Mental Health
in Cheshire East

The Annual Report
of the
Director of Public Health

2016

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Contents

Foreword

This Annual Report continues the theme of mental health that we started last year. Although it has adult mental health as its primary focus, we are also reporting on what has happened since the publication of last year's Public Health report "Supporting the Mental Health of Children and Young People".[1] We have included chapters on perinatal mental health and on children and young people's mental health, as well as describing some of the many national initiatives and reports in relation to this younger age group. One of these was the publication in November 2016 of the third and final report of the Education Policy Institute's Mental Health Commission – "Time to Deliver".[2] The Commission made several important policy recommendations, but we particularly want to highlight one of these:

> *"The practice of making a young person leave their support service on their 18th birthday must end. Young people should be able to choose when to transition up to the age of 25 with support from their therapists and parents or carers."*

This echoes a recommendation that we made in last year's Public Health report. It is timely to re-emphasise the importance of this as there is still much to be done to ensure that this is the case locally.

Over the last few years, close working arrangements have developed between the two Public Health teams at Cheshire East Council and Cheshire West and Chester Council. The teams have jointly carried out Cheshire-wide needs assessments on children and young people's mental health, and more recently on adult mental health. One of our colleagues in Cheshire West and Chester Council has completed a rapid literature review on adult mental health[3], and he has kindly given permission for us to use extracts from his work in this Annual Report. These extracts appear in Chapters Four and Five.

For perinatal mental health, we note that considerable investment is being put into some large-scale initiatives across Cheshire and Merseyside and the North West, but addressing the mental health needs of the majority of pregnant women remains a significant local need. We know that maintaining good mental health is as important as maintaining good physical health in pregnancy, yet there remains significant room for improvement in achieving "parity of esteem" in practice. Systems on the whole need to be more responsive to the needs of women.

It is important that we don't just follow historic models of thinking. Services can make the most of modern connectivity that can link women quickly to peer or professional support. Services can create further and new opportunities for sharing antenatal care more widely with midwives and empowering women to take greater control over determining the support that they may need during pregnancy.

Cheshire East Council has taken some important first steps towards creating a unified Parenting Journey, with clearly stated time points. However, much more work remains to be done to ensure that the Parenting Journey properly addresses the needs of women during pregnancy and capitalises upon key opportunities to improve their physical and mental health at this time. There is also clear evidence that not enough women are accessing the Journey during pregnancy, particularly at the

statutory contact at 28 weeks when the majority of women should have a face-to-face contact with their health visitor.

In Cheshire East, 19 out of every 20 women are seen by their health visitor following birth, but only 7 of those same women see the health visitor 12 weeks prior to birth. The Parenting Journey includes a contact at the Children's Centre on a fixed date just four weeks before birth. However, there are other opportunities earlier on in pregnancy to organise necessary support.

Most women will not require additional support to be organised through the Parenting Journey, but for those that do, the Journey could start earlier in their pregnancy. We are recommending that the addition of a new "Booking Stop" at between 10 to 16 weeks gestation, and the movement of the current "Stop 2" on the Cheshire East Parenting Journey to 32 weeks instead of the current 36 weeks gestation should be explored.

Later in the report, we again draw attention to the marked under-recording of moderate learning disability by schools in Cheshire East. Currently only 1.23% of pupils are recorded by local schools as having a moderate learning disability compared to 3.46% of all pupils in England. This under-recording has important consequences for the health of young people as they grow to adulthood.

We turn now to the second major set of findings in this Annual Report. In Chapter Seven we report on new evidence that suggests that the quality of care for people with serious mental illness is falling below what is being achieved in other areas of the country. Outcomes of care cannot be assessed for large numbers of people in Cheshire East who have a serious mental illness, either because they are excluded from quality monitoring processes in primary care, or because their specialist mental health services are not using the correct clinical codes to allow their outcomes to be monitored.

The use of clinical codes provides a bridge between the clinician who is caring for the patient and the commissioners who are monitoring the outcomes of that care. Where clinical codes are incomplete or inconsistently reported, it becomes more difficult for commissioners to understand needs at a population level, and patient groups cannot understand and challenge poor outcomes of care.

Several indicators can be used to assess outcomes of care in Cheshire East, and collectively these are suggesting that outcomes are on the whole worse than in other areas of the country. Another key piece of evidence that draws attention to the quality of care locally is that people in Cheshire East who have a serious mental illness have higher death rates than England, and that the gap in death rates between Cheshire East and England has remained wide for the last two years.

Overall, there is still much to be done to truly achieve "parity of esteem" for mental health in Cheshire East. As stated in The Five Year Forward View for Mental Health[4]:

> *"Mental health has not had the priority awarded to physical health, has been short of qualified staff and has been deprived of funds. We must provide equal status to mental and physical health, equal status to mental health staff and equal funding for mental health services as part of a triple approach to improve mental health care – a fresh mindset for mental health within the NHS and beyond."*

List of Recommendations

The following are a list of recommendations from within this report:

Chapter 3 (Progress on Perinatal Mental Health)

3.1 The North West Coast Strategic Clinical Network Perinatal Mental Health Working Group for Cheshire and Merseyside should consider how clinical pathways for specialist perinatal mental health community services in Cheshire East might support a mother's inpatient care to be provided in the Manchester Mother and Baby Unit (located at Wythenshawe Hospital) or the South Staffordshire and Shropshire Mother and Baby Unit (located in Stafford), depending on where she lives;

3.2 Improve cross-sector partnership working to identify and respond to gaps in peer support provision and capacity issues in meeting needs, share best practice and identify where consistent approaches across organisations would be beneficial;

3.3 Develop cross-sector pathways between providers of perinatal mental health support which facilitate women to access the right support at the right time for them;

3.4 Consideration should be given to adding a new "Booking Stop" to the Cheshire East Parenting Journey at between 10 to 16 weeks gestation;

3.5 Consideration should be given to moving the current "Stop 2" on the Cheshire East Parenting Journey to 32 weeks instead of the current 36 weeks gestation;

3.6 Local materials should be developed for women and their families to outline what they can expect to receive as part of the Healthy Child Programme, and the pathways they can choose to follow. These materials need to be developed quickly, and promoted very widely including to all women who are either pregnant or a planning a pregnancy;

3.7 Local Authority and CCG commissioners in Cheshire East should work closely together within the Local Maternity System to plan how and where the new maternity community hubs should be developed inside the borough.

Chapter 6 (Mental Health in People with Learning Disabilities)

6.1 Steps should be taken to improve the ongoing significant shortfall in recording pupils with moderate learning disability in secondary schools in Macclesfield, Congleton, Crewe and Wilmslow. Head Teachers should be asked to inform the general practitioner about any child or young person that the school identifies as having a learning disability.

Chapter 7 (Serious Mental Illness and Psychosis)

7.1 Commissioners of mental health services (CCGs, NHS England and local authority commissioners) should consider within their quality and performance function or equivalent, whether there is a systematic data coding issue with their local mental health providers for severe mental illness and take appropriate action;

7.2 Local commissioners and providers should consider the variations in the local CCG performance on serious mental illness compared with peer CCGs, using comparative approaches

such as RightCare to guide further enquiry.

Chapter 8 (Smoking and Mental Illness)

8.1 As the main commissioners of stop smoking services for Cheshire East, Public Health should work with the specialist stop smoking service to develop their approaches to meet the specific needs of individuals with different forms of mental illness. Performance measures should include the number and proportion of smokers with serious mental illness who are engaged with the service, and outcomes for this group;

8.2 Cheshire East should consider enhancing this service with further investment in order to increase the number of people with a mental illness receiving support and hence achieving an increase in the number of quits for this group of people;

8.3 Mental health services should ensure that a holistic approach is taken when assessing patients and reviewing their care plans. Lifestyle related behaviours such as physical activity, diet, alcohol use and tobacco are all crucial to ensuring that patients do not continue to be at increased risk of premature mortality due to risk factors that are preventable. The integrated approach to lifestyle services provided through One You Cheshire East must be made available to all those receiving mental health services;

8.4 All mental health service staff should continue to receive training in very brief advice as well as providing stop smoking support. Where possible, but especially within inpatient facilities, stop smoking support to patients should be integrated within mental health services. This stop smoking support should range from harm reduction measures such as provision of nicotine replacement therapy on admission, to structured behavioural support and pharmacotherapy for those who want to achieve abstinence;

8.5 All primary care professionals should assess all patients smoking status and offer very brief advice, using the free online training in Very Brief Advice. Smokers should be signposted to the appropriate service – community services (this includes those with low level mental illness) and specialist services for those with a severe mental illness.

Chapter 9 (Suicide and Self-harm)

9.1 As part of the new approaches to real-time suicide surveillance, the Cheshire East Public Health Intelligence Team should create a new Suicide Prevention Database that is directly accessible to the Cheshire East suicide lead and the Director of Public Health. The database should have defined processes to capture and collate the following information about suspected suicides:

- coroner-related information such as substances specified in self-poisoning deaths;
- contact with primary care services including reasons for the contact and frequency;
- demographic and family details such as age, gender, ethnicity and family structure;
- social, educational, occupational, residential and workplace characteristics;
- contacts with acute hospital services such as A&E attendance and inpatient admission;
- psychiatric history and psychological assessments.

Chapter One

New Guidance, Research, and Expert Resources for Mental Health

This chapter draws attention to relevant information and resources for local commissioners that have either recently been published or are due to be published in the near future.

Survey of the Mental Health of Children and Young People

The last national survey of the mental health of children and young people was carried out in 2004. A new survey is being carried out in 2017 and NHS Digital will report on the findings in 2018. This survey will update and extend our understanding of the prevalence of mental health conditions in children and young people in the general population. It is also finding out about issues that have become more common since the previous survey, including eating disorders, the impact of social media and cyberbullying.

The Department of Health is also looking at how to improve our understanding of the mental health of some vulnerable groups of children and young people, such as those who are cared for or voluntarily in care. It is likely that separate studies will be carried out for those groups.

Mental Health in Schools

In May 2016, the Institute for Public Policy Research published an independent report that highlighted a substantial level of variation in the availability and quality of school-based early intervention provision.[5] They suggested that this is due to four major barriers:

1. Schools' inability to access sufficient funding and resources;
2. A lack of established mechanisms by which schools can influence commissioning decisions taken by clinical commissioning groups. In the current school system, schools often lack the internal expertise they need to commission mental health support effectively;
3. The inconsistent quality of mental health support (particularly school counselling) available to schools to buy in directly. Schools often do not receive sufficient guarantees that the specialists they commission or purchase have suitable levels of training and experience;
4. An insufficient level of external checks on the appropriateness and quality of the professional support available in individual schools, with just one third of Ofsted reports making explicit reference to pupils' mental health and/or emotional wellbeing.

The independent social research agency NatCen has been commissioned by the Department for Education to carry out a study of mental health provision in schools across England. Their sample survey has already commenced and is covering a range of topics including:

- How each school identifies and provides for mental health needs;
- What support the school offers individual pupils with specific mental health needs;
- Activities in the school that promote good mental health;
- What it has been like to set up mental health provision in the school;
- Training for staff.

This research, which is likely to be published later in 2017, will provide new information about the types of mental health provision available to children and young people, how schools put this into practice and what the barriers are to supporting pupil's mental health needs. The Department for Education has indicated that the research will be used to inform future Government policy surrounding mental health provision in schools.

Adverse Childhood Experiences

There is emerging evidence of the importance of adverse childhood experiences (ACEs) in longer term health behaviours and outcomes. Increasing numbers of ACEs have been shown in recent research to be associated with lower life satisfaction and mental wellbeing[6]. Adverse childhood experiences are childhood stressors that can alter brain and biological development. They include physical, sexual or emotional abuse and neglect as well as indirect experiences such as witnessing abuse within the household.

There is furthermore an interactive relationship between mental health and domestic abuse. Those with mental health disorders or problems with substance misuse may be more vulnerable and having been subject to domestic abuse can increase the risk of mental health disorders, substance misuse, self-harm and suicide. Interventions aimed at breaking the ACE cycle are thus critical.

Government Response to the Five Year Forward View for Mental Health

The Government has recently published its response to the Mental Health Taskforce report "Implementing the Five Year Forward View for Mental Health"[7] and has accepted the Taskforce's recommendations in full [8]. In relation to children and young people, the Government is planning to take the following steps:

- Publishing a Green Paper on children and young people's mental health later in 2017;
- Supporting schools, colleges and local NHS services to work closely together to provide dedicated children and young people's mental health services;
- A programme of peer support for young people, testing the provision of well-trained mentors within a comprehensive support structure in schools, colleges and community settings;
- A programme testing three different approaches to mental health promotion and the prevention of mental health illness, to help schools decide which programmes are most effective for their pupils;
- Requesting that the Care Quality Commission undertakes an in depth thematic review of children and young people's mental health services in 2017/18.

Priorities for Mental Health Economic Report

This report provided an economic analysis of possible priorities for service improvement in mental health[9]. It was commissioned by NHS England as an input to the five-year strategy recently produced by the independent Mental Health Taskforce. The Centre for Mental Health found that there was a strong evidence base for a range of interventions in mental health which produce better outcomes

at lower cost. However, these are not always widely available or their effectiveness is reduced by poor implementation.

A key ingredient of any mental health strategy should therefore be to promote the wider adoption of best practice, as represented by the delivery of specific evidence-based interventions in line with national guidelines. The report examined nine possible areas for service improvement where there is good evidence of cost-effective interventions, with specific costed proposals. The nine areas can be grouped under three main headings.

Prevention and early intervention

- Identification and treatment of maternal depression and anxiety during the perinatal period;
- Treatment of conduct disorder in children up to age 10;
- Early intervention services for first-episode psychosis.

Better mental health care for people with physical health conditions

- Expanded provision of liaison psychiatry services in acute hospitals;
- Integrated physical and mental health care in the community for people with long-term physical health conditions and co-morbid mental health problems;
- Improved management of people with medically unexplained symptoms and related complex needs.

Improved services for people with severe mental illness

- Expanded provision of evidence-based supported employment services for people with severe mental illness;
- Community-based alternatives to acute inpatient care for people with severe mental illness at times of crisis;
- Interventions to improve the physical health of people with severe mental illness.

We covered the first two of these (maternal depression and anxiety, and treatment of conduct disorder in young children) in some detail in the 2015 Public Health Report, where we highlighted the considerable gains that can be achieved locally at low cost. [10]

Prevention Concordat Programme for Better Mental Health

As part of delivering the recommendations in the Five Year Forward View for Mental Health [2], Public Health England is working with partners to develop a Prevention Concordat Programme for Better Mental Health. This programme aims to:

- Galvanise local and national action around the prevention of mental illness;
- Facilitate every local area to put in place effective prevention planning arrangements led by Health and Wellbeing Boards, clinical commissioning groups and local authorities;
- Enable every area to use the best data available to plan and commission the right mix of provision to meet local needs.

The Prevention Concordat Programme is aimed at supporting all Health and Wellbeing Boards to put in place updated Joint Strategic Needs Assessments and joint prevention plans that include mental health and co-morbid alcohol and drug misuse, parenting programmes, and housing, by no later than 2017. The first resources include a rapid review of the evidence of what works [11]. Other resources will include a Mental Health Promotion and Prevention Return on Investment tool that will be published in the spring of 2017.

The Adult Psychiatric Morbidity Survey 2014

The Adult Psychiatric Morbidity Survey is carried out every seven years and provides data on the prevalence of treated and untreated psychiatric disorder in the English adult population aged 16 and over. The fourth survey was carried out in 2014 and the findings were published in September 2016 [12]. The report contains chapters on common mental disorders, mental health treatment and service use, post-traumatic stress disorder, psychotic disorder, autism, personality disorder, attention-deficit/hyperactivity disorder, bipolar disorder, alcohol, drugs, suicidal thoughts, suicide attempts and self-harm, and comorbidity.

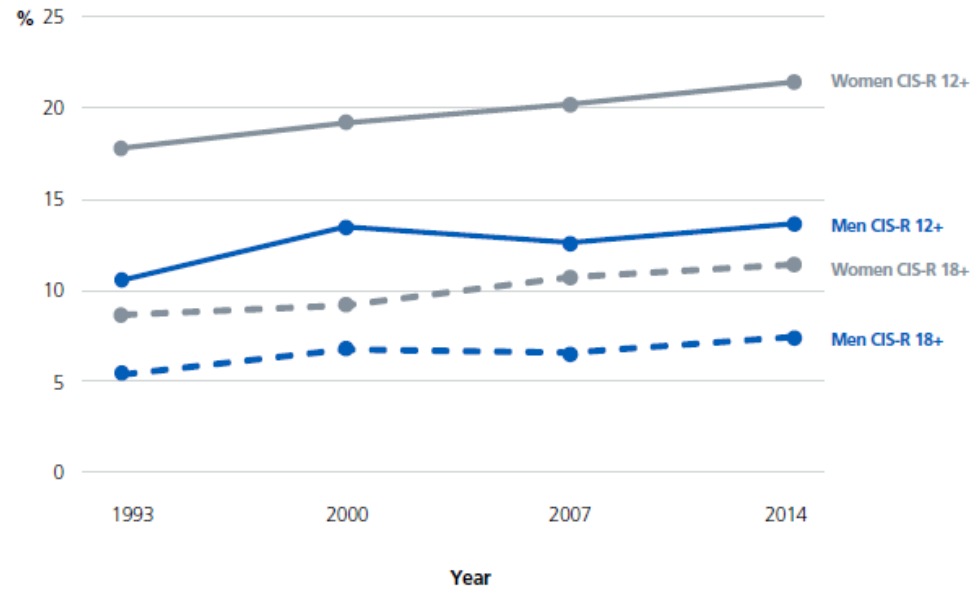
The report makes the observation that the following changes in the economy and models of mental health service delivery mean that the context of mental health has evolved since 2007. Although the survey cannot tell us whether these changes have impacted on mental health, it does provide a recent profile of mental health in England:

- Since the 2007 survey, society has experienced changes in technology and media and the onset of recession;
- Treatment services have undergone change, including the introduction of the Improving Access to Psychological Therapy (IAPT) programme;
- The cross-government strategy “No Health without Mental Health” has sought to mainstream mental health and give it parity with physical health.

Overall, one adult in six (17.0%) had a common mental disorder – about one woman in five (20.7%) and one man in eight (13.2%). Since 2000, rates of common mental disorder in England have steadily increased in women and remained largely stable in men. The presence of common mental disorder in the past week was assessed using the revised Clinical Interview Schedule (CIS-R). Disorders such as depression and generalised anxiety disorder (GAD) were identified, and a severity score produced. A score of 12 or more indicated symptoms warranting clinical recognition, a score of 18 or more is considered severe and requiring intervention. Women were also more likely than men to report severe symptoms.

CMD symptoms in past week (CIS-R score 12+ and 18+) by sex: 1993 to 2014

Base: adults aged 16–64



One in three adults aged 16-74 (37%) with a common mental disorder such as anxiety or depression reported current use of mental health treatment in 2014, an increase from the one in four (24%) who reported this in 2000 and 2007. This was driven by steep increases in reported use of psychotropic medication. Increased use of psychological therapies was also evident among people with more severe common mental disorder symptoms. Since 2007, people with common mental disorder have become more likely to use community services and more likely to discuss their mental health with a general practitioner.

Most common mental disorders were more common in people living alone, in poor physical health, and not employed. Claimants of Employment and Support Allowance (ESA), a benefit aimed at those unable to work due to poor health or disability, experienced particularly high rates of all the disorders assessed. Although poverty and unemployment tend to increase the duration of episodes of common mental disorder, it is not clear whether or not they cause the onset of an episode. Debt and financial strain are associated with depression and anxiety, and increasingly the evidence is suggestive of a causal association.

Young women have emerged as a high-risk group, with high rates of common mental disorder, self-harm, and positive screens for post-traumatic stress disorder and bipolar disorder. The gap between young women and young men has increased. This may be linked to increases in some of the known associations, including work stress and social isolation, being a member of some ethnic groups, physical and sexual abuse, and problems with alcohol and illicit drugs. There is an increasing understanding about how these risk factors act in in combination, and risk algorithms for predicting depression and anxiety disorders are already influencing prevention efforts in primary care.

In 2014, one in five 16 to 24 year old women reported having self-harmed at some point in her life when asked face-to-face and one in four reported this in the self-completion section of the survey.

Most of the young people who reported self-harming did not seek professional help afterwards. Individuals who start to self-harm when young might adopt the behaviour as a long-term strategy for coping; there is a risk that the behaviour will spread to others; and also that greater engagement with the behaviour may lead in time to a higher suicide rate.

Other disorders were rarer, for example psychotic disorder and autism each affected about one adult in a hundred. Bipolar disorder was covered for the first time in the survey series in 2014, the Mood Disorder Questionnaire identified traits in about one adult in fifty.

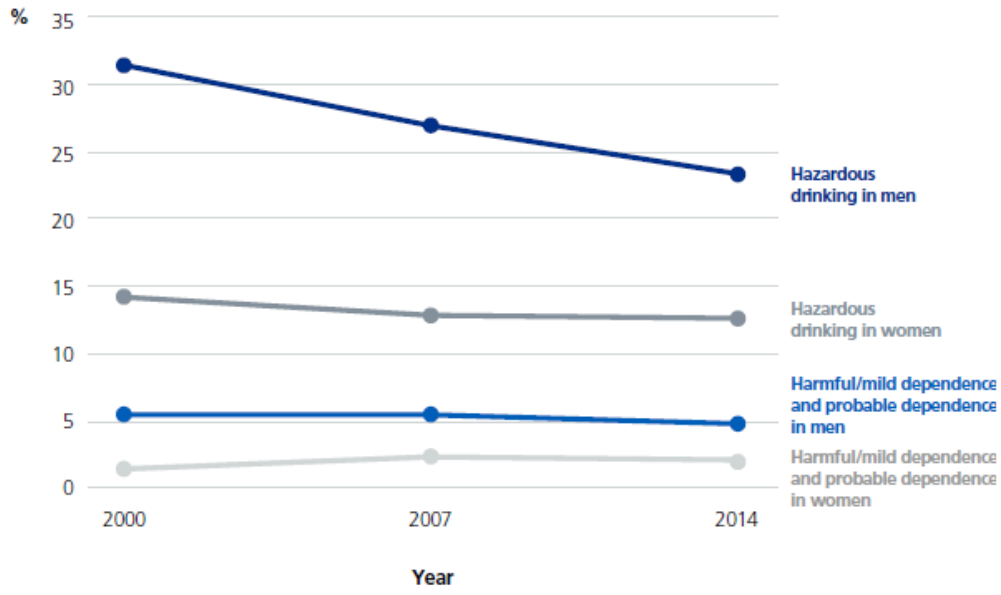
The data from the Adult Psychiatric Morbidity Survey was also used to examine comorbidity between physical and mental illnesses. The report focused on five chronic physical conditions: asthma, cancer, diabetes, epilepsy, and high blood pressure. All had some association with at least one mental disorder. Even sub-threshold levels of common mental disorder symptoms were associated with higher rates of chronic physical conditions.

Adult Psychiatric Morbidity Survey: Hazardous and Harmful Drinking

Signs of drug dependence were evident in one adult in thirty, with a similar level found for probable alcohol dependence (an AUDIT score of 16 or more). Both types of substance dependence were twice as likely in men as women. Since 2000, rates of hazardous drinking (AUDIT scores 8–15) declined in men and remained (at a lower level) stable in women. Levels of harmful or dependent drinking (AUDIT 16+) had not experienced a corresponding fall. When the survey findings were examined by age group, a decline in rates of harmful and probable dependent drinking since 2000 was clearly seen in young men, although such improvements are less evident in young women.

Hazardous and harmful/dependent drinking (AUDIT score 8+ and 16+) in past year by sex: 2000, 2007 and 2014

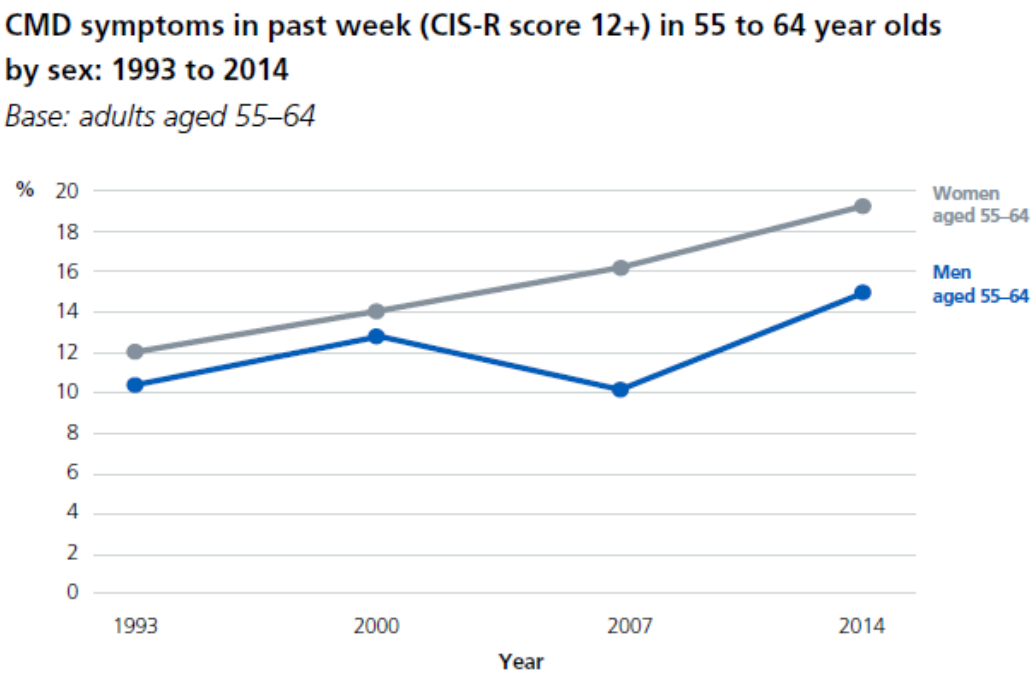
Base: adults aged 16–74



In contrast with the decline in rates of probable alcohol dependence in young men since 2000, there was no evidence of any decline in alcohol dependence rates in men and women aged 55 to 64.

Adult Psychiatric Morbidity Survey: Mental Illness in Late Midlife

Since 2007, there have been increases in common mental disorder symptoms in late midlife men and women (aged 55 to 64). This continued an upward trend in common mental disorder in midlife women since 1993 (the longer term trend in men is less clear). Like young people, those in late midlife had also seen a steep increase in rates of reported lifetime self-harm. Men in this age-group have the highest rates of registered suicide, and have been identified as a priority group in England's National Suicide Prevention Strategy.



Implementing the Five Year Forward View for Mental Health

This report provides the responses for the Taskforce recommendations made to NHS England, and is intended as a blueprint for the changes that NHS staff, organisations and other parts of the system can make to improve mental health. [13] It describes initiatives to better integrate physical and mental health services, develop specialist perinatal mental health services, test new approaches to delivering mental health care, and develop Liaison and Diversion services for people who may have mental health needs and find themselves in the court system or police services.

A Public Health Approach to Mental Health Improvement

This report on "Better Mental Health for All"[14] was commissioned from the Mental Health Foundation by the Faculty of Public Health and supported financially by Public Health England. It included a list of key actions that all professionals working in public health and beyond can take to promote mental wellbeing and prevent mental health problems:

- Whether you work in a specialised public health role or generalist/general work force, consider what you can do within your sphere of influence to advance the public's mental health as a leader, partner and advocate;
- Move, wherever possible, from deficit to strengths-based approaches and ensure you promote good mental wellbeing, address the factors that create mental wellbeing and tackle mental health problems;
- Adopt a proportionate universalism approach, including universal interventions to promote mental wellbeing across whole populations, with more progressively targeted interventions to address specific needs among more vulnerable and at risk groups;
- As part of the universal approach, ensure that you are working towards your own mental wellbeing and that of your colleagues;
- Move towards ensuring mental health receives the same billing and priority as physical health in your work;
- Adopt a life course approach. The foundations of mental health are laid down in infancy in the context of family relationships. Place-based intervention in settings such as schools, workplaces and communities complements the life course approach and makes the most of existing opportunities;
- Reduce stigma and discrimination by increasing mental health and wellbeing literacy across the whole population. Include interventions to improve understanding of the impact stigma and discrimination have on the lives of people with mental health problems;
- Contribute to the expansion of the public mental health evidence base and focus on the interventions and activities that make the biggest impact;
- Ensure that you build evaluation into everyday practice and monitor the effects of practice on mental health.

Chapter Two

Progress on Transforming Mental Health Services for Children and Young People

Children and young people's mental health has become a priority for partners across the NHS, public health, children's social care, youth justice and education sectors. The Cheshire East Children and Young People's Trust, CVS Cheshire East and Healthwatch Cheshire East are all closely involved.

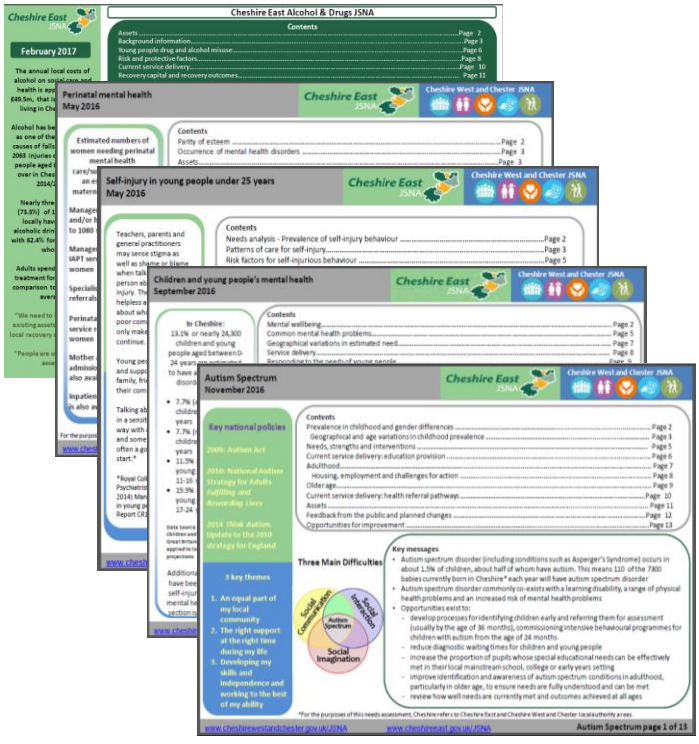
In this chapter we look at some of the work that has taken place locally during 2016, and the key features of the Local Transformation Plan, now in its second year of existence.

Joint Strategic Needs Assessment

The Children and Young People's Mental Health Joint Strategic Needs Assessment (JSNA) has been prepared as a partnership between Cheshire East Council and Cheshire West and Chester Council. Although the JSNA is a joint resource for both Health and Wellbeing Board areas, it presents information separately for the two local authorities and the four clinical commissioning groups.

The JSNA can be found at: http://www.cheshireeast.gov.uk/social_care_and_health/jsna/jsna.aspx and it currently includes five sections of particular relevance to children and young people:

- Perinatal mental health – May 2016;
- Self-injury in young people under 25 years – May 2016;
- Children and young people's mental health – September 2016;
- Autism spectrum – November 2016;
- Alcohol and drugs – February 2017.



In relation to children and young people's mental health, the main finding from the JSNA is that mental health services for young people in Cheshire are characterised by a complex system of provision, and care is being provided by NHS consultants from three very different specialities – Child and Adolescent Mental Health Services (CAMHS), Community Paediatrics, and Adult Psychiatry. True transformation will address the connectivity between these specialities and the other services that exist for children and young people who are experiencing mental health difficulties.

The JSNA also suggests that the key requirements to meet need are to reduce teenage referrals to specialist services, and then to restructure existing capacity to improve access for younger children.

Emotionally Healthy Schools

Some of the difficulties associated with improving mental health and mental wellbeing in school settings are already being tackled head-on through innovative work that is being carried out in Cheshire East. In 2015, the Director of Public Health allocated part of the ring-fenced public health budget to pump-prime an initiative to support the development of emotionally healthy schools. This drew in additional funding from NHS England and the Department for Education and led to two other linked schemes (Cheshire East's Vulnerable Children in Schools Project and the Child and Adolescent Mental Health Service and Schools Link Scheme) that together involved six secondary schools and fourteen out of thirty of their partner primary schools.

Phase 1 of the emotionally healthy schools programme was delivered in partnership by a number of CAMHS providers including Visyon, Just Drop In, the Children's Society, and Cheshire and Wirral Partnership NHS Foundation Trust. This included a CAMHS link role and the development of systems, approaches and tools to enable schools to improve their support to children with emotional health needs. The pilot was independently evaluated by Salford University and the findings have been used to develop an enhanced Phase 2 programme for wider delivery across Cheshire East. There are five main components to Phase 2 of the emotionally healthy schools programme:

1. access to specialist mental health advice (single point of access) and a brokerage model to support professionals working with children and young people (CYPMH Link Programme);
2. wider access to the tools "Tools for Schools" piloted in phase 1 and support to professionals to implement them;
3. education specialist leadership;
4. systems and processes to identify and support children and young people in the different Thrive groups (Vulnerable Children's Project);
5. development of the 'Getting Advice' quadrant of the Thrive model including an on-line platform.

Component 3 (Education specialist leadership) and Component 5 (Development of the 'Getting Advice' quadrant of the Thrive model) are currently in a co-production phase. Component 4 (Vulnerable Children's Project) has been extended to July 2017. Components 1 (the CYPMH Link Programme) and 2 (Tools for Schools) have already been commissioned by Cheshire East Council and began in January 2017. The key aims of these two programmes are:

Component 1 (CYPMH Link Programme):

- pathways, assessment and threshold development;
- mental health service consultation sessions;
- group facilitated reflection;
- training;
- liaison between schools, primary care and other providers.

Component 2 (Tools for Schools):

- develop leadership and management that supports and champions efforts to promote emotional health and wellbeing;
- support curriculum, teaching and learning to promote resilience and support social and emotional learning;
- enable the student voice to influence decisions;
- interventions to support staff development to support their own wellbeing and that of students;
- support identifying need and monitoring impact (e.g. tools to support whole school surveys of wellbeing – either anonymously or identifiable with consent);
- support working with parents and carers;
- support interventions linked to appropriate referral;
- support an ethos and environment that promotes respect and values diversity.

Cheshire East Children and Young People's Trust

In 2016, the Children and Young People's Trust updated its strategy for supporting children and young people's mental health to take account of the Local Transformation Plan, the local needs described in the JSNA, national guidance, and the emotionally healthy schools work referred to above. The updated "Supporting the Mental Health of Children & Young People Strategy (2016-2018)", which is part of the Children and Young People's Plan, can be found at:

http://www.cheshireeast.gov.uk/children_and_families/childrens_trust/childrens_trust.aspx

This new strategy contains six strategic priorities:

1. put front-line mental health care and support into every community;
2. support all women who experience anxiety and depression during pregnancy;
3. diagnose and treat young children with mental health problems during their second year of life;
4. improve awareness and support for young people with autism spectrum disorder and learning disability;
5. help teenagers to deal with the dark feelings that can lead to self-injury;
6. bring together all emotional health and wellbeing services for young people, possibly up to the age of 25.

A Children and Young Peoples Mental Health Strategy Group has been established to take forwards local work on these strategic priorities. The membership of this group includes Cheshire East Council

(Public Health and Children's Prevention leads), NHS Eastern Cheshire CCG, NHS South Cheshire CCG, CAMHS providers (Voluntary and Community Sector and Health) and School leaders.

The Children and Young Peoples Mental Health Strategy Group is also the accountable group for the delivery of the Local Transformation Plan and Phase 2 of the Emotionally Healthy Schools project.

Cheshire East Local Transformation Plan

The purpose of the Local Transformation Plan is to describe the full range of local actions for the prevention and care of mental health problems, ensuring that the most vulnerable are supported and that gaps between services and age transitions are reduced. The Plan should be:

1. **Transparent**: containing a full description of local needs assessments, the current and planned investments to meet those mental health and wellbeing needs; and declarations by local providers about the services that they already provide, including staff numbers, skills and roles, waiting times and access to information;
2. **Transformative**: clearly showing how all partners will collaborate with children and young people, and their families and schools, to improve mental health and wellbeing services so that they are locally accessible, responsive, appropriate to need, and outcome-focussed;
3. **Tracking change**: with auditable statements about achievement towards the aspirations set out in Future in Mind and the Children and Young People's Trust six strategic priorities.

The first annual update of the Local Transformation Plan was due in late 2016, but was delayed. In the refreshed Local Transformation Plan that was published in February 2017, the vision and ambitions for 2020 is described as having built on existing practice to ensure:-

- every young person in Cheshire East has access to a graduated and timely response to emotional health issues, ranging from maintaining a healthy mind to acute crisis;
- that Cheshire East has a joined up system that operates across the THRIVE Model and harnesses the capacity of the third sector;
- all Cheshire East educational settings are better equipped to support the Emotional Health of their populations working within the getting advice and getting help quadrants of the Thrive model;
- coordinated robust risk support for the most vulnerable between partners including youth justice;
- everyone in contact with children and young people feels equipped to actively support their mental health and wellbeing;
- that access to getting more help and risk support is available through local settings including primary, acute and specialist care, is timely, and based on clear pathways of care linked to different types of need;
- well informed commissioners with comprehensive intelligence about needs and provision who strive to co-produce with children, young people and their families leading to innovative, creative and responsive support across a range of services from primary to inpatient and secure settings.

Chapter Three

Progress on Perinatal Mental Health

Perinatal mental health problems are those which occur during pregnancy or in the first year following the birth of a child. They include mental health problems that arise for the first time, as well as problems that were present before the pregnancy began.

In Cheshire East around 3,800 women go through pregnancy each year. Up to 30% (1,100) will experience some form of minor or moderate mental health problem during their pregnancy, and around half of these women can be safely managed by their midwife and/or health visitor. The remainder can usually be managed by their GP or by a psychological therapies (IAPT) service. Serious perinatal mental health problems requiring referral to specialist perinatal mental health services are much less common, and affect around 3% (110) of pregnant women annually.

In last year's report we highlighted how promoting positive mental wellbeing among all pregnant women can help to reduce levels of anxiety and stress, and how this would protect the mental health of around 10-15% of babies during a critical period of brain development in the womb.

This chapter looks at some of the progress that has been made since last year and outlines some of the transformation work that remains to be completed in Cheshire East.

The Transformation of Perinatal Mental Health Care

This process is being led by a National Transformation Board that is filling gaps in the availability of Mother and Baby Units and the provision of specialist perinatal mental health community services. Locally, transformation changes are being led by a Working Group for Perinatal Mental Health that has been set up to cover the Cheshire and Merseyside Sustainability and Transformation Plan (STP) footprint.

NHS England is commissioning four new Mother and Baby Units nationally. One of these units will be built in Lancashire and Cumbria, and this will help to address the significant access issues that exist in the North West. This new unit will provide much needed inpatient mother and baby support for women who are experiencing severe mental health crisis including post-partum psychosis.

Although the new North West unit will help to improve access to this very specialist form of care, the STP Working Group for Perinatal Mental Health should consider how clinical pathways for specialist perinatal mental health community services in Cheshire East might support a mother's inpatient care to be provided in the Manchester Mother and Baby Unit (located at Wythenshawe Hospital) or the South Staffordshire and Shropshire Mother and Baby Unit (located in Stafford), depending on where she lives. Both of these units are geographically convenient to women in Cheshire East.

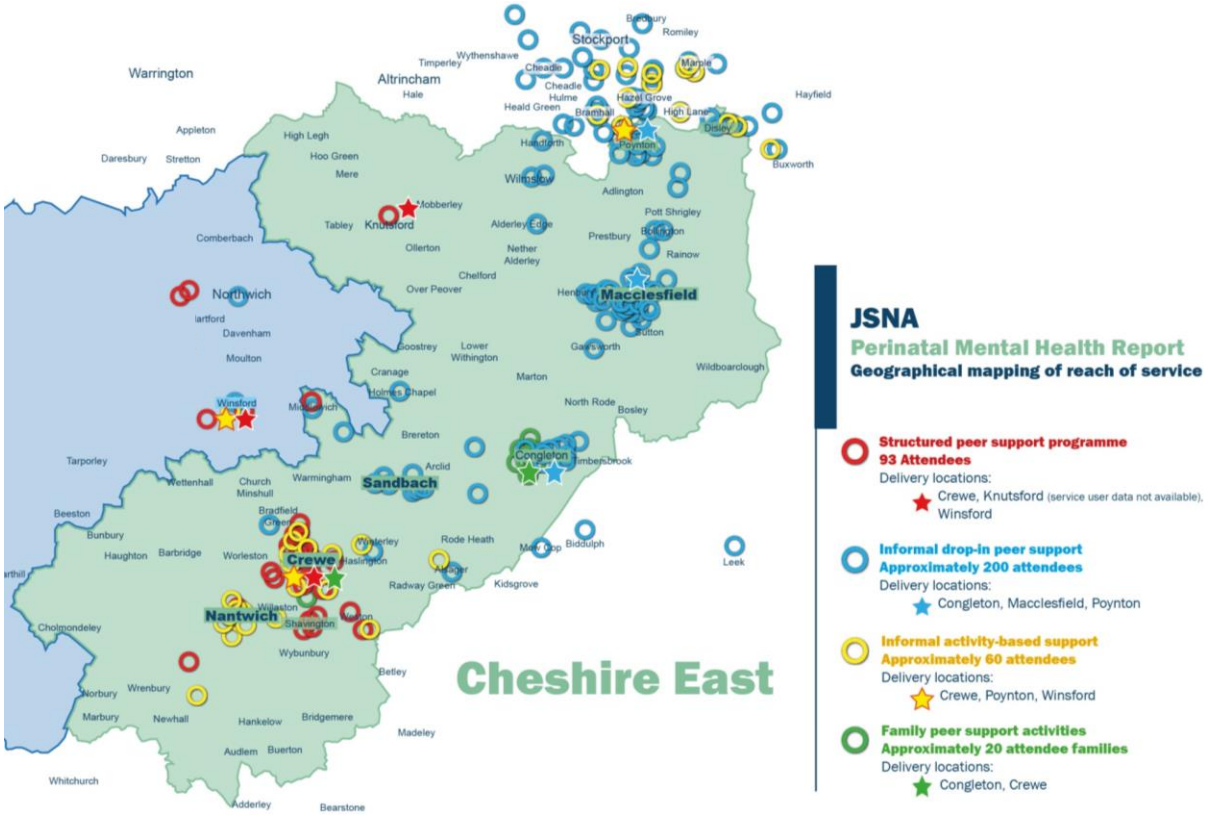
NHS England has also established a Perinatal Community Services Development Fund and has awarded £3.3m to Cheshire and Merseyside Sustainability and Transformation Plan (STP) to develop community perinatal mental health services. This money will be used to develop a Specialist Perinatal Community Mental Health Service which will be delivered through three locality teams across Cheshire and Merseyside. These teams, provided by Cheshire and Wirral Partnership, 5

Boroughs Partnership and Mersey Care NHS Foundation Trusts, will support women with serious mental health problems during pregnancy and in the first year after birth."

Supporting Maternal Mental Health

In last year's Public Health Report we identified that if we want the best outcomes for our children we need to provide the best possible emotional care for pregnant women. Although very common, anxiety and depression in pregnant women goes largely undetected and untreated. A wide range of circumstances can cause stress, anxiety and depression, including a poor relationship with the partner. Appropriate personalised help and support should be available to every woman.

In their recent Community JSNA report on Perinatal Mental Health, Cheshire East CVS looked at the needs and usage of peer support services for pregnant women in Cheshire East[15]. They identified four local service providers, three from the Voluntary, Community and Faith Sector (VCFS) – "Motherwell CIC", "SMILE" and "Poynton Pandas", and one public service provider – Wirral Community NHS Trust, whose health visitors run "Lavender Groups". The distribution of service contacts is shown in the map.



The key findings from this Community JSNA report include:

- The groups offer a range of services including: structured peer support programmes; informal drop-in peer support sessions; informal activity-based support and family support activities and events (including We Are Family Motherwell sessions for lesbian, gay, bisexual, and transgender parents);

- All of the VCFS groups can be accessed by self-referral or professional referral;
- There is a predominance of structured peer support in the south of the borough with a lack of informal drop-in peer support;
- Poynton PANDAS attracts many service users from outside the borough;
- The SMILE Group will be providing a new informal drop-in peer support group in Sandbach;
- Motherwell CIC also have experience, with their 6 week programme, of supporting mums who have had children removed.

Some of the main characteristics of the peer support services in Cheshire East are illustrated in the table. Mums tend to 'journey' through the menu of services as their need for support changes over time. A number of the mums have stayed on with groups who provide informal drop-in sessions as peer supporters themselves, and are trained by the groups (these positions are either voluntary or paid, but all are provided with training).

Some of the characteristics of peer support services in Cheshire East				
	SMILE	Poynton PANDAs	Motherwell	Lavender
Delivery location	Children's Centres	Church Hall	Lifestyle Centre	Children's Centre
Peer support groups	weekly, all year	weekly, term time	6-week programme	6-week programme
One-to-one support	yes	no	yes	no
Online support	no	yes	no	no
Can drop-in with friends/relatives	yes	yes	no	no
Method of referral	self-referral or by a professional	self-referral or by a professional	self-referral or by a professional	only referral by a Health Visitor
Quality assurance	yes	yes	yes	yes
Outcomes measurement	CORE10	no specific mechanisms	GAD	EPND/GAD
Community JSNA report on Perinatal Mental Health, Cheshire East CVS				

This Community JSNA illustrates that there are inconsistencies in the level of peer and professional support for women in Cheshire East. Peer support groups are not yet in place in all areas although some developments are underway. Programmed approaches to treatment such as the Lavender groups will not meet the immediate needs of many women as the scheduling may lead to time delays before women can start attending a group. These groups should therefore form part of a broad range of peer support rather than being the primary service offer. In developing future provision, there is a need to understand the capacity of all peer support providers to deal with current and future levels of demand. Cross-sector pathways could then be developed which facilitate women to access the right support at the right time for them. There are also opportunities, through improved partnership working, to share best practice and identify where consistent approaches across organisations would be beneficial.

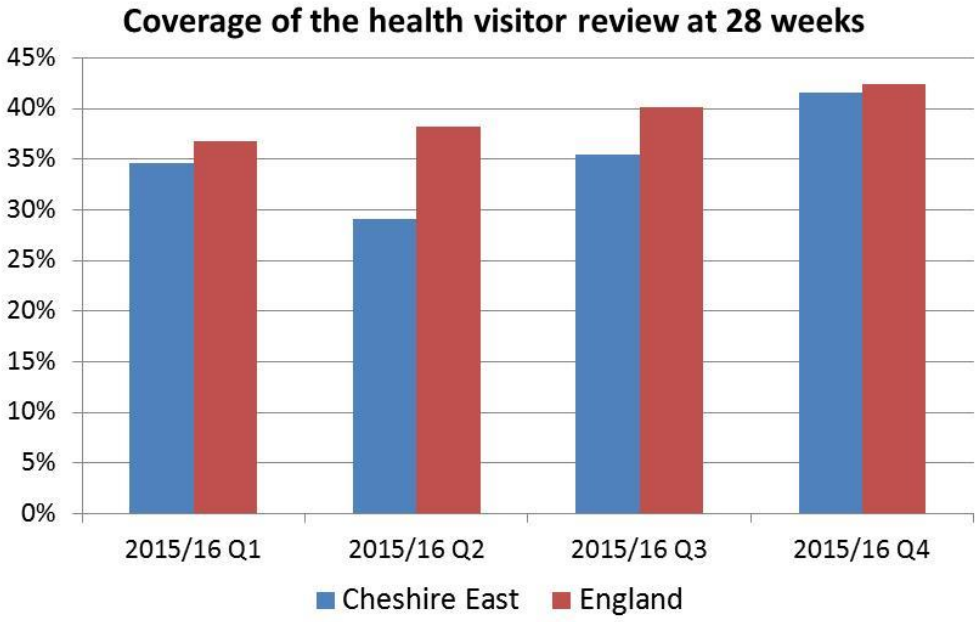
The Universal Health Visitor Review at 28 Weeks

Cheshire East Council must ensure that universal health visitor reviews are offered to pregnant women and young children at specified stages in their development.[16] The details of these health

and development reviews are set out in the Healthy Child Programme.[17] The review is generally carried out by a health visitor although it may be delegated to a suitably qualified health professional or nursery nurse, or a family nurse within the Family Nurse Partnership. The 28 week review cannot be carried out as an activity that is offered to a group of pregnant women.

One of the universal health visitor reviews is offered during pregnancy to women who are more than 28 weeks pregnant. The review should be offered to all women and not just those who are booked to deliver in the two local maternity units. In 2015, 83.2% women from Cheshire East (3,177 out of 3,818) delivered their baby in a maternity unit inside the borough, and 90 (2.3%) women delivered at home. This suggests that over 85% of pregnant women received their antenatal and intrapartum care from midwives locally. 6.5% and 2.7% of women delivered at Wythenshawe and Stepping Hill hospitals, and 1.8% each at Royal Stoke and St Mary's hospitals.

Although the number of pregnant women who receive a first face-to-face antenatal contact with a health visitor is collected every quarter, coverage rates are not normally calculated due to the difficulties in defining the denominator. As the review is usually offered at 28 weeks, which is three months before the expected birth date, coverage can be estimated using the number of births that take place in the following quarter.



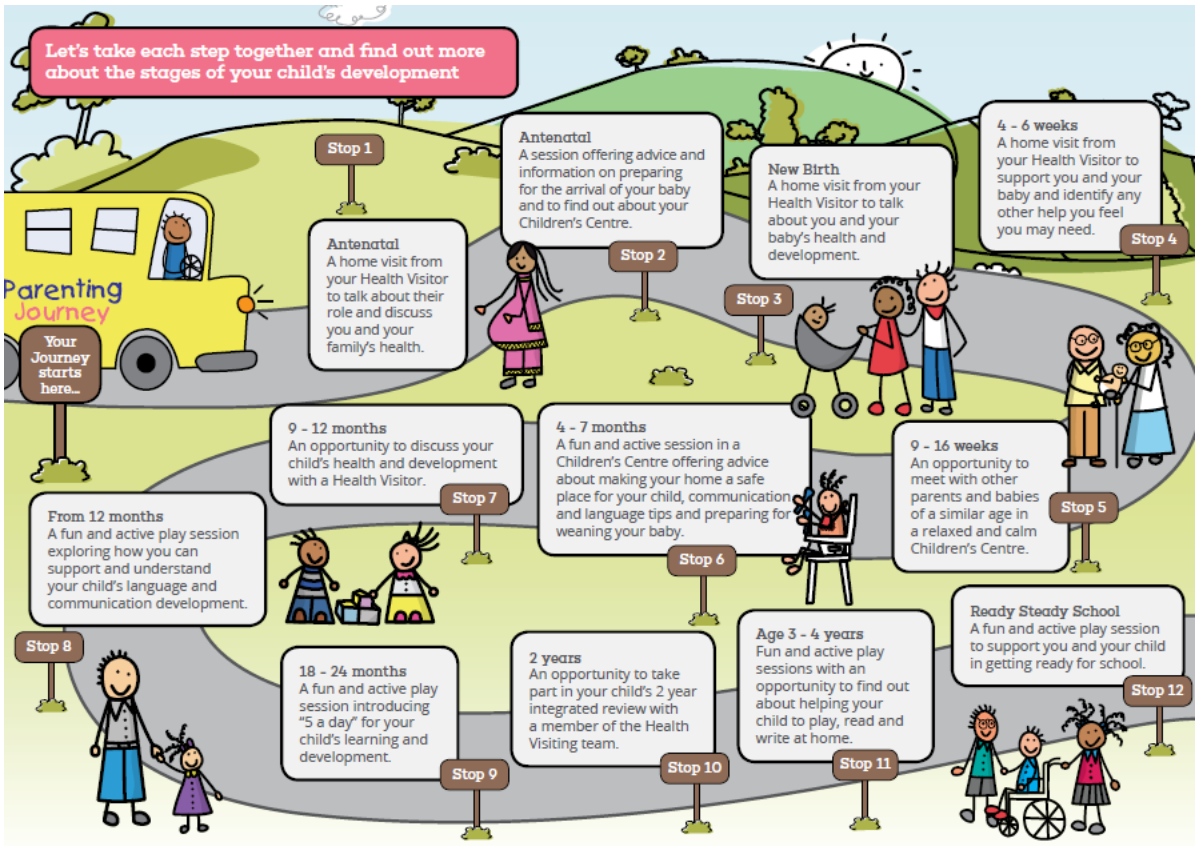
This chart and Appendix B illustrate recent trends in the number and proportion of the 28 week reviews. In Cheshire East there are variations from quarter to quarter, and coverage has fallen markedly in the first two quarters of 2016/17, although this may be a data quality issue. This is quite different to what is happening in England, where the rates for the four quarters of 2015/16 (calculated using the same approach) are 36.8%, 38.2%, 40.2% and 42.5% - i.e. increasing by a relatively steady 2% each quarter. Cheshire East's rate for the whole of 2015/16 was just 35.1%, compared to 40.3% in Cheshire West and Chester and 69.2% in Wirral.

The Cheshire East Parenting Journey

Cheshire East has created an integrated Parenting Journey that runs until the child starts school. This work has led to co-location of healthy child services (health visitors and school nursing services) in Children's Centres, and new joint working arrangements for groups of staff.

The Cheshire East Parenting Journey currently starts at 28 weeks (70% of the way through pregnancy) with the antenatal visit from the health visitor. This is termed Stop 1 and it allows the health visitor "to talk about their role and discuss you and your family's health". This particular contact with the pregnant woman is a statutory requirement under current legislation.

The second contact in the Cheshire East Parenting Journey (Stop 2) occurs at 36 weeks (90% of the way through pregnancy) when the woman is invited to come to the local Children's Centre to "prepare for the arrival of your baby and find out about your Children's Centre". Heavily pregnant women may choose not to take up this offer and it may be of limited benefit (with respect to modifying any lifestyle or environmental factors that could impact on the outcome of the pregnancy) so late in the pregnancy. For this reason, we think that the timing of this 'stop' could be reviewed.



In both of the last two Public Health Reports, we have drawn attention to the critical importance of early pregnancy to the physical and mental development of a child, and we have recommended that Children's Centres should become a resource for parents at all stages of pregnancy, including:

> *(2014) Preconception care can reduce the number of babies who are exposed to risks during the earliest stages of their development, particularly from alcohol and smoking. There should be access to preconception advice for second and subsequent pregnancies from health*

visitors. Children's centres should help and support couples to receive alcohol counselling and advice, smoking cessation services and signpost to weight reduction if needed.

(2014) As children's centres become established as part of the antenatal pathway, they need an agreed approach to enable them to respond to midwives' and health visitors' assessment of which families and children are most able to benefit from support to improve their health, including those that have newly moved to the area. Children's centres must agree methods to track the outcomes that are achieved amongst these children.

(2015) The universal health visitor review during pregnancy should also include an offer of practical help with any relationship problems that the pregnant woman may be experiencing, a discussion about any additional social support that she might need, and practical help with any housing issues or worries.

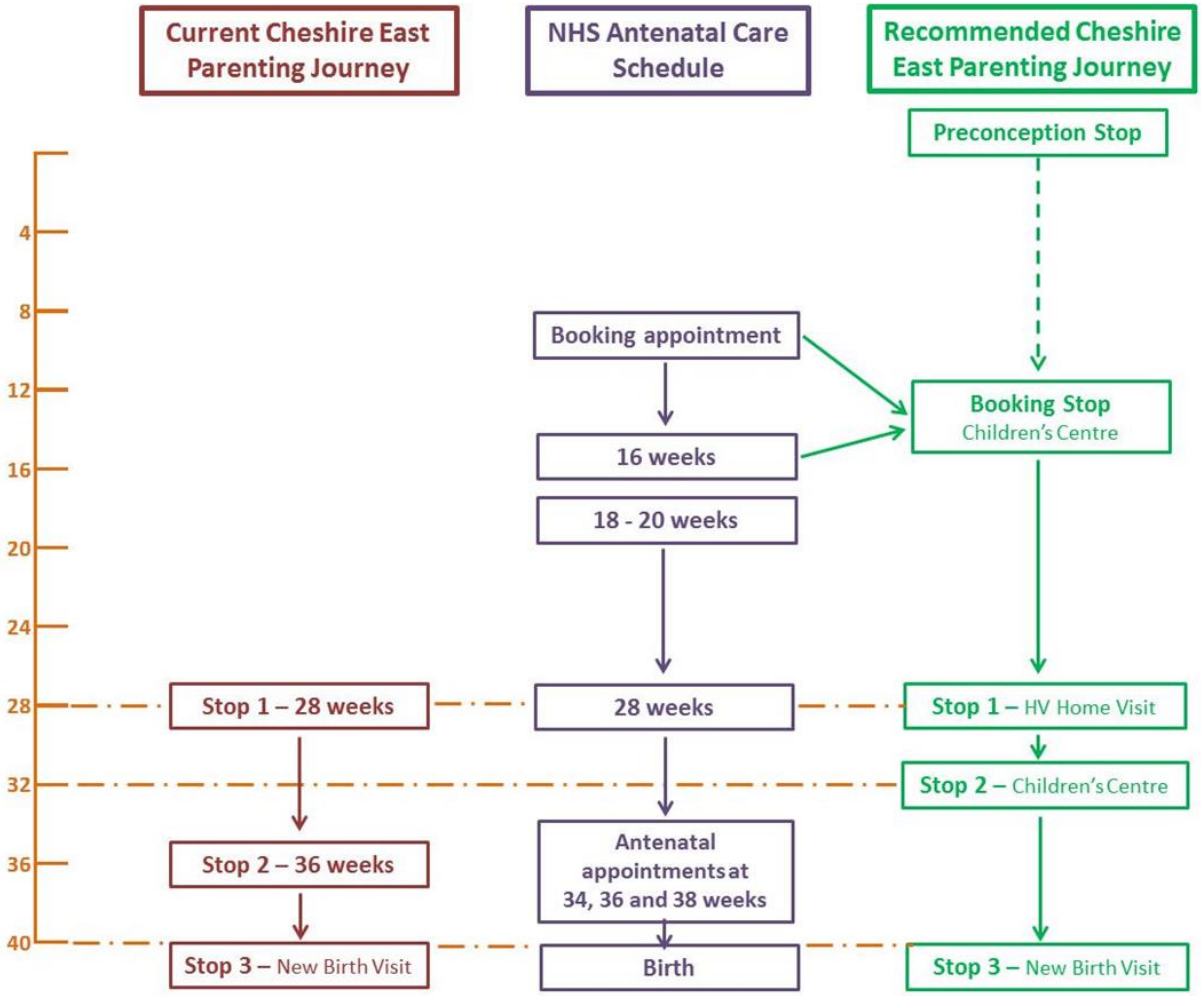
It may be that some professionals have concerns about starting the Cheshire East Parenting Journey too early because they believe that a higher proportion of pregnancies may be non-viable before 28 weeks compared to later on in gestation. They may be worried about recruiting a woman onto a journey that may not continue should she miscarry. Research indicates that rates of miscarriage (of a recognised pregnancy) are highest before about 11 weeks of pregnancy. After this time the miscarriage rate declines quickly and it stays at a low rate from about 16 weeks onwards, although the risk of stillbirth does increase in late pregnancy. When risk of miscarriage is considered from the stage of ultrasound at 7 to 10 weeks, and those pregnancies that have been considered unlikely to survive due to fetal abnormalities are excluded, the overall rate of pregnancy loss is thought to be as low as 2 to 3 per cent.

As a woman's risk of pregnancy loss declines significantly after the 11 week stage, it may be reasonable to identify the start of the Cheshire East Parenting Journey to be either after a woman has her booking appointment, which usually happens at around 10 weeks into a pregnancy, or to start her Parenting Journey following the 16 week appointment with her midwife, which is a time when women are being prepared by their midwife for their parenting role by providing more information and encouraging attendance at antenatal classes.

In either case the decision to commence on the Cheshire East Parenting Journey should be taken by the woman herself in conjunction with her midwife and health visitor. If she begins her Parenting Journey earlier in pregnancy, she may wish to be offered a choice of appointments at the Children's Centre so that she can attend on days and times that are convenient for her.

Those women who do miscarry are likely to have greater needs for advice and support in their next pregnancy, and they are probably **more** likely to want to participate in a Parenting Journey that is reframed to start from preconception onwards (i.e. the first 2014 recommendation shown above).

The current Parenting Journey could also be better connected to a woman's antenatal care pathway, particularly given that in some areas the NHS Antenatal Care pathway is already being delivered within Children's Centres.



For the many reasons outlined above, we are recommending that the addition of a new "Booking Stop" in the Cheshire East Parenting Journey at 10-16 weeks depending on when the midwife notifies the staff in the Healthy Child Programme about prospective parents requiring additional early intervention and prevention (as listed in the box at the end of this chapter) should be explored. Pregnant women should also be able to refer themselves to this "Booking Stop" if they have other needs. This new "Booking Stop", which should take place at a Children's Centre, will be a key opportunity for Health Visitors and Children's Centre staff to assess these families' needs.

We also recommend exploring the movement of the current Stop 2 on the Parenting Journey earlier to 32 weeks (or 34 weeks if it is carried out during the same visit as the 34-week antenatal care appointment) instead of the current 36 weeks. This would allow much more effective support to be put in place for those women whose needs arise later on in their pregnancy.

Healthy Child Programme: Pregnancy and the first five years of life

At this juncture, it is worth reminding ourselves about the Best Practice Guidance for the Healthy Child Programme that was originally set out in 2009 by the Department of Health and the then Department for Children, Schools and Families (predecessor to the Department for Education).[17] This

Best Practice Guidance was specifically referenced in the new Public Health Regulations that came into force on 1st October 2015.[16] Regulation 5A(5) states:

> *(5) In this regulation, "the Healthy Child Programme" means the programme of that name, described in a policy guidance paper published by the Department of Health on 27th October 2009(b), that—*
>
> *(a) is intended for the benefit of pregnant women, children aged under five years and the families of such pregnant women and children;*
>
> *(b) provides for health and development assessments and reviews, screening tests, immunisations and health promotion guidance and support tailored to the needs of the pregnant woman, child, or their family at specified stages of development of the pregnant woman or child; and*
>
> *(c) assists the identification of families in need of additional health or well-being support and children who are at risk of suffering poor health or well-being.*

The following introductory paragraph in the Foreword for the Healthy Child Programme, written in 2009 by Dr Sheila Shribman, National Clinical Director for Children, Young People and Maternity Services, is as relevant today as it was then.[17] Her advice requires very little in the way of update or modification:

> *"This is a critical moment in the development of the Healthy Child Programme. The advances taking place in neuroscience and genetics – and our understanding of how early childhood development can be both promoted and damaged – create an imperative for the Healthy Child Programme to begin in early pregnancy. At the same time, the development of Sure Start children's centres gives us an opportunity to make more of a difference to children – across a wider set of outcomes – than we have been able to in the past."*

The following are some of the core requirements of the Healthy Child Programme **for women up to 28 weeks gestation** (fuller details in Appendix C). There are **other requirements after 28 weeks gestation**. The national Healthy Child Programme policy guidance paper provides a clear blueprint for developing the detailed content of the antenatal stage of the Cheshire East Parenting Journey:

- ***Promotion of health and wellbeing****, including a full health and social care assessment of needs, risks and choices by 12 weeks of pregnancy by a midwife or maternity healthcare professional, with notification to the Healthy Child Programme team of prospective parents requiring additional early intervention and prevention;*
- ***Promotion of health and wellbeing****, including introduction to resources, including Sure Start children's centres, Family Information Services, primary healthcare teams, and benefits and housing advice;*
- ***Preparation for parenthood****, including information on services and choices, maternal/paternal rights and benefit, and social support using group-based antenatal classes in community or healthcare settings that respond to the priorities of parents;*

- ***Women experiencing domestic abuse.*** *Women are at increased risk of domestic abuse during pregnancy, and this should be identified as part of the Healthy Child Programme (see the box on page 32). Interventions include information, advice and support from the Cheshire East Domestic Abuse Hub;*

- ***Women with ambivalence about pregnancy, low self-esteem and relationship problems,*** *including techniques to promote a trusting relationship and develop problem-solving abilities within the family;*

- ***Women experiencing anxiety or depression,*** *including interventions ranging from social support, assisted self-help, brief non-directive counselling or referral for treatment;*

- ***Women who smoke, or who are overweight or obese,*** *including smoking cessation interventions or weight control strategies.*

Apart from the figure on page 26, demonstrating the Cheshire East Parenting Journey, there are no other materials available for women and their families that outline what they can expect to receive as part of the Healthy Child Programme, and the pathways they can choose to follow. These materials should be developed quickly, and promoted very widely including to all women who are either pregnant or are planning a pregnancy.

New Community Hubs for Personalised Maternity Care

A major redesign of maternity care is currently taking place in the NHS. The Cheshire and Merseyside Women's and Children's Partnership (an acute care collaboration vanguard set up by NHS England to link local hospitals together to improve their clinical and financial viability and reduce variation in care and efficiency) is working as an Early Adopter to implement the recommendations of the 2016 National Maternity Review: *Better Births*. This Partnership will be the delivery vehicle for the establishment of a single Local Maternity System (LMS) for Cheshire and Merseyside.

A local maternity system aims to ensure that women, their babies and their families have equitable access to the services they choose and need, as close to home as possible. To achieve this, the Cheshire and Merseyside Women's and Children's Partnership intends to bring together all providers involved in the delivery of maternity and neonatal care, develop a local vision for improved maternity services based on the principles of Better Births, co-design services with service users and local communities, and put in place the infrastructure needed to support services working together.

At the present time, the plans of the Cheshire and Merseyside Women's and Children's Partnership are highly focused on the NHS and do not fully consider the other stakeholders who are also working to achieve gains in maternal and newborn health. For example, the Partnership is intending to measure success by measuring improvements in the four maternity-related CCG outcomes (neonatal mortality and stillbirths, maternal smoking at time of delivery, women's experience of maternity services, and choice in maternity services). The Partnership does not appear to be considering other Outcomes Frameworks including the Public Health Outcomes Framework (low birth weight of term babies, breastfeeding initiation and prevalence, under-18 conceptions, pregnancy and newborn screening, and infant mortality).

One of the important recommendations of the National Maternity Review is that personalised maternity care should be delivered in local "community hubs" to help women to access care in the community from their midwife and a range of other agencies:

> *(Better Births 2016) Community hubs should be established, where maternity services, particularly ante- and postnatally, are provided alongside other family-orientated health and social services provided by statutory and voluntary agencies. Community hubs should work closely with their obstetric and neonatal unit(s).*

The concept of a maternity community hub is that it is a local centre where women can access various elements of their maternity care. *Better Births*[18] suggests that a community hub could be located in a children's centre, or in a freestanding midwifery unit, or be embedded in new at-scale models of primary care. Different providers of care can work from a community hub, offering midwifery, obstetric and other services that are easily accessible for women. Small teams of 4 to 6 midwives who are based in the community will become part of the core workforce of each community hub.

Other services based in maternity community hubs might be ultrasound services, voluntary services providing peer support for perinatal mental health, and smoking cessation services in some areas. Women will be able to meet and get to know the Early Years workers who will become more involved with them after childbirth. In some community hubs there may be birthing facilities. These community hubs will also need to provide timely access to personalised advice on smoking, alcohol, immunisation, breastfeeding and nutrition for every woman and her family **before, during and after** her pregnancy, which fits well with the Cheshire East Parenting Journey outlined above.

It is evident from the above that the development of maternity community hubs in Cheshire East will have considerable implications for the future development and co-location of the NHS, Local Authority, Voluntary Sector and Private Sector workforces. This means that Local Authority and CCG commissioners will need to work closely together within the Local Maternity System to plan how and where the new maternity community hubs should be developed inside the borough.

Properly designed maternity community hubs will become valued facilities for the local community and, as *Better Births* suggests, will lead to fuller integration of the family-orientated health and social services provided by statutory and voluntary agencies. Under Cheshire East's Local Plan, many towns in the Borough will be experiencing sustained population growth through new housing developments, which will attract more young families and drive up fertility rates. Over time, maternity community hubs sited in these towns will become more cost-effective because of this increased throughput.

Recommendations

3.1 The North West Coast Strategic Clinical Network Perinatal Mental Health Working Group for Cheshire and Merseyside should consider how clinical pathways for specialist perinatal mental health community services in Cheshire East might support a mother's inpatient care to be provided in the Manchester Mother and Baby Unit (located at Wythenshawe Hospital) or the South Staffordshire and Shropshire Mother and Baby Unit (located in Stafford), depending on where she lives;

3.2 Improve cross-sector partnership working to identify and respond to gaps in peer support provision and share best practice;

3.3 Develop cross-sector pathways between providers of perinatal mental health support which facilitate women to access the right support at the right time for them;

3.4 Consideration should be given to adding a new "Booking Stop" to the Cheshire East Parenting Journey at between 10 to 16 weeks gestation;

3.5 Consideration should be given to moving the current "Stop 2" on the Cheshire East Parenting Journey to 32 weeks instead of the current 36 weeks gestation;

3.6 Local materials should be developed for women and their families to outline what they can expect to receive as part of the Healthy Child Programme, and the pathways they can choose to follow. These materials need to be developed quickly, and promoted very widely including to all women who are either pregnant or a planning a pregnancy;

3.7 Local Authority and CCG commissioners in Cheshire East should work closely together within the Local Maternity System to plan how and where the new maternity community hubs should be developed inside the borough.

Early identification of need and risk

(Taken from page 17 of the Healthy Child Programme report)

It can be difficult to identify risks early in pregnancy, especially in first pregnancies, as often little is known about the experience and abilities of the parents, and the characteristics of the child. Useful predictors during pregnancy include:

- young parenthood, which is linked to poor socio-economic and educational circumstances;
- educational problems – parents with few or no qualifications, non-attendance or learning difficulties;
- parents who are not in education, employment or training;
- families who are living in poverty;
- families who are living in unsatisfactory accommodation;
- parents with mental health problems;
- unstable partner relationships;
- intimate partner abuse;
- parents with a history of anti-social or offending behaviour;
- families with low social capital;
- ambivalence about becoming a parent;
- stress in pregnancy;
- low self-esteem or low self-reliance; and
- a history of abuse, mental illness or alcoholism in the mother's own family.

Chapter Four

Aspects of Common Mental Illnesses

This section gives a brief overview of common mental illnesses including aspects of presentation and current treatments. The section is by no means comprehensive and it gives an indication of what is current and the most recent literature in specific areas.[19]

Anxiety Disorder

Previous evidence has demonstrated that general practitioners (GPs) fail to diagnose up to half of common mental disorders. A meta-analysis of 34,902 patients indicated that anxiety is no exception. The study showed that GPs' diagnostic accuracy increased from 30.5% to 63.6% when "assisted" i.e. using severity scales/instruments/diagnostic techniques.[20] In other words, without the use of this technique, GPs are picking up less than a third of cases. Use of these tools might improve detection of anxiety disorders in primary care.

A large systematic review (163,366 persons) published in 2014 concluded that various socio-demographic, psychosocial and mental – physical health risk factors are determinants of the onset of both panic and generalised anxiety disorders in the adult population. Specifically, these risk factors are age, female, few economic resources, smoking and alcohol problems for panic disorder and for anxiety the associated risk factors are age, divorce, widowed and few economic resources. The findings indicate possible areas for preventive interventions.[21]

The National Institute for Health and Care Excellence (NICE) advocates a "stepped care" approach. [22] [23] However, in terms of medication, the most cost-effective medicine will depend on the balance of its effectiveness and side-effects and how the latter dictate discontinuation.[24] A promising technique is therapist supported internet Cognitive Behavioural Therapy (CBT) for anxiety disorder in adults. This proved to be effective compared to waiting list or online discussion groups. Further research is still required to compare this to face-to-face CBT and also to identify the harms.[25]

Depressive Disorder

As above, NICE recommend a stepped care approach with the least intrusive, most effective intervention provided first, followed by a measured progression depending on condition and response.[26] Most recently (2016), the American College of Physicians produced guidelines for treatment based on a systematic review. The guidelines recommend either CBT or second generation antidepressants (e.g. mianserin) for major depressive disorder. Evidence for the other interventions such as psychotherapies, complementary and alternative medicines (acupuncture, omega-3 fatty acids, adenoysl methionine, St John's wort) and exercise was low quality.[27]

A much earlier systematic review (2011) confirmed that mindfulness-based CBT is a useful technique to prevent relapse in recurrent major depressive disorder (a 34% reduction in relative risk). This is a group based intervention consisting of training in mindfulness meditation in combination with CBT.[28] A systematic review published in the same year also showed that music therapy reduces depressive symptoms.[29]

Bipolar Disorder

A systematic review published in the British Journal of Psychiatry (2016) reviewed 55 trials with 6010 participants who had undertaken individual psychological interventions for bipolar disorder. Overall, there was a reduction of between 32% – 34% in post-treatment relapses and hospital admissions.[30]

On the other hand, group psychoeducation improves medication adherence and short-term knowledge about medication and also appears to be effective in preventing any relapse and manic/hypomanic relapse (Number Needed to Treat = 5 – 8) but not depressive relapse. Although the authors warned of limitations due to heterogeneity of their data, they concluded that group psychoeducation is effective in preventing relapse in bipolar disorder with less evidence for individually delivered interventions.[31]

Schizophrenia and Psychosis

The incidence of schizophrenia is different in men and women. It peaks in men aged 20 – 29 years with a median rate of 4.15 per 10,000 person – years. However, for women in the same age range, the median rate is 1.71 per 10,000 person-years. This peak is followed by a decline in incidence up to the age 60 years – a reduction that occurs more in men than women. This suggests different susceptibility in men and women at different stages of life.[32]

People with schizophrenia also tend to smoke more heavily than the general population. This contributes to high morbidity and mortality from smoking-related illnesses. A Cochrane review concluded that bupropion (Zyban) is effective as an aid to smoking abstinence without jeopardising mental state whereas varenicline (Champix) may do the same but the possibility of psychiatric adverse effects cannot be ruled out.[33] Similarly, patients with a first episode psychosis are known to have a very high prevalence of tobacco use (prevalence estimated at 58.9%).[34]

The mainstay of treatment for schizophrenia has been chlorpromazine for over 50 years. Although well established, the treatment is imperfect owing to its adverse effects.[35] A more recent mode of treatment is CBT although the evidence for this is not strong.[36] [37] Similarly, there are insufficient data to identify differences in outcome between supportive therapy (which ranges from simple befriending to giving support for daily living) and standard care.[38] In its clinical guideline, NICE recommends provision of specialist mental health services, early intervention for psychosis service and crisis resolution and home treatment.[39]

Psychosis, which involves experiencing hallucinations and/or delusions, is one aspect of schizophrenia and can occur across a spectrum ranging from mild schizoid personality disorder at one end to severe schizophrenia at the other.[40] Theoretically, early intervention should improve current functioning and reduce symptomatology and reduce the risk of progression to full psychosis.[41] However, evidence for early intervention is inconclusive.[42] There is moderate quality evidence that CBT reduces transition to psychosis at 12 months.[43]

Eating Disorder

Anorexia nervosa carries high morbidity and significant mortality and is most common in young adult women.[44] However, emerging evidence suggests that eating disorders are surprisingly common in

older women to the extent that clinicians should be alert for eating and body image disorder even in women well beyond the younger age range.[45] The clinical context is further complicated as one study showed that anorexia and bulimia nervosa cases present to Accident and Emergency departments with a multitude of vague complaints.[46]

Regarding treatment, a review published in 2013 indicated that individual and group CBT are superior to waiting list for the treatment of body dysmorphic disorder. However the authors acknowledged the need for further head-to-head studies with appropriate controls.[46] Also, although anorexia nervosa is often preceded by excessive physical activity, a review written in the same year concluded that supervised exercise training and the comprehensive management of patients with anorexia nervosa appears to be safe and showed improvements in strength and cardiovascular fitness without any detrimental effect to observed anthropometry.[47]

Less encouraging is a Cochrane review (2015) which was unable to draw conclusions about individual psychological therapy in the outpatient treatment of adults with anorexia nervosa because of data limitations. Focal psychodynamic therapy (FPT) encourages people with anorexia to think about how early childhood experiences may have affected them with the aim of finding more successful ways of coping with stressful situations and negative thoughts and emotions.[44]

Of utmost concern are the implications of the Royal College of psychiatrists' MARSIPAN: Management of Really Sick Patients with Anorexia Nervosa report.[48] The authors were aware of several cases of young people dying unnecessarily on medical units as a result of anorexia. Deaths can occur because of under- or over-feeding (re-feeding syndrome) in people whose general metabolic status is severely compromised. The College recommends that both medical and psychiatric ward staff are aware of the risk in these patients. Most adults should be treated in specialist eating disorder units and medical teams should have adequate support from psychiatry. In addition, commissioners should be aware of inadequate local provision and ensure robust plans are in place for adequately trained and resourced medical, nursing and dietetic staff. In essence, this means that the mental and physical needs of these desperately ill patients are met simultaneously.

Other Mental Illnesses

The classification of Post-Traumatic Stress Disorder (PTSD) has recently been updated in the new Diagnostic and Statistical Manual of Mental Disorders (DSM – 5) and includes symptoms clustered into 4 domains – intrusive symptoms, active avoidance, disturbed emotional states and alterations of arousal and reactivity. The condition has a lifetime prevalence of 10%.[49] Medications are modestly more effective than placebo to treat the symptoms and Selective Serotonin Reuptake Inhibitors (SSRIs) are considered a safe initial choice. However, prolonged exposure therapy and cognitive reprocessing therapies have been widely validated. In women with postnatal PTSD, the symptoms are similar to PTSD and CBT is effective in both.[50]

Exposure and ritual prevention using CBT is regarded as a standard treatment for Obsessive Compulsive Disorder.[51] NICE suggests that adults with anxiety, panic, PTSD, OCD or body dysmorphic disorder should receive psychological interventions based on a stepped care approach.[23]

Finally, the interconnectedness of various mental disorders is illustrated by a review published in 2014 which notes the relationship between adult ADHD and bipolar disorder as these present with

similar symptoms.[52] In the USA, ADHD affects 4.4% of adults and 1.4% for bipolar disorder. Around 27% of adults with ADHD have bipolar and up to 20% of adults with bipolar also have ADHD. Determining whether a patient has one or both is a complex task.

Chapter Five

Programmes to Improve Population Level Mental Health and Wellbeing

A variety of initiatives to improve mental wellbeing of the population have been developed.

Small improvements in wellbeing can help to decrease some mental health problems and also help people to flourish. The New Economics Foundation on behalf of Foresight, set out five actions (Five Ways to Wellbeing) to improve personal wellbeing:[53]

- connect;
- be active;
- take notice;
- keep learning;
- give.

Using insight research, the Cheshire and Merseyside Public Health Collaborative (Champs) have developed the Make Time Campaign[54] which is based on the Five Ways to Wellbeing Model. The existing five ways to wellbeing have been reframed into messages that better resonate with the public. The question 'When was the last time you …' was used for five posters (see overleaf) which provide ideas for activities, and are linked to the Five Ways to Wellbeing messages.

The mental health challenge is already showing that local authority member champions have the potential to raise the profile of mental health and wellbeing in local communities, to enable councils to integrate mental health into the full range of their policies and responsibilities, and to link up with other local leaders to foster partnerships and encourage action to promote mental health and life chances. The challenge was launched in September 2013 and so far over 35 councils have taken the challenge and appointed member champions for mental health. Consideration should be given to Cheshire East also signing up to this challenge.

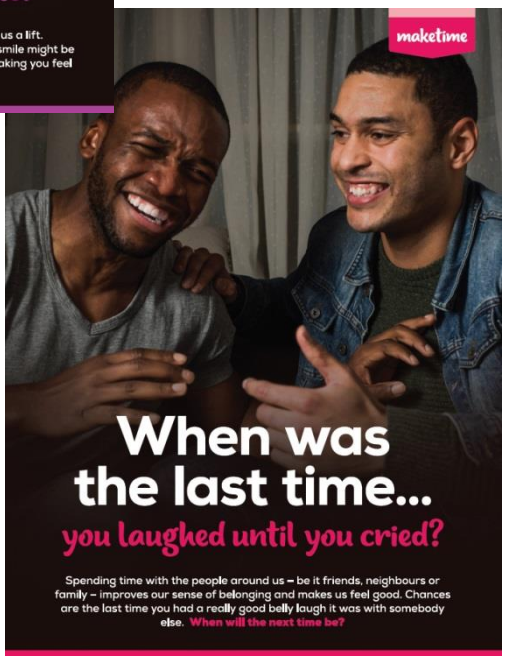
The National Institute for Health and Care Excellence (NICE) has produced guidelines to improve mental health in the workplace.[55] [56] These cover how to improve the health and wellbeing of employees, with a focus on organisational culture and the role of line managers and are for employers, senior leadership and managers, human resource teams and all those with a remit for workplace health. They aim to create a supportive environment that enables employees to be proactive when and if possible to protect and enhance their own health and wellbeing, and to develop policies to support the workplace culture such as respect for work-life balance.


maketime
When was the last time...
you tried something new?
It's never too late to learn a new skill or take on a new challenge – like trying a new recipe, learning an instrument or taking that computer course. Doing it will make us feel proud. Some of your best memories might be thanks to a time when you decided to give something a go. When will the next time be?


maketime
When was the last time...
you noticed things around you?
It's not often that we stop to notice the world around us, think about how we're feeling or try to live in the moment. It may have been a while since you were curious or took some time to be aware of everything happening around you. When will the next time be?


When was the last time...
you made someone smile?
However we do it, doing something for someone else gives us a lift. Helping a friend or stranger could make their day. Just giving a smile might be enough. And that simple act of kindness can go a long way to making you feel good too. When will the next time be?


When was the last time...
you got up and out?
Being active isn't all about looking good, it helps us feel good too. Something as simple as going outside for a walk can make a positive difference to our mood. Discovering something you really like doing is the most important bit. When will the next time be?


maketime
When was the last time...
you laughed until you cried?
Spending time with the people around us – be it friends, neighbours or family – improves our sense of belonging and makes us feel good. Chances are the last time you had a really good belly laugh it was with somebody else. When will the next time be?

The Workplace Wellbeing Charter[57] has been adopted by Cheshire East Council. It is a statement of intent, showing commitment to the health of employees. Organisations using the Charter benefit in many ways including:

- The ability to audit and benchmark against an established and independent set of standards – identifying what the organisation already has in place and what gaps there may be in the health, safety and wellbeing of employees;
- Developing strategies and plans – The Charter provides a clear structure that organisations can use to develop health, safety and wellbeing strategies and plans;
- National recognition – The Charter award process is robust and evidence based. With over 1,000 organisations across England holding the award, the Workplace Wellbeing Charter is now widely recognised as the business standard for health, safety and wellbeing across England. The award helps to strengthen the organisation's brand and reputation, and supports sales and marketing activities.

The next section summarises the literature published in the last five years on general systems and models of care currently in use for the treatment of mental illness. It concentrates on evidence-based recommendations. There is also a focus on other aspects of mental health and illness taking into account risk factors, the wider determinants and the impacts on employment and physical health.

Overview of Evidence-based Practice

In 2013, the World Health Organisation set out its vision for a world in which mental health is valued, promoted and protected.[58] The overall goal is to promote mental wellbeing, prevent mental disorders, provide care, enhance recovery, promote human rights and reduce the mortality, morbidity and disability for persons with mental disorders. One of the main objectives is to provide a comprehensive integrated and responsive mental health and social care service in community based settings. This involves integration of mental health care and treatment into general hospitals and primary care, continuity of care between different providers and levels of the health system, effective collaboration between formal and informal care providers and the promotion of self-care, for instance, through the use of electronic and mobile health technologies.

In a briefing document (2015), the King's Fund reviewed recent-history large scale transformations in the mental health sector and suggested that reconfigurations from the past have been implemented when the evidence base was limited. In future, therefore, there is a need to focus on using evidence to improve practice and reduce variation.[59] This theme is echoed by an editorial in the British Medical Journal (BMJ) which suggested that mental health policy documents in the past have tended to be aspirational rather than rational.[60]

The Royal College of Psychiatrists (2015) concur with the view that the best model of service delivery should be based on evidence that the model will deliver better care for patients – any proposed changes should be piloted first and then evaluated before wide-scale implementation.[61] The College also says that the principles underpinning a new service are ease of access, delivery of evidence-based treatment and continuity of care - ideally, patients should not be referred and assessed by different parts of the service before being provided treatment. The College goes on to say that

different service configurations may deliver the best outcomes in different areas. Finally, psychiatry is probably better served by having a generic community mental health team, with whom the patient is known and vice versa, although there is still a place for very specialist services such as perinatal, eating disorder and early intervention in psychosis. According to NICE, important aspects of effective care are a stepped care approach (a) and active involvement of the service user.[62] [63] [64]

(a) A stepped-care model provides the least intrusive, most effective intervention first, has clear and explicit criteria between the different levels and monitors progress to ensure the most effective interventions are delivered and the person moves up or down the pathway as needed.

Liaison Psychiatry

In a separate report (2013), the Royal College of Psychiatrists outlined their service model for liaison psychiatry.[65] This is a critical service (b) which should be integral to all acute hospitals. Staffing levels and skill mix need to be tailored to local factors and services require dedicated accommodation on the acute hospital site to ensure safety, privacy and dignity. Referrals should be accepted for any mental health problem that is moderate to severe and/or impairing physical health care.

(b) Liaison psychiatry addresses the mental health needs of people being treated in hospital for physical health problems. Such services are multidisciplinary, specialist mental health teams, skilled to address a range of mental health problems that arise in all clinical areas of acute hospitals. Some call for the expansion of this service into primary care.

However, in the National Audit Office report on preparations for improving access to mental health services (2016), it appears that only 7% of acute hospitals had liaison psychiatry operating 24/7 in 2014/15.[66] This is at odds with NICE guidance (2015) which suggests that every emergency department as a routine should have urgent access to a multidisciplinary liaison team which includes a consultant psychiatrist and registered psychiatric nurses and able to work with children and adults. A full mental health assessment should be available within one hour of the alert from the emergency department at all times.[67]

Vulnerable Groups and Domestic Abuse

A qualitative review (2012) searched for articles on hard to reach groups and their problems in accessing mental health services in primary care. The review identified 8 groups which included homeless, long-term unemployed, adolescents with eating disorders, depressed elderly, advanced cancer sufferers, patients with medically unexplained symptoms, asylum seekers and people from black and minority ethnic groups.[68] Many of the participants regarded their mental health problems as being rooted in social problems with resulting social isolation.

Another systematic review examined the mental health of sexual minorities. The majority of studies reported elevated risks for depression, anxiety, suicide attempts or suicide and substance related problems in this cohort. Bisexual individuals seem to be at highest risk.[69] Prevalence of psychiatric disorders which includes PTSD and major depression is also higher in soldiers than civilians.[70]

Adult victims of domestic abuse (all genders) commonly present with mental health problems. Including anxiety, depression, low self-esteem, inability to trust others, flashbacks, sleep

disturbances and emotional detachment. Other significant mental health impacts include the development of post-traumatic stress disorder, self-harming, and an increased risk of attempted or completed suicide (particularly in women). Services aim to prevent, identify and respond to incidents of domestic abuse. The Cheshire East Domestic Abuse Hub is a single 24/7 point of help, assessment and referral for anyone affected by domestic abuse – victim, perpetrator, young person, professional, or concerned member of the community.

Older People

Of particular concern is the mental health of older people. It has been estimated that around one third of older people experience problems with their mental health. Those without support i.e. who are socially isolated and/or physically unwell may experience significant mental distress.[71] It is not surprising that elderly patients with psychiatric illness commonly have comorbid medical conditions, the management of these are often sub optimal and can affect quality of life and increase mortality.[72] For many conditions such as cardiac disease, cerebrovascular disease, cancer, chronic kidney disease, chronic obstructive pulmonary disease and Parkinson's disease, there is emerging evidence that treatment can be effective in reducing depressive symptoms.[73] Collaborative care models appear particularly well suited to medically unwell older adults with benefits across both mental and physical health measures.

It has also been suggested that the current healthcare infrastructure isn't adequate to meet the present and much less so future need of the ageing population, particularly those with depression and physical health comorbidities.[74] Worryingly, it has been stated there is a gap in both policy and quality research evidence on how to meet the needs of this vulnerable group. Much of the literature originates from the USA with limited pockets of good practice in the UK.[75]

In addition, a UK systematic review suggested that community mental health teams are central to the provision of care for older people. However, limited evidence was found regarding the effectiveness of the core attributes of these teams which drive recommended policy directives. Further research is required.[76]

More specifically, severity of depression is significantly associated with poor quality of life in older people, a relationship which was stable over time.[77] A meta-analysis (2014) of 44 studies concluded that CBT is effective in late life depression.[78] However, a literature review from the USA concluded that expanding the use of antidepressants in older Americans hasn't been associated with notable decreases in the burden of geriatric depression.[79] Other work has shown that antidepressants reduce the risk of relapse but the benefits may not extend beyond 2 – 3 years. No interventions have been shown to reduce the long-term complications associated with depression and there is a need to develop preventive interventions which target risk factors.[80]

Mixed anxiety and depression is a more common presentation than depression alone, relapse rates are high and there is considerable under-treatment in the community.[81] It is currently unknown how current models will deal with this problem in the ageing population.[82] CBT is thought to be effective for anxiety alone but evidence suggests it might be less effective in the cohort of people older than working age.[83]

Physical Health

A BMJ editorial written in 2011 drew attention to the disparity between treatment of mental and physical illness. Only a quarter of mentally ill people across Europe receive any form of physical healthcare compared with 80% of people with diabetes – this is despite a much higher prevalence of illness in the former. Also, people with certain mental illnesses such as psychotic, affective, personality, drug related, and alcohol related disorders die on average about 20 years earlier than their mentally well counterparts.[84]

Two years later, a systematic review examined the impact of integrated mental and physical health services on general medical outcomes in people with serious mental illnesses.[85] The limited data available showed some positive outcomes in terms of process (e.g. increase in immunisation rates) but inconsistent results in terms of physical functioning. The relatively small number of trials (only 2/4 were deemed high-quality studies) and limited range of treatment models tested and outcomes reported point to the need for additional study in this area.

The King's Fund proposes 10 areas where integration is needed most, shown in the table below.

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

The level of academic rigour utilised in producing this report is not clear. The report does suggest some ways of how these priorities could be tackled but the underpinning evidence is lacking. It should be noted that the King's Fund is not a "NICE accredited" evidence source neither has this specific report been subject to peer review.

Finally, the Royal College of Psychiatrists (2015) endorses the integration of physical and mental health care.[86] In a joint statement with the Royal Colleges of GPs and Physicians, the College proposes two considerations. These are co-location of physical and mental health care provision plus integration of mental health care provision into existing medical pathways and services – either primary or secondary care.

Chapter Six

Mental Health in People with Learning Disabilities

This chapter describes the mental health of people who are recorded by their general practitioner as having a learning disability. Learning disabilities are varied conditions, but are defined by three core criteria:

- Lower intellectual ability;
- Significant impairment of social or adaptive functioning;
- Onset in childhood.

The last two sections of this chapter, on depression and severe mental illness, borrow heavily from the findings presented in a recent preliminary report on a data collection designed to identify differences in the health and care of people with learning disabilities.[87]

Children and Young People with Learning Disabilities

There are several reasons why young people with learning disabilities are at greater risk of developing a mental health problem than those who do not have learning disabilities:

1. The intellectual impairment associated with learning disability reduces the child's capacity for finding creative and adaptive solutions to life's challenges;
2. Children and young people with learning disabilities are more likely to be in poverty and be socially disadvantaged;
3. They also experience higher rates of stressful life events and abuse than children and young people who do not have a learning disability;
4. Some causes of learning disability lead to vulnerability to particular mental health problems.

Although we explored mental health in some detail in the "Mental Health of Children and Adolescents with Learning Disabilities" chapter of the 2015 Public Health Report [88], it is worth reminding readers of this report that an analysis of the combined data from the two national epidemiological surveys of the mental health of children and adolescents in 1999 and 2004 has suggested that, when the above factors are taken into account, there is potential to reduce the increased risk of mental health problems associated with learning disabilities by at least two-thirds.[89]

In the 2014 Public Health Report, we first drew attention to a marked under-recording of moderate learning disability in schools in Cheshire East. In the following year, we found that although there had been an improvement in recording in primary schools between January 2014 and January 2015, there had been no equivalent increase in the secondary schools. By January 2016 the number of secondary school pupils with special educational needs due to moderate learning disability recorded by the Cheshire East annual schools census had fallen to just 138, many fewer than expected. This shortfall is mainly because secondary schools in Macclesfield, Congleton, Crewe and Wilmslow have fewer young people with moderate learning disability compared to secondary schools in other areas.

It is noteworthy that 3.46% of all pupils in England were recorded as having a moderate learning disability in January 2016. This figure is almost three times higher than Cheshire East, where only 1.23% of pupils were recorded by their school as having a moderate learning disability.

Pupils with Special Educational Needs in Cheshire East						
	January 2014		**January 2015**		**January 2016**	
	Mod LD	**Sev LD**	**Mod LD**	**Sev LD**	**Mod LD**	**Sev LD**
Primary schools	189	37	466	43	496	50
Secondary schools	130	10	159	16	138	21
Special schools	0	195	0	186	2	179
	319	**242**	**625**	**245**	**636**	**250**
Rate per 1,000 pupils						
	January 2014		**January 2015**		**January 2016**	
	C. East	**England**	**C. East**	**England**	**C. East**	**England**
Moderate LD	**5.9**	**15.6**	**11.6**	**28.6**	**12.3**	**34.6**
Severe LD	**4.5**	**5.0**	**4.5**	**5.1**	**4.8**	**5.5**
Severe Learning Difficulty includes Profound and Multiple Learning Difficulty						
SFR 26/2014, SFR 25/2015, SFR 29/2016. Special educational needs schools census						

Work that is currently being carried out by the Cheshire East Children's Team for the Special Educational Needs (SEN) Joint Strategic Needs Assessment (JSNA) is suggesting that a small number of pupils with moderate learning disability are being educated in schools outside the borough. However, even taking this into account, there is still likely to be an under-recording of young people with moderate learning disability in secondary schools within Cheshire East. A more accurate picture will become available when the work on this JSNA section has been completed.

As previously outlined, this under-recording is important because some young people with learning disability will require "reasonable adjustments" to be made to the services that they receive. For example, some young people with learning disabilities have reduced health literacy, and find it more difficult than others to understand issues such as what it means to be healthy, to have a healthy diet, the dangers of substance misuse, and the benefits of exercise.

If the young person's general practitioner does not know that they have a learning disability, these reasonable adjustments cannot be made and health inequalities will persist. In addition, young people with a learning disability are likely to need additional support to make the transition to adult life. Without a good understanding of their individual needs, it is more difficult to co-ordinate care around these needs, and to ensure continuity and the best outcomes.

We made the following three recommendations in last year's Public Health Report.

> *(2015) The Children's Joint Commissioning Team co-ordinate actions to tackle the shortfall in recording of children and young people with a moderate learning disability. This shortfall is concentrated in secondary schools in Macclesfield, Congleton, Crewe and Wilmslow, which is where efforts to recognise and record these young people need to be focused.*
>
> *(2015) The Children's Joint Commissioning Team initiate work to try to identify how many young people with moderate or severe learning disability are currently able to access mental health services that meet their needs.*

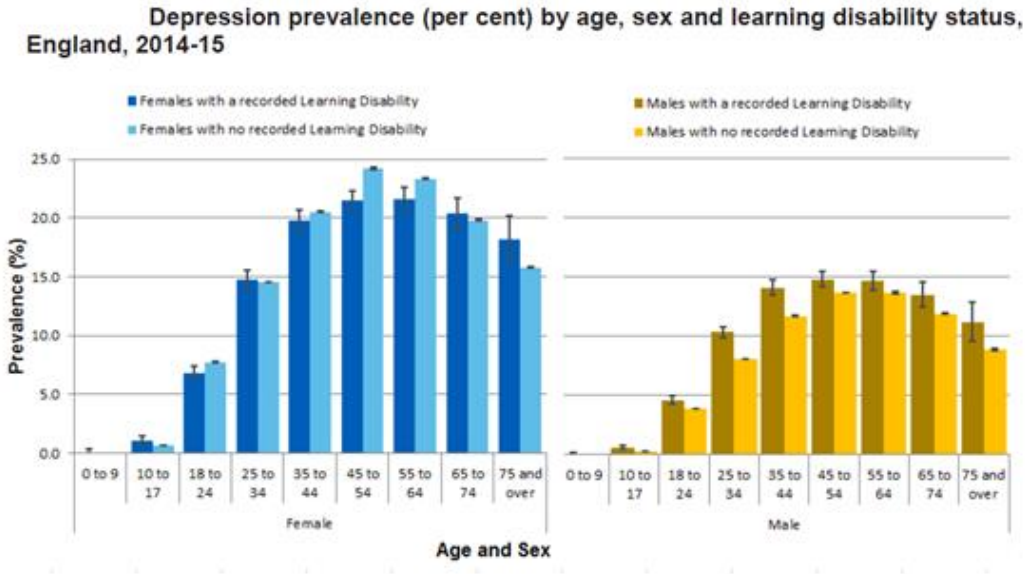
(2015) All Head Teachers in Cheshire East utilise a common approach to informing general practitioners about any child or young person that the school identifies as having a learning disability.

This year, we are recommending that this ongoing significant shortfall in recording of children and young people with a moderate learning disability in Cheshire East's secondary schools still needs to be tackled.

Depression and Learning Disability

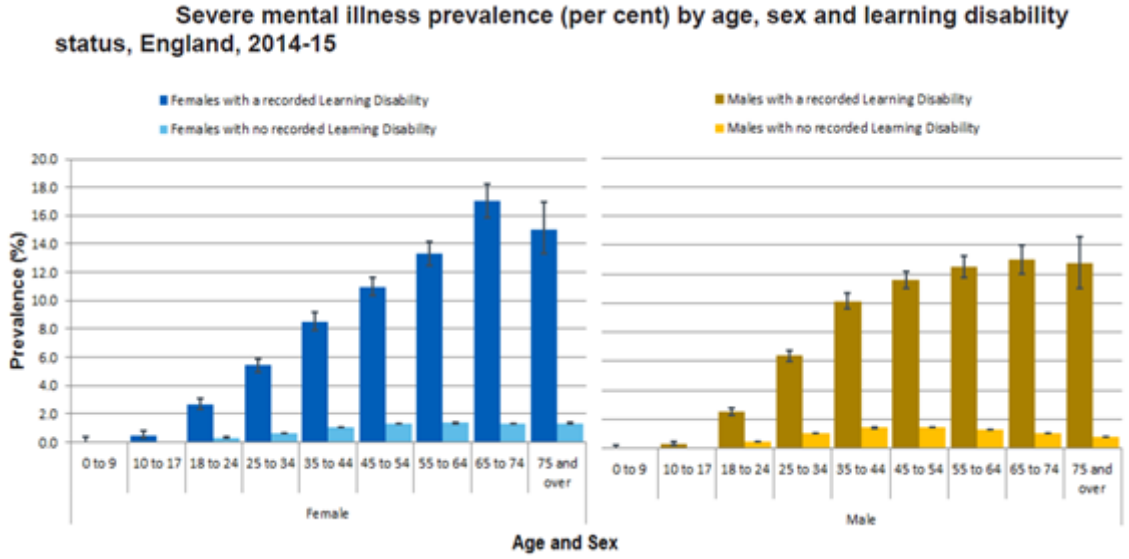
Depression is a major and treatable cause of distress and disability for people both with and without learning disabilities. In people with learning disabilities, particularly those with limited ability to communicate, it can be expressed in behavioural ways understood by carers or care staff as 'challenging'. This makes clarity about diagnosis particularly important.

The overall rate of having a diagnosis of depression in adults with learning disabilities (13.9%) is very similar to that for people without learning disabilities (14.5%). As shown in the chart, the rates for both groups rise with age until late middle age and then fall slightly in old age. For England as a whole, the number of cases in people with learning disabilities was just 4.3% above the number expected if general population rates had applied. Eastern Cheshire CCG had a standardised prevalence ratio for depression of 99.8% (similar to England), but South Cheshire CCG had a much higher ratio of 138.3% (i.e. this CCG had 38% **more** people with a learning disability and depression than expected). These ratios are based on 156 people who were recorded by general practitioners as having depression and learning disability, 61 in Eastern Cheshire CCG and 95 in South Cheshire CCG.



Severe Mental Illness and Learning Disability

People with learning disabilities are known to suffer more commonly with severe mental illnesses including schizophrenia, bipolar disorder and other less well defined psychotic conditions. However, exactly how much more commonly is difficult to assess since diagnosis of these conditions is substantially more difficult, particularly in those with more severe learning disabilities and little or no ability to communicate verbally. In people without learning disabilities, psychotic disorders are relatively uncommon in childhood, appearing usually in adolescence or young adulthood.



Overall, general practitioners across England recorded 7.8 per cent of people with learning disabilities as having severe mental illnesses (8.8 per cent in those aged 18 and over). This compared to 0.87 per cent of people without learning disabilities (1.1 per cent in those aged 18 and over). Adjusting for age and sex profile, the number of people with learning disabilities recorded as having a severe mental illness was 8.04 times what would be expected if national general population age and sex specific rates applied. 15.3 per cent of CCGs had a standardised prevalence ratio for severe mental illness that was significantly lower than the England figure and 13.2 per cent of CCGs had a ratio that was significantly higher.

Eastern Cheshire CCG had a standardised prevalence ratio for severe mental illness of 681% (lower than the England ratio of 804%) and South Cheshire CCG had a ratio of 737% (again lower than the England ratio of 804%). Some caution in interpretation is needed as these ratios are based on just 76 people who were recorded by local general practitioners as having both a severe mental illness and a learning disability (34 in Eastern Cheshire CCG and 42 in South Cheshire CCG), but this might also suggest that severe mental illness may not be being fully diagnosed in this group of people.

Nationally, the large variability in the rates of severe mental illness strongly suggests that this is being under-diagnosed (and possibly under treated) in some areas and over-diagnosed in others. This is an important issue in clarifying the appropriateness of use of antipsychotic and anti-depressant medications.

An audit of deaths that have occurred in people with a learning disability is currently in progress. This audit is being supported by the Cheshire East Public Health Team, and the report of the audit should be available by June 2017.

Recommendation

6.1 Steps should be taken to improve the ongoing significant shortfall in recording pupils with moderate learning disability in secondary schools in Macclesfield, Congleton, Crewe and Wilmslow. Head Teachers should be asked to inform the general practitioner about any child or young person that the school identifies as having a learning disability.

Chapter Seven

Serious Mental Illness and Psychosis

Serious mental illness covers a collection of conditions, including schizophrenia, bipolar disorder, psychotic depression and other less common psychotic disorders. Psychosis is characterised by hallucinations, delusions and a disturbed relationship with reality, and can cause considerable distress and disability for the person and their family or carers.

Early Intervention Services for First-episode Psychosis

The term first-episode psychosis is used to describe the first time a person experiences a combination of psychosis symptoms. Each person will have a unique experience and combination of symptoms. The core clinical symptoms are usually divided into 'positive symptoms', so called because they are added experiences, including hallucinations (perception in the absence of any stimulus) and delusions (fixed or falsely held beliefs), and 'negative symptoms', so called because something is reduced (such as emotional apathy, lack of drive, poverty of speech, social withdrawal and self-neglect). A range of common mental health problems (including anxiety and depression) and coexisting substance misuse may also be present.

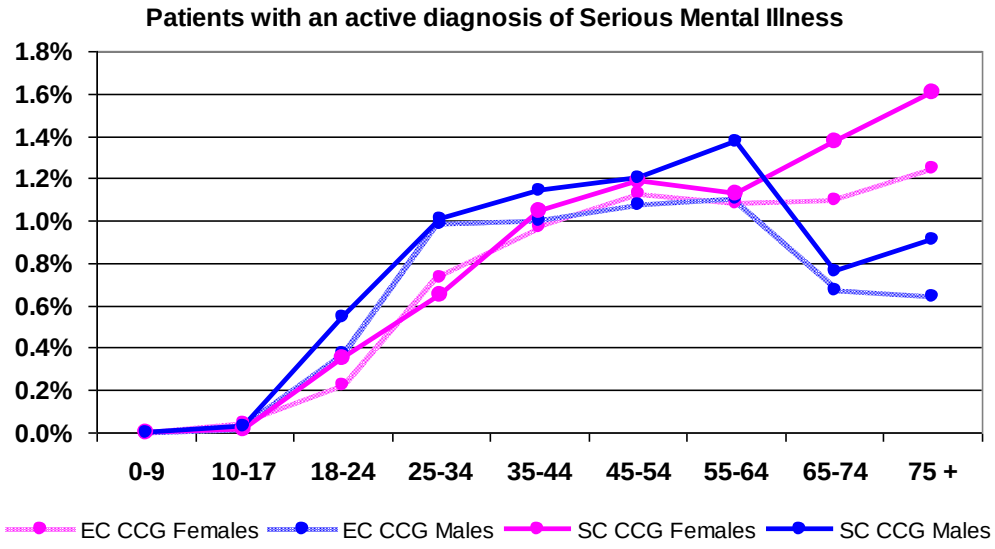
Typically, before their first-episode of psychosis, many people will experience a relatively long period of symptoms, which is described as being in an at-risk mental state. These may include:

- A more extended period of less severe psychotic symptoms;
- An episode of psychosis lasting less than seven days;
- An extended period of very poor social and cognitive functioning (perhaps accompanied by unusual behaviour including withdrawal from school or friends and family) in the context of a family history of psychosis.

First-episode psychosis is thought to affect about 38 people in Cheshire East each year, with most being aged between 15 and 35. Delays in providing treatment and support at this time can lead to poorer clinical and social outcomes over their whole lifetime. Early intervention services provided by dedicated multidisciplinary teams are strongly effective in improving outcomes and reducing future health service costs, particularly inpatient care costs.[90] The new Early Intervention in Psychosis waiting time standard requires that people experiencing a first episode of psychosis should have access to a NICE-approved care package within two weeks of referral.

Care of People with Serious Mental Illness

Cheshire East has over 3,100 people of all ages with a serious mental illness, comprising about 0.82% of the population. Although the frequency of serious mental illness is lower in both clinical commissioning group areas than nationally, the chart shows that rates are higher in South Cheshire CCG than in Eastern Cheshire CCG in almost all age groups. Illness rates increase with age and are higher in men than women, except over the age of 65 due to higher mortality in older men.



Public Health England has recently published a report providing data for each clinical commissioning group for a range of indicators across the psychosis care pathway.[91] The report brings together data from general practices (Quality and Outcomes Framework Serious Mental Illness Registers) and specialist mental health services (from the Mental Health and Learning Disabilities Data Set).

Although these indicators are based on measures of treated prevalence (counts of contacts with services) and not true prevalence, they highlight a number of significant local issues and concerns:

1. **variation in numbers of people with psychosis**. General practices in Eastern Cheshire CCG have **statistically significantly fewer people with serious mental illness** on their practice registers than nationally. Given the other data quality concerns for both primary and specialist mental health services locally, it is not possible to be confident at this time that this represents the true position for this clinical commissioning group;

2. **variation in access to a range of care and support interventions for people with psychosis**. The proportion of people with severe mental illness in primary care with a comprehensive care plan is significantly lower in both CCGs (indicator 5). The proportion of people with severe mental illness who have received the complete list of primary care physical health checks is also significantly lower in both CCGs (indicator 10). Another concern relates to indicator 6 (people with psychosis in specialist mental health services with a crisis plan in place), where data was suppressed for both CCGs because there were fewer than 5 people with such plans. As many of the other CCGs in the country had several hundreds of people with crisis plans, this either represents particularly poor data quality or a possibility that these crisis plans may not be in place;

3. **gaps in routine data relating to psychosis**. No specialist mental health services data could be reported for Eastern Cheshire CCG because of data suppression due to low data quality. This particularly affected indicators 3 (number of people with psychosis), 4 (people with psychosis who are on CPA), 6 (people with a crisis plan), 8 (people in employment) and 9 (people in settled accommodation);

4. **quality issues with current data relating to psychosis**. Both local clinical commissioning groups had some of the most **incomplete data from specialist mental health services** for any area nationally. Of people in scope, only 48% in Eastern Cheshire CCG and 50% in South Cheshire CCG were assigned to a care cluster, compared to 85% for England. The recorded number of people with psychosis known to specialist mental health services is significantly lower in South Cheshire CCG even though the number of people with severe mental illness known to general practitioners in South Cheshire CCG is not significantly different to England. In addition, both of the local clinical commissioning groups had a **statistically significantly higher number of people with severe mental illness who were exempt from physical health checks in primary care** (indicator 11). This raises concerns about the validity of the other four indicators that focus on primary care – indicators 5 (people with a comprehensive care plan), 10 (people with physical health checks), 12 (people who are current smokers) and 13 (women who have had a cervical screening test).

Excess Premature Mortality for people with Severe Mental Illness

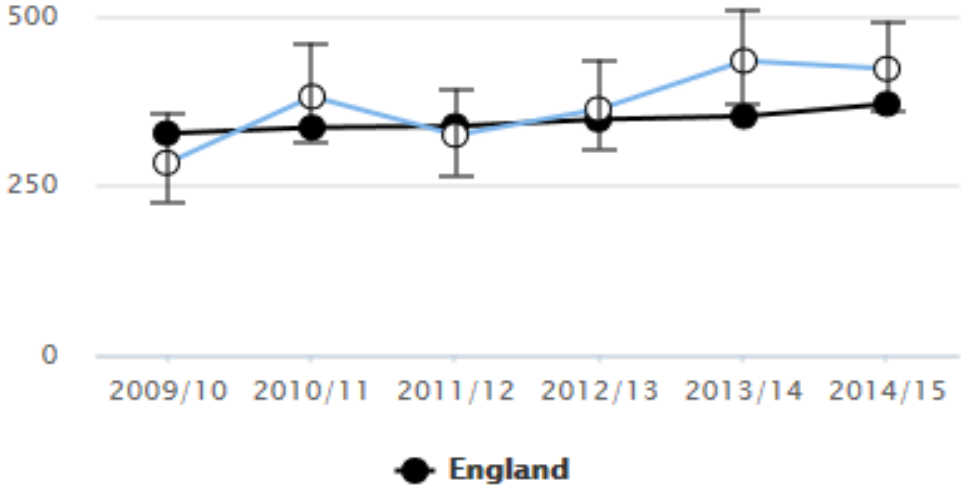
There is extensive published evidence that people with severe mental illness die between 15 and 25 years earlier than the average for the general population. The causes of premature death are mainly from chronic physical conditions such as coronary heart disease, type 2 diabetes and respiratory diseases. These physical conditions are associated with modifiable risk factors such as smoking, obesity and high blood pressure, and are also associated with side effects of psychiatric medication. However, they are seen as preventable with comprehensive assessment, treatment, and recommended safe monitoring of physical health and the side effects of medication.

This is why indicators 10 (people with severe mental illness who have received the complete list of primary care physical health checks) and indicator 11 (people with severe mental illness who were exempt from physical health checks) are of such importance. Indicators 10 and 11 are statistically significantly worse than England for both Eastern Cheshire CCG and South Cheshire CCG.

The excess under 75 mortality rate among adults with serious mental illness is a key outcome indicator for assessing the health of people with serious mental illness. People with serious mental illness are first identified from the Mental Health and Learning Disabilities Data Set. These records are then linked to the Primary Care Mortality Database to identify deaths amongst people with serious mental illness. For each local authority, the numerator is the observed count of deaths occurring amongst people with serious mental illness who are in the Mental Health and Learning Disabilities Data Set.

This indicator is only available at local authority level – it is not published for individual CCGs. For the latest available year, under-75 mortality among adults with serious mental illness in Cheshire East was 4.21 times higher than in the general population. This is a worse position than England where the ratio was 3.70 times higher.

Excess under 75 mortality rate in adults with serious mental illness: Ratio of observed to expected mortalities: Cheshire East



It should be noted that as the concerns about local mental health data quality relate to missing or inadequately coded data, there is a possibility that some people with serious mental illness are being excluded from this calculation, correction of which would have the effect of worsening the indicator. It is possible that the true position may be even worse than the indicator currently suggests.

Recommendations

7.1 Commissioners of mental health services (CCGs, NHS England and local authority commissioners) should consider within their quality and performance function or equivalent, whether there is a systematic data coding issue with their local mental health providers for severe mental illness and take appropriate action;

7.2 Local commissioners and providers should consider the variations in the local CCG performance on serious mental illness compared with peer CCGs, using comparative approaches such as RightCare to guide further enquiry.

NHS Eastern Cheshire CCG				
See descriptions of the rationales for the indicators at end of chapter	**Number of people**	**CCG rate / %**	**England rate / %**	**Comparison with England**
1. Estimated number of new cases of psychosis	20.29	16.5 per 100,000	24.2 per 100,000	no significant difference
2. Recorded number of people with severe mental illness	1646	0.80%	0.88%	significantly lower
3. Recorded number of people with psychosis	low data quality	low data quality	400.9 per 100,000	data suppressed due to low data quality
4. People with psychosis in specialist mental health services who are on CPA	low data quality	low data quality	51.77%	data suppressed due to low data quality
5. People with severe mental illness in primary care with a comprehensive care plan	1107	74.25%	77.20%	significantly lower
6. People with psychosis in specialist mental health services with a crisis plan in place	low data quality	low data quality	30.04%	data suppressed due to low data quality
7. People with psychosis admitted to hospital in an emergency	53	41.2 per 100,000	35.8 per 100,000	no significant difference
8. People with psychosis in specialist mental health services in employment	low data quality	low data quality	5.8%	data suppressed due to low data quality
9. People with psychosis in specialist mental health services in settled accommodation	low data quality	low data quality	83.16%	data suppressed due to low data quality
10. People with severe mental illness who have received the complete list of primary care physical health checks	392	28.5%	34.8%	significantly lower
11. People with severe mental illness who were exempt from physical health checks	706	15.49%	10.74%	significantly higher
12. People with severe mental illness who are current smokers	479	35%	40.5%	significantly lower
13. Women aged 25 to 64 years with severe mental illness who have had a cervical screening test	356	74.32%	71.6%	no significant difference
14. Excess premature mortality for people with severe mental illness (Cheshire East 2013/14)	506	4.334 times higher	3.518 times higher	significantly higher
Source: Psychosis Data Report. Public Health England. October 2016				

Indicator definitions can be found in Appendix D

NHS South Cheshire CCG				
See descriptions of the rationales for the indicators at end of chapter	**Number of people**	**CCG rate / %**	**England rate / %**	**Comparison with England**
1. Estimated number of new cases of psychosis	17.47	16.46	24.2 per 100,000	no significant difference
2. Recorded number of people with severe mental illness	1492	0.84%	0.88%	no significant difference
3. Recorded number of people with psychosis	525	360.21	400.9 per 100,000	significantly lower
4. People with psychosis in specialist mental health services who are on CPA	265	50.5%	51.77%	no significant difference
5. People with severe mental illness in primary care with a comprehensive care plan	1321	74.26%	77.20%	significantly lower
6. People with psychosis in specialist mental health services with a crisis plan in place	low data quality	low data quality	30.04%	data suppressed as fewer than five cases
7. People with psychosis admitted to hospital in an emergency	36	27.7 per 100,000	35.8 per 100,000	no significant difference
8. People with psychosis in specialist mental health services in employment	35	6.7%	5.8%	no significant difference
9. People with psychosis in specialist mental health services in settled accommodation	225	84.9%	83.16%	no significant difference
10. People with severe mental illness who have received the complete list of primary care physical health checks	286	30.1%	34.8%	significantly lower
11. People with severe mental illness who were exempt from physical health checks	490	12.21%	10.74%	significantly higher
12. People with severe mental illness who are current smokers	375	39.6%	40.5%	no significant difference
13. Women aged 25 to 64 years with severe mental illness who have had a cervical screening test	283	71.83%	71.6%	no significant difference
14. Excess premature mortality for people with severe mental illness (Cheshire East 2013/14)	506	4.334 times higher	3.518 times higher	significantly higher
Source: Psychosis Data Report. Public Health England. October 2016				

Indicator definitions can be found in Appendix D

Chapter Eight

Smoking and Mental Illness

Smoking Prevalence

Smoking rates in individuals with depression or anxiety are thought to be twice as high as those in the general population, and are three times higher in those with schizophrenia and bipolar disorder.[92] In 2014/15 general practices in Cheshire East identified that 36.8% (854 out of 2,317) of adults with a severe mental illness were current smokers.[93] By comparison, the overall rate of smoking among the general adult population in Cheshire East is 12.4% (95% CI 10.4-14.6) which is significantly lower than England where prevalence rates are 16.9% (95% CI 16.6-17.1).[94]

When reviewed at clinical commissioning group level, the rate of smoking among adults with a severe mental illness in NHS South Cheshire CCG is 39.6% (95% CI 36.5-42.7 – not significantly different) and in NHS Eastern Cheshire CCG is 35.0% (95% CI 32.5-37.5 – significantly lower), compared to 40.5% (95% CI 40.4-40.7) for England. [93]

Excess Risk of Smoking

The impact of high smoking rates on individuals with mental illness leads to a significantly higher risk of dying from a smoking related disease. It is estimated that the excess risk of dying for all tobacco-linked diseases combined is 2.45 (95% CI 2.41–2.48) for schizophrenia, 1.57 (95% CI 1.53–1.62) for bipolar disorder, and 1.95 (95% CI 1.93–1.98) for severe depression.[95] This also contributes heavily to the overall additional burden of death experienced by this group of people, which was discussed in chapter seven.

Stopping Smoking

Smoking is an important factor behind the health inequalities that are experienced by people who have a chronic mental illness.[92] Stopping smoking offers a range of benefits for these individuals including improvements in physical health, mental health and quality of life. The cost savings also offer the potential to improve access to higher quality food and social activities. As well as benefits to the individual, there are also significant potential savings to be achieved for the NHS by supporting mental health patients to stop smoking. It is estimated that treating smoking related illnesses in people with mental illness costs the NHS £720 million each year.[96]

Patients with a severe mental illness can find it particularly challenging to stop smoking. It is often assumed by health professionals that this client group uses nicotine as a form of self-medication, but there is little evidence to support this.[97] Patients with schizophrenia and depression report the experience of craving and withdrawal as the primary reason they continue to smoke.[98] An exception to this is individuals with bipolar disorder who do report using smoking as a way of coping with the symptoms of their mental illness.[97] Managing cravings, withdrawal symptoms and lack of ability to cope with negative affect are some of the main reasons found to influence quit attempts in this client group.

Support from Professionals

It is crucial that health professionals in primary care assess all patients smoking status and offer very brief advice and access to appropriate treatment for those patients who are current smokers. Everyone who works in primary care should complete the free online training in Very Brief Advice.[99] This training ensures that smoking can be quickly and easily integrated into each consultation without it having a significant impact on the time available for each patient.

To ensure that patients are given the greatest opportunity to successfully quit smoking, services need to be designed to meet this client group's needs. Community based specialist stop smoking services need to work in close partnership with community mental health services to establish clear referral pathways between the services. For those within secondary care services, support should commence prior to admission if the admission is planned or immediately upon admission in an emergency situation. Support should continue throughout the patient's stay in secondary care as outlined in the NICE (2013) Smoking: acute, maternity and mental health services public health guidance.[100] It should also be recognised that abstinence may not initially be possible, so harm reduction interventions as outlined in the NICE (2013) smoking harm reduction guideline should be provided.[101] It is also important that mental health services adopt a supportive and encouraging culture. It is clear that supporting individuals with a chronic mental illness to stop smoking will have a significant benefit for both the individual and the NHS. Successfully quitting smoking should be recognised by mental health service providers as something that is achievable and beneficial for patients.

Following the evidence the local specialist stop smoking service, a part of the One You Cheshire East Services[102] has been commissioned to provide a specialist mental health stop smoking service. This service is exclusively designed for those identified as having a mental illness. It is provided in the community and includes a harm reduction programme (with pharmacotherapy support for a longer period of time) for those that find it difficult to follow the standard 12 week quit programme. The capacity of the service means that the outcome of this intensive programme is 58 quits per year.

The local mental health service provider – Cheshire and Wirral Partnership Trust - supports their patients to quit and works with specialist service to support those attending the local mental health resource centres.

Recommendations

8.1 As the main commissioners of stop smoking services for Cheshire East, Public Health should work with the specialist stop smoking service to develop their approaches to meet the specific needs of individuals with different forms of mental illness. Performance measures should include the number and proportion of smokers with serious mental illness who are engaged with the service, and outcomes for this group;

8.2 Cheshire East should consider enhancing this service with further investment in order to increase the number of people with a mental illness receiving support and hence achieving an increase in the number of quits for this group of people;

8.3 Mental health services should ensure that a holistic approach is taken when assessing patients and reviewing their care plans. Lifestyle related behaviours such as physical activity, diet, alcohol use and tobacco are all crucial to ensuring that patients do not continue to be at increased risk of premature mortality due to risk factors that are preventable. The integrated approach to lifestyle services provided through One You Cheshire East must be made available to all those receiving mental health services;

8.4 All mental health service staff should continue to receive training in very brief advice as well as providing stop smoking support. Where possible, but especially within inpatient facilities, stop smoking support to patients should be integrated within mental health services. This stop smoking support should range from harm reduction measures such as provision of nicotine replacement therapy on admission, to structured behavioural support and pharmacotherapy for those who want to achieve abstinence;

8.5 All primary care professionals should assess all patients smoking status and offer very brief advice, using the free online training in Very Brief Advice.[99] Smokers should be signposted to the appropriate service – community services (this includes those with low level mental illness) and specialist services for those with a severe mental illness.

Chapter Nine

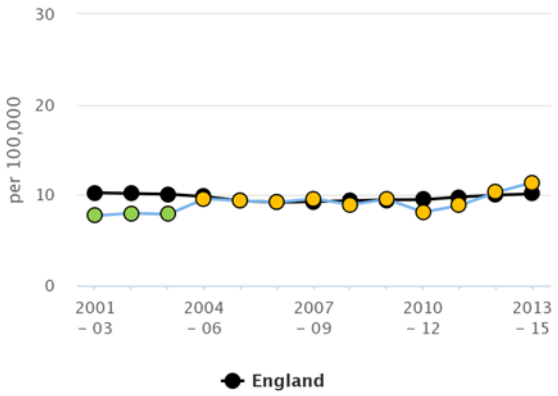
Suicide and Self-harm

The prevention of suicide is like a jigsaw. It requires many pieces to be fitted together in their correct positions. (Adapted from Public Health England's Local Suicide Prevention Planning resource [103])

The Occurrence of Suicide in Cheshire East

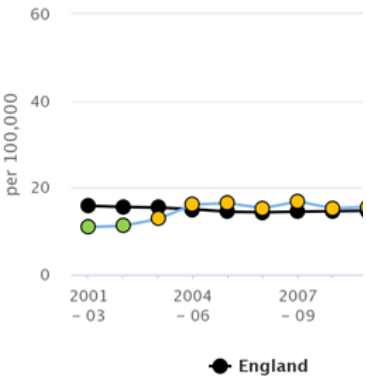
The national definition of suicide includes deaths with an underlying cause of intentional self-harm or an injury or poisoning of undetermined intent. In England, it has been customary to assume that most injuries and poisonings of undetermined intent are cases where the harm was self-inflicted but there was insufficient evidence to prove that the deceased deliberately intended to kill themselves.

Suicide rate (Persons)

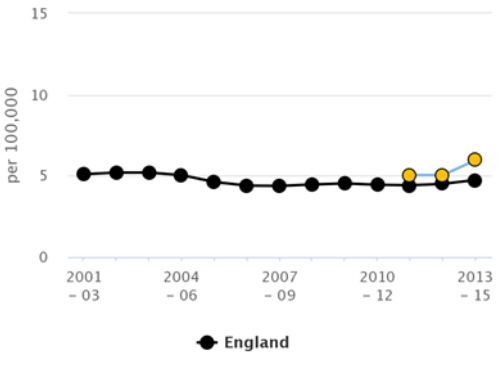


Cheshire East had 115 deaths (85 male, 30 female) from suicide and injury of undetermined intent during the period 2013-2015, an average of 38 deaths per year. The death rate in Cheshire East has recently increased and is currently around 12% higher than the equivalent national rate. Suicide rates in males have increased but remain similar to nationally. Over the recent years for which data has been published, suicide rates in women in Cheshire East have been higher than England.

Suicide rate (Male)



Suicide rate (Female)



During the five year period from 2010 to 2014, the majority (60%) of male suicides in Cheshire East were in men aged between 35 and 64 years. 20% of men were younger than 35 and 20% were older than 65. The figures for women are similar but with a slightly higher proportion of women over 65.

The Cheshire and Merseyside Suicide Reduction Network

The Cheshire East Council Public Health Team is an active part of The Cheshire and Merseyside Suicide Reduction Network (CMSRN) which was formed in 2008 to seek greater co-ordination of responses to and understanding of patterns of suicide. In 2013 the CMSRN came under the collective leadership of the Cheshire Merseyside Directors of Public Health. CMSRN consists of four components: a Partnership Board, an Operational Group, Local Suicide Prevention Groups and a Stakeholder Network. The four components take an integrated approach to a strategic direction and the systematic implementation of action plans and robust provision of effective prevention, treatment and crisis services.

In 2015 the NO MORE Zero Suicide Strategy[104] was published with the key aims of developing Suicide Safer Communities, for healthcare to transform to achieve zero suicides, to support those bereaved and ensure the efforts of the network are sustained.

Outcomes from Year One of the Strategy are:

- Joint Cheshire and Merseyside Suicide Audits have provided the evidence for shared action planning;
- AMPARO, a suicide liaison service, has been jointly commissioned;
- Three Mental Health Trusts have transformed their partnership working;
- Primary Care suicide prevention training is being delivered at scale.

To be effective suicide prevention strategies and interventions need to be multi-disciplinary, combining a range of integrated interventions that build individual and community resilience and target groups of people at heightened risk of suicide.

The Canadian 'Suicide Safe Communities' model has been adopted by Cheshire & Merseyside, Greater Manchester and Brighton and is gaining traction across the UK. The 'Suicide Safer Communities' model has nine pillars that incorporate this multi-disciplinary approach: leadership, intelligence, awareness, training, community interventions, clinical interventions, support for those bereaved, evaluation and sustainability.[105]

The Local Suicide Prevention Group in Cheshire East aims to co-ordinate action across Cheshire East to reduce suicide and self-harm; to ensure communities and individuals are equipped to get the support they need at the right time to prevent further harm.

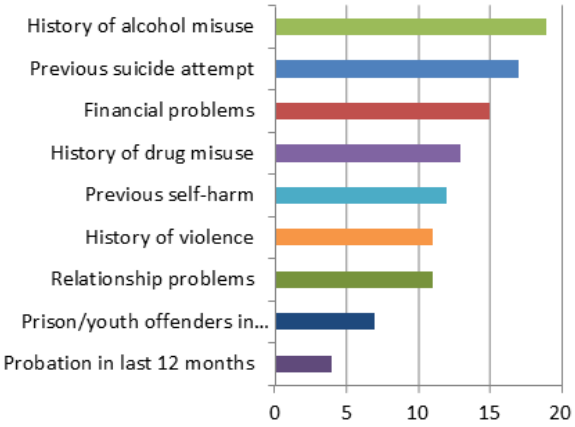
The Group has a Suicide Reduction Action Plan which aligns to the priorities of the National Suicide Reduction Strategy and the Cheshire and Merseyside Zero Strategy.

Suicide risk reflects wider inequalities in society, and there are marked differences in suicide rates according to people's social and economic circumstances. Specific groups of people at higher risk of suicide are those living in poorer communities and young and middle-aged men. Specific factors which are known to increase the risk of suicide are misuse of alcohol and drugs, long term physical health problems, being in the care of mental health services, being in contact with the criminal justice system and having a history of self-harm. Other population risk factors are social isolation and significant life events, for example domestic violence, marital break-up, unemployment, homeless and leaving care.

During early 2016, a member of the public health team carried out a suicide audit which included all inquests with a suicide, open or narrative verdict from November 1st 2014 to October 31st 2015. 45 cases were audited and included 33 suicide verdicts, 7 open verdicts and 5 narrative verdicts. The most common method of suicide was hanging/strangulation which accounted for 39% of deaths. This was closely followed by self-poisoning which accounted for 30% of deaths.

80% of the cases in the audit had at least one known risk factor, as illustrated in the diagram below. Most of these risk factors correspond closely with the national risk factors summarised above, although financial problems were present in a higher than expected proportion of cases locally.

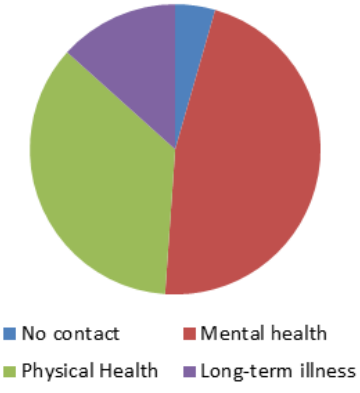
Presence of Known Risk factors



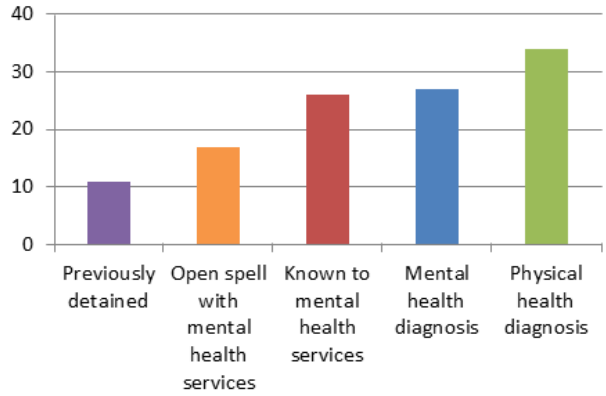
Summary of Most Recent Contact with Services

	GP contact	Mental health contact
Within 1 week	6	8
Within 1 month	20	14
Within 3 months	28	16
Within 6 months	34	18
Within 1 year	39	20
More than 1 year	4	4
No contact	2	21

Reason for Last GP contact



Health Status



Suicide audits identify that many people who die present to their GP in the months prior to their death. The reasons for their presentation have been found to be physical as well as mental illness. This identifies the importance of assessing emotional wellbeing regardless of the primary cause of presentation. In general practice depression screening instruments such as the Patient Health Questionnaire (PHQ-9) are commonly used. It is currently unclear though what the agreed procedure is when a patient answers positively to the question "Do you ever have thoughts that you would be better off dead or thoughts about hurting yourself in some way?"

The recent suicide audit suggested that a suicide risk assessment process is carried out in primary care but a review of case notes identified that this process is often not formally documented. It is suggested that clinicians should document the information that has been considered as part of the risk assessment process. This includes any identified warning signs, protective and risk factors, such as information about the thoughts they have been having, any plans they have made, and past experiences of suicide attempts. This information should then be considered alongside other information such as psychiatric history and treatment to inform the action taken to support the patient's safety.

Real-time Suicide Surveillance

Real-time suicide surveillance is a process that alerts relevant professionals where the circumstances of the death suggest suicide in advance of the Coroners' conclusion. [104] Suicide surveillance can:

1. Be linked to systems that provide timely support to people who have been bereaved or affected by a suspected suicide;
2. Provide intelligence that enables the public health team and/or a multi-agency suicide; prevention group to respond quickly to emerging patterns that could indicate clusters, increasing trends or new methods of death. [105]

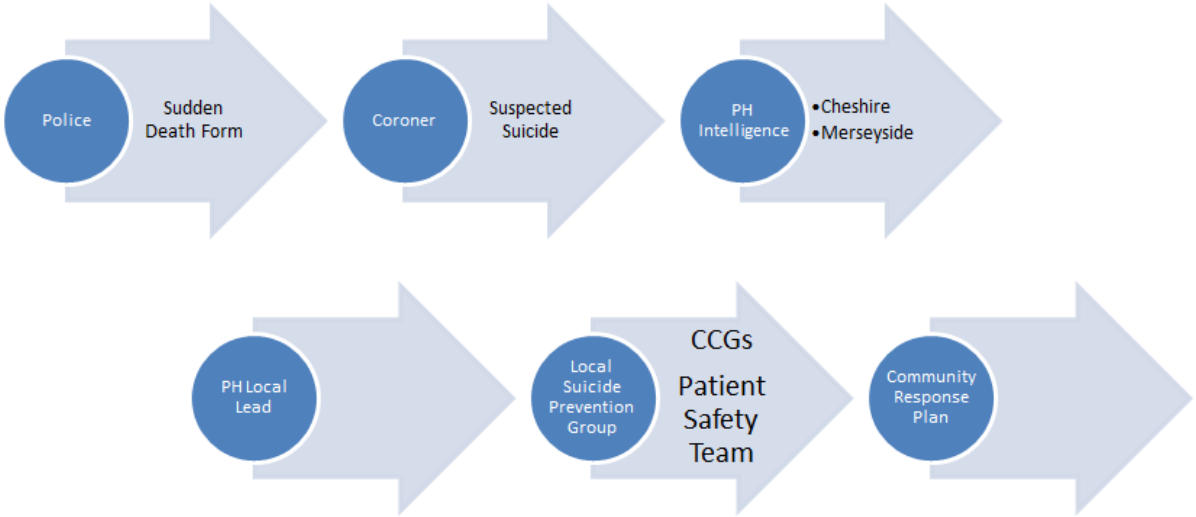
National studies indicate that there are two potential models for real-time suicide surveillance. One can be led by Coroners and the other can be led by the Police who are often the first responders at the scene of a death.

To be effective, either model of real-time surveillance requires the existence of a multiagency partnership that can consider the real-time data in a timely way. A system-wide response process is also required that sets out the agreed triggers and protocols for escalating further action, with clearly set out roles and responsibilities. The potential benefits and limitations are listed below.

Potential benefits	Potential limitations
Provision of timely and appropriate support to people affected: family, community, workplace, social and virtual	Requires considerable partner engagement, information sharing protocols and effective administration, to secure timely, accurate and detailed information
Identification and response to potential suicide clusters and contagion among a particular community or area	Requires agreeing when and how to respond to changing trends and what level of variation is normal so as to ensure measured and effective responses
Identification of any increasing or decreasing suicide patterns within the area including the emergence of new methods	Notified deaths are not confirmed suicides – and may be proven subsequently not to be suicide
Responding to increasing suicides within institutions (e.g. hospitals, prisons, schools) and particular communities	
Identifying any high frequency locations within the area	
Supporting continuous quality improvement of suicide prevention strategies and action plans	

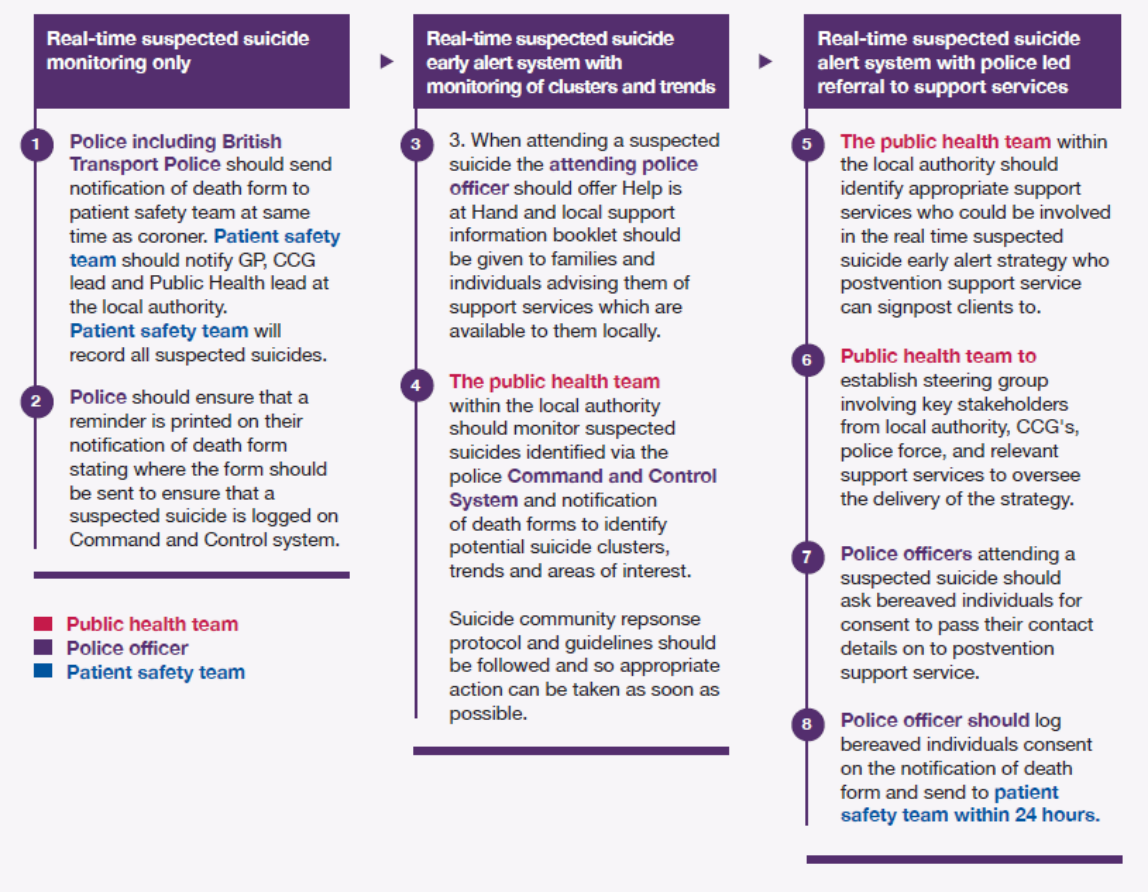
The Cheshire and Merseyside Public Health Collaborative "ChaMPs" is currently developing a real-time surveillance system for Cheshire and Merseyside.[106] The proposed pathway is long and complex and relies on two public health intelligence leads (one for Cheshire and one for Merseyside) receiving information from the Coroner via secure email and then acting on this information in a timely manner. The local public health team then puts arrangements in place to ensure that there is a same-day assessment and response for these notifications throughout the working week.

Diagram: Proposed real-time surveillance system for Cheshire and Merseyside



Other models also exist, and the following example illustrates different elements of a police-led response that may vary according to the desired outcomes of the surveillance system.[107] Note that this approach does not directly involve the Coroner as part of the communication pathway, and it would probably lead to a more timely response than the Cheshire and Merseyside model.

Diagram: Potential model for real-time suicide surveillance



The Public Health Intelligence team in Cheshire East has already carried out considerable planning and development work in preparation for introducing a new suicide surveillance system.[108] It would be feasible for such a system to become operational within just a few months of the decision being taken by the Cheshire East Suicide Prevention Group.

A consensus statement is available specifically about information sharing and suicide prevention.[109] It is helpful to agree a protocol between the relevant multi-agency partners to support effective suicide prevention planning and delivery. An agreement would usually outline the need for each involved organisation to co-operate and provides the legal basis, as well as operational guidelines, for how information will be shared. It ensures that all parties have confidence in what and how the data is being used, as well as ensuring data protection measures are in place. The value of information sharing applies not just to an individual death by suicide or suicidal crisis but also to broader community-based suicide surveillance activities. A Data Sharing Protocol is currently being developed by the Cheshire and Merseyside Public Health Collaborative and will in due course be given to Cheshire East Council to approve.

Supportive Response to Suicide

An effective suicide strategy should have a range of services in place to support those bereaved by suicide, or who are experiencing relationship difficulties, or experiencing financial difficulties. There are currently two support services in place in Cheshire East, both of whom are engaged with the Cheshire East Suicide Prevention Group and support the Suicide Prevention and Response Strategy.

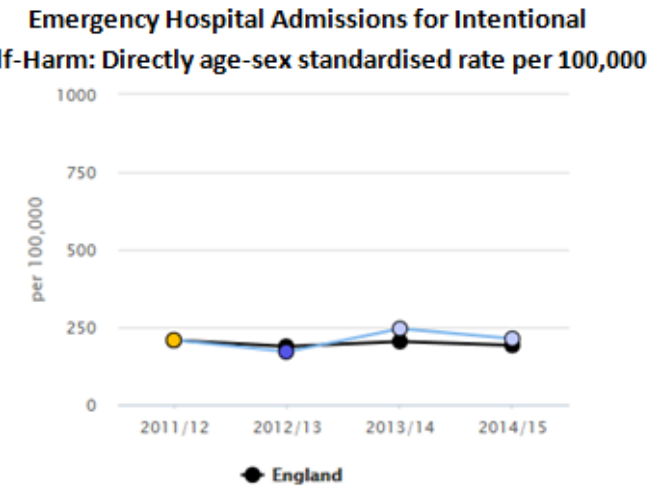
- **Suicide postvention support** – this service is currently provided by Amparo, who are alerted by the Coroner, Police or other professional following a suspected suicide. The initial contact to the bereaved person is within 24 hours of the notification and Amparo will also accept referrals from the bereaved person themself or third parties. Amparo complete a full needs assessment with the individual which highlights their needs and they may then refer the individual to relevant statutory services such as social care or the welfare rights/benefits team, or other support services such as such as Papyrus, the Samaritans and Life Links. Counsellors working for Amparo offer one to one individual support, help with any media enquiries, give practical support around dealing with the police and the Coroner, help with overcoming the isolation experienced, and contacting and signposting to local services;
- **A critical response team for primary and secondary schools** – who support the family and colleagues of the person who has taken their life.

Emergency Hospital Admissions for Self-Harm

The strongest identified predictor of suicide is previous episodes of self-harm. Mental ill-health and substance misuse also contribute to many suicides. We drew attention to the characteristic and patterns of self-injury and self-harm among teenagers and young adults in last year's public health report. We have since published information about patterns of accident and emergency attendances and hospital admissions up to the age of 24 on pages 3, 4 and 10 of the JSNA section on "Self-injury in young people under 25 years" referred to earlier in this report.

Cheshire East had a statistically high number of emergency hospital admissions for self-harm in both 2013/14 and 2014/15, when 874 and 749 people respectively were admitted to hospital after having deliberately harmed themselves.

Primary and secondary care health services are key partners in tackling this high rate of self-harm.



These services come into contact with high risk groups such as people who have long-term mental health problems, people who are misusing drugs and or alcohol, or are feeling isolated or depressed. Suicide prevention strategies must therefore consider and link to programmes of early identification and effective management of self-harm, mental ill-health and substance misuse.

Recommendation

9.1 As part of the new approaches to real-time suicide surveillance, the Cheshire East Public Health Intelligence Team should create a new Suicide Prevention Database that is directly accessible to the Cheshire East suicide lead and the Director of Public Health. The database should have defined processes to capture and collate the following information about suspected suicides:

- coroner-related information such as substances specified in self-poisoning deaths;
- contact with primary care services including reasons for the contact and frequency;
- demographic and family details such as age, gender, ethnicity and family structure;
- social, educational, occupational, residential and workplace characteristics;
- contacts with acute hospital services such as A&E attendance and inpatient admission;
- psychiatric history and psychological assessments.

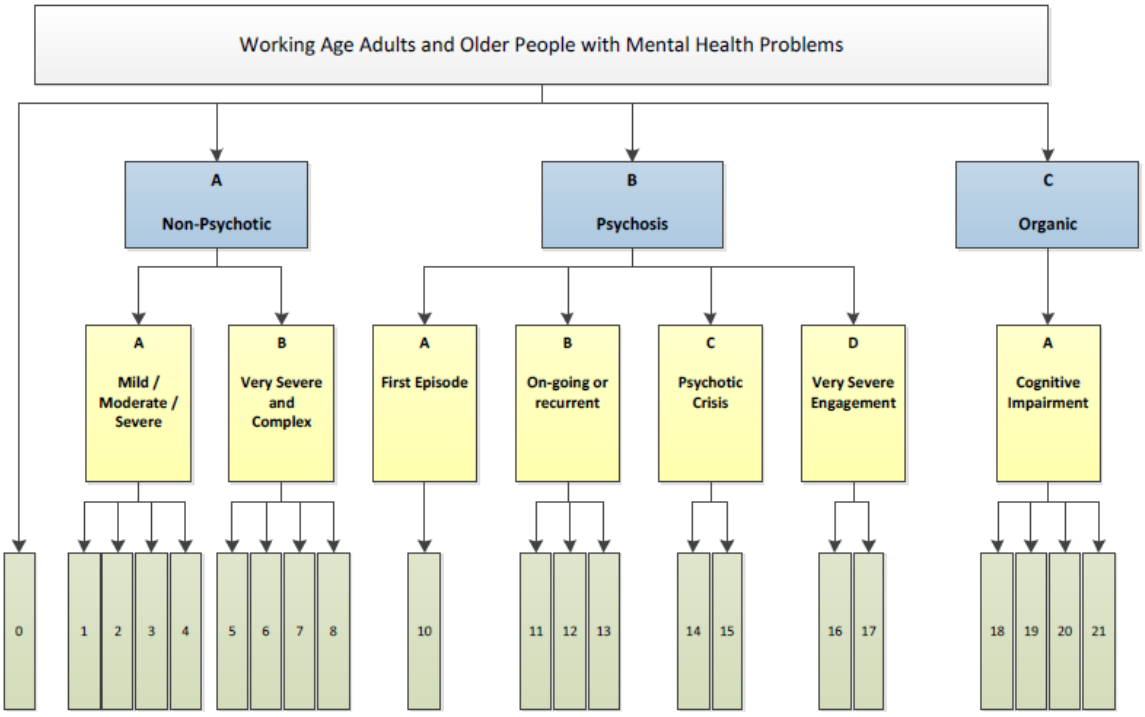
Appendix A – Mental Health Commissioning Currencies

We have chosen to include a technically-focused Appendix in this Public Health report because of the very poor quality of the mental health service data that we used for the children and young people's JSNA, and more recently for the adult mental health JSNA. In chapter seven we remarked how Public Health England also struggled to analyse the data from local specialist mental health services.

We believe that the importance of data quality in examining variations in mental health provision and outcomes should be more widely understood.

Mental Health Care Clusters

Mental health care clusters are the nationally mandated currency for mental health. They cover most mental health services for working age adults and older people. Care clusters allow mental health services to group people together based on their needs. There are currently 21 care clusters, further grouped into three 'super classes' based on much broader similarities in need – Non-Psychotic, Psychosis and Organic, as illustrated in the diagram.



It is recommended that packages of care, based on NICE and other best practice guidance, be agreed for each cluster and translated into cluster based service specifications. It is good practice for commissioners and providers to involve service users, carer groups and general practitioners in this process. The approach aims to:

- Support providers to better understand the care they provide to patients and the resources used to deliver that care;
- Support clinicians to make decisions that deliver the best possible outcomes for patients and improve the quality of care provided;

- Provide information which will enable commissioners and patients to compare provider organisations and to make well-informed decisions.

Assigning Service Users to the Care Clusters

The initial assessment can be triggered in a number of ways, as part of a general practitioner or mental health practitioner referral, in response to a specific request by an organisation such as the police or social services, or through service user self-referral. These initial assessments can be classified in two ways, according to how the assessment was initiated and whether an individual is allocated to a care cluster or not. An assessment may include electronic solutions such as telephone consultations and telemedicine, in addition to a face-to face meeting.

For payment purposes, initial assessment is deemed to be complete once a cluster is assigned or a patient is signposted to other services. If accepted for treatment, the service user will be allocated to a cluster. An electronic decision support tool is available to assist the clinician in allocating a service user to the correct cluster. This should ideally be embedded within clinical systems and used as a part of routine clinical recording. At various points throughout the service user's care, this allocation will be reviewed.

Using the Mental Health Clusters for Payment

Care clusters and initial assessments must be used as the currencies in the standard contract between commissioners and providers, except where providers and commissioners agree an alternative payment approach. An episodic payment approach provides payments to a provider for an individual patient's episode of care, and can help providers and commissioners to better understand the care they provide and the resource used to deliver that care.[110]

For 2017-19, NHS Improvement and NHS England have made changes to the local pricing rules to require providers and commissioners of adult and older adult mental healthcare to adopt either a capitated or episodic/year-of-care payment approach. In either approach, a proportion of prices must be linked to the achievement of locally agreed quality and outcome measures.[111] (2)

Each of the cluster currencies has a maximum review period, as illustrated in the table below. This means that a reassessment should have taken place at the end of the period to check whether the current cluster is still appropriate or whether a new cluster should be assigned. Most of the clusters lend themselves to a year-of-care payment, and for the others the maximum review period should be the indicative episode of care for payment.

All the currencies are independent of setting, and therefore there should be an incentive for providers to care for patients as close to home as possible, in the least restrictive and most cost-effective setting appropriate.

Cluster	Cluster label	Max cluster review period	Suggested payment approach
0	Variance group cluster allocation not initially possible	6 months	Episode
1	Common mental health problems (low severity)	12 weeks	Episode
2	Common mental health problems	15 weeks	Episode
3	Non-psychotic (moderate severity)	6 months	Episode
4	Non-psychotic (severe)	6 months	Year of care
5	Non-psychotic (very severe)	6 months	Year of care
6	Non-psychotic disorders of overvalued Ideas	6 months	Year of care
7	Enduring non-psychotic disorders (high disability)	Annual	Year of care
8	Non-psychotic chaotic and challenging disorders	Annual	Year of care
10	First episode in psychosis	Annual	Year of care
11	Ongoing recurrent psychosis (low symptoms)	Annual	Year of care
12	Ongoing or recurrent psychosis (high disability)	Annual	Year of care
13	Ongoing or recurrent psychosis (high symptoms and disability)	Annual	Year of care
14	Psychotic crisis	4 weeks	Cluster episode (at first presentation)
15	Severe psychotic depression	4 weeks	Cluster episode (at first presentation)
16	Dual diagnosis (substance abuse and mental illness)	6 months	Year of care
17	Psychosis and affective disorder difficult to engage	6 months	Year of care
18	Cognitive impairment (low need)	Annual	Year of care (annual review)
19	Cognitive impairment or dementia (moderate need)	6 months	Year of care (annual review)
20	Cognitive impairment or dementia (high need)	6 months	Year of care
21	Cognitive impairment or dementia (high physical need or engagement)	6 months	Year of care

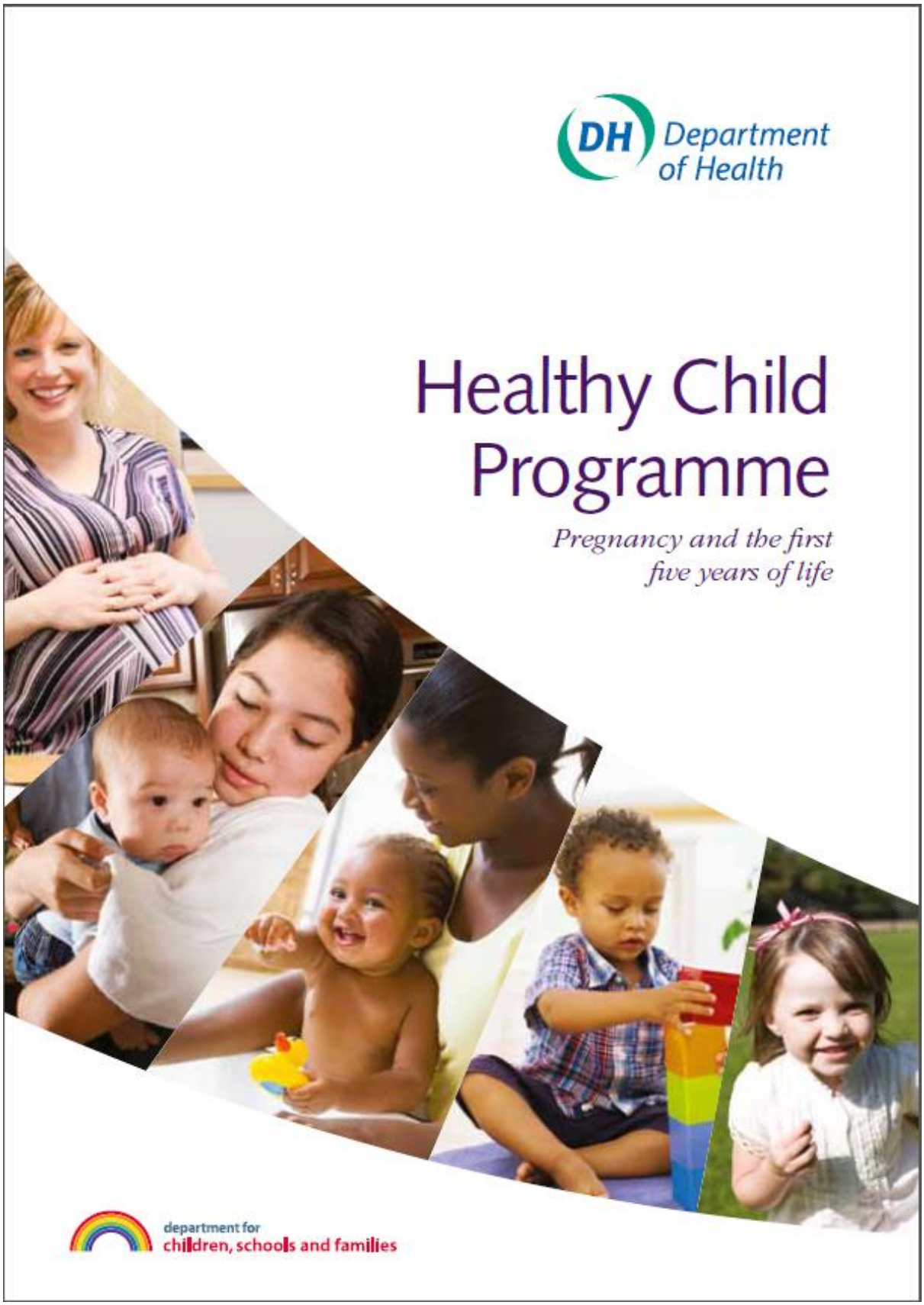
Appendix B - Coverage of the health visitor antenatal check and health visitor new birth visit in Cheshire East

	2015/16 Q1	2015/16 Q2	2015/16 Q3	2015/16 Q4	2016/17 Q1	2016/17 Q2
Face to face HV contacts at 28 weeks	302 (34.6%)	255 (29.1%)	339 (35.5%)	346 (41.6%)	90 (9.2%)	120 (11.7%)
Face to face HV new birth visits by 14 days	830 (94.9%)	832 (95.3%)	837 (95.4%)	925 (96.9%)	785 (94.5%)	795 (81.1%)
Estimated pregnancies at 28 weeks	873	877	955	831	980	1024
Infants who turned 30 days	875	873	877	955	831	980
Source: Health Visitor Service Delivery Metrics at www.chimat.org.uk/transfer						

It is suspected that data quality issues are affecting the Quarter 1 and Quarter 2 figures for Face to face HV contacts at 28 weeks, following the introduction of a new I.T. system.

Appendix C - Healthy Child Programme. Pregnancy and the first years of life.

Department of Health Guidance



UP TO
28
WEEKS

Pregnancy

Universal

Promotion of health and wellbeing

- A full health and social care assessment of needs, risks and choices by 12 weeks of pregnancy by a midwife or maternity healthcare professional.
- Notification to the HCP team of prospective parents requiring additional early intervention and prevention (see page 17).
- Routine antenatal care and screening for maternal infections, rubella susceptibility, blood disorders and fetal anomalies. Health and lifestyle advice to include diet, weight control, physical activity, smoking, stress in pregnancy, alcohol, drug intake, etc. See NICE guidance on antenatal care CG6 (National Collaborating Centre for Women's and Children's Health, 2003).
- Distribution of *The Pregnancy Book*[11] to first-time parents; access to written/online information about, and preparation for, childbirth and parenting; distribution of antenatal screening leaflet.
- Discussion on benefits of breastfeeding with prospective parents – and risks of not breastfeeding.
- Introduction to resources, including Sure Start children's centres, Family Information Services, primary healthcare teams, and benefits and housing advice.
- Support for families whose first language is not English.

Preparation for parenthood

To begin early in pregnancy and to include:

- information on services and choices, maternal/paternal rights and benefits, use of prescription drugs during pregnancy, dietary considerations, travel safety, maternal self-care, etc.; and
- social support using group-based antenatal classes in community or healthcare settings that respond to the priorities of parents and cover:
  - the transition to parenthood (particularly for first-time parents); relationship issues and preparation for new roles and responsibilities; the parent–infant relationship; problem-solving skills (based on programmes such as Preparation for Parenting, First Steps in Parenting, One Plus One[12]);
  - the specific concerns of fathers, including advice about supporting their partner during pregnancy and labour, care of infants, emotional and practical preparation for fatherhood (particularly for first-time fathers);
  - discussion on breastfeeding using interactive group work and/or peer support programmes; and
  - standard health promotion.

11 www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107302

12 www.oneplusone.org.uk/

Pregnancy

UP TO 28 WEEKS

Progressive (including Universal)

Ambivalence about pregnancy, low self-esteem and relationship problems

Problems should be addressed using:

- techniques to promote a trusting relationship and develop problem-solving abilities within the family (e.g. promotional/ motivational interviewing; the Family Partnership Model;[13] and the Solihull Approach[14]):
  - establish what each parent's individual support needs are;
  - provide one or two structured listening support contacts;
  - work in partnership with families to develop problem-solving skills;
- support to access antenatal care; and
- preparation for parenthood (which could include separate sessions for fathers only).

Women experiencing anxiety/ depression in addition to the problems above

- If no previous episode of depression or anxiety: social support (individual or group-based, including antenatal groups and parenting classes); assisted self-help (computerised cognitive behavioural therapy; self-help material presented to a group or individuals by a health worker/ paraprofessional).
- For women with previous episodes of non-clinical symptoms of depression and anxiety: brief (four to six weeks), non-directive counselling delivered at home (listening visits[15]) by skilled professionals, and access to local social support; or referral for brief psychological treatments (such as cognitive behavioural therapy or interpersonal therapy).

Women who smoke

Women who smoke should be offered:

- smoking cessation interventions, including behavioural interventions combined with social support and incentives for achievement, and telephone counselling (NHS helplines);
- involvement of partners, if they agree, in the implementation of smoking-reduction/ cessation programmes; and
- additional strategies, such as planning of smoke-free environments for children (e.g. areas within the home that are smoke-free).

Women who are overweight or obese

Women who are overweight or obese should be offered:

- weight control strategies to reduce risks to both mother and baby;
- advice about healthy eating and physical activity; and/or
- referral to weight management services.

Breastfeeding

- Discussion on infant feeding and support to tackle practical barriers to breastfeeding.
- Discussion of benefits and drawbacks for mother and child.
- Discussion with the prospective father.

13 www.cpcs.org.uk/
14 www.solihull.nhs.uk/solihullapproach/

15 Listening visits are defined as unstructured, client-led discussions involving the counsellor in: active listening; reflection; providing empathic responses; encouraging the expression of experiences and accepting the emotions expressed; and not offering information or advice.

Pregnancy

AFTER 28 WEEKS

Universal

Promotion of health and wellbeing

- Ongoing identification of families in need of additional support using criteria identified above (see page 33).
- As for pregnancy up to 28 weeks.

Preparation for parenthood

- As for pregnancy up to 28 weeks (see page 33).
- Distribute the *Parent's Guide to Money* information pack, designed to help expectant parents plan their family finances.[17]

Involvement of fathers

- As for pregnancy up to 28 weeks (see page 33).

Antenatal review for prospective mother and father with HCP team

- Focus on emotional preparation for birth, carer–infant relationship, care of the baby, parenting and attachment, using techniques such as promotional interviewing (see page 23) to:
  - identify those in need of further support during the postnatal period; and
  - establish what their support needs are.
- Inform about sources of information on infant development and parenting, the HCP and Healthy Start.
- Distribute newborn screening leaflet.
- Provide information in line with Department of Health guidance on reducing the risk of SIDS.
- Distribute and introduce personal child health record.

Progressive (including Universal)

- As for pregnancy up to 28 weeks (see page 34).

For parents at higher risk

- As for pregnancy up to 28 weeks (see page 35).

17 Information on the *Parent's Guide to Money* is available at www.fsa.gov.uk

For parents at higher risk

Including at-risk first-time young mothers; parents with learning difficulties; drug/ alcohol abuse; domestic violence; serious mental illness.

At-risk first-time young mothers

- Intensive, evidence-based programmes that start in early pregnancy, such as the Family Nurse Partnership programme.[16]
- Multimodal support combining home visiting, peer support, life skills training and integration within social networks recommended for pregnant adolescents.

Parents with learning difficulties

- Information on support available to parents with learning disabilities, and assistance in interpreting information and accessing other sources of support.
- Specialist multi-agency support should include individual and group-based antenatal and parent education classes, and home visiting.
- Further support designed to address the parent's individual needs might include speech, language and occupational therapy.

Drug abuse

- Referral of one or both parents to local specialist services as part of a multi-agency strategy.
- HCP team to contribute to care package led by specialist service.
- Doula programmes (a combination of home visiting, role modelling and community support) may also help to prevent attrition and increase sensitivity of mothers who are in recovery.

Alcohol abuse

- Referral of one or both parents to local specialist services as part of a multi-agency strategy.
- HCP team to contribute to care package led by specialist service.

Domestic violence

- Follow local guidelines.
- Following assessment, provision of a safe environment in which victims of domestic violence can discuss concerns.
- Provision of information about sources of support for domestic violence.
- Referral to local specialist services as part of a multi-agency strategy.
- HCP team to contribute to care package led by specialist service.

Serious mental illness

- Referral of one or both parents to specialist mental health/perinatal mental health service.
- HCP team to contribute to care package led by specialist service.

16 Currently being piloted in England.

Appendix D – Psychosis Report Indicator Definitions

1. Estimated number of new cases of psychosis. This indicator is an estimate of the number of new, clinically-relevant cases of first episodes of psychosis among people aged 16-64. The actual demand for severe mental health care services, including early intervention services, will likely be higher than the predictions, given a degree of people who will consume service resources and who may require some form of mental health care intervention, but who are not found to meet clinical criteria for severe mental illness.

2. Recorded number of people with severe mental illness. The number of people on a general practitioner mental health register (people diagnosed with schizophrenia, bipolar disorder or other psychoses or on lithium therapy) expressed as a percentage of the total GP register population for all ages.

3. Recorded number of people with psychosis. The number of people in scope for mental health currencies at the end of November 2015 assigned to the psychosis supra cluster expressed as a rate per 100,000 resident population. There are some issues with data quality as only 85% of people in scope for Mental Health currencies were assigned to a care cluster.

4. People with psychosis in specialist mental health services who are on CPA. The number of people in scope for mental health currencies at the end of November 2015 assigned to the psychosis supra cluster (clusters: 10 to 17) who had an open care programme approach episode at the end of November 2015.

5. People with severe mental illness in primary care with a comprehensive care plan. Up to half of people who have a serious mental illness (SMI) are seen only in a primary care setting, it is important therefore that the primary care team takes responsibility for discussing and documenting a care plan in their primary care record. Patients on the SMI register should have a documented primary care consultation that acknowledges, especially in the event of a relapse, a plan for care. The consultation should include the views of the person with SMI, and relatives or carers where appropriate. This indicator reflects good professional practice and is supported by NICE guidelines.

6. People with psychosis in specialist mental health services with a crisis plan in place. People with mental health problems should have the same rapid access to high quality care as people with physical health problems. In 2014 the Crisis Care Concordat formed to plan improvement to the crisis care that people received. The Concordat describes what people experiencing a mental health crisis should be able to expect of public services (health, local authority and criminal justice) that respond to their needs and is arranged around: access to support and prevention before crisis point; urgent and emergency access to crisis care; the right quality of treatment and care when in crisis; recovery and staying well, and preventing further crises. Monitoring levels of people with a crisis plan will identify the first stages of ensuring good professional practice in the planning of crisis care for people with psychosis.

7. People with psychosis admitted to hospital in an emergency. Emergency admissions to hospital can be avoided if local systems are put in place to identify those at risk prior to attendance and target primary care services, as well as to identify those emergency department attendees better

cared for outside of hospital and provide a safe route into more appropriate community care. Monitoring emergency hospital admissions gives an indication of the effectiveness of local health and care services in working better together to support people's health and independence in the community and reducing the number of unplanned admissions to hospital.

8. People with psychosis in specialist mental health services in employment. It is estimated that just 5-15% of people with schizophrenia are in employment, and people with severe mental illness are six to seven times more likely to be unemployed than the general population. Employment is an important factor in supporting the recovery process. The Five Year Forward View for Mental Health highlights the importance of stable employment in contributing to good mental health.

9. People with psychosis in specialist mental health services in settled accommodation. Housing is an important factor in supporting the recovery process. The Five Year Forward View for Mental Health highlights the importance of stable housing contributing to good mental health but people with mental health problems are less likely to be home owners and far more likely to live in unstable environments. Monitoring levels of people in settled accommodation will identify where people with psychosis are being supported to enable them to lead full and independent lives.

10. People with severe mental illness who have received the complete list of primary care physical health checks. People with mental health problems such as psychosis are at increased risk of poor physical health and premature mortality. The causes of premature death are mainly from chronic physical conditions such as coronary heart disease, type 2 diabetes and respiratory diseases. These physical conditions are associated with modifiable risk factors such as smoking, obesity and high blood pressure and are seen as preventable with recommended monitoring of physical health together with appropriate interventions and treatment. NICE quality standard QS808 includes Quality Statement Six: Assessing physical health. This requires evidence of local arrangements to ensure adults with psychosis or schizophrenia receive comprehensive physical health assessments on a regular basis, with a focus on cardiovascular disease risk assessment. There are six advised cardiometabolic assessments: family history, smoking, body mass index (BMI), blood glucose, blood lipids and blood pressure. NICE guidelines CG1786 includes recommendations on continuing to check for physical health problems and covers relevant NICE guidance on treatment of those identified as having high blood pressure, abnormal lipid levels, being obese, or have diabetes and/or cardiovascular disease.

11. People with severe mental illness who were exempt from physical health checks. An exception relates to registered patients who are on the relevant disease register who should be included in the indicator denominator, but who are excepted by the GP practice on the basis of one or more of the exception criteria as set out in General Medical Services Statement of Financial Entitlements Directions. The concept of exception reporting is to ensure that GP practices are not penalised on practice achievement, for example, where patients have been recorded as being invited to attend for review, but have refused. However, where exceptions are applied this may result in people with SMI who are in most need, and need outreach to be brought into appointments, being excluded from physical health checks. Seeking to understand why some areas have higher rates of QOF exceptions and sharing models of good practice in offering enhanced services and outreach to these harder to reach patients would greatly benefit this patient group?

12. People with severe mental illness who are current smokers. People with mental health problems such as psychosis are at increased risk of poor physical health and premature mortality. One of the main causes of premature death is respiratory disease which is associated with modifiable risk factors such as smoking, and is seen as preventable with recommended monitoring of physical health together with appropriate interventions and treatment.

13. Women aged 25 to 64 years with severe mental illness who have had a cervical screening test. This indicator encourages practices to ensure that women with schizophrenia, bipolar affective disorder or other psychoses are given cervical screening according to devolved national guidelines.

14. Excess premature mortality for people with severe mental illness. There is extensive published evidence that people with severe mental illness, such as schizophrenia, die between 15 and 25 years earlier than the average for the general population. The causes of premature death are mainly from chronic physical conditions such as coronary heart disease, type 2 diabetes and respiratory diseases. These physical conditions are associated with modifiable risk factors such as smoking, obesity and high blood pressure, and are also associated with side effects of psychiatric medication. However, they are seen as preventable with comprehensive assessment, treatment and recommended safe monitoring of physical health and the side effects of medication. This indicator covers deaths age 18-74 that occurred between 1/4/2013 to 31/3/2014 among people who were in contact with MHMDS from 1/4/2011 to 31/3/2014.

Appendix E - Data Tables for Suicide and Self-Harm rates in Cheshire East

Suicide Rate (Persons)

Recent trend: –

Period		Count	Value	Lower CI	Upper CI	North West	England
2001 - 03	●	73	7.7	6.0	9.7	11.2	10.3
2002 - 04	●	75	8.0	6.3	10.0	10.7	10.2
2003 - 05	●	75	7.9	6.2	9.9	10.9	10.1
2004 - 06	●	92	9.6	7.7	11.8	10.8	9.8
2005 - 07	●	90	9.4	7.5	11.5	10.7	9.4
2006 - 08	●	89	9.2	7.4	11.4	10.3	9.2
2007 - 09	●	93	9.6	7.7	11.8	10.7	9.3
2008 - 10	●	88	8.9	7.2	11.0	10.5	9.4
2009 - 11	●	94	9.6	7.7	11.7	10.8	9.5
2010 - 12	●	79	8.1	6.4	10.1	10.8	9.5
2011 - 13	●	87	8.9	7.1	10.9	11.3	9.8
2012 - 14	●	104	10.3	8.4	12.5	11.5	10.0
2013 - 15	●	115	11.4	9.4	13.7	11.3	10.1

Source: Public Health England (based on ONS source data)

Compared with benchmark ● Better ● Similar ● Worse

Suicide Rate (Male)

Recent trend: –

Period		Count	Value	Lower CI	Upper CI	North West	England
2001 - 03	●	51	10.9	8.1	14.4	17.1	15.9
2002 - 04	●	51	11.2	8.3	14.8	16.3	15.6
2003 - 05	●	59	12.9	9.7	16.6	16.9	15.4
2004 - 06	●	73	16.1	12.5	20.4	17.0	15.1
2005 - 07	●	75	16.4	12.8	20.7	17.1	14.5
2006 - 08	●	69	15.3	11.8	19.5	16.5	14.4
2007 - 09	●	77	16.9	13.2	21.1	17.0	14.5
2008 - 10	●	71	15.3	11.9	19.3	16.8	14.6
2009 - 11	●	74	15.6	12.3	19.6	17.2	14.7
2010 - 12	●	57	12.2	9.2	15.8	17.3	14.8
2011 - 13	●	62	13.3	10.1	17.1	18.2	15.5
2012 - 14	●	78	16.0	12.6	20.0	18.2	15.8
2013 - 15	●	85	17.2	13.7	21.3	17.6	15.8

Source: Public Health England (based on ONS source data)

Suicide Rate (Female)

Recent trend: –

Period		Count	Value	Lower CI	Upper CI	North West	England
2011 - 13		25	5.0	3.2	7.5	4.7	4.4
2012 - 14		26	5.0	3.3	7.4	5.1	4.5
2013 - 15		30	6.0	4.0	8.5	5.3	4.7

Source: Public Health England (based on ONS source data)

Emergency Hospital Admissions for Intentional Self-Harm: Directly age-sex standardised rate per 100,000

Recent trend: –

Period		Count	Value	Lower CI	Upper CI	North West	England
2011/12		685	208.3	192.7	224.8	271.8	207.9
2012/13		614	170.8	157.4	185.0	245.3	188.0
2013/14		874	245.4	229.3	262.4	271.5	204.0
2014/15		749	213.1	198.0	229.1	257.7	191.4

Source: Hospital Episode Statistics (HES), Health and Social Care Information Centre for the respective financial year, England. Hospital Episode Statistics (HES) Copyright © 2016, Re-used with the permission of The Health and Social Care Information Centre. All rights reserved. Local Authority estimates of resident population, Office for National Statistics (ONS) Unrounded mid-year population estimates produced by ONS and supplied to the Public Health England. Analysis uses the single year of age grouped into quinary age bands, by sex.

Compared with benchmark Better Similar Worse Lower Similar Higher Not Compared

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Chapter Two

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