

Component 1: Coursework Portfolio

Task 1: Guided Scenario Response – Community Mental Health Services (Mini-Report)

Task 2: Essay – The Ambulance Service

Name: Muhammad Ali Faisal

Student number: 2525261

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Task 1: Guided Scenario Response – Mini-Report

To: Councillor Sabina Akhtar, Cabinet Member for Healthy, Caring and Inclusive Communities (Health, Wellbeing and Social Care), London Borough of Tower Hamlets

From: **Muhammad** Ali Faisal

Date: 15 October 2026

Subject: Addressing the shortage of community mental health services in Tower Hamlets

1. Introduction

Dear Councillor Akhtar,

This report proposes how the Council can address the shortage of community mental health services in Tower Hamlets, drawing on Part One of the Care Act 2014. Section 1 requires the Council to promote individual wellbeing, which expressly includes mental health and emotional wellbeing (Care Act 2014, s.1), and statutory guidance describes wellbeing as the common theme around which care and support is built (DHSC, 2025a). Sections 2 to 5 add duties to prevent needs, integrate with the NHS, provide information and advice, and shape a diverse, high-quality provider market.

Demand is outstripping capacity. Nationally, secondary mental health services received an average of 453,930 new referrals each month in 2024/25, 15% more than in 2022/23, and one third of respondents to the 2024 community mental health survey waited three months or more between assessment and first treatment appointment (CQC, 2025). Locally, the Health and Wellbeing Board heard in February 2026 that the previous adult mental health strategy expired in 2024 and that a system-wide approach is required (LBTH, 2026).

2. Impact on the community

Need is rising and unequal. The latest national survey found that 22.6% of adults aged 16 to 64 had a common mental health condition in 2023/4, rising to 25.8% among young adults, with socioeconomic inequalities persisting (Morris et al., 2025). Tower Hamlets' needs assessment links mental illness to deprivation, shows higher common mental illness among women, and reports that Black men experience disproportionately high rates of severe mental illness, hospital admission and detention under the Mental Health Act (LBTH, 2026).

Community mental health teams have also reported increasing complexity among referrals (LBTH, 2021).

Capacity cannot keep pace. Vacancy rates in NHS mental health services exceed those across the wider NHS (King's Fund, 2024), staff shortages and poor integration undermine community care, and urgent referrals to crisis services have risen steeply (CQC, 2025). There are significant differences in waiting times, ranging from two weeks for early intervention in psychosis to much longer for other services (Centre for Mental Health, 2025). Residents' needs become a crisis if they are not met in time, which puts additional strain on emergency services and reduces the Council's capacity to fulfil its wellbeing and assessment obligations (Care Act 2014, ss.1, 9). Reform of the Mental Health Act, which received Royal Assent in December 2025, aims to reduce reliance on detention and therefore increases the need for robust community alternatives (DHSC, 2026; RCPsych, 2026).

3. Recommended response

I recommend that the Council, with NHS and voluntary sector partners, takes the following actions:

1. Adopt a co-produced adult mental health strategy by spring 2027, using the Joint Strategic Needs Assessment as its evidence base and giving the Mental Health Partnership Board a clear role (LBTH, 2026).
2. Develop neighbourhood mental health teams jointly with the NHS, embedding mental health social workers, in line with the national neighbourhood model (DHSC, 2025b; DHSC, 2026). This discharges the integration and cooperation duties in sections 3 and 6.
3. Shape the market under section 5 by refreshing the market position statement and using partnership commissioning with voluntary, community and faith organisations, which better reflects the Act's co-productive intent than purely contract-driven approaches (Needham et al., 2022). Prioritise culturally tailored provision for Black men and for women.
4. Improve prevention and access (sections 2 and 4) through peer support and accessible, easy-to-understand information to residents to get help before crisis.
5. Report assessment and waiting times quarterly to the Health and Wellbeing Board and fund and monitor delivery using pooled Better Care Fund resources, which government intends to reform to ensure consistent joint funding (DHSC, 2026).

These measures are realistic in that they are based on existing partnerships and reconfiguration of existing spending, not the development of new services. The pace of

change will be limited by national workforce shortages (King's Fund, 2024) and so a phased delivery with clear milestones is recommended.

4. Conclusion

The provision of community mental health services has not matched the increasing and inequitable demand in Tower Hamlets. The Council can help to reduce waiting, prevent crisis and improve wellbeing by taking action on its responsibilities under Part One of the Care Act 2014. I recommend that Cabinet approve these five actions and ask for a report back to the Health and Wellbeing Board in six months.

Yours sincerely,

[Your name]

Task 2: Essay

The ambulance service: origins, contemporary functioning and contribution to quality of life

Introduction

Ambulance services are often considered as just a means of transport for infectious patients, but they are a complex clinical and organisational system that has developed from transporting infectious patients to providing urgent treatment. This essay explores the history and development of ambulance services in England, critically reviews the current role of ambulance services and considers their importance to the quality of life of those who use them.

Origins and historical context

The provision of organised ambulances was not a development of emergency medicine, but of public health in the nineteenth century. In London the Metropolitan Asylums Board, established to look after the sick poor, was given powers in 1879 to provide ambulances and operated the first horse-drawn service, transporting patients with fevers to isolation hospitals (London County Council, 1958). Provision remained fragmented: the London County Council began its own accident ambulance service in 1915 and absorbed the Board's service on 1 April 1930 (London County Council, 1958; London Ambulance Service, n.d.a). After the NHS was established, local health authorities provided a free ambulance service, but its function remained largely transport.

The decisive shift came with the Millar Report of 1966, which recommended that crews deliver lifesaving treatment at the scene (London Ambulance Service, n.d.b). Administrative change followed: London's services were unified in 1965, transferred from local government to the NHS in 1974, and became an NHS trust in 1996 (London Ambulance Service, n.d.a). Paramedics subsequently became a regulated profession with a protected title in the early 2000s, although their history is considerably older (Eaton, 2023).

How the service functions today

Today ambulance services are one component of the wider urgent and emergency care system. Calls are prioritised by clinical urgency, and the standard for Category 2 emergencies such as stroke, heart attack, sepsis or major trauma is an 18-minute average, temporarily relaxed to 30 minutes during recovery (NHS Providers, 2025). NHS England's 2025/26 plan retains a 30-minute target and introduces a maximum 45-minute hospital handover standard (NHS England, 2025). Performance has improved: Category 2 calls averaged 27 minutes 34 seconds in April 2025, despite the busiest April on record with 748,540 incidents (NHS Providers, 2025).

However, this is fragile and relies on factors outside of the control of the ambulance. The Health Foundation (2022) reported that in July 2022, the average wait for a handover was over 15 minutes, which resulted in a loss of almost 20% of ambulance capacity, and that a fifth of ambulance staff sickness absence was due to poor mental health. Harm is also significant: a clinical review identified that more than 80% of patients who were delayed beyond 60 minutes potentially experienced harm, and 9% potentially severe harm (AACE, 2021); and delays increased over a decade (AACE, 2023). Importantly, these data indicate that targets focus on symptoms, as response times are influenced by hospital flow and community capacity, not just ambulance resources. The Health Foundation (2022) therefore calls for investment in community services, such as mental health services, to help to decrease demand.

The profession is also evolving. Paramedics are now employed in primary and urgent care, but a systematic review identified a lack of detail regarding the clinical contribution of paramedics (Eaton et al., 2020). Advanced life support skills are central to the identity of the profession, but make up less than 10% of the current workload, and knowledge of the role of the paramedic in policy is low (Eaton, 2023). This discrepancy between training focus and real need should be further explored.

Significance for quality of life

The ambulance service has a tangible impact on quality of life. The time-sensitive nature of the issues identified in national policy, where delay can result in death or permanent disability, is crucial (NHS England, 2025). Home or community treatment can also prevent unnecessary admissions and maintain independence. There is evidence that paramedics in primary care can decrease the workload of general practitioners for urgent, non-complex patients, but that sometimes supervision issues extended consultations (Eaton et al., 2020). On the other hand, long waiting times and handovers in the corridors have a negative impact on dignity and safety, and patients and staff suffer the consequences (AACE, 2021; AACE, 2023). Ambulance crews are also often the first point of contact in a mental health crisis, and the significant increase in urgent referrals to crisis services highlights the importance of integrated pathways between emergency and community care for vulnerable individuals (CQC, 2025).

Conclusion

The ambulance service has developed from transporting infectious patients to mobile clinical care and continues to play a key role in the safety, recovery and wellbeing of service users. Its effectiveness, however, depends on integrated urgent care and strong community

services. System-wide reform is needed to sustain improvements in quality of life, as well as ongoing development of the paramedic workforce.

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