Mental Health

Overview of our current system

It is estimated that nationally one in four adults and one in six children experience mental illness, yet across London only a quarter of those experiencing difficulties are receiving treatment. Need and demand for mental health services varies across SEL's six boroughs, however, SEL's mental health index is the highest of the five ICS' in London. Often people with mental health illness have poor health outcomes with people with severe mental illness (circa. 20,000 people in SEL) living 10-15 years less than the general population; this 'mortality' gap is higher in five out of six SEL's boroughs, when compared to the London average.

Strengths / opportunities

- Ring-fenced funding for mental health through the Mental Health Investment Standard and Service Development Funds; opportunity to align further through the ICS Medium Term Financial Strategy and ensure this continues.
- Expansion and adoption of community transformation programme led at Place offers the opportunity to intervene earlier and provide tailored intervention which meets the needs of the different populations within SEL. Opportunity to focus on early years and family approaches to reduce the burden of mental health during the life course of an individual.
- Mental health identified as a priority as part of the ICP strategy; opportunity through this work to also consider the wider determinants of health.
- Opportunities to work with the voluntary and community sector and diversify roles and the support offer – multiple Voluntary, community and social enterprise sector (VCSE) organisations, many of which are integral to local communities.

Challenges

- Known disparities in access, outcomes and experience of care for of mental health services. For example, children from black and mixed heritage backgrounds are poorly represented in CYP mental health services, yet black men are over-represented in adult inpatient services.
- Significant mortality gap for people with severe mental illness with these individuals living 10-15 years less than the general population.
- High dependency on the acute care pathway across SEL remains.
- Delivery of national access ambitions for several mental health service lines, coupled with long waiting times for services due to high demand.
- Workforce availability – challenges in workforce availability and retention across health and care staff working in mental health services
- Wider systemic issues, e.g. Cost of Living Crisis that will impact on our communities' mental health and emotional wellbeing, inflationary pressures.

What we've heard from the public

- Mental health for both adults and children and young people is one of the key priority areas of the upcoming Integrated Care Partnership Strategy. Members of the public reflected on the need for timely early intervention and support through different routes (not just statutory services).
- Through the South London Listens Programme, our communities have told us how important good mental health is to them, wider than just mental health services. The actions from the Programme focus on co-designed solution which will build community resilience and improve mental health for all residents.

Mental Health - Our vision and objectives

Our vision

To ensure our residents receive mental health and emotional wellbeing support across their life course, which is timely, culturally appropriate, anti-discriminatory, trauma-informed, co-ordinated and holistic, and enables the development of resilient communities in which more people live longer, healthier and more independent lives in the community.

Our key objectives – what we want to achieve over the next five years

Over the next five years, we want to:

1. **Build community resilience and prevent mental illness from developing through collaboration and partnership**: Working with local communities, VCSE, local authorities, primary care and other members of our Local Care Partnerships, to develop and test tailored early intervention and mental health support offers as part of the expansion of our community offer supporting the development of resilient communities across South East London, focusing on the whole life course.

2. **Ensure secondary and tertiary mental health services are safe, effective and efficient for those who need them**: To provide high quality, culturally competent, and safe care in our secondary and tertiary mental health services, including timeliness of response and delivery of any applicable access and performance targets

3. **Drive forward opportunities to integrate care including mind and body approaches**: To integrate care across health and care, and with VCSE partners to provide a holistic approach to health service delivery, including supporting our residents with severe mental illness to better manage their physical health and reduce the mortality gap.

4. **Reduce health inequalities, particularly for our CORE20Plus population**: Through delivery of objectives 1 – 3, embedding population health management approaches and the development of tailored and co-produced interventions, to increase in the number of people accessing mental health and emotional wellbeing support from our CORE20Plus population and specifically focusing on reducing over-representation from our black and ethnic minority groups in our inpatient services.

South East London Integrated Care System

Mental Health - Our priority actions

NHS South East London

Our priority actions – what we will do

1. **Acute & Crisis Care**: Develop a consistent, equitable and comprehensive model for acute and crisis care which focuses on providing proactive, joined-up care, ensures availability of crisis care outside of emergency departments, enables timely and effective discharge from acute mental health services and enables people to receive care and support in the least restrictive setting as possible, empowering them to take ownership of their own care.

2. **Early Intervention & Community Support:** Working collaboratively with residents, primary care, VCSEs and local authorities, expand the provision of early intervention and community-based support offers for adults through both statutory and non-statutory organisations, and across health and care services, focusing on upskilling community organisations and building mental health community resilience, with targeted interventions for our Core20Plus population.

3. **Children & Young People's Mental Health & Wellbeing**: Ensure the sustainability of children and young people's mental health and emotional wellbeing services, including the provision of targeted early intervention through cross-agency working, increasing the support offers in schools, timely and rapid access to specialist services, improvements in health inequalities and access to care and support, and provision of support for parental mental health.

4. **Older Adults Mental Health & Wellbeing**: Develop and implement a new core offer for older adults mental health services that provides fast access to dementia diagnosis, delivers high quality pre- and post-diagnostic care, enables people to live well for longer and supports family members and friends providing care.

5. **Improving Physical Health for People with SMI:** Ensure people with severe mental illness can access tailored physical health interventions and support to reduce the mortality gap, through the completion of a high-quality physical health check and supported by effective population health management approaches and mind and body integration.

Mental health priority action 1 – Acute & Crisis Care

Acute and Crisis Care

Develop a consistent, equitable and comprehensive model for acute and crisis care which focuses on providing proactive, joined-up care, ensures availability of crisis care outside of emergency departments, enables timely and effective discharge from acute mental health services and enables people to receive care and support in the least restrictive setting as possible, empowering them to take ownership of their own care.

How we will secure delivery

Actions for 23/24

- Delivery against the South East London Discharge Framework.
- Continued development of crisis alternatives including opening of a dedicated CYP crisis house for South East London and the NHS 111 Press 2 service.
- Following a review of demand and capacity, development of an agreed core offer for acute and crisis care which includes crisis avoidance, delivery of crisis alternatives and acute care provision.
- Working with South London Partnership, to deliver a joined-up recovery and rehabilitation pathway and adapt S117 to incorporate personal health budgets

Actions for 24/25

- Following completion of a baseline assessment, delivery and implementation of the agreed core offer for acute and crisis care, in line with learning and recommendations from 2023/24.
- Consistent investment in peer support workers as part of ED liaison services
- Increase focus on the delivery of personalised and trauma-informed care geared around more psychological, holistic centred approaches aimed at tackling individual mental health and wellbeing.

Intended outcomes in 5 years time

- Availability of same day emergency care access for people experiencing mental health crisis through a variety of settings (less focus on emergency departments).
- Zero inappropriate out of area placements for South East London residents
- Average length of stay for both providers consistently within national benchmarks
- Patients clinically ready for discharge and occupying mental health beds less than 5% of the total South East London bed base
- Bed occupancy rate at 85%
- Patients who require an inpatient admission (whether in emergency departments or in home treatment team/community team caseloads) are allocated a bed within 4 hours of identification of need
- All patients who are entitled to S117 aftercare are offered a personal health budget (100%) with uptake to be monitored and measured regularly.

NB. Patient reported measures to be developed during 2023/24.

Mental health priority action 2 – Early Intervention & Community Support

Early Intervention and Community Support

☆ ICS Strategic Priority

Working collaboratively with residents, primary care, VCSEs and local authorities, expand the provision of early intervention and community-based support offers for adults through both statutory and non-statutory organisations, and across health and care services, focusing on upskilling community organisations and building mental health community resilience, with targeted interventions for our Core20Plus population.

How we will secure delivery

Actions for 23/24

- Delivery of the adult community mental health transformation programme.
- Development of a core offer for IAPT for people with long term conditions.
- Through Local Care Partnerships and the South London Listens Programme, and in collaboration with residents and VCSEs, to develop, build and test alternative models and opportunities for early intervention and support for mental health and emotional wellbeing, including for the Core20Plus population (e.g. neighbourhood hubs, local awareness campaigns).
- Testing of primary care models to provide choice for depot antipsychotics.

Actions for 24/25

- Continue to embed delivery of community and primary care mental health and wellbeing services.
- Through Local Care Partnerships, and in collaboration with residents and VCSEs, to continue to develop and build alternative models and opportunities for early intervention and support for mental health and emotional wellbeing, including for the Core20Plus population.

Intended outcomes in 5 years time

- Each PCN/neighbourhood within South East London to have a fully established integrated community mental health teams bringing together health and social care and VCSE providers.
- Contacts through community mental health to have increased 5% on average every year, with contacts representing the demographics and need of the local population.
- Increases in the number of people accessing employment support.
- Increased access to IAPT (including for people with long term conditions) and equitable recovery outcomes for all population groups in South East London.
- Increased investment in VCSE providers with noted improvements in the diversity of the VCSE provider landscape for both adults and CYP.
- Upskilling of at least 250 community leaders and volunteers as Be Well Champions, and establishing a minimum of 75 hubs providing regular wellbeing activities/spaces and signposting
- Increase in the number of local listening and action campaigns and outcomes, led by VCSEs.

NB. Patient reported measures to be developed during 2023/24.

Mental health priority action 3 – Children & Young People's Mental Health & Wellbeing

Children and Young People's Mental Health & Wellbeing

☆ ICS Strategic Priority

Ensure the sustainability of children and young people's mental health and emotional wellbeing services, including the provision of targeted early intervention through cross-agency working, increasing the support offers in schools, timely and rapid access to specialist services, improvements in health inequalities and access to care and support, and provision of support for parental mental health.

How we will secure delivery

Actions for 23/24

- Roll out of the Empowering Parents Empowering Communities programme
- Investment into CAMHS to reduce the number of children and young people on secondary and tertiary care waiting lists
- Development of a local integrated single point of access in each Place.
- Expansion of perinatal and maternal mental health services.
- Expansion of support via schools including mental health support teams in schools and other co-produced offers.

Actions for 24/25

- Continued investment into CAMHS to reduce the number of children and young people on secondary and tertiary care waiting lists
- Continued expansion of the mental health and emotional wellbeing support available through schools either via mental health support teams or locally designed/implemented solutions.
- Development of tailored support for people children and young people with special educational needs (SEND) and neurodiversity, as part of wider SEND workstream across the ICS.

Intended outcomes in 5 years time

- All Places will meet the principles and framework of the iThrive Model including joined-up approaches to deliver care and an integrated single point of access for access to mental health and emotional wellbeing support.
- Improved partnership working across health and children's services.
- 100% coverage of either mental health support teams in schools and/or other locally tailored support offers
- All children and young people who need to access secondary and tertiary mental health services to receive assessment and treatment within at least 18 weeks, with an overall reduction in referrals for community CAMHS due to earlier intervention and better support offers elsewhere.
- Reduction in the number of children and young people in inpatient beds and children and young people presenting in crisis.
- Increases in the numbers of parents (both mothers and fathers) accessing parental support including maternal mental health services and perinatal.
- Reporting of patient reported outcome measures (baseline tbc in 23/24).

Mental health priority action 4 – Older Adults Mental Health & Wellbeing

Older Adults Mental Health & Wellbeing

Develop and implement a new core offer for older adults mental health services that provides fast access to dementia diagnosis, delivers high quality pre- and post-diagnostic care, enables people to live well for longer and supports family members and friends providing care.

How we will secure delivery

Actions for 23/24

- Development of common standards for older adults community mental health services which includes timely dementia diagnosis and high quality pre- and post-diagnostic care. Self-assessment of all services to be carried out.
- Development of clear actions plans for each service to recover the 66% dementia diagnosis rate by the end of the financial year.
- Working with local authorities, to develop local initiatives to prevent loneliness and isolation for older people (through our Local Care Partnerships).

Actions for 24/25

- Implementation of the agreed framework for older adults community mental health services.
- Working through Local Care Partnerships, to develop actions and initiatives that enable those with long-term conditions to access better joined up physical and mental health care.

Intended outcomes in 5 years time

- Each Place to have a clear and consistent pathway for dementia diagnosis and post-diagnostic care across all communities.
- At least 66% of people aged 65 years and over to receive a dementia diagnosis (as a percentage of the estimated prevalence based on GP registered populations).
- 100% of people referred to receive a dementia assessment within 6 weeks whether that be in primary care or memory assessment clinics.

NB. Patient reported measures to be developed during 2023/24.

Mental health priority action 5 – Improving Physical Health for People with SMI

Improving Physical Health for People with Severe Mental Illness

Ensure people with severe mental illness can access tailored physical health interventions and support to reduce the mortality gap, through the completion of a high-quality physical health check and supported by effective population health management approaches and mind and body integration.

How we will secure delivery

Actions for 23/24

- Development of a clear service model for the delivery of PHCs across primary care, secondary care, and VCSE partners, underpinned by co-production.
- Development and full implementation of a data dashboard.
- Working with the Cancer Alliance, to understand uptake of cancer screening for people with SMI and develop a targeted improvement plan.
- Implementation of a physical health framework to empower community mental health teams to support the physical health of their service users.

Actions for 24/25

- Full implementation of the new proposed service model.
- Development of common standards and outcomes to ensure a range of interventions are available for people who receive a physical health check and require intervention and support, supported by population health management approaches and co-production/co-design with service users.

Intended outcomes in 5 years time

- Over 90% of people with a severe mental illness have an annual physical health check completed and recorded.
- Range of interventions available and accessed by service users to support them in managing their diet, weight, alcohol consumption, smoking status and other elements, through a consistent core offer for South East London.
- Increase in the take-up of cancer screening services from people with severe mental illness N.B Measure to be defined over time and once baseline data is established.

NB. Measures reflecting management of other physical health needs including blood pressure and weight management and patient reported measures will be developed over the course of 2023/24.

South East London Integrated Care System

Enabler requirements

NHS South East London

Workforce

- Development of a clear workforce plan that supports delivery of the system's mental health delivery ambition, and includes statutory and non-statutory services.
- Dedicated workforce resource to support the development, co-ordination and oversight of a mental health workforce plan, as well as supporting with transformation models to ensure the workforce meets the needs.
- Training and support for staff to ensure service delivery is anti-discriminatory and trauma informed.
- Organisational development support to build integrated teams across community and primary care settings, in line with the ambitions of the mental health community mental health services transformation programme.
- Training and support to build awareness of mental health and emotional wellbeing needs across all health and care staff, to enable better detection and recognition and earlier intervention.

Digital

- Interoperability and the ability to better share data between primary and secondary health care services e.g. to support the completion of physical health checks and reporting of these health checks.
- Ability to share data and information across health and care providers and voluntary and community sector providers to support effective crisis management and develop integrated community mental health teams

Estates

- Estates across providers need to be able to support effective remote working and the use of digital/virtual appointments. There needs to be the appropriate space in providers to support the delivery of confidential conversations and patient care.
- Estates across providers need to be able to support the development and co-location of integrated teams.

Data

- Improve mental health data through the Mental Health Minimum Dataset (MHMDS).
- Using MHMDS to develop a core, common dataset for South East London to evidence the expansion and transformation of mental health services, and the impact on population health, with a focus on activity, timeliness of access, equality, quality and outcomes. This needs to be able to provide data and outcomes at both a system level and through Local Care Partnerships.
- Expansion of business intelligence data, with knowledge of MHMDS, to build and develop population health management approaches across ICS partners.