NHS
South West London

DRAFT

Our Mental Health Strategy:

For everyone who lives, works or studies in South West London

Executive Summary

Mental health is of critical importance to individuals, communities and wider society and we want SWL to be the best place to live for emotional wellbeing.

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Whilst we have high quality mental health services across our six boroughs, we have many challenges to tackle. We know that our services don't always meet the needs of our local communities and we have unequal service availability, access and outcomes; rising demand, acuity and complexity; and workforce gaps.

In SWL we don't spend as much as some other areas on mental health – 10% of our NHS budget compared to nearly 14% as an average across England – and we want to address this investing more in prevention and early support and in mental health for children and young people specifically.

Our new SWL Mental Health Strategy has been developed through analysing population needs and listening to issues raised by residents, stakeholders and those with lived experience of mental health issues. This is a Strategy that focuses on prevention (from pregnancy and birth onwards for the whole life course) as much as treatment which values emotional wellbeing and community resilience. And this Strategy is for everyone who lives, works or studies in Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth.

Our vision is that in SWL we want everyone to have access to the right support at the right time for their emotional wellbeing and mental health. We recognise that many influences come from wider factors such as employment, education, housing, and community and we will work in partnership with local authority colleagues to address these. Our services will work effectively together and with people who use our services as early as possible to meet needs and ensure everyone receives the support they need in the most appropriate setting.

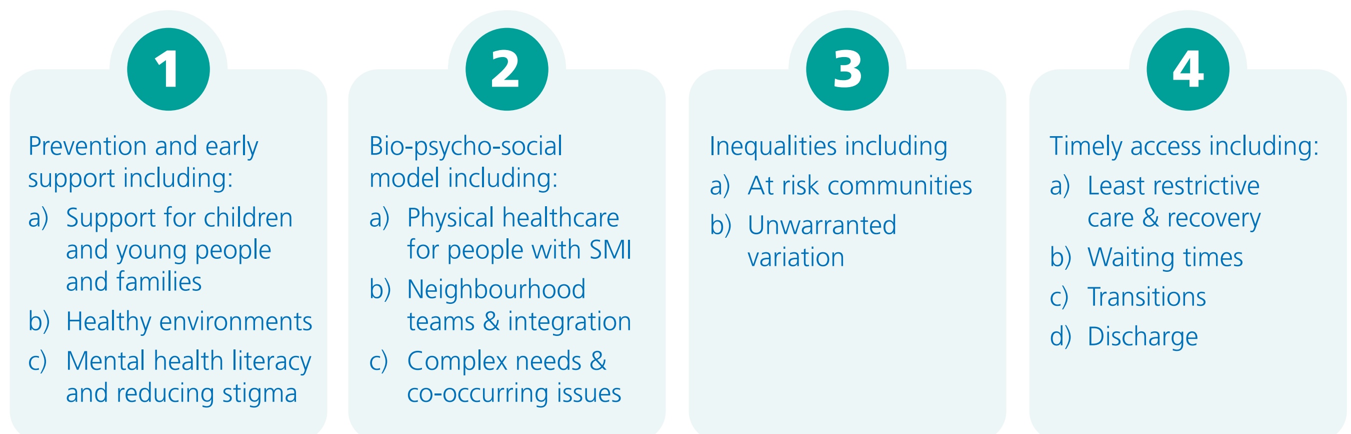
The aims of this strategy are to:

- Prevent mental illness and provide early support for recovery as we know this promotes good recovery and reduces the burden of Ill-health.
- Increase equity of access, experience and outcomes for all SW Londoners – reducing unwarranted variation and ensuring a fair and sustainable allocation of resources.
- Better support and equip our CYP and those that support them to manage their mental health and emotional wellbeing in the future.
- Design a new model for mental health workforce including voluntary and community sector and peer support to tackle mental health recruitment and retention issues.
- Expand bio-psycho-social care to address the mortality gap and the opportunity to increase years of quality life.
- Co-produce delivery of this strategy with service users/ residents in SWL, putting partnership with those who use services and those in our communities at the heart of everything we do.

We have high aspirations for the mental health and wellbeing of our SWL residents and communities. To reflect these we have set ourselves ambitious goals over a ten year period:

By 2032/33 we will have	
Population	**Services**
• Increased equity of service access to reflect community demographics with no unwarranted variation in outcomes • Improved mental and emotional wellbeing for residents in SWL • Reduced the 'mortality gap' between those with SMI and the general population • Eliminated racial inequality around overrepresentation of black people in detention, inpatient and crisis care • Ensured no person known to mental health services presents to A&E unless for physical health issue • Eliminated restrictive practices • Zero suicide • Significantly reduced self-harm • Eliminated inpatient stays outside of SWL for SWL residents • Closed unneeded acute inpatient beds	• Fully integrated mental health care in place for people with SMI and physical health needs, social care needs (including supported living), LDA, homelessness and substance misuse • Allocated resources based on need • Redirected mental health investment with the majority of spend occurring in primary care, VCSE and community settings • Increased funding into mental health benchmarked with other areas nationally and increased the proportion of funding spent on CYP mental health specifically • Fully staffed services with new roles in our workforce and positive staff wellbeing, satisfaction and morale • Embedded research and evaluation of services, operational models and initiatives as standard practice using meaningful recovery and experience measures • Services responsive to population health needs and flexibly delivering changes

We will deliver our Strategy through work across 4 themes with specific focus and content:



Our Strategy will link to wider SWL ICS programmes especially around workforce, population health management and digital technology.

We will deliver our work using annual plans with strategic leadership and drive through the SWL Mental Health Partnership Delivery Group which comprises clinical and non-clinical representatives from across our six places, our mental health providers and our ICB teams.

In year 1 we will focus on making improvements to children and young people's mental health and embedding transformation of community services for adults with SMI. We will support these areas of change by completing a detailed strategic review of mental health investment to date and the outcomes delivered from this, agreeing approaches to outcomes measurement and evaluation and reviewing public mental health work to identify future initiatives for deployment in SWL and ensuring mental health leadership and resourcing is in place.

We are excited about the changes that we can make in collaboration and we invite you to join us on our journey.

1. Introduction

Welcome to our new South West London Mental Health Strategy. This is for everyone who lives, works or studies in South West London. We believe everyone has the right to good mental health.

The importance of mental health

We know that poor mental health adversely affects individuals, their families and communities and wider society. The impacts of mental ill-health are wide ranging and stark: People with mental health issues are more likely to live in areas of deprivation, have lower incomes, live in less stable housing, find it harder to secure and retain employment, have fewer qualifications, have poorer physical health and die younger than the general population. And mental ill-health can affect us all – with one in four people experiencing a mental health problem of some kind every year with one in six experiencing a common mental health problem in any given week in England.

We know that there are things we can do to improve emotional wellbeing and resilience with new evidence around treatment, care and support emerging all the time. But improving mental health is not just about treatment. We need to consider wider wellbeing and social determinants of health as well as prevent mental illness developing in young people. By taking a whole population approach to mental wellbeing and encouraging access to green spaces, being physically active, making connections through communities or friends and family, we can shift the whole population towards flourishing and reduce the numbers of people experiencing troubling mental health problems[1].

We want SWL to be the best place to live for your emotional wellbeing and this is a Strategy for everyone who lives, works or studies in Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth.

1. https://neweconomics.org/uploads/files/d80eba95560c09605d_uzm6b1n6a.pdf

In the years that mental health has been a national health priority we have achieved a great deal across our six boroughs through partnership working and clear ambitions, but we need to do more. Access to services and outcomes remain unequal; we know that not everyone gets the support they need. Too little resource is dedicated to early support or prevention of mental distress; some people don't receive help until they are in crisis meaning recovery is longer and more complex. Health and care organisations (including mental health services) don't always work well together making it confusing and complicated for service users. We need to change the way that we design and deliver mental health services and the way that we collectively think about, talk about and support strong mental health across and within our communities.

Our new Mental Health Strategy outlines the challenges we face in SWL, the ambitions we have for change and how we intend to go about delivering this. We are excited to begin our journey now in the spirit of partnership and collaboration as our SWL ICS embeds.

We will hold ourselves to account for clear delivery plans and annual progress and we invite you to join us because mental health is everyone's business.

2. National context

We recognise that all our local work in the NHS sits within a broader, often complex, environment. The key strategic elements relevant to mental health – including opportunities and challenges – are outlined below. Taken together with our understanding of our SWL population, this forms our case for change.

The importance of mental health

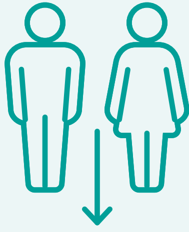
It's hard to overstate the importance of mental health for us in the 21st century. The facts speak for themselves.

From an individual perspective:

At least **one in four** people will experience a mental health problem at some point in their life and one in six adults has a mental health problem at any one time.

Nearly **one sixth** of the workforce is affected by a mental health condition.

Half of those with lifetime mental health problems first experience symptoms by the age of 14 and three-quarters before their mid-20s.



The life expectancy of people with a serious mental illness is 15-20 years shorter than for those without[2].

People with mental health problems often have fewer qualifications, find it harder to both obtain and stay in work, have lower incomes, are more likely to be homeless or insecurely housed, and are more likely to live in areas of high social deprivation.

If you have a mental health issue you are more likely to have physical health problems and up to 50% of people with a severe mental illness have at least one (and often multiple) long-term physical health condition(s)[3].

At a societal level:

Mental ill health represents up to **23% of the total burden** of ill health in the UK and is the largest single cause of disability.

£26 billion

Mental health related absences cost UK employers an estimated £26 billion per year.

Whilst the majority of NHS spending is on physical health, estimates suggest that the cost of treating mental health problems could double over the next 20 years.

More than £2 billion is spent annually on social care for people with mental health problems. In 2003 estimates put the costs of mental health problems in England at £77 billion; in 2022 this figure was estimated at nearly £101 billion. And these figures do not include costs related any exacerbation of physical health issues, reduced performance at work, costs to housing or criminal justice sectors, suicide and self harm or alcohol substance misuse.

Our most deprived communities have the poorest mental and physical health and wellbeing.

Despite this, we still struggle to adequately support people to recover from mental illness, to ensure people with mental health conditions play an active and valued role in society and their communities and to intervene early and prevent mental health issues occurring or reoccurring.

2. Brown S, Kim M, Mitchell C, Inskip H. Twenty five year mortality of a community cohort with schizophrenia. British Journal of Psychiatry. 2010;196(2):116-21.
3. https://www.kingshealthpartners.org/our-work/mind-and-body/khp-mindbody

The strategic environment

Mental health is a national health priority in England.

Over the past 25 years mental health policy and practice have evolved significantly, growing from the *National Service Framework for Mental Health* to the first clinical guideline (for Schizophrenia) published by the National Institute of Clinical Evidence (NICE) to the mental health outcomes strategy *No Health without Mental Health* to the *Five Year Forward View for Mental Health* and most recently the *NHS Long Term Plan (LTP).* These developments have led to clear standards, national priorities and targets and additional investment.

Alongside this, awareness of mental wellbeing has grown. More parents understand emotional literacy and how they can support their children's mental wellbeing, supporting happiness and resilience. Collectively, as a society, we are more open to talking about mental health at all ages and in different groups, although, of course, there is more to do to eradicate stigma and shame which persists in many communities.

We are seeing increasing evidence for prevention and public mental health initiatives and we know that addressing the social causes of ill health such as securing good housing, employment, connecting with people, being physically active, being in nature/ accessing green spaces, learning new skills and practicing mindfulness, all positively impact on our mental health and reduce stress. Organisations have responsibilities to provide health workplaces and this can be achieved through a culture of participation, equality and fairness and developing the role of line managers. Schools can tackle mental health and wellbeing by offering support through a 'whole school approach'.

Finally, the implementation of integrated care systems with their focus on population health, inequalities, productivity and value, and broader development offers opportunities to connect mental wellbeing to our communities and to improve mental health care and reduce fragmentation and gaps in existing pathways. This will be accomplished by partners co-operating in new ways.

Current pressures

As we publish this Strategy, the NHS continues to manage the legacy and impacts of Covid-19. From a mental health perspective, around a third of adults and young people reported their mental health worsened during the pandemic[4], certain groups – young adults, women, those from ethnic minority communities and those experiencing socio-economic disadvantage – were identified as most at risk of adverse mental health outcomes[5] and new types of presentations occurred – emotionally based school avoidance in CYP for example. Current cost of living pressures have added to pressure on individuals, families and communities.

Post-pandemic increases in demand (referrals), complexity and acuity have been seen with services struggling to cope. In 2021 a record 4.3 million referrals were received for mental health in the NHS and March 2022 1.2 million people were waiting for mental health treatment. Between 2017 and 2021 Across the country there has been a rise in the percentage of children identified as having a probable mental health disorder from 11.6% in 2017 to 17.4% in 2021 – with CAMHS the fastest growing speciality. Longer waiting times lead to deterioration for many people and increase presentation into crisis and emergency services. When individuals do access care their recovery is likely to take longer and potentially require more support.

Whilst mental health has welcomed increased funding since 2015, the sector still represents a small portion of overall health funding with just 13.8% of local health spend allocated to mental health, including learning disabilities and dementia[6] in 2022/23. In addition, budget pressures in social care and increasing inflation make it challenging to meet needs.

All of these issues, alongside the wider national context, result in pressures within the NHS workforce. There are high levels of vacancies and challenges in retaining existing staff. Individuals are choosing not to work in or to leave the NHS for a variety of reasons including burnout and ill-health, lack of job satisfaction, wanting better work-life balance, wanting better rewards or opportunities. Workplace culture also plays a part with discrimination, bullying and abuse reported through the NHS Staff Survey. Whilst training, attraction and retention programmes exist rates of workforce growth are too low to meet demand for services.

We need to consider this landscape when setting our ambitions for mental health care in SWL.

4. https://www.mind.org.uk/coronavirus-we-are-here-for-you/coronavirus-research/
5. https://researchbriefings.files.parliament.uk/documents/POST-PN-0648/POST-PN-0648.pdf
6. https://www.england.nhs.uk/mental-health/taskforce/imp/mh-dashboard/

3. The SWL landscape

It is critical that our mental health services meet the needs of our SWL population. Understanding population needs is the foundation of our Strategy.

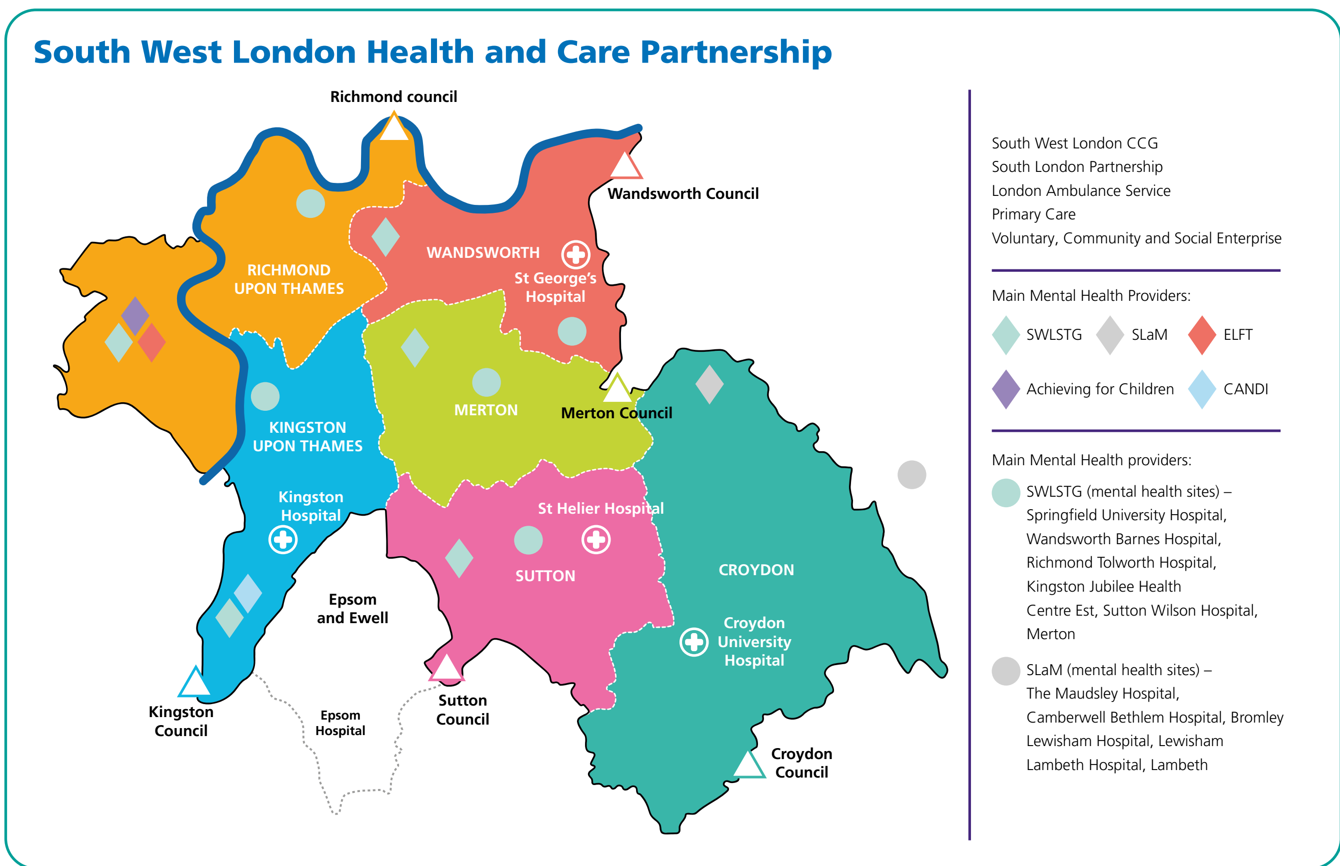
Our mental health services

SWL is made up of the boroughs of Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth and has a population of 1.5 million people.

Health and care services for our population are delivered by a broad range of partners across the SWL ICS including six local authorities, four acute trusts, mental health trusts, community physical healthcare services, social care, public health teams, the London Ambulance Service, voluntary and community sector enterprises (VCSEs), primary care (including general practice, pharmacy, dentistry and optometry) – increasingly organised into primary care networks or neighbourhood teams. Healthwatch organisations, community groups, individuals with lived experience and residents all play important roles in service review and development.

The SWL ICB spends around £300 million each year (10% of its total allocation) providing mental health services. This supports around 50,000 people from all age groups and backgrounds to access support for mild, moderate, severe and complex mental health needs within the community, as inpatients or within crisis settings.

South West London and St George's Mental Health NHS Trust (SWLSTG) and South London and Maudsley NHS Foundation Trust (SL&M) deliver the majority of our mental health services with circa 2,700 whole time equivalent staff. Outside of specific mental health provision, primary care and schools are often the first port of call for initial support for adults and children respectively.



Our population and their needs

30% of SWL's residents are aged under 25, **57%** between 25-64 and **13%** over 65

SWL has an **older population compared to the rest of London**. Whilst the boroughs have similar age profiles to each other

Wandsworth has a high proportion of working-age adults (**63%**), **Croydon** has a high proportion of CYP (**32%**) and **Richmond** has a higher proportion of older adults (**16%**)

The ethnic background across SWL boroughs varies with Croydon being the most ethnically diverse and the SWL CYP population under the age of 25 being more diverse compared to the population of SWL as a whole. Specific communities and populations can be found across SWL.

Overall, SWL is affluent with Richmond, Kingston and Sutton the three least deprived boroughs in London. Croydon is the most deprived SWL borough remaining just above the London average. Within SWL however there are neighbourhoods with struggling with higher poverty and deprivation including new Addington, Old Coulsdon, North Croydon in Croydon; Norbiton and Berrylands in Kingston; Mitcham and Morden in Merton; Richmond Riverside and Hampton North in Richmond; Roundshaw and St Helier in Sutton; and Roehampton and Putney Vale in Wandsworth.

SWL boroughs have some of the highest employment rates in London with all boroughs meeting or exceeding the London and national average rate of people agreed 16-64 in employment. SWL boroughs also have some of the highest median

weekly earnings in London however there is significant inequality in earnings both between and within boroughs. People living in Sutton earn on average £210 less per week that people living in Wandsworth. Kingston and Wandsworth have the highest level of pay inequality, with the greatest difference in hourly pay between those earning in the top 20% compared to those in the lowest 20%. Housing affordability varies with less affordable housing compared the London average in Merton, Richmond and Wandsworth and more in Croydon, Kingston and Sutton.

Vulnerability exists across SWL in other markers as well. For example, Sutton has the highest rate of children on child protection plans compared to the London and national average. Croydon has higher rates of children looked after (CLA) compared to the London and national rate, as well as the highest absolute number of CLA and high number of unaccompanied asylum seekers.

In terms of education, children in SWL tend to perform well in school. For example, in Attainment 8 scores which measure the performance of students in their 8 best GCSE results, every SWL borough achieves a higher score than the national average. Richmond has the highest score of all London boroughs with Kingston and Sutton being third and fourth highest. When looking at the proportion of 16-17 year olds in education, employment or training, the picture is more mixed however, with Wandsworth and Croydon being below the London average.

In terms of mental health needs data show us that:

- CYP in SWL have a high level of need for mental health support. A higher proportion of under-18s access NHS community mental health services compared to other London ICSs.
- For CYP there are also some distinct population groups with particular needs which cross boroughs boundaries – for example CYP living in poverty or CYP at high performing schools experiencing eating disorders.
- In CLA emotional wellbeing is a cause for concern for approximately a third of children across London, rising to 37% nationally. In Richmond, Merton and Kingston this is a concern for half of all CLA.
- Across SWL, 16% of CYP have special educational needs (SEN). The number is increasing with the fastest growth in Kingston and Richmond. The proportion of pupils with SEN in SWL with a primary need for social, emotional and mental health support is above the London and national averages with highest rates in Wandsworth and Merton. Additionally, both the proportion of pupils with SEN with an autistic spectrum disorder or with a learning difficulty are both above the London and national averages.
- Self harm is a key issue. For adults Kingston, Richmond and Sutton have the three highest rates of admission for self-harm of all London boroughs and for CYP these three boroughs along with Wandsworth and Merton are in the top ten London boroughs for admission to hospital for self-harm. In Kingston, self harm admission rates for CYP and adults are twice as high as the London average.
- SWL has the lowest level of SMI in London yet there is a higher prevalence of depression in working age adults and high suicide rates compared to the London average in 5/6 SWL boroughs (excepting Wandsworth and Merton respectively). In addition, there are high levels of physical health conditions in our SMI population with over 50% of people with SMI have co-morbid diabetes. There is some variation in prevalence of mental health conditions which can in part be linked to demographic variation. For example, Croydon has a higher prevalence of SMI (e.g. bipolar disorder, psychosis) than Richmond.

- SWL has higher rates of people in treatment specialist alcohol misuse services but lower rates (excepting Sutton) for drug misuse.
- For people in contact with secondary mental health services a higher proportion live in stable and appropriate accommodation in SWL but a lower proportion are in employment compared to other London boroughs.
- For older adults, less than half of social care users aged 65 and over have as much social contact as they would like. This will add to social isolation and loneliness as factors that impact on their mental health.
- Our older adult population has a higher prevalence of dementia compared to other London ICSs.

Across both CYP and adult services demand for mental health support has increased in recent years and nationally, CAMHS is the fastest growing specialty of any across the whole NHS. This demand is being felt within SWL mental health services. Forecast population growth will impact further on this and, along with an ageing population, needs consideration when planning and delivering mental health support.

Meeting population needs

Mental health is a clear priority for SWL partners.

SWLSTG and SL&M services are rated as 'good' by the Care Quality Commission and we have established processes for seeking and responding to feedback and including those with lived experience in service improvement and transformation initiatives.

We have previously set system level ambitions for mental health and mental health is included as a priority in the local health and care plans for each of our six boroughs. We have a strong tradition of values-led collaborative working in mental health with an established partnership delivery group, transformation board and the South London Mental Health and Community Partnership (SLP) a formal collaborative between SWLSTG, SL&M and Oxleas NHS Foundation Trust which works at scale to deliver transformation and improvements to specialist mental health pathways and as well as supporting clinically driven improvements to mental health services at local system level.

Our partnership working is critical as we have clear issues to tackle.

Our greatest challenge is that service availability is not equitable. The borough you live in SWL affects the services you can access, how long you wait and the outcomes you can expect. Historic funding disparities exist between boroughs, meaning the level of resourcing (both financial investment and workforce) in each borough in not proportionate to need.

Variation continues as a key theme when we look in more detail at our mental health services:

- Both the level of access to mental health services and the amount of contact with mental health services varies for people in all age ranges across all six boroughs. For CYP, adult SMI and perinatal services the numbers of people accessing services are below expectation.
- At points of transition – moving from children's to adult services, or between different types of care – activity often reduces meaning some individuals are falling into a gap.
- Performance across national metrics is mixed. SWL has the lowest performance in London for CYP access to eating disorder services yet consistently meets recovery rate targets for IAPT and two week access targets for Early Intervention in First Episode Psychosis. Both improvements in key performance areas – e.g., carrying out physical health checks for people with SMI, and dementia diagnosis – and deteriorations – e.g., people being placed out of area for acute inpatient care – are evident over recent years.
- Use of services differs between boroughs and population groups. For example, CYP in SWL have a disproportionately high level of mental health A&E attendances compared to the general population; Croydon has the highest rate of working age adult activity taking place in crisis settings; and older adults have longer lengths of stay compared to those under 65 years of age. Admission rates to mental health inpatient wards varies and once admitted the length of stay is similarly mixed.

- Ethnic inequalities exist in service access and activity across SWL with a range of impacts seen. For example, CYP from Asian/ Asian British groups are under-represented in mental health services and CYP from minority ethnic groups have a longer length of stay when admitted. For adults, those from black population groups have more contact with secondary care mental health teams, are more likely to be admitted once seen by crisis teams and once admitted have a longer length of stay.

Alongside this variation, SWL has experienced Covid-19 impacts in line with other geographies with increased demand, acuity and complexity of need across the system presenting as increases in referrals, longer waiting times, longer lengths of stay and delayed discharges. Partners are struggling to recruit and retain staff (vacancy rates average 20%) and find suitable provision for people with complex needs.

When considering investment and taking the relative level of population need into account, SWL spends more per head of population on mental health services compared to other London areas, however, this still benchmarks low compared to areas outside of London where spend is an average of 14% of the ICB budget, compared to the 10% in SWL. For CYP mental health investment specifically the picture is more stark with SWL spending the lowest level across London.

Our starting point

The above elements, alongside the national context, form the foundation for our Strategy. This is summarised below in SWOT – strengths, weaknesses, opportunities and threats analysis.

Strengths	Weaknesses
• Effective collaborative working • High quality existing services • Rich and varied mental health provider landscape including VCSE partners including prevention initiatives within local authorities. • Strong, longstanding mental health leaders • Committed and resilient workforce • Embedded ethos of co-production and involvement	• Lower historic levels of mental health investment compared to other areas • Unwarranted variation in investment levels, access, activity, outcomes and services provided between boroughs • Clear ethnic inequalities in service access • High vacancy rates and competition for staff • Lack of provision for complex individuals
Opportunities	**Threats**
• Passion and enthusiasm for mental health amongst a range of stakeholders • Increasing evidence base of mental health prevention initiatives • New mental health environments at Springfield, Barnes and Tolworth integrated with local housing, wider services and new green space • Population health management intervention development and testing • Digital delivery of care and support • Research and education expansion • Community organisation and asset mobilisation through South London Listens • Green agenda driving sustainable models of care	• Focus on physical healthcare elective recovery effectively deprioritises mental health • Deficit financial position within the SWL ICS NHS partners • Local authority funding pressures and forecasts and s114 notice from Croydon • Continuing rises in mental health demand, acuity and complexity • Changes to policy direction and the existing political landscape • Lack of long-term workforce model

Our understanding of our challenges and our opportunities has supported us in developing our MH strategy.

4. How we developed our strategy

We developed our Strategy in three stages:

1

Assessment of population health need, strategic landscape analysis and identification of innovation.

2

Engagement with our local population (including service users and carers) and professional stakeholders with an online survey, virtual and face-to-face discussions and reflective discussion sessions.

3

Synthesis of data and information into key content.

1. Assessment of population health need, strategic landscape analysis and identification of innovation and best practice

In 2022, we reviewed quality, operational performance, workforce and finance data from our NHS mental health providers, commissioning data from our six places, local and national benchmarking data, as well as publicly available data from the Office for National Statistics, Public Health England, Local Health and Care Plans, Joint Strategic Needs Assessments and national mental health datasets. The data analysis was discussed with key health and care leads and interpretation was augmented with stakeholder workshop discussions.

This work created detailed outputs on population health needs and the strategic landscape that acted as background and context from which to develop the Strategy.

The review work also collected evidence on best practice and innovation across mental health care. This was formulated into a catalogue and available for us to consider alongside published material as we begin to consider transformational developments for SWL.

2. Public and partner engagement

We developed an extensive engagement plan to ensure we were able to hear the views of service users, their carers and families, clinicians, wider stakeholders and residents in SWL. We used both survey and discussion approaches over a number of months.

Our survey received 966 responses (mostly online but some in hard copy) and asked people about how they maintain good mental health and/or where or to whom they would turn if they started to struggle with their mental health or after a mental health crisis.

Overall, family and/ or friends were highlighted as the primary source of support for anyone struggling with mental health problems, with over 60% of respondents indicating it would be their first choice for help if they started to struggle. The same held true for maintaining good mental health and recovering after a mental health crisis. Respondents also indicated that exercise and time in nature (both 52%) or doing activities they enjoy (32%) were identified as supportive with digital tools not scoring highly.

"In early adulthood I would rely exclusively on my friends when feeling close to a depressive period."

When people start to struggle, they turn to the NHS, with 57% of respondents indicating they have or would seek NHS support, while 28% would seek help from a charity or voluntary sector organisation. Some people do go to the private sector, with 25% saying they have or would do this.

3. Synthesis of data and information into key content

Once we had collected all the information we drew together key commitments under our four themes and aligned outcomes to these. These describe the work that we will deliver and what we expect to achieve.

Many respondents reported an overall positive experience with mental health care, whether that was a helpful and responsive GP in their local practice, or access to an IAPT service. However, many others highlighted problems with how our services are set up currently.

The main difficulty people reported when trying to get help was long waiting times, with 51% of respondents indicating this was the greatest barrier to seeking help.

"The waiting time to see someone was a year. By then I found someone I pay Private which took a huge toll on my finances."

The second most highly ranked barrier was "stigma or shame" with 38% reporting this.

"When I was first diagnosed with severe clinical depression, my feelings were belittled by my partner at the time. He said I wasn't depressed and I was making it up. However my GP took things seriously and realised just how ill I was. It was definitely people around me though that didn't understand and made me feel ashamed and useless for having these difficulties and feelings."

We need to continue to raise public mental health awareness and tackle access issues to improve mental health and wellbeing across SWL.

Our meetings and discussions provided additional feedback and asked us to consider:

- What more can be done with local authorities and education around prevention and early support for CYP around mental health?
- How can services across health, social care and the voluntary sector develop better links and reduce fragmentation to prevent escalation and reduce demand on NHS services?
- How can social prescribing and voluntary sector services support more people experiencing mental ill health?
- Can primary care offer a greater provision of mental health services?
- How can carers be more supported when caring for someone with dementia or mental ill health?

Towards the end of our engagement period we held open, virtual sessions for stakeholders to review and reflect on our vision and aims and provide additional information or views for consideration. Over 50 people attended across four reflective sessions. These sessions helped confirm we were focused on the right things and provided input to help us refine our language and the development of themes.

5. Vision, aims and outcomes

Vision

In SWL we want everyone to have access to the right support at the right time for their emotional wellbeing and mental health. We recognise that many influences come from wider factors such as employment, education, housing, and community and we will work in partnership with local authority colleagues to address these. Our services will work effectively together and with people who use our services as early as possible to meet needs and ensure everyone receives the support they need in the most appropriate setting.

Aims

The aims of this strategy are therefore to:

- Prevent mental illness and provide early support for recovery as we know this promotes good recovery and reduces the burden of Ill-health.
- Increase equity of access, experience and outcomes for all SW Londoners – reducing unwarranted variation and ensuring a fair and sustainable allocation of resources.
- Better support and equip our CYP and those that support them to manage their mental health and emotional wellbeing in the future.
- Design a new model for mental health workforce including voluntary and community sector and peer support to tackle mental health recruitment and retention issues.
- Expand bio-psycho-social care to address the mortality gap and the opportunity to increase years of quality life.
- Co-produce delivery of this strategy with service users/ residents in SWL, putting partnership with those who use services and those in our communities at the heart of everything we do.

Outcomes

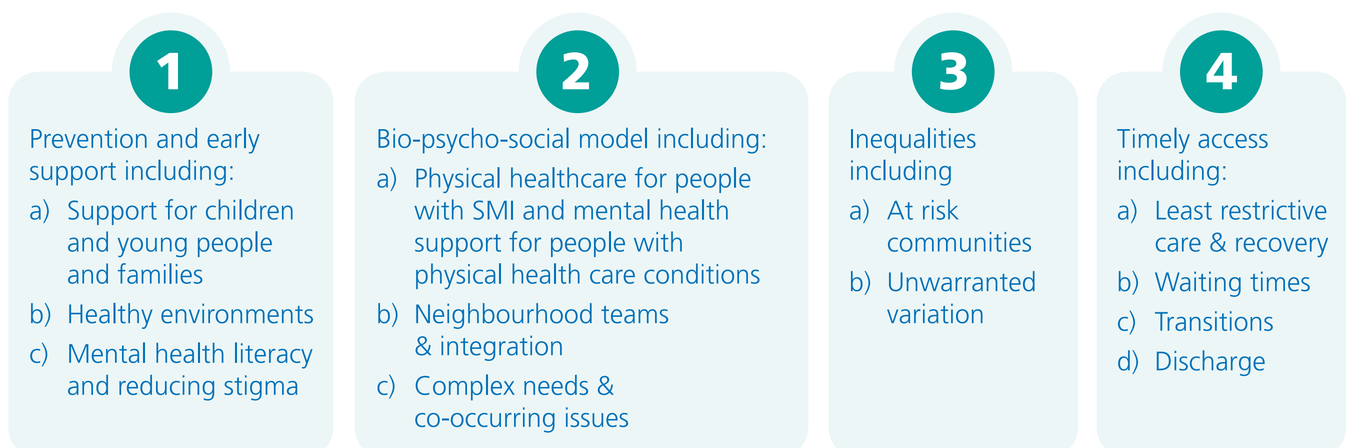
We have high aspirations for the mental health and wellbeing of our SWL residents and communities. To reflect these we have set ourselves ambitious goals over a ten year period:

By 2032/33 we will have	
Population	**Services**
• Increased equity of service access to reflect community demographics with no unwarranted variation in outcomes • Improved mental and emotional wellbeing for residents in SWL • Reduced the 'mortality gap' between those with SMI and the general population • Eliminated racial inequality around overrepresentation of black people in detention, inpatient and crisis care • Ensured no person known to mental health services presents to A&E unless for physical health issue • Eliminated restrictive practices • Zero suicide • Significantly reduced self-harm • Eliminated inpatient stays outside of SWL for SWL residents • Closed unneeded acute inpatient beds	• Fully integrated mental health care in place for people with SMI and physical health needs, social care needs (including supported living), LDA, homelessness and substance misuse • Allocated resources based on need • Redirected mental health investment with the majority of spend occurring in primary care, VCSE and community settings • Increased funding into mental health benchmarked with other areas nationally and increased the overall proportion of funding directed to CYP mental health specifically • Fully staffed services with new roles in our workforce and positive staff wellbeing, satisfaction and morale • Embedded research and evaluation of services, operational models and initiatives as standard practice using meaningful recovery and experience measures • Services responsive to population health needs and flexibly delivering changes

Due to their scale and their nature, we expect that these goals will take longer than the life of this five-year strategy to deliver. We have therefore included more specific outcomes for each of our themes which can be found in the following sections. During the first 6 months of our Strategy we will work with people with lived experience to set targets for delivery.

Themes

We will deliver our Strategy through work across 4 themes with specific focus and content:



The detail of the themes are outlined in the following specific sections.

6. Theme 1: Prevention and early support

Including:

- Support for children and young people and families
- Healthy environments
- Mental health literacy and reducing stigma

What we know

Early support for mental wellbeing is vital. Evidence shows that when we support people to focus on better mental wellbeing fewer people struggle with mental health problems or they're better able to cope with existing conditions.

Supporting people to maintain good mental health is about understanding what helps to keep us balanced and able to cope with struggles and manage our emotions. Issues such a poverty, homelessness, unemployment and discrimination impact are detrimental to our wellbeing. Things such as connecting with other people, being physically active, being in nature/ access to green spaces and learning new skills are proven to improve self-esteem and self-confidence, help people develop a sense of purpose or belonging and reduce stress.

Preventing mental health problems also benefits physical health outcomes and ensures people can live well and maintain a healthy lifestyle. Embedding prevention and early support initiatives in communities can destigmatise mental illness and support the

development of positive beliefs around mental wellbeing and mental health literacy. Connecting these approaches into our buildings and organisations supports us to build health environments and support work on the wider determinants of health.

Whilst prevention and early support is beneficial for all, research demonstrates that around 75% of all mental health problems develop by 24 years of age. In addition, the first 1,001 days (including pregnancy) are critical for a child's life in terms of both physical and emotional wellbeing. Stress and adverse childhood experiences in this period can have lifelong impacts. If we are serious about improving mental health of our population over time, we must focus on preventing children and young people developing mental health issues including supporting parents during pregnancy and onwards.

Demand for CYP mental health services from has increased significantly during and following the Covid pandemic. The rise in the percentage of children identified as having a probable mental health disorder noted in the strategic landscape section above represents a 50% increase – a shift so considerable it requires national, regional and local attention. The position is similar across SWL where referral numbers have significantly increased alongside the acuity and complexity of the people needing support.

What people told us

Prevention and early support were key issues highlighted in our survey and through discussions with service users, carers, clinicians and partners.

We heard that people want the prevention and early support agenda around mental ill-health to have the same focus as that around physical ill-health. There are many examples of initiatives to support improved physical health across the life span and mental health needs to do the same.

"Make promotion of good mental health (and prevention of mental ill health) an equal basis to physical health"

"Low cost or free physical activity, plenty of green spaces, free activities for low-income people."

People are more open to discussing mental health now, which is a positive change. Stigma and shame still exist, though, and we heard suggestions to improve information and advice in the community where people go every day, not just through health services or the voluntary sector.

"Provide easily accessible information both online and via health & Wellbeing Hubs or through key community points of access e.g. Faith groups, Barbers, Shopping Malls etc"

CYPs mental health was a priority across many groups that we spoke with. People recognise that supporting CYP early can prevent mental ill health later, and one of the ways to do this is by supporting parents to have good mental health.

"More support for parents and prospective parents - adverse childhood experiences correlate with poor mental health (as well as physical health, social and occupational outcomes)."

To support CYP to develop and maintain good mental health, it's clear that prevention needs to start early and be accessed in the places CYP are, which is primarily education, but also social services.

"More prevention and early support in CYP mental health to better link Local Authority services and education."

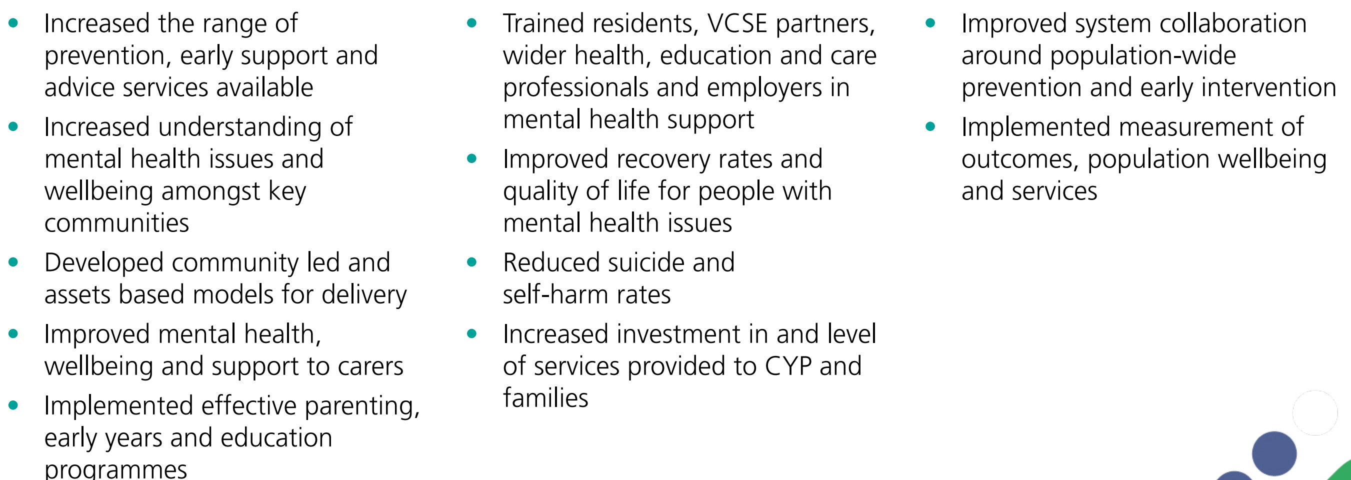
"Focus on people long before they need mental health services and work with schools etc to start a lifelong journey in good mental health."

What we need to do

- Increase the availability of evidence-based prevention and early support initiatives and increase funding into these areas year-on-year.
- Develop an approach to public mental health drawing on work underway at national level and drawing on expertise in our local authority public health teams.
- Develop an "assets based" approach to promoting mental health and wellbeing working with communities and non-health organisations as full partners.
- Continue to work in conjunction with South London Listens (a partnership between the NHS, Local Authority and VCSE) to develop and deliver community defined change around mental health.
- Train and develop colleagues working outside of mental health to identify mental distress early and provide effective input and signposting.
- Expand Mental Health First Aid Training across SWL and promote best practice approaches.
- Work with partners to further develop a co-ordinated approach to suicide prevention.
- Build upon the success of social prescribing and join up the offer across SWL to provide consistent and effective non-clinical support to develop and maintain mental wellbeing.
- Expand the availability of parenting programmes, perinatal mental health services and early years support for families in partnership with local authorities in particular for vulnerable parents.
- Increase the proportion of funding that is used for CYP mental health recognising that tackling issues earlier prevents mental health ill health in adulthood.
- Deliver focused prevention work for cohorts of CYP known to be at higher risk of developing mental health issues.
- Move away from the tiered system of service access for CYP and families and implement a needs based framework removing gaps and simplifying provision.
- Ensure the best range of digital support options and that these are regularly reviewed and updated and uptake monitored.
- Continue to develop the 'whole school approach' with ongoing investment into schools Mental Health Support Teams.
- Develop, support and deliver mental health promotion programmes in line with the evidence outlined in the prevention concordat for mental health.
- Through place-based partnerships, work to address social and economic factors that have an adverse effect on mental wellbeing.

Outcomes we expect to deliver

- Increased the range of prevention, early support and advice services available
- Increased understanding of mental health issues and wellbeing amongst key communities
- Developed community led and assets based models for delivery
- Improved mental health, wellbeing and support to carers
- Implemented effective parenting, early years and education programmes
- Trained residents, VCSE partners, wider health, education and care professionals and employers in mental health support
- Improved recovery rates and quality of life for people with mental health issues
- Reduced suicide and self-harm rates
- Increased investment in and level of services provided to CYP and families
- Improved system collaboration around population-wide prevention and early intervention
- Implemented measurement of outcomes, population wellbeing and services



7. Theme 2: Bio-psycho-social model

Including:

- Physical healthcare for people with SMI and mental health support for people with physical health care conditions
- Neighbourhood teams & integration
- Complex needs & co-occurring issues

What we know

Having a serious mental illness can adversely impact on an individual's physical health. This is related to a number of factors including medication impacts, wider determinants of health and lifestyle factors such as being more likely to live in unsettled accommodation or smoking or alcohol use and challenges in managing an existing long term condition such as diabetes, COPD or cardiovascular disease. Whilst there are initiatives to support people with SMI to access an annual physical health check, the levels of uptake are low and the support available to improve their physical health lower still.

The integration of health and care services has been a long-held ambition. We know that our services are fragmented and vary by borough. We also know that our services don't always talk to each other or to other services or agencies supporting the same person. Our statutory services also don't always provide wholly person-centred care and people can feel 'done to' rather than involved in their care. We know there are a range of different therapies, interventions and support that we could deliver but we don't always have the space, time, or resource to offer them. We have a good offer of voluntary sector support across our geography but, again, it varies by borough and offer

or level of support making it even more complicated to know that support exists and how to access it. The implementation of our SWL ICS, the examples of integration emerging at different levels, across England, offers a platform to make change happen.

People don't always present with 'simple' issues for resolution; many people experience challenging situations and some people will have complex needs or range of issues they need support with such as substance misuse, ADHD, learning disability and autism or dementia. At present our pathways and care packages do not always support people to recover or to live as independently as possible. Sometimes support breaks down leading to crisis or placement far from home. Tailored and specific care pathways and packages are needed and these can only be developed and delivered through partnership working.

What people have told us

Through our engagement work people told us that they want a model that joins up physical and mental health and is person-centred:

"A focus on physical and mental health together. Any new diagnosis of a long-term condition should also include an offer of mental health support."

"Listen to them and what they need. Everyone is different and a 'one type fits all approach' might not be right."

People also talked about wanting local access with better support in primary care and suggested how we could work better together across services, including primary care or the voluntary sector.

"Create multi-agency pathways with lots of different entry points to encourage the idea that there is not just one doorway to support and advice that can help."

"Skill up GPs to be able to deal more with MH issues confidently such that patients get very early primary intervention."

"Placing mental health workers in General Practice."

People told us how valuable peer support or voluntary sector services were to them. Including wider partners in integrated teams would be positively received.

"More support for people around housing, benefits. People within teams who are specialists in these areas so that the support is more holistic."

"I was lucky enough to get a peer support worker. We worked together for approximately two years and she came up with some really helpful coping strategies, shared ideas and she gave me hope."

"MIND and Samaritans were fantastic."

What we need to do

- Establish a comprehensive approach to physical healthcare for people with SMI detailing expectations, support available and roles of different professionals.
- Ensure that physical health checks for people with SMI are carried out and results are acted upon with brief interventions, signposting or referrals as appropriate.
- Revise training curricula for all health and care professionals to include a mandatory set of competencies around understanding/ recognising, communicating and signposting to psycho-social support.
- Ensure that mental health support is available to those with physical health conditions working with primary care and acute partners (including the SWL Acute Provider Collaborative) to build this into physical health pathways.
- Facilitate the creation of successful partnerships and shared learning with NHS, local authority, primary care, education, police and voluntary sector partners.
- Embed mental health into emerging neighbourhood teams and primary care networks – developing multi-disciplinary team working and shared population health approaches and supporting the SWL Primary Care Strategy.

- Promote the co-ordination of care around an individual's needs in a seamless way, embedding this as a core principle in any redesign or transformation.
- Develop coherent and responsive pathways involving specialist, community and VCSE services, and peer support, for people with co-occurring physical and mental health issues and ensure that health and local authority services work jointly together as needed (for those with substance misuse issues for example).
- Pool system expertise to develop an inclusive, recovery focused model of care and commissioning approach for people with complex mental health needs recognising and tackling funding and provision challenges.

Outcomes we expect to deliver

- Improved health outcomes for people with SMI with physical health conditions.
- Integrated mental health care with primary care, social care and education partners.
- Reduced services user experiences of services feeling fragmented or disconnected and needing to tell their stories multiple times.
- Included VCSE partners and peer support in mental health pathways.
- Made services easier to navigate and more joined up.
- Improved independence and recovery for people with complex mental health needs.
- Developed a sustainable model with clear pathways for those complex needs provision including rough sleepers, co-occurring substance misuse, learning disabilities and autism.

8. Theme 3: Inequalities

Including: • At risk communities • Unwarranted variation

What we know

Understanding the population and their needs is crucial in designing and delivering inclusive and effective services. Health inequalities – unfair and avoidable differences in health across the population, and between different groups within society – impact on how long people are likely to live, the health conditions they may experience and the care that is available to them. We can tackle health inequalities but this requires dedicated and structural approaches and partnership working to impact on the wider determinants of health.

The Core20PLUS5 model is a national initiative aimed at supporting ICSs to drive action around health inequalities. recognising and understanding health inequalities. It was developed for adults but has now been adapted for CYP. Core20 refers to the most deprived 20% of the national population, PLUS refers to additional population groups identified for health inclusion at local level (such as people from BAME communities, those experiencing homelessness or people LDA or multiple health conditions) and 5 refers to clinical focus areas which require accelerated improvement (SMI is one of these 5 for adults and mental health more broadly is one of the 5 for CYP).

As has been described earlier in this Strategy the SWL population is diverse and varied. Across our six boroughs we have deprived communities, a range of educational attainment and employment levels, ethnically diverse communities, some high levels of children looked after and CYP with additional needs, and a people from all protected characteristic population groups as defined under the Equalities Act 2010. We also know that people from black ethnic backgrounds are more likely to be detained under the Mental Health Act and experience inpatient and crisis services. We have made commitments to anti-racism but we need to make this real.

In addition, our mental health services are not all designed to meet a standard set of expectations or to address population needs, there are different expectations and processes that people need to navigate and there is unwarranted variation in quality, outcomes nad experience. We want to transform our services to ensure equity across SWL.

What people have told us

A range of people participated in our survey and discussions, however, we recognise that some voices are still heard less frequently and we have more work to do to reach people in all our communities.

We heard that people from some communities experience shame or stigma in trying to access services. This is a barrier before they even reach a service and then they face all of the other issues identified in our discussions: long waiting times, inflexible support, not being listened to, etc. There were suggestions around doing more specific work around those from ethnic minorities.

"Design a specific peer support group for BAME as they may feel more comfortable disclosing early symptoms to someone who they can ethnically identify with."

"Keep on talking about mental health - making people aware that mental health does not choose class, colour, wealth, age or ability/disability. Everyone can and is affected by it."

What we need to do

- Develop a co-production approach to working with communities, residents, service users, carers and wider stakeholders bringing lived experience and seldom heard voices to the fore.
- Further develop our understanding of the SWL population through work with public health teams and in conjunction with the SWL ICP Strategy.
- Provide more support into groups that analysis shows to be overrepresented in terms fo those detained under the Mental Health Act or underrepresented in early access to mental health services.
- Use a community outreach model to engage with communities in partnership with local voluntary sector partners.
- Develop a health inequalities work programme in line with national, regional and local approaches and CORE20PLUS5.
- Identify communities and population cohorts most at risk of mental ill health ((for example, children looked after) and use a population health management approach to design and implement interventions to maximise emotional wellbeing and develop resilience.
- Build upon the existing Ethnicity in Mental Health Improvement Project (EMHIP) to share learning across all six SWL boroughs and in relation to other cohorts.
- Tackle racism and discrimination and deliver our anti-racism framework.
- Annually allocate recurrent investment to tackles health inequalities around mental health.
- Review care models and performance by service area and implement a consistent core offer to reduce unwarranted variation in service availability, quality of care and outcomes.

- Move resources, with appropriate consultation, planning and impact assessment, between boroughs and service areas to ensure equitable provision based on population health needs (both in terms of burden of mental ill health and wider socio-economic factors).
- Work closely with places and neighbourhood teams to tailor core offers to be culturally sensitive and acceptable.
- Proactively look outside of SWL and identify learning, evidence and best practice around communities at risk, health inequalities and unwarranted variation

Outcomes we expect to deliver

- Increased levels of community participation in mental health programmes and projects.
- Improved levels of access to mental health services for people from across underrepresented communities.
- Services provided closer to communities we serve with more care and treatment delivered by people from these communities.
- Positive recruitment and career development initiatives for people from local communities.
- Improved outcomes for people from at risk communities.
- Reduced rates of detention generally and the disproportionate use of detention for people from black ethnic backgrounds.
- Improved experience and mental health, wellbeing and support for carers.
- Redistributed resources to reflect population needs.

9. Theme 4: Timely access

Including:

- Least restrictive care & recovery
- Waiting times
- Transitions
- Discharge

What we know

Delivering the right care and support as early as possible improves and shorten people's recovery journey. When people deteriorate significantly or experience a crisis they are more likely to need intensive interventions and inpatient care. To keep people safe in these circumstances increased restrictive practices may be required – such as detention under the Mental Health Act, seclusion, increased observations, physical or pharmacological restraint – all of which can negatively impact on an individual's experience and dignity and can imping on people's human rights. In developing community based and early support services, and reviewing our crisis and inpatient services, we aim to reduce restrictive practices.

Once people are unwell and need support, whether it be a physical or mental health issue, they want to access that support quickly. We have waiting time targets for all elements of NHS care specifically to ensure that people do not endure unduly long waits for support. Mental health is no different to physical health in the evidence that providing specific interventions or therapies in a timely manner supports a better chance of recovery and reduced likelihood of further deterioration, however, mental health waits do not attract the same attention or scrutiny as those for physical health services.

Waiting times for mental health services have increased since the pandemic, owing primarily to increased demand (numbers) but also the acuity and complexity of those presenting for help.

Often, there are not enough clinicians to enable services to provide safe care to the numbers presenting and, thus, a waiting list develops. While it is not always harmful for someone to wait for a service, the waiting times seen in mental health are too long and in some areas impact on wider elements of life – CYP waiting for mental health support may struggle school or have reduced educational attainment. Our mental health services are struggling to reduce waits without any additional support. We want to tackle waiting times and improve access to care, including offering additional support available when waits occur.

Sometimes people need support from a number of different types of services or they may need to move services at specific points – such as CYP moving into adult services. Poorly managed 'transitions' can mean people fall into gaps between teams or deteriorate as new services don't understand their needs. In addition, if people are discharged from services too early or without adequate support they can experience a relapse or needing to re-engage with services in an unplanned way. We have high quality mental health services in SWL but their organisation and operational processes are not always as clear and simple as they could be; we want to improve this.

What people have told us

People told us that the number one barrier to accessing services was waiting times. We heard this through meetings and through the survey results. Interestingly, people said they could accept waiting for certain services but that they wanted to have some sort of support or check-in while they waited.

"Provide mental health treatment promptly. Waiting months or years for mental health treatment is not acceptable."

"Quicker access to services or some form of monitoring regularly whilst on waiting lists."

Generally, people were positive about the services they received and how quickly they were assessed, especially in IAPT or CAMHS, but then having to wait for treatment without any additional support means many people suffered more than they had to. Some people suggested signposting to other services, providing peer support or a plan of action for the person while they wait for their treatment.

"Have support available e.g. peer groups or education groups for person and carers during the waiting time between asking for help and seeing specialist services so that there is not a complete vacuum of support during this period."

Discharge (from inpatient or community services) and the support following it also came up for those that had been in services. It's clear that people can feel "lost" following discharge and it can be difficult to re-integrate into the community and the period following discharge from inpatient services is known to be a time of heightened risk of suicide. We also need to recognise the importance of relationships in mental health care and feeling of loss when relationships with teams or services. Some suggestions included regular check-ins or ongoing community support. They want to be able to get back in easily if they relapse or have issues post-discharge.

"More support for those that have been discharged so that they do not relapse. I personally believe that the door should be left open and at the point of discharge the service user informed that if things get worse then you know where we are and if you need help then contact us."

What we need to do

- Increase investment in community services to maximise opportunities for close to home, least restrictive care available.
- Ensure all partners are signed up to principles of delivering least restrictive care and have clear processes in place around care planning, crisis management, goal setting and risk management to facilitate this.
- Share learning and innovation around least restrictive practice and implement new models in support of this approach.
- Reduce waiting times for access to services and starting treatment through pathway improvements and optimised referral processes, and by reviewing and potentially revising service availability in terms of population need.
- Provide consistently clear and early information on waiting times and provide access to self-help resources or support from wider partners including VCSE whilst people wait.
- Make it easier for people to navigate services and know where to access support with a dynamic and maintained directory and map of SWL mental health services.
- Better support people to move between services and ensure transitions are proactively managed to avoid people falling through the gaps.
- Reduce hand offs and interfaces between teams within and between organisations creating integrated ways of working and seamless pathways.
- Promote a positive experience of, and clear expectations around, discharge – as a part of their recovery journey – from an early point in a person's care experience.
- Improve step down approaches enabling people to return to services as needed at their own initiative therefore avoiding deterioration or crisis and reducing unnecessary administrative processes around referrals and assessments.
- Increase continuity of care by stabilising and developing the mental health workforce.
- Increase peer support for more positive step down, transition and discharge experiences.

Outcomes we expect to deliver

- Reduced restrictive practices of all types
- Reduced presentations to A&E for people known to mental health services except for physical health issues
- Eradicated out of area placements for acute mental health provision
- Reduced waiting times for services
- Improved positive feedback around transitions and discharges from services
- Increased peer support levels available across all boroughs
- Improved workforce retention, satisfaction, wellbeing and morale
- Standardised models of care with consistently high performance across a range of indicators

10. Enabling programmes

As well as developing key activities and priorities within mental health, the delivery of the Strategy will be made possible by working with colleagues across the SWL ICS on a number of enabling programmes. We will ensure that there is a strong mental health presence within these workstreams.

1. Population Health Management

Population Health Management (PHM) offers opportunities to understand needs of specific population groups and communities and to develop focused interventions to address these.

Within SWL mental health is represented within PHM Programme Board but as yet there is no defined or dedicated work in this area.

We will develop an appropriate approach and bring together experts in this areas. We will work with colleagues from informatics teams to review data and address gaps. We will learn from the successful pilots of PHM at place and primary care network level. We will deploy this approach to ensure we develop services to respond to current needs, not historic service models, and increasingly focus earlier in the patient pathway to ensure people are supported more in the community. This will further help to support prevention and reduce health inequalities.

2. Workforce

Sustained workforce challenges is arguably the greatest pressure the NHS has to tackle. In line with the national and regional picture, SWL has high vacancy levels in some services, high turnover and difficulties recruiting to some roles. Both SWLSTG and SL&M have flexible working models in place which will continue to develop to respond to changes in employment expectations post-pandemic. In addition, we have begun to include new and extended roles in our services models and to develop new career pathways. We offer training and preceptorship opportunities but as anchor institutions and with our partners in South London Listens, the SWL ICB, SWLSTG and SL&M, can do more to support people in our communities to consider and enter a career in mental health.

We support the wider ICP strategy first year focus on workforce and will support the SWL People Board and broader initiatives. Workforce elements will form a core part of the Strategy annual delivery plan.

3. Digital

This Strategy recognises the increasing role digital technology plays in healthcare. We believe that digital tools such as internet resources, mobile apps, online services and video consultations can augment traditional service delivery and access to support.

We already have a solid foundation of digital delivery which was extended during the pandemic. For example, video consultations remain are an option for service users and we have commissioned platforms such as Kooth (the online mental health resource for CYP).

We will better co-ordinate digital initiatives across the ICS to ensure a joined-up approach. We will continue to develop links with London wide initiatives such as the Good Thinking resource. We will work with the Health Innovation Network to identify and review opportunities for further innovation and technology use. We will monitor usage and outcomes from digital resources and continue to develop new approaches and ensure that all digital elements are reviewed and approved to ensure quality standards are met. We also recognise that digital exclusion exists and we will work to ensure people who want to access digital resources have opportunities to do so. We will work with the SWL Digital Programme to support the delivery of the Digital Strategy and Programme.

In addition we will work with wider partners around the Primary Care Strategy and the delivery of the SWL ICB Joint Forward Plan.

11. Implementing our Strategy

We want to thank everyone who has been involved in developing our Strategy. We know that we are only at the beginning of the journey and that co-producing and delivering the changes that have agreed will need energy, commitment and partnership working.

Our delivery structure

In SWL we are developing an integrated approach to mental health meaning that we will have a strong collaborative structure to support the delivery of the Strategy.

The SWL MH Partnership Delivery Group (PDG) will oversee the implementation of the Strategy and provide updates to the SWL ICB and ICP. This group is chaired by the SWL ICB Partner Member for Mental Health and brings together SWL ICB officers, all 6 SWL places, the two main mental health providers (SWLSTG and South London and Maudsley NHS Foundation Trust – SL&M) and the SLP. The PDG sub-groups will focus on key service areas – such as CYP MH, provide technical input – around planning or finances, or lead on development areas – including inequalities and population health management approaches.

A small group of senior leaders will take overall responsibility for the Strategy delivery, setting the annual plan, involving stakeholders and monitoring and reporting on progress.

The two main mental health providers in SWL – SWLSTG and SL&M – will come together in a SWL Mental Health Provider Collaborative structure under the existing South London Mental Health and Community Partnership (SLP) to set common standards and models of care, transform existing provision and effectively connect specialist and local services.

Each place will support the delivery of the Strategy locally through mental health partnership boards and nominated leaders, tailoring work relevant to local communities and challenges.

Measuring success and progress

Critical to success is having clear plans. We will develop an annual delivery plan as part of the standard planning cycle. This plan will detail the priority areas, milestones and outputs expected. It will be signed off by the PDG. The plan will identify and confirm funding and wider resources required for delivery.

Our planning and our work will be transparent and clear for all to understand.

Quarterly updates on the annual plan will be made to the PDG and onwards to the SWL ICB Board 6-monthly. Metrics will be agreed to measure progress towards expected outcomes. We will develop 'return on investment' approaches to help understand the impact of investment decisions and we will evaluate and assess changes we make. Impact assessments will be undertaken before changes are made.

Year 1 focus

In our first year – 2023/24 – we will focus on two key areas for delivery of improvements:

1. Going further and faster for CYP making improvements around support available for CYP and families whilst waiting, support available in schools and transitions to adult or wider services.
2. Embedding transformation of community transformation for adults with SMI.

We will also set up our delivery structures and carry out a number of pieces of enabling work to help us work together across the system.

This will include:

1. Ensuring our governance structures are in place to support delivery.
2. Completing a detailed strategic review of mental health investment to date and the outcomes delivered from this to form the basis of a longer term model aimed at allocating resources based on need.
3. Agreeing approaches to outcomes measurement and evaluation (including setting targets for delivery with people with lived experience and understanding our baseline data) and reviewing public mental health work to identify future initiatives for deployment in SWL.
4. Confirming mental health leadership and resourcing is in place.

12. Glossary

Term	Definition
SWL	South West London – geographic area formed of the six boroughs of Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth.
ICS	Integrated Care System – a partnership of organisations that come together to plan and deliver joined up health and care services to improve the lives of people in their area. They will be responsible for how health and care is planned, paid for and delivered. An ICS has four key purposes: 1. improving outcomes in population health and healthcare 2. tackling inequalities in outcomes, experience and access 3. enhancing productivity and value for money 4. supporting broader social and economic development
ICB	Integrated Care Board which is the statutory NHS body within an ICS that decides how the NHS budget for their area is spent and develop a plan to improve people’s health, deliver higher quality care, and better value for money, and
ICP	Integrated Care Partnership which brings the NHS together with other key partners, like local authorities, to develop a strategy to enable the Integrated Care System to improve health and wellbeing in its area

www.southwestlondon.icb.nhs.uk

May 2023