# Southwark's Joint Health and Wellbeing Strategy

# 2022 - 2027

*Full Report & Action Plan*

# Foreword

This new Joint Health & Wellbeing Strategy sets out our commitment to improving the health and wellbeing of all residents in Southwark, with a focus on reducing inequalities that we have seen exacerbated by the COVID-19 pandemic, and more recently by the rising Cost of Living Crisis.

Our call to action for the borough and partners is to unite to tackle inequalities wherever they may be. We are committed to providing additional support to residents that have the poorest outcomes, focusing our efforts on our most disadvantaged neighbourhoods and communities.

This new strategy gives us an opportunity to restate our commitment to improving health and wellbeing as well as setting out how we want to continue to improve services. Our five priorities outline how we want to build on the progress we have made as a partnership, and address the challenges that our residents continue to face.

At the core of the strategy is a commitment of our partners to work with our communities in designing and delivering services, ensuring their needs and wishes are at the heart of what we do.

We welcome this strategy and are committed to delivering for the people of Southwark.Working together we will ensure every child has the best start in life, our residents are supported to stay well, and everyone can access the quality services they need.

**Councillor Kieron Williams**

Leader, Southwark Council

Chair of the Health and Wellbeing Board

**Dr Nancy Kuchemann**

Deputy Chair of the Health and Wellbeing Board

Co-chair, Partnership Southwark

**Councillor Evelyn Akoto**

Cabinet Member for Health and Wellbeing, Southwark Council

Co-chair, Partnership Southwark

# Contents

**1. Executive Summary ... 4**

**2. Background ... 7**

The Health and Wellbeing Board ... 7

Addressing local population needs ... 7

Informed and shaped by our communities ... 9

The Marmot framework ... 10

**3. The State of Health & Inequalities in Southwark ... 11**

What are health inequalities? ... 11

National and local impacts of COVID-19 ... 13

Key Inequalities in Southwark ... 14

**4. Southwark's Joint Health & Wellbeing Strategy ... 16**

Delivering the Strategy: Drive, Sponsor and Observe ... 17

Drive ... 17

*Drive 1: A whole-family approach to giving children the best start in life ... 18*

*Drive 2: Healthy employment and good health for working age adults ... 21*

*Drive 3: Early identification and support to stay well ... 24*

*Drive 4: Strong and connected communities ... 27*

*Drive 5: Integration of Health and Social Care ... 29*

Sponsor ... 31

Observe ... 34

**5. Systems Transformation ... 36**

**Appendix 1: Outcomes Framework ... 40**

**Appendix 2: Joint Health and Wellbeing Strategy Action Plan ... 47**

**Appendix 3: References ... 62**

# 1. Executive Summary

## Background

The Joint Health and Wellbeing Strategy sets out our aims for the health and wellbeing of people in Southwark. This strategy has been developed by Southwark's Health and Wellbeing Board, which brings together key agencies with a role in improving health in Southwark.

Data, research and needs assessments have informed this strategy and helped us to understand health inequalities in Southwark. Engagement with local communities has helped to shape our priorities. We will continue to work with our communities and partners to develop action plans that will deliver the priorities set out in this strategy.

## The State of Health & Health Inequalities in Southwark

Southwark is a young, diverse and rapidly growing borough with large numbers of young adults and residents from a wide range of ethnic backgrounds. Across the borough there have been significant improvements in health and wellbeing in recent years, and there are many areas of success that should be celebrated:

- Our residents are living longer and healthier lives than ever before, with life expectancy comparable or better than the national average.
- Levels of relative deprivation in the borough continue to reduce.
- Key risk factors such as smoking, alcohol and physical inactivity are comparable or better than the national average.
- Preventable mortality has reduced by half since 2001, narrowing the gap with England.

While there have been substantial improvements in outcomes in Southwark, these improvements have not always been equal and many challenges remain. The COVID-19 pandemic has exposed and exacerbated the inequalities that too many of our residents experience. ***These inequalities are both avoidable and unfair***. All parts of the Council and NHS, along with our wider partners have a responsibility to reduce them.

***Call to action – Improving health for all and narrowing the gap***

Our call to action for the borough and partners is to unite to tackle inequalities. We will do this by taking a community and place focus. This involves providing additional support to the population groups that have the poorest outcomes and focusing on our most disadvantaged neighbourhoods, while maximising health and care opportunities for all through integration.

## The Southwark Joint Health & Wellbeing Strategy

### *Our delivery approach – Drive, Sponsor, Observe*

Our Strategy takes a three-tiered approach:

- **Drive:** These areas will be the focus of the delivery and monitoring of our Strategy. We will drive and strengthen our activities in these areas to reduce inequalities in health. Local data and our stakeholders, including local communities, have told us these areas are important.
- **Sponsor:** Work is already taking place in these areas; there are existing strategies or action plans. The named lead organisation will monitor progress and highlight when the Health and Wellbeing Board needs to consider aspects of this work in detail.
- **Observe:** Although much of these areas are important to population health, the decision-making sits outside of the Health and Wellbeing Board. The Board's role is to observe and influence.

### *Our Drive areas*

#### Drive 1: A whole-family approach to giving children the best start in life

We want ensure all families in Southwark receive access to good-quality maternity care, reducing differential outcomes between population groups. We want to build resilient families through holistic care in pregnancy and early years, improve mental health for the whole family and keep children safe through early identification and support for families at risk of adverse childhood experiences.

#### Drive 2: Healthy employment across the health and wellbeing economy and good health for working age adults

Across the health and wellbeing economy, we want to increase access to good quality jobs, promote health through employment support, enable people to lead healthy lifestyles building on the already strong work on the Vital 5 and promote and maximise access to leisure and physical activity.

#### Drive 3: Early identification and support to stay well

We want to ensure services prevent ill-health through early detection. We want to help people stay well through falls prevention, support for recovery from hospital admission, and wellbeing support for carers and families. We will have an enhanced focus on communities and neighbourhoods with poorer health to ensure better uptake of prevention and services to manage long-term conditions

#### Drive 4: Strong and connected communities

We want to ensure local people shape their local areas and services. We want to ensure that services are accessible to the most excluded groups and reduce social isolation and loneliness. We will develop strong collaborations between statutory services and the voluntary and community sector, undertake targeted work to remove barriers to services and focus work on addressing loneliness.

### Drive 5: Integration of Health and Social Care

The opportunities to deliver better outcomes for Southwark residents through the South East London Integrated Care System (ICS) will be optimised through strengthening joined up care, exploring where care can be delivered at a neighbourhood level and strengthening how we involve local people in delivery of our work. The development of Partnership Southwark provides us with the governance and structures to do this. By bringing NHS, council and community organisations together we can define the shared outcomes we want for our population and ensure the right leadership, accountability and oversight to support our work.

## *Our Principles*

Five principles are central to the delivery of this strategy:

1. Embedding an approach to tackling health inequalities across all our policy-making, services and delivery.
2. Making sustainability and tackling climate change an integral part of protecting and improving health.
3. Targeted place-based approach and population groups.
4. Community empowerment and co-production.
5. Delivering high quality, joined-up and person-centred health and social care.

## *Systems Transformation*

This strategy tackles issues that will require all partners to work together to achieve progress, including people in Southwark. We will work with local communities to further develop how we embed community voices into our work.

We have developed an action plan that sets out key actions we will deliver in the first two years of the Strategy. We will monitor delivery against this plan through a progress update every six months, and review it when necessary to ensure it reflects current delivery priorities.

We will monitor health outcomes and inequalities in three ways - through an outcomes framework tracking key indicators linked to our five drive areas, through the annual JSNA report that provides the story of health and wellbeing in Southwark, and through updates on the progress of the action plan.

## 2. Background

Southwark's Joint Health and Wellbeing Strategy sets out our aims for the health and wellbeing of people in the borough. The development of the strategy has been led by Southwark's Health and Wellbeing Board. Engagement with stakeholders and our communities has helped shape the priorities. The strategy focuses on the factors that affect health and wellbeing and lead to health inequalities, including the conditions in which people are born, live, work and age in Southwark.

### The Health and Wellbeing Board

The Health and Wellbeing Board provides the leadership for health and wellbeing in Southwark, bringing together partners and organisations in the borough that have a role in improving health. Our board in Southwark includes Southwark Council, South East London Integrated Care System, Community Southwark, Healthwatch Southwark, the three NHS Trusts which provide care to people in Southwark (Guy's and St Thomas' NHS Foundation Trust, King's College Hospital NHS Foundation Trust, and South London and Maudsley NHS Foundation Trust), and Guy's and St Thomas' Foundation.

There is a statutory responsibility for the Board to produce a Joint Health and Wellbeing Strategy that addresses the needs and improves the health of our population[i]. The strategy does not stand alone and must be considered alongside the accompanying thematic strategies, action plans and evolving work that is taking place within the borough to improve health and wellbeing in specific areas. Key population needs are identified through a programme of Joint Strategic Needs Assessments.

### Addressing local population needs

Existing research and health literature has been reviewed to determine the key priorities to improve health and wellbeing in Southwark. The national research and evidence base alongside the Joint Strategic Needs Assessments (JSNAs) on the health of the population in Southwark have shaped the core principles that underpin the strategy. This includes the JSNA annual report, which provides an overview of health, wellbeing and inequalities in Southwark. The principles and aims in the strategy have also been shaped by what local people have told us, through community engagement and listening, and existing local strategies and plans.

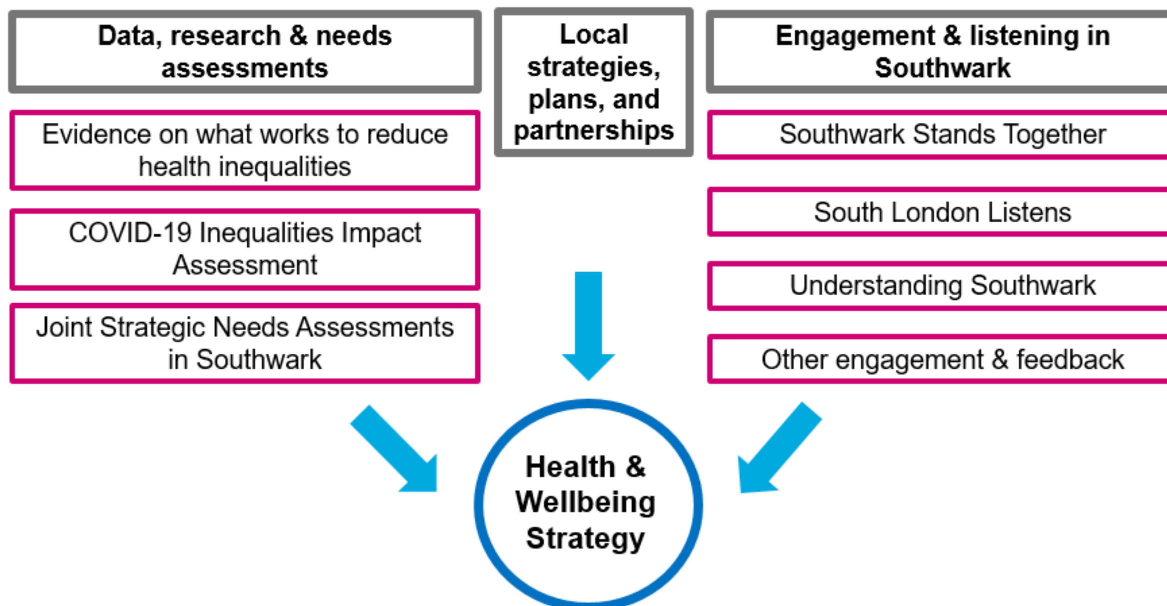



Figure 1: Summary of evidence used to shape Joint Health and Wellbeing Strategy

## Box 1. Joint Strategic Needs Assessment in Southwark

There is a statutory responsibility to produce a Joint Strategic Needs Assessment (JSNA), which identifies the key issues affecting the health and wellbeing of people in Southwark, now and in the future . To do this, we review a wide range of data and information, as well capturing the views of people who use our services or live in the borough.

The Southwark JSNA is in the form of a work programme across four themes: population groups, behaviours and risk factors, wider determinants of health, health conditions and healthcare. Each JSNA topic takes a systematic approach to looking at health issues that affect people in Southwark and makes recommendations to improve health and reduce health inequalities. In the past five years, JSNAs have covered a broad range of groups and topics, from school-age children to mental health, long term chronic health conditions, air quality and healthy weight.

An annual JSNA report is also produced as part of the JSNA programme, providing the story of health and wellbeing in Southwark.

The JSNA programme is used to inform the development of key policies and action plans. They are public documents and have also been used as a resource by wider Voluntary and Community Sector organisations for community conversations and to support local action.

For more information, please visit the JSNA webpage.

## Informed and shaped by our communities

Extensive community and stakeholder engagement have helped to shape our priorities. Local people have told us what matters. Telephone and online surveys, focus groups, stakeholder discussions, street interviews and walking ethnographies have all contributed to our understanding of local issues and informed our strategy.

Engagement cannot be a one-off. There will be further work with communities to co-produce actions, feedback on our achievements and identify where our responses can be strengthened. This will take place with the aim of developing and adopting an even stronger community voice in the Health and Wellbeing Board's work on the Joint Health and Wellbeing Strategy.

### Box 2. Understanding Southwark (Social Life)

Social Life carried out an extensive and in-depth community research programme between April 2020 and August 2021 on behalf of Southwark Council.

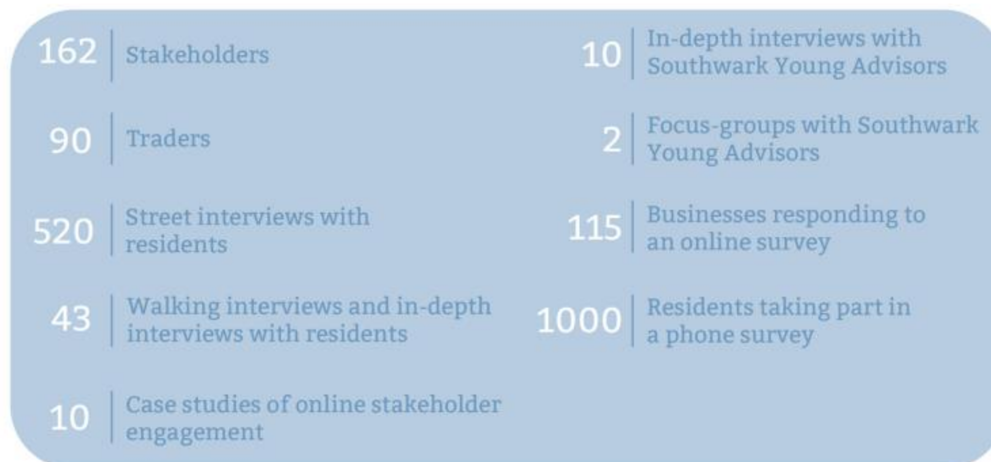



**Figure 2: Summary of engagement in Social Life's research, 2021**
**Source:** Understanding Southwark: Daily Life and the impact of Covid-19 across the borough

The research looked at daily life across the whole of the borough as well as in-depth research into six of the most deprived parts of the borough undergoing change and regeneration. There were interviews with residents and stakeholders, surveys and case studies. The research provides insight into people's experiences of their local areas and the impact of the COVID-19 pandemic on people and businesses. A set of themes and local issues are identified which highlight the assets in Southwark that supported people during the pandemic, local people's concerns and the inequalities present in the borough. The research reinforces the importance of tackling the priorities that are proposed in the Joint Health and Wellbeing Strategy and have helped inform the development of its aims.

For more information, please visit the webpage 'Understanding Southwark: an in-depth account of six areas'

**Box 3. The strong voices from local communities**

***Southwark Stands Together***

Southwark Stands Together is the borough wide initiative established in 2020 as a response to Black Lives Matter, the murder of George Floyd and the disproportionate impact of the Covid-19 pandemic on our Black, Asian and minority ethnic communities. It sets an ambitious programme to tackle the injustice and racism experienced by Black, Asian and minority ethnic communities to bring about a fairer and more equal society. The programme involved extensive engagement in 2020 including listening events, face-to-face engagement sessions, and themed round-tables. The action plan includes actions on street scape and the physical environment, initiatives to support educational achievement, support for good employment and investigating potential systemic bias in commissioning.

For more information, please visit the Southwark Stands Together webpage.

***South London Listens***

The South London Listens programme started as an urgent mental ill-health prevention response to the COVID-19 pandemic and was launched in 2020 by the NHS mental health trusts in South London. It is a partnership involving local authorities, the South London Mental Health and Community Partnership, Citizens UK, local Healthwatch organisations, South East and South West London Integrated Care Systems, and over 100 community organisations including schools, colleges, universities, faith organisations and small charities. The programme has so far included a listening campaign and three digital summits, leading to a series of asks made by the community to the NHS and local authorities. The South London Listens Action Plan has now been published, which sets out what work will be done to meet those asks.

For more information, please visit the South London Listens webpage.

## The Marmot framework

The national evidence base has shaped this strategy. The Marmot Review into health inequalities in England[ii] sets out a framework for reducing health inequalities. The review focuses on six areas:

1. Ensure the best start in life for every child
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure a healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill health prevention.

This framework underpins the strategy and was used as a structure for our ‘Sponsor’ and ‘Observe’ categories.

# 3. The State of Health & Inequalities in Southwark

Southwark is a young, diverse and rapidly growing borough with large numbers of young adults and residents from a wide range of ethnic backgrounds. Across the borough there have been significant improvements in health and wellbeing in recent years, and there are many areas of success that should be celebrated:

- Our residents are living longer and healthier lives than ever before, with life expectancy comparable or better than the national average.
- Levels of relative deprivation in the borough continue to reduce.
- Key risk factors such as smoking, alcohol and physical inactivity are comparable or better than the national average.
- Preventable mortality has reduced by half since 2001, narrowing the gap with England.

While there have been substantial improvements in outcomes in Southwark, these improvements have not always been equal and many challenges remain. The COVID-19 pandemic has exposed and exacerbated the inequalities that too many of our residents experience. These inequalities are both avoidable and unfair. All parts of the Council and NHS, along with our wider partners have a responsibility to reduce them.

## What are health inequalities?

Health inequalities are preventable and unfair differences in health across the population and between different groups of people.

These differences in health can include differences in health status (such as life expectancy), in access to care, in the quality and experience of care, in behaviours that affect health (such as smoking), and in the wider determinants of health[iii]. The wider or social determinants of health are the broad conditions that people experience over their lifetimes, including education and employment, and the places, communities, and homes in which people live. These conditions together have a large impact on people's health and contribute to health inequalities. These wider determinants of health are a focus of this strategy.

Health inequalities affect many different groups and are closely linked to disadvantage. From national evidence we know that people who live in more deprived areas have a lower life expectancy and spend more of their lives in ill-health compared to people in less deprived areas[iv]. Socially excluded groups, such as people experiencing homelessness, often have much worse health outcomes than the rest of the population[v]. There are also inequalities in health between people with different characteristics, such as by gender or ethnicity.

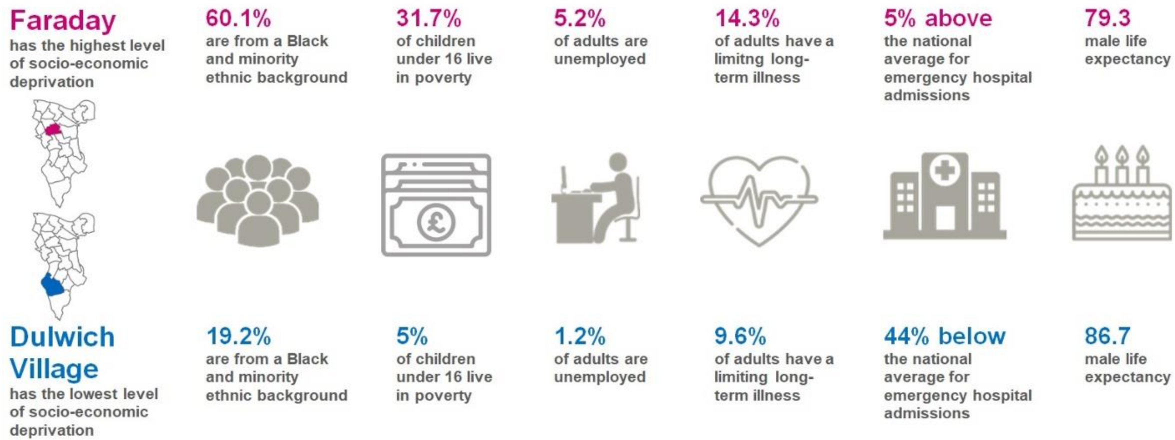



**Figure 4: Health and wellbeing geographic inequalities infographic**
**Source: Southwark Council (2022). Annual JSNA Report.**

While inequalities are often measured according to one factor (for example income), disadvantages interact and multiply. Within disadvantaged groups, experiences of inequalities are not homogenous; people can experience multiple disadvantage, which will overlap and cumulate. This means that some people, groups, and communities experience even greater health inequalities. Health inequalities also collect over the course of people's lives. This means that it is important to intervene at multiple different stages and in particular at critical stages such as early childhood.

Structural racism creates and exacerbates health inequalities, through inequalities in the wider determinants of health and differences in experiences of health services. National and local inequalities in health disproportionately impact Black, Asian and minority ethnic groups. These issues have been exacerbated by the Covid-19 pandemic.

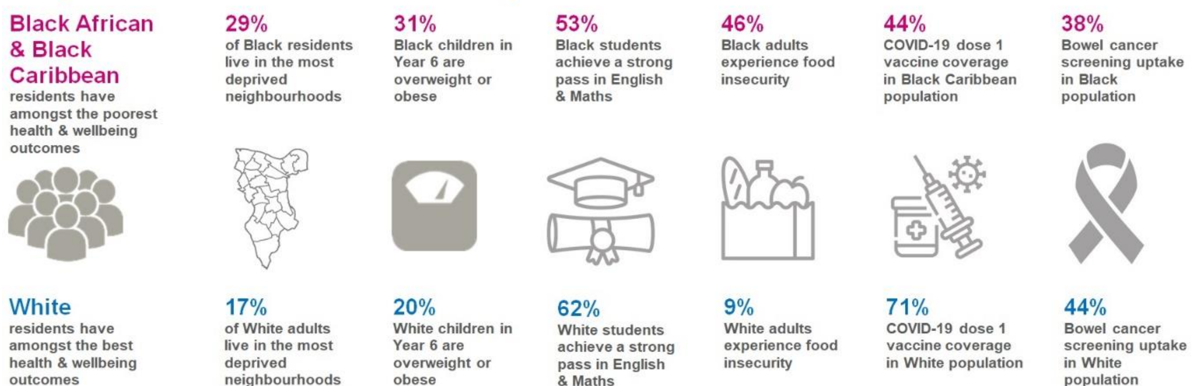



**Figure 5: Health and wellbeing ethnicity inequalities infographic**
**Source: Southwark Council (2022). Annual JSNA Report.**

**Box 4: Investigating potential systemic bias in commissioning**

The pandemic has shone a spotlight on pre-existing structural inequalities. An innovative approach is being piloted to investigate potential biases in how services are commissioned and to develop a toolkit to address these biases.

Commissioning describes the full process of assessing population needs, designing and procuring services, and monitoring how services are addressing needs. Each of these stages, separately and together, may create or exacerbate barriers to services and contribute to poorer outcomes for Black, Asian and minority ethnic communities. We are undertaking work to review our processes during these stages, to better understand the impact of bias.

The pilot will focus on the commissioning practice of Southwark Council's Public Health team. The toolkit developed from this work should be transferable across the wider health and social care system. This toolkit will be used to help commissioners work with providers to reduce bias in service design, delivery and practice.

## National and local impacts of COVID-19

We have reviewed national[vi] and local evidence[vii] to further understand the impact of Covid-19 on people in Southwark. The pandemic has impacted everyone but some groups have been impacted more than others, particularly those that were already experiencing inequalities. There have been inequalities in serious illness and death from COVID-19 infection[viii]. Issues such as digital exclusion have become heightened during the pandemic, directly affecting people's wellbeing.

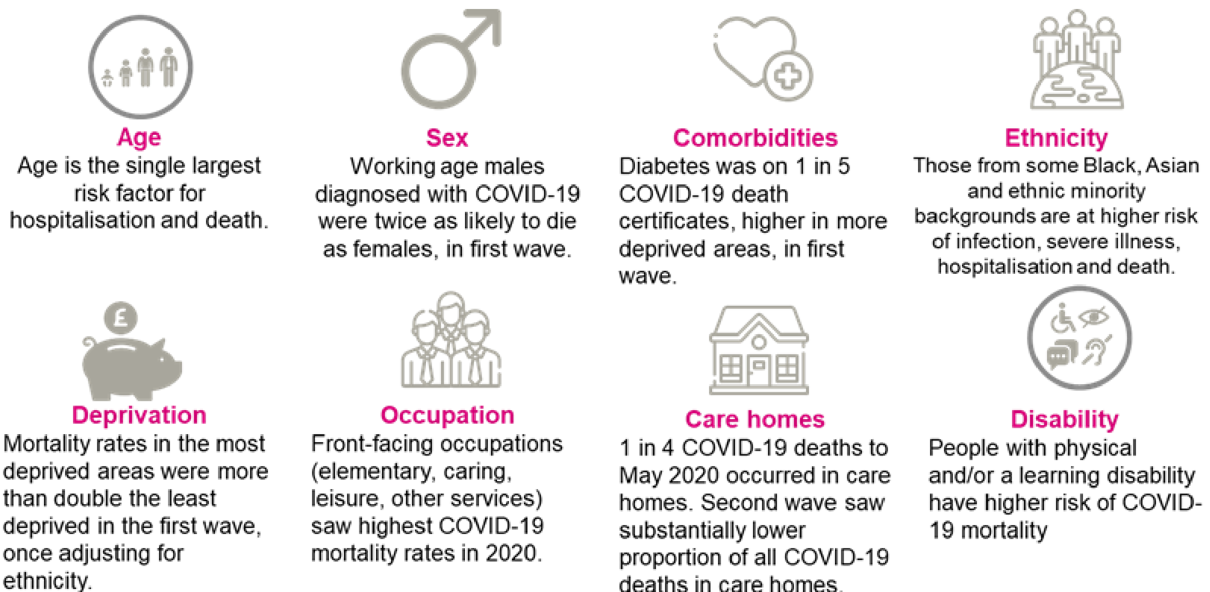
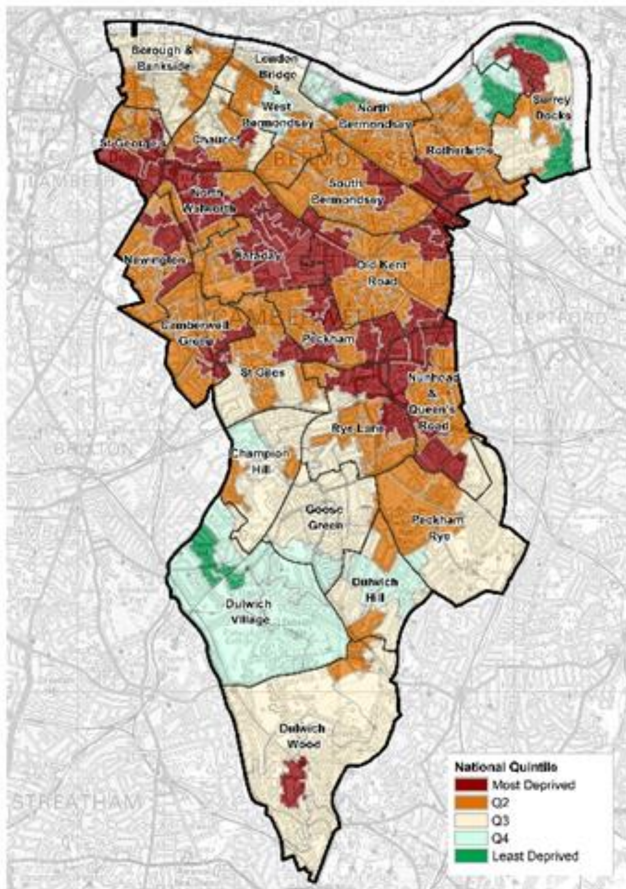



Figure 6: Groups disproportionately affected by Covid-19 nationally
Source: Covid-19 Inequalities Impact Assessment. Southwark Council. London. 2021

## Key Inequalities in Southwark

### *Geographic Inequalities*

The Indices of Deprivation is the official measure of relative deprivation in England, encompassing a wide range of indicators assessing health, social and economic conditions. Southwark has seen an improvement in its ranking relative to other local authorities since 2015, yet remains one of the most disadvantaged in the country.




Map 1: Indices of Deprivation 2019

Across a wide range of health, social and economic measures, from child poverty through to obesity, hospital admissions and life expectancy, outcomes are poorer in central and northern parts of Southwark. In particular, communities in Faraday and Peckham wards. However, it is important to acknowledge that pockets of deprivation also exist within areas of affluence, such as the Kingswood estate in Dulwich Wood and Downtown estate in Surrey Docks.

### *Population Inequalities*

There are also significant gaps in outcomes between population groups in Southwark. These often mirror the inequalities we see at a national level, with those from Black, Asian and minority ethnic groups experiencing poorer outcomes compared to those from a White ethnic background. In particular, residents from a Black African and Black Caribbean background are more likely to live in communities with high levels of deprivation, develop a greater number of long-term conditions, have poorer mental health, and experience discrimination and racism when accessing services.

It is estimated that Southwark has one of the largest LGBTQI+ communities in the country. There is increasing academic evidence that key public health challenges disproportionately impact this population group, with higher levels of smoking, alcohol use, incidence of some cancers and mental ill-health. LGBTQI+ individuals also experience discrimination and homophobia when accessing health, care and other services.

There are also a number of notable health inclusion groups in Southwark. These are groups that are often socially excluded, have multiple risk factors for poor health, and experience stigma and discrimination, including:

- People with learning disabilities
- Carers
- Asylum seekers and refugees

As a borough we are committed to reducing inequality in the access to services and outcomes our residents experience. To do this effectively we need to focus not only on our most disadvantaged neighbourhoods, but also provide additional support to the groups that have the poorest outcomes.

Key conditions driving poor health for these neighbourhoods and population groups remain cancer, heart disease and respiratory illness. In addition, we know that mental ill-health has a significant impact on the quality of life for many residents. Improving outcomes and reducing inequalities for these conditions requires sustained action by all partners in areas including:

- Behavioural risk factors such as smoking, obesity and high blood pressure
- Social and economic factors such as employment & skills, access to food and fuel security
- Environmental factors such as good quality housing and the quality of the air we breathe

In addition, these communities often see lower uptake and later access to services designed to identify and deal with problems early. This can be related to services being inaccessible, as well as poor experience in the past. These delays in accessing support too often lead to poorer outcomes for those most in need.

Reducing the inequality gap between the neighbourhoods and population groups with the poorest outcomes and the rest of the borough, whilst improving outcomes for all residents, is our central purpose. This principle should direct the work of everyone in the borough. Through each of our Drive priorities our partnership is committed to targeting our action in those areas of greatest need, ensuring we continually focus on closing the inequality gap both in access to services and outcomes.

Evidence clearly shows that poverty, low income and the wider determinants of health significantly influence health outcomes. Through our Sponsor and Observe tiers, we will strengthen our work with all parts of the Council, NHS and wider partners to ensure reducing inequalities is at the heart of everyone's business. Only by improving social and economic conditions, along with those in healthcare, can we make a sustained and meaningful impact on inequalities in the borough. By ensuring action relating to issues such as employment & skills, housing and climate change have reducing inequality at their core, we will harness the efforts of everyone in our borough. ***Tackling inequality is everyone's business.***

# 4. Southwark's Joint Health & Wellbeing Strategy

## Principles

Five principles are central to the delivery of this strategy:

1. **Embedding an approach to tackling health inequalities across all our policy making, services and delivery.** Health inequalities are preventable and unfair differences in health across the population and between different groups of people. We will ensure that all of our services embed an approach to reducing health inequalities, including recognising the role of structural inequalities and discrimination. This principle is accompanied by a training programme to make tackling health inequalities everybody's business, from ensuring the use of equality impact assessments, to enhanced Making Every Contact Count training for the workforce and wider system.
2. **Making sustainability and tackling climate change an integral part of protecting and improving health.** The climate emergency will have a direct impact on the residents of Southwark and it is often those who are vulnerable who are most directly impacted. Tackling climate change is therefore an integral part of our approach to reducing inequalities.
3. **Targeted place-based approach and population groups.** We will target services and support to communities who need them most. Recognising inequity and levelling up to ensure equity is key. This means that we must give special consideration to parts of the borough and neighbourhoods that are most deprived and population groups with the highest needs and those who face challenges in accessing services.
4. **Community empowerment and co-production.** We recognise that individuals are experts in their own lives and their local communities. We will work in partnership with our communities to deliver this strategy, embedding community-led work and ambitions to improve health and wellbeing in Southwark.
5. **Delivering high quality, joined-up and person-centred health and social care.** We want local health and care services to work for local people; we know we can only achieve that if our local communities shape those services. We also know that joined-up care, delivered close to people's homes, will lead to better outcomes for local people.

## Delivering the Strategy: Drive, Sponsor and Observe

Taking a population health approach to tacking health inequalities requires a complex multi factorial approach. We will ensure delivery and monitor success using a three tiered approach: **Drive**, **Sponsor** and **Observe.**

**Drive** – The 'Drive' category describes the areas of the strategy that are at the top of our agenda. These areas are important to people in Southwark and require all agencies to work together to achieve change. Each agency on the Health and Wellbeing Board will play a role in improving health and reducing inequalities. We will shape this work by prioritising these areas in strategy discussions, delivery and measuring the difference we are making.

**Sponsor** – The 'Sponsor' category describes the areas where work is already underway and our role as a Board is to sponsor that work. There will be a named lead organisation who will monitor progress and work with all agencies to ensure that we are achieving our objectives. These areas will not be included as rolling agenda items, but will be considered if the delivery lead highlights the need for more in-depth consideration by the Health and Wellbeing Board.

**Observe** – The 'Observe' category describes areas that are important to improving the health of people in Southwark, but may require less direct attention from the Board. Action on these areas may be driven by different decision-makers in Southwark, or be part of the business as usual of one of our agencies. In these areas, we have outlined what we want to achieve but will only consider these areas in detail by exception.

## Drive

The five areas that we will drive are summarised below.

**Drive 1: A whole-family approach to giving children the best start in life**

Focused on ensuring families receive care that works for them during pregnancy and a child's first years, and good mental health support for the whole family

**Drive 2: Healthy employment and good health for working age adults across the health and wellbeing economy**

Focused on improving access to good quality jobs through our employment and procurement practices and helping working age adults to lead healthy lifestyles

**Drive 3: Early identification and support to stay well**

Focused on keeping people well as they age through prevention, early detection and intervention, and support for carers

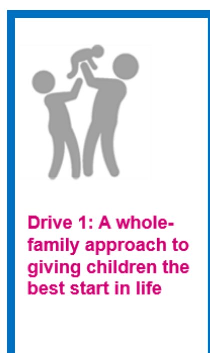
**Drive 4: Strong and connected communities**

Focused on shaping services with communities, tackling isolation and ensuring services are accessible to all

**Drive 5: Integration of Health and Social Care**

Focused on joined-up, person-centred care, accountability and making the best use of the Southwark pound

## Drive 1: A whole-family approach to giving children the best start in life



### *Why is this important?*

Ensuring the best start in life is a priority for two reasons. Firstly, this is an important period for child development and for new parents. Providing the right support during pregnancy and the first years of a child's life can lay the foundation for healthy, resilient families. Secondly, inequalities in maternal health and early childhood experiences can lead to disadvantages that affect families throughout their lives. Reducing inequalities at this stage can have long-term impact on the lives of people in Southwark. This includes taking action to prevent and reduce the impact of traumatic and stressful experiences in childhood (sometimes referred to as Adverse Childhood Experiences) and to enable children to develop to the best of their potential.

The first 1,001 days from conception to the age of two are a critical time for a child's cognitive, physical and emotional development.[ix] A child's experiences during this period of rapid brain development can have a lifelong impact on their emotional and mental health. Exposure to chronic stress can negatively affect a baby's development, including exposure pre-birth.

Pregnancy and the period after birth is also a time of rapid change for parents, physically and emotionally. Some families experience greater disadvantage during this time. There are stark inequalities in deaths in pregnancy, with people from Black ethnic groups four times more likely to die in pregnancy than people from White groups.[x] Pregnancy can cause or exacerbate mental health conditions.[xi] Ensuring families receive the right support can help them to keep healthy and ensure they are equipped to give responsive and appropriate care.

### *The Southwark picture*

#### First 1,001 days

There are in-borough inequalities in pregnancy outcomes in Southwark. Preterm birth rates are higher in Southwark among women living in the two most deprived areas compared with women living in the two least deprived areas. The national picture of inequalities in maternal mortality between ethnic groups is stark; maternity services in Southwark should work to understand and tackle inequity.

Disadvantage starts before birth and accumulates throughout life**.** Maternal risk factors such as age, ethnic group, migration status, deprivation and other sociodemographic characteristics, obesity and smoking often overlap and combine together in a way that results in health inequalities for children in Southwark. Smoking during pregnancy can impact growth and development of the baby and health of the mother. Smokers are more likely to have complications during pregnancy and labour. In Southwark, 5% of mothers said they smoked at the time of delivery, similar to London as a whole.

New birth visits can identify any development issues with the infant, provide safe sleeping advice, support feeding and discuss concerns and worries, including maternal mental health. In Southwark, over 95% of new birth visits are completed within first 14 days after birth. Almost 70% of children are totally or partially breastfed at 6-8 weeks post-birth, which is higher than London average. Breastmilk provides the ideal nutrition for infants in the first stages of life, and can protect against infections and disease. Breastfeeding can also build a strong emotional bond between mother and child, as well as providing health benefits for the mother.

Healthy food is a key part of giving children and families the best start in life and initiatives to support healthy eating can support women to be healthy during and after pregnancy and young children to grow and develop.

**Adverse childhood experiences (ACEs)**

In Southwark, the total number of live births is falling year on year. However, increased referrals to children's social care suggests that the challenges families are facing are more complex. Approximately 2,000 children aged 0-4 years in Southwark (10%) may be living in a household affected by four or more ACEs. As they develop into adulthood these children are more likely to use illicit drugs, have unhealthy diets, experience an unplanned teenage pregnancy, become involved in violence, and have poor mental wellbeing. Adverse childhood experiences were exacerbated during the Covid-19 pandemic due to a combination of factors, including greater stressors to parents and care givers, increases in children's vulnerabilities and reduction in access to universal services.

**Mental health and wellbeing of children and young people**

In 2016, almost 1 in 10 children (9.8%) aged 5-16 years old in Southwark were estimated to have a mental health disorder, equivalent to about 3,900 children, higher than London and England averages. Research increasingly highlights the significant impact of the COVID-19 pandemic on mental health and wellbeing.

***What have we heard from communities and stakeholders in Southwark?***

Families have told us that they want to receive the support they need as their child reaches each milestone, and know how to access the services their family needs.[xii]

Over the course of the pandemic, strong concerns were voiced about vulnerable parents, children and young people including families who are struggling financially[xiii]. Peer support for parents' mental health was an ask in the South London Listens work[xiv].

### *What do we want to achieve?*

**Aim 1: Ensure all families in Southwark receive access to good-quality maternity care.**

- This work will further be developed through Partnership Southwark's Start Well workstream.

**Aim 2: Build resilient families, by ensuring that there is holistic support and care for families during pregnancy and the first years of life.**

- Resilience refers to the ability to recover from adverse events or shocks. This requires connected communities where families are able to build strong networks.
- We want to make it easy for families to get help when they need it, by identifying and removing barriers to family services for those most in need, such as accessibility issues or language barriers.

**Aim 3: Improve the mental health and wellbeing of families, children and young people.**

- Risk factors for poor mental health are linked to wider inequality, including poverty, discrimination and stress. Improving the mental wellbeing of families requires action to reduce wider inequalities across Southwark, which is covered elsewhere in this Strategy. To ensure that our services can meet the mental health needs of the whole family, we will scale up and improve support.

**Aim 4: Keep children and young people safe through early identification and support for families at risk of adverse childhood experiences.**

- We want to reduce the gap between children living in the most and least deprived areas in Southwark who are exposed to more than four adverse childhood experiences.

### *How will we monitor success?*

We will monitor progress in this area by focusing on antenatal booking, low birth weight, self-reported child wellbeing and admission to hospitals. A full outline of measures is included at Appendix 1.

## Drive 2: Healthy employment and good health for working age adults

Drive 1: A whole-family approach to giving children the best start in life

Drive 2: Healthy employment and good health for working age adults

Drive 3: Early identification and support to stay well

Drive 4: Strong and connected communities

Drive 5: Integration of Health and Social Care

### *Why is this important?*

People who are unemployed often have worse health than people in work. We also know that the quality of work matters; including getting a wage that prevents poverty and provides safe and secure working conditions. The local health and wellbeing economy will work together to improve the wellbeing of people in Southwark through procurement and employment practices, as leaders and major employers of local people.

Unequal access to employment, low incomes and zero-hours contracts are some of the challenges which people in Southwark face. Southwark residents from Black, Asian and minority ethnic groups, and people with disabilities, are more likely to be unemployed and receive disproportionately lower earnings.

Lifestyle factors are also significant in the health of working age adults. Inequalities in the "Vital 5" (obesity, smoking, alcohol intake, high blood pressure, and mental ill-health) contribute to substantial health inequalities and tackling these is an important local aim.

There are also inequalities in lifestyle factors, with risk factors clustered in some population groups. An example is LGBTQI+ communities, where there is increasing evidence that key public health challenges (smoking, alcohol use, incidence of some cancers and mental ill-health) disproportionately impact this population group. It is estimated that Southwark has one of the largest LGBTQI+ communities across the country. Targeting healthy lifestyle work to population groups who will benefit most can maximise efforts to improve health of Southwark residents.

### *The Southwark picture*

#### Economic inactivity

Economic inactivity in Southwark is significantly below regional and national levels. Most people who are economically inactive are not seeking work, including students and those who are long-term sick. However, some people who are economically inactive would like a job, known as involuntary unemployment. Around 30% of people without a job in Southwark would like one, which is higher than London (20.6%) and England (18.6%).

### Income inequality

The average household income in Southwark in 2021 was £33,848 broadly comparable to the national average of £32,549. Despite household incomes reflecting the national median and average, the very wide distribution in Southwark means that there are many households in Southwark experiencing poverty. Around 1 in 7 households in the borough have an income less than £15,000 per year, and a similar proportion earn over £75,000. There are significant geographical inequalities within the borough, with levels highest in Dulwich Village (£61,271) and lowest in Old Kent Road (£24,632). 'In-work' poverty is a concern given the relatively higher costs of living in London and the 'cost of living crisis'.

There have been improvements in pay inequality over the last decade. Southwark's pay inequality stands at 2.34 in 2021, meaning hourly wages for the top 20% of earners in the borough are 2.34 times higher than the remaining 80%. This gives Southwark better pay equality than London (2.64) and places it fifth most equal among London boroughs. This is a substantial improvement from 2011, when Southwark's pay inequality ratio was 3.07 and the fifth most *unequal* borough in London.

### Employment for people with long-term conditions

Hypertension, depression and diabetes are the three most prevalent long-term conditions in Southwark, with over 35,000 residents diagnosed with hypertension in 2020/21. Multiple long-term conditions can lead to poor health – diabetes and depression are most frequently identified as being present for those with multiple long-term conditions, demonstrating the importance of a holistic approach to both physical and mental health. There is a 9% gap in employment between those with a long-term condition and overall employment rate in the borough. Prevention of long-term conditions along with inclusive employment are both needed to reduce the gap. Poor mental health and stress are often the most common factors cited in work sickness absences.

### Healthy behaviours

Healthy behaviours can prevent poor health and keep people well. Opportunities to stay active are an important part of this; physical activity can help people to maintain good mental and physical health and prevent or manage disease. Lifestyle factors such as smoking, alcohol intake, lack of physical activity and poor diet contribute to poor health, in the medium term e.g. obesity and longer term e.g. chronic obstructive pulmonary disorder, cancers.

Lifestyle risk factors are often clustered in specific population groups and in neighbourhoods with higher deprivation, both increasing the risk of poor health outcomes for the individual, and widening health inequalities between communities.

### *What have we heard from communities and stakeholders in Southwark?*

Work and wages emerged as one of the priority areas of South London Listens[xv]. The Understanding Southwark research highlighted the importance of employment and the local economy to residents[xvi]. Through Southwark Stands Together, local residents

highlighted how multiple aspects of identity can impact on career progression. The quality of jobs can positively and negatively impact local people's wellbeing.

### *What do we want to achieve?*

**Aim 1:** Across the health and wellbeing economy, we will increase access to good quality jobs, creating new routes to employment and providing support to those facing barriers to good quality jobs, including those facing systemic inequality such as those from Black, Asian and minority ethnic backgrounds, women and disabled people.

**Aim 2:** Promote health and wellbeing across the health and wellbeing economy, through improving access to integrated wellbeing and employment support.

**Aim 3:** Lead by example by promoting good health and wellbeing across our workforce, and supporting this through our procurement practices.

**Aim 4:** Support people to lead healthy lifestyles that keep them well, working with population groups and communities where lifestyle risk factors are clustered.

**Aim 5:** Maximise access to leisure and physical activity, ensuring that financial circumstance is does not limit access.

### *How will we monitor progress?*

We will monitor progress in this area by focusing on employment gaps, in-work poverty, and lifestyle factors (smoking, physical activity). A full outline of measures is included at Appendix 1.

## Drive 3: Early identification and support to stay well

Drive 1: A whole-family approach to giving children the best start in life

Drive 2: Healthy employment and good health for working age adults

Drive 3: Early identification and support to stay well

Drive 4: Strong and connected communities

Drive 5: Integration of Health and Social Care

### *Why is this important?*

Supporting people to maintain their independence and keep healthy is a key strand of tackling inequalities over the life course. Screening programmes and NHS health checks can ensure timely treatment of disease in the adult population.

Prevention can also keep people staying healthy and happy in their homes as they age. This includes programmes that keep people well as they age, such as falls prevention and early detection of dementia. Carers play a substantial role in supporting their loved ones to stay well, yet evidence suggests carers themselves are at risk of poor physical, mental and financial health outcomes[xvii]. Supporting carers will have impact on their health and the wellbeing of their families.

### *The Southwark picture*

#### Cancer screening

The early diagnosis of cancer is an important factor in ensuring the best health outcomes. Prior to the pandemic cancer screening coverage in Southwark was broadly comparable to the London average in the south of the borough, with levels lower in the north. However, coverage was below the national average for all programmes. Cervical and breast cancer screening has declined across South East London and nationally during the pandemic, whilst bowel cancer screening has continued to increase. There have been recent innovations in the bowel cancer screening process and the tests can be done at home, whereas cervical and breast cancer screening has to be done in person at a GP/ hospital.  Increased efforts are needed to address the decline seen for breast and cervical cancers.

#### NHS health checks

NHS health checks aims to help prevent heart disease, stroke, diabetes and kidney disease. Everyone between the ages of 40-74, who has not already been diagnosed with one of these conditions, will be invited to have a check. Half of all eligible residents have had a health check over the last four years. The introduction of targeted invitations in Southwark has increased attendance from Black, Asian and ethnic minority residents over the last two years, and cardiovascular disease risk identification has more than doubled from 2020 to 2021.

### Falls

Falls are the largest cause of emergency hospital admissions among older people and can significantly affect longer term outcomes. Emergency hospital admissions for injuries due to falls in older people in Southwark are consistently above national and regional levels. Admission rates also increase significantly with age, mirroring the national pattern. Rates among those aged 80 and over are more than four times those under 80.

### Dementia

Research shows a timely diagnosis of dementia can have a significantly positive impact on a person's quality of life. Latest estimates suggest that just over two thirds of those thought to be living with dementia in Southwark have received a diagnosis; comparable to regional and national levels.

### Transformation Programmes

This Drive area is covered in part by transformation work that is already happening within the borough. Targeted work is taking place to review specific pathways via Partnership Southwark's 'Well' groups. We have also recently refreshed our Mental Health and Wellbeing Strategy, which sets out our short term and long term objectives to improve mental health of people in the borough.

## *What have we heard from communities and stakeholders in Southwark?*

The effects of the pandemic on mental health emerged as a key theme from residents and stakeholders in the Understanding Southwark research[xviii]. Through South London Listens, people have told us in detail what they need from us to support their recovery from the mental health impacts of the pandemic – themes have included loneliness, work and wages, good mental health for families and access to mental health services for migrants, refugees and diaspora communities. These themes have been reflected throughout this strategy.

Carers have told us that their roles can be intense and emotional.[xix] The interaction with health and social care services can have positive effects when communication is good, and compound feelings of stress where improvements are required. Carers value personalised, varied models of support.

## *What do we want to achieve?*

**Aim 1:** Ensure that there are effective and accessible services that help prevent illness, including immunisations, screening and measures to tackle "The Vital 5" (hypertension, obesity, smoking, alcohol and mental health).

**Aim 2:** Focus on preventing admission to hospital for falls.

**Aim 3:** Promote good mental health by supporting wellbeing and early detection

**Aim 4:** Provide the right support which helps people to recover from admission to hospital

**Aim 5:** Support carers and families to look after their own wellbeing.

### *How will we monitor success?*

We will monitor progress in this area by focusing on NHS health checks uptake, screening coverage, support available for carers, hospital admissions due to falls and successful re-ablement on discharge from hospital. A full outline of measures is included at Appendix 1.

**Case Study 1. Community Health Ambassadors**

The Community Health Ambassadors Network was set up by Southwark Council in partnership with Community Southwark and Healthwatch Southwark. They have helped to inform, empower and support the community during the Covid-19 pandemic. Ambassadors are provided with accurate information about Covid-19 guidance, vaccines, testing, health and wellbeing, food and financial support. Ambassadors also provide feedback about barriers and challenges the community is facing. Ambassadors are helping to break down these barriers, to ensure that communities receive information from trusted sources and we develop a better understanding of access barriers for local people.

To see the community ambassadors in action, please watch Southwark Community Health Ambassadors Network clip here: Community Health Ambassadors Network - YouTube

## Drive 4: Strong and connected communities

Drive 1: A whole-family approach to giving children the best start in life

Drive 2: Healthy employment and good health for working age adults

Drive 3: Early identification and support to stay well

Drive 4: Strong and connected communities

Drive 5: Integration of Health and Social Care

### *Why is this important?*

The places and communities in which we live affect our health. Community networks, relationships and connectedness benefit mental wellbeing and have onwards effects on physical health. The value of connected communities has been particularly visible during the Covid-19 pandemic, where the support Southwark residents have provided to one another has been remarkable.

Our Health and Wellbeing Board has a role in supporting strong and connected communities. This involves ensuring communities shape their local areas and services and are empowered to make change. It also involves taking measures to support community connectedness, reducing social isolation and ensuring that local services improve the lives of all.

Culture and the arts can play a key role in tackling the health and social inequalities faced by Southwark's communities. Creativity and cultural engagement can improve individual health, and the health of our communities.

### *The Southwark picture*

#### Local engagement

The borough has a number of assets to support strong and connected communities – active voluntary, community and faith organisations, community spaces through a network of modern libraries and good quality green spaces. Our local residents and community organisations have mobilised during the Covid-19 pandemic, quickly forming new alliances to respond to the challenges. Southwark benefits from local people who are committed to improving their areas and local services.

#### Inequalities and excluded groups

Geographic inequalities in Southwark remain – with health, social and economic outcomes consistently being poorer in central and northern parts of the borough. There are also gaps between population groups. These inequalities affect the population in multifaceted and complex ways – the experiences of population groups are not homogenous and some people within a population group will be more disadvantaged than others.

Some notable health inclusion groups have multiple risk factors for poor health, and experience stigma and discrimination. These groups include people facing multiple disadvantage, learning disabled people, carers, rough sleepers, and asylum seekers and refugees. Part of creating strong and connected communities involves reducing discrimination and stigma, and ensuring that services work for all.

### *What have we heard from communities and stakeholders in Southwark?*

Local community organisations, parks and green spaces are seen as valuable assets by residents[xx]. Local people have told us how important it is that their voices are used to shape change in their local area and services.

During the pandemic, local people have voiced concern about some groups falling through gaps in support[xxi]. Digital exclusion has contributed to loneliness and social isolation during the pandemic[xxii].

### *What do we want to achieve?*

**Aim 1:** Ensure people shape their local areas and services through collaboration and co-design.

**Aim 2:** Ensure that services are accessible to and meet the needs of all - including people facing multiple disadvantage, people experiencing homelessness, refugees, asylum seekers and vulnerable migrants.

**Aim 3:** Reduce social isolation and loneliness, by creating a place where people feel connected and where loneliness is tackled as early as possible.

### *How will we monitor success?*

We will monitor progress in this area by focusing on how people in Southwark view the area and have a sense of belonging, and the percentage of people who feel lonely in Southwark. A full outline of measures is included at Appendix 1.

### Case Study 2: Connectivity in Communities - Partnerships for People and Place

Southwark has been chosen as one of 13 pilot areas in England to work with local partners and central government on the 'Partnerships for People and Place' pilot[xxiii]. The pilot will take a whole neighbourhood approach, aimed at improving connectivity and developing a social safety net for people in the Walworth area. The pilot will bring together a new community of residents, policy makers and practitioners, building on the cross-sector and central/local collaboration and insights generated during the pandemic. It is hoped that this will strengthen resilience in the community and lead to long-term and lasting change – making a positive impact on inequalities in Walworth.

## Drive 5: Integration of Health and Social Care

Drive 1: A whole-family approach to giving children the best start in life

Drive 2: Healthy employment and good health for working age adults

Drive 3: Early identification and support to stay well

Drive 4: Strong and connected communities

Drive 5: Integration of Health and Social Care

### *Why is this important?*

There is a strong requirement and case for health and social care integration. Care works best when services are seamless, easily accessible locally and through a common front door.

People often work with a number of services to manage their health – this can include their local GP, specialist services for their physical and mental health, social care support, and others. Integrating health and social care means that different services work together as a partnership. This puts people at the centre of their care, ensuring that they have choice and control over services that are able to respond to their needs. It prevents fragmentation and reduces the effort needed to navigate the system.

There are also benefits to integrating health and social care at a strategic level. A number of organisations work in Southwark to improve population health and reduce health inequalities. Working together allows us to be ambitious for our population, recognising that no part of the system can tackle health inequalities alone. It also allows us to share knowledge, skills and budgets across the system to achieve the best possible outcomes with the resources available. When referring to health and care, this includes the NHS, social care and voluntary and community sector partners involved in delivering health and care services.

### *The Southwark Picture*

Changes are already making a difference to how the Health and Wellbeing Board partner organisations work together to improve the health and wellbeing of people in Southwark.

Partnership Southwark is Southwark's local care partnership within the Our Healthier South East London Care System. It brings together local health, care and VCS organisations to better join up care, improve health and wellbeing outcomes and address inequalities within our communities in Southwark. Partnership Southwark is working to join up services and support, and the 'Start Well', 'Live Well', 'Age Well' and 'Care Well' workstreams will play a key role in coordinating local work to improve health.

This strategy is closely linked to the Partnership Southwark Health and Care Plan which is in development. The Health and Care Plan will set out the actions Partnership

Southwark will take to meet our overall aims for improving health and reducing health inequalities. It will help us to set out in detail how we will deliver the ambitions within this strategy.

### *What have we heard from communities and stakeholders in Southwark?*

Communities have emphasised the importance of seamless services and simplifying access. We can do more to ensure that people can hold us accountable for how we act on engagement and feedback.

### *What do we want to achieve?*

**Aim 1:** Ensure care is delivered close to home, including exploring where care can be developed at a neighbourhood level.

**Aim 2:** Strengthen how we involve local communities to help us better understand their needs and to co-design and implement services to meet their needs.

**Aim 3:** Ensure partners are able to hold each other to account in delivering good care to our residents.

**Aim 4:** Align budgets where possible to make the best use of the “Southwark pound”.

### *How will we monitor progress?*

We will measure progress in this area through feedback from local people in Southwark and from organisational self-assessment and auditing.

## Sponsor

The areas our Board will 'sponsor' are set out in the tables below. Work is already taking place in these areas; there are existing strategies or action plans. These areas have been set out against the framework provided by the Marmot review. In each of these areas, we have set out what we want to achieve, in addition to the Drive actions, and the named lead organisation for this work.

| **Ensure the best start in life for every child** | |
|---|---|
| **Aims** | **Lead** |
| 1. Support every child to maximise school readiness<br>2. Enable families to set the foundations for healthy life-long behaviours in children, including physical activity and healthy diet<br>3. Protect and safeguard children from harm using a whole family approach | Health visiting / Education<br><br>Southwark Healthy Weight Network /Public Health Team<br><br>Family Early Help / Safeguarding Board |
| *What strategies and action plans do these link to?*<br><br>Southwark Safeguarding Priorities and Themes<br><br>Southwark Family Early Help Offer<br><br>Partnership Southwark Recovery Plan<br><br>Southwark Healthy Weight Strategy (in development) | |

| **Enable all children, young people and adults to maximise their capabilities and have control over their lives** | |
|---|---|
| **Aims** | **Lead** |
| 1. Support all children to achieve their potential in education – including through tackling the underlying causes of school exclusions and supporting children with special educational needs and disabilities, and children in contact with children's social care<br>2. Make the borough a safer place for everyone including through tackling violence and domestic abuse, protecting and safeguarding vulnerable adults, understanding and tackling exploitation and reducing discrimination<br>3. Reduce serious youth violence through trauma-informed services and preventing adverse childhood experiences | Southwark Education / SEND team<br><br>Adult Safeguarding Board<br><br>Family Early Help |

| | |
|---|---|
| *What strategies and action plans do these link to?*<br><br>Southwark Council's Youth New Deal<br><br>Special Educational Needs and Disability (SEND) Strategy<br><br>Southwark Community Safety Partnership Plan 2017-2020<br><br>Southwark Violence Against Women and Girls Strategy 2019-2024 | |

| **Create fair employment and good work for all** | |
|---|---|
| **Aims** | **Lead** |
| 1. Reduce in-work poverty, by promoting the London Living Wage and providing support for residents into better quality, more secure work.<br>2. Maintain a skills and training offer that is aligned to the needs of key economic sectors and provides the high-quality training needed to access good quality jobs. | Southwark Economy Team |
| *What strategies and action plans do these link to?*<br><br>Southwark Council's Economic Renewal Plan<br><br>Southwark's Economic Wellbeing Strategy (and emerging Economic Strategy 2022-2030)<br><br>Southwark Council's Fairer Future Procurement Framework | |

| **Ensure a healthy standard of living for all** | |
|---|---|
| **Aims** | **Lead** |
| 1. Improve food security and access to healthy and sustainable food<br>2. Reduce fuel poverty within Southwark<br>3. Identify and act on opportunities to mitigate the impacts of poverty including issues such as transport poverty<br>4. Support our residents to manage debt | Public Health<br><br>Fuel Poverty Partnership Group<br><br>Financial Inclusion Forum |
| *What strategies and action plans do these link to?*<br><br>Southwark Food Security Action Plan<br><br>Partnership Southwark Recovery Plan | |

<table>
<tr><th colspan="2">Create and develop healthy and sustainable places and communities</th></tr>
<tr><td>Aims</td><td>Lead</td></tr>
<tr><td>1. Plan town centres, high streets and public spaces that are inclusive and promote health<br>2. Support people to live healthy lives through provision of good quality Council housing</td><td>Southwark Planning<br><br>Southwark Council Housing</td></tr>
<tr><td>What strategies and action plans do these link to?<br><br>The Southwark Plan 2022 (the local plan)<br><br>Southwark Asset Management Strategy (in development)</td><td></td></tr>
</table>

<table>
<tr><th colspan="2">Strengthen the role and impact of ill health prevention</th></tr>
<tr><td>Aims</td><td>Lead</td></tr>
<tr><td>1. Actively promote and provide opportunities for residents to improve their health and wellbeing through physical activity, movement and active travel<br>2. Reduce the impact of Covid-19<br>3. Ensure community-based care services that maximise people's independence and support them to live healthy lives in their own homes</td><td>Southwark Leisure / Transport Planning<br><br>Southwark Public Health<br><br>Southwark Adult Social Care</td></tr>
<tr><td>What strategies and action plans do these link to?<br><br>Southwark Healthy Weight Strategy 2016-2021<br><br>Southwark Council Sport and Physical Activity Strategy 2019-2023<br><br>Southwark Movement Plan<br><br>Southwark Adult Social Care Business Plan</td><td></td></tr>
</table>

## Observe

The areas our Board will 'observe' are set out in the tables below. Although much of these areas are important to population health, the decision-making sits outside of the Health and Wellbeing Board. These areas have been set out against the framework provided by the Marmot review. In each of these areas, we have set out what we want to achieve and the delivery strategy or action plan that guides this work.

| **Ensure the best start in life for every child** | |
|---|---|
| **Aims** | **Delivery Strategy / Action Plan** |
| *Our key priorities are in 'Drive' and 'Sponsor' categories.* | |

| **Enable all children, young people and adults to maximise their capabilities and have control over their lives** | |
|---|---|
| **Aims** | **Delivery Strategy / Action Plan** |
| 1. Support people of all ages to access lifelong learning and skills development | Southwark Skills Strategy 2018-2022 |

| **Create fair employment and good work for all** | |
|---|---|
| **Aims** | **Delivery Strategy / Action Plan** |
| 1. Support businesses to become more resilient and to thrive, particularly those providing essential goods and services and those more vulnerable to economic shocks<br>2. Provide additional support for entrepreneurs who are underrepresented in specialist and growth sectors, including women, disabled and Black entrepreneurs | Southwark Council's Economic Renewal Plan<br><br>Southwark Skills Strategy 2018-2022 |

| **Ensure a healthy standard of living for all** | |
|---|---|
| **Aims** | **Delivery Strategy / Action Plan** |
| 1. Improve digital inclusion and avoid exclusion related to poverty, cognition and frailty | Southwark Digital Infrastructure Strategy |

| Create and develop healthy and sustainable places and communities | |
|---|---|
| **Aims** | **Delivery Strategy / Action Plan** |
| 1. Ensure everyone has access to good quality parks and green spaces<br>2. Improve air quality and reduce the impact of air pollution<br>3. Tackle climate change. | The Southwark Plan 2022 (the local plan)<br><br>Air Quality Strategy and Action Plan 2017-22<br><br>Air Quality Action Plan 2023-2027 (in development)<br><br>Southwark Climate Change Strategy |

| Strengthen the role and impact of ill health prevention |
|---|
| *Our key priorities are in 'Drive' and 'Sponsor' categories.* |

# 5. Systems Transformation

The priorities in this strategy tackle complex issues that are shaped by multiple factors. Many of them will require the whole system to work together to achieve progress.

### Box 5. Anchor institutions

Anchor institutions are large public-sector organisations that do not move from an area (they are "anchored"). Through their resources and as an employer they can have a big impact on people living nearby, for instance by becoming more environmentally sustainable, widening job opportunities, and spending money locally[xxiv]. The organisations that are part of the Health and Wellbeing Board, such as the NHS Foundation Trusts, recognise the impact they have on the local communities and environments. A Southwark Anchor Network has been established to leverage strategic influence and investment to improve health and reduce health inequalities.

For more information, please see:

The Guy's and St Thomas' NHS Foundation Trust page on Sustainability

The South London and Maundsley NHS Foundation Trust Strategy

### Working together with communities

People who live and work in Southwark have helped to shape this strategy through previous engagement. Their input has deepened our understanding of the borough – of how people experience their local areas, assets in the borough and challenges that people face. Much of the skills and expertise to reduce health inequalities in Southwark are recognised to be within communities. Similarly, much of the activities delivered by communities through support networks, faith groups, grassroots initiatives, all contribute immeasurably to the health and prosperity of the borough. The Joint Health and Wellbeing Strategy is a commitment by the Health and Wellbeing Board to work with communities as partners in health and wellbeing, co-designing and co-delivering actions to reduce health inequalities.

### Embedding community voices into our work

The Joint Health and Wellbeing Strategy will create and support opportunities to work with communities in a way that builds on and strengthens community relationships. This means working with people over time and creating lasting commitments to work together.

Work is taking place to establish a Southwark Lived Experience Assembly to ensure local communities continue to shape health and care in Southwark. This is an opportunity to strengthen the way that local people engage directly with the Joint

Health and Wellbeing Board and Partnership Southwark, ensuring that they contribute and shape the actions for the Joint Health and Wellbeing Strategy.

**Box 6. Ongoing community engagement and coproduction in the Joint Health and Wellbeing Strategy – Year 1**

In the first year of the strategy, there is further work taking place with communities to co-produce specific actions for priority objectives. These can be actions that communities want to take forward themselves with our support or community views that can inform wider statutory and VCS activity. The longer term aim is to develop approaches to enable local communities to feed into and strengthen how the Health and Wellbeing Board engages with communities, holds community conversations, as well as being accountable for improving health and wellbeing. There is an opportunity to align this community engagement work to shape and inform on the development of the SEL Integrated Care System.

## Monitoring Outcomes & Inequality

Local data and intelligence is critical for helping us understand health inequalities locally. To support this strategy, an updated approach to monitoring health outcomes and inequalities has been developed. This includes:

- A borough level outcomes framework, tracking key indicators associated with the drive areas of the strategy. The framework sits alongside this strategy and helps us to monitor improvements over time for Southwark as a whole. We have worked with partners to ensure indicators align with other plans in the borough to ensure that the best available data is utilised. As part of this process, we are also seeking to identify a number of indicators that can be used to monitor change in inequalities within the borough. Activities outlined in the strategy will generate new ways of monitoring progress across the drive areas, particularly in areas where new work will begin, and will be included in future iterations of the framework.

- An update of the annual JSNA report that provides the story of health and wellbeing in Southwark. The report will provide the narrative as well as analysis of health, wellbeing and inequalities in the borough, including wider determinants of health such as income or crime.

- A six-monthly progress update on the action plan, to ensure that actions to deliver the Strategy are driven forward and continue to reflect the work we need to take to achieve our ambitions for the health of Southwark communities.

The outcomes framework shows the measures used to demonstrate progress on the objectives and why these measures have been chosen. The outcomes framework is included at Appendix 1.

Work to improve inequalities monitoring is taking place across the system in new and innovative ways, and will be incorporated into future iterations of the outcomes framework. This include better linking and access to data across the health system, and a possible health and wellbeing survey across Southwark, led by Impact on Urban Health, which will understand a range of healthy behaviours and how these differ between wards and demographic groups. Findings from this survey will support areas of the outcomes framework where data is not updated frequently and/or where inequality data are not currently available.

**Box 7. Developing community-led accountability**

A community approach to monitoring and accountability will be proposed and piloted in 2022/23. We want our communities to have a bigger say in the monitoring and feedback on the actions being taken to improve health and wellbeing and to reduce health inequalities. We will build on work already taking place within the Integrated Care System and from the Council to develop mechanisms of community accountability.

## Governance

The Joint Health and Wellbeing Strategy is ambitious and touches on much of the work of each organisation represented on the Health and Wellbeing Board.

The Health and Wellbeing Board will maintain strategic oversight of the strategy, and monitor progress through the borough level outcomes framework, the annual JSNA report and the progress report on the action plan.

Partnership Southwark Executive will be responsible for:

1) Ensuring empowerment remains embedded into the delivery of the strategy;
2) Ensuring that the strategy continues to reflect the priorities of all of our stakeholders;
3) The outcomes achieved through the strategy, via the data, monitoring and intelligence programme.

## Refreshing and reviewing the strategy

The work to improve health and wellbeing will evolve over time. The Health and Wellbeing Board's ambitions to work closely with communities on the delivery of this strategy will further shape our knowledge about addressing health inequalities. The recovery from the Covid-19 pandemic will also highlight new, long-term issues that affect our communities. Delivery of this strategy must be flexible and responsive. The strategy will be updated and refreshed as our knowledge and evidence base extend, to ensure that the Southwark partnership system continues to improve health and wellbeing in Southwark.

**Box 8. Joining up care for people, places and populations**

The national government published a White Paper[xxv] in February 2022, setting out its vision for the future of the integration of health and social care. The paper describes the government's expectations on collaboration at place-based levels. The proposals include the introduction of national shared outcomes, which span the health and social care system, and a framework for setting outcomes priorities locally. There is a recognition that leadership at a place-based level is the best way of prioritising the outcomes that matter the most for local people.

The changes proposed focus on working together to jointly deliver for communities. Emphasis is also placed on prevention. These are both principles that are embedded throughout this strategy. It is proposed that there is a shared outcomes plan building on this strategy as a next stage in refreshing this strategy.

## Appendix 1: Outcomes Framework

| How will we measure this? | Baseline | | Why measure this? |
|---|---|---|---|
| | Southwark | London | |
| **Drive 1: A whole family approach to giving children the best start in life** | | | |
| Percentage of pregnant women who have their booking appointment with a midwife within 10 completed weeks of their pregnancy | 63% (2020) | 63% (2020) (England) | The National Institute for Health Care Excellence recommends antenatal booking by 10 weeks of pregnancy. The booking appointment allows scheduling of her ultrasound scan, identification of women who might need more than usual care, either because of medical history or social circumstances, for discussion of antenatal screening, taking blood pressure and measuring the woman's height and weight, identification of risk factors such as smoking and offering support, discussion of mood and mental health. |
| Low birth weight of term babies | 3.1% (2020) | 3.3% (2020) | Low birth weight increases the risk of childhood mortality and of developmental problems for the child and is associated with poorer health in later life. Inequalities measures will be identified in future iterations of this outcomes framework. |
| Percentage of 12 month development reviews (health review 1) completed by the time the child turned 12 months | 77% (2020/21) | 53% (2020/21) | Health visiting is one way that families are supported during the first years of a child's life. Health visitors can provide advice and support on a range of developmental issues, and signpost to services which may be helpful as well as providing a safeguarding function. |
| Percentage of children achieving a good level of development by the end of Early Years Foundation Stage | Asian – 72%<br>Black – 70%<br>Chinese – 77% | Asian – 76%<br>Black – 71%<br>Chinese – 84% | School readiness is identified though a wide range of developmental areas assessed at the end of Early Years Foundation Stage. Children from areas of social and economic disadvantage are at greater risk of poorer development. Educational outcomes vary by ethnicity across Southwark and London and must be reduced as one way of reducing health inequalities longer term. |

| | | | |
|---|---|---|---|
| | Mixed – 79%<br>White – 80%<br>Total – 74%<br>(2018/19) | Mixed – 77%<br>White – 76%<br>Total – 74%<br>(2018/19) | |
| Percentage of Y6 children who are very happy or happy with their life | 75% (2016) | NA | Measuring how happy children self-report to be with their life at the moment can give a picture of wellbeing for children who attend schools in Southwark. Children's wellbeing is both a cause and a consequence of issues such as body image, self-esteem and poor mental health. |
| Percentage of Y8 and Y10 children who are very happy or happy with their life | 60% (2016) | 65% (2016) (National survey sample) | |
| Percentage of pupils achieving a good pass (>5) in English and Maths GCSE, by broad ethnic group | Asian – 75%<br>Black – 56%<br>Chinese – 83%<br>Mixed – 55%<br>Other – 54%<br>Unclassified – 68%<br>White – 62%<br>Total – 59% | Asian – 69%<br>Black – 51%<br>Chinese – 83%<br>Mixed – 53%<br>Other – 57%<br>Unclassified – 52%<br>White – 56%<br>Total – 57% | A good education is key to ensuring the best start in life for children and will influence their ability to secure healthy employment in adult life. Educational outcomes vary by ethnicity across Southwark and London and must be reduced as one way of reducing health inequalities longer term. |

| | | | |
|---|---|---|---|
| | (2021/22) | (2022/22) | |
| Percentage of school pupils with social, emotional and mental health needs | 2.8% (2021) | 2.5% (2021) | Information is collected on primary type of need for children with special educational needs; social, emotional and mental health needs is recorded as one of the needs. Local activities can be informed by this prevalence. This only captures children where these needs have been identified as a special educational need, and won't show children with lower level, but still present, need. |
| Hospital admissions as a result of self-harm (10-24 years old) | 191.5/100,000 (2020/21) | 210.5/100,000 (2020/21) | Hospital admissions for self-harm can act as one indicator for prevalence of mental health conditions, although not all acts of self-harm will lead to hospitalisation. With links to other mental health conditions such as depression, the emotional causes of self-harm may require psychological assessment and treatment. Future iterations of the outcomes framework will work to have more mental health indicators, beyond the acute crisis stage. |
| **Drive 2: Healthy employment and good health for working age adults** | | | |
| Proportion of those who are economically inactive who want a job (involuntary unemployment) | 30% (2021) | 21% (2021) | The economically inactive population mainly includes students, people who are long-term sick and those who are looking after family/home. However, some people want a job but cannot get one, known as involuntary unemployment. Increased job opportunities, access to skills development and inclusive employment will all reduce involuntary unemployment. |
| Gap in the employment rate between those with a long-term health condition and the overall employment rate | 9.4% (2019/20) | 12% (2019/20) | The gap in employment rate demonstrates the impact limiting long-term illness has on employment for those in the Live Well life stage. Inclusive employment which focuses on stable and healthy jobs will reduce this gap. |
| Gap in the employment rate between those in contact with | 75% (2019/20) | 68% (2019/20) | The gap in employment demonstrates the impact mental illness has on employment for those in the Live Well life stage. Inclusive employment which |

| | | | |
|---|---|---|---|
| secondary mental health services and the overall employment rate | | | focuses on stable and healthy jobs will reduce this gap. |
| Gap in the employment rate between those who are in receipt of long term support for a learning disability (aged 18 to 64) and the overall employment rate | 70% (2020/21) | 68% (2020/21) | The gap in employment demonstrates the impact a learning disability has on employment for those in the Live Well life stage. Inclusive employment which focuses on stable and healthy jobs will reduce this gap. There are many barriers that face people with a learning disability to access employment including lack of support, employers' attitudes, and a general lack of understanding of what someone can achieve with the right support, from education through to employment. |
| Percentage of physically active adults | 71% (2020/21) | 61% (2020/21) | Physical activity reduces risk of many physical health conditions (e.g. cardiovascular disease, coronary heart disease, stroke, diabetes, obesity) and is associated with improved mental health. An individual is deemed physically active if they do at least 150 moderate intensity equivalent minutes of physical activity per week. |
| Smoking prevalence in adults | 16% (2019) | 13% (2019) | Smoking is the most important cause of preventable ill health and premature mortality in the UK. Smoking is a major risk factor for many diseases including heart disease, chronic obstructive pulmonary disorder, and lung and many other types of cancer. |
| Smoking prevalence among adults aged 18-64 in routine and manual occupations | 24% (2020) | 19% (2020) | Smoking is the most important cause of preventable ill health and premature mortality in the UK. Smoking is a major risk factor for many diseases including heart disease, chronic obstructive pulmonary disorder, and lung and many other types of cancer. In 2019 in UK, around 1 in 4 people in routine and manual occupations smoked compared with just 1 in 1 people in managerial and professional occupations. Focus on smoking prevalence in the population group with highest smoking rates is needed to make the biggest change in overall smoking prevalence. |

| Proportion of those receiving Universal Credit who are employed (proxy for in-work poverty) | 35% (2021) | 38% (2021) (Inner London) | In-work poverty affects people based on the sector they work in, their hourly pay and number of hours worked, age, gender, ethnicity and disability. Barriers like access to childcare and transport can also determine whether those working can earn enough to not need to claim Universal Credit to subside their income (<£15,000). |
|---|---|---|---|
| **Drive 3: Early identification and support to stay well** | | | |
| Cancer screening coverage – bowel cancer | 57% (2021) | 59% (2021) | Bowel cancer screening supports early detection of cancer and polyps which are not cancers but may develop into cancers overtime. About one in 20 people in the UK will develop bowel cancer during their lifetime. This indicator provides an opportunity to incentivise screening promotion and other local initiatives to increase coverage of bowel cancer screening. Current work between Public Health and NHS colleagues aims to identify inequalities in screening coverage. |
| Cancer screening coverage – cervical cancer (aged 25 to 49 years old) | 60% (2021) | 59% (2021) | Cervical screening supports detection of cell abnormalities that may become cancer and is estimated to save 4,500 lives in England each year. Improvements in coverage would mean more cervical cancer is prevented or detected at earlier, more treatable stages. Current work between Public Health and NHS colleagues aims to identify inequalities in screening coverage. |
| Cancer screening coverage – breast cancer | 48% (2021) | 55% (2021) | Breast cancer screening supports early detection of cancer, at more treatable stages. Screening is estimated to save 1,400 lives in England each year. Current work between Public Health and NHS colleagues aims to identify inequalities in screening coverage. |
| Cumulative percentage of the eligible population aged 40-74 who received an NHS health check | 50% (2016/17-2020/21) | 37% (2016/17-2020/21) | The NHS health check programme aims to help prevent heart disease, stroke, diabetes and kidney disease. Everyone between the ages of 40-74, who has not already been diagnosed with one of these conditions, will be invited to have a check. A high uptake is important to identify early signs of poor health leading |

| | | | |
|---|---|---|---|
| | | | to opportunities for early interventions. |
| Proportion of all NHS health checks completed by residents from a Black, Asian or minority ethnicity background | TBC | NA | The NHS health check programme aims to help prevent heart disease, stroke, diabetes and kidney disease. Social and economic factors play a part in the risk of developing these diseases. By monitoring the proportion of all health checks who are completed by residents from a Black, Asian or minority ethnic background, an equitable service can be ensured in line with the strategy. |
| Dementia diagnosis rate for 65+ years old (recorded/ expected) | 80% (Sept 21 – Sept 22) | 67% (Sept 21- Sept 22) | Not everyone with dementia has a formal diagnosis. This measure compares the number of people thought to have dementia ith the number of people with a disgnosis, aged 65 and over. The target is for at least two thirds of people with dementia to be diagnosed |
| Proportion of adult carers who have found it easy to find information and advice about support, services or benefits | 53% (2018/19) | 60% (2018/19) | Unpaid or informal carers play an integral role in supporting the family members and friends they care for. Carers should be able to easily access information to aid their caring responsibilities. Better engagement with support and services will benefit both carers and their dependents. |
| Number of emergency hospital admissions due to falls in people aged 65 and over | 2,005 per 100,000 (2020/21) | 2,023 per 100,000 (2020/21) | Falls are the largest cause of emergency hospital admissions for older people and impact on long-term outcomes e.g. move from home to nursing or residential care. Measure shows the rate of patients with fall related emergency admissions entering a hospital setting – not all falls will result in emergency admission, and not all falls can be prevented within the falls prevention work. |
| Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services | 82% (2020/21) | 84% (2020/21) | Reablement services (enablement, intermediate care and rehabilitation following a hospital episode) aim to help people to remain at home. This measure reflects the joint work of health and care services. Additional measures will be included to cover all aspects of reablement after a stay in hospital. |

| Drive 4: Strong and connected communities | | | |
| --- | --- | --- | --- |
| Percentage of residents who say they belong to their local area | 71% (2018/19) | 73% (2018/19) | The Greater London Authority include a measure on belonging to local area in the annual Survey of Londoners to understand perceived relationships. Belonging promotes trust, safety and feeling supported. |
| Percentage of residents who say they feel lonely often or always | 9% (2018/19) | 8% (2018/19) | The Greater London Authority include a measure on loneliness in the annual Survey of Londoners to understand perceived relationships. In Southwark in 2019, people who were single and with no children, with long-term mental health conditions, with low and very low food security and living in social housing were more likely to report feeling lonely often. |
| Percentage of residents who have participated in formal volunteering in the last year | NA | 28% (2018/19) | The Greater London Authority include a measure on volunteering in the annual Survey of Londoners to understand participation. Volunteering benefits the local community, can build self-esteem and new skills, and builds a sense of belonging. Volunteers are essential to support the role the voluntary and community sector play in promoting health and wellbeing. |
| Percentage of residents who agree that their local areas is a place where people from different backgrounds get on well together | 76% (2018/19) | 75% (2018/19) | The Greater London Authority include a measure on different backgrounds in the annual Survey of Londoners to understand perceived relationships. There are many economic and cultural benefits of diversity, and these can be experienced by everyone in the community to promote similar life opportunities for all. |
| **Drive 5: Integration of Health and Social Care** | | | |
| Current work in Partnership Southwark to identify how to evaluate the effectiveness of partnership working will inform this section of the outcomes framework. A possible health and wellbeing survey will help to capture residents' views on how well this integration works for them. | | | |

# Appendix 2: Joint Health and Wellbeing Strategy Action Plan

**Drive 1: A whole-family approach to giving children the best start in life**

***Population health measures:***

- Percentage of pregnant women who have their booking appointment with a midwife within 10 completed weeks of their pregnancy
- Low birth weight of term babies
- Percentage of 12 month development reviews (health review 1) completed by the time the child turned 12 months
- Gap in percentage of children achieving a good level of development at the end of Reception, between White and minority ethnic children
- Percentage of Y6 children who are very happy or happy with their life
- Percentage of Y8 and Y10 children who are very happy or happy with their life
- Percentage of pupils achieving a good pass (>5) in English and Maths GCSE, by broad ethnic group
- Percentage of school pupils with social, emotional and mental health needs
- Hospital admissions as a result of self-harm (10-24 years old)

| No. | Aim | Action | Owner | Measure / milestone | Timeframe |
|---|---|---|---|---|---|
| 1 | Ensure all families in Southwark benefit from access to good-quality maternity care and support to maximise maternal wellbeing, reducing differential outcomes for Black women in maternity care | Review causes of inequalities in and between maternal access, outcomes and experiences | Start Well: Public Health | Review completed and recommendations developed | End July 2023 |
| | | Scope and develop a collaborative maternity partnership group within Southwark to oversee the aim | Partnership Southwark Delivery Executive | Agreed approach across stakeholders and establishment of group | End July 2023 |
| | | Development of action plan on tackling local inequalities based on recommendations on maternal access, outcomes and experiences | | Agreed timeline and delivery of action plan, with link and read across to South East London maternity services work (see below) | 2023-24 |

| | | | | | |
|---|---|---|---|---|---|
| | | Deliver action plan to implement national recommendations on maternity services, with a focus on addressing differential outcomes in maternity services | South East London Local Maternity and Neonatal System | Development and delivery of action plan | 2023-24 |
| **2** | Build resilient families, by ensuring that there is holistic support and care for families during pregnancy and the first years of life. | Develop children and family centres to facilitate multi-disciplinary working in geographical areas with the highest levels of deprivation | Start Well: Children and Families Service | Feedback from service users and increased number of attendances at children and family centre activities<br><br>'Core offer' is agreed across the partnership | December 2023<br><br>December 2023 |
| **3** | Improve the mental health and wellbeing of families, children and young people, ensuring 100% of children and young people who need support can access emotional wellbeing or mental health services | Increase the number of Mental Health Support Teams in schools | Start Well: Mental Health Children and Young People Working Group | Number of schools with Mental Health Support Teams | July 2023 |

| | | | | | |
|---|---|---|---|---|---|
| | | Ensure that the improving mental health resilience in schools (IMHARS) support package and Mental Health Support Teams offer is comprehensive and equitable | Start Well: Mental Health Children and Young People Working Group | Completion of gap analysis and development of action plan | April 2023 |
| **4** | Keep children and young people safe through early identification and support for families at risk of adverse childhood experiences. | Redevelop an early identification and prevention approach to Adverse Childhood Experiences in Southwark | Start Well | Early Help Strategy is completed that sets out Southwark's approach to mitigating impact of ACEs<br><br>Completion of work to embed early help as everyone's responsibility across partnership | March 2023<br><br>September 2023 |
| | | Identify opportunities to strengthen how data on adverse childhood experiences is shared between services | Start Well | Data sharing approach is agreed | By summer 2024 |
| **5** | Accelerate the reduction in childhood excess weight and obesity in Southwark | Extend the motivational interviewing work which supports pathway into child weight management programme | Start Well: Public Health | Every child measured as overweight or obese is contacted by provider | August 2023 |
| | | Strengthen National Child Measurement Programme (NCMP) pathway, building on best practice in other areas | Start Well: Public Health | Review completed<br><br>Plan in place to implement recommendations | March 2023<br><br>July 2023 |

**Drive 2: Healthy employment and good health for working age adults**

***Population health measures:***

- Proportion of those who are economically inactive who want a job (involuntary unemployment)
- Gap in the employment rate between those with a long-term health condition and the overall employment rate
- Gap in the employment rate between those in contact with secondary mental health services and the overall employment rate
- Percentage of physically active adults
- Gap in the employment rate between those who are in receipt of long term support for a learning disability (aged 18 to 64) and the overall employment rate
- Smoking prevalence in adults
- Smoking prevalence among adults aged 18-64 in routine and manual occupations
- Proportion of those receiving Universal Credit who are employed (proxy for in-work poverty)

| No. | Aim | Action | Owner | Measure / milestone | Timeframe |
|---|---|---|---|---|---|
| 1 | Across the health and wellbeing economy, we will increase access to good quality jobs, creating new routes to employment and providing support to those facing barriers to good quality jobs, including those facing systemic inequality such as those from Black, Asian and minority ethnic backgrounds, older people, women and disabled people.<br>. | Explore opportunities to use the apprenticeship levy in Partnership Southwark and voluntary and community sector roles | Partnership Southwark Delivery Executive | Increased number of local people in Southwark apprenticeship programme | March 2024 |
| | | Develop an inclusive apprenticeship programme within the social care workforce, focusing on staff who have the ambition to join the registered workforce and may have been excluded from traditional university routes. | Age/Care Well: Adult Social Care | Development of pre-apprentice programme to encourage apprentice readiness from a wider group<br><br>Planning for Cohort 2 of the apprenticeship programme.<br><br>Exploring further apprenticeship opportunities | October 2022<br><br>January 2023<br><br>March 2023 |

| | | | | | |
|---|---|---|---|---|---|
| | | Implementation of Workforce Race Equality Standard in Adult Social Care as an early adopter local authority | Age/Care Well: Adult Social Care | Data is collated within ASC for reporting against Workforce Race Equality Standard | April 2023 |
| | | Support the development, delivery and utilisation of the South East London ICS Health Hub to provide targeted support towards employment in the health and wellbeing economy, with a focus on underrepresented population groups and our most deprived communities | Partnership Southwark Delivery Executive | Number of successful job applications by Southwark residents | March 2024 |
| **2** | Promote health and wellbeing across the health and wellbeing economy, through improving access to wellbeing and employment support. | All anchor institutions to proactively provide accessible information for wellbeing and employment support, such as information on the Keeping Well Hub | Partnership Southwark Delivery Executive | Improved staff retention and measures of staff satisfaction | On-going |
| **3** | Lead by example by promoting good health and wellbeing across our workforce, and supporting this through our procurement practices. | Roll out Residential Care Charter to ensure fair pay for care staff | Age/Care Well: Adult Social Care | 100% sign up by 2025 | 2025 |
| **4** | Support people to lead healthy lifestyles that keep them well, working with population groups and | Evaluate stop smoking provision and implement recommendations to improve access and outcomes for at risk groups | Southwark Council: Public Health | Increased number of pregnant women and patients with mental health conditions who achieve a 4 week quit | On-going (redesign by March 2023 with annual review) |

| | | | | | |
|---|---|---|---|---|---|
| | communities where lifestyle risk factors are clustered. | Provide specialist training to non-alcohol specialist healthcare professionals on initiating conversations about alcohol use | Southwark Council: Drug and Alcohol Team | Increased confidence of non-alcohol specialist healthcare professionals to initiate conversations about harmful alcohol use<br><br>Increased number of people being referred to specialist treatment services for harmful alcohol use | March 2023<br><br>On-going (with annual review) |
| **5** | Maximise access to leisure, daily movement and physical activity, ensuring that financial circumstance does not limit access. | Undertake collection of data across communities and groups to inform and understand current levels of participation and engagement in physical activity and sport | Live Well: Leisure | Completed profile of leisure and sports participation across the borough. | 2023/24 |
| | | Connect communities and promote opportunities to engage in physical activity and sport, particularly for unrepresented groups and those in greatest need | Live well: Leisure | Number of people engaged in physical activity across the borough | On-going |
| | | Improve the signposting and promotion of the Council's sport and leisure offer by the wider health & care system | Live Well: Leisure | Increased number of social prescribing referrals to exercise and physical activity programmes<br><br>Increased uptake of sport and leisure programmes | September 2023<br><br>Benchmark 2023-24 |

| | | | | | |
|---|---|---|---|---|---|
| | | Review the current targeted leisure offer, following insourcing of leisure provision in June 2023, with a view to further promoting services to target those who are least active, have poorer health or greater health risks | Live Well: Leisure | Programmes realigned in response to findings of leisure and sport profiles | 2024 |
| | | Evaluate access to Exercise on Referral ensuring services is reaching target groups | Live Well: Public Health | Review completed<br><br>Uptake of Exercise on Referral by target groups is increased | January 2023<br><br>April 2024 |

**Drive 3: Early identification and support to stay well**

***Population Health Measures:***

- Cancer screening coverage – bowel cancer
- Cancer screening coverage – cervical cancer (aged 25 to 49 years old)
- Cancer screening coverage – breast cancer
- Cumulative percentage of the eligible population aged 40-74 who received an NHS health check
- Proportion of all NHS health checks completed by residents from a Black, Asian or minority ethnicity background
- Dementia diagnosis rate for 65+ years old (recorded/ expected)
- Proportion of adult carers who have found it easy to find information and advice about support, services or benefits
- Number of emergency hospital admissions due to falls in people aged 65 and over
- Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services

| No. | Aim | Action | Owner | Measure / milestone | Timeframe |
|---|---|---|---|---|---|
| 1 | Ensure that there are effective and accessible services that help prevent illness, including immunisations, screening and measures to tackle "The Vital 5" (hypertension, obesity, smoking, alcohol and mental health). | Increase uptake of NHS health checks by those with greater risks along with risk reduction interventions | Live Well: Public Health | Increased uptake of NHS health checks among residents from a Black, Asian or minority ethnicity background (%) | On-going |
| | | Extend the Community Health Ambassadors Programme, empowering more people to increase uptake of vaccinations and cancer screening and health improvement opportunities in their communities, focusing on areas with poorer health and higher levels of deprivation | Live Well: Public Health | Increased number of Community Health Ambassadors<br><br>Number of community events and activities aimed at Black, Asian and ethnic minority communities, supported by community health ambassadors | On-going<br><br>On-going |

| | | | | | |
|---|---|---|---|---|---|
| | | Pilot and evaluate a weight management programme for men aged 45+, targeting black, Asian and minority ethnic groups | Live Well: Public Health | Increased take up of healthy weight services by men over 45 years and black, Asian and minority ethnic groups | June 2023 |
| | | Develop and pilot healthy eating and physical activity interventions with faith groups and evaluate the outputs and outcomes | Live Well: Public Health | Targeted faith groups are engaged in delivery of healthy eating and physical activity interventions | September 2023 |
| | | Develop and deliver a Targeted Lung Health Check programme for people aged between 55-74 years who are current or ex-smokers. | Live Well: Guys and St Thomas NHS Foundation Trust | Lung Health Check programme in place with clear pathway into local stop smoking provision | March 2023 |
| | | Evaluate peer mentor programme for substance misuse in hostel and hospital settings | Live Well: Drug and Alcohol Team | Completion of evaluation with recommendations developed | 2023-24 |
| **2** | Promote good mental health by supporting wellbeing and early detection. | Complete system-wide scoping activity to identify opportunities to integrate mental health in all policies, to improve the social determinants of poor mental health | Live Well: Public Health | Completion of scoping activity | March 2023 |
| | | Develop and implement an evidence-based suicide prevention strategy and action plan to reduce risk of self-harm and prevent incidences of suicide | Partnership Southwark Delivery Executive | Strategy and action plan developed | March 2023 |

| | | | | | |
|---|---|---|---|---|---|
| **3** | Focus on preventing admission to hospital for falls. | Deliver public awareness campaign focused on how to reduce falls risk and services that can be accessed to reduce risk of falls | Age Well: Guys and St Thomas' NHS Foundation Trust | Increased utilisation of falls prevention services (including handy-person service, home visiting opticians and falls service) | March 2023 |
| | | Deliver education and training on falls risk and availability of local services for community healthcare, social care and primary care workers. | Age Well: Guys and St Thomas' NHS Foundation Trust | Staff report improved knowledge in competence and confidence and supporting people at risk of falls | September 2023 |
| **4** | Provide the right support which helps people to recover from admission to hospital. | Further embed the hospital discharge and community support guidance throughout the Southwark system. | Age Well | - Reduction in permanent residential placements from hospital<br>- Increased positive re-ablement outcomes<br>- Increased number of people having their assessment in the community. | June 2023 |
| | | Pilot a 'Hospital Buddies' programme offering volunteer support to older people before and after elective surgery | Age Well | Reduced readmissions within 3 months for users of the hospital buddies programme | June 2023 |
| **5** | Support carers and families to look after their own wellbeing. | Develop the signposting to Ageing Well Southwark to ensure that a greater number of carers know how to access support | Age Well: Adult Social Care | Increased proportion of adult carers who have found it easy to find information and advice about support, services or benefits | March 2023 |

| Drive 4: Strong and connected communities<br><br>*Population Health Measures:*<br><br>- Percentage of residents who say they belong to their local area<br>- Percentage of residents who say they feel lonely often or always<br>- Percentage of residents who have participated in formal volunteering in the last year<br>- Percentage of residents who agree that their local areas is a place where people from different backgrounds get on well together | | | | | |
|---|---|---|---|---|---|
| **No.** | **Aim** | **Action** | **Owner** | **Measure / milestone** | **Timeframe** |
| 1 | Strengthen how we involve local communities to help us better understand their needs and to co-design and implement services to meet their needs. | Establish a new approach to embedding community voices in shaping and implementing health and care priorities (for example, through a Lived Experience Assembly[1] and other methods) | Partnership Southwark Delivery Executive: ICB Communications and Engagement Team | Increased involvement of voluntary and community sector in Partnership Southwark Strategic Board and Health and Wellbeing Board<br><br>Increased membership of voluntary and community sector on Partnership Southwark workstreams | End March 2023<br><br>June 2023 |
| **2** | Ensure that services are accessible to and meet the needs of all - including people facing multiple disadvantage, people experiencing homelessness, refugees, asylum | Mental health practitioners to be embedded in communities and neighbourhoods through Be Well Hubs<br><br>Complete needs assessment to better understand health needs of refugees, | Community Mental Health Transformation Programme Delivery Group<br><br>Live Well: Public Health | Increased referrals and access among vulnerable groups | September 2023<br><br>December 2022 |

[1] Lived Experience Assembly is a working title; work will focus on establishing a structure or process that embeds community voices into shaping strategic priorities. It does not presume a 'formal assembly' approach and will need to consider 'outreach' mechanisms and tackle barriers to inclusivity.

| | | | | | |
|---|---|---|---|---|---|
| | seekers and vulnerable migrants. | asylum seekers and vulnerable migrants in the borough | | Needs assessment completed and evidence-based recommendations developed | |
| **3** | Reduce social isolation and loneliness, by creating a place where people feel connected and where loneliness is tackled as early as possible. | Support model of social prescribing that helps to connect local residents to relevant services that can tackle loneliness and social isolation, focusing on factors associated with severe loneliness<br><br>Delivery of Making Every Contact Count training to staff working regularly with people at risk of severe loneliness or isolation | Partnership Southwark Delivery Executive | Increased number of referrals from social prescribing to VCS organisations for people experiencing loneliness and/or social isolation<br><br>Number of staff completing MECC training | March 2023<br><br>September 2023 |
| **4** | Improve access to affordable, healthy food by adopting a Right to Food approach | Develop and implement a Right to Food Action Plan. This will include:<br><br>1. Children's food<br>2. Food for older and disabled people<br>3. Healthy food neighbourhoods and physical access to food<br>4. Cash first approaches | Southwark Council / Southwark Food Action Alliance | *Note: Measures are yet to be agreed as will form part of the Sustainable Food Strategy in development:*<br><br>Increased access of low income families to universal and targeted food support (School meals, Healthy Start Vouchers, Holiday provision with food, and breastfeeding support).<br><br>Needs assessment completed on food security of older people in Southwark and | 2023-2026 |

| | | | | | |
|---|---|---|---|---|---|
| | | | | recommendations reviewed with key partners.<br><br>Incentivising healthy food retail in our town centres and expanding food growing opportunities for neighbourhoods.<br><br>Increasing uptake of welfare support and income maximisation, increasing number of local employers supporting the Living wage. | |
| **5** | Work together to mitigate the impacts of the cost of living crisis for people in Southwark | Undertake analysis of the likely health impacts of the cost of living crisis, identifying those who will be most impacted | Southwark Council: Public Health | Analysis completed focused on population groups most affected | January 2023 |
| | | Ensure those working directly with residents most affected are aware of the support offer available in Southwark | Southwark Council: Public Health | Information sessions delivered to GPs, pharmacies, opticians and dentists | March 2023 |
| | | Identify health and wellbeing partners who can refer people into the Southwark Council Cost of Living Fund | Southwark Council: Public Health | Number of Community Referral Partners | On-going |

## Drive 5: Integration of Health and Social Care

Current work in Partnership Southwark to identify how to evaluate the effectiveness of partnership working will inform this section of the outcomes framework.

| No. | Aim | Action | Owner | Measure / milestone | Timeframe |
|---|---|---|---|---|---|
| 1 | Ensure joined-up care is delivered close to home, including exploring where care can be developed at a neighbourhood level. | Develop and pilot approaches to co-located multi-disciplinary teams (including primary care, secondary care and social care) in neighbourhood settings. | Partnership Southwark Delivery Executive | Neighbourhood MDT working is developed and informed by pilots | March 2024 |
| | | Develop and implement a person-centred model for community mental health, based around primary care networks and neighbourhoods, in which primary care, secondary care, VCSE organisations and local authority staff work together to deliver care and support. | Community Mental Health Transformation Delivery Group | Outcomes framework developed to identify and monitor success measures | September 2022 |
| | | | | Access to community mental health support is timely with key services meeting targets for reduced waiting times for access to services | 2023/24 |
| | | | | Increase the ratio of people accessing mental health support through a 'step up' community pathway rather than crisis services being the first point of contact | 2023/24 |

| | | Increase nursing care provision in the borough | Adult Social Care | New nursing home open | 2026 |
|---|---|---|---|---|---|
| **2** | Strengthen how we involve local communities to help us better understand their needs and to co-design and implement services to meet their needs. | Establish a new approach to embedding community voices in shaping and implementing health and care priorities (for example, through a Lived Experience Assembly[1] and other methods) | Partnership Southwark Delivery Executive: ICB Communications and Engagement Team | Increased involvement of voluntary and community sector in Partnership Southwark Strategic Board and Health and Wellbeing Board<br><br>Increased membership of voluntary and community sector on Partnership Southwark workstreams | End March 2023<br><br>June 2023 |
| | | Pilot a new approach to engagement and neighbourhood working through the We Walworth programme and a second neighbourhood pilot | Partnership Southwark Delivery Executive | Evaluation of We Walworth pilot completed<br><br>Establishment of second neighbourhood pilot | March 2023<br><br>September 2023 |
| **3** | Ensure partners are able to hold each other to account in delivering good care to our residents. | Establish transparent governance arrangements following the formation of the Local Care Partnership | Partnership Southwark Delivery Executive | Local health and care plan agreed with clear actions and accountability | End March 2023 |
| **4** | Align budgets where possible to make the best use of the "Southwark pound". | Set out how budgets can be aligned and or pooled under the Partnership Southwark Health and Care Plan. | Partnership Southwark Executive Group | The health and care plan sets out the level of ambition around integrated resources | End March 2023 |
| | | Increase voluntary contributions to the Better Care Fund | Adult Social Care / SEL ICS | Voluntary contributions are above minimum level | Annual review |

# Appendix 3: References


[i] Department of Health (2012), Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies
[ii] Marmot, Allen, Boyce, Goldblatt, Morrison (2020), Health equity in England: The Marmot Review 10 years on. London: Institute of Health Equity
[iii] The King's Fund (2020), What are health inequalities?
[iv] Marmot, Allen, Boyce, Goldblatt, Morrison (2020), Health equity in England: The Marmot Review 10 years on. London: Institute of Health Equity
[v] Public Health England (2021), Inclusion Health: applying All Our Health1
[vi] Public Health England (2020), Disparities in the risks and outcomes of Covid-19
[vii] Covid-19: Inequalities Impact Assessment. Southwark Council: London. 2021.
[viii] Public Health England (2020), Disparities in the risks and outcomes of Covid-19
[ix] Department of Health and Social Care (2021), The best start for life: a vision of the critical 1,001 days
[x] MBRRACE-UK (2021), Saving Lives, Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2017-19.
[xi] Department of Health and Social Care (2021), The best start for life: a vision of the critical 1,001 days
[xii] Partnership Southwark (2022), 'I statements'
[xiii] Social Life (2021), Understanding Southwark: Daily Life and the impact of Covid-19 across the borough
[xiv] South London Listens (2021), South London Listens Action Plan: November 2021 - November 2023
[xv] South London Listens (2021), South London Listens Action Plan: November 2021 - November 2023
[xvi] Social Life (2021), Understanding Southwark: Daily Life and the impact of Covid-19 across the borough
[xvii] NHS England, Carer Facts
[xviii] Social Life (2021), Understanding Southwark: Daily Life and the impact of Covid-19 across the borough
[xix] Healthwatch Southwark (2020), The impact of caring on unpaid carers
[xx] Social Life (2021), Understanding Southwark: Daily Life and the impact of Covid-19 across the borough
[xxi] Social Life (2021), Understanding Southwark: Daily Life and the impact of Covid-19 across the borough
[xxii] South London Listens (2021), South London Listens Action Plan: November 2021 - November 2023
[xxiii] Department for Levelling Up, Housing and Communities. (2021) Partnerships for People and Place
[xxiv] The Health Foundation, The NHS as Anchor Institutions
[xxv] Department of Health and Social Care (2022), Joining up care for people, places and populations

# Southwark's Joint Health and Wellbeing Strategy

## Find out more at: southwark.gov.uk/jhws