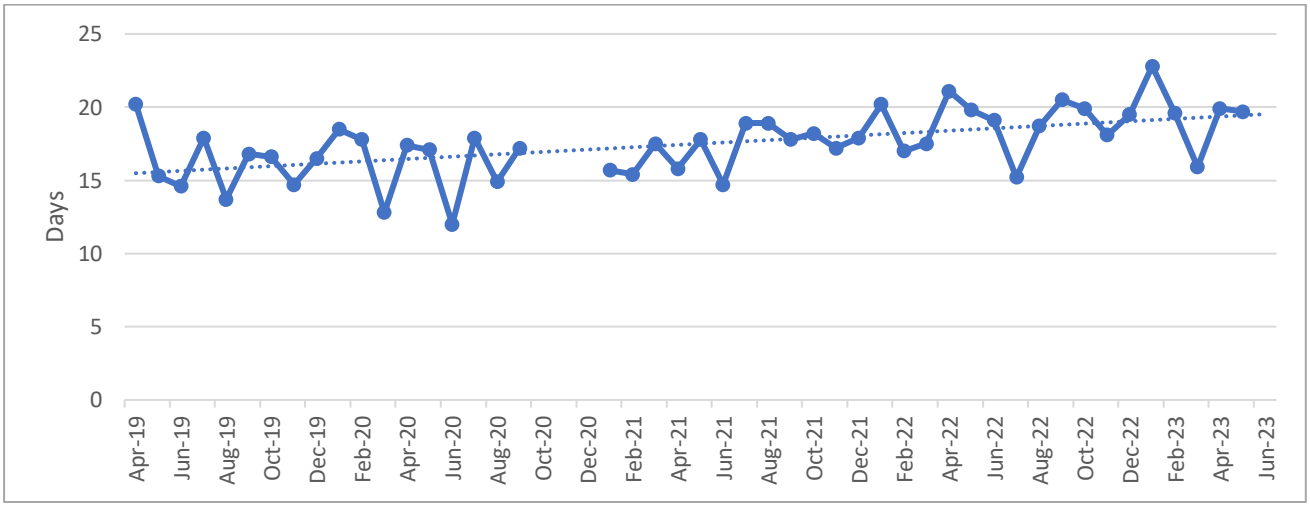
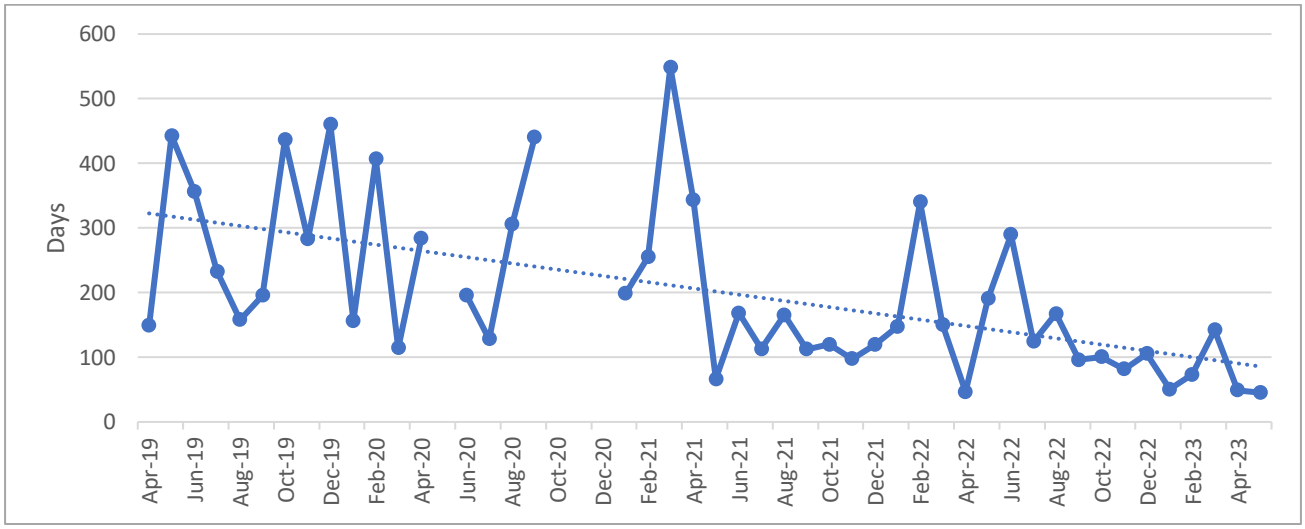


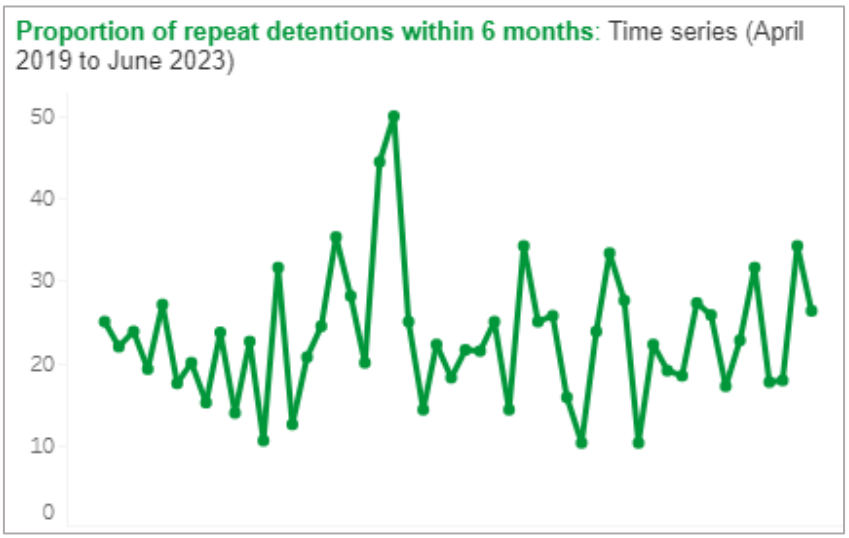
Figure 53: Average length of MHA episodes (section 3) for adults aged 18 – 64, Cambridgeshire and Peterborough ICS, April 2019 – May 2023. Data source: [MHA Dashboard - Mental Health, Learning Disability and Autism Resource Hub - FutureNHS Collaboration Platform]



Repeat detentions

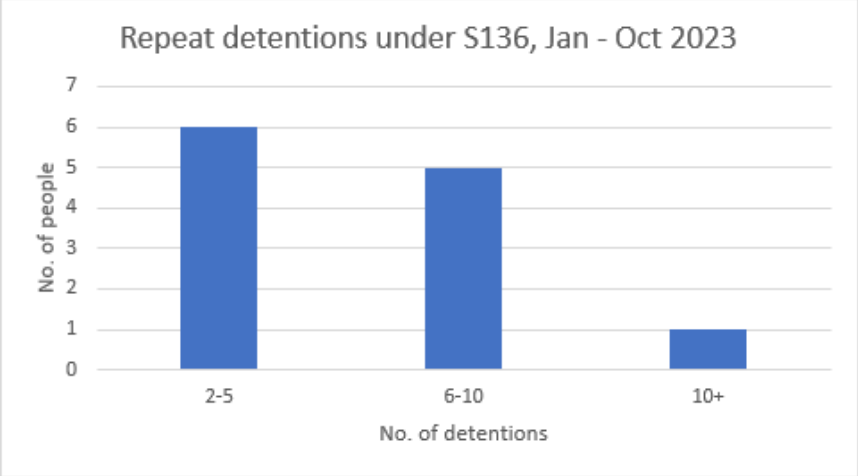
In the past year, an increasing proportion of people have been detained under the Mental Health Act, after having previously been detained in the preceding six months.

Figure 54: The proportion of repeat detentions within 6 months, Cambridgeshire and Peterborough ICS, April 2019 – June 2023. Image source: [MHA Dashboard - Mental Health, Learning Disability and Autism Resource Hub - FutureNHS Collaboration Platform]



There are a small number of individuals who are detained under Section 136 multiple times. For example, in the 10 months from January to October 2023, 5 people were detained between 6 to 10 times, and one person was detained over 10 times.

Figure 55: Repeat detentions under Section 136, January – October 2023.



Which groups are more likely to be detained by the Mental Health Act?

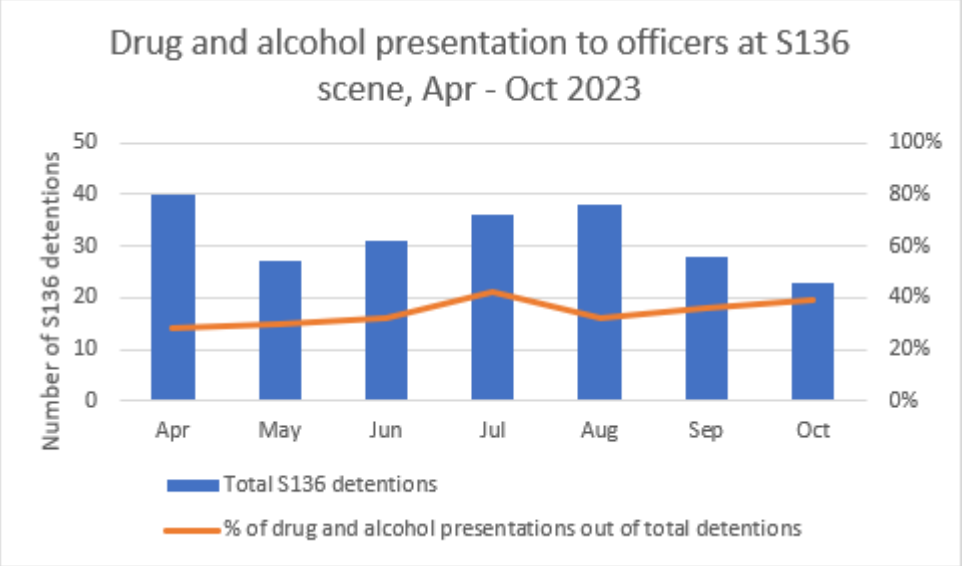
In the 12 month period ending in June 2023, in Cambridgeshire and Peterborough:

- A similar proportion of men and women were detained under all sections the Mental Health Act. However, men made up 83% of the people detained via the criminal justice system and 70% via community treatment orders.
- 44% of people detained under Section 136 were from the most deprived quintile.
- The proportion of people detained under the Mental Health Act who were from 'Black', 'Mixed' or 'Other' ethnic groups was substantially overrepresented compared to the proportion within the general population.
- 23% of people detained under the Mental Health Act were age 65 or over, although the age breakdowns of people detained varied substantially by the type of section. All the people detained under Section 136 were aged between 18 and 54 years, with a higher proportion among the 35 to 44 age group.
- 11% of all people detained under the Mental Health Act had a learning disability and/or were autistic. About 1 in 5 people detained via the criminal justice system had a learning disability and/or were autistic.

More detailed breakdowns by the type of section can be found here (embed slides). For more information on the national trends in Mental Health Act detentions, see this report (link to slides).

From April to October 2023, 30 to 40% of Section 136 detentions each month were thought to involve drug or alcohol presentations. This means that police officers believed that the individual involved had used drugs and/or alcohol, so may not reflect true figures.

Figure 56: Recorded drug and alcohol presentations by officers at Section 136 scene, April – October 2023.



Voluntary and community sector

There is a range of voluntary and community sector support for people experiencing mental health crisis. Some of the largest organisations offering this support locally are Lifecraft, CPSL Mind and the Samaritans; although there are also a range of helplines run by national organisations.

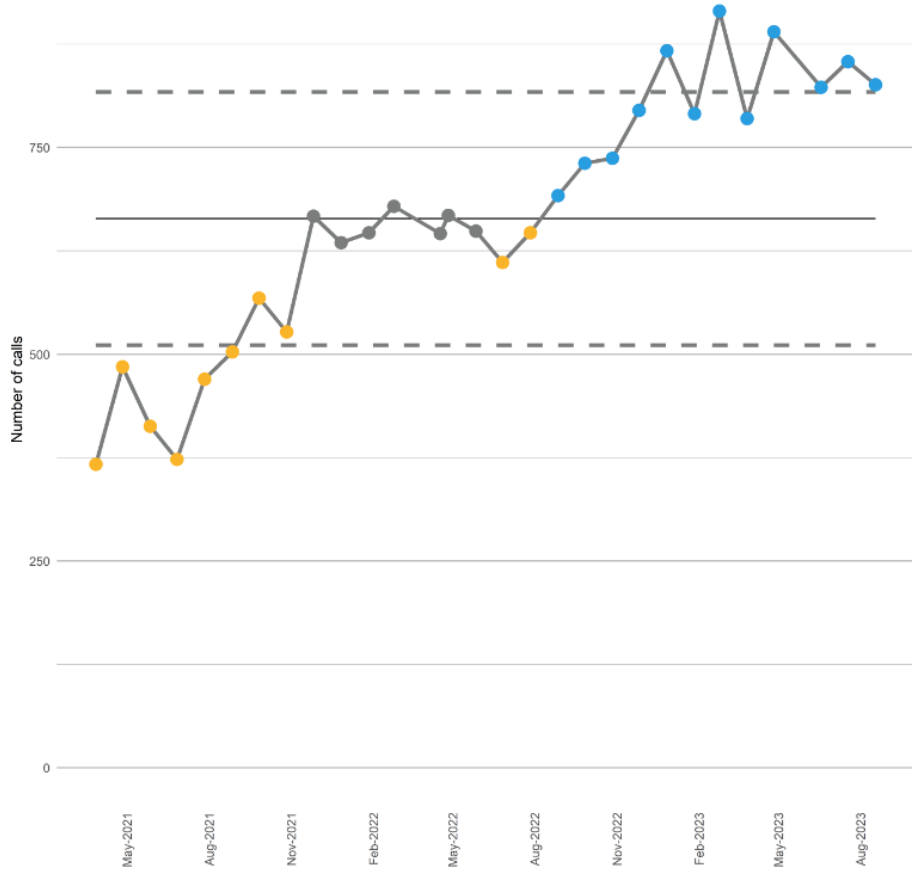
Lifeline

Lifeline is a 'free, confidential and anonymous telephone helpline service for people in Cambridgeshire and Peterborough that is currently available from 11am – 11pm every day. Lifeline provides listening support and information to someone experiencing mental distress or if you are supporting someone in distress' (Lifecraft, 2023b). It is run by Lifecraft (add link). In 2022/23:

- This service took 8,749 calls and was open for 4,015 hours.
- Volunteers offered 2,904 hours of support.
- 710 people called Lifeline for the first time.
- The most common reasons for calling were isolation (19%), anxiety (14%), distress (8%) and depression (7%).

The number of callers to Lifeline has increased from October 2022 to August 2023, but there has not been a significant change in the number of first-time callers over this time. This does not necessarily reflect an increase in mental distress in the population: Lifeline has increased their advertising over this time period, and the number of calls taken by this service is impacted by the number of open lines. However, anecdotal evidence suggests that callers to Lifeline has been more unwell and had more complex experiences of distress.

Figure 57: Number of calls to Lifeline, April 2021 – August 2023



Samaritans

Cambridge Samaritans provides emotional support to anyone in distress. This includes walk in support from 10.30 am to 10pm daily, and telephone and email support (Samaritans, 2023). In 2021, the Cambridge Samaritans branch:

- Answered 26,943 calls.
- Spent 8,452 hours on the phone.
- Sent 1,089 e-mails.

The Sanctuary

CPSL Mind run Sanctuaries in Cambridgeshire and Peterborough. These offer telephone support (between 11am and 5pm) and face-to-face support (6pm to 1am) for people experiencing mental health crisis (CPSL Mind, 2023).

After discharge from crisis services, individuals can be supported by the Discharge Buddy Service. This offers short-term social, practical and emotional support to help recovery and prevent future crisis. This service is open to young people and adults, who are referred via the crisis care pathway and community mental health teams (CPSL Mind, 2023).

Follow up support (Lifecraft)

Lifecraft provides a range of follow-up support for people after discharge from The Sanctuary, after being detained under Section 136 and for those who have been missing from home. In 2022/23:

Sanctuary Aftercare Service

- 1,349 referrals into the service and 877 unique people supported
- 1,129 signposts made
- 70 safety plans created and 12 updated

S136 Follow-up Service

- 51 referrals into the service and 38 people supported
- Over 22 hours of support given

Missing from Home Service

- 74 referrals into the service and 46 people supported
- Over 20 hours of support provided

Additional Resources

- NHS England » Crisis and acute mental health services
- All Age Crisis Care | Royal College of Psychiatrists (rcpsych.ac.uk)
- Mental Health – Adult Crisis and Acute Care GIRFT Programme National Specialty Report
- National Partnership Agreement: Right Care, Right Person
- Right Care Right Person toolkit
- My Crisis PACk (Preferences for Admission, treatment and Care) tool

Inpatient

- Acute inpatient services provide treatment when a person's mental health condition cannot be managed in the community, and where specialist care is required in a safe and therapeutic setting (Public Health England, 2019). Inpatient admissions should be purposeful, integrated with other services, open and transparent, and as local and short as possible (Care Quality Commission, 2015).
- Although mental healthcare is often discussed in terms of inpatient treatment, only around 3% of people accessing mental health services in 2018/19 received inpatient care (Davidson, 2021).
- Nationally, inpatient mental health services are managing increasing demand and acuity, alongside the wider workforce pressures across the NHS (NHS England, 2023b).
- The GIRFT view is that NHS mental health provision should be thought of as a community-based secondary care service, to which an acute inpatient service is attached to serve people when access is essential. Community mental health services play a crucial role in delivering mental health care for adults and older adults with severe mental health needs as quickly and as close to home as possible. Inpatient care, when it is essential, should also be accessible locally and rapidly (Davidson, 2021).

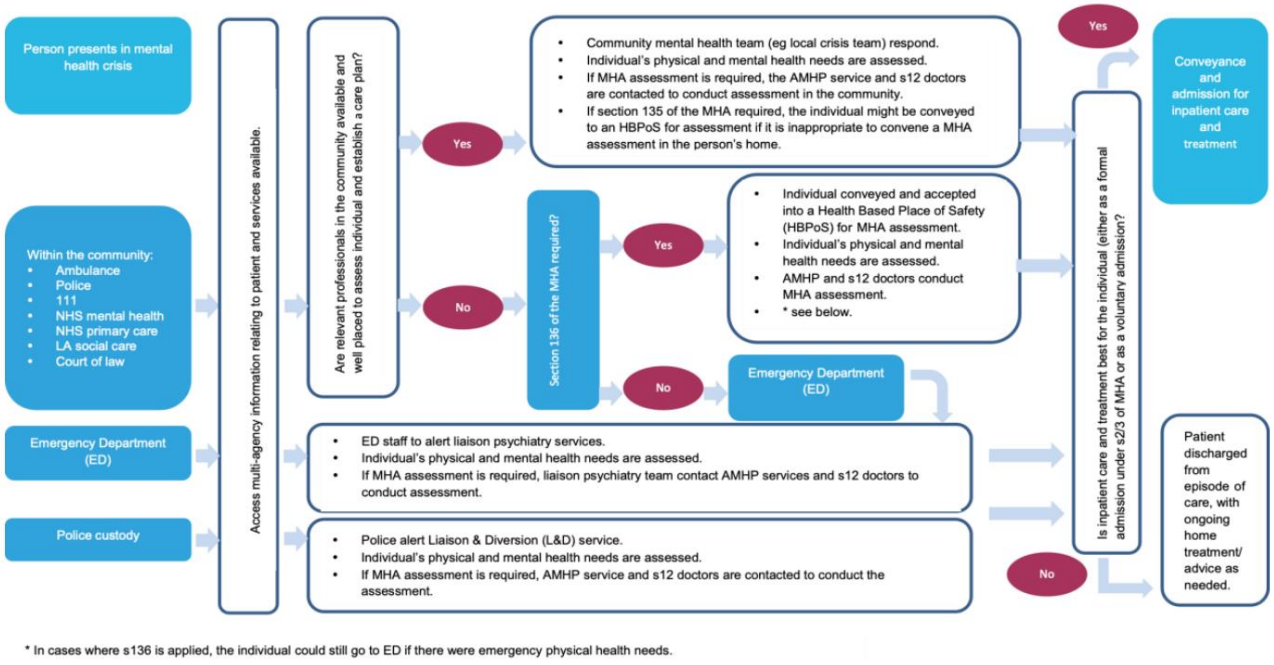
Data from Cambridgeshire and Peterborough suggests there are both strengths and areas for improvement in local inpatient services. The vast majority of people admitted to hospital are already known to community mental health services, and the number of admissions where people are detained under the Mental Health Act are decreasing. However, there are high levels of occupancy of acute mental health beds and an increasing number of inappropriate out of area placements compared to previous years. More people are spending over 60 days in inpatient care. Contributing factors to this may include:

- Staffing pressures, which led to the closure of Mulberry Ward 3.
- Increase in mental distress (demand and acuity), due to the cost of living crisis and wider impacts of the COVID-19 pandemic
- Greater acuity when people become inpatients because of delays to admission (finding beds)
- Greater reliance on out of area placements, which are associated with greater length of stay
- Delays to discharge because of wider system pressures (such as in housing and social care)

Pathways into inpatient care

There are a range of pathways into inpatient care for people experiencing mental health crisis. The diagram below reflects key pathways in our local system, although it does not capture all routes into inpatient care such as the joint mental health response car, or alternatives to inpatient care such as The Sanctuary.

Figure 58: Pathways from mental health crisis into inpatient care. Image source: [Access to mental health inpatient services in London (all ages)]



National context

The Strategy Unit's 2019 report Exploring Mental Health Inpatient Capacity across Sustainability and Transformation Partnerships in England summarised the increasing demand on inpatient mental health services across England:

- Since the 1970s/80s, mental health services have shifted away from focusing on inpatient services to community-based care. From 1989 to 2019, there was a 73% reduction in the number of mental health beds across England. This reduction has been managed by a reduction in the number of people admitted to hospital and a reduction in the length of time people spend in hospital.
- National data shows that from the mid-2000s, the length of time people spent as inpatients has not decreased. The level of mental ill health of people admitted to hospital in 2018 was greater than that in 2013, which may indicate that thresholds to accessing an inpatient bed have increased over recent years.
- People with lived experience report not being able to access inpatient care when they need it. Healthcare professionals report that wider system pressures have contributed to challenges around inpatient beds, including staff shortages, pressures on community mental health services and social and demographic changes.

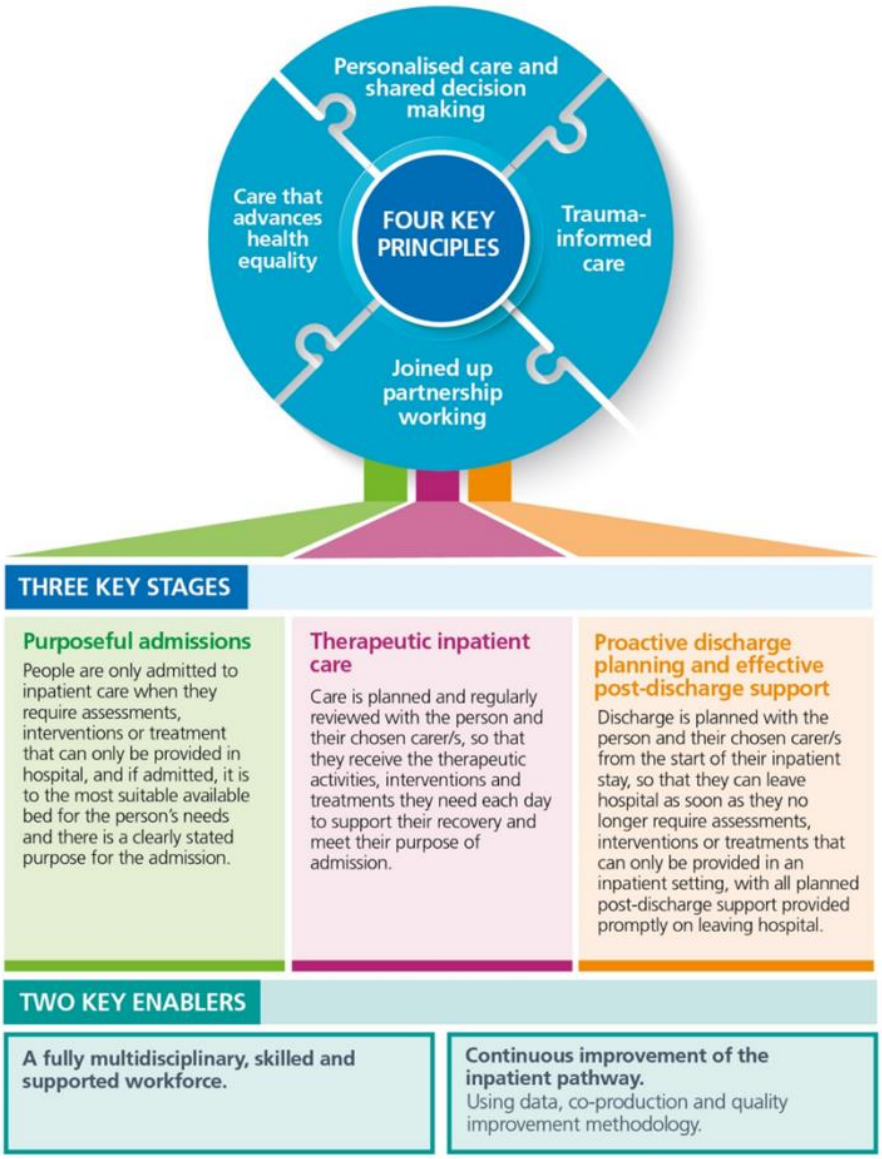
National policy

- The Crisp Review (2016) highlighted pressures on mental health beds and recommended an end to acute out of areas admissions (Commission to review the provision of acute inpatient psychiatric care for adults, 2016). The Government adopted this goal, with the aim to end inappropriate out of area placements by 2020/21. However, this target has not been met across England.
- The Royal College of Psychiatrists state that 'challenges to reduce the persistently high rates of inappropriate out of area placements and provide timely access to and discharge from acute inpatient

services remain substantial', due to a lack of capacity in the system to meet the population level of mental health need (Royal College of Psychiatrists, 2019b).

- In 2023, NHS England produced a national policy document supporting the commissioning of acute inpatient mental healthcare for adults and older adults. This identified key elements of effective inpatient mental healthcare, with four key principles, three key stages and two key enablers.

Figure 59: Key elements of the inpatient pathway. Image source: NHS England



Local context

- In Cambridgeshire and Peterborough, acute mental healthcare is based on the '333 model', where inpatient pathways for assessment are provided within 3 days, treatment within 3 weeks and recovery within 3 months (Ray et al., 2019).
- This model is focused on recovery, and aims to improve access to healthcare, delivery early treatment and reduce the length of hospital stays.
- There are three pathways through inpatient care, for which the typical length of stay varies:
    - Assessment unit – 3 days (Mulberry 1): provides a safe holding environment for patients and enables a thorough assessment of mental and physical health needs, and social circumstances.

    - Interventions unit – 3 weeks (Mulberry 2): patient's needs and strengths are assessed, and collaborative care plans are developed. This may include a social as well as pharmacological and psychological interventions.
    - Recovery unity – 3 months (Mulberry 3): takes a recovery-based approach to meet the needs of patients with more complex needs. This includes intensive support from staff, to meet long-term recovery goals. This ward was closed in May 2022.
- The community mental health team and crisis home resolution treatment team (CRHTT) supports the 333 model in the community, including by setting expectations of admission.

Minimising restrictive practises is a national priority (Department of Health and Social Care, 2018). CPFT has previously been a national leader in this endeavour. PROMISE (PROactive Management of Integrated Services and Environments) was developed by CPFT staff and people with lived experience to reduce coercive practises and use of force. Over a 3-year period, CPFT experienced a dramatic reduction in all forms of restraint as well as registering high patient experience scores. This was achieved through a transformation of ward culture using PROMISE's five-step governance framework (Report, Reflect, Review, Rethink and Refresh). Unfortunately, the benefits lessened in the context of the COVID-19 pandemic. However, it is proposed that this programme be re-activated in a refreshed form.

What do people say?

National reports highlight that:

- Some people who access inpatient care report positive experiences, whilst others experience issues in accessing care that meets their needs. This can include delays in accessing inpatient services and disproportionate use of restrictive practices (NHS England, 2023b).
- Being placed out of area can be particularly difficult for individuals and their family, friends or carers, due to the distance from support networks and disruption in continuity of care (NHS England, 2023b).
- Culture is key for both patients and staff. Patients need a 'kind, compassionate and hopeful' experience to feel safe and make progress; and staff also need to feel safe and supported to speak up when services to not meet the standards they want to provide (Department of Health and Social Care, 2023).
- Pathways for giving feedback are not always clear or easy to use for patients, carers or staff. Despite this, many staff report feeling frustrated at the amount of time they spend inputting data into different systems, which can take away from time they spend with patients (Department of Health and Social Care, 2023).

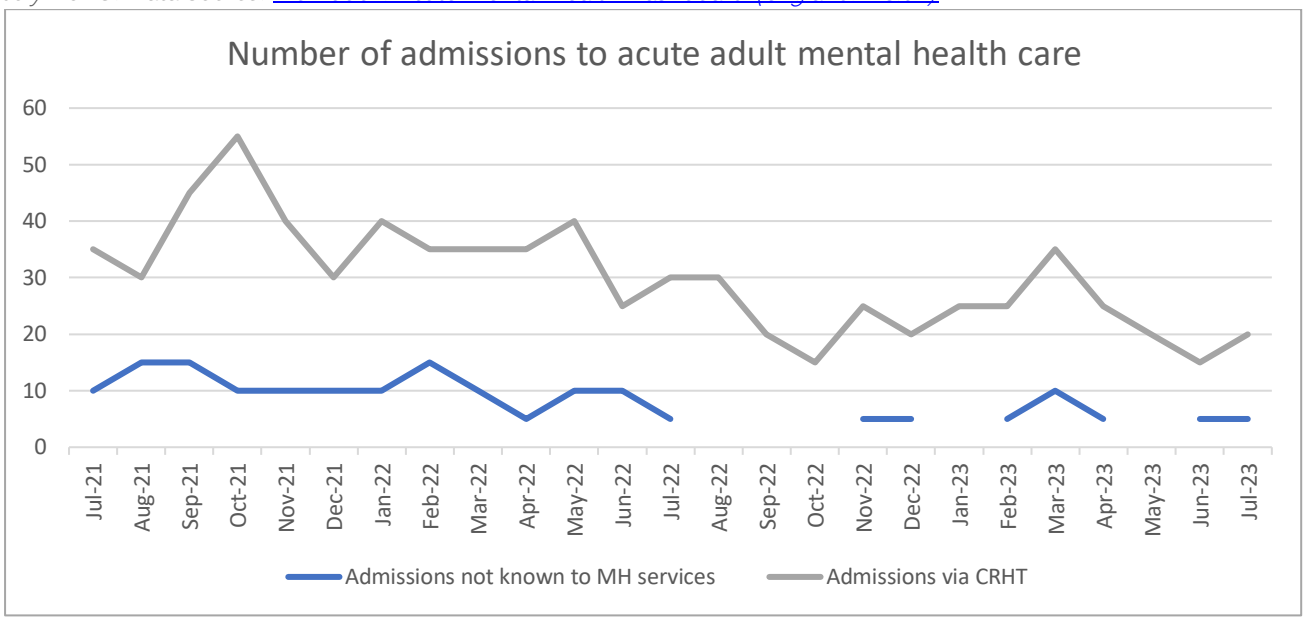
As part of the Cambridgeshire and Peterborough Mental Health Act Assessment Pathway Review (2023), people with lived experience of the pathway (including as carers) highlighted the following issues relating to high levels of occupancy in local inpatient services:

- Delays in informal admissions when a person would have previously been admitted as an inpatient. As a result of this, people are supported in the community, which can have a detrimental impact on their mental state, as well as cause distress and anxiety to carers.
- Community mental health teams are already under significant pressure due to staff vacancy rates and managing existing demand and are having to prioritise people with the greatest level of need, potentially leading to more people relapsing and needing inpatient admission or a Mental Health Act assessment.
- Planned Mental Health Act assessments are not completed when an identified bed is not available.
- Inappropriate out of area placements (OAPs) have a detrimental impact upon the individual's recovery and means that they can be placed hundreds of miles away from their family and support network.

How many people are admitted?

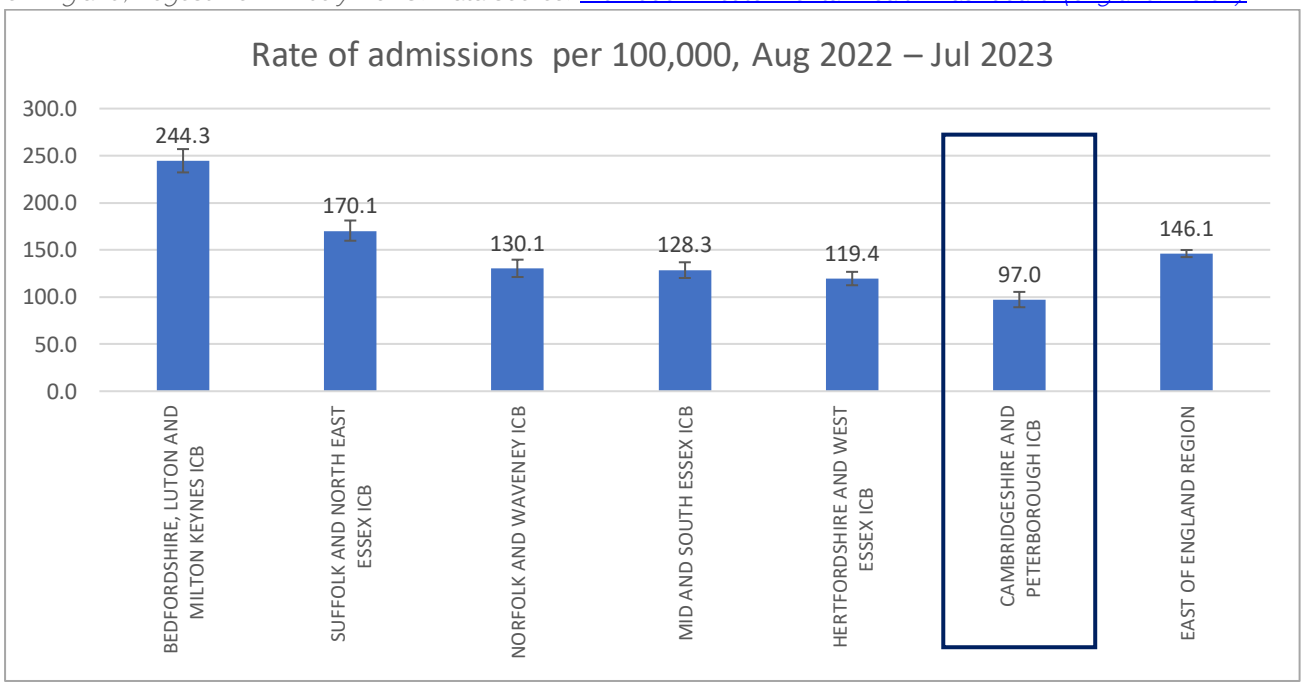
In Cambridgeshire and Peterborough ICS, the number of admissions to adult acute inpatient mental health care via the crisis resolution team shows a declining trend. The number of adult acute mental health admissions and the percentage of admissions with no previous contact show no significant change between February 2022 and July 2023.

Figure 60: Admissions to adult acute inpatient mental health care, Cambridgeshire and Peterborough ICS, July 2021 – July 2023. Data source: Workbook: Acute Mental Health Dashboard (england.nhs.uk)



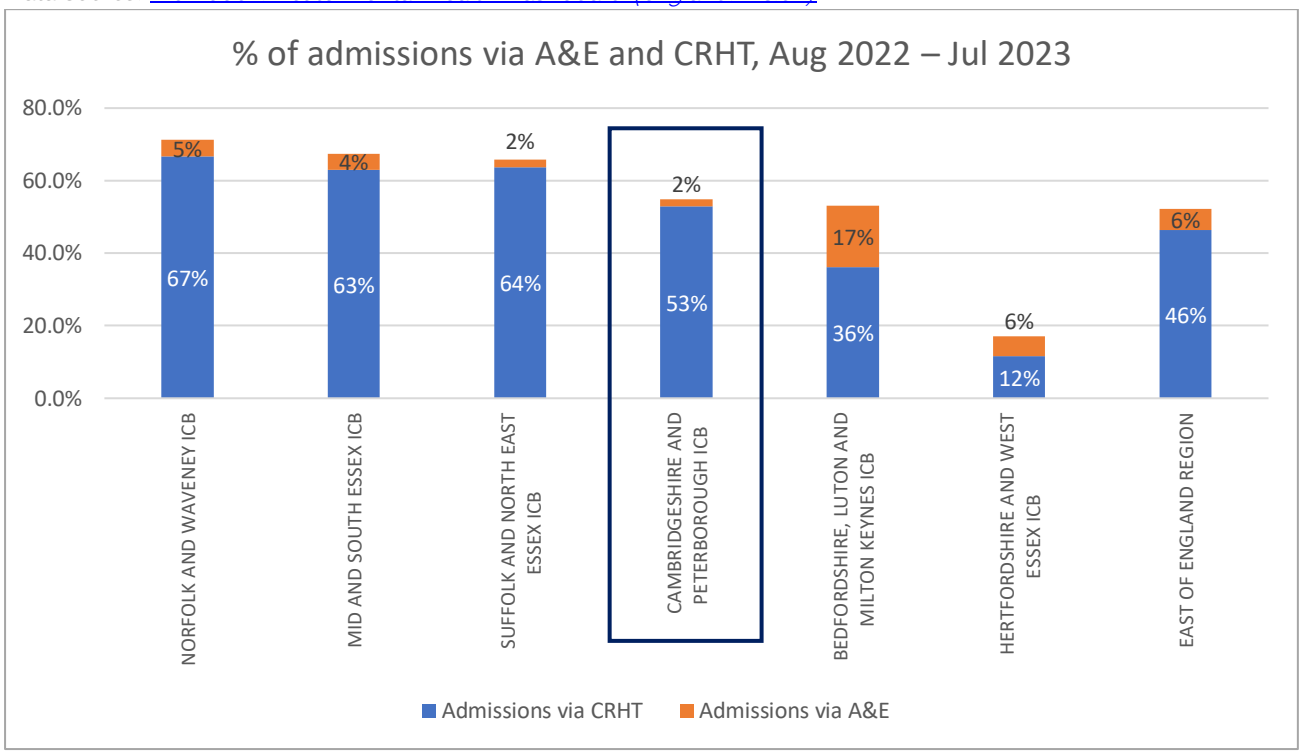
In August 2022 to July 2023, the rate of admissions to acute inpatient mental healthcare per 100,000 of the population was significantly lower in Cambridgeshire and Peterborough compared to other areas in the East of England.

Figure 61: Rate of admissions to adult acute inpatient mental health care per 100,000 of the general population, East of England, August 2022 – July 2023. Data source: Workbook: Acute Mental Health Dashboard (england.nhs.uk)



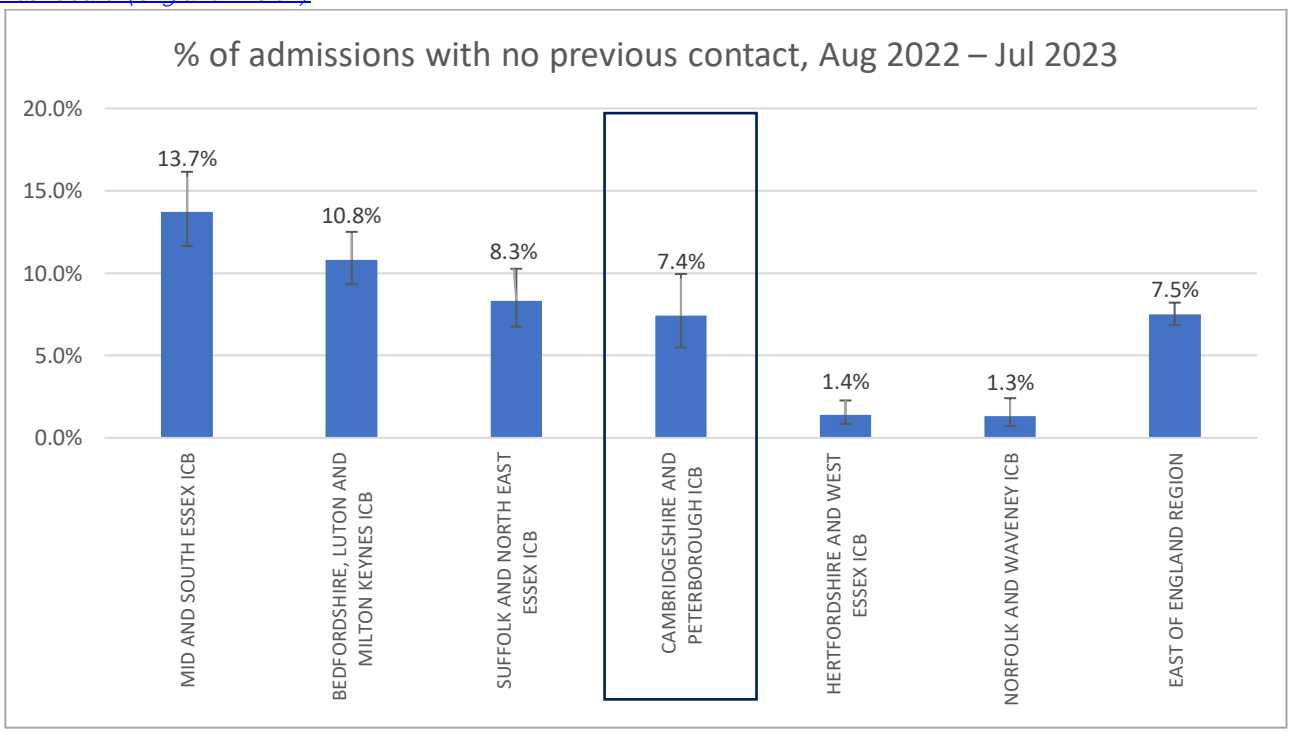
53% of admissions to acute adult inpatient care in Cambridgeshire and Peterborough ICB were admitted through the Mental Health Crisis Resolution Home Team (CRHT), and 2% through Accident and Emergency.

Figure 62: Route of admissions to adult acute inpatient mental health care, East of England, August 2022 – July 2023. Data source: [Workbook: Acute Mental Health Dashboard (england.nhs.uk)]



7.4% of people to admitted to inpatient care from August 2022 to July 2023 had not been in contact with core community mental health services within the period 6 months prior to admission, which is statistically similar to the East of England average. This group may include some people who were in contact with other services to support their mental health (such as voluntary sector organisations or primary care).

Figure 63: Proportion of admissions to adult acute inpatient mental health care with no contact with core mental health services in the past 6 months, East of England, August 2022 – July 2023. Data source: [Workbook: Acute Mental Health Dashboard (england.nhs.uk)]

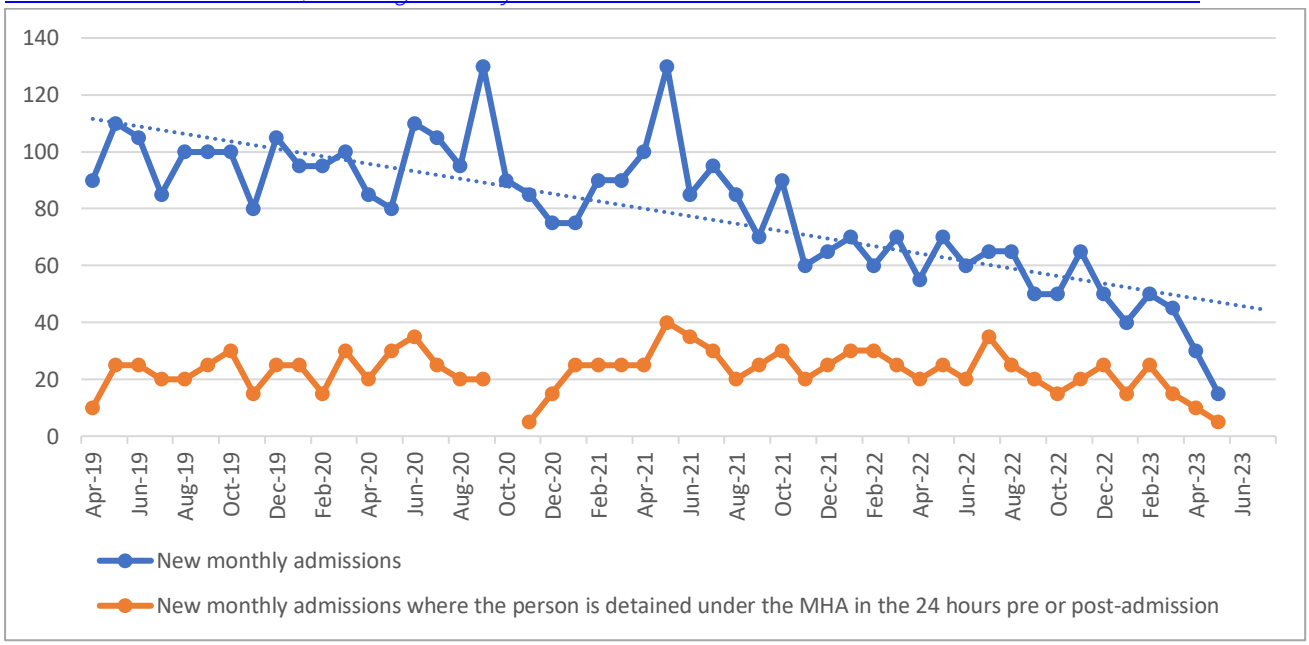


National research suggests that a quarter (26%) of cases where people are admitted to acute hospital for any reason, there have been missed opportunities to make interventions that would be prevented the need for admission (Local Government Association, 2016). There are no statistics which are specific to admissions to acute mental healthcare or our local area.

How many people are admitted under the Mental Health Act?

The number of new monthly inpatient admissions has substantially decreased over the last couple of years in Cambridgeshire and Peterborough. A shortage of beds may have contributed to this trend. The number of new monthly admissions where the person is detained under the MHA in the 24 hours pre-admissions or post-admissions shows a relatively stable trend.

Figure 64: New monthly admissions and new monthly admissions where the person is detained under the MHA in the 24 hrs pre- or post-admission, Cambridgeshire and Peterborough ICS, April 2019 – June 2023. Data source: MHA Dashboard - Mental Health, Learning Disability and Autism Resource Hub - FutureNHS Collaboration Platform



How many people are admitted into detox beds?

- NICE guidelines highlight that people in acute alcohol withdrawal, or those who are high risk, should be offered admission to hospital for medically assisted alcohol withdrawal ('detoxification' or 'detox') (National Clinical Guidelines Centre, 2010).
- There were previously 3 inpatient detox beds in Cambridgeshire, based in the Mulberry 1 Ward (CPFT). Since the Cambridgeshire drug and alcohol treatment system was recommissioned in October 2018, inpatient beds have been purchased by Change Grow Live (CGL) from a range of providers across the county. Regionally commissioned inpatient beds are now based in Chelmsford.

In June 2023, there were 17 inpatients in detox beds in June 2023 in Cambridgeshire, and 17 in Peterborough. The trends in inpatient uptake of detox beds may reflect the availability of beds: there was a decrease in inpatient uptake in Cambridgeshire from 2019, when the number of beds declined; whist the increase in uptake in Peterborough from 2023 may have been due to greater investment in provision through the Drugs Strategy.

Figure 65: Inpatient uptake of detox beds, Cambridgeshire, July 2022 to June 2023. Data source:

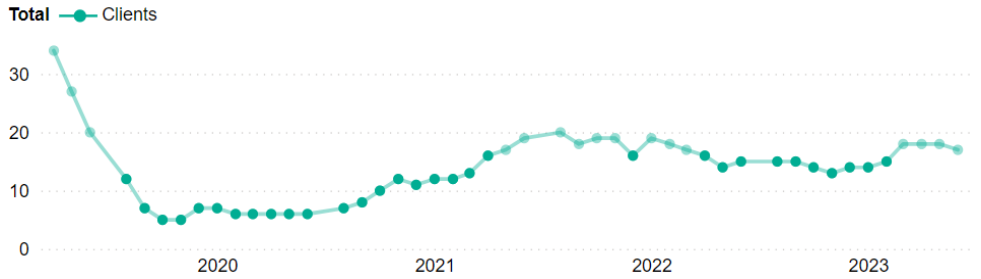
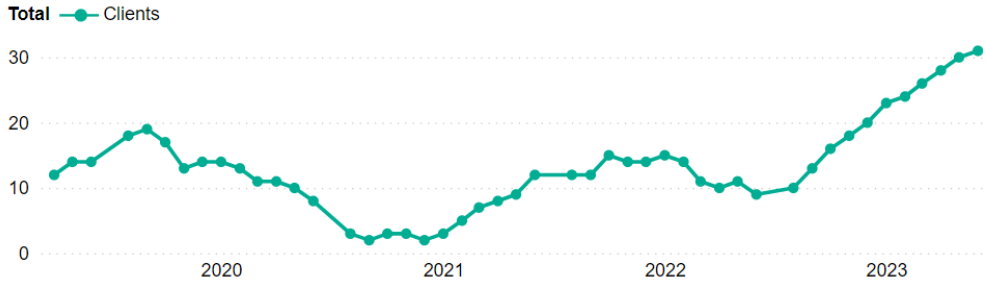


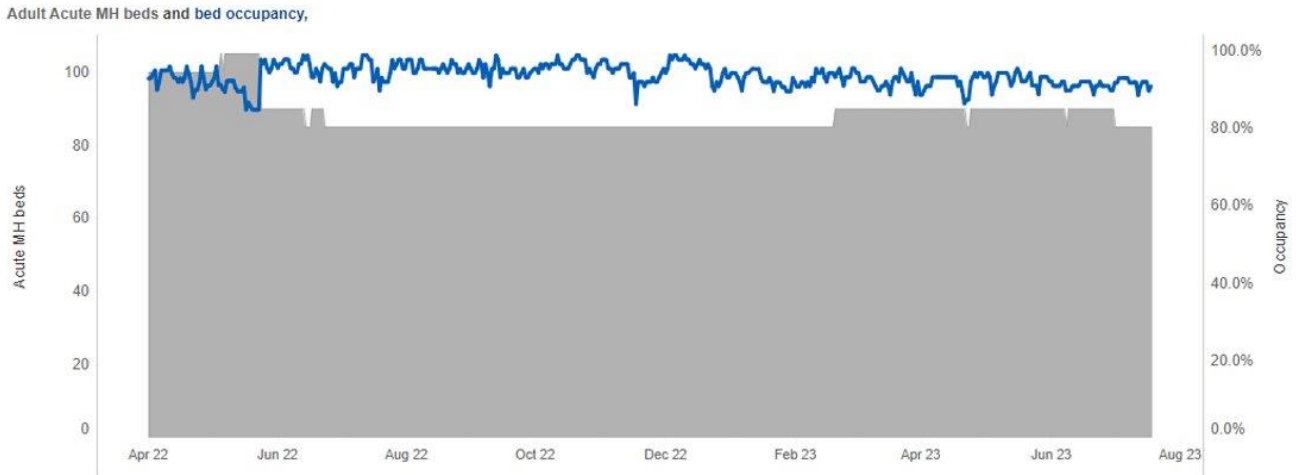
Figure 66: Inpatient uptake of detox beds, Peterborough, July 2022 to June 2023. Data source:



How many beds are occupied?

- High levels of bed occupancy are an important measure of pressure on the acute mental health pathway. For patients, this can mean that they are not admitted to hospital until they are very unwell (Liberati et al., 2023).
- The Royal College of Psychiatry suggests that 85% is the maximum level of occupancy of mental health beds (Royal College of Psychiatrists, 2019c). Spare bed capacity is important to manage variation in demand and make sure that patients can flow smoothly through the system.
- From 2010/11 to Q3 2022/23, there was a 23% decrease in the number of mental health beds in England, from 23,515 to 18,152 beds (Nuffield Trust, 2023).
- In June 2023, 75 out of 85 (91%) of adult acute mental health beds in Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) were occupied.
- The Mulberry 3 Ward, a 16-bed treatment ward (13 acute and 3 forensic step-down beds), was closed on 21st May 2022 due to staffing pressures. This is likely to have contributed to pressures on bed occupancy and there are plans to reopen this ward when enough staff have been recruited.

Figure 67: Adult acute mental health beds (grey) and occupancy (blue) in Cambridgeshire and Peterborough ICS, April 2022 – June 2023. Data source: [Workbook: Adult acute mental health benchmarking dashboard (england.nhs.uk)]



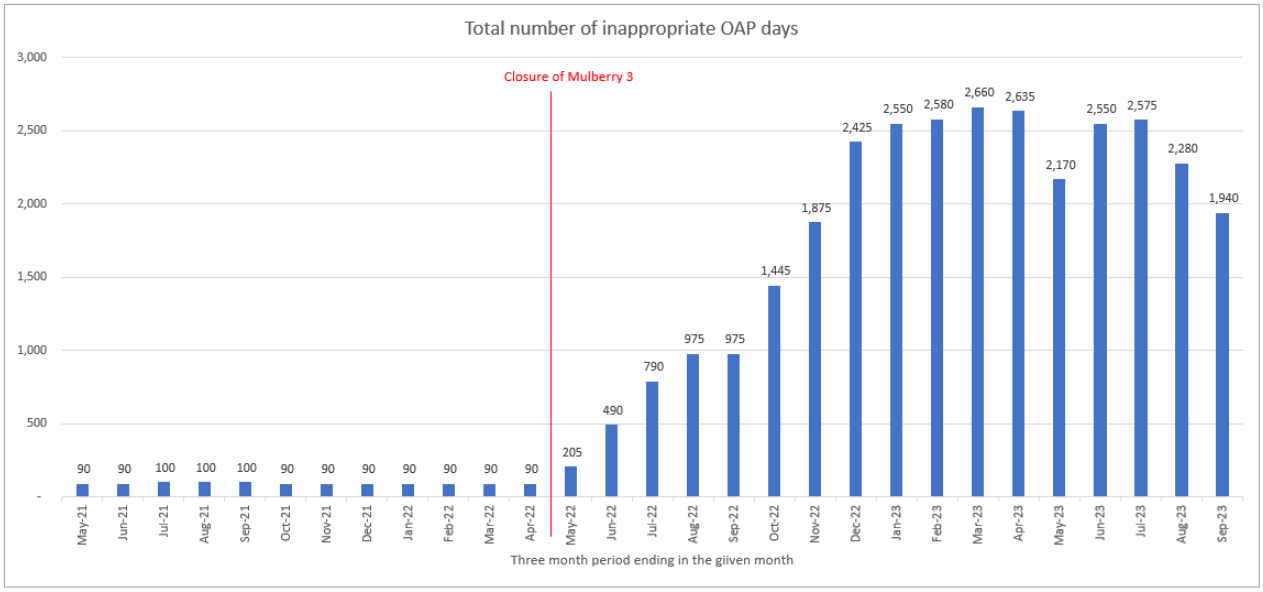
Research suggests that there should be between 30 to 60 psychiatric beds per 100,000 of the population (Mundt et al., 2022).

How many people are placed out of area?

Inappropriate placement of mental health patients in hospitals outside their local area (known as inappropriate out of areas placements or OAPs) occur when suitable inpatient provision is not available locally. Appropriate out of area placements are made when a specialist service is not provided locally.

- Inappropriate out of area placements reflect pressures on mental health services and staff (Department of Health & Social Care, 2023), often from a combination of high admission rates, long hospital stays and delays in discharge (NHS England, 2023b).
- Service users report that out of area placements can be hugely detrimental, as they are isolated from local support networks and local services that they may have previously been supported by. This places immense pressures on families and loved ones, for whom it may be unaffordable to travel long distances; and can make it harder for staff to plan and coordinate post-discharge care.
- The number of out of area placements from patients within Cambridgeshire and Peterborough ICS has risen substantially since April 2022. Before this time, the days spent in out of area placements was between 90 to 100 in each three-month period, compared to 2660 in the period ending in April. This represents an over 20 times increase in out of area days from April 2022 to April 2023 (NHS Digital, 2023).
- During the period ending September 2023, there were 1,940 OAP days, and a decline is seen since the period ending July 2023.
- The closure of the Mulberry Ward 3 (which had 16 beds) in May 2022 may account for nearly half out of area bed days in the three months to June 2023. The reduction in out of area placements may be due to recent quality improvement efforts to improve patient flow, including a new patient flow group and dashboard to help with flow (NHS Digital, 2023).
- The average costs of inappropriately out of area placements for Cambridgeshire and Peterborough is £625 per bed each day (interquartile range £600 to £750); with a total of cost of £1,729,589 in April to June 2023. 96% of this cost was due to inappropriate placements (NHS Digital, 2023).

Figure 68: Total number of inappropriate out of area days in Cambridgeshire and Peterborough ICS in the three-month period ending in the given month, May 2021 – September 2023. Data source: Out of Area Placement Report, NHS Futures



Note that bed days are counted as the total number of beds (available or occupied) on each day, as a total sum of all the days in the month (NHS, 2020). *For example, if there were 100 beds available over 30 days, there would be 100 x 30 = 3,000 bed days. This is a simplified example as the number of beds often varies daily.*

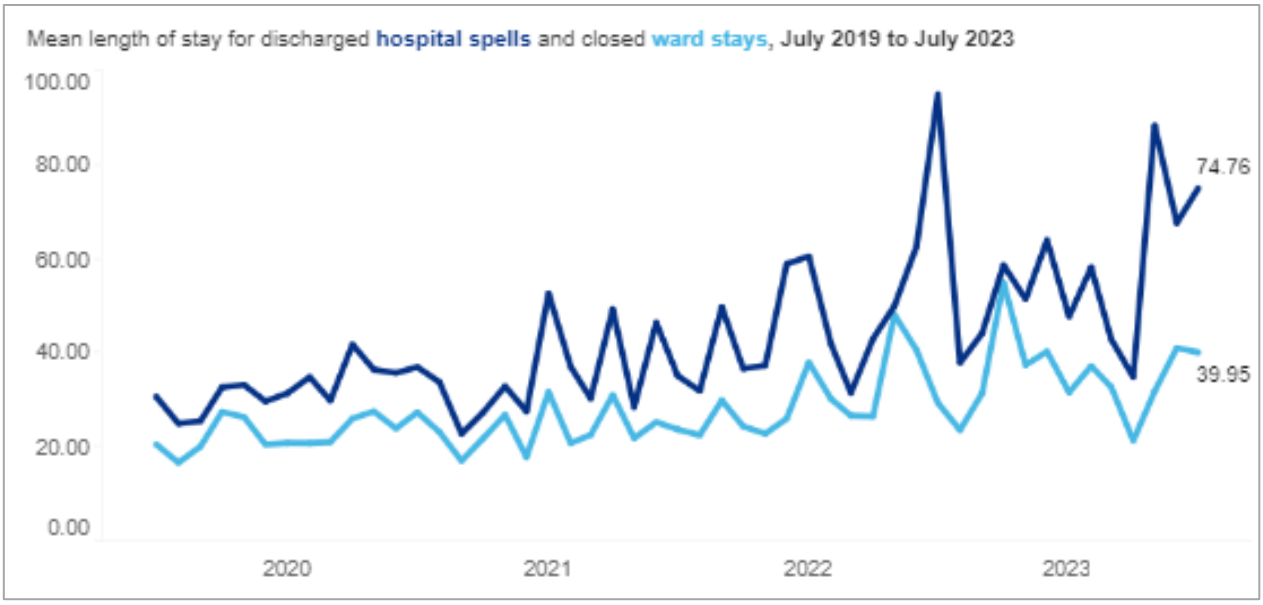
There has been a sustained decline in the number of inappropriate out of area placements since the summer of 2023 and there are plans to reopen Mulberry 3.

How long do people spend as inpatients?

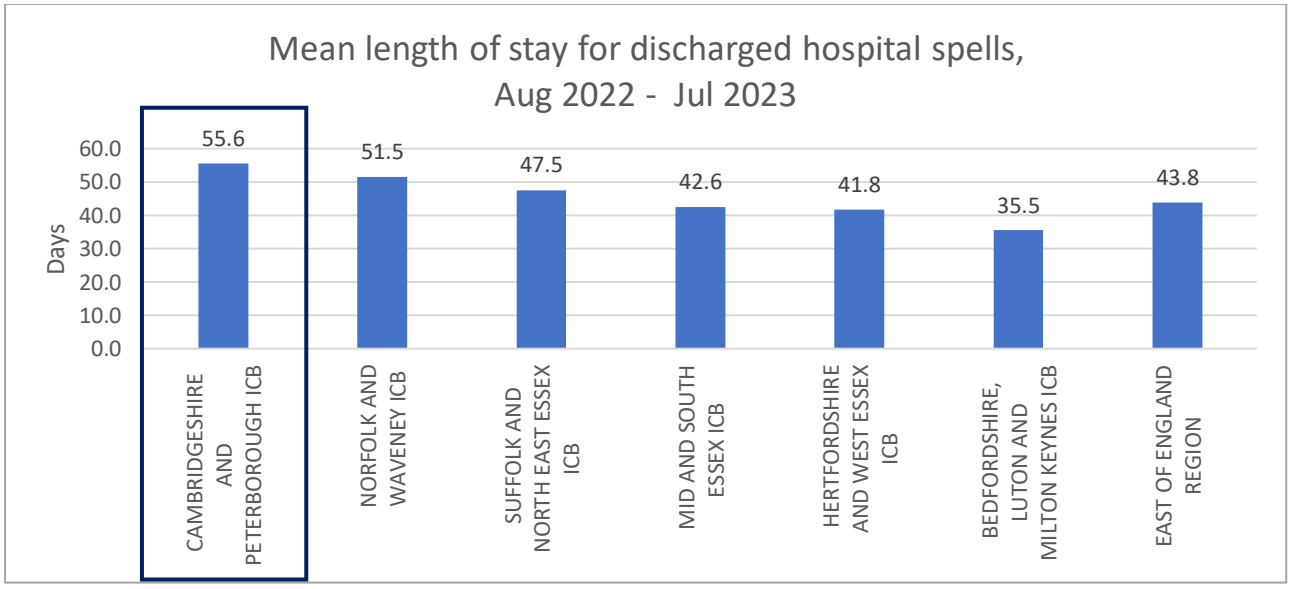
Delays in the transfer of care are a major issue in mental health providers in England (Public Health England, 2019), with the CQC highlighting in 2023 that 'insufficient capacity in adult social care is continuing to contribute to delays in discharging people' from hospitals (across the entirety of the healthcare system) (Care Quality Commission, 2021). There is however international research which highlights effective interventions to improve the discharge process (Tyler et al., 2019).

The average length of stay of hospital spells and closed ward stays in Cambridgeshire and Peterborough has increased since July 2019.

Figure 69: Mean length of stay for discharged hospital spells and closed ward stays, Cambridgeshire and Peterborough ICS, July 2019 to July 2023. Data source: Workbook: Acute Mental Health Dashboard (england.nhs.uk)

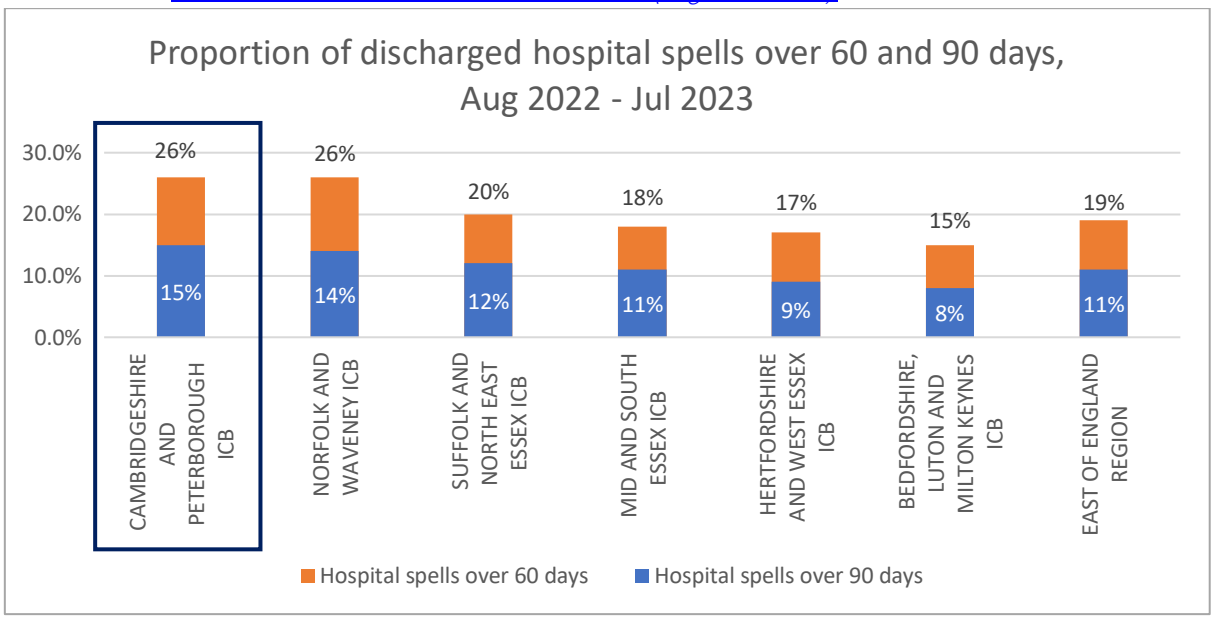


The average length of stay for discharged hospital spells in Cambridgeshire and Peterborough ICB is higher than the regional average.



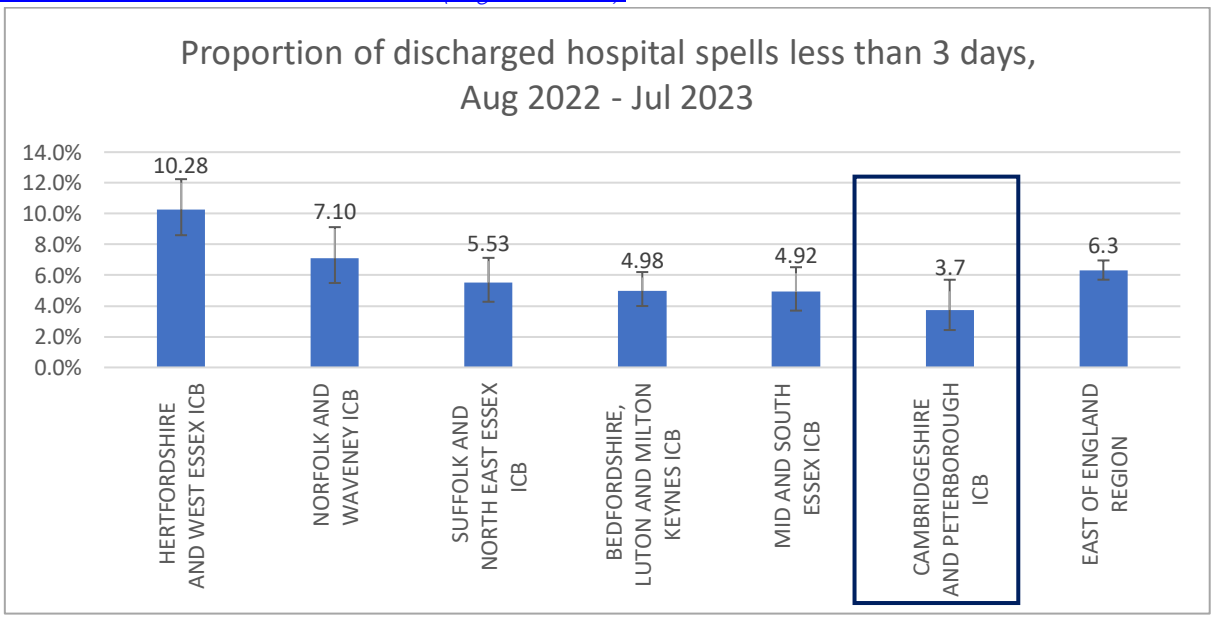
When explored in more detail, there has not been a significant change in the proportion of people spending over 60 days in hospital from February 2022 to July 2023. However, from August 2022 to July 2023, Cambridgeshire and Peterborough ranked highest for the proportion of discharged hospital spells where the length of stay is over 60 days (26%) and 90 days (15%) compared to other areas in the East of England.

Figure 70: Proportion of discharged hospital spells less than 3 days and over 60 days, East of England, August 2022 – July 2023. Source: Workbook: Acute Mental Health Dashboard (england.nhs.uk)



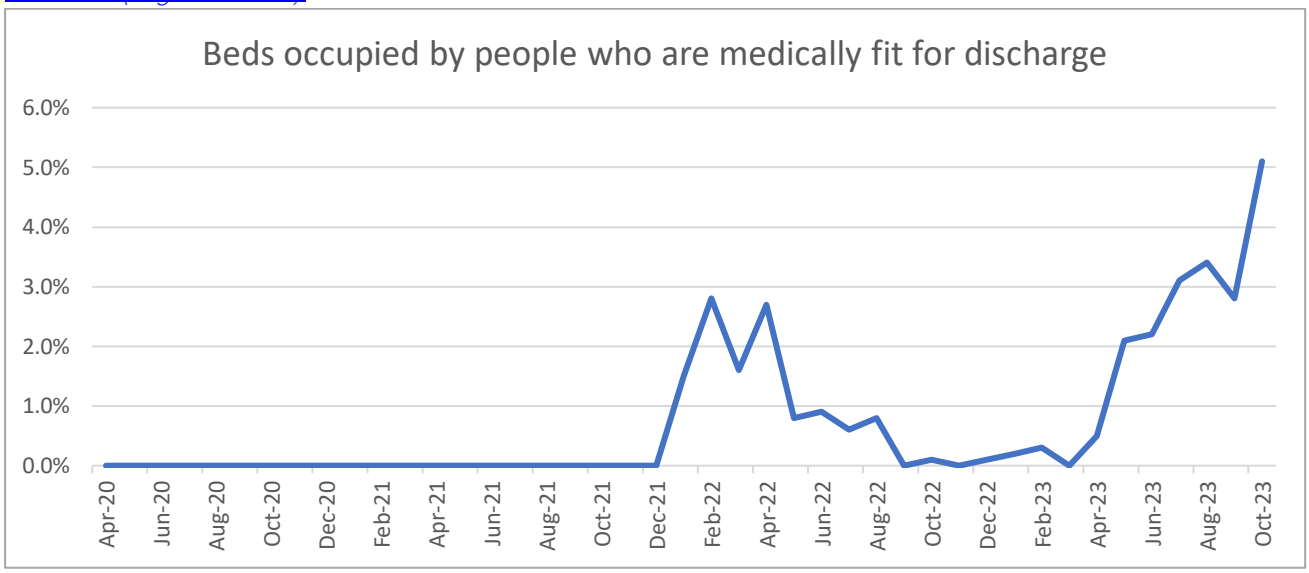
For the period between August 2022 and July 2023, the proportion of discharged hospital spells where the length of stay was less than 3 days was significantly lower in Cambridgeshire and Peterborough ICB compared to the East of England average.

Figure 71: Proportion of discharged hospital spells less than 3 days, East of England, August 2022 – July 2023. Source: Workbook: Acute Mental Health Dashboard (england.nhs.uk)



The proportion of beds occupied by people who are medically fit for discharge show an increasing trend since March 2023; though is still relatively small overall.

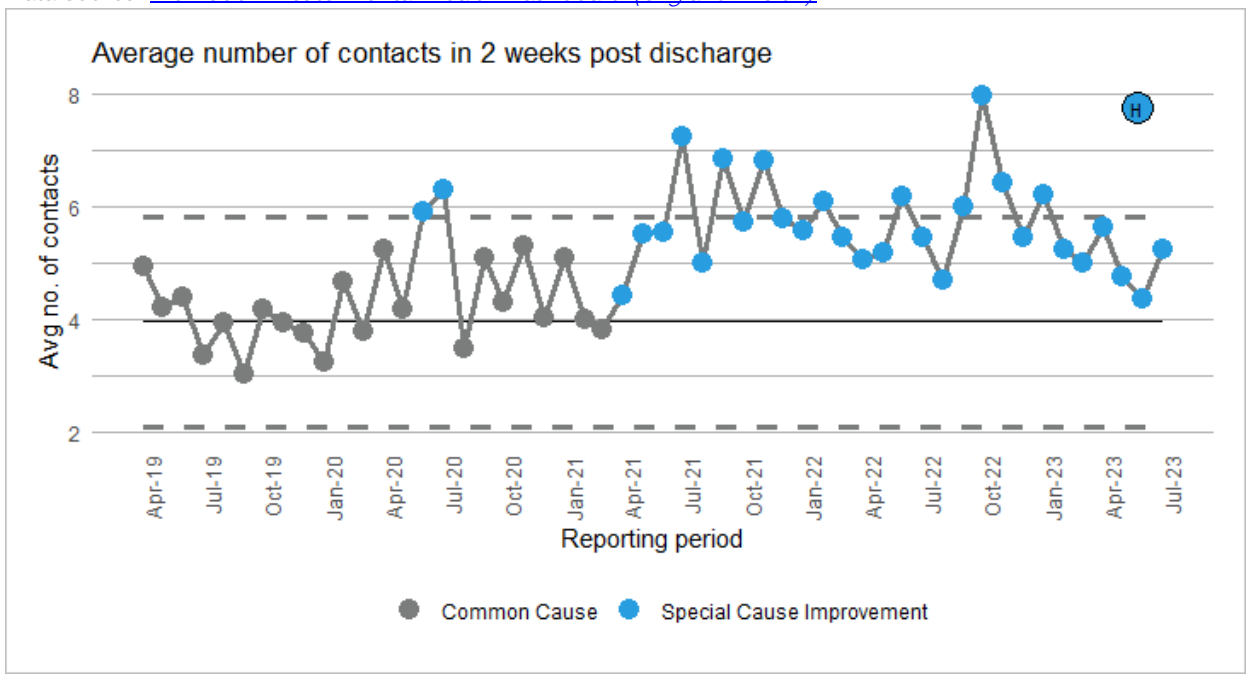
Figure 72: Mental health inpatient bed occupancy by adults (aged 18+) who are clinically ready for discharge, Cambridgeshire and Peterborough ICB, April 2020 – October 2023. Data source: [Workbook: All Age UEC Pathway Pressures (england.nhs.uk)]



What are people's outcomes after being discharged?

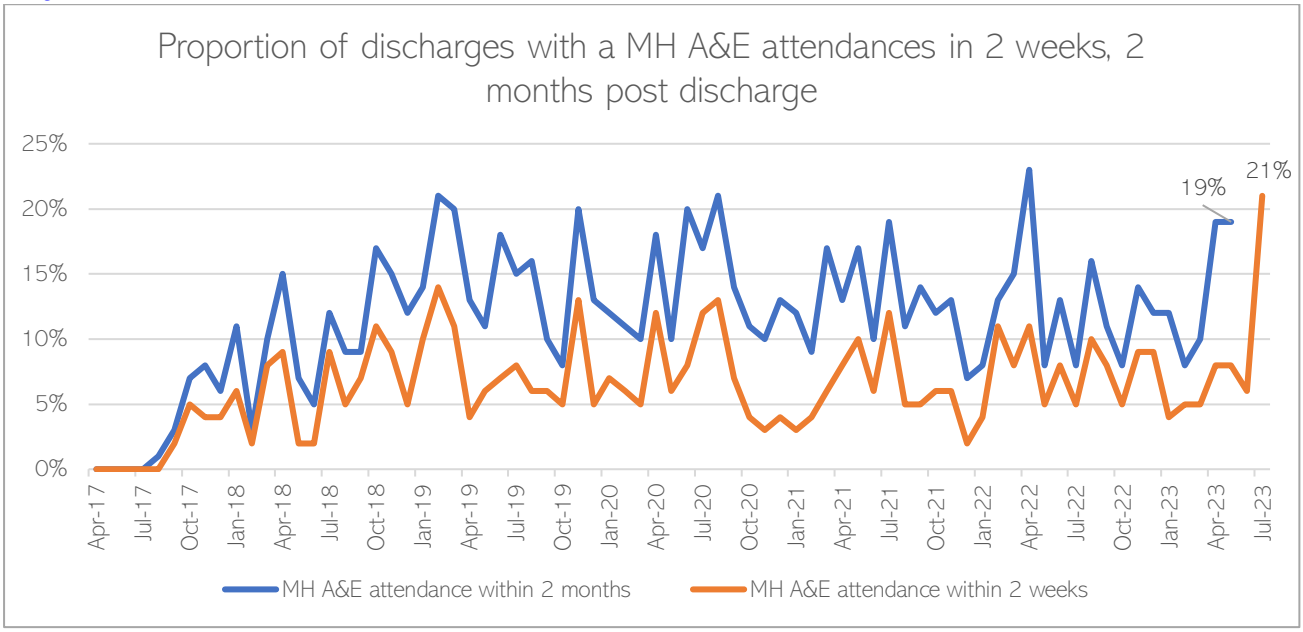
- In 2019/20, an NHS target (CQUIN indicator) was introduced that at least 80% of adults should be followed up within 72 hours of discharge from mental health inpatient care. This target was introduced based on evidence showing that there is an increased risk of dying by suicide 2 to 3 days after being discharged from hospital (Appleby et al., 1997).
- This target has not been met nationally since data became available in June 2020, with 73% of adults receiving a follow up within 72 hours in April 2023 (The Nuffield Trust, 2023).
- In Cambridgeshire and Peterborough, the proportion of hospital spells with follow-up within 3 days of the discharge date shows a significant increase since March 2021.

Figure 73: % of adults who were followed up within 72 hours of being discharged from mental health inpatient care. Data source: [Workbook: Acute Mental Health Dashboard (england.nhs.uk)]



The proportion of people attending Accident and Emergency due to mental health within 2 weeks and 2 months of discharge from hospital shows fluctuations over time.

Figure 74: % of adults had a mental health-related attendance at Accident and Emergency within 2 weeks and 2 months of being discharged from mental health inpatient care. Image source: [Workbook: Acute Mental Health Dashboard (england.nhs.uk)]



Additional Resources

- Acute inpatient mental health care for adults and older adults
- Old problems, new solutions: Improving acute psychiatric care for adults in England
- Eliminating Inappropriate Out of Area Placements in Mental Health

Rehabilitation services

Enhanced rehabilitation services 'help people recover from the difficulties of longer-term mental health problems' (Royal College of Psychiatrists, 2019a). They provide specialist assessment and support for people whose complex needs cannot be met by general mental health services, to help them build the skills needed to live successfully in the community (Joint Commissioning Panel for Mental Health, 2016).

NICE guidelines on rehabilitation for adults with complex psychosis state that rehabilitation services should take a recovery-orientate approach that is embedded in local mental healthcare services. Experts in rehabilitation state that (Killaspy et al., 2021):

- Inadequate provision of mental health rehabilitation services results in thousands of people with complex psychosis across the UK receiving inpatient rehabilitation many miles from home, which prolongs their time in hospital unnecessarily and undermines the rehabilitation process.
- People with complex psychosis wait too long to access rehabilitation; on average, they have been known to mental health services for 10 years and experienced recurrent admissions before they are referred for mental health rehabilitation.
- People treated in out of area rehabilitation units have twice the length of stay of those treated locally.

CPFT had a dedicated rehabilitation pathway for people with complex psychosis, which was de-commissioned in 2012. There is currently no community rehabilitation service or pathway specifically for adults in Cambridgeshire and Peterborough. Instead, community support to this cohort is provided by adult locality teams.

Additional Resources

- Guidance for commissioners of rehabilitation services for people with complex mental health needs
- Enabling recovery for people with complex mental health needs: A template for rehabilitation services

Voluntary and community sector support

There is a range of voluntary and community organisations that support people with severe mental illness, including organisations offering social support. This section is not comprehensive but covers some of the largest local organisations, CPSL Mind and Lifecraft.

Summary: Building community into the integrated care system

- It is estimated that 1 in 8 people with poor mental health/mental illness in the community receive support from a mental health charity (Hanif, 2023).
- Key facilitators for working with Integrated Care Systems (ICSs) partners across the NHS, local authority and voluntary and community sector include (Rethink Mental Illness, 2023b):
    - Engaging with the voluntary and community sector
    - Making local authorities an equal partner in the ICS
    - Considering contracting and funding (such as considering if contracts are long enough to enable sustainability in voluntary sector organisations)
    - Facilitating data and reporting
    - Ensuring coproduction is central to decision making
    - Building alliances across different organisations and sectors
    - Integrating delivery (such as improving transitions between services)

CPSL Mind

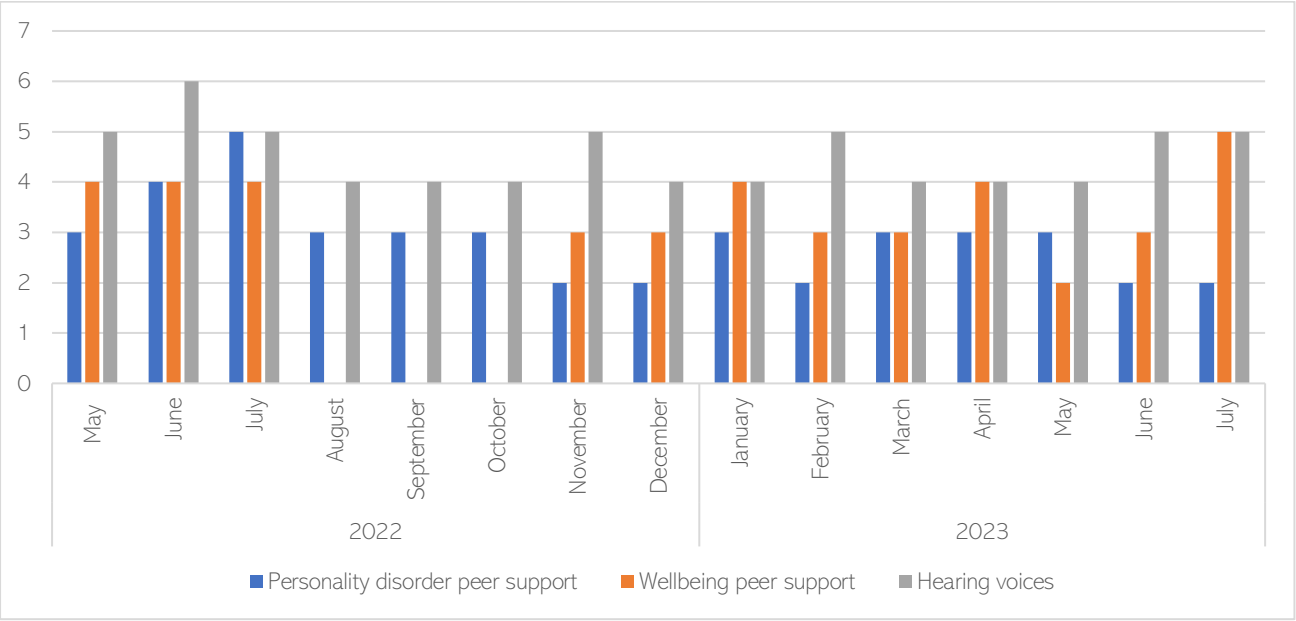
CPSL Mind (Cambridgeshire, Peterborough and South Lincolnshire Mind) provides a range of support services and activities that promote good mental wellbeing through the Good Life service. This includes peer support groups, which offer opportunities to people to connect and form supportive bonds with others who have had similar experiences. There are 5 types of peer support groups offered:

- Personality disorder, for adults living with a diagnosis, or experiencing feelings and behaviours associated with a personality disorder.
- Waves, a weekly life skills programme for anybody who identifies with experiencing symptoms of a Personality Disorder is eligible to join this programme.
- Hearing voices, for adults living with hearing voices.
- Five Ways to Wellbeing.
- Anger Management Workshops.

The average number of people each specialist support group varies. From May 2022 to July 2023, on average:

- 3 people attended each session of the personality disorders peer support group.
- 4 people attended each session of the wellbeing peer support group.
- 5 people attended each session of the hearing voices support group.

Figure 75: Average attendances per session at CPSL Mind support groups, May 2022 – July 2023.



Note: the wellbeing peer group was on hold from August to October 2022

Lifecraft

Lifecraft run a range of services, which are developed and run by people with lived experience of mental health issues (Lifecraft, 2023a), including:

- Creative Groups: groups which offer people the opportunity to express themselves creatively.
- Recovery Support: support groups and courses.
- Social Activities: group activities for people living with mental health issues.
- Employment and volunteering: support to enter the workforce or begin volunteering, including within Lifecraft.
- Suicide bereavement support: a support services for friends and family who have experienced the loss of a loved one by suicide.
- Counselling: long-term counselling for up to two years.

Lifecraft also runs Lifeline (add link), a confidential telephone helpline service that provides support to people experiencing mental distress.

Membership

In 2022/23, Lifecraft delivered 279 sessions and groups. Over this time period:

- 42 new members joined Lifecraft.
- 108 members attended at least one group session. Members from all districts attended, including an increase in members from East Cambridgeshire.
- An average of 7 to 10 people attended each of the weekly ongoing groups.

Ely activity groups

18 unique people access the Ely groups and activities, with an average of 7 people a week at the drop-ins.

- 9 member employees or volunteers working for Lifecraft via the member employee scheme.
- Average of 2.2 work hours per week provided by each member employee or volunteer.

Counselling service

The Lifecraft counselling service offers in-person sessions in Ely and Cambridge. In 2022/23:

- 40 members were supported, with 12 starting counselling and 18 completing treatment.
- 35 members were on the waiting list.

- 87% available appointments were attended.

Suicide bereavement support

Through additional funding from the local authority, Lifecraft has recently increased their provision of specialist emotional and practical support, established a new suicide bereavement counselling service (providing up to 14 sessions of therapy) and is working to reintroduce our peer support groups.

Active suicide bereavement support is currently provided to an average of 60 people per month, with 110 individuals supported during 2022/23. Over this timer period:

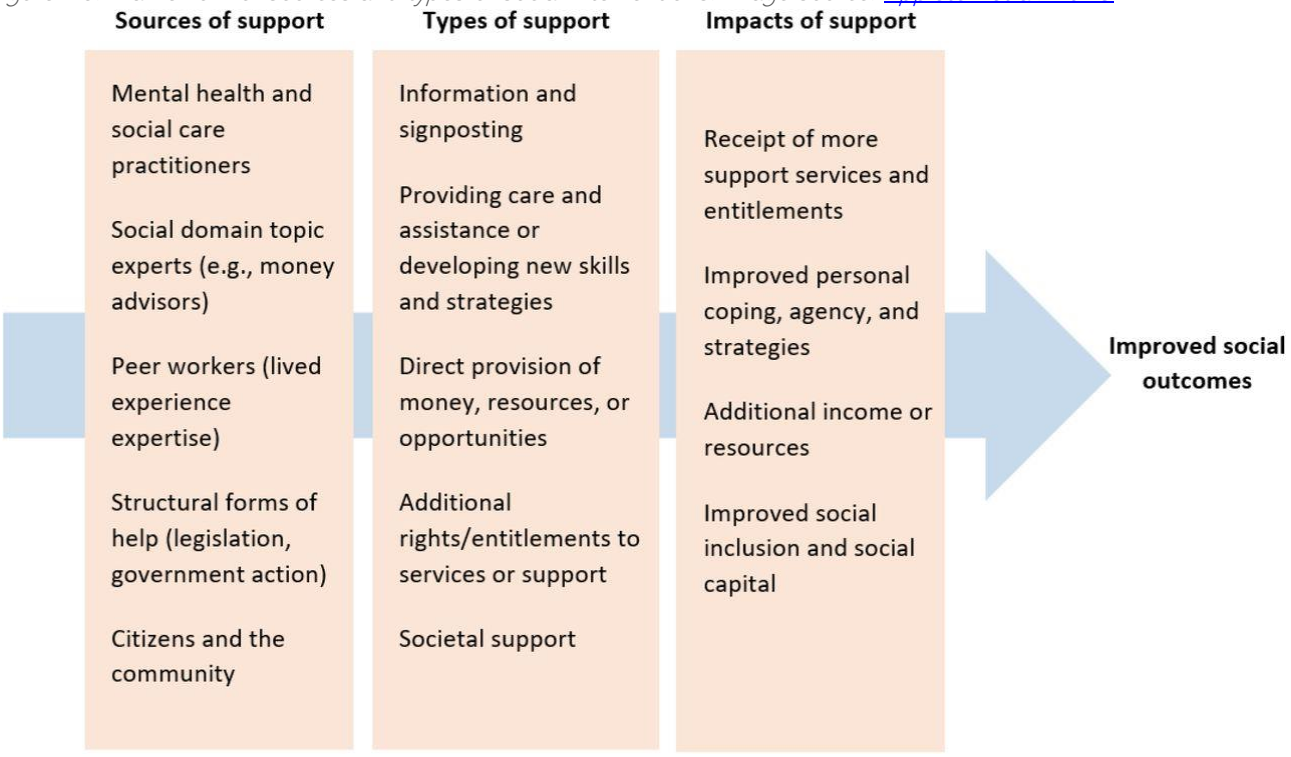
- There were 1,344 contacts with clients, over approximately 380 hours.
- 83 people were referred into the service and 88 new clients were supported.
- People supported had a range of relationships to the person who died from suicide, including their spouse/partner, parent, child and sibling.

Practical and social interventions

- Social exclusion has a negative impact on people's mental health. Likewise, people with serious mental health conditions are more likely to face social exclusion and have poorer social outcomes, such as in terms of housing and employment (Appleton et al., 2023).
- Social interventions support people with other issues that may be impacting their lives, such as housing, work and education. This can be just as important to people's recovery as clinical interventions. These interventions can also help to address inequalities.
- Social interventions should include population-level measures to enhance community assets which prevent poor mental health and promote health behaviours, such as high-quality housing and employment (Public Health England, 2019).

There is a range of different types of social interventions, with the framework below highlighting that support can come from a range of different sources; but often falls within 5 broad types. There are a range of potential impacts, with some interventions (such as IPS) providing multiple support types and having a wide range of benefits.

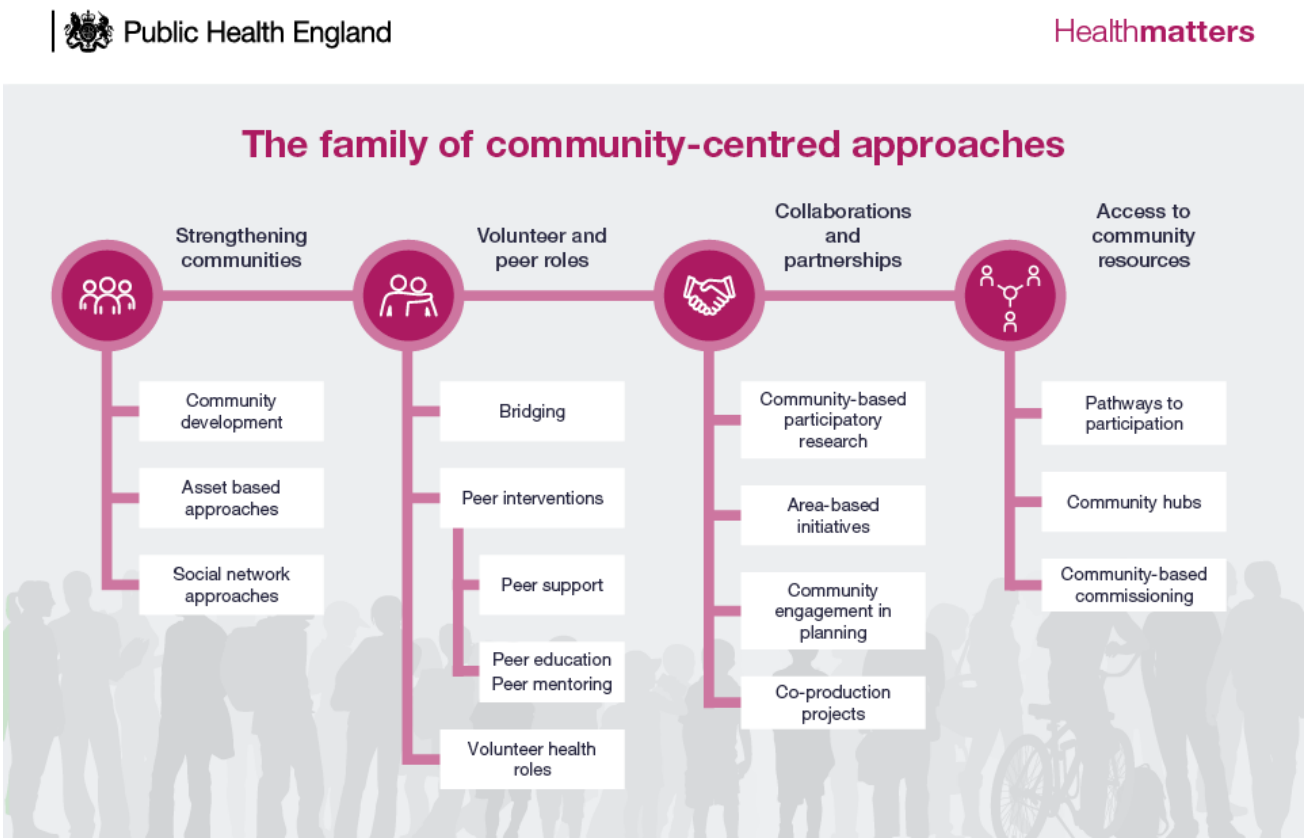
Figure 76: Framework of sources and types of social interventions. Image source: Appleton et al. 2023



Another model for thinking about this type of support is to community-centred approaches. These use assets within communities to promote community health and wellbeing and increase people's control over their health and lives (South et al., 2019). This includes (South et al., 2019):

- Strengthening communities: approaches which build on community resources to improve health and social determinants of health, such as time banking and asset-based approaches.
- Volunteer and peer roles: approaches where individuals provide support, advice or organise activities in their own or other communities, such as peer support, volunteer-led schemes and befriending.
- Collaborations and partnerships: approaches where communities and local services work together, such as co-produced work and local forums.
- Access to community resources: approaches which connect individuals to community resources, such as social prescribing or community groups in local libraries.

Figure 77: Family of community-centres approaches. Image source: Public Health England



Social prescribing

NHS England describes social prescribing as 'an approach that connects people to activities, groups, and services in their community to meet the practical, social and emotional needs that affect their health and wellbeing' (NHS England, 2023i). Social prescribers (often known as a 'social prescribing link workers') work collaboratively with individuals, providing information and signposting to relevant groups and services (NHS England, 2023i). For example, they may refer an individual who is isolated to a local walking group, to help them feel more connected to their local community.

Figure 78: Model of social prescribing. Image source: NHS England

- The NHS Long Term Plan commits to embedding social prescribing across the NHS, so that there is a service in every primary care network (PCN) (NHS England, 2023i).
- There are a range of social prescribers working across Cambridgeshire and Peterborough, although these roles may have different job titles (NHS Cambridgeshire and Peterborough, 2023).
- A national review of primary care-based social prescribers found that the current evidence base for social prescribing is small and inconclusive (Robinson & Jackson, 2022):
    - More research is needed to explore the impact of a range of different social prescribing models, and facilitators of effective interventions.
    - Most studies evaluating social prescribing interventions are low quality and few show clinical or statistical significance.

Additional Resources

- Delivering effective, networked social prescribing services

How Are You (HAY) website

The How Are You (H.A.Y.) website began as H.A.Y. Peterborough and has since expanded to become a family of district sites, one for each of the localities in Cambridgeshire and Peterborough. It was developed in response to coproduction work in the Peterborough Exemplar, where local people recognised that whilst there were various pre-existing directory websites (such as Keep Your Head and local council directories), there was a need for a new approach. A team of digital and community engagement coordinators, and sets about to meet three asks raised in initial coproduction work:

- Create a super local resource, celebrating community assets at locality-level that add value to wellbeing for local people.
- Address barriers to accessing mental health support by creating a website that does not feel clinical and does not require people to self-define as needing support for their mental health.
- Acknowledge the barrier for engaging in supportive activities are not simply ones of information and knowledge, but rather often related to confidence and motivation. Be not just a listings directory site, but provide information to help people access community activities, groups and services, such as by including introductory videos of group organisers, video tours from outside the building into the setting, and taster clips where possible.

The How Are You websites split into activities and support. Types of support listed includes:

GP practices	Mental Health – Online	Mental Health – Self-refer	Mental Health – GP referral	Mental Health – Crisis	Women's Wellbeing
Men's Wellbeing	Pregancy – Baby and Parenting	Children and Young People	Older People	Memory Loss and Dementia	Befriending and Social
Carers	LGBTQ+	Independent Living	Neurodiversity	Disability Services	Physical Health
Healthier Weight	End of life and Bereavement	Domestic and Sexual Abuse	Addiction	Housing and Cost of Living	Transport
Employment and Training	Rural	Making a Life in the UK	Faith and/or Language-based	Advocacy	Pharmacy

The How Are You website provides a directory of groups and organisations across Cambridgeshire and Peterborough that support good mental wellbeing, including:

Arts, Crafts and Creativity	Animal Activities	Cafes and Shops	Games and Gaming	Groups in Other Languages
Hair, Beauty and Spa	Learning	Live Online Activities	Movement and Exercise	Museums and Libraries
Music, Dance and Performance	Outdoor Spaces	Sports	Talking	Volunteering
		Yoga, Pilates and Mindfulness		

Carer support

- Note on terminology: Anyone who 'who looks after a family member, partner or friend who needs help because of their illness, frailty, disability, a mental health problem or an addiction and cannot cope without their support' can be classified as a carer (NHS England, 2022). Not everybody who falls into this group will consider themselves to be carers.
- As highlighted Chapter Two of this mental health needs assessment, carers are more likely to experience poor mental health and may face specific barriers to accessing mental health support.
- In 2021, unpaid carers were estimated to provide care worth £1,549 million in Cambridgeshire, and £557 million in Peterborough (Petrillo & Bennett, 2021).
- There are three main organisations that provide support to carers in Cambridgeshire and Peterborough: Caring Together, Centre 33 and Making Space.

Caring Together

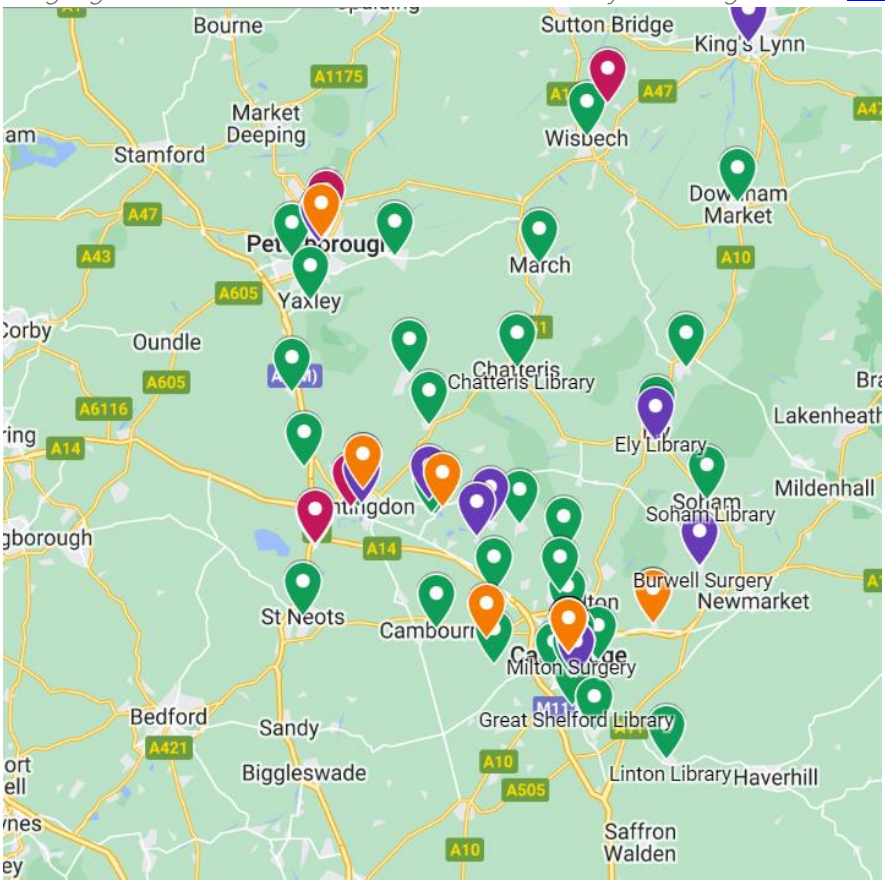
Caring Together provides a range of support for carers, including:

- A specialist carers helpline
- Information and advice, including around emergency planning
- Carers hubs
- Breaks from caring
- Counselling
- One-to-one support from carer advisers

This includes a 'What if' service, which provides support for adults with care needs if there is an emergency involving their carer. This support is available 24/7.

Caring Together raises awareness of carers amongst employers, health organisations and community groups through the Carer Friendly Tick accreditation scheme. The map below shows organisations which have received the Carer Friendly Tick.

Figure 79: Map showing organisations that have received the Carer Friendly Tick. Image source: [Caring Together]



Centre 33

Centre 33 provides support to young carers (aged 8 – 18) in Cambridgeshire and Peterborough. This service offers young carers needs assessment, individual and group support and support with life transitions (such as moving to secondary school or entering the workplace). The Young Carers Advisory Board provides young carers with the opportunity to share their experiences and views.

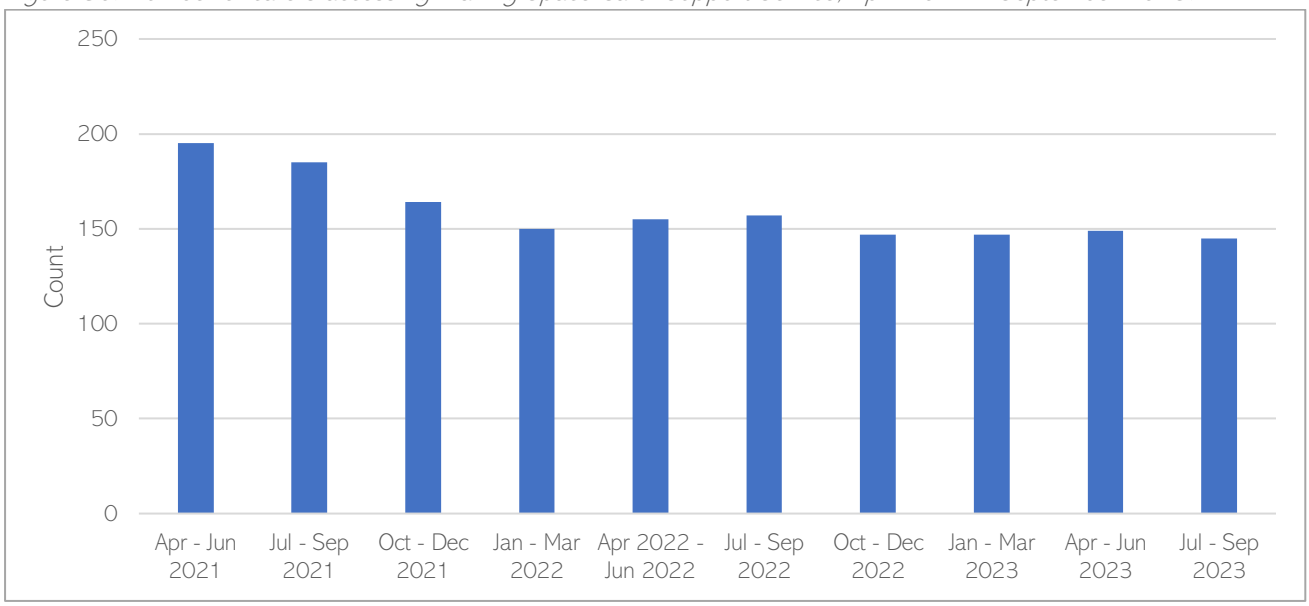
Making Space

Making Space run the Cambridgeshire and Peterborough Carer Support Service for adults (aged 18+) who care for someone with a mental health condition. They provide one-on-one support, specialist information and advice, and signposting to other services.

How many people access this service?

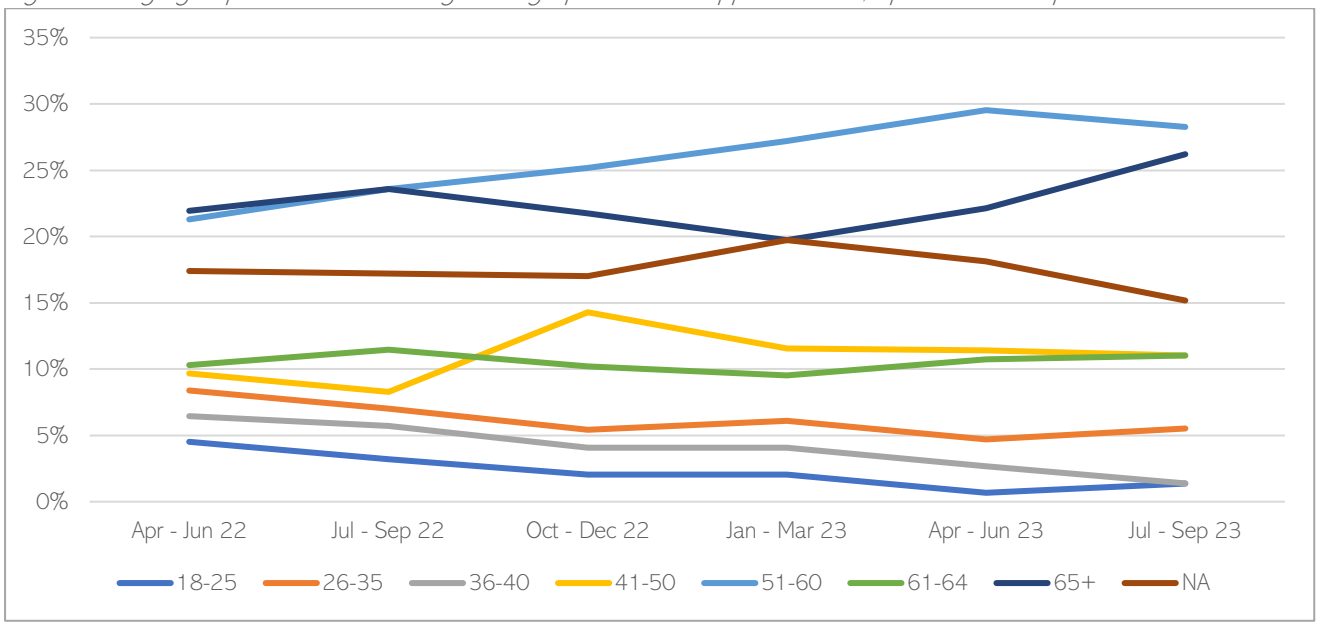
From April 2021 to September 2021, between 150 to 200 carers accessed Making Space each quarter.

Figure 80: Number of carers accessing Making Space Carer Support Service, April 2021 – September 2023.



The majority of the carers who accessed the service were female. An increasing proportion of people accessing this service age added between 51 and 60 years, and 65+.

Figure 81: Age group of carers accessing Making Space Carer Support Service, April 2021 – September 2023.



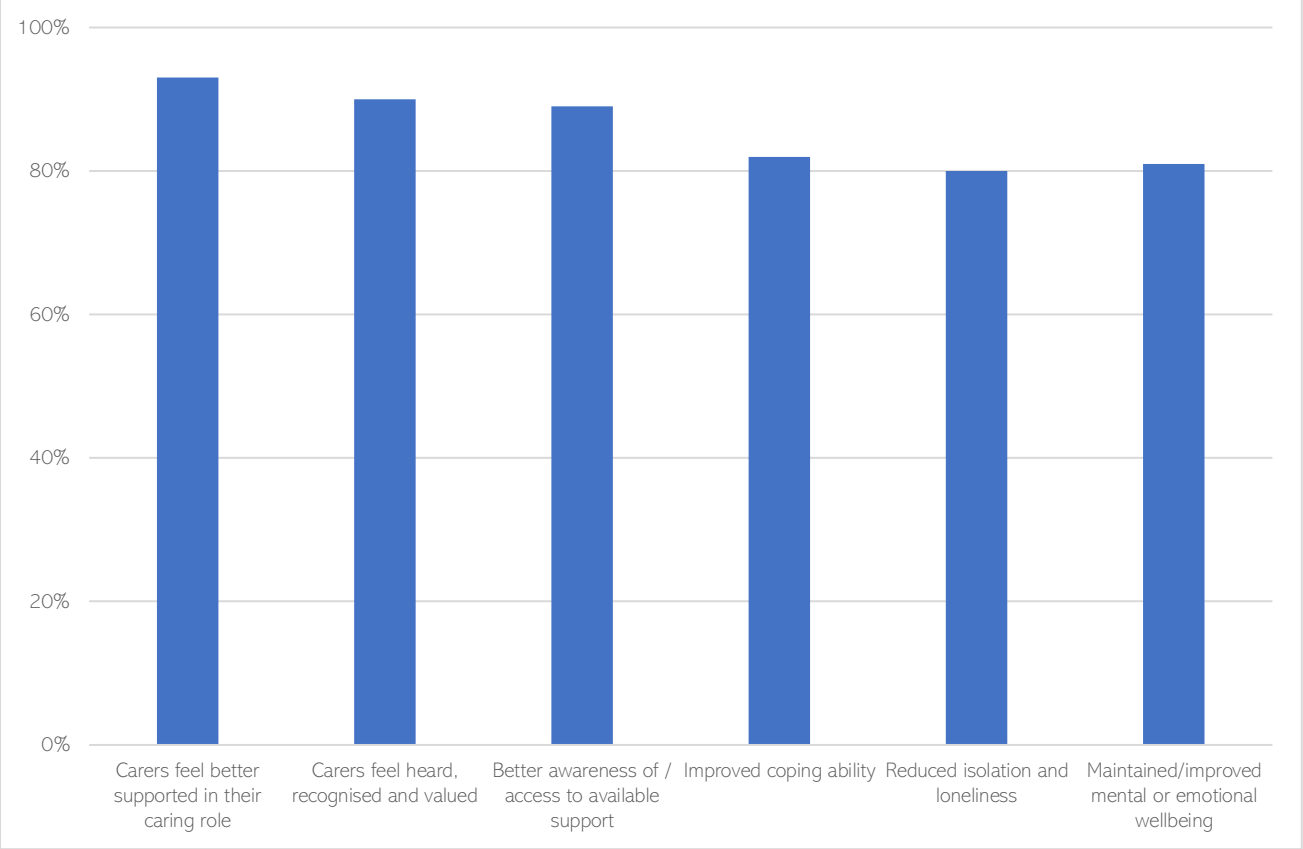
What do people say about this service?

Charity Fundraising Ltd were commissioned to undertake an independent evaluation of Making Space. They used two surveys, one in 2021 (61 responses) and another in 2023 (56 responses). This evaluation found that up to 98% of carers felt that support provided to them was 'good' or 'very good', with up to 98% saying they would recommend the service that supported them. There were high levels of satisfaction for:

- the staff and volunteer teams (98%)
- timing of support (97%)
- accessibility of support (up to 97%)

Key areas for impact were that carers felt better supported in their caring role (up to 93%) and they felt heard, recognised and valued (up to 90%).

Figure 82: Key impacts of all-age carers services (upper limit scores), 2022/23. Data source: Evaluation of All-Age Carers Service



Rethink Carer Support Cambridgeshire and Peterborough

Rethink Carers Support is a support group support specifically for people who have a friend or family member with a mental health condition. This support group is visited by speakers, have a large amount of local knowledge and experience, and constantly welcomes new carers.

Additional Resources

- Cambridgeshire and Peterborough Carers Strategy (2022 – 2026)
- Carers speak out: The voices and experiences of unpaid carers of all ages across Cambridgeshire, Peterborough and Norfolk
- The Winding Road

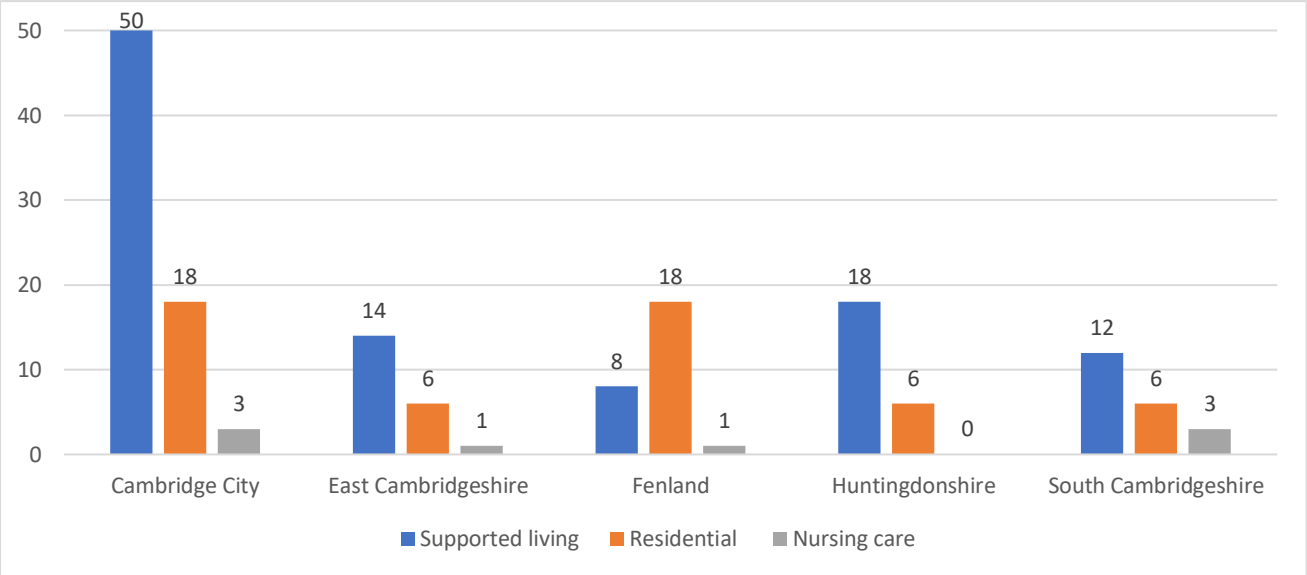
Housing

- Housing can be a vital aspect of recovery for people living with serious mental illness (NHS Confederation, 2022). Around 10 – 20% of people with severe mental illness develop long-term needs that impact their ability to live independently (Sanders, 2022).
- Mental health supported accommodation are services which provide support to people with mental health conditions living in community-based accommodation (Sanders, 2022). This includes shared accommodation and individual living arrangements where people are supported by on-site staff.
- Some models of community-based supported housing are associated with improved quality of life, happiness and self-esteem, reductions in symptoms of mental illness and relapse prevention (Sanders, 2022). However, there is a lack of high-quality research into supported housing.

- In Cambridgeshire and Peterborough, a housing, mental health and substance misuse toolkit was developed in 2022 to improve outcomes for people when mental health, substance use and housing issues co-occur.
- Issues around housing provision for older adults with mental health needs will be explored in the next chapter of the mental health needs assessment.

In Cambridgeshire in 2022, there were 167 units supporting people due to a primary support reason of 'mental health'. 102 units were supported living accommodation, 56 units were residential accommodation and 9 were nursing care accommodation.

Figure 83: Units of accommodation supporting people with mental health primary support reason, Cambridgeshire, 2022. Data source: Cambridgeshire County Council Learning Disability, Autism, Mental Health and Physical Disability Specialist Accommodation Needs Assessment.



When housing demand outstrips supply, this results in either delayed discharge or sub-optimal placements using alternative sources (e.g. out of area placements or going outside of contracted arrangements). Approximately 25 sub-optimal placements are made per year in Cambridgeshire and Peterborough.

P3 Supported Accommodation

Adding local data

A case study of someone using this service can be found here (add link).

Sanctuary Housing Association Supported Living Service

Sanctuary Housing Association (SHA) is an organisation that provided housing for a wide variety of needs. Support for people with mental health needs had varying levels: intensive round the clock support, mid-level floating support, and low-level independent living with fewer contact hours. The service aim was to nurture and support individuals experiencing mental health conditions to be able live independently, by teaching life skills such a cooking, paying bills and food shopping.

An evaluation of the Sanctuary Housing Association Supported Living Service was carried out in June 2022 by the Service User Network (SUN). It included surveys from service users, staff and other stakeholders. Key conclusions of this report were:

- There appears to be an inequity in the service that were provided at each site. Some of the sites were been viewed more favourably by residents, social workers, and other stakeholders.
- However, the staff at each site were praised for their role in looking after each individual, within the scope of their job role and beyond this. The passion of the staff was palpable, and their dedication to their work and the residents was acknowledged. There was a sense that these positive aspects could be enhanced

by the provision of appropriate training in understanding the remit and autonomy of the role, mental health and drug and alcohol training and a good insight into external local service provision to further support residents. A challenge within this type of service appears to be that there is no one size fits all, and the staff members worked to cater what they provided to each individual fairly, but also to accommodate individual need.

- There was an inconsistency of care from the perspective of residents and stakeholders, who have observed that each staff member was unsure of the boundary in which they were allowed to operate resulting in differing levels of care per resident. Stakeholders believed that staff could be doing more to engage the residents in communal activities and to discuss and encourage the two-year move on, for the benefit of the individuals. This would also benefit the system and allow for the freeing up of spaces for others in need of supported housing. Conversely, residents were often not ready to move on within the proposed two years and there is a lack of appropriate onward accommodation for them to move to.
- The system appeared to have downfalls within its process regarding the banding allocation to enable residents to leave supported housing to go on to independent living. Only certain residents, and residents at certain sites to be on 'band A' and able to expeditiously access independent accommodation when they are ready. This created reluctance in residents to engage in this process as they may have to wait a long period of time to be re-banded and be eligible for their own accommodation, and a dilemma for staff who feel they need to start the process at the very beginning of a residents tenancy and try and judge the point at which the resident is ready to move on, and the appropriate accommodation may become available.
- There was a high level of demand for this type of service within the region and there were suggestions that the majority of Cambridgeshire would benefit from additional supported housing locations. This also could be with the intention to service drugs and alcohol, homelessness, women only housing, and varying age groups. Consideration would also need to be given to ensure allocations are appropriate to the individuals, the geographical area, the accommodation, and the staffing levels to best service the resident.
- There were strong arguments that an interim service to support individuals leaving hospital is absolutely needed, and urgently. This will maximise the efficacy of the pathway and free up spaces, whilst importantly catering for and accommodating the transitional needs of the service user.

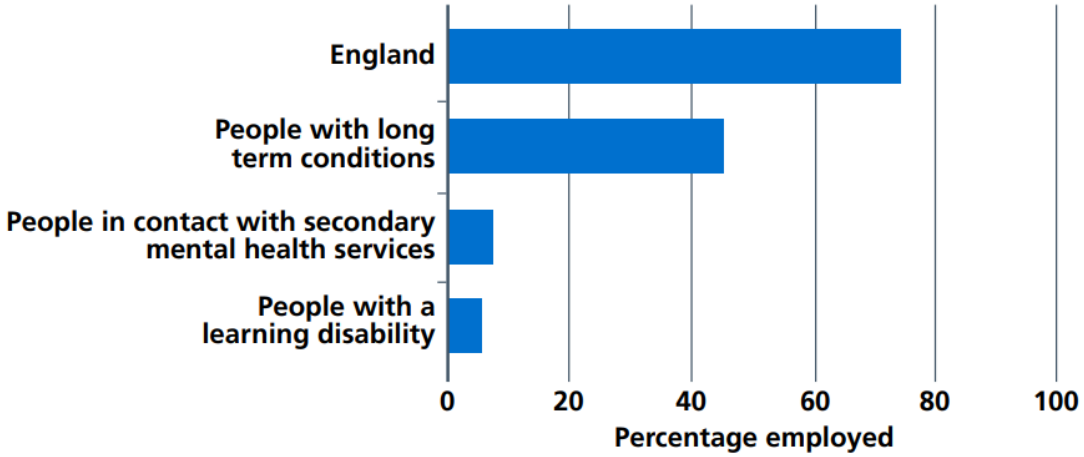
Additional Resources

- Accommodation based support for adults with mental health conditions
- More than medicine: new services for people powered health
- More than shelter: Supported accommodation and mental health

Employment support

National data from 2016/17 shows a 65% employment gap for people being supported by secondary mental health services in comparison to the general population (NHS, 2019).

Figure 84: Percentage of the population who are employed, by disability status, England, 2016 to 2017. Image source: NHS Long Term Plan



Individual placement and support (IPS) is an evidence-based model of support for job seekers with severe and enduring mental health conditions (Brinchmann et al., 2020). This was implemented as part of the NHS Long Term Plan, which also states that IPS should be embedded within integrated models of primary and community mental health services.

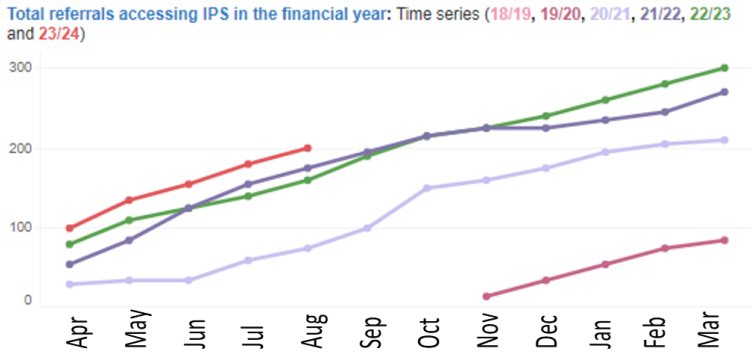
In Cambridgeshire and Peterborough:

- The Individual Placement and Support service is run by CPFT (Cambridgeshire and Peterborough NHS Foundation Trust). The size of this team has expanded over the past 3 years, including expanding to deliver IPS within primary care in 2022.
- Lifecraft also provides a Careers and Employment Service to support people recovering from mental health difficulties who are ready to enter the workplace or volunteering.

How many people access this service?

The number of referrals accessing IPS services in the month of April–August 2023 is higher than that of the previous years for the same time period, due to the expansion of the CPFT service.

Figure 85: Cumulative number of referrals accessing CPFT IPS within the financial year, April 2018 – August 2023. Data source: IPS Dashboard - Mental Health, Learning Disability and Autism Resource Hub - FutureNHS Collaboration Platform



A review of the CPFT IPS service in July 2023 showed that the people accessing this service are representative of the general local population. The majority of referrals were from adult locality mental health teams, with around 10 – 20% being from primary care.

The Lifecraft Employment Service was relaunched in July 2022. From this time to August 2023, this service:

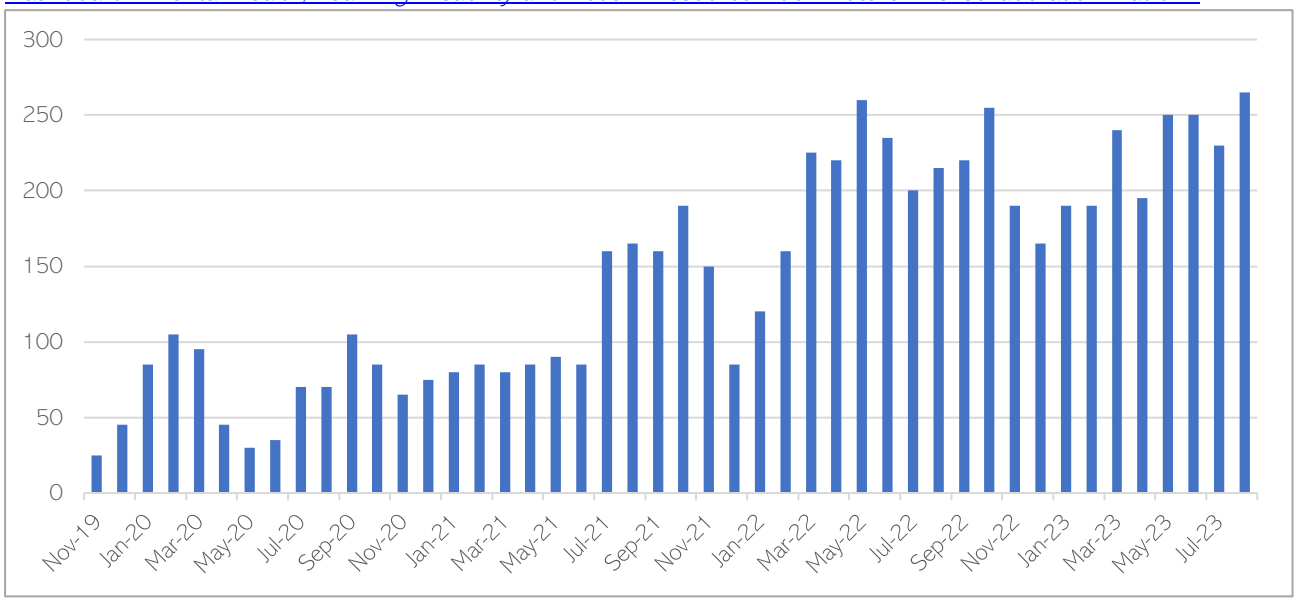
- Had 27 individual referrals.
- Supported 9 people into work and 1 person into volunteering.
- Supported another 6 people to move towards their employment goals.

- Referrals into the service came from a variety of channels: self-referral (6), IPS (6), Lifecraft (5), Red Balloon in the Air (4), primary care (3) and other (3).
- The average age of those referred to the service was 36.

Contacts

The number of direct contacts (face-to-face, telephone, or video) made by CPFT's IPS service has substantially increased since November 2019.

Figure 86: Number of direct contacts with the CPFT IPS service, November 2019 – August 2023. Data source: IPS Dashboard - Mental Health, Learning Disability and Autism Resource Hub - FutureNHS Collaboration Platform



What are people's experiences of this service?

From the CPFT IPS service:

- Service users report that '*I don't know where I would be today without the help of my Employment Specialist*'
- Clinical teams say that '*IPS is a really good service, they are extremely helpful for my role and it is great that there is support out there for people who feel that they have no purpose. IPS is another strand of the road to recovery for people. Particularly, the collaborative working is great, the IPS team are approachable, friendly, happy to help and always visible*'
- A case study of Pansy, who was supported by this service, is provided on their website.

Until November 2022, The Richmond Fellowship also provided support through their Access to Work service. This service provided assistance with skills such as interview techniques, application forms, CV writing and career guidance. It also offered coping strategies and aims to provide signposting and support for mental health challenges. Service user feedback from this service was very positive, with a small survey with 9 participants finding that people felt highly satisfied by the service and that advisors help to build their confidence in job searching.

Additional Resources

- Individual placement and support for severe mental illness
- IPS Grow and IPS resources

Adult social care

- There is a substantial overlap between adult social care and mental health support: 11% of national social care spending for working-age adults was on mental health support in 2021/22 (The King's Fund, 2023).
- Add data summary

What is the overlap between adult social care and the mental health system?

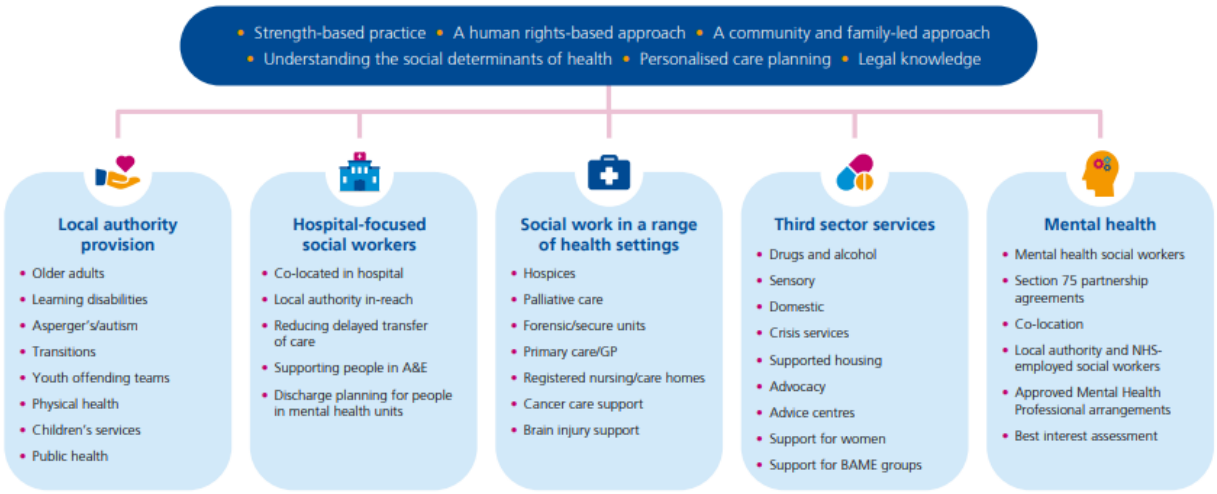
The role of adult social work in adult mental health was defined by The College of Social Work in 2014 as falling into one of five categories (Department of Health, 2016):

1) 'Enabling citizens to access the statutory social care and social work services and advice to which they are entitled, discharging the legal duties and promoting the personalised social care ethos of the local authority.
2) Promoting recovery and social inclusion with individuals and families.
3) Intervening and showing professional leadership and skill in situations characterised by high levels of social, family and interpersonal complexity, risk and ambiguity.
4) Working co-productively and innovatively with local communities to support community capacity, personal and family resilience, earlier intervention and active citizenship.
5) Leading the Approved Mental Health Professional (AMPH) workforce'.

There are a range of roles social worker may take on which fit within these categories – as shown in the diagram below. For example:

- Some people with mental health conditions may be supported by social services to meet their health or social care needs.
- Social workers make up 95% of Approved Mental Health Professionals (AMHPs), who coordinate Mental Health Act assessments (Health Education England, 2023).
- Some social workers based within mental health services, with one 2018 survey of NHS trusts finding that 80% of community mental health teams included social workers (Abendstern et al., 2022). National research suggests that service users and carers value social workers for their holistic and person-centred approach (Abendstern et al., 2022).
- People who have been detained under certain sections of the Mental Health Act are entitled to free health and social care after they leave hospital, which is known as Section 117 aftercare.

Figure 87: The social work contribution to health settings. Image source: Health Education England



Pressures on adult social care have a direct impact on the NHS. Workforce pressures can make it harder to meet people's mental health needs in the community, leading to poorer outcomes and making it more likely that people will be admitted to hospital. Similarly, pressures on social care can also delay discharge from hospital (NHS England, 2023g).

Case study

The following case study, reported by the Centre for Mental Health, highlights the importance of social care mental health services:

'*Take Beth as an example. She suffered from very serious and traumatic mental health problems which eventually led her to receive an urgent assessment led by our (local authority) Approved Mental Health Professionals in an emergency out-of-hours team. She was detained to a secure hospital under section 3 of the Mental Health Act. With the right care, medication and a stable environment she began to recover and after eight months was ready to be discharged. The discharge plan led to a right to aftercare from social care and health agencies. She was allocated a social worker and received a support package under the Care Act that led to her being placed in supported housing commissioned by the Local Authority with a direct payment to help her learn the skills she needed to live independently. Eventually she attended a voluntary sector employment project funded by the LA and began the long road back to work and independence. She is just about to move into her own flat – provided by the council housing services and funded by council housing benefit. She is being supported with the help of council-funded advocacy and advice services.*' – Mark Trewin, 2017 (Trewin, 2017)

What is the local picture?

Social care data will be added:

This data visualisation shows up-to-date data on the Cambridgeshire and Peterborough social care workforce.

Additional Resources

- Social work for better mental health: A strategic statement
- Transforming mental health social work
- Guidance on Social work: improving adult mental health
- New partnerships and integration models between health and social work
- Approved Mental Health Professional (AMHP) National Service Standard

Advocacy

Advocates are independent professionals who with people to help them understand their rights and have their voices heard. Rethink Mental Illness describes five main types of advocacy services which may be relevant to people with mental health conditions and people caring for them (Rethink Mental Illness, 2023a):

- Independent mental health advocacy: supports people who are detained in hospital under the Mental Health Act, or are on a Community Treatment Order, to understand their rights and medication.
- Independent mental capacity advocacy: supports people who have been assessed as lacking mental capacity to make decisions and work out what their best interests are.
- NHS complaints advocacy: provides support and advice to people making complaints to the NHS.
- Care Act advocacy: supports people who are being assessed under the Care Act who have difficulties being involved in decisions about their social care and support.
- Generic advocacy: provides a range of support, such as with attending meetings and getting your voice heard.

In Cambridgeshire and Peterborough, the main advocacy service is Voiceability.

Voiceability

Voiceability services are about empowerment, giving people with disabilities the opportunity to speak up for their rights and make positive changes to their lives. Voiceability provides independent advocacy support for people making complaints and for people sectioned under the Mental Health Act.

In April to June 2023, 361 new advocacy cases were opened in Cambridgeshire and 199 in Peterborough. The most common themes for the service were:

- Care Act (Care Review)
- General Advocacy (Community Mental Health Advocacy)
- IMCA (Long-Term Accommodation)
- IMHA (Rights)
- NHS Complaints (Formal Complaint)
- Relevant Person's Representative (RPR) (Represent/Support Client)

Voiceability also runs the TotalVoice advocacy service, in partnership with Cambridgeshire Deaf Association and the National Youth Advocacy Service; as well as Speak Out Council, which acts as a voice for people with a learning disability and autistic people aged 14 or above.

National Youth Advocacy Service

The National Youth Advocacy Service (NYAS) provide advocacy for children and young people in Cambridgeshire who are Looked After or In Need; or unaccompanied or seeking asylum; or who have special educational needs or disabilities (SEND).

Additional Resources

- A review of advocacy for people with a learning disability and autistic people who are inpatients in mental health, learning disability or autism specialist hospitals

Neurodevelopmental services

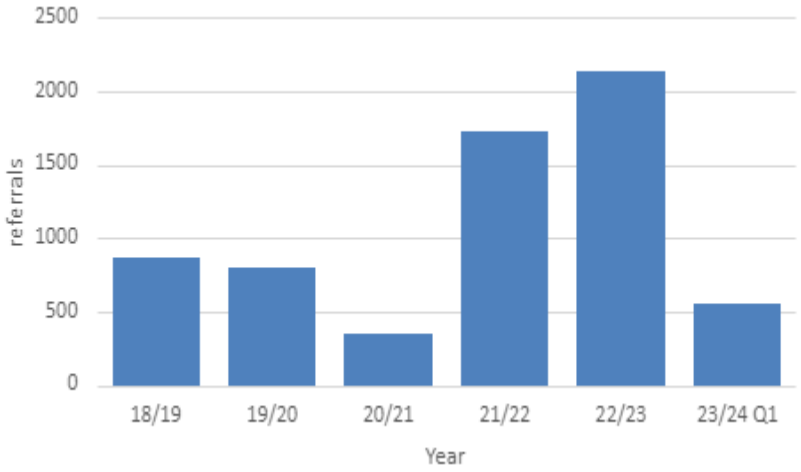
These services will be covered in more detail in the later chapter focusing on neurodiversity (which will be published in 2024). The following information is given as a brief outline of the services that provide diagnostic support for adults with ADHD and autistic adults.

Adult Attention Deficit Hyperactivity Disorder (ADHD) clinic

The adult Attention Deficit Hyperactivity Disorder (ADHD) clinic is a specialist service offering assessment, diagnosis and treatment for adults with possible ADHD and for those with previously diagnosed ADHD. The clinic also offers pre-referral advice for GPs, such as medication monitoring and symptoms management.

There has been a substantial increase in the number of adults referred to the ADHD clinic since 2019/20, although referral numbers decreased in 2020/21, most likely due to the wider impacts of the COVID-19 pandemic.

Figure 88: Referrals to the adults ADHD clinic, 2018/19 – 2023/24 Q1



Cambridgeshire Lifespan Autism Spectrum Service

Cambridgeshire Lifespan Autism Spectrum Service (CLASS) service offers a specialist diagnostic assessment for adults (18 years and over) who may meet the diagnostic criteria for autism without an intellectual disability. For people who are diagnosed, they offer post-diagnostic support.

Integrating physical and mental health

- As covered in chapter two of the mental health needs assessment, there is a close bidirectional relationship between physical and mental health. People with long-term physical health conditions are between 2 to 3 times more likely to experience mental health problems than the general population (Naylor et al., 2012).
- The reasons behind the increased rates of poor physical health amongst people with enduring mental health conditions are complex, and include healthcare factors, patient factors and wider system factors side effects of antipsychotic medication, and health behaviours (Lawrence & Kisely, 2010).
- People with co-morbid physical and mental health conditions are more likely to experience poor outcomes, including greater rates of hospitalisation and less effective self-management (Public Health England, 2019).
- Physical and mental health problems should be supported in an integrated way across all aspects of the health system, from public health and prevention initiatives to the care provided by GPs, hospitals and social care (Public Health England, 2019). There are cost-effective interventions which protect the mental health of people with long term conditions (Public Health England, 2019).

This section of the mental health needs assessment focuses on policies and services which aim to address physical health inequalities faced by people with mental illnesses, particularly those with severe mental illnesses.

Integrated physical and mental health care

Many services within Cambridgeshire and Peterborough provide integrated physical and mental health care. This includes some services which have a specific focus on improving the physical health of people experiencing mental illness (such as free and low cost fitness activities run by Cambridge City Council) and the mental health trainers within Healthy You. Other approaches include integrating physical and mental health, such as liaison psychiatry (add link) or a local pilot where general practitioners had placements within CPFT.

Talking Therapies for people with long-term physical health conditions

- People with co-occurring mental and physical health conditions are more likely to have poorer physical health outcomes (Naylor et al., 2016).

- The NHS Long Term Plan set out plans to expand Talking Therapies, stating that all ICSs should commission specific support for people with long term conditions (LTC). This builds on the core Talking Therapies model by including integrated care with physical healthcare services (Clarke et al., 2018).
- Early evaluations of this support identified positive benefits for both service users and healthcare systems: service users reported that they benefited from receiving specialist support, and physical health services reported varying levels of savings (Clarke et al., 2018).

NHS Cambridgeshire and Peterborough Talking Therapies provides a specific pathway of support for people with long-term physical health conditions, including coronary heart disease, chronic pain and diabetes (Cambridgeshire and Peterborough NHS Foundation Trust, 2023a). An initial evaluation of this service found for people who used the long-term condition pathway there was a (NHS England, 2023f):

- 73% reduction in GP appointments for diabetes, cardiovascular health and respiratory health.
- 61% reduction in Accident and Emergency attendances.
- 75% reduction in hospital admissions.

Identifying risk factors

- Young people with psychosis are at a high risk of developing cardiometabolic disorders such as cardiovascular disease and type 2 diabetes.
- Recent NIHR funding led to the development of the Psychosis Metabolic Risk Calculator (PsyMetRiC), the first age-appropriate cardiometabolic risk prediction algorithm tailored specifically for young people with psychosis (Perry et al., 2021).
- This tool has been validated in multiple settings across the UK and is going through classification with the Medicines and Healthcare products Regulatory Authority (MHRA) so it can be used in clinical settings (Perry et al., 2021). Approval of PsyMetRiC will transform CPFT opportunities for further funding of the PsyMetRiC project by demonstrating feasibility and a path toward clinical integration and implementation.

Cancer screening

People with a mental health condition are 1.4 to 2 times more likely to die from cancer, although the overall incidence of cancer is similar to that in the general population (Solmi et al., 2020).

International studies suggest that people with any mental illness are almost 25% less likely be screened for cancer compared to the general population (Solmi et al., 2020). A 2018 analysis by Public Health England found that in 2018, eligible people on the SMI register illness in England were (Public Health England, 2021):

- 18% more likely to have not participated in breast screening.
- 20% more likely not to have participated in cervical screening.
- 31% more likely not to have participated in bowel screening.

Cancer screening participation amongst people with SMI is lowest for people living in the most deprived areas and people from 'Black' ethnic groups (Kerrison et al., 2023).

What are the barriers to cancer screening faced by people with mental health conditions?

Known barriers to screening for people with severe mental illness include (Syson-Nibbs, 2018):

- Administrative barriers: for example, people who are long-term residents of mental health providers are often not registered with a GP, so may not be invited to screening.
- Healthcare barriers: clinical teams not knowing what screening patients are eligible for.
- Patient barriers: patients may experience anxiety around screening processes.

What is the evidence around improving cancer screening uptake?

National service specifications state that screening services should address health inequalities and people with severe mental illness are identified as key group that may require additional support to access screening (Syson-Nibbs, 2018). A systematic review of interventions to increase the uptake of screening amongst people with severe

mental illness identified 22 interventions which all had a positive impact on screening uptake but found that there is a lack of high-quality evidence on this topic (Lamontagne-Godwin et al., 2018).

- Interventions were either focused on changes to health service delivery or the introduction of tools to facilitate screening. They were delivered in a range of locations, including primary care and mental health services.
- Only one study focused on cancer screening (Heyding et al., 2005). This involved women who attended an inner-city community health centre, many of whom experienced mental illness and homelessness. Introducing staff accompanied groups to attend breast cancer screening was associated with an increased screening uptake.

Research focused on general physical health checks shows that people are more likely to attend screening after being offered screening when they are already attending a face-to-face consultation for another reason (Tanner et al., 2022).

Additional Resources

- Mental health-friendly health check resources for health and social care professionals
- Making screening more accessible for people with a severe mental illness

Smokefree inpatient mental health services

- NHS England recommends that all inpatient mental health units should be 'smokefree' by 2018. This is defined as the absence of tobacco smoke, so does not cover e-cigarettes (Public Health England, 2016).
- NICE recommends that people should be informed about smokefree sites before attending hospital and that they should be offered behavioural and pharmacological support to stop smoking if relevant. People with severe mental health conditions should be offered tailored support that is delivered by a specialist with mental health expertise (NICE, 2022b).
- There are a range of benefits associated with smokefree inpatient mental health units:
    - One study carried out across four hospitals found that over 2 hours a day of clinical time in inpatient wards was spent facilitating smoking breaks, with a cost of between £18,250 to £86,870 per ward each year (Robson et al., 2016).
    - A 2010 audit found that 96% of managers whose services had become smokefree indoors believed that this policy had positive impacts on staff, patients and services, and led to improvements in quality of care (Public Health England, 2016).

In Cambridgeshire and Peterborough NHS Foundation Trust (CPFT):

- Inpatient services became smokefree in 2017, but over the COVID-19 pandemic some wards allowed patients to smoke in the gardens.
- The aim is that CPFT sites will become completely smokefree again by the 1st April 2024.
- There is a Tobacco Dependency Service (staffed by a Tobacco Dependency Lead and two part time Band 4 nurses) offering smoking cessation support for inpatients in CPFT services.

Additional Resources

- Action on smoking and health's articles on smokefree mental health services and resources to support practice
- Smokefree mental health services in England: Implementation document for providers of mental health services

Annual physical health checks for people with severe mental illness

- The physical health inequalities faced by people with severe mental illness are not unavoidable.
- Annual physical health checks were introduced to address these inequalities: as part of this, everyone on the SMI register is invited to an annual physical health check.
- Physical health checks assess alcohol use, blood glucose levels, blood lipid levels, blood pressure, body mass index (BMI) and smoking status.

In NHS guidance on 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, 2018b), although people in 'remission' are excluded from this register. This definition is used 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 their own physical health risks (NHS England, 2018b).

What is the evidence base for annual physical health checks?

- One large scale study found that annual physical checks for people with SMI are associated with a lower risk of attendance at Accident and Emergency services, hospital admission due to mental illness and lower overall healthcare costs (Jacobs et al., 2020).
- Evidence shows that there are effective interventions which support people with severe mental illness to improve physical health, such as managing antipsychotic-induced weight gain (Álvarez-Jiménez et al., 2008). However, if people are not offered help and support after their health check, it is very unlikely that their physical health, and therefore morbidity and mortality rates, will improve (How to Improve the Physical Health of People with Severe Mental Illness, 2021).
- This is the key emphasis of the cardiovascular intervention framework, the Lester Tool, the core principle of which is 'don't just screen – intervene'.

Local model for annual physical health checks

The Cambridgeshire and Peterborough ICS Health and Wellbeing Strategy set the target that 60% of people on the SMI register should receive annual physical health checks, as a key priority for tackling inequalities. This is in line with the NHS Long Term Plan (NHS England, 2018a). The local aim in 2023/24 is that at least 80% of people on the SMI register will receive their annual physical health check and be offered an additional 20-minute follow-up appointment where useful, to support them to access interventions to improve their physical health.

Since 2020, Specialist Health Care Assistants (SHACs) have offered to deliver SMI physical health checks to all patients in GP practices within Cambridgeshire and Peterborough. The Specialist Health Care Assistants:

- Deliver 12-point annual physical health checks, including echocardiograms (ECGs) if needed, as well as flu and COVID-19 immunisations.
- Provide 45-minute appointments for physical health checks, with an offer of 20 minute 'follow-up' appointments to support access to interventions as needed.
- Provide physical health checks within a primary care setting and offer a home visit option if patients cannot attend their GP surgery for any reason.
- Have strong pathways and links to voluntary sector and local authority resources, including digital resources.
- Deliver medical monitoring of people with mild-to-moderate eating disorders.

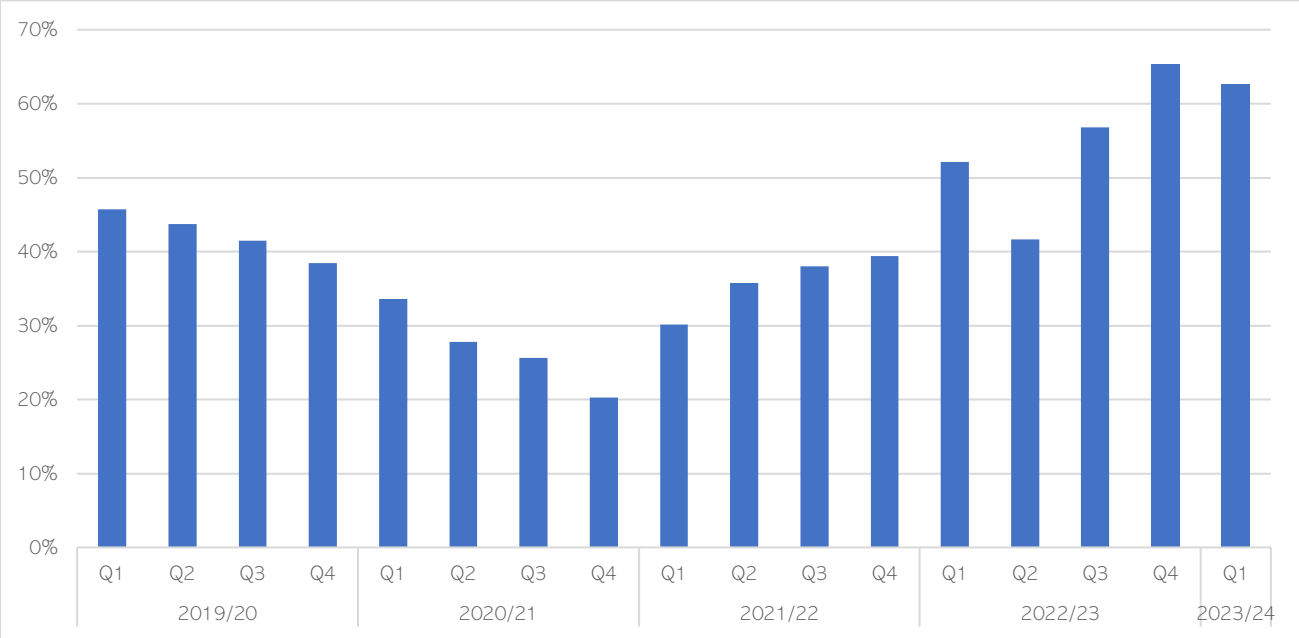
By 2022/23, Specialist Health Care Assistants delivered 80% of all annual physical health checks in Cambridgeshire and Peterborough, with GP practices delivering the remaining 20% due to patient choice or circumstance.

Personalised Care Support Plans (PCSP) have been developed in collaboration with service users and the SUN (Service User Network) and were rolled out across the county in April 2023 to support the ambition of patients and healthcare truly taking a holistic approach to the patients' needs.

How many people receive annual physical health checks?

- Cambridgeshire and Peterborough was the highest performing area in the East of England in 2022/23, in terms of the proportion of people on the SMI register having their annual physical health check against the Long Term Plan target agreed with each ICB.
- There has been a consistent increase in the uptake of physical health checks in Cambridgeshire and Peterborough from the start of 2021/22, with 63% of people on the SMI register receiving all six physical checks by the first quarter of 2023/24.

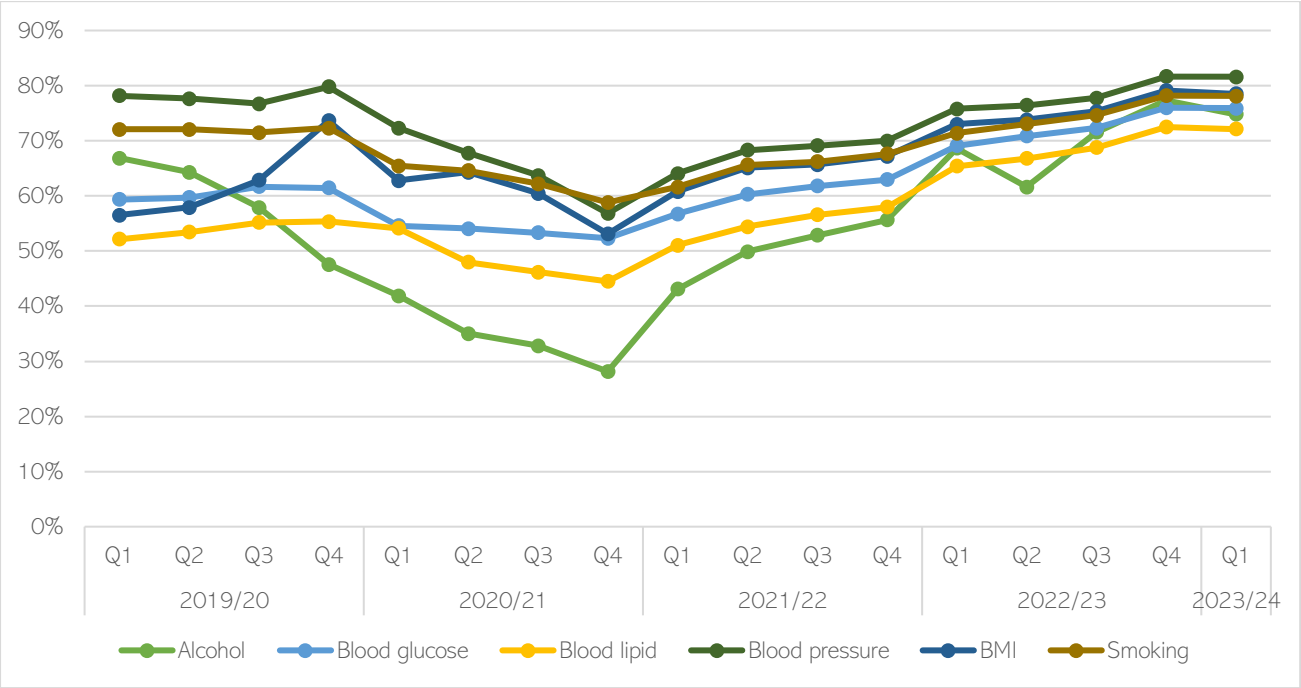
Figure 89: Proportion of people on the SMI register who have received all six physical health checks within the past 12 months in Cambridgeshire and Peterborough, 2019/20 – 2023/24. Data source: NHS England



The proportion of eligible people who have received different elements of the physical health checks varies. There is a consistently higher rate of blood pressure checks, and consistently lower rate of blood lipid and alcohol checks, although this gap is closing. For example, in the first quarter of 2023/24, the uptake of checks was (NHS England, 2018a):

- 75% for alcohol
- 79% for BMI
- 76% for blood glucose
- 72% for blood lipid
- 82% for blood pressure
- 78% for smoking

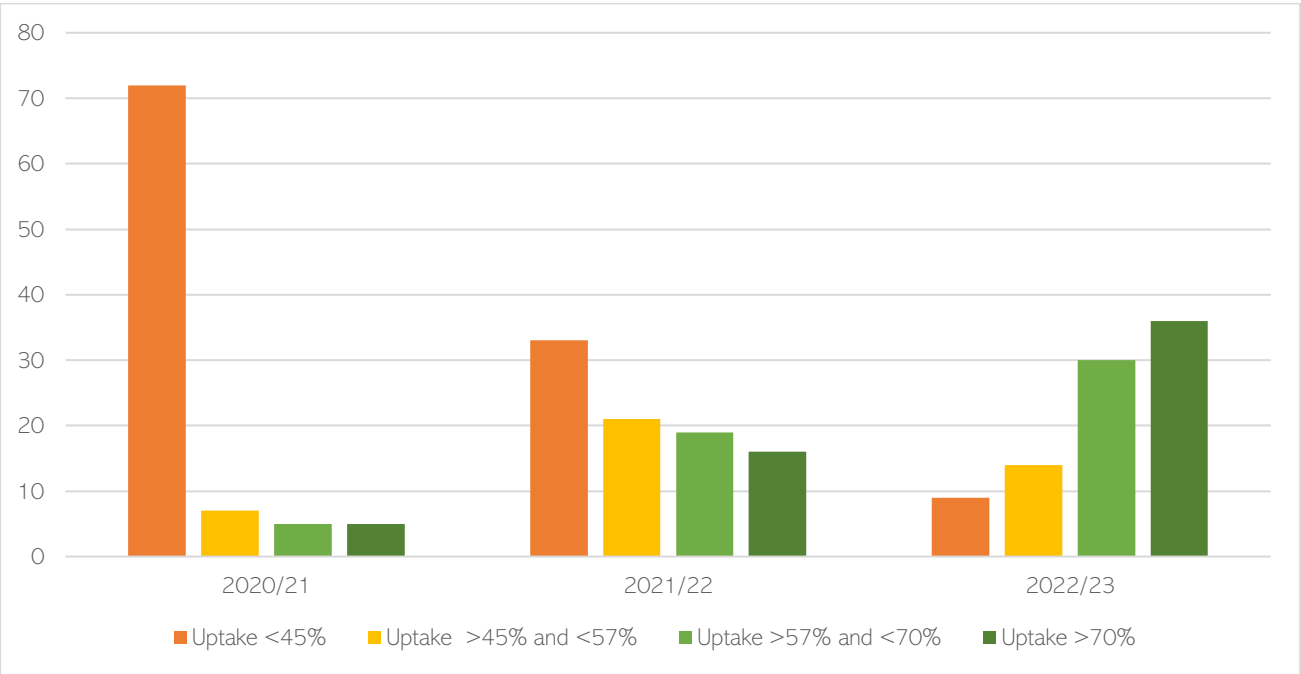
Figure 90: Proportion of people on the SMI register who have received physical health checks in Cambridgeshire and Peterborough within the past 12 months, 2019/20 – 2023/24. Data source: NHS England



How does physical health check uptake vary by general practice?

In the three years since the implementation of Specialist Health Care Assistants, there has been an increase in the uptake of annual physical health checks across the system.

Figure 91: Uptake of annual physical health checks across 89 general practices in Cambridgeshire and Peterborough, 2020/21 – 2022/23.



What do people say about this service?

Feedback from people who received annual physical health checks from Specialist Health Care Assistants shows that almost everyone felt they were contacted about their appointment in a way that was right for them and that the staff listened to them. Feedback in 2022/23 (289 respondents) found that:

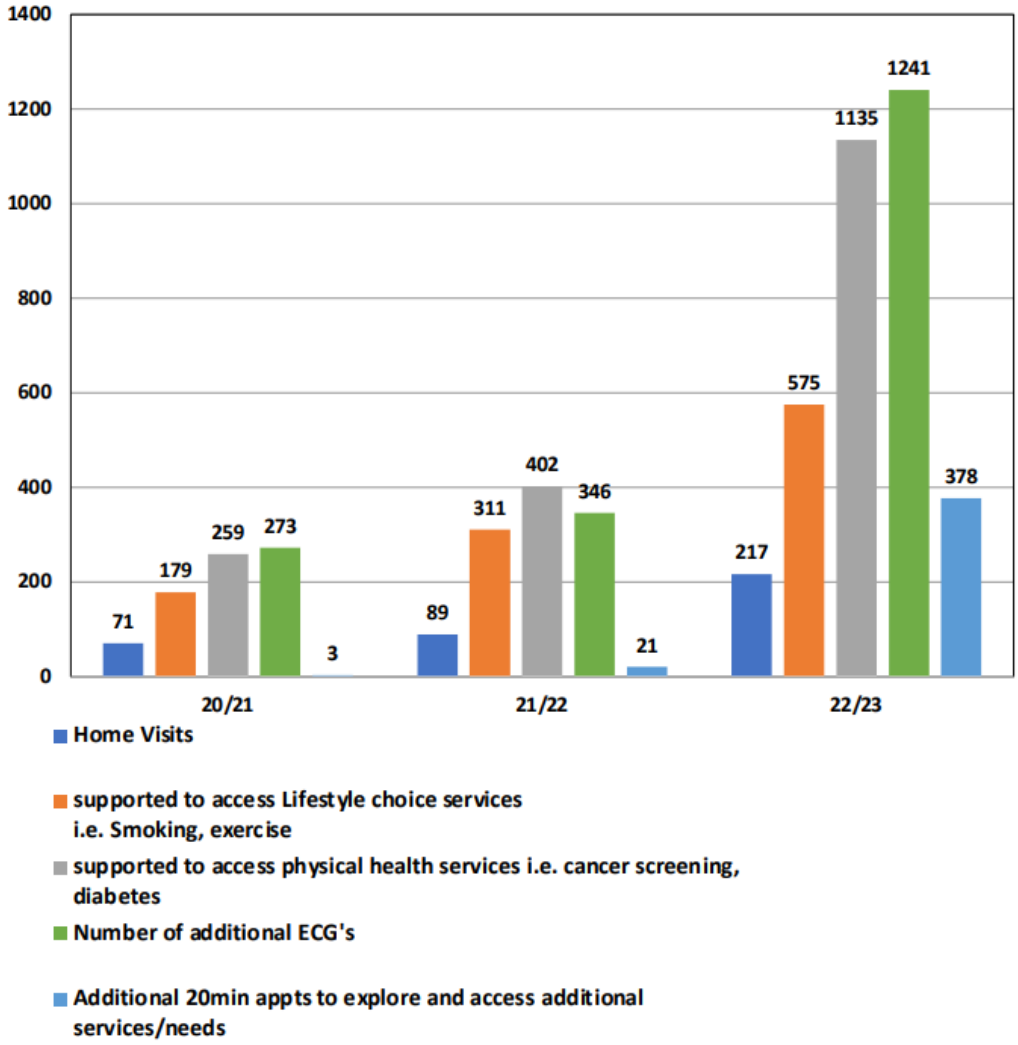
- 96% of people felt they were contacted about their appointment in a way that was right for them.
- 72% said they were given enough information about the appointment and why they had been invited before they attended their appointment.
- 93% of people felt that the Specialist Health Care Assistant listened to any concerns they may have had around their mental or physical wellbeing.
- 90% said the appointment met their expectations.

What are the outcomes of annual physical health checks?

In March 2023, there were 7,128 people on the SMI register, of whom 4,667 (65%) received a full physical health check within the past 12 months. Out of people who had received a health check, the following were given additional support through Specialist Health Care Assistants:

- 1,241 (27%) had their heart assessed using a 12 lead ECG.
- 1,135 (24%) were supported to access physical health services (such as cancer screening, cardiovascular risk assessment, dental care).
- 575 (12%) were supported to access health behaviour services (relating to smoking, weight or exercise).
- 378 (8%) attended a 20-minute follow-up appointment to explore health behaviour or physical health services that might benefit them.

Figure 92: Outcomes of annual physical health checks in Cambridgeshire and Peterborough, 2020/21 – 2022/23.



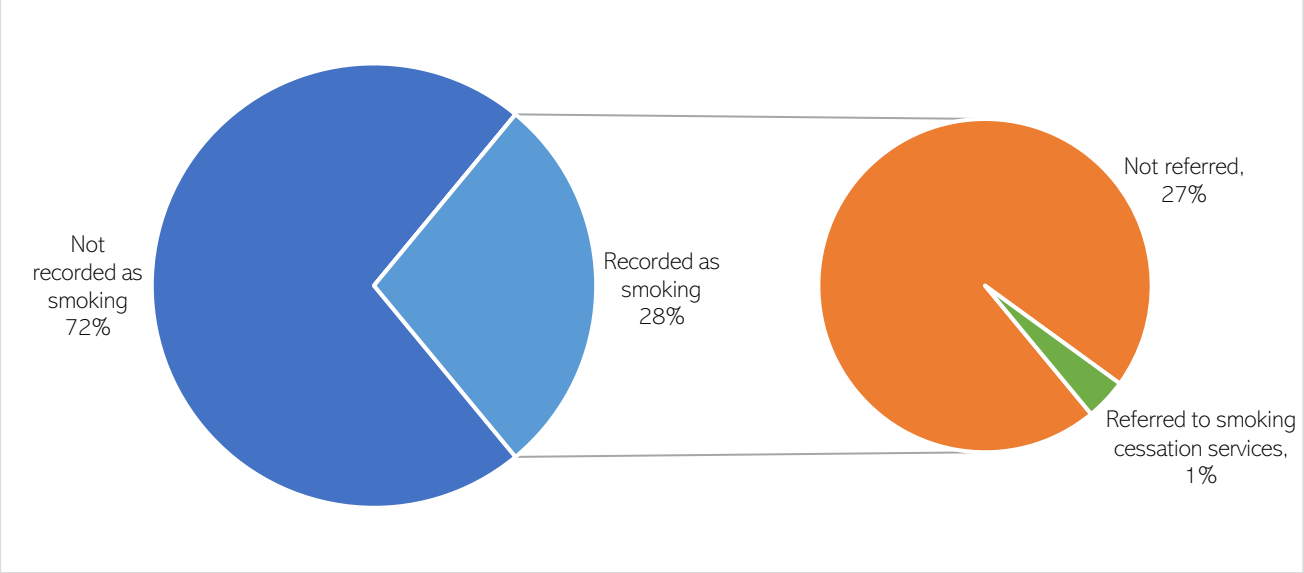
Referrals to smoking cessation services

Referrals to smoking cessation for people who received physical health checks from Specialist Health Care Assistants have been analysed, the links to interventions for the other risk factors (alcohol, blood glucose, blood lipid, blood pressure and BMI) are unknown.

In Cambridgeshire and Peterborough, at the end of year March 22/23, there were:

- 7,128 people on the SMI register.
- 1,977 people on the SMI register were recorded as smokers.
- 80 people who received an annual physical health check were referred for smoking cessation support (such as Healthy You or support within their general practice).

Figure 93: Breakdown of people on the SMI register by smoking status, Cambridgeshire and Peterborough ICS, end of year March 22/23



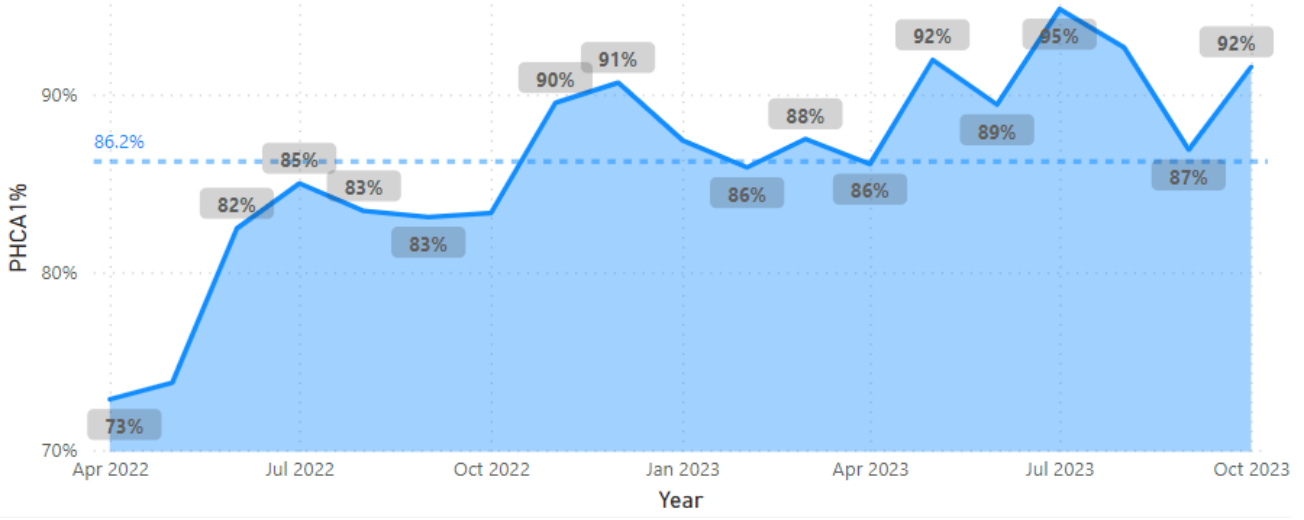
However, this data has several limitations:

- It is likely to underestimate the number of people on the SMI register who were smoking at this time, because not everyone was asked about their smoking status.
- It may underestimate the number of referrals to smoking cessation services, as it only includes referrals made by health care assistants within the Annual Physical Health Checks (APHC) team. Other healthcare professionals, such as GPs, may have also made referrals to these services.
- It does not record whether people attended smoking cessation services or were successful in cutting out or reducing their smoking.

How many people receive physical health checks within mental health services?

There has been a sustained drive in CPFT to improve the percentage of inpatients that receive a physical health check within 24 hours of admission. The uptake of physical health checks does not show significant variation across ethnic groups or deprivation.

Figure 94: Proportion of inpatients who receive a physical health check in CPFT, April 2022 – October 2023.



Data from the National Clinical Audit of Psychosis (NCAP) report in 2022/23 suggested that 60% of people with first episode psychosis using CAMEO had a physical health review and relevant interventions in the last year. This may not reflect the true picture, as there have been issues with data access and recording.

Models for improving physical health outcomes

One way of understanding and tackling inequalities in health is through the framework of inclusion health. NHS England states that 'inclusion health groups… require an explicit, tangible focus in system efforts to reduce healthcare inequalities' (NHS England, 2023a).People with severe mental illness can be considered as an inclusion health group, as they face substantial social and health inequalities. For example, some people with severe mental illness may face difficulties navigating the healthcare system or have experiences of being turned away from healthcare services.

NHS England sets out five key principles of inclusion health: committing to action; understanding people's needs; developing workforce; delivering integrated and accessible services; and demonstrating impact and improvement through action (NHS England, 2023a).

Figure 95: Five principles of inclusion health. Image source: NHS England

Successful examples which have improved outcomes from physical health checks include optimising pathways between primary and secondary care and offering tailored follow up support. This approach was taken by another NHS Trust as it was found that a high proportion of people with severe mental illness were already attending appointments in secondary care (Trueland, 2020). Practical adjustments (such as offering appointments at a different time or access to a quiet waiting area) may also make it easier for people to attend appointments (How to Improve the Physical Health of People with Severe Mental Illness, 2021).

Additional Resources

- NHS guidance on Improving the physical health of people living with severe mental illness and Improving physical healthcare for people living with severe mental illness (SMI) in primary care
- Physical health and severe mental illness scenario
- Improving the physical health of adults with severe mental illness: essential actions
- Improving the physical health of adults with severe mental illness: essential actions and a practical toolkit
- Department of Health: Improving the physical health of people with mental health problems: Actions for mental health nurses
- Positive Cardiometabolic Health Resource: An intervention framework for people experiencing psychosis and schizophrenia (the Lester Tool)
- A national framework for NHS – Action on inclusion health
- Mind & Body Quality Improvement Network

Medically unexplained symptoms

Medically unexplained symptoms are persistent physical symptoms, that do not appear to be linked to a medical condition. They can impact people's ability to function and not understanding the cause can make them harder to deal with (NHS, 2023). This term is used as it the most widely recognised, although we acknowledge that patients may prefer other terminology (Marks & Hunter, 2015).

- More than a quarter of primary care patients in England have medically unexplained symptoms such as chronic pain, irritable bowel syndrome, or fatigue (Public Health England, 2019). In secondary and tertiary care, around 1 in 3 new neurological outpatients have symptoms thought by neurologists to be 'not at all' or only 'somewhat' explained by disease (Public Health England, 2019).
- Persistent physical medically unexplained symptoms are important as they are common, and without appropriate treatment, the outcomes for people with these symptoms are poor (Public Health England, 2019). Patients with medically unexplained symptoms often have poor experiences of healthcare and poor quality of life, benefitting less from treatment and incurring high healthcare costs (Hartman et al., 2017).

Treatment for medically unexplained symptoms

People experiencing medically unexplained symptoms are often referred for multiple assessments and investigation, which can cause harm to individuals (Naylor et al., 2016) and is estimated to cost the NHS £3 billion, around 10% of total NHS expenditure on services for the working-age population (Public Health England, 2019). The needs of people with these symptoms vary substantially (Naylor et al., 2016).

- Persistent physical medically unexplained symptoms are generally managed with limited psychological support (Public Health England, 2019). Without appropriate treatment, outcomes for many patients are poor (Public Health England, 2019).
- The King's Fund highlights that GPs can play an important role in supporting people experiencing persistent medically unexplained symptoms, by exploring relevant psychosocial factors and acknowledging the impacts of physical symptoms (Naylor et al., 2016).
- People with more complex symptoms may require multi-disciplinary support (Public Health England, 2019). This will enable people to access the services most appropriate for their problems, resulting in improved outcomes for patients and substantial cost-savings for the healthcare system (Public Health England, 2019).

Additional Resources

- Long term conditions and medically unexplained symptoms

Recommended areas for future work

The following questions were raised in the writing of this chapter and highlight potential future areas of future work needed. These should be read alongside the other areas for future work already highlighted in Chapter Two of this needs assessment, to ensure a focus on the groups of people at highest risk of mental illness and least likely to access services and support at the right time.

Mental health need

- Continue to update and publish estimates of mental health need in Cambridgeshire and Peterborough, in line with national evidence.
- Recognise that demand for services is still affected by COVID-19 and that this needs to underpin short-term service planning.
- Compared the estimated number of people experiencing first-episode psychosis (FEP) in our local population against the number of people who access CAMEO, to assess potential unmet need.
- Develop the system understanding of the prevalence of hoarding in Cambridgeshire and Peterborough and the cost that untreated hoarding disorder on local services.
- Develop system understanding of inequalities in access to mental health services by CORE20PLUS5 subgroups, across the pathway from early intervention to crisis support. Investigate barriers to access.

System enablers

- Recognise and support the development of a learning health system for adults' mental health.
- Support the work in providers across the system on auditing the use of evidence-based interventions for both common mental health conditions and severe mental illness. Highlight gaps in the provision of effective evidence interventions to the system.
- Outcome measures should be available as part of the development of a learning health system. Support work to record and report on these and highlight inequalities in outcome measures by population groups.
- Where variation in outcomes relates to not using evidence-based practice in line with NICE guidance, highlight and review this at a system level.
- Work towards services routinely being able to answer the following questions:
    - Need: Do we understand the needs in the population that is using the service?
    - Demand: Who is presenting to services? How has this changed over time? What is the modelling/predictions for the future?
    - Supply/Capacity: How well is the system able to meet the needs of the population? What are the key constraints?
    - Flow and outcomes: How do people flow through the different services to receive care?
    - Inequalities: Which groups of people are less likely to access services/drop out along the way/have poorer experiences and outcomes/do not have their needs met?
- Ensure a continued focus on sharing data across the system to understand the increase in need for support for both common mental health conditions and severe mental illnesses.
- Build the pool of expertise for mental health analysis that is available across the integrated care system. This should involve reviewing and mapping the data analytical expertise currently contributing to understanding of mental health pathways from across different organisations in the ICS.

Funding

- Ensure that the Mental Health Investment Standard is met locally and in line with the needs outlined across the system.
- Develop understanding of system mental health spend by service type, including prevention and early intervention.
- Develop understanding of the cost effectiveness of mental health interventions and the potential to increase allocative efficiency across the mental health system.

Communications

- Establish resources available from across the different parts of the sector (integrated care board, NHS trust, voluntary and community sector, local authorities) that can contribute on system-wide communications strategy.
- Ensure that communication strategies follow an evidence-based approach.

Digital

- Support mental health providers across the system in improving the digital maturity of their organisations.
- Build understanding of how digital health technologies can support the patient journey in terms of:
    - Effective treatment or guiding care choices
    - Helping people manage their own mental health
    - Releasing staff time

Workforce

- Workforce is a major constraint on the system's ability to meet population needs. Carry out joined-up working to map and model future needs that will contribute to workforce planning across the system.
- Recognise the critical importance of workforce considerations in system decisions.

Integration of lived experience

- Review the systematic inclusion of lived experience alongside other types of data to contribute to developing a learning health system. This should include experience both from people who have used services and those with mental ill health that have not.
- Evaluate mental health services against NICE guidelines for service user experience

Support for common mental health conditions

- Evaluate how local services are meeting NICE guidelines around depression in adults and generalised anxiety disorder in adults
- Explore local antidepressant prescriptions, including:
    - Prescription rates over time and which diagnoses are linked to antidepressant prescriptions, including insomnia and chronic pain.
    - Rates of antidepressant reviews.
    - How local services ensure informed consent when initiating and reviewing antidepressants; and if care plans are put in place and shared with patients/carers with clear rationale and expectations around antidepressant reviews and expected duration of treatment.
    - Prescribers' knowledge and confidence around on deprescribing and what support is available for patients who struggle with withdrawal/discontinuation symptoms.
- Exploring the availability and uptake of non-pharmacological interventions for depression and whether they are being fully utilised (in line with NHS England recommendations around optimising personalised care for adults prescribed medicines associated with dependence or withdrawal symptoms)
- Support the development of primary care network and general practice dashboards which include relevant mental and physical health indicators. Work to expand the data available to general practice staff to understand their local population's use of mental health services, including routine care, crisis care and patient outcomes.

- Investigate re-referral rates in NHS Talking Therapies, including which groups are more likely to be re-referred to this service and the reasons behind this.

Support for severe mental illness

- Support the development of learning communities of clinical care between primary and secondary care.
- Explore mental health presentations in ambulance data, across calls and conveyances.
- Analyse who is admitted into inpatient care, segmented by ethnicity, deprivation and diagnosis
- Develop strategy to increase engagement with the Recovery College service.
- Explore antipsychotic prescriptions within Cambridgeshire and Peterborough, in terms of:
    - The number of people Peterborough currently on antipsychotic medication but who are not the SMI register, including in terms of demographic factors and diagnoses (learning disability, mental illnesses, dementia and palliative care). Investigate how many people in this group receive annual physical health checks.
    - Understand areas needing a focus on deprescribing and how to support this, including for people with a personality disorder diagnosis who are currently on antipsychotics.
- Explore access to depot antipsychotics across Cambridgeshire and Peterborough, to see if there are any geographic inequalities.
- Investigate the roll out of the Stepped Care model across the county, including the perspectives of people with lived experience, carers and professionals.

Inpatient and Crisis care

- Partners across the crisis system to evaluate and refresh the crisis dashboard, in collaboration with Right Care, Right Place
- Review inpatient bed numbers in line with the Crisp Commission (2016) to model the number of beds needed to ensure average inpatient bed occupancy rates are no more than 85% in line with Royal College guidelines, and to eliminate inappropriate out of area admissions. This review should include local inpatient detox bed provision.
- Use Emergency Department data sources from across the county to understand who presents to this service in mental health crisis.
- Investigate why an increasing proportion of people attending A and E for reasons relating to mental health spend more than 6 or 12 hours in the department, including why this is longer than people attending for their physical health.
- Investigate the increasing length of stay for inpatients using tools from the GIRFT approach
- Develop a plan improve the proportion of those followed up within 72 hours of discharge from hospital.
- Continue the work of the Crisis Concordat to improve pathways and reduce inequalities in people who detained under the Mental Health Act
- Explore SystmOne data on how many people assessed under the Mental Health Act access community support instead of being detained. Explore this by ethnicity and by district.
- Support implementation of the recommendations of the local Mental Health Act Pathway review
- Investigate whether inpatient bed availability is a barrier to people being assessed under the Mental Health Act
- Conduct a review of cases where people return to hospital within 90 days, exploring the contributing system factors.
- Evaluate how local services are meeting NICE guidelines around alcohol-use disorders
- Review options for the provision of a community rehabilitation pathway for people with complex mental health needs.

Social support and connection

- Understand the system understanding of how social prescribing services, such as community connectors, may impact demand for mental health services.

- Develop work to increase system understanding of need, demand, supply/capacity, flow and outcomes in social care for mental health.
- Develop work to increase system understanding of future need, demand, supply/capacity, flow and outcomes in supporting housing for people with mental health needs.
- Understand CPFT data on non-statutory social care
- Investigate local barriers to people moving on from supported housing, including the criteria of the housing banding system, wating times and potential facilitators.
- Audit local processes of discharge from inpatient mental healthcare against NICE guidelines and investigate potential housing issues relating to discharge from inpatient mental healthcare. Areas to explore include evaluating if partnership working between agencies promotes optimal discharge, whether people are held back in hospital because they cannot access the right accommodation for them and reviewing the discharge co-ordinator pilot to implement learning.
- Explore if people using carer support services are representative of the local population of people who provide care.
- Investigate the 'waiting list' offer for carers.

Integrating physical and mental health

- Understand the mental health needs of people in Cambridgeshire and Peterborough living with long-term physical health conditions.
- Develop understanding around the impact of annual physical health checks on health outcomes. Investigate drop out along the pathway from check to improvement for each elements of the health check.
- Investigate the integration of physical health check data across the system (including inpatient physical health checks)
- Segment Healthy You access and outcomes data for people on the SMI register.
- Investigate eye and dental health needs for people with severe mental illness
- Look at opportunities to better provide physical healthcare through CPFT, including evaluating the GP pilot scheme within CPFT
- Explore extending the Lester tool for use for all people with severe mental illness
- Develop a strategy to improve cancer screening attendance amongst people with severe mental illness

References

Abendstern, M., Wilberforce, M., Hughes, J., Arandelovic, A., Batool, S., Boland, J., Pitts, R., & Challis, D. (2022). The social worker in community mental health teams: Findings from a national survey. *Journal of Social Work*, *22*(1). https://doi.org/10.1177/1468017320979932

Akther, S. F., Molyneaux, E., Stuart, R., Johnson, S., Simpson, A., & Oram, S. (2019). Patients' experiences of assessment and detention under mental health legislation: systematic review and qualitative meta-synthesis. *BJPsych Open*, *5*(3). https://doi.org/10.1192/bjo.2019.19

Álvarez-Jiménez, M., Hetrick, S. E., González-Blanch, C., Gleeson, J. F., & McGorry, P. D. (2008). Non-pharmacological management of antipsychotic-induced weight gain: Systematic review and meta-analysis of randomised controlled trials. In *British Journal of Psychiatry* (Vol. 193, Issue 2). https://doi.org/10.1192/bjp.bp.107.042853

Appleby, L., Shaw, J., & Amos, T. (1997). National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. In *The British journal of psychiatry : the journal of mental science* (Vol. 170). https://doi.org/10.1192/bjp.170.2.101

Appleton, R., Barnett, P., Chipp, B., Clark, M., Goldblatt, P., Jeffreys, S., Machin, K., Needle, J. J., Shah, P., Thompson, G., Trevillion, K., Webber, M., Worden, M., Johnson, S., & Lloyd-Evans, B. (2023). Development of a

conceptual framework to guide description and evaluation of social interventions for people with serious mental health conditions. *SSM - Mental Health*, *4*, 100271. https://doi.org/10.1016/j.ssmmh.2023.100271

Bagri, S. (2023). *NHS mental health services: what's changed?* Nuffield Trust. https://www.nuffieldtrust.org.uk/news-item/nhs-mental-health-services-what-s-changed

Brinchmann, B., Widding-Havneraas, T., Modini, M., Rinaldi, M., Moe, C. F., McDaid, D., Park, A. L., Killackey, E., Harvey, S. B., & Mykletun, A. (2020). A meta-regression of the impact of policy on the efficacy of individual placement and support. In *Acta Psychiatrica Scandinavica* (Vol. 141, Issue 3). https://doi.org/10.1111/acps.13129

Cambridgeshire and Peterborough NHS Foundation Trust. (2023a). *NHS Cambridgeshire & Peterborough Talking Therapies*. https://www.cpft.nhs.uk/talkingtherapies/

Cambridgeshire and Peterborough NHS Foundation Trust. (2023b). *Primary Care Mental Health Team*. https://www.cpft.nhs.uk/primary-care-mental-health-team/

Care Quality Commission. (2015). *Right here, right now*. https://www.cqc.org.uk/sites/default/files/20150630_righthere_mhcrisiscare_full.pdf

Care Quality Commission. (2021). *The state of health care and adult social care in England 2021/22*. https://www.cqc.org.uk/sites/default/files/2022-10/20221024_stateofcare2122_print.pdf

Clarke, K., Furmaniak, K., & Pilling, S. (2018). *IAPT-LTC Early Implementers Programme Report on the implementation and process evaluation of Wave 1 early implementer sites*. https://www.rcpsych.ac.uk/docs/default-source/improving-care/nccmh/iapt/iapt-ltc-early-implementers-programme-report.pdf

Commission to review the provision of acute inpatient psychiatric care for adults. (2016). *Old Problems, New Solutions: Improving Acute Psychiatric Care for Adults in England*. https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/policy/policy-old-problems-new-solutions-caapc-report-england.pdf

CPFT. (2023a). *Adult Locality Mental Health Teams*. https://www.cpft.nhs.uk/service-detail/service/adult-locality-mental-health-teams-102/

CPFT. (2023b). *Arts Therapy*. https://www.cpft.nhs.uk/service-detail/service/arts-therapy-13/

CPFT. (2023c). *Recovery Coach Team*. https://www.cpft.nhs.uk/search/service/recovery-coach-team-204

CPSL Mind. (2023). *Mental Health Crisis Support*. https://www.cpslmind.org.uk/how-we-help/mental-health-crisis-support/

Davidson, I. (2021). *Mental Health – Adult Crisis and Acute Care GIRFT Programme National Specialty Report*. https://gettingitrightfirsttime.co.uk/wp-content/uploads/2021/09/Mental-Health-Sept21i.pdf

Department for Health and Social Care, & Home Office. (2023). *National Partnership Agreement: Right Care, Right Person (RCRP)*. https://www.gov.uk/government/publications/national-partnership-agreement-right-care-right-person/national-partnership-agreement-right-care-right-person-rcrp

Department of Health. (2016). *Social work for better mental health: A strategic statement*. https://assets.publishing.service.gov.uk/media/5a7f9f0ce5274a2e8ab4d499/Strategic_statement_-_social_work_adult_mental_health_A.pdf

Department of Health & Social Care. (2023). *Progress in improving mental health services in England*. https://www.nao.org.uk/wp-content/uploads/2023/02/Progress-in-improving-mental-health-services-CS.pdf

Department of Health and Social Care. (2018). *Modernising the Mental Health Act – final report from the independent review*. https://www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review

Department of Health and Social Care. (2023). *Rapid review into data on mental health inpatient settings: final report and recommendations*. https://www.gov.uk/government/publications/rapid-review-into-data-on-mental-health-inpatient-settings-final-report-and-recommendations/rapid-review-into-data-on-mental-health-inpatient-settings-final-report-and-recommendations

East of England Ambulance Service. (2021). *Joint Mental Health Response Car goes live*. https://www.eastamb.nhs.uk/news/joint-mental-health-response-car-goes-live/3762

Elliot, S., & Allan, T. (2018). *Evaluation of the Primary Care Service for Mental Health (PRISM): Final Report Cambridgeshire and Peterborough NHS Foundation Trust*. https://www.cpft.nhs.uk/download.cfm?doc=docm93jijm4n942.pdf&ver=1257

Garratt, K. (2023). *Reforming the Mental Health Act*. https://commonslibrary.parliament.uk/research-briefings/cbp-9132/

Garrett, C., Lee, T., Blackburn, S., Priestly, L., & Bhui, K. (2011). Personality disorder: Challenges in service development in the light of the new NICE guidelines. *Psychiatrist*, *35*(1). https://doi.org/10.1192/pb.bp.109.029249

Hanif, D. (2023). *The Association launches the first national picture of mental health service provision*. https://amhp.org.uk/first-national-picture-mental-health-service-provision-launched-pr/

Hardoon, S., Hayes, J., Viding, E., McCrory, E., Walters, K., & Osborn, D. (2022). Prescribing of antipsychotics among people with recorded personality disorder in primary care: A retrospective nationwide cohort study using the Health Improvement Network primary care database. *BMJ Open*, *12*(3). https://doi.org/10.1136/bmjopen-2021-053943

Hartman, T. C., Rosendal, M., Aamland, A., van der Horst, H. E., Rosmalen, J. G. M., Burton, C. D., & Lucassen, P. L. B. J. (2017). What do guidelines and systematic reviews tell us about the management of medically unexplained symptoms in primary care? *BJGP Open*, *1*(3). https://doi.org/10.3399/bjgpopen17X101061

Health Education England. (2023). *Social workers*. https://www.hee.nhs.uk/our-work/mental-health/new-roles-mental-health/social-workers

Heyding, R. K., Cheung, A. M., Mocarski, E. J. M., Moineddin, R., & Hwang, S. W. (2005). A community-based intervention to increase screening mammography among disadvantaged women at an inner-city drop-in center. *Women and Health*, *41*(1). https://doi.org/10.1300/J013v41n01_02

How to improve the physical health of people with severe mental illness. (2021). https://www.southeastclinicalnetworks.nhs.uk/wp-content/uploads/2021/05/SMI_PN-April-20211.pdf

Jacobs, R., Aylott, L., Dare, C., Doran, T., Gilbody, S., Goddard, M., Gravelle, H., Gutacker, N., Kasteridis, P., Kendrick, T., Mason, A., Rice, N., Ride, J., Siddiqi, N., & Williams, R. (2020). The association between primary care quality and health-care use, costs and outcomes for people with serious mental illness: a retrospective observational study. *Health Services and Delivery Research*, *8*(25). https://doi.org/10.3310/hsdr08250

Joint Commissioning Panel for Mental Health. (2016). *Guidance for commissioners of rehabilitation services for people*. https://www.rcpsych.ac.uk/docs/default-source/members/faculties/rehabilitation-and-social-psychiatry/rehab-social---joint-commissioning-panel---guidance-for-commissioners-of-rehabilitation-services-for-people-with-complex-mental-health-needs---2016.pdf

Kerrison, R. S., Jones, A., Peng, J., Price, G., Verne, J., Barley, E. A., & Lugton, C. (2023). Inequalities in cancer screening participation between adults with and without severe mental illness: results from a cross-sectional analysis of primary care data on English Screening Programmes. *British Journal of Cancer*, *129*(1). https://doi.org/10.1038/s41416-023-02249-3

Killaspy, H., Baird, G., Bromham, N., & Bennett, A. (2021). Rehabilitation for adults with complex psychosis: summary of NICE guidance. *The BMJ*, *372*. https://doi.org/10.1136/bmj.n1

Lamontagne-Godwin, F., Burgess, C., Clement, S., Gasston-Hales, M., Greene, C., Manyande, A., Taylor, D., Walters, P., & Barley, E. (2018). Interventions to increase access to or uptake of physical health screening in people with severe mental illness: A realist review. In *BMJ Open* (Vol. 8, Issue 2). https://doi.org/10.1136/bmjopen-2017-019412

Lawrence, D., & Kisely, S. (2010). Inequalities in healthcare provision for people with severe mental illness. In *Journal of psychopharmacology (Oxford, England)* (Vol. 24, Issue 4 Suppl). https://doi.org/10.1177/1359786810382058

Liberati, E., Richards, N., Ratnayake, S., Gibson, J., & Martin, G. (2023). Tackling the erosion of compassion in acute mental health services. *BMJ (Clinical Research Ed.)*, *382*. https://doi.org/10.1136/bmj-2022-073055

Lifecraft. (2023a). *Lifecraft* . https://lifecraft.org.uk/our-services/

Lifecraft. (2023b). *Lifeline*. https://lifecraft.org.uk/our-services/lifeline/

Local Government Association. (2016). *Efficiency opportunities through health and social care integration*. https://www.local.gov.uk/sites/default/files/documents/Efficiency%20opportunities%20through%20health%20and%20social%20care%20integration.pdf

Marks, E. M., & Hunter, M. S. (2015). Medically Unexplained Symptoms: An acceptable term? *British Journal of Pain*, *9*(2). https://doi.org/10.1177/2049463714535372

Marston, L., Nazareth, I., Petersen, I., Walters, K., & Osborn, D. P. J. (2014). Prescribing of antipsychotics in UK primary care: A cohort study. *BMJ Open*, *4*(12). https://doi.org/10.1136/bmjopen-2014-006135

Mind. (2011). *Listening to experience: An independent inquiry into acute and crisis mental healthcare*. https://www.mind.org.uk/media-a/4377/listening_to_experience_web.pdf

Mind. (2023). *Sectioning*. https://www.mind.org.uk/information-support/legal-rights/sectioning/about-sectioning/

Mizuno, Y., McCutcheon, R. A., Brugger, S. P., & Howes, O. D. (2020). Heterogeneity and efficacy of antipsychotic treatment for schizophrenia with or without treatment resistance: a meta-analysis. *Neuropsychopharmacology*, *45*(4). https://doi.org/10.1038/s41386-019-0577-3

Mundt, A. P., Rozas Serri, E., Irarrázaval, M., O'Reilly, R., Allison, S., Bastiampillai, T., Musisi, S., Kagee, A., Golenkov, A., El-Khoury, J., Park, S. C., Chwastiak, L., & Priebe, S. (2022). Minimum and optimal numbers of psychiatric beds: expert consensus using a Delphi process. In *Molecular Psychiatry* (Vol. 27, Issue 4). https://doi.org/10.1038/s41380-021-01435-0

National Clinical Guidelines Centre. (2010). *Alcohol use disorders: diagnosis and clinical management of alcohol-related physical complications*. National Clinical Guidelines Centre.

National Collaborating Centre for Mental Health. (2014). Psychosis and schizophrenia in adults: treatment and management. *Nice*, *February*.

National Institute for Health and Care Excellence. (2011). Service user experience in adult mental health: Improving the experience of care for people using adult NHS Mental Health Services. *National Institute for Health and Care Excellence (NICE)*, *December*.

National Institute for Health and Care Excellence. (2015). Care of dying adults in the last da Care of dying adults in the last days of life ys of life NICE guideline. *NICE Guideline*, *December 2015*.

National Institute for Health and Care Excellence, NHS England, & National Collaborating Centre for Mental Health. (2016). Implementing the Early Intervention in Psychosis Access and Waiting Time Standard: Guidance. *NHS England*, *February*.

Naylor, C., Das, P., Ross, S., Honeyman, M., Thompson, J., & Gilburt, H. (2016). *Bringing together physical and mental health: A new frontier for integrated care*.

https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Bringing-together-Kings-Fund-March-2016_1.pdf

Naylor, C., Parsonage, M., Mcdaid, D., Knapp, M., Fossey, M., & Galea, A. (2012). *Long-term conditions and mental health*. https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/long-term-conditions-mental-health-cost-comorbidities-naylor-feb12.pdf

NHS. (2019). *NHS Long Term Plan*. https://www.longtermplan.nhs.uk/

NHS. (2020). *Bed Availability and Occupancy Quarterly Return Definitions (KH03)*.

NHS. (2021). *Overview - Antidepressants*. https://www.nhs.uk/mental-health/talking-therapies-medicine-treatments/medicines-and-psychiatry/antidepressants/overview/

NHS. (2023). *Medically unexplained symptoms*. https://www.nhs.uk/conditions/medically-unexplained-symptoms/

NHS Cambridgeshire and Peterborough. (2023). *Social prescribing*. https://www.cpics.org.uk/social-prescribing/

NHS Confederation. (2022). *Healthy foundations: integrating housing as part of the mental health pathway*. https://www.nhsconfed.org/publications/healthy-foundations-integrating-housing-part-mental-health-pathway

NHS Digital. (2023). *Out of Area Placements in Mental Health Services*. https://digital.nhs.uk/data-and-information/publications/statistical/out-of-area-placements-in-mental-health-services

NHS England. (2018a). *Improving physical healthcare for people living with severe mental illness (SMI) in primary care Guidance for CCGs*. https://www.england.nhs.uk/wp-content/uploads/2018/02/improving-physical-health-care-for-smi-in-primary-care.pdf

NHS England. (2018b). *Improving physical healthcare for people living with severe mental illness (SMI) in primary care Guidance for CCGs: Supporting Annexes*. https://www.england.nhs.uk/wp-content/uploads/2018/02/improving-physical-health-care-for-smi-in-primary-care-annexes.pdf

NHS England. (2022). *Who is considered a carer?* https://www.england.nhs.uk/commissioning/comm-carers/carers/

NHS England. (2023a). *A national framework for NHS – action on inclusion health*. https://www.england.nhs.uk/long-read/a-national-framework-for-nhs-action-on-inclusion-health/

NHS England. (2023b). *Acute inpatient mental health care for adults and older adults*.

NHS England. (2023c). *A&E Attendances and Emergency Admissions 2023-24*. https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/ae-attendances-and-emergency-admissions-2023-24/

NHS England. (2023d). *Implementing the early intervention in psychosis access and waiting time standard*. https://www.england.nhs.uk/wp-content/uploads/2023/03/B1954-implementing-the-early-intervention-in-psychosis-access-and-waiting-time-standard.pdf

NHS England. (2023e). *Implementing the early intervention in psychosis access and waiting time standard*. https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/04/eip-guidance.pdf

NHS England. (2023f). *Integrating mental health therapy into primary care*. https://www.england.nhs.uk/mental-health/adults/nhs-talking-therapies/integrating-mental-health-therapy-into-primary-care/

NHS England. (2023g). *NHS Long Term Workforce Plan*. https://www.england.nhs.uk/publication/nhs-long-term-workforce-plan/

NHS England. (2023h). *NHS mental health dashboard Q4 2022/23*. https://www.england.nhs.uk/publication/nhs-mental-health-dashboard/

NHS England. (2023i). *Social prescribing*. https://www.england.nhs.uk/personalisedcare/social-prescribing/

NHS, & National Collaborating Centre for Mental Health. (2019). *Adult Eating Disorders: Community, Inpatient and Intensive Day Patient Care: Guidance for commissioners and providers*. https://www.england.nhs.uk/wp-content/uploads/2019/08/aed-guidance.pdf

NICE. (2014). Psychosis and schizophrenia in adults: prevention and management. *Nice*, *February*.

NICE. (2022a). Depression in adults: treatment and management. In *NICE guideline [NG222]*. https://www.nice.org.uk/guidance/ng222

NICE. (2022b). *Tobacco: preventing uptake, promoting quitting and treating dependence*. https://www.nice.org.uk/guidance/ng209/chapter/Recommendations-on-treating-tobacco-dependence#support-to-stop-smoking-in-secondary-care-services

Nuffield Trust. (2023). *Hospital bed occupancy*. QualityWatch. https://www.nuffieldtrust.org.uk/resource/hospital-bed-occupancy

Osimo, E. F., Perry, B. I., Cardinal, R. N., Lynall, M. E., Lewis, J., Kudchadkar, A., Murray, G. K., Perez, J., Jones, P. B., & Khandaker, G. M. (2021). Inflammatory and cardiometabolic markers at presentation with first episode psychosis and long-term clinical outcomes: A longitudinal study using electronic health records. *Brain, Behavior, and Immunity*, *91*. https://doi.org/10.1016/j.bbi.2020.09.011

Perry, B. I., Osimo, E. F., Upthegrove, R., Mallikarjun, P. K., Yorke, J., Stochl, J., Perez, J., Zammit, S., Howes, O., Jones, P. B., & Khandaker, G. M. (2021). Development and external validation of the Psychosis Metabolic Risk Calculator (PsyMetRiC): a cardiometabolic risk prediction algorithm for young people with psychosis. *The Lancet Psychiatry*, *8*(7). https://doi.org/10.1016/S2215-0366(21)00114-0

Personalised Eating Disorder Support. (2023). *What does PEDS offer?* https://www.pedsupport.co.uk/about-us/what-does-peds-offer

Petrillo, M., & Bennett, M. (2021). *Valuing Carers 2021*. https://centreforcare.ac.uk/wp-content/uploads/2023/05/Valuing_Carers_WEB2.pdf

Pettitt, B., Greenhead, S., Drennan, V., Hart, T., Hogg, J., Borschmann, R., Mamo, E., & Moran, P. (2013). *At risk, yet dismissed*. https://www.mind.org.uk/media-a/4121/at-risk-yet-dismissed-report.pdf

Primary Care Networks - Overview. (2019). https://democracy.peterborough.gov.uk/documents/s39957/7.%20Appendix%201%20Primary%20Care%20Networks%20Overview.pdf

Public Health England. (2016). *Smokefree mental health services in England: Implementation document for providers of mental health services*. https://assets.publishing.service.gov.uk/media/5c6a9163ed915d4a3e826670/SF_MH_services_in_England__Guidance_for_Providers.pdf

Public Health England. (2019). *Guidance: Working age adults*. Mental Health and Wellbeing: JSNA Toolkit. https://www.gov.uk/government/publications/better-mental-health-jsna-toolkit/6-working-age-adults

Public Health England. (2021). *Severe mental illness (SMI): inequalities in cancer screening uptake report*. https://www.gov.uk/government/publications/severe-mental-illness-inequalities-in-cancer-screening-uptake/severe-mental-illness-smi-inequalities-in-cancer-screening-uptake-report

Ray, M. K., Lombardo, C., Syed, Z., Patel, N., Denman, C., & Jones, P. B. (2019). Embedding recovery to transform inpatient mental health care: The 333 model. *Psychiatric Services*, *70*(6). https://doi.org/10.1176/appi.ps.201800284

Rethink Mental Illness. (2023a). *Advocacy for mental health*. https://www.rethink.org/advice-and-information/rights-restrictions/rights-and-restrictions/advocacy-for-mental-health/

Rethink Mental Illness. (2023b). *Building community into the integrated care system*. https://www.rethink.org/media/6552/15631-rethink-mental-illness-report_final_spreads.pdf#%23

Roberts, K., Travers-Hill, E., Coker, S., Troup, J., Casey, S., Parkin, K., & Kim, Y. (2021). Brief psychological interventions for anxiety and depression in a secondary care adult mental health service: An evaluation. *Cognitive Behaviour Therapist*, *14*(5). https://doi.org/10.1017/S1754470X21000258

Robinson, S., & Jackson, C. (2022). Delivering effective, networked social prescribing services. In *Scottish Parliament Health and Sports Committee*. Mercer et al. https://healthinnovationeast.co.uk/wp-content/uploads/2023/03/20221130_d_desktop-review_branded-Social-prescribing.pdf

Robson, D., Yates, M., Craig, T. J. K., Healey, A., & McNeill, A. (2016). Time to smoke: Facilitating smoking breaks in mental health inpatient settings. *Nicotine and Tobacco Research*, *18*(8). https://doi.org/10.1093/ntr/ntw103

Royal College of General Practitioners. (2017). *Mental health in primary care*. https://www.rcgp.org.uk/representing-you/policy-areas/mental-health-in-primary-care

Royal College of Psychiatrists. (2013). *Liaison psychiatry for every acute hospital*. https://www.rcpsych.ac.uk/docs/default-source/members/faculties/liaison-psychiatry/cr183liaisonpsych-every-acute-hospital.pdf

Royal College of Psychiatrists. (2019a). *Mental health rehabilitation services*. https://www.rcpsych.ac.uk/mental-health/treatments-and-wellbeing/mental-health-rehabilitation-services

Royal College of Psychiatrists. (2019b). *Response from the Royal College of Psychiatrists: Exploring mental health inpatient capacity*. https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/policy/exploring-mental-health-inpatient-capacity-report---rcpsych-response-final-(002).pdf

Royal College of Psychiatrists. (2019c). *Standards for Inpatient Mental Health Services*. https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/ccqi-resources/rcpsych_standards_in_2019_lr.pdf

Sacre, M., Albert, R., & Hoe, J. (2022). What are the experiences and the perceptions of service users attending Emergency Department for a mental health crisis? A systematic review. In *International Journal of Mental Health Nursing* (Vol. 31, Issue 2). https://doi.org/10.1111/inm.12968

Samaritans. (2023). *Cambridge Samaritans* . https://www.samaritans.org/branches/cambridge/

Sanders, R. (2022). *Accommodation based support for adults with mental health conditions*. https://www.iriss.org.uk/sites/default/files/2022-11/esss_outline_-_accommodation_based_support_for_adults_with_mental_health_conditions.pdf

Solmi, M., Firth, J., Miola, A., Fornaro, M., Frison, E., Fusar-Poli, P., Dragioti, E., Shin, J. Il, Carvalho, A. F., Stubbs, B., Koyanagi, A., Kisely, S., & Correll, C. U. (2020). Disparities in cancer screening in people with mental illness across the world versus the general population: prevalence and comparative meta-analysis including 4 717 839 people. *The Lancet Psychiatry*, *7*(1). https://doi.org/10.1016/S2215-0366(19)30414-6

South, J., Bagnall, A. M., Stansfield, J. A., Southby, K. J., & Mehta, P. (2019). An evidence-based framework on community-centred approaches for health: England, UK. In *Health Promotion International* (Vol. 34, Issue 2). https://doi.org/10.1093/heapro/dax083

Swinson, E., Berkman, N., Brown, C., Gaynes, B., & Palmieri, W. (2016). Disparities within serious mental illness. *Agency for Healthcare Research and Quality*, *25*.

Syson-Nibbs, L. (2018). *Making screening more accessible for people with a severe mental illness*. https://phescreening.blog.gov.uk/2018/11/22/making-screening-more-accessible-for-people-with-a-severe-mental-illness/

Tanner, L., Kenny, R. P. W., Still, M., Ling, J., Pearson, F., Thompson, K., & Bhardwaj-Gosling, R. (2022). NHS Health Check programme: A rapid review update. In *BMJ Open* (Vol. 12, Issue 2). https://doi.org/10.1136/bmjopen-2021-052832

The King's Fund. (2023). *Social care in a nutshell*. https://www.kingsfund.org.uk/projects/nhs-in-a-nutshell/social-care-nutshell

The Nuffield Trust. (2023). *Follow-up care for people discharged from mental health inpatient care*. QualityWatch. https://www.nuffieldtrust.org.uk/resource/follow-up-care-for-adults-with-mental-health-problems

Tiffin, E. (2023). *What I have learned about embedding mental health practitioners in primary care*. NHS Confederation. https://www.nhsconfed.org/articles/what-i-have-learned-about-embedding-mental-health-practitioners-primary-care

Trevillion, K., Stuart, R., Ocloo, J., Broeckelmann, E., Jeffreys, S., Jeynes, T., Allen, D., Russell, J., Billings, J., Crawford, M. J., Dale, O., Haigh, R., Moran, P., McNicholas, S., Nicholls, V., Foye, U., Simpson, A., Lloyd-Evans, B., Johnson, S., & Oram, S. (2022). Service user perspectives of community mental health services for people with complex emotional needs: a co-produced qualitative interview study. *BMC Psychiatry*, *22*(1). https://doi.org/10.1186/s12888-021-03605-4

Trewin, M. (n.d.). *Why is social care so often invisible in mental health policy?* Centre for Mental Health . Retrieved November 30, 2023, from https://www.centreformentalhealth.org.uk/why-social-care-so-often-invisible-mental-health-policy/

Trueland, J. (2020). Increasing physical health check coverage for those with serious mental illness. *Health Service Journal*. https://www.hsj.co.uk/the-hsj-awards/increasing-physical-health-check-coverage-for-those-with-serious-mental-illness/7027139.article

Tyler, N., Wright, N., & Waring, J. (2019). Interventions to improve discharge from acute adult mental health inpatient care to the community: Systematic review and narrative synthesis. *BMC Health Services Research*, *19*(1). https://doi.org/10.1186/s12913-019-4658-0

Whiskey, E., Barnard, A., Oloyede, E., Dzahini, O., Taylor, D. M., & Shergill, S. S. (2021). An evaluation of the variation and underuse of clozapine in the United Kingdom. *Acta Psychiatrica Scandinavica*, *143*(4). https://doi.org/10.1111/acps.13280