

LCHS4003 Component 1

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TASK 1

Community mental health services		
Explanation of the Service Community Mental Health Services (CMHS) are one of the essential pillars of the UK National Health Service (NHS), and they are tailor-made to offer psychiatric care and clinical treatment to the population in their respective homesteads or their neighborhoods. In contrast to the traditional inpatient care that requires a hospital residency, CMHS is incompatible with the so-called recovery model, which views the maintenance of independence, social networks, and life quality of a service user as he or she has to cope with the long-term or acute mental health disorders. Who Uses the Service? The service is mainly used by adults and older adults who have moderate to severe mental health issues that can only be addressed by more specialist intervention than the General Practitioner (GP) can do (Roussak et al., 2024). This covers persons who are diagnosed with complex conditions like schizophrenia, bipolar affective disorder, severe clinical depression, post-traumatic stress disorder (PTSD) and different personality disorders. Who Provides the Service? Treatment is provided in the form of a complex Multi-Disciplinary Team (MDT). The team approach that is used here will make sure that the psychological, social as well as the biological needs of the patient are addressed at the same time. Key professionals include: • Psychiatrists: Medical doctors in the diagnosis and medication management. • Community Mental Health Nurses (CMHNs): Who do the coordination of care and clinical follow up (Averill et al., 2024). • occupational therapists: those who help service users to acquire functional skills to live. • Social Workers: Who assume the protection, residential, and social assimilation.	Brief History of the Service The development of CMHS can be considered one of the most crucial changes in British social policy, shifting to the integration instead of segregation. The Victorian asylum model dominated the 19th century and the early 20th century (Jones, 2023). Thousands of people became incarcerated under the 1845 Lunacy Act in huge, remote institutions situated at the city limits. The changing point came with Mental Health Act 1959, which was the first instance that introduced the idea of deinstitutionalisation. The 1961 speech by Health Minister Enoch Powell on the landmark Hospital Plan speech was above that. The speech by Powell titled Water Tower was the legendary one which foretold the death of the giant and remote mental hospitals and suggested their substitution by psychiatric units in general hospitals and strong support services in the community. In the 1980s and 1990s, the Care in the Community program increased this shift, and after the Victorian asylums had been shut down, local hostels, supported housing, and community teams came to replace them (McIntyre et al., 2022). This care was given a contemporary legal framework by the Mental Health Act 1983. It placed particular focus on the principle of least restrictive, which rendered that patients should be classified in the community provided that they can be safely handled.	Challenges Issue 1: The Workforce Crisis. Of utmost concern is a chronic lack of qualified professionals in the field of healthcare. Presently, there is a great national shortage of mental health nurses and psychiatrists. The NHS Confederation (2025) states that such shortages result in dangerously high caseloads that can cause one nurse to have 30 to 40 complex patients (Silvonen, 2025). Such a working environment leads to a burnout cycle and staff exit the profession after experiencing stress which only increases the situation. To the service user this proves to be lack of continuity, the service user may experience a number of different locum workers as opposed to a developing therapeutic relationship with one particular clinician which is essential to mental health recovery. Issue 2: The Treatment Gap and Increased Demand. The ensuing cost of living crisis and COVID 19 pandemic has caused a flood of mental health referrals. This is however, not matched by the funding and capacity. The Care Quality Commission (2025) has indicated the existence of an increasingly large treatment gap whereby patients who are then rated as requiring assistance are placed on a waiting list of months, or even years, until specialist psychological treatments. In most areas, one in every three users of services has to wait more than 18 weeks to obtain a first treatment session. In this waiting period, a good number of them become worse, as they shift to a level between "moderate" distress to a complete and full-blown crisis, which only ends up giving more weight on the emergency services and the inpatient wards.
 Sources: (McIntyre et al., 2022)		
Current Functioning CMHS is no longer an organization but a web of specialized pathways in the present environment where appropriate care is given at the appropriate time. The contemporary service has been incorporated in the NHS long-term plan, which addresses proactive and not reactive care. • Community Mental Health Teams (CMHTs): These are the mainstay of the service. They deal with intermittent care management of patients with chronic illnesses, which includes frequent check-ins, control of medications and social support, which helps them to avoid relapse. • Crisis Resolution and Home Treatment Teams (CRHTs): Sometimes referred to as the A&E of mental health, these teams offer intensive, short-term engagement of individuals going through a mental health emergency. • Early Intervention in Psychosis (EIP): This is an evidence-based service targeting patients under 65 and above. Studies indicate that early intervention can have a considerable long-term outcome, as it lowers the risk of permanent disability (NHS England, 2021). • Intensive Care Systems (ICS): Mental health services are becoming engaged with primary care (GPs) and the voluntary sector in accordance with the provisions of the Health and Care Act 2022 (McSherry et al., 2022).		
 Sources: (McSherry et al., 2022)		

TASK 2 Essay: Ambulance Services

Origins and Historical Context.

The British ambulance service has experienced a radical change from a simple transportation service to a multi-layered mobile clinician. In the past, the service originated from the need to overcome the Napoleonic Wars, during which the wounded used to be transported by so-called flying ambulances. Back in the late 19th century, the Metropolitan Asylums Board in the UK had machines that were drawn by horses to take the patients with fevers; however, that was purely to get them to a hospital rather than to treat them.

The most crucial moment in the history of the National Health Service (NHS) is the creation of the system in 1948 (Snow and Whitecross, 2022). In the National Health Service Act 1946, ambulance services were planned under the care of the local authorities and not by a national unit (Tubton, 1956). The staff of this period were mainly drivers who received basic first-aid training, and the approach of operation was scoop and run; it was important to transport the person to the hospital as fast as possible. It was in 1966 with the Millar Report that the UK started to professionalise the service, although it suggested specialised training of the ambulance crews and installation of high-level resuscitation equipment, marking the beginning of the modern paramedic profession.

Present State of Operation and Evaluation.

In the modern day, the UK ambulance services present themselves as advanced regional NHS Trusts that are actively involved in much more than the conventional "emergency" role. The modern model has moved to the scene-based clinical assessment. The paths of hearing, seeing, and treating are evidence of this. Hear and Treat brings clinicians to the control rooms to offer telephone triage and therefore reduce unnecessary ambulance dispatch. In contrast, See and Treat enables highly competent paramedics to assess and treat patients and discharge them to their homes.

Nevertheless, the critical analysis of the existing service shows that there is a tense situation of operation. Although the service has improved its clinical capabilities (12-lead ECGs are now used, and drugs are used to save lives during myocardial infarctions), a recent problem with the

service is the delay in handovers in the Emergency Departments (Williams, 2022). During the process of transporting patients to hospital treatment, paramedics take hours to transport the patients and the absence of ambulances on the road eliminates the ambulances to go to the scene to respond to other life-threatening calls. These systemic pressures notwithstanding, technology, including Electronic Patient Records (EPRs), has enhanced continuity of care between the community and hospital context.

Significance and Quality of Life.

The ambulance service is not only important in the saving of lives, but also in the general quality of life of the service users. To victims of acute medical crises such as strokes or cardiac arrests, the service gives them the golden hour of intervention that defines long-term disability or recovery. The service relieves the physical and psychological burden of illness on the patient and family by offering high-quality and quick care.

Moreover, the service is crucial, as it helps the vulnerable and older population. In most cases, paramedics are on the frontline when dealing with patients who have fallen or those victims of social isolation. Through their organisation with community teams, ambulance services will be able to leave patients in their respective homes, save their dignity and independence. This is a total service provision to make sure that it is not just a transport service, but, at the same time, one of the nets that guarantee fair access to healthcare by all citizens, irrespective of their location.

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