

## Health and Wellbeing Board

Thursday 13 March 2025

10.00 am

Southwark Council, Ground floor meeting rooms, 160 Tooley Street, London SE1 2QH

### Membership

Councillor Evelyn Akoto (Chair)	Cabinet Member for Health and Wellbeing
Dr Nancy Kuchemann (Vice-Chair)	Co-Chair Partnership Southwark and Joint Chair of the Clinical and Care Professional Leadership Group
Councillor Jasmine Ali	Deputy Leader and Cabinet Member for Children, Education and Refugees
Councillor Maria Linforth-Hall	Opposition Spokesperson for Health
Althea Loderick	Chief Executive, Southwark Council
Toni Ainge	Acting Strategic Director of Environment, Neighbourhoods and Growth, Southwark Council
Hakeem Osinaike	Strategic Director of Housing, Southwark Council
David Quirke-Thornton	Strategic Director of Children's and Adults' Services, Southwark Council
Darren Summers	Strategic Director for Integrated Care & Health (NHS South East London)
Sangeeta Leahy	Director of Public Health, Southwark Council
Alasdair Smith	Director of Children and Families
Anood Al-Samerai	Chief Executive, Community Southwark
Peter Babudu	Executive Director of Impact on Urban Health, Guy's and St Thomas' Foundation
Cassie Buchanan	Southwark Headteachers Representative
Louise Dark	Chief Executive for Integrated and Specialist Medicine Clinical Group, Guy's and St Thomas' NHS Foundation Trust
Ade Odunlade	Chief Operating Officer, South London & Maudsley NHS Foundation Trust
Rhyana Ebanks-Babb	Healthwatch Southwark representative

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## INFORMATION FOR MEMBERS OF THE PUBLIC

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### **Contact**

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Webpage: [Health and Wellbeing Board - Southwark Council](#)

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Members of the committee are summoned to attend this meeting

**Althea Loderick**

Chief Executive

Date: 5 March 2025



# Health and Wellbeing Board

Thursday 13 March 2025

10.00 am

Southwark Council, Ground floor meeting rooms, 160 Tooley Street, London SE1  
2QH

## Order of Business

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2.	<b>APOLOGIES</b>  To receive any apologies for absence.	
3.	<b>CONFIRMATION OF VOTING MEMBERS</b>  Voting members of the committee to be confirmed at this point in the meeting.	
4.	<b>NOTIFICATION OF ANY ITEMS OF BUSINESS WHICH THE CHAIR DEEMS URGENT</b>  In special circumstances, an item of business may be added to an agenda within five clear days of the meeting.	
5.	<b>DISCLOSURE OF INTERESTS AND DISPENSATIONS</b>  Members of the committee to declare any interests and dispensation in respect of any item of business to be considered at this meeting.	
6.	<b>MINUTES</b>  To agree as a correct record the open minutes of the meeting held on 14 November 2024	1 - 7

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<b>7.</b>	<b>PUBLIC QUESTION TIME</b>	
	To receive any questions from members of the public which have been submitted in advance of the meeting in accordance with the procedure rules. The deadline for the receipt of public questions is 11.59pm Friday 7 March 2025.	
<b>8.</b>	<b>HEALTHWATCH UPDATE AND RECOMMENDATIONS FROM BLACK MENTAL HEALTH</b>	8 - 77
	To receive the recommendations arising from Healthwatch research in 24/25, including their most recent Black mental health report.	
<b>9.</b>	<b>ANNUAL PUBLIC HEALTH REPORT</b>	78 - 107
	To consider the Annual Public Health Report on health inequalities in Southwark.	
<b>10.</b>	<b>SOUTHWARK JOINT HEALTH AND WELLBEING STRATEGY ACTION PLAN 2025-27</b>	108 - 163
	To consider and agree the refreshed Joint Health and Wellbeing Strategy action plan for the remainder of the strategy period.	
<b>11.</b>	<b>MATERNITY COMMISSION</b>	Verbal Report
	To receive a verbal update on the development of the Maternity Commission Action Plan.	
<b>12.</b>	<b>DELIVERY OF CONNECT TO WORK IN SOUTHWARK</b>	164 - 176
	To provide an update on the Connect to Work programme, raise awareness of the role of this programme in supporting health and wellbeing, and engage key partners in its development.	
<b>13.</b>	<b>JOINT FORWARD PLAN - 2025/26 REFRESH</b>	177 - 191
	To consider and approve the South East London (SEL) Joint Forward Plan in line with NHS England requirement, ensuring it aligns with the local Joint Health & Wellbeing Strategy.	



## HEALTH AND WELLBEING BOARD

MINUTES of the Health and Wellbeing Board held on Thursday 14 November 2024 at 10.00 am at Ground Floor West - Southwark Council, 160 Tooley Street, London SE1 2QH

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**PRESENT:**

Councillor Evelyn Akoto (Chair)  
Dr Nancy Kuchemann (Vice-Chair)  
Councillor Jasmine Ali  
Toni Ainge  
David Quirke-Thornton  
Darren Summers  
Sangeeta Leahy  
Anood Al-Samerai  
Cassie Buchanan  
Louise Dark  
Ade Odunlade

**OFFICER  
SUPPORT:**

Chris Williamson, Assistant Director - Place, Partnerships & Intelligence  
Maria Lugangira, Principal Constitutional Officer

### 1. WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting.

### 2. APOLOGIES

Apologies for absence were received from;

- Althea Loderick
- Charlene Young
- Councillor Maria Linforth-Hall
- Peter Babudu
- Alasdair Smith

### 3. **CONFIRMATION OF VOTING MEMBERS**

Those listed as present were confirmed as the voting members.

### 4. **NOTIFICATION OF ANY ITEMS OF BUSINESS WHICH THE CHAIR DEEMS URGENT**

There were none.

### 5. **DISCLOSURE OF INTERESTS AND DISPENSATIONS**

There were none.

### 6. **MINUTES**

**RESOLVED** - That the minutes of the meeting held on 18 July 2024 were approved as a correct record of the meeting.

### 7. **PUBLIC QUESTION TIME (15 MINUTES)**

There were none

### 8. **SOUTHWARK MATERNITY COMMISSION**

Liz Brutus, Assistant Director in Public Health, Southwark Council and Layla Glover Public Health Programme Manager, Southwark Council presented the report.

The Board was provided with the context and background of the work undertaken over the last year to deliver Councillor's Akoto, Cabinet Member for Health and Wellbeing's vision for the Southwark Maternity Commission (SMC) which was launched on the 30th September 2024.

The Commission was set up to assess and address inequalities in maternity care, particularly for families from a minority ethnic and/or socially disadvantaged background. It engaged with over 750 local residents, voluntary and community sector representatives, local maternity care service providers and local workforce.

Through its work five overarching themes were identified and along with their findings 10 recommendations were made. Three were asks of central government and the remaining seven targeted the local maternity system, voluntary and community sector organisations and Southwark Council.

The Southwark Maternity Commission identified five overarching themes:

1. Tackling discrimination and better supporting women with specific needs.
2. Making sure women are listened to and supported to speak up, whatever their language or background.
3. Providing women with the right information at the right time in the right way.
4. Joining up council and NHS services better around women's needs, and making sure care is consistent across borough borders.
5. Supporting the workforce to remain in their roles and be able to give compassionate and kind care for all mothers.

The Southwark Maternity Commission ten recommendations:

1. Leadership in addressing racism that leads to unequal maternal health
2. Develop a new national way of reporting maternal health
3. Review the maternity workforce
4. Evaluate the fairness of maternity services
5. Listen to and empower families
6. Preparation and support before pregnancy
7. Give parents the right information, at the right time, in the right way
8. Create a joined-up approach to families' needs between the NHS, southeast London boroughs, and voluntary and community sector
9. Southwark Council to review their role in maternity care
10. Review how feedback is dealt with.

As a result of these recommendations, the Commission set out its ambition for improvements around five key outcomes within the next five years

**Outcome 1:** Reduced infant mortality

**Outcome 2:** Reduced maternal morbidity

**Outcome 3:** Increased positive experience of maternity care

**Outcome 4:** Increased staff satisfaction

**Outcome 5:** Closing the health inequality gaps

Next steps for the Commission is the development of an action plan, with the implementation of actions early next year, followed by a 3 year interim review and then final 5 year review.

Establishing the governance arrangements around the maternity Commission is a key part of developing the action plan and ensuring it can be implemented across the health system.

There was discussion around making sure that the right resourcing and support is in place to ensure the successful delivery of the action plan. Included in this should be aspects such as performance monitoring, making sure the required funding is available. The Board acknowledged the importance of having a lead officer and lead partner to bring this work together and it was suggested that this role is designated the commissioners. It was further discussions would be need to help establish who this lead would be.

The Board agree to receive at its next meeting an update on the development of the Maternity Commission Action Plan

The Board acknowledged the comprehensive amount of work undertaken in helping establishing the Maternity commission and expressed their thanks to all those involved.

**RESOLVED** - That the Health and Wellbeing Board:

1. Note the findings of the Southwark Maternity Commission report and its ten recommendations and agree to take on the oversight of this work which includes a five-year action plan involving a range of local partners including Southwark residents.
2. Receives an annual update on the progress of the Southwark Maternity Commission, a fuller three year interim review of progress in September 2027 and a final five year evaluation of progress in September 2029.

## 9. HEALTH WEIGHT IN SOUTHWARK

The Board received a presentation from Gillian Boundy, Senior Health Programme Manager and Sheila Katureebe, Policy and Programme Officer (Healthy Weight and Physical Activity)

The presentation highlighted that children from a black ethnic background are more likely to be living with obesity than those from a white ethnic background and that this increased with age; children from Asian, mixed or other ethnic backgrounds fell in the middle.

It addressed the inequalities within obesity rates in Southwark which have informed the identification of the 5 population groups prioritised in this strategy:

- Maternity and early years
- Children and young people
- Black, Asian and minority ethnic groups
- People experiencing food insecurity
- Men aged 45 years and above.

To help address the above a set of ambitions and related planned actions has been developed for each priority group. This will be reviewed annually.

Southwark's Healthy Weight Strategy 2022-27 sets how obesity is being tackled. This involves Partnership between Southwark Council, the South East London ICB (Southwark) and VCS. The strategy is currently in year 3

**RESOLVED** - The Health and Wellbeing Board;

1. Notes the healthy weight profile for the child and adult population in Southwark, the progress made in implementation of the Southwark Healthy Weight Strategy and the potential areas for further development set out at paragraph 23 of the report.



## 10. HEALTH PROTECTION ANNUAL REPORT 2023/24

Sarah Robinson, Senior Public Health Programme Manager presented the report that covered the period 1 April 2023 to 31 March 2024 and provided an overview of activity, incidents, risks and achievements related to health protection, infectious diseases, environmental risks and screening programmes in Southwark. The Plan also included work delivered by public health, environmental health, NHS, emergency planning and VCS.

The oversight and assurance of the local Health Protection system continues via the Health Protection board which is chaired by Southwark's Director of Public Health. This multi-agency partnership provides challenge and oversight of local Health Protection arrangements and ensures inequalities are considered and risks are mitigated, reduced and managed.

Some areas of work and risks highlighted included the significant increase in measles cases which led to the UKHSA incident response level being raised in January 2024. This increase in cases in London was in part driven by falling vaccination rates as a result of the pandemic.

Further highlighted was that measles cases are higher in more deprived areas reflecting vaccination inequalities. Work has been undertaken across the system particularly with the ICB primary care and public health to try and address those falling vaccination rates and bring coverage back up to pre pandemic levels.

Some examples of this work includes a whole programme of pop-up clinics and outreach delivered in libraries, children and family centres. There's been an enhanced offer of the MMR vaccination in schools and a lot of training and awareness raising in particular with Southwark's community health ambassadors who have helped and spread the message. There are also small grant programmes for community groups to help address vaccine confidence within their own communities.

**RESOLVED** - The Southwark Health and Wellbeing Board;

1. Notes the Health Protection Annual Report 2023/24 and health protection activity across the system during this period.
2. Agrees to receive a health protection report annually

## 11. SOUTHWARK JOINT HEALTH AND WELLBEING STRATEGY 2022-27 - PROGRESS REPORT: NOVEMBER 2024

Rosie Dalton-Lucas, Head of Place and Partnerships, Public Health presented the report Dominic Dee, Public Health Speciality Registrar

The Joint Health & Wellbeing Strategy 2022-27 provides the strategic vision for both improving health & wellbeing and reducing health inequalities in the borough. Outlined in the strategy are five priority areas:

1. A whole-family approach to giving children the best start in life
2. Healthy employment and good health for working age adults
3. Early identification and support to stay well
4. Strong and connected communities
5. Integration of health and social care

The presentation highlighted that most actions had been progressed with the report outlining what had been achieved. It showed the overview and breadth of work that was ongoing in the strategy.

Some of the achievements further highlighted:

- 460 mental first aiders in 96 schools. Children and family support centres were successfully being utilised to target individuals from the most disadvantaged areas.
- The health and care jobs hub were helping support individuals from underrepresented communities gain the skills they need to access good quality health and care. The six-week programme supported 41 residents to date being offered work in local health jobs, health and care. Work such as administrative work in local GP practises. The residential care charter ensures high quality care for residents and safe and fair pay for care home staff.
- Targeted lung health check programme has reached over 6000 people with targeted CT scans and checks for smokers and high risk people
- Peer mentors have supported over 100 people with substance misuse problems
- The making every contact count programme has already in the first six months of the programme trained 500 staff and volunteers
- Following on from the success of the free school meal programme, a new process of auto enrolment has meant that over 600 new pupils have been identified for free school meals

**RESOLVED** - The Southwark Health and Wellbeing Board;

1. Notes progress against actions contained within the Joint Health and Wellbeing Strategy and areas that may require further development and focus.
2. Agrees to the development of a new action plan to cover the years 2025-27 and agrees to receive the new action plan in March 2025 after a period of engagement.
3. Agrees that the process of receiving updates to actions contained within a refreshed action plan will be determined at future meetings.

## **12. PARTNERSHIP SOUTHWARK HEALTH AND CARE PLAN REFRESH OF STRATEGIC PRIORITIES**

Rebecca Jarvis, Director of Partnership Delivery and Sustainability presented the report which provided an update on the work underway to refresh the strategic priorities and develop plans to support delivery of these priorities for the next 12-18 months.

The refresh aims to complement and enhance the two plans and emphasis the strong alignment between the five strategic priority areas that have been chosen as the areas of focus for the next three years.

**RESOLVED** - The Southwark Health and Wellbeing Board;

1. That The Health and Wellbeing Board notes the five refreshed strategic priorities of the Partnership Southwark Health and Care Plan and the work underway to develop delivery plans for each priority

## **13. AIR QUALITY ANNUAL STATUS REPORT 2023**

**RESOLVED** - That the Health and Wellbeing Board;

1. Note the contents of the Southwark Annual Status Report 2023 (ASR 2023), presented as Appendix 1 of the report.
2. Has oversight of the Air Quality Action Plan, through the Director of Public Health and the Air Quality Delivery Board. This enables policies and plans that impact on air quality, to be considered by the Board's membership ensuring a comprehensive strategic approach to air quality in Southwark.

## **14. PHARMACEUTICAL NEEDS ASSESSMENT (PNA) BRIEFING**

**RESOLVED** - That the Health and Wellbeing Board:

1. Note the scope, process and timeline set out in this document for the refresh of the Pharmaceutical Needs Assessment (PNA).

## **15. ANY OTHER BUSINESS**

There was none.

<b>Meeting Name:</b>	Health and Wellbeing Board
<b>Date:</b>	13 March 2025
<b>Report title:</b>	Healthwatch update and recommendations from Black Mental Health report
<b>Ward(s) or groups affected:</b>	All
<b>Classification:</b>	Open
<b>Reason for lateness (if applicable):</b>	Not applicable
<b>From:</b>	Healthwatch Southwark

## RECOMMENDATION(S)

1. That the Health and Wellbeing Board notes the recommendations from the Healthwatch Black Mental Health report and considers how these can be addressed through delivery of the Joint Health and Wellbeing Strategy action plan 2025-27, Partnership Southwark Health and Care Plan, and Southwark 2030 goal for “Staying Well”.

## BACKGROUND INFORMATION

2. Healthwatch Southwark is the local independent champion for people who use health and social care services. They provide advice and information to help people navigate health and social care, and conduct community-based research and engagement exercises to make recommendations for service improvement.
3. Healthwatch Southwark are hosted by Community Southwark.
4. In 2024, Healthwatch Southwark conducted a project to explore how Black African and Caribbean communities in Southwark perceive and experience mental health services. This item presents the findings and recommendations from this work.

## KEY ISSUES FOR CONSIDERATION

5. *“Towards inclusive healthcare: rethinking mental health services for Black African and Caribbean communities in Southwark”* was a project prompted by evidence of persistent inequalities in access, experiences of care, and treatment outcomes for Black African and Caribbean communities.
6. The research involved two phases: a survey and focus groups capturing general perspectives on mental health services, followed by additional focus groups and interviews focusing on Black men’s views on non-clinical mental health support. A total of 79 individuals participated.

7. The recommendations from this work are:
  - a. Establish long-term funding for community-based mental health services.
  - b. Utilise the current Creative Health programme hosted by South East London Integrated Care Board to implement targeted projects for Black Men.
  - c. Provide training and support for VCS groups and community leaders.
  - d. Facilitate cross-sector collaboration. 5. Embed the Patient and Carer Race Equality Framework (PCREF) across all mental health services.
  - e. Commission a 'Taster Day' event for community-based mental health services and use learnings to support the implementation of Recommendation 2.
  - f. Consultation with non-clinical and community-based mental health services to identify needs and establish good practice models.
  - g. Implement a targeted mental health awareness campaign for Black men.
8. Healthwatch Southwark have also recently developed a [directory of mental health support services for Black men](#).

### **Policy framework implications**

9. Recommendations from this work should be addressed through implementation of the Joint Health and Wellbeing Strategy action plan 2025-27, Partnership Southwark Health and Care Plan, and Southwark 2030 goal for "Staying Well", all of which have aims related to improving mental health and reducing inequalities.

### **Community, equalities (including socio-economic) and health impacts**

10. The report makes recommendations for improving outcomes related to mental health inequalities.

### **Climate change implications**

11. None identified.

### **Resource implications**

12. Members of the Health and Wellbeing Board are required to separately consider the resource, legal and financial implications relating to the recommendations of this report, as and when action is taken to address the recommendations.

### **Consultation**

13. The Black Mental Health report summarises the findings and recommendations from a community engagement exercising involving 79 residents.

## BACKGROUND DOCUMENTS

Background Papers	Held At	Contact
<a href="#">Healthwatch Southwark Annual Report 2023-24</a>	Healthwatch Southwark, 11 Market Place Bermondsey London SE16 3UQ	Rhyana Ebanks-Babb <a href="mailto:Rhyana@communitysouthwark.org">Rhyana@communitysouthwark.org</a>

## APPENDICES

No.	Title
Appendix 1	Towards inclusive healthcare: rethinking mental health services for Black African and Caribbean communities in Southwark

## AUDIT TRAIL

<b>Lead Officer</b>	N/A		
<b>Report Author</b>	Rhyana Ebanks-Babb, Healthwatch Southwark		
<b>Version</b>	Final		
<b>Dated</b>	3 March 2025		
<b>Key Decision?</b>	No		
<b>CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER</b>			
<b>Officer Title</b>		<b>Comments Sought</b>	<b>Comments Included</b>
Assistant Chief Executive, Governance and Assurance		No	No
Strategic Director of Resources		No	No
<b>Cabinet Member</b>		No	No
<b>Date final report sent to Constitutional Team</b>			4 March 2025

# **Towards Inclusive Healthcare: Rethinking mental health services for Black African and Caribbean communities**

Healthwatch Southwark  
January 2025



## Acknowledgements

We are deeply grateful to everyone who contributed to this project, in particular, the participants who generously shared their time, insights, and lived experiences with us. Thank you for your openness and trust.

We are thankful to our steering group members for their guidance and commitment. We are also grateful to our volunteers and Community Health Ambassadors, whose efforts in supporting data collection and reviewing this work have been invaluable.

Finally, we would like to thank staff and volunteers of the incredible VCS organisations who facilitated engagement for this project, namely Holistic Well Woman, RJ4ALL, The Redeemed Assemblies Food Bank, Paxton Green Time Bank, and Change Grow Live.

If you have any questions or comments on the report, please contact Ruman Kallar (Research & Projects Officer) at [ruman@healthwatchsouthwark.org](mailto:ruman@healthwatchsouthwark.org)



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## 1. Executive Summary

This project explores how Black African and Caribbean communities in Southwark perceive and experience mental health services. It is prompted by evidence of persistent inequalities in access, experiences of care, and treatment outcomes for these communities (Department of Health and Social Care 2018).

The research involved two phases: a survey and focus groups capturing general perspectives on mental health services, followed by additional focus groups and interviews focusing on Black men's views on non-clinical mental health support. A total of 79 individuals participated.

Findings reveal significant barriers to accessing mental health support, including stigma, distrust of public services, and limited awareness of available resources, particularly for early intervention and preventive care. Many participants associated mental health services with negative experiences, including being medicated or detained, leading to fear and avoidance. These challenges disproportionately affect Black men.

Isolation was identified as the most significant contributor to poor mental health among Black men. Most male participants described that they currently rely on informal coping strategies like socialising and exercising, rather than using mental health services. Participants, including men and women, expressed interest in non-clinical support, such as peer groups, exercise, and creative activities, but noted a lack of information about how to access such services.

Community-based services were seen as vital for providing accessible, culturally appropriate care. Participants highlighted the role of voluntary and community sector (VCS) groups, community leaders, and faith leaders in addressing stigma and building trust. Suggestions for improvement included long-term funding, integrated activities, accessible locations, and collaboration with mainstream services to ensure appropriate care.

The findings inform recommendations for improving mental health care for these communities, detailed in section 4 of the report.

## 1.1. Summary of Recommendations

This research provides targeted recommendations to enhance access to mental health services for Black African and Caribbean communities. Several recommendations also have the potential to drive broader improvements across mental health services, ultimately benefiting all patients.

1. Establish **long-term funding** for community-based mental health services.
2. Utilise the current Creative Health programme hosted by South East London Integrated Care Board to **implement targeted projects for Black Men**.
3. Provide **training and support** for VCS groups and community leaders.
4. Facilitate **cross-sector collaboration**.
5. **Embed the Patient and Carer Race Equality Framework (PCREF)** across all mental health services.
6. **Commission a 'Taster Day'** event for community-based mental health services and use learnings to support the implementation of Recommendation 2.
7. Consultation with non-clinical and community-based mental health services to **identify needs and establish good practice models**.
8. Implement a **targeted mental health awareness campaign** for Black men.

The complete set of recommendations is contained in section 4 of this report.

## 2. Introduction

Black African and Caribbean communities are known to face inequalities in accessing mental health care, as well as in their experiences of care and the quality of treatment outcomes (Department of Health and Social Care 2018). They are more likely to access treatment at crisis point, be subjected to coercive care, and arrive at mental health services through adverse pathways, such as the criminal justice system (Ibid; CQC 2024).

In recognition of this, improving mental health services for Black African and Caribbean communities has been identified as a priority area at national and local levels (Department of Health and Social Care 2018; CQC 2024; South London and Maudsley NHS Foundation Trust 2024a). Southwark-based South London and Maudsley NHS Foundation Trust became the pilot site for the Patient Care Race Equality Framework (PCREF) in 2020, an initiative designed to tackle mental health inequalities for ethnic minority groups (South London and Maudsley NHS Foundation Trust 2021).

This project aims to contribute to this work by gathering direct feedback from Black African and Caribbean residents who have experienced poor mental health, to understand their perspectives and experiences of mental health services in Southwark. As a result of data collected in the early phases of this research, we shifted our focus to investigate Black men's preferences for non-clinical mental health services, aiming to identify ways these services can promote access to inclusive and culturally appropriate care.

### 2.1. Background Research

#### Underuse and Access Inequality in Mental Health Services

Research indicates that Black African and Caribbean communities consistently underuse mental health services, despite higher reported mental health needs. For example, Black women experience higher rates of common mental disorders than women from other ethnicities (Birmingham City Council 2022), and in Southwark, severe mental illnesses including psychotic conditions such as schizophrenia and bipolar disorder, disproportionately affect individuals from Black ethnic groups

(Southwark Council 2017).<sup>1</sup> Despite this, Black adults have the lowest treatment rate (6.5%) for emotional and mental health issues among all ethnic groups (Ahmed et al 2021). This study (Ibid) indicates that inequalities in access to treatment for anxiety and depression are increasing among Black communities.

## **Barriers to Accessing Suitable Treatment**

Studies indicate disparities in the types of mental health treatments offered to Black communities, and in how these treatments are accessed. Black African and Caribbean individuals are less frequently offered psychological treatments such as Improving Access to Psychological Therapies (IAPT), and when they are, they are more likely to drop out before completing treatment (Birmingham City Council 2022). In Southwark, referrals analysis suggests that GPs can be a barrier to IAPT, supporting the finding by Brown et. al (2014) that GPs are particularly poor at detecting the mental health needs of Black Caribbean groups.

This trend is coupled with a tendency for medication to be offered over preferred options like talking therapies, negatively affecting treatment outcomes (Ahmad et al., Raleigh 2023; Savage et. al 2016). To address these inequalities, South London and Maudsley NHS Foundation Trust's Southwark Directorate has an ongoing project to improve access to psychological therapies for Black males within Southwark Community Mental Health teams, though outcomes from this work are not yet known (South London and Maudsley NHS Foundation Trust 2024a).

## **Over-representation in Coercive Care**

The over-representation of Black men in coercive mental health care has been highlighted as an urgent issue in the Care Quality Commission (CQC) State of Care report (2024) and the Modernising Mental Health Act report (Department of Health and Social Care 2018). Black men are over four times more likely to be detained under the Mental Health Act and face restrictive interventions, such as physical restraint or isolation whilst in hospital, than white men (NHS Digital, 2021). Black men also experience longer hospital stays and are more than ten times as likely to receive Community Treatment Orders, meaning that they are kept under supervised care for longer periods of time than men from other ethnic groups

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<sup>1</sup> However, diagnostic figures require careful scrutiny, as Black men are disproportionately over-diagnosed with conditions such as schizophrenia (Fearon et al., 2006 cited in Myrie et al.).

(CQC 2024; NHS Digital 2021). Additionally, Chui et al. (2021) report that Black individuals, especially those from Black African backgrounds, are often referred to mental health services through social and criminal justice systems, bypassing early preventive care.

Southwark's rate of mental health hospital admissions and detentions under the Mental Health Act are substantially higher than the national average (Southwark Council 2017). Southwark Council's (2017) "Mental Health Joint Strategic Needs Assessment" notes that higher levels of hospitalisation in Southwark may reflect the ethnic diversity of our local population, as according to national figures, individuals from Black ethnic groups are twice as likely to be hospitalised for mental health than those from white ethnic groups.

## Low Engagement with Services

Brown et. al's (2014) study of South East London Community Health finds that 60% of people with mental health problems do not seek help from professionals. Instead, they are more likely to pursue "informal" support, such as speaking to friends or family. Reluctance to engage with mental health services stems from previous negative interactions with healthcare providers, cultural and social norms emphasising resilience shaped by ideas that lead to hyper-masculinity, and stigmatisation of mental health issues (Ibid; Memon et al. 2016; Myrie et al. 2013). These issues are particularly pronounced among men, who may feel less inclined to discuss psychological stress or seek help (Memon et al. 2016; Myrie et. al 2013).

Many Black individuals fear racial discrimination leading to coercive treatment and surveillance by social services, further discouraging engagement (McLean et al. 2003 cited in Myrie et al.; Department of Health and Social Care 2018). Barriers such as language differences, long wait times, poor communication, and a perceived lack of culturally appropriate care compound these challenges (Memon et al. 2016; CQC. 2024).

## Recommendations

Several studies advocate for a shift toward community-based services, reducing the reliance on acute services and coercive care (Birmingham City Council 2022, Mind 2019, Department of Health and Social Care 2018, NHS Foundation Trust 2023). This reflects a broader "public health approach," which prioritises prevention and a shift in resources and power to strengthen community services (Department of

Health and Social Care 2010). This is also emphasised in the recommendations from Lord Darzi's NHS review, and Change NHS project to set a new 10 Year Health Plan for England (Department of Health and Social Care 2024; Change NHS N.D).

The Patient and Carer Race Equality Framework (PCREF) seeks to reduce racialised mental health inequalities by establishing a mechanism to hold providers to account and incorporate patient and carer input into service design (NHS Foundation Trust 2023). Recommendations set out in the PCREF include increasing Black male staff, implementing anti-racist training, and leveraging community spaces like barber shops and places of worship to build trust with Black communities.

## 2.2. Aims

This project was carried out in two parts. Mental health inequalities for Black African and Caribbean communities was identified as a key issue in our Priorities Survey 2022/3, forming part of our broader work on health inequalities for minority ethnic groups in Southwark. The project initially set out to:

- Develop relationships with residents from Black African and Caribbean communities in Southwark.
- Provide a platform for these groups to voice their views.
- Find out the key issues, needs and priorities of the communities, so that we can share them with decision makers to raise awareness and drive change.

Once we established the main concerns surrounding mental health access in our first cycle of engagement, we used these insights to narrow the project's focus.

In doing so, this project builds upon existing work, which indicates a need to explore the role of non-clinical mental health services for Black African and Caribbean men (Race Equality Foundation 2024; NHS Foundation Trust 2023; Department of Health and Social Care 2018).

Non-clinical mental health services are defined as support services that focus on improving mental well-being without involving diagnosis and medication. These can include peer support, some talking therapies, creative practices, and other community programmes aimed at helping individuals manage stress and build coping skills. These are typically provided by VCS groups and trained peers, and



are designed to be more accessible than clinical services. They are not always a replacement for clinical treatment, and can be used alongside treatment such as medication to improve an individual's overall health and well-being.

Therefore, our final set of aims are to:

- Build relationships with Black African and Caribbean men in Southwark, and provide a platform for them to voice their opinions on mental health services.
- Enhance service providers' understanding of community views on clinical and non-clinical mental health services.
- Co-produce recommendations and share them with decision makers to increase access to both clinical and non-clinical mental health services for Black African and Caribbean men in Southwark.

## 2.3. Methodology

Research was carried out in two phases. The first phase took place between spring and summer of 2023, during which time we ran an online survey (in total 41 participants) and two focus groups (in total 14 participants).

Insights were used from the first phase to refine the project's focus and research questions, leading to the second phase in autumn 2024. This involved four focus groups and two 1-1 interviews (in total 24 participants).

Overall, we engaged with 79 participants.

### Survey

The survey included a mix of closed and open questions to gather detailed personal experiences (Appendix 3). It was distributed online and promoted by voluntary and community sector (VCS) groups working with Black communities, Southwark Council and Partnership Southwark. We also circulated physical copies at Community Mental Health Teams locations. This yielded both quantitative and qualitative data. While this study relies predominantly on qualitative analysis for narrative capture, quantitative data is useful for identifying service usage patterns and feedback trends.

### Focus Groups

This study employs qualitative research methods to enable participants to contribute in their own words, creating greater potential for original explanations (Savage et al 2016).

We opted for semi-structured focus groups to allow for dynamic group interactions, where participants can build upon or challenge each other's ideas, uncovering shared experiences or contrasting viewpoints. This can foster camaraderie between participants, with peers comforting and encouraging each other through sensitive discussions. We used a preset question guide to steer discussion, but maintained flexibility to explore unexpected emergent themes based on the group's responses (Appendix 4). Participants were also given pencils and paper, and the option to speak with the researcher discreetly after the session, to enable them to share privately.

The first phase of focus groups was hosted at Peckham Levels and led by local VCS group, Holistic Well Woman, which had previously led community-based research into Black fathers' mental health (Unpublished).

The second phase of focus groups was hosted at several spaces; RJ4ALL, The Redeemed Assemblies, Paxton Green Time Bank, and Change Grow Live. These venues were selected based on their location, as we aimed to cover the expanse of the borough. We also hosted one online focus group using Zoom, in response to demand from participants.

These venues are VCS-led and operate various services such as food banks, time banks and generalised community centres. The Redeemed Assemblies also functions as a church, distinct from its food bank. Change Grow Live specialises in substance misuse and criminal justice interventions. This provides important context to the backgrounds of several participants who use these services, which will be reflected in our findings.

## 1-1 Interviews

We adapted our methodology to include 1-1 interviews for participants who were unable to participate in focus groups. This option was built into our methodology as a secondary method, as we recognised that group exercises may not be suitable for everyone. We used the focus group question guide in these interviews to ensure data consistency (Appendix 4).

## Participant Criteria

To be eligible to participate in the study, individuals had to be aged 18 and above, and self-identify as being from Black African and/or Black Caribbean (including mixed Black) ethnic backgrounds. The first engagement phase was open to individuals of all genders, whilst the second engagement phase required participants to self-identify as men.

Participants were individuals who had experienced mental health challenges. They were not required to have used mental health services.

Focus group participants were offered a £20 gift voucher and a “goodie bag” including information about local mental health services and a national directory of Black-led VCS organisations.

## Participant Recruitment

Each focus group venue promoted the focus groups to their service users, approaching individuals who met the participation criteria. We also promoted through other VCS organisations that work with Black men, such as Black Thrive and the Black Men’s Consortium; through local mental health services such as Southwark Wellbeing Hub; Healthwatch Southwark, Community Southwark, Partnership Southwark and Southwark Council communications, and by posting flyers on local estates’ noticeboards, and at shops, libraries and barber shops.

## 2.4. Analysis

We used Meridian Artificial Intelligence software to transcribe audio files from focus groups and interviews. We manually validated AI transcription by listening to the audio files.

We used thematic analysis to process our qualitative data, focusing on how people described their experiences and what this revealed about perceptions of mental health and mental health services. We employed an inductive approach to allow the data to shape our themes. These themes were reviewed across the dataset to ensure they provide comprehensive and accurate representations of recurring issues and key ideas. We also used thematic summaries generated by Meridian AI to validate our manual analysis, checking for additional themes we may have missed.

Lastly, we used content analysis to quantify qualitative data generated by the survey. For example, to understand the prevalence of a particular theme, we counted how many times it was mentioned across the dataset.

## 2.5. Challenges

We recognise that recruiting participants via VCS service user networks may contribute to bias in our findings. This method of recruitment utilised the trusting relationships held between VCS organisations and their service users to encourage individuals to participate in the study. Several individuals explained that this trust was essential to their participation, given the stigmatisation of mental health and widely held scepticism surrounding research involving historically marginalised communities. The role of VCS organisations in recruitment was particularly significant in the second cycle of engagement, which focused on Black men.

Comparatively, public promotion of the focus groups proved less effective. We facilitated widespread engagement beyond VCS networks to mitigate against bias, however, suspicious bot activity prevented genuine individuals from signing up online, contributing to low attendance rates from online signups. It was also difficult to ensure whether online signups met the participation criteria. Recruiting via VCS networks therefore became essential to successful engagement for this project.

### Online Engagement

As above, it was difficult to confirm that participants in our online focus group met the participation criteria. We required that online participants had their cameras switched on during the session, but this was difficult to monitor and enforce throughout. This issue affects the 12 participants who took part in online engagement.

### Researcher Demographics

This research was conducted by our predominantly Black, female team at Healthwatch Southwark. During the second engagement phase which was aimed at Black men, we received feedback from participants that research should be

conducted by Black men, who could best understand the opinions and experiences shared by participants.

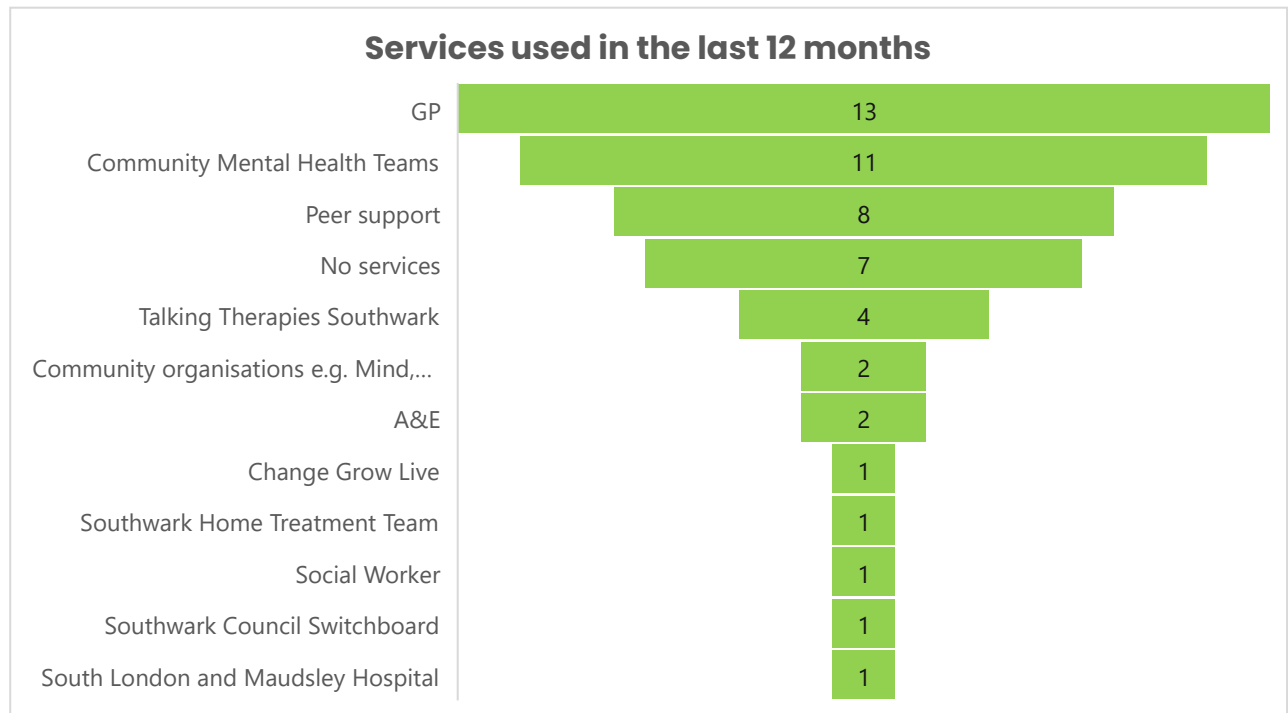
We actioned this feedback by engaging a Community Health Ambassador who identifies as a Black man to lead two focus groups, with the support of Healthwatch researchers. This Ambassador was known to seven participants prior to this study, as they are service users of the VCS organisation he operates. In another focus group, we invited a Black male member of staff from the host VCS organisation to support facilitation. This individual has a staff-client and peer relationship with two participants. The nature of these relationships poses a risk of bias which may be reflected in our findings. However, we felt that this approach was essential to facilitating a safe environment for participants, and is demonstrative of community-informed research practices.

## 3. Findings

### Survey

83% of participants (34 individuals) said they used at least one service to access mental health support in the last year. This includes clinical services such as GPs and A&E, and non-clinical services such as peer support.

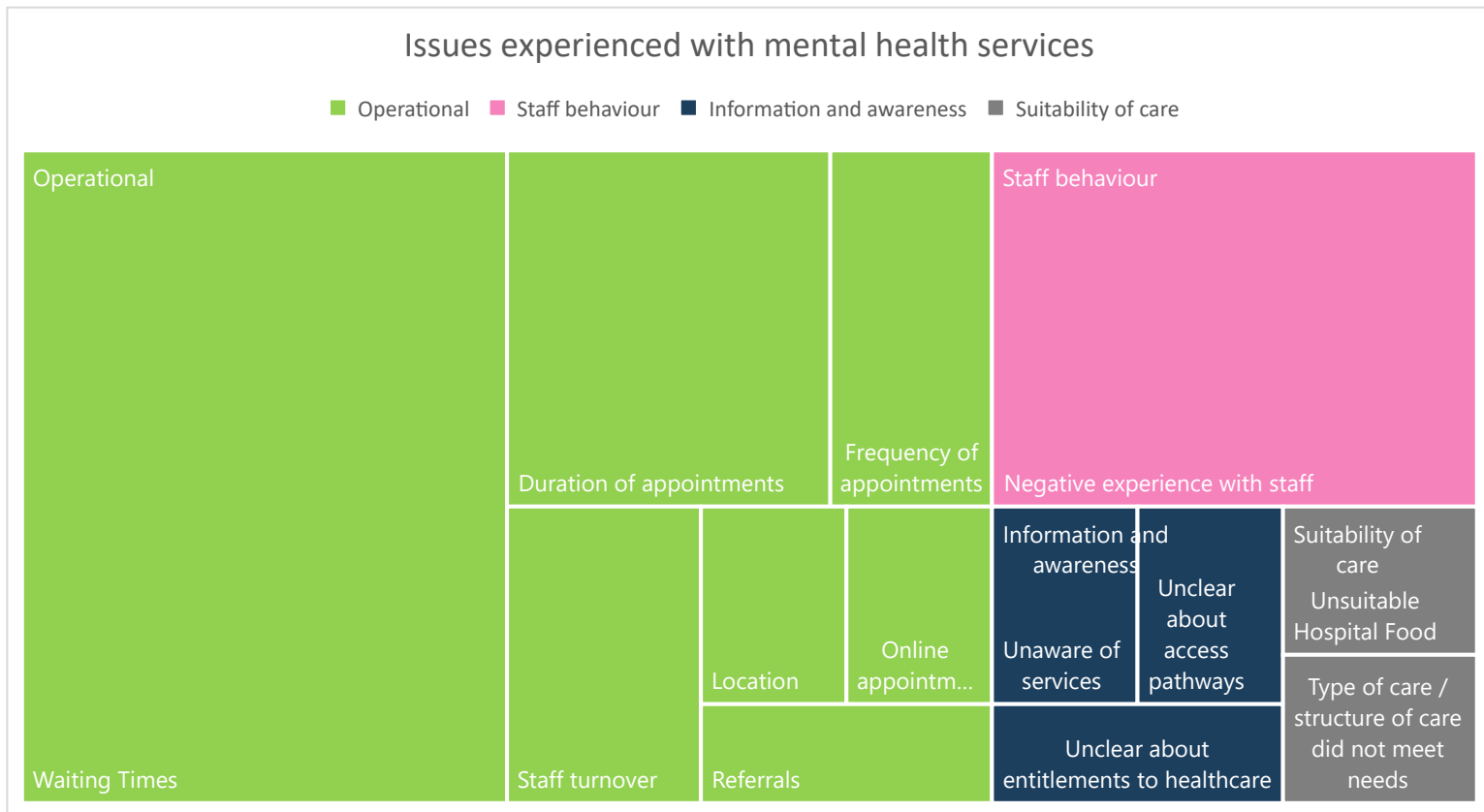
The most used service was GPs (13 individuals), followed by Community Mental Health Teams (11 individuals) and peer support (eight individuals). Seven individuals had not used any mental health services.



### 3.1. Key Issues

67% of participants who had used a mental health service in the last year (23 individuals) experienced at least one issue with the care they received. These issues related to GPs, Community Mental Health Teams, Talking Therapies, South London and Maudsley Hospital and A&E services.

The issues described can be categorised into four main themes: operational, staff behaviour, information and awareness, and suitability of care.



The graph above shows an overview of the issues described. Each section is proportionate to the number of responses that mention that theme.

## Operational Issues

Most feedback was related to operational issues (14 participants), including waiting times, the duration and frequency of appointments, staff turnover, issues with referrals, and lack of face-to-face appointments.

The most common complaint flagged by 11 participants was that waiting times are too long, particularly for GPs and Talking Therapies. Three participants turned to informal support networks as a result.



"It was difficult to get a timely appointment (for Talking Therapies) and the issues I was (experiencing) required early intervention. I was then forced to talk to family members who I would never have wanted to talk to."



"I tried looking for an appointment at a time in my life when I felt I wasn't at a good place mentally but had to wait forever until I sought help from my church."



"There was a day when I was overwhelmed with emotions. I didn't really know what was wrong and called to book an appointment. I was told the earliest appointment I would get was in two weeks and I wasn't even given an emergency appointment or referred to another service which could offer help. I called a friend who I knew was trained in mental health awareness. It was she who helped me and even helped me to tweak my diet to help me cope and kept checking on me until I was OK. My GP surgery has up to now not followed up to check on me."

The structure of appointments was also flagged as a key issue. Four participants reported that GP appointments are too short, causing them to feel rushed and unable to communicate fully when seeking help. Two participants felt that extended gaps between appointments for Talking Therapies negatively impacted their experience of treatment.



"Sometimes you feel rushed to complete what you are trying to express, and you only have a few minutes to talk. There doesn't seem to be much personal touch."

Regarding Community Mental Health Teams, two participants experienced disruptions to care due to staff turnover, and one participant flagged that they struggled to complete their treatment as the service relocated to a less accessible site.

## Staff Behaviour

Six participants described negative experiences with healthcare professionals, feeling dismissed, and rushed, and that staff lacked "empathy" for their circumstances.

"I found it difficult opening up because my therapist seemed to be in a rush. I felt my concerns were not being taken seriously."



One participant explained that their relative's mental health condition declined to crisis point because their GP did not take them seriously when they presented symptoms. The lack of early intervention care led to police involvement and significant hardship for their family.

"My sister suffered from depression and became suicidal. Her GP didn't take her seriously when she reported that mentally she didn't feel OK. She then (had an incident) where her children called the police."



## Information and Awareness





Two participants indicated a lack of awareness about mental health services, and how they could access them, “I know I suffer from depression, but I don’t know where to seek help.”

Another participant did not access mental health services because they were unsure of their entitlements to use NHS healthcare, given their immigration status.

### Suitability of Care

Finally, two participants expressed that the care they received did not meet their needs. For example, one individual received culturally inappropriate food during an in-patient hospital stay, which they felt adversely impacted their recovery.

“My time in Maudsley, the food was not culturally tailored and therefore it made me feel lower.”



Another participant was unable to find a service or treatment plan that suited the complex needs of their family.

“My children (have been affected by bereavement) and Southwark did not have provisions to strengthen our family during these difficult times. Each of us would have to access therapy separately. This made the process quite tedious and tiresome...as I’m a lone parent with a limited support network.”



## 3.2. Suggestions for Improvement

We asked survey participants for ideas on how mental health services could be improved to meet their needs.

Suggestions included:

### Operational Factors

- Increase early intervention support and provide timely appointments for urgent mental health needs.
- Provide longer appointments and more face-to-face appointments.
- Maintain staff consistency during mental health treatment to enable patients to build relationships with healthcare providers.
- Streamline administrative processes to ensure that referrals are actioned, and patients are kept informed on the status of their care.
- Follow-up with patients who have indicated mental health needs.

## Staff Behaviour

- Provide anti-racist, diversity and inclusion training to patient-facing staff.

## Information and Awareness

- Advertise mental health services in community spaces and GP surgeries.
- Connect with Black-led organisations and community leaders to promote services, dispel misinformation and de-stigmatise mental health.



"Education should be given about mental health to help reduce the stigma associated with it."

"Assure parents that their kids will not be taken away from them if they seek help for their mental well-being. This is the general perception."

## Suitability of Care

- Consult Black-led organisations and community leaders to inform the development of culturally appropriate mental health services.
- Improve access to psychological therapies and non-clinical forms of mental health support.
- Provide extended support programmes to promote long-term recovery and well-being. For example, encourage joined-up working between sectors to provide wrap-around support on topics such as benefits, healthy living and employment advice.
- Fund and equip Black-led organisations to deliver community-based health and well-being programs.



"I would like to see more support given to patients who are suffering or are recovering from mental health issues. An example of this would be home visits to discuss any other life changes, shortage of food, electricity, heating."

"Offer more talking therapy and small community groups, not just medication to Black people. Work with organisations who specialise with Black people to find the right approach."

## Focus Groups (2023)

### 3.3. Key Issues

Whilst our survey findings predominantly highlighted operational issues such as waiting times and appointment structure, our focus group findings emphasised the role of cultural and systemic barriers to accessing mental health support for Black African and Caribbean communities.

#### Information and awareness

As above, participants expressed a lack of awareness about mental health services and support. Services identified by participants were limited to GPs and South London and Maudsley hospital, whereas community-based services and talking therapies were not mentioned until prompted.

"Maudsley Hospital. That's the only one I know."

"I've never heard of any mental health services in Southwark."



Some participants had little or no understanding of 'mental health' as a term. These individuals explained that they would not approach healthcare services for support, as they would not recognise symptoms of poor mental health as a health condition.

"I think we might not recognise what's happening. We might think things are not quite right, but that it will be okay. You don't know what's normal...You don't realise that you need help."



However, levels of understanding and knowledge did vary between participants, for example one individual indicated a confident understanding of services.

"I feel good about finding services. I would know where to find it, I'm proactive."



Another participant shared a positive example of their GP acknowledging their treatment preferences and referring them to a suitable service.

"I want to say that my GP is a blessing. Because I have a GP and he supports me, when I said I didn't want to be on medication he agreed with me and said I should do talking therapies instead."



## Stigma

The impact of stigma on mental health and individuals' ability to access support was emphasised during focus group discussions. Demonstrating how multiple barriers can intersect, participants highlighted how lack of understanding about mental health within some communities can lead to misinformation, preventing individuals from seeking mental health services. For example, participants described that symptoms of mental ill health can be misinterpreted, particularly within faith groups, where these symptoms may be attributed to "witchcraft," "demons," or to lack of faith, which further stigmatises vulnerable individuals.

The effect this has on children and young people was emphasised, as parents can be reluctant to seek help or dissuaded from doing so by family and community leaders such as pastors. One participant highlighted how this contributes to intergenerational trauma within some families and communities, where mental health conditions are unaddressed and met with shame.

The impact of stigma on men was further highlighted, as gendered expectations of "strength" and stoicism make it difficult for men to seek both formal (e.g., NHS services) and informal mental health support (e.g., speaking to a friend or family member) (Brown et al. 2014). The gendered aspect of stigma was raised as a key issue by male and female participants.



"As a people we shy away from mental health as a culture...because of the stigma we carry."



"The church misdiagnoses a lot of medical issues as demon possession. They apply so much of the religious part of it that they don't see the person. That there's a real underlying medical thing going on and not so much of a demonic possession. You have a church full of people suffering with mental issues that no one will ever address. Those people are still suffering, their grandchildren. Especially males. In our culture, generally, females will speak. Us men are taught we talk too much. By the time we get



to adulthood, why you not talking? How can you ask me to talk about something I'm not used to? Males in our community are suffering more and even dying at a faster rate. It's a real drastic condition we are facing in our community, life or death."

## Institutional racism and distrust of services

Several participants expressed distrust of mental health services due to experience or knowledge of institutional racism in the healthcare system. This related to intergenerational trauma, as participants discussed how their parents' experiences of racism in Britain created longstanding scepticism of public services throughout their families. Others described firsthand experiences of racism from healthcare professionals, particularly receptionists. Participants recognised that Black people, and Black men in particular, are more likely to be medicated for mental health conditions, and more likely to be sectioned and detained.

"It feels like Black Africans / Caribbean they get the end bit. They get sectioned, they don't get the first line care."

"The whole thing around how Africans and Caribbeans were treated in the mental health system, where we were the ones who were going to be sectioned, for little things, so a white woman would get an Indian head massage, and you're getting sectioned. You go in for one little thing and you're locked up for five years."

We can infer a connection between the limited awareness of early intervention and preventive mental health services, and this sense of distrust. As most participants were only familiar with South London and Maudsley Hospital, which is primarily intended to treat acute mental health conditions, their understanding of mental health support was directly linked to coercive care.

"I don't think people are in denial of mental health. I think people think of the worst-Maudsley hospital, medication all that stuff."

## Perceived lack of targeted services for men

Two participants suggested that there is a lack of mental health support available for men, particularly early intervention and community-based options. Links were drawn between this perceived lack of non-clinical support and the over-representation of Black men in acute mental health services.



"There are more services for women than men. There's nothing out there for men. There is just barber shop, maybe the pub, parties...when you talk to your friend. It's just 'man up man up', men have nothing there. Men are left alone."



"Men have the barber shop. And you're not getting the right advice there, it's not a professional service."

## Lack of Representation

In addition, two participants indicated that a lack of Black representation among mental health professionals further perpetuates the idea that mental health services are "not for us." One participant expressed that the lack of Black representation results in a lack of understanding of Black culture and experiences, meaning that services cannot provide culturally appropriate and effective support.

"Why is it the services that are meant to be run for majority Black people are run by people who don't look like them,"



However, this topic was debated amongst participants, with others expressing concern that Black healthcare professionals could bring cultural stigma into their care.

"Sometimes they will understand, sometimes they're more dangerous. Sometimes they see you and make all these judgements about you and won't even give you the time."



Most participants indicated that they did not have a preference for the racial or ethnic background of healthcare staff, as long as they were treated equally "I would go with anyone I've got an appointment with. I wouldn't mind."

## Socioeconomic Inequalities

Participants expressed that the type of mental health support they want is not available locally. This includes non-clinical services such as support groups and various leisure and well-being activities. Three participants flagged the role of class in access to services, indicating that service provision is inconsistent across neighbourhoods, as well as for different socioeconomic groups within the same neighbourhood.



"Someone who lives in a nice area can come down to Peckham and get Indian head massage but the people who live in the borough who may need that service, not even a second look, they get hand over fist."



"A bunch of young people are sent to a youth centre, they get a little football, they walk around, there's no motivation. A similar group of people, just (elsewhere), the day's planned, mountain-climbing, rock-climbing. The same group of children, same problems, same age, but where the postcode change a little bit there's plans."

### 3.4. Suggestions for Improvement

When asked how mental health services could be improved for Black African and Caribbean communities, participants made the following suggestions:

- Implement targeted awareness campaigns about mental health, using approachable and non-stigmatising language and representing Black service users.
- Train community members to spread information and awareness about mental health, particularly in faith groups and hairstylists/barber shops.
- Offer a wider range of services for holistic mental health support, including peer support, talking therapies, art therapies, and exercise classes alongside clinical treatment.

"Train staff in the church in mental health first aid. It needs to be someone that understands what's going on in the community."



"I want them to see me as a person. (Medication), okay it prevents an episode. However, whilst I'm trying this, why can't I also try that. Water without flour doesn't make dumpling. Chicken without jerk doesn't make jerk chicken. It's got to work together."



Insights from the first engagement phase indicated that participants were interested in exploring non-clinical mental health support services, and felt that these services would be particularly valuable for Black men. Our

second engagement phase therefore set out to answer the follow research question:

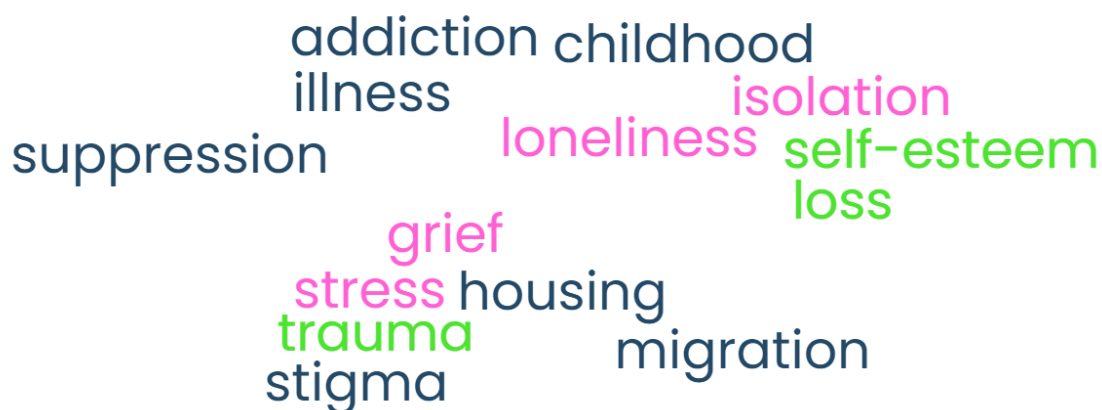
How can non-clinical mental health support be optimised to meet the needs of Black men in Southwark?

## Focus Groups (2024)

### 3.5. Understanding and Awareness

Participants expressed varying levels of understanding about mental health. During discussion, there was frequent mention of common mental health disorders such as depression and anxiety. Otherwise, participants used terms such as “feeling low,” “struggling,” or “breakdown” to articulate poor mental health.

Factors identified as contributing to poor mental health included: bereavement; relationship breakdown or moving away from social networks; long-term physical health conditions; trauma; emotional suppression; experiencing racism at interpersonal and institutional levels; stress related to housing; migration; and unemployment; and low self-esteem. Isolation was the most common factor indicated.



“I’ve been burned by too many people, I don’t know how to be intimate with others anymore...I’m crying for connection, making new friends, being in a relationship. In the past I would use a bit of drugs or alcohol to be comfortable, to connect, but I know I can’t do that anymore.”





"I've been through grief as well...the loss of my parents was hard for me. It's like you don't even know how to channel this emotion because you've not even been allowed to from a young age."



"I've suffered corporal punishment since I was a child. And I do suffer trauma from the way my father used to beat my mum physically."



"I look at myself in the mirror every day and I doubt myself that I'm gonna really find true happiness."

Awareness of mental health services also differed between participants. Some participants had no knowledge of existing services,



"I didn't think the GP was for mental health issues. I didn't know that there was a support system for anyone going through a mental health change."

"I would be open to getting help, but I don't know any (services)."

However, most participants had some knowledge of clinical mental health services, including South London and Maudsley Hospital and GPs.



"In the community, there is no awareness about where you could get some help if you want to do these things without involving friends or family. Apart from Maudsley hospital, which everyone seems to know is a mental health service, but I think people get scared of even mentioning wanting to go there."

There was less awareness of non-clinical services, though some participants mentioned talking therapies, mental health helplines, Southwark Wellbeing Hub, Change Grow Live, and "support groups". All participants who had accessed non-clinical services had been referred to these services through clinical pathways such as GPs, South London and Maudsley Hospital, and A&E. One participant was referred to a non-clinical substance misuse support service through the criminal justice system (probation officer).

## 3.6. Service User Experience

Participants presented a mixed picture of mental health services when describing their experiences as service users.

"I personally have gone through therapy, and it really helped me. So, therapy does work, but it's getting the right person and having awareness of what it does."



"Going to hospital (South London and Maudsley) was probably one of the best things for my mental health."



"Services don't understand or relate, they just listen to respond. They're not really helping you."

"I waited for like eight, nine hours in A&E. And I spoke to the guy for like... 25 minutes. And with my GP, I've kind of been dismissed, but he put me to referral to do talking therapy...but the talking therapy made me worse. The GP tried to do his best, but I don't feel that he was mental health trained, so it wasn't good enough."



Some participants indicated knowledge or experience of using acute mental health services, but not of early intervention or preventive support,

"I used to use South London and Maudsley. That's after you get a section. I think there needs to be something before that initial sectioning and before you feel not the same. But I'm not aware of anything that does that."



"I know that within hospitals, there's always somebody on site to deal with you if you're suicidal, but that's very, very far down the line."



Across all focus groups, there was a notable gap in awareness and actual usage of services, where participants were able to name services or, more commonly, types of services such as 'support groups,' but had not made use of them.

"I'm aware of a few like counselling, therapy, and I think support groups, but I haven't had time to try it out."



"I'm aware of some services, I choose not to use them."

We explored possible reasons for this, outlined in the next section.

## 3.7. Key Issues

Participants were asked to consider challenges that may prevent them from accessing non-clinical mental health support. However, most participants spoke about mental health services more generally. This is likely because participants were not familiar with the term 'non-clinical mental health services,' and most participants had not previously used these services.

### Trust and Confidentiality

The main barrier to community-based services was concern regarding trust and confidentiality. Since these services are typically led by peers, many participants worried about sharing sensitive information, feeling that community-based services might be less confidential than mainstream services. This perception stems from assumptions that these services lack professional structures and means of accountability. Concerns about confidentiality were linked to stigma surrounding mental health and gendered expectations, as well as risk factors like migrant status.



"The peer-led sessions concern me because they're not supervised, so you get abusers. The sessions are good because no one knows more than someone who has been through it. But they are just left to do whatever they want to do."



"I've heard of social clubs where I could really benefit from, I think they are so much of importance. But I have this kind of biased feelings about those kind of clubs because of interactions and relationships could really go so extreme and delve into more private topics and I'm usually scared of that."



"When I had anxiety and depression episodes, I felt I needed someone to talk [to], but the trust factor was really taking a hold on me because it would require a whole level of trust for me. To get support requires you to reveal some personal details down to things going on in your household. So I really, I really feared this. I really feared this. And it was really a challenge for me, accessing support services in my community."

### Stigma (see also section 3.3 above)

There was consensus that mental health is not widely understood or addressed by Black men, due to stigma surrounding mental health and masculinity. As in the first phase of focus groups, discussions revealed a widely-held perception that poor mental health would be interpreted as "weakness" by others, and that stereotypes attributed to Blackness and masculinity intersect to place additional pressure on Black men to demonstrate emotional strength. Participants agreed that these expectations contribute to the deterioration of Black men's mental health, and their increased likelihood of accessing late stage, acute mental health services.

"Seeking for mental health services is something that most men generally refrain from until they are at breaking point. As a Black man, you're supposed to be strong. You're not supposed to be weak. We are trained to absorb all of this



until you're completely at breaking point. So, most of the time before (seeking help), you're almost having psychosis."

"If (we) were to cry in front of (our) daughters or wives they would lose respect for (us) so (we) hold it in."

Additionally, one participant described how stigmatisation of queerness within African communities has impacted their mental health, whilst further reducing their ability to seek help,

"Even sexual preference. Coming from an African heritage, that's not something you openly disclose to family. You will have a target on your back."



## Perceived Ineffectiveness of Services

Another frequently mentioned barrier to accessing mental health services was the belief that these services were ineffective for Black men. This connects to the earlier issue of representation, where participants felt that a lack of Black service providers limited mental health services' ability to understand and address the unique mental health challenges that Black communities face. This theme became even more prominent in the second phase of focus groups with Black men.



"Sometimes when I'm going to these appointments, I'm seeing my therapist online. Maybe not consciously, but subconsciously, I'm thinking, 'You don't know what I'm going through. You don't understand what it's like to walk at night, worried about being stopped, searched, or even stabbed. You're from a different world, maybe way outside of London.'"



"As a Black man, I wonder, are they going to understand me? If I speak truthfully about how I feel about society, class, slavery, or the unequal rights for Black people in this country, will they get it?"

The quotes above underline the importance of an intersectional perspective, as participants describe racial, class and place-based identities.

Several participants expressed that their mistrust in mental health services stems from seeing other Black men in the community who visibly struggle with mental health issues, but don't appear to receive effective support. They noted that, despite seeing many men in need, they haven't witnessed success stories of Black men getting adequate help.



"I see so many Black men out here, whether they're dealing with addiction or something else, but it just keeps getting worse. It feels like they're not getting any support or help at all. And instead, people label them as troublemakers or violent-'Stay away from them; they're crazy.' It's really sad to see. I'm definitely not going to end up like that."



"If it was (effective). You wouldn't see so many people walking the streets in a state of despair, and everyone walking past like it's normal."

Some participants further questioned the approach of mental health services, which they felt lacked variety and practical impact. This aligns with the findings of Brown et al. (2014) that Black communities often see mental health issues as rooted in social challenges. Several participants expressed frustration that mental health services "only listen" without addressing the underlying issues, such as unemployment, unsuitable housing, concerns about migrant status and isolation.



"When you get to a certain point, it's like you've talked to everyone. I'm just tired of talking. I want things to change."



"You talk to some Black people, and they'll say, 'What are they going to do for me? Are they going to solve my problem?'"



One participant who is experiencing homelessness critiqued the capacity of community-based, non-clinical services to improve his mental health, "the community can't help me get a place of my own."

## Negative Experiences of Public Services

Participants shared that negative past experiences with public services have contributed to their lack of trust in mainstream mental health services. These experiences could involve any public sector service, such as the NHS, job centres, local councils, or public-adjacent providers such as housing associations. When individuals encounter failure in one part of "the system," they often lose confidence in the system's overall ability to meet their needs. These experiences may be personal or involve friends, family, or anecdotes heard through word-of-mouth. Such encounters often reinforce feelings that the state does not prioritise vulnerable people.

"Come on, Southwark Council, how many decades? I've been on this estate for two decades now. There was an elderly couple that lives downstairs from me... I



couldn't believe that 70% of their place was black mould and his wife even died of it. Yet the Council denied any responsibility... When they did work in my house, I got treated very bad. When I say something it's like 'you're a trouble maker, shut up.' I know that being on benefits anytime I used to deal with the dole people they would talk to you like a piece of rubbish. I didn't bother complaining to the council (about my housing association), I've had enough. Because you know what, it's because I'm Black."



### **Institutional Racism (see also section 3.3 above)**

Institutional racism emerged as a central theme in participants' hesitation to engage with mental health services, underlining other concerns, including perceived ineffectiveness, failure to meet cultural need, and fears around medication and coercive care. Many participants shared how personal experiences of racism impacted their mental health and their willingness to seek support. They described incidents of misdiagnosis, as well as culturally insensitive and undignified treatment, rooted in racist stereotypes held by healthcare providers. These experiences reinforced a lack of trust in the system's ability to provide appropriate care for Black patients. As previously discussed, this lack of trust can stem from experiences with other public services, and reflects a broader distrust in "the system."

A participant from a Rastafarian background explained that he felt pressured to cut his dreadlocks by his GP. He shared that the loss of his dreadlocks continues to affect his well-being and self-esteem years later.



"My GP persuaded me to have an operation. I had dreadlocks down to here and I lost them. She was patronising me, so I shaved the locks. And when I went to an appointment after that, she said, you look very well. I was so angry. I said, Why don't you listen to me? If someone asks me, why you lost your dreadlocks? I tell them it's her fault... I just felt like there's no room for Black people when it comes to the hospital, mental health."



"The barrier I face is my presentation as a Black man. They see us as non-educated people who don't have ideas, which is really bad. We have a lot of ideas, and we have a lot of knowledge. We're being pressed down in society."

For some, this sense of alienation was compounded by experiences that felt undignified and dehumanising.



"When they were (discharging me from hospital), there was like five doctors at the door with the door open and I half had my trousers on, waiting for me to leave. I felt well is it because of the colour of my skin or because I have dreadlocks... I felt (like they were hiding things from me). And it's just really horrible...I find it really difficult to mentally fit into society sometimes as a Black person."

Finally, when asked about current anti-racist initiatives taken by healthcare services, such as equality, diversity, and inclusion (EDI) training, most participants were unfamiliar with these measures but open to their potential. Others, however, felt these initiatives were more symbolic than transformative.



"Box ticking. It's only learning if people care."

## Concerns about Medication

Scepticism towards medication is connected to previous discussions on institutional racism in healthcare. Participants explained that they would be hesitant to seek mental health support, for fear that they would be medicated against their will. Several emphasised a preference for alternatives to medication.

"I would (prefer) anything that is not going to get me swallowing drugs, taking things that will have to force me to sleep or in order to get into a restful state."



"Medication is overused in the Black community. It's experimentation."

Importantly, two participants discussed how treatment involving medication may not be suitable for those with a dual diagnosis<sup>2</sup>. Prescribed medications can be difficult to self-administer, particularly for those who have previously misused substances to manage their mental health, with the potential to trigger regressive behaviours. Alternative therapies are therefore increasingly crucial for affected individuals.

## Capacity of Community-Based Support

Participants recognised that many VCS groups struggle to secure long-term, unrestricted funding and rely on the good will, skills, and flexibility of volunteers. As

<sup>2</sup> Dual diagnosis refers to the co-occurrence of a mental health disorder and a substance use disorder such as alcoholism.



a result, some participants felt reluctant to engage with community-based services, out of concern for the sustainability of these initiatives.



"Maybe the person (delivering the service) is passing through a lot more than me, or maybe there are more people coming to give problem for solution. So maybe the person is busy, more busy than me. That's the main thing that would disturb me."



"There are elements of our community which do help. They don't have the resources that they need."

Furthermore, the perception that those offering help may be facing similar challenges added to participants' hesitance to engage with these services.



"If it's an NGO, charity...The people who are meant to be advising you are also needy, 'I'm having those problems too. I'm trying to apply for those things too.'" This raised concerns about the ability of community-based services to produce outcomes for service users.

## Limited Duration of Support

Participants described the limited duration of support provided by mental health services as a significant barrier. In mainstream services, some found the short-term nature of treatment plans unhelpful, feeling that the limited timeframe wouldn't allow them to achieve meaningful progress.

"I didn't even bother to go there anyway (Mental Health & Substance Misuse Service), because, I (was) referred to them. But when I got there, I was only offered 12 weeks before discharge."



In community-based services, several participants reported experiences where projects that provided valuable support ended unexpectedly.

"I've been a part of some of these projects and suddenly they don't exist."



Some participants described the adverse impact this abrupt withdrawal of support had on their mental health.

"There's a charity they help people that has just been discharged, or they might be sitting in service, but there's a place where you can do music...You find a community of people. They try to help you express yourself, so I found that very





good...But then it stopped and that kind of disturbed everything. And that's when I realised not going to these things made me feel a bit lazy, made me smoke more, made me feel depressed."



"I was part of a project where we would go to faith groups and reach out to Black men about their health, it was very good but...most of these projects come to an end...I think there should be a continuity plan for the social clubs."



The lack of sustained support left some participants feeling hesitant to engage with these services, fearing a repeat of previous disappointments.

### Treatment Thresholds

Participants highlighted that criteria or thresholds to access mental health services can pose a significant barrier for individuals with a dual diagnosis. These requirements often mandate that individuals be substance-free for a certain period before they can start treatment.



"You cannot have therapy whilst you're still using. The using has to go first and then the therapy after."



Describing their experience with a service offering Dialectical Behaviour Therapy (DBT), "I approached a service for DBT. And they said that the minimum time that they would need to see someone clean from substances, is like three months. This was when I was in a temporary accommodation. I had a good few months, during that time would have been the perfect time for me to have therapy, particularly with the diagnosis of BPD that I was diagnosed with. And I felt let down by that service."



For those experiencing addiction and mental health challenges, these criteria can create barriers to timely support and exacerbate both conditions, particularly when treatment opportunities arise during periods of stability.

## 3.8. Current Coping Strategies

Most participants relied solely or predominantly on informal coping mechanisms such as exercise, socialising and listening to music to improve and maintain their mental health. This aligns with the findings of Brown et. al's (2014) that 60% of participants in their South East London Community Health study sought informal

help for their mental health, and that men are more reluctant than women to seek formal help. Whilst most participants preferred these strategies to using mental health services, some individuals acknowledged that more severe mental health issues would require clinical interventions.

Participants described a range of activities they use to support their mental health:

- Seeking guidance from community leaders, like advice from a pastor.
- Sports and fitness activities, such as going to the gym or attending exercise classes.
- Socialising with trusted friends or joining groups at church or through hobbies, sometimes discussing mental health, but not always.
- Independent activities like listening to music, writing poetry, cooking, or engaging in self-care.
- Volunteering with local charities.
- Religion and spiritual practices, such as reading religious texts, praying, or meditating.
- Utilising non-clinical services, like talking therapy or recovery groups through organisations such as Change Grow Live.
- Substance use, including alcohol and marijuana, particularly in times of poor mental health.

Participants also spoke about the importance of "safe spaces," defined as local, free public areas where they could socialise and access support if needed.

One participant explained, "A safe space is where you feel that you're listened to, you're respected, you're not threatened. Definitely no judgement." Examples of safe spaces included an open mic poetry forum, and a local church/food bank, offering consistency, practical help, and a community of "genuine people."

"You can see me sometimes, five o'clock in the morning, standing outside (the food bank), waiting for the doors to be opened... The pastors, you can ask them any questions. They can send you to the right place or a telephone number who you can talk to... That's the kind of person that gives me inspiration. He's been a good man to me. If it weren't for them, I would be in these shops stealing."

"The church has really been very fantastic when it comes to this. There are certain groups, where you belong to and on a weekly basis different people sharing their experiences. And for me that has really been very fantastic. So sometimes you're going through painful situations, like there was a time we were talking about migrants coming to the UK, navigating your way... It really helped a lot."

"Sometimes I go to the gym, or I go out with my friends to the café and watch sports together and play games together. And I also listen to music."

"I would go to my friends first, friends I trust. Not just any friends, friends who won't judge me. Friends who are going through what I'm going through."

"My therapy is sitting out there, getting drunk and trying to forget everything else."

"I like all the fitness, the HIIT training stuff and the bootcamp. You're sweating and then when you get home, your muscles are aching. You know what, I miss this. I miss this kind of feeling. I miss that feeling."

"I don't really like to talk to people. I will figure it out to myself."

"It really made me very good to clean my house, to clean myself, to cook my food. I found that therapeutic."



## 3.9. Suggestions for Improvement


All participants expressed an interest in non-clinical mental health services. Preferences for the type of services varied, as indicated by the range of personal coping strategies above. When asked how non-clinical services could better meet the needs of Black men in Southwark, participants offered the following suggestions:


### Community-Based Services

Most participants expressed a preference for community-based, non-clinical mental health services, believing these could better understand and address their needs. Community-based services were seen as valuable for their ability to provide meaningful and accessible support, while fostering lasting connections within the community.


## Representation and Shared Experience

Participants emphasised the importance of representation in the design and delivery of non-clinical mental health services. Seeing relatable individuals in support roles was viewed as essential for overcoming stigma, fostering trust, and cultural understanding.

 "The best counsellors that I've seen are the ones that come from the backgrounds of the people that they're helping. So, I think representation is an important thing, definitely. There's a cultural understanding that needs to happen."


 "I feel the best way to get me to share my problems is when I'm sitting around a table with other people who have similar experience like mine, you know, get me kind of motivated and kind of free...and I know I'm not going to be judged."

Additionally, participants wanted to see success stories of Black men who had benefited from mental health services, believing this would encourage others to seek support.

 "I think, if they see a representative. Black men, talking and saying the benefits of using this support. They'll be more aware of it, they'll make use of it a lot more."

## Integrated Activities

Participants indicated a preference for holistic approaches to mental health support, involving social and leisure activities such as art therapy and dance, practical guidance such as advocacy and nutritional advice, and more targeted mental health support such as peer support groups. Participants felt that integrating a variety of activities could make mental health services more approachable. For example, exercise classes could be used as a precursor to engage and build trust with service users, which could then encourage openness to discuss their mental health. Moreover, there was an emphasis on the need for practical guidance linking to social determinants of mental health, such as housing and employment.

 "Boot camps keep a lot of them together to work out together, building a brotherhood. And with that brotherhood, you build a bond, and with that bond, they can be more open to discuss their health as well."

"I think they need to be more encouraging for people to come. Sort of like, 'Oh, I want to go there because we're going to do this today'...maybe they encourage you to do a bit of gym...You speak to someone for half an hour, then you do some art work or music."



"Guidance from experienced individuals, advising people how they can focus, how they can start their business or whatever they want to do. And housing support, help finding a good and sustainable place to live."



## Governing Framework

One of the key concerns participants had towards community-based mental health services, particularly peer support models, was that they lack formal supervision and an accountability framework. Participants worried that these services may not consistently safeguard vulnerable people, provide accurate information and maintain confidentiality of their service users' information. A proposed solution was to establish a consistent framework for community-based services, which would prevent misinformation and enable service users to report misconduct to an external body, ideally within the VCS or similar. Establishing a consistent framework across community-based services would increase individuals' trust, making them more likely to engage.



"There should be some kind of supervision, not necessarily by a professional."

## Training

As participants expressed a preference for community-based services, individuals who deliver these services should receive appropriate training and support, such as mental health first aid and safeguarding information. In addition to VCS organisations, participants highlighted that key figures in the community such as faith leaders, barbers and hairdressers should receive training to support individuals who present with symptoms of poor mental health in everyday contexts.

"Train staff in the church to be mental health first aiders. It needs to be someone who does it that understands what's going on in the community."



## Accessible Locations

Most participants preferred non-clinical mental health services to be delivered in-person at consistent, accessible local sites. In-person services are seen as crucial

for fostering healthy socialisation and enabling service providers to monitor individuals' mental and physical well-being. Suggested locations included estate Tenants and Residents' Association (TRA) halls, community centres, and religious spaces. Local transport links and disabled access were noted as essential considerations when choosing premises. Additionally, some participants expressed interest in remote options, such as online groups or 1-1 phone calls with a mentor or counsellor, especially for times when they are experiencing low mental health.



"People living in estates, they've got community halls and things like that. Easy access for people to go to, whether you suffer with mental health or not. Especially in the wintertime, who wants to come out and go too far and freeze? If there was a gym around here, where people can do yoga, or whatever it is, a little bit of light exercise, it's better."

"I actually prefer a service that is really reachable, has (considered the) accessibility concerns of everyone."

## Resources for Sustained Engagement

As discussed, several participants had positive experiences with non-clinical, community-based services that ended abruptly due to lack of sustained funding. Participants emphasised that VCS groups need long-term funding to provide consistent, reliable support. Knowing that services are well-funded and have stable infrastructure would reassure service users that the support they rely on won't suddenly disappear. Furthermore, sustained engagement with individuals builds trust, helping people get the most from available services.

"It takes me some time before I trust, trust needs to be earned"

"It should find ways to be supported by the government because they could actually give more if they get more (funding)."



## Early Intervention Support

Participants identified a critical gap in early intervention support for Black men. Community-based services could either provide preventive and early support directly, or act as a bridge to mainstream mental health services. By offering timely, accessible support or guiding individuals to appropriate resources,

community-based services could help prevent mental health conditions from escalating.

## Joined-up Working

Some participants recognised that community-based, non-clinical services may not be best equipped to support individuals with more severe mental health needs. Instead, they recommended that these services collaborate closely with mainstream providers to establish a clear signposting or referral system, ensuring that individuals can access the right level of support.



“There should be some sort of signposting for people because (community-based, non-clinical services) are more like a preventive approach rather than a curative approach. So, there should be sort of a signposting in case the mental health problem goes beyond non-clinical approaches.”

This system should operate in both directions, with mainstream services referring patients to community-based support for supplementary or recuperative care. By working together, community and mainstream services can create a more seamless support network that proactively meets individuals' needs at every stage of their mental health journey.

## Inclusivity

Some participants emphasised the importance of inclusivity in community-based services. They considered the needs of various intersections of the community such as LGBTQIA+ groups, as well as various ethnic and religious groups. Some people also said they would feel most comfortable in a diverse setting, with individuals from all backgrounds, as this would indicate that they are being treated equally.

“We're only talking about being men, what about trans men? Or gay men?”

“Services should be personally tailored for individuals irrespective of their identity, gender identity, cultural identity, you know, you need to be sensitive enough to this kind of social diversity.”

“Making more groups, more space for Black men to come and share their own problems and also bringing both white and Black together and taking them together. So, in a way where you treat a Black man as the same as a white man,



his depression will be reduced. He'll be like, OK, these people take everyone as the same. He won't feel bad."

## Information and Awareness

Finally, participants expressed that more should be done to raise awareness about non-clinical mental health support, including mainstream and community-based services. This should involve targeted advertisements that use approachable, non-stigmatising language and represent Black service users. Messaging should be routed through trusted community figures, such as faith groups, barbers and beauticians.



"The mental health community should start promoting little clips and things that shows everyone from different groups using the services, different people from different communities."



"Having people out in the community who are of the same faith and community as them, to say just because you're a Christian or a Muslim, doesn't mean these things can't happen to you."

An example of non-clinical mental health services incorporating cultural and personal preferences for managing mental health, such as better promotion of how individuals can access Personal Health Budgets.

### Case Study: Community Psychology Model in Tower Hamlets



This case study highlights a culturally responsive, non-clinical mental health initiative delivered by East London NHS Foundation Trust (ELFT) through a community psychology framework, **Gardening for Health**.

#### 1. Gardening for Health

- **Target Group:** Bengali women aged 30–50 experiencing chronic pain, low mood, and isolation.
- **Approach:**





- Shifted from a medicalised model to a biopsychosocial framework, which takes a holistic view of the person and focuses on personal strengths.
  - Integrated psychology, physiotherapy, and occupational therapy with gardening activities.
  - Activities were designed around interests expressed by participants, such as gardening and recipes, which resonated with their cultural and personal coping strategies.
  - Sessions focused on physical activity, social connection, and connecting with nature
- **Outcomes:**
    - Increased physical activity among participants, and a shift in sense of identity beyond their health challenges.
    - Promoted social bonds, reduced isolation and fostered a sense of purpose.
    - Boosted job satisfaction and well-being among staff.
    - Successfully adapted to virtual formats during COVID-19 disruptions.

#### Key Lessons and Good Practices:

- Co-production and partnerships with VCS groups were critical for relevance and engagement.
- Safe, trusted environments outside clinical settings promoted accessibility.
- Activities were aligned with service users' existing coping mechanisms or areas of interest, reinforcing cultural relevance and personal empowerment.
- Focusing on strengths rather than deficits empowered participants and encouraged shared learning.

## 4. Recommendations

Based on feedback from participants, as well as our own analysis of the findings, we have compiled a summary of targeted recommendations set out below. We will share this with local stakeholders and work collaboratively to implement these recommendations.

### 1. Establish long-term funding for community-based mental health services.

Create a dedicated fund to ensure sustainable, long-term financial support for community-based, non-clinical mental health services, in line with the Mental Health Investment Standard. This includes VCS groups delivering activities to promote mental well-being for Black African and Caribbean communities. Funding opportunities should consider the insight and recommendations shared in Community Southwark's (2023) [State of the Sector report](#).

### 2. Utilise the current Creative Health programme hosted by South East London Integrated Care Board to implement targeted projects for Black men.

Allocate funding for targeted projects focusing on prevention and early intervention of mental health issues for Black men. Support the integration of arts-based approaches by developing projects that take a holistic approach to mental health, including practical and emotional support, physical activities, and creative arts and well-being practices. These should be delivered by or in partnership with VCS organisations where possible, following the principles of the [South East London VCSE Alliance Charter](#). The Creative Health Programme should draw on learnings from the National Centre for Creative Health and All-Party Parliamentary Group for Arts, Health and Wellbeing to deliver this work.

### 3. Provide training and support for VCS groups and community leaders, and evaluate the effectiveness of these courses for all service providers.

Collaborate with and provide training opportunities for community leaders and VCS organisations to promote mental health literacy, enabling them to provide informed support in community spaces. Relevant courses could include Culturally Appropriate Peer Support and Advocacy training, Mental Health First Aid, Suicide First Aid, Safeguarding, access to the NHS e-learning for health platform, and additional training requested by recipients that reflect service user and/or organisational needs to address health disparities.

Evaluate the impact of these courses for NHS staff and community-based services. for example, through peer-review, self-assessment and analysing performance data.

#### **4. Facilitate cross-sector collaboration.**

Enhance collaboration between sectors, including Public Health, Social Care, Local Medical Committee, and VCS organisations. This includes utilising insights to address gaps, improving signposting and referral pathways, and increasing the visibility of non-clinical opportunities in primary care, for example by building communications channels and resources to share opportunities and good practice more easily (Performing Medicine 2024). Southwark Council and South East London Integrated Care Board can demonstrate their commitment to cross-sector, preventative action by becoming signatories of the [Prevention Concordat for Better Mental Health](#).

#### **5. Embed the Patient and Carer Race Equality Framework (PCREF) across all mental health services.**

Integrate the PCREF in all mental health services, including non-clinical and community-based services, to ensure that equitable, safe, and culturally appropriate care is delivered by all service providers. Inform patients and local communities about the evaluation process for the PCREF and increase promotion of PCREF Network meetings. Share evaluation results to show how PCREF's implementation has brought improvements to service provision and enhanced patient experience.

## **6. Commission a 'Taster Day' event for community-based mental health services and use learnings to support the implementation of Recommendation 2.**

Commission a 'Taster Day' event to introduce community members to local mental health services, helping them become familiar with support options. This should be facilitated in an accessible, community-based location with good transport links. Consider financial support for transport and care costs to enable attendees' participation.

## **7. Consult with non-clinical and community-based mental health services to identify needs and establish good practice models.**

Identify examples of good practice in community-based services that are currently offering mental health support, to establish and export successful models following Centric's (N.d.) [guidance to evaluating Black-led initiatives](#). Consult with these practitioners to further understand how they can be supported to deliver sustainable services.

This should involve drawing on learnings from South London and Maudsley's upcoming pilot community mental health service in Lewisham (South London and Maudsley 2024b), and rolling out the Culturally Appropriate Peer Support and Advocacy service across South East London Boroughs. Other examples of good practice could include Croydon Health and Wellbeing Space (Mind in Croydon N.D) and South West London's Ethnicity and Mental Health Improvement Project (EMHIP N.D).

## **8. Implement a targeted mental health awareness campaign for Black men.**

Review and update communications about mental health services to use approachable, non-stigmatising language and highlight positive stories of Black men who have successfully used mental health support to encourage engagement. Increase awareness of non-clinical and community-based services options by disseminating information through Community Health Ambassadors, VCS organisations, social prescribing services, Public Health

outreach (i.e., Vital 5 checks), faith groups, and venues such as barber shops. NHS North Central London ICB and Islington Council's "Barber's Round Chair Project," aimed at improving mental health outcomes for young Black men, can be used as a model of good practice (Islington Council N.D).

Barrier	Recommendation(s)
Stigma	6,8
Institutional Racism	2,5,8
Trust and Confidentiality	5
Institutional Racism	2,5,7
Perceived Ineffectiveness of Services	2,3,4,6,7,8
Negative Experiences of Public Services	2,4,5,7
Concerns about Medication	1,2,4,8
Capacity of Community-Based Support	1,2,3,4
Limited Duration of Support	1,4
Treatment Thresholds	4

## 5. Conclusion

In conclusion, this report further examines the challenges faced by Black African and Caribbean communities in accessing mental health services. Our findings align with existing research, emphasising how stigma, lack of information, institutional racism, and distrust in services create significant barriers to mental health support, particularly for Black men.

By examining participants' current coping strategies, this report builds on Brown et al. (2014)'s findings that Black African and Caribbean communities in South London often rely on informal networks for mental health support. We explored participants' interest in non-clinical and community-based mental health services for their potential in providing early intervention and preventive care. This approach helped us identify ways to make mental health services more accessible and culturally appropriate for Black men.

These insights informed our recommendations to strengthen the community sector and foster holistic mental health support for Black African and Caribbean communities in Southwark. We encourage service providers and partners to collaborate in creating actionable plans to address these needs effectively.

## 5.1. Lessons, Limitations and Opportunities for Further Research

During this research, we identified several principles of good practice that we plan to carry forward to future projects. These include:

- **Collaborating with Voluntary and Community Sector (VCS) groups:** Partnering with VCS groups already embedded within communities to steer research design and support participation.
- **Establishing a timeline for long-term engagement:** This involves asking participants how they would like to be informed about the research outcomes and providing clear communication on when updates will be shared.
- **Providing tangible resources to participants:** Offering practical support, such as signposting to relevant services during the engagement phase and developing a directory of non-clinical mental health services, helps participants access support. This ensures that the research provides direct, immediate benefits to participants.
- **Identifying good practice examples:** Learning from successful examples across sectors and boroughs demonstrates how recommendations can be effectively implemented.

This research engages with individuals from Black African and Caribbean communities. Future research should disaggregate data on ethnicity, and migrant and refugee status, to explore differences in the perceptions, experiences and needs of different communities within this wider group.

Moreover, targeted engagement with Black men who identify as LGBTQIA+ would help to better understand their specific needs. We recognise that individuals who identify as LGBTQIA+ may not have felt able to participate unreservedly in our focus groups, which may have privileged the experiences of heterosexual, cisgender men. As we did not collect data on sexuality, we cannot ascertain the representativeness of our participant sample in this regard.

## 5.2. Next Steps

We will share this report with key stakeholders including:

- Partnership Southwark Strategic Board Meeting
- Southwark Council Health and Wellbeing Board
- Southwark Council Health Scrutiny Committee
- Southwark Culture Health & Wellbeing Partnership (SCHWeP)
- Southwark Council and NHS South-East London ICB Integrated Commissioning
- King's College Hospital, Guy's & St Thomas' and South London and Maudsley NHS Foundation Trusts
- Southwark Adult Social Care
- Southwark Primary Care Network
- Southwark Independent Advisory Group
- Impact on Urban Health
- Peter Minet Trust
- Maudsley Charity
- Peckham Settlement
- South East London Mind
- Black Thrive
- Southwark Wellbeing Hub
- London Healthwatch Staff Network
- Healthwatch England Research and Insight Network

Statutory partners will be asked to respond formally to the recommendations made in this report. Responses will be available to view on Healthwatch Southwark's website. We will then carry out reviews with partners six and 12 months after this report's publication, to monitor progress against our recommendations.

We will produce a summary version of this report, as well as a map of VCS organisations offering mental health support for Black African and Caribbean communities in Southwark. These resources will be available on our website and shared directly with participants. We will also provide updates to participants six and 12 months after the report's publication about our impact, and share a one year update on our website and social media.

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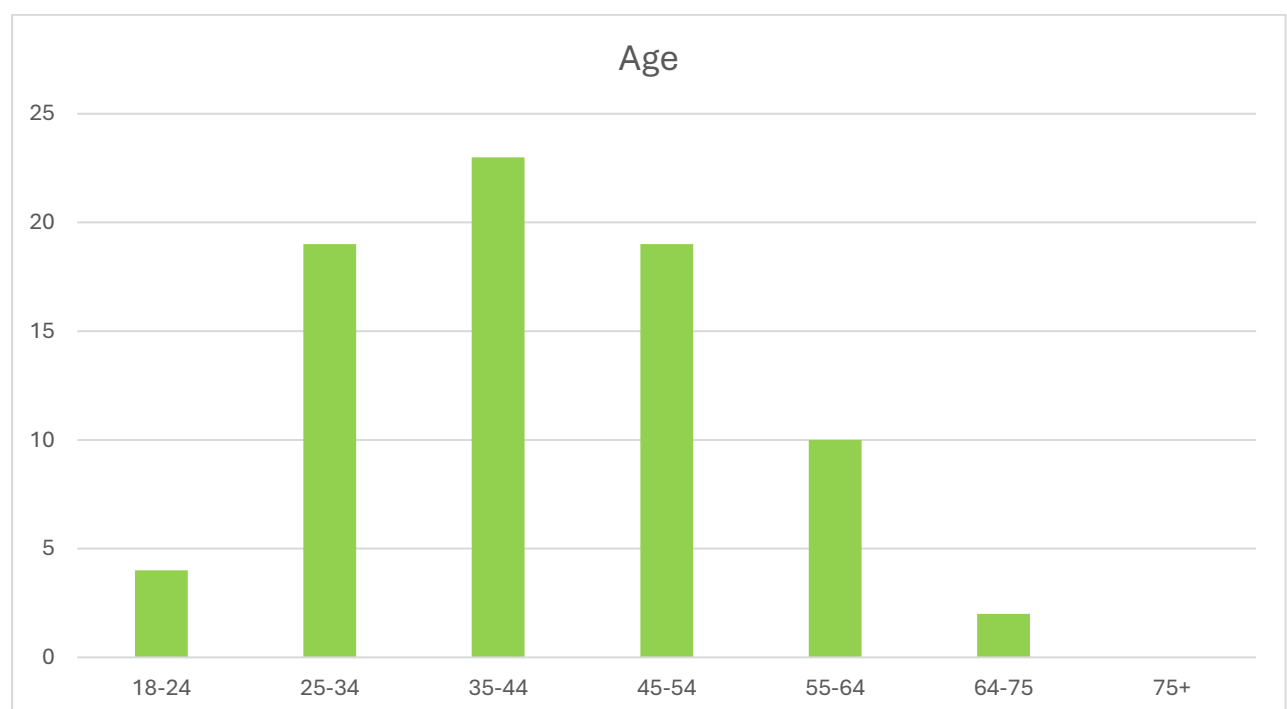
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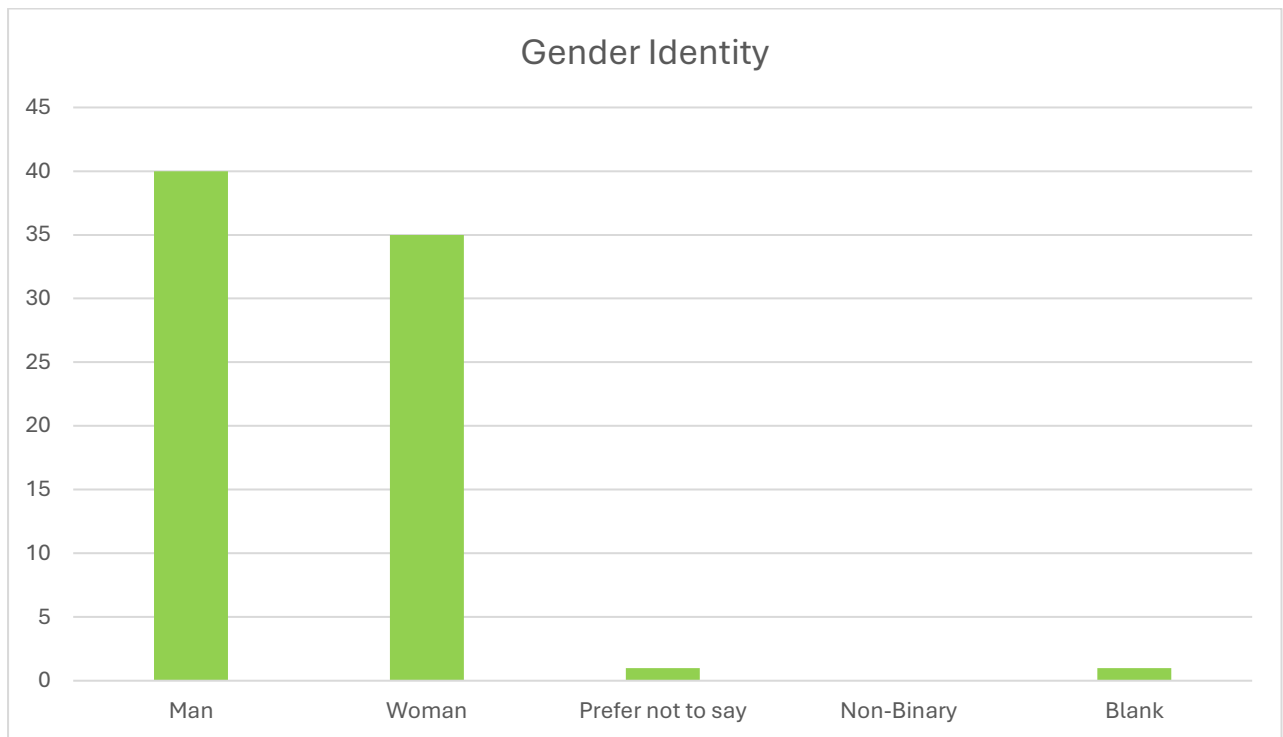
## Appendices

### Appendix 1- Equalities Data

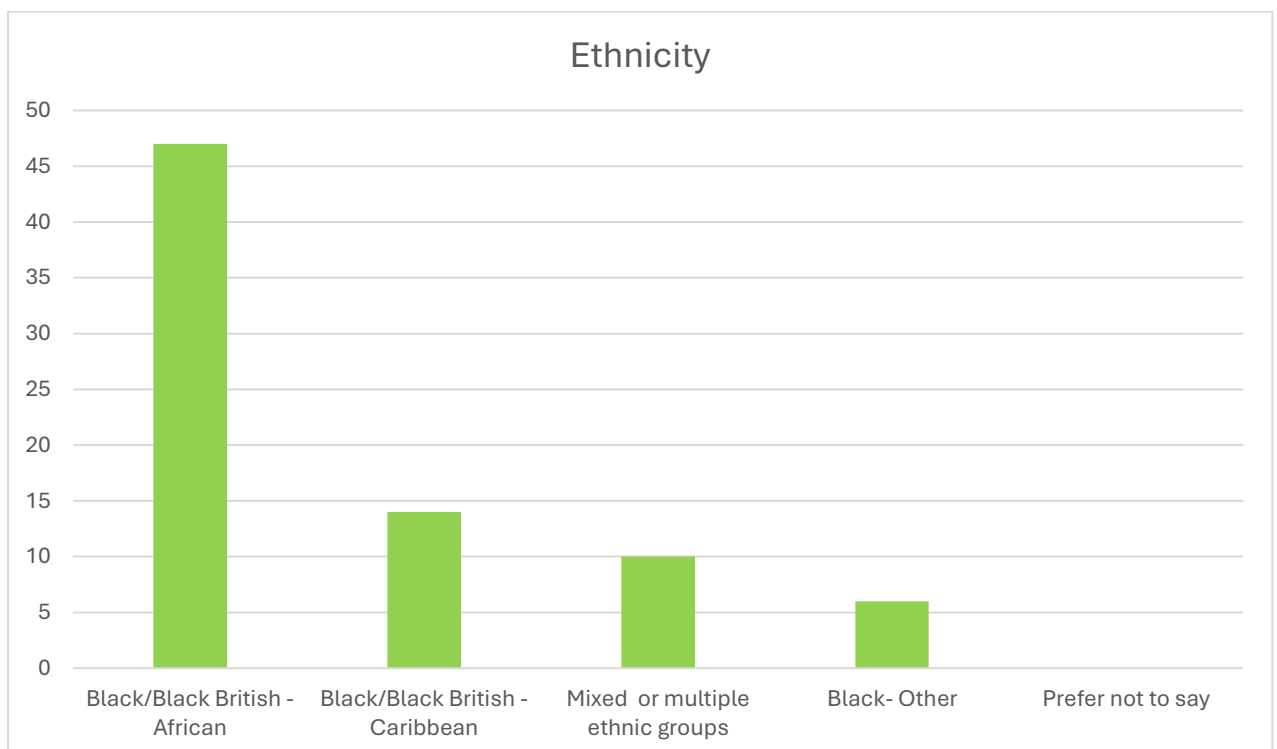
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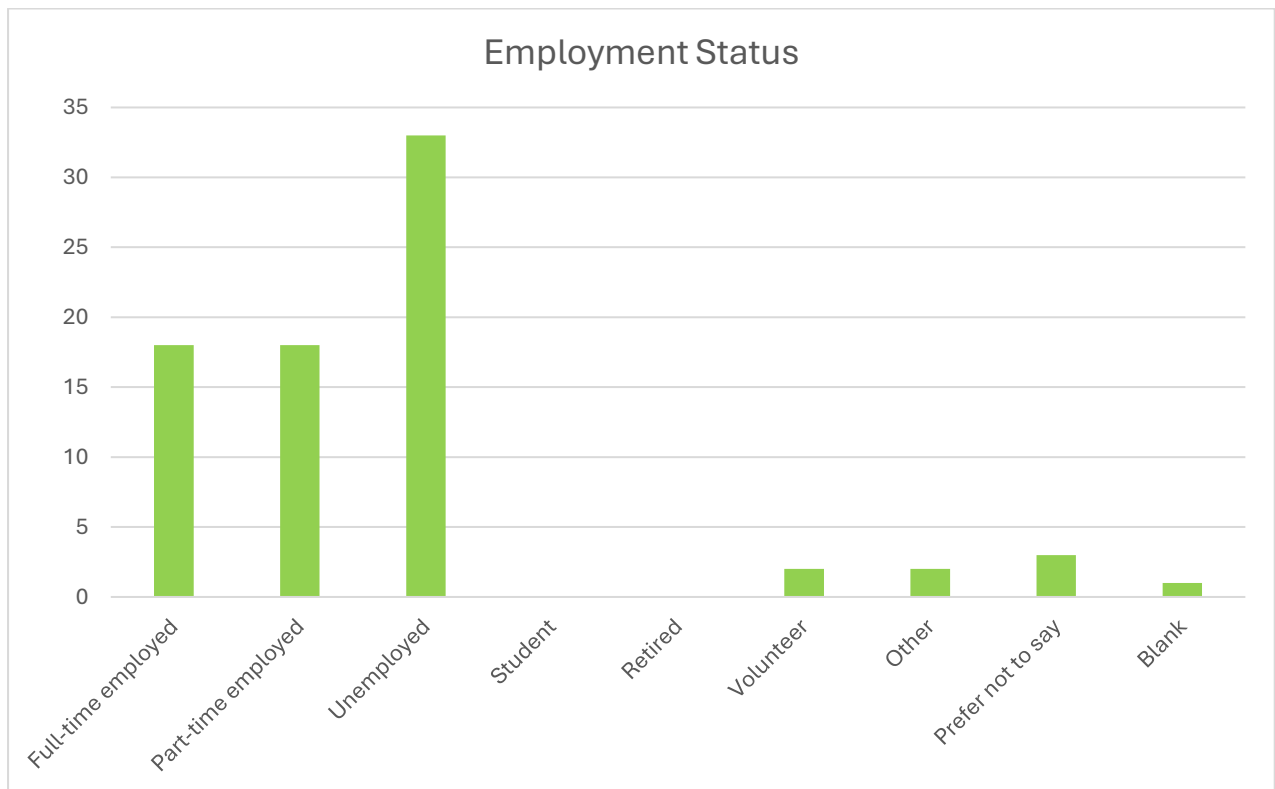
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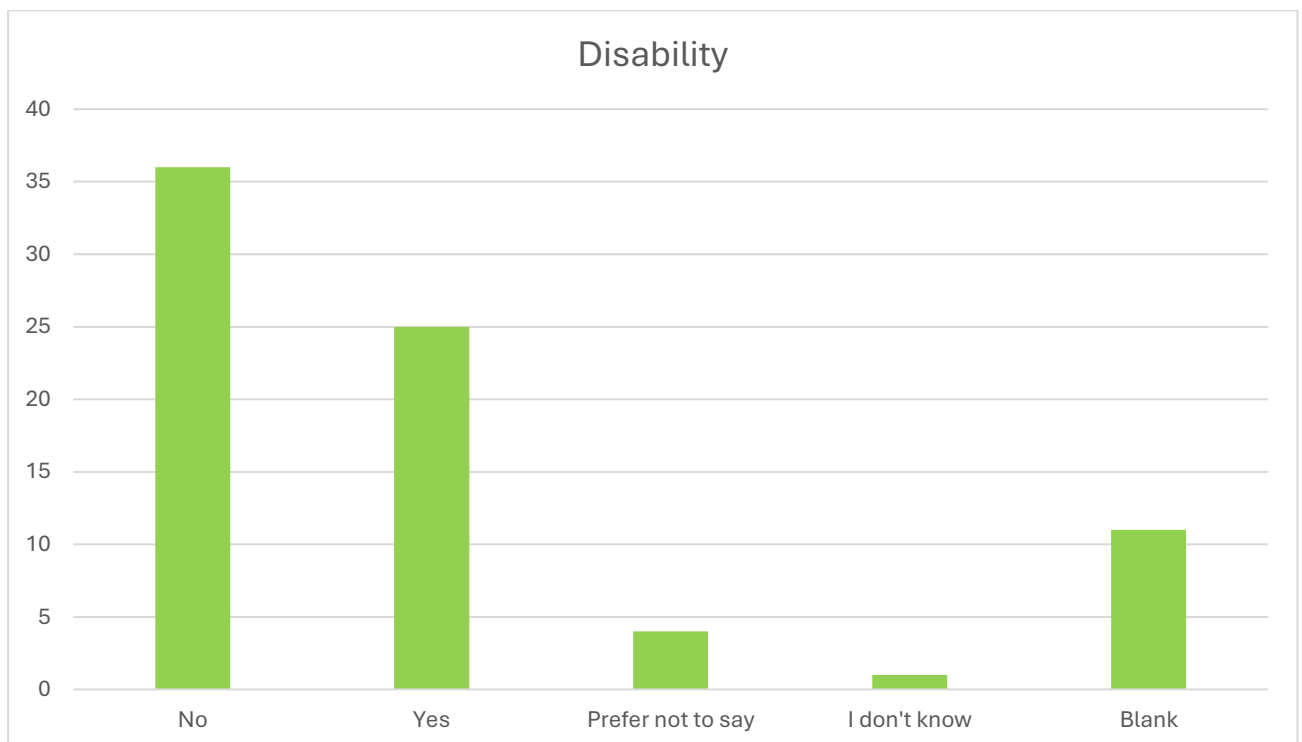
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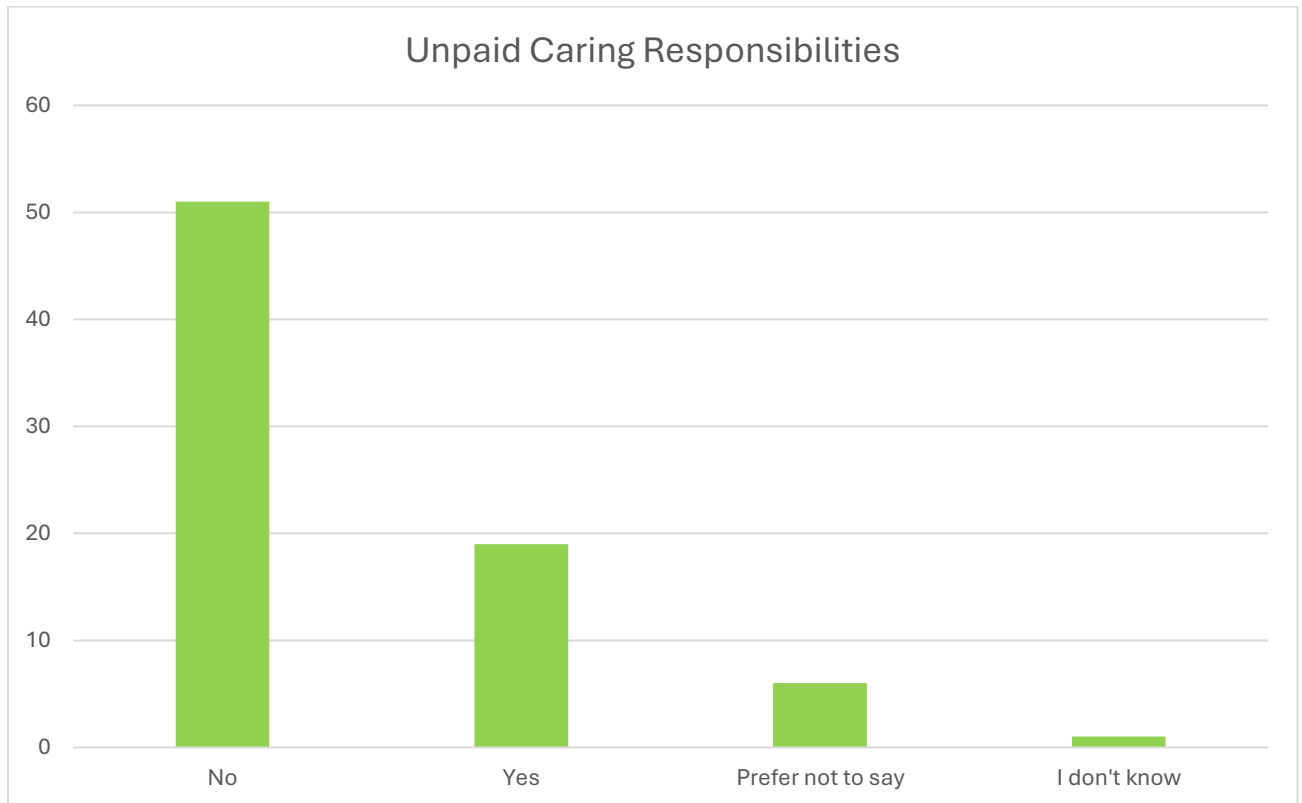
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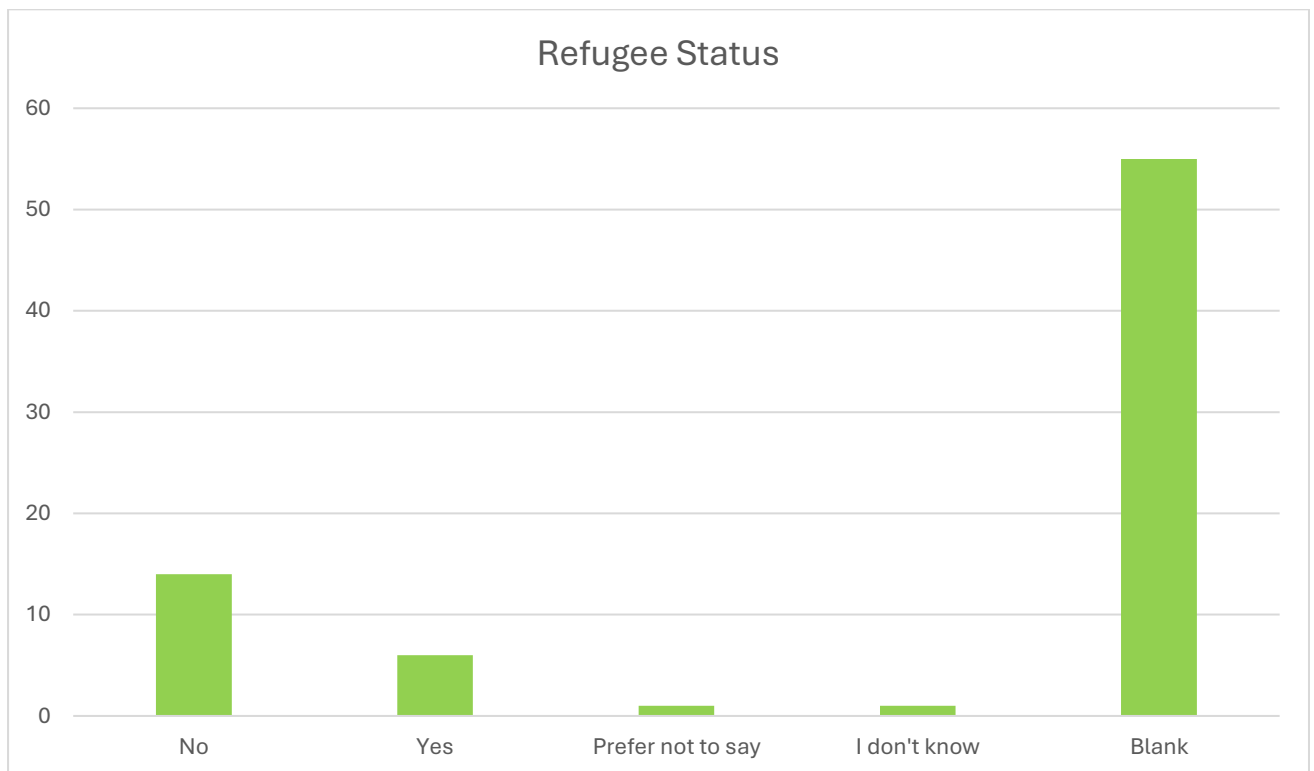
## Disability



## Unpaid Caring Responsibilities



## Refugee Status



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\*The Equalities, Diversity and Inclusion monitoring form used by Healthwatch Southwark in the first engagement cycle (representing 55 participants), did not ask participants about their refugee status. Therefore, we only have this data for participants in the second engagement cycle (24 participants).

## Appendix 2- Survey

### Survey

**Healthwatch Southwark is your independent health and social care champion. We listen to local people about what matters to them and ensure that NHS leaders and decision-makers take this on board to drive improvements. More information about Healthwatch Southwark and our work can be found [here](#).**

**Resident feedback has suggested that Southwark's Black/African/Caribbean communities face challenges/issues with accessing mental health services. As a result of this initial feedback, Healthwatch Southwark has prioritised exploring the problems/challenges further and has decided to engage with the wider Black/African/Caribbean community to hear your experiences and gather your suggestions for improving services/access.**

**This survey will be open from the 7th of December and close 30th of April 2023 at 5 pm.**

**We want to highlight that we treat your data as confidential and protect it accordingly. We will always make sure that your data is protected and treated securely. Please read our complete [Privacy Statement](#) here.**

**If you have any questions about the survey or would like support completing the study, please get in touch with us via email: [at info@healthwatchsouthwark.org](mailto:info@healthwatchsouthwark.org) or phone: at 02038486546**



\* 1. Please tell us where you have tried to get help for your mental wellbeing over the last 12 months. Please mark all that apply.

- ☐ **Talking Therapies Southwark (provided by South London & Maudsley)**- [A service providing cognitive behavioural therapy (CBT), online CBT and workshops for common (and milder) mental health conditions depression, anxiety, stress, insomnia and post-traumatic stress disorder (PTSD).
- ☐ **Integrated Psychological Therapy Team (IPTT)**- This is a specialist psychological therapy service (secondary care) that provides assessment, care and treatment including talking therapies for people aged 18-65 who have a severe mental illness and live in the London borough of Southwark. Referrals are accepted by mental health professionals from IAPT and Community Mental Health Teams (CMHT's).
- ☐ **Community Mental Health Teams (CMHT)** - Used by SLaM to cover all the other services including community mental health teams, IPTT, psychosis, psychiatric assessment and liaison, crisis line - these are all being merged into one 'stepped care' model
- ☐ **Mental health assessment** at the Emergency Department at Kings/St Thomas hospitals
- ☐ **Drug and Alcohol Service**- by Change Grow Live
- ☐ **Mental Health Team for older adults** (Southwark) provides community-based assessment, treatment and care for people aged over 65 who have mental health problems and younger people with a diagnosis of dementia.
- ☐ **Southwark Home Treatment Team**- A way of helping people at home rather than in hospital.
- ☐ **Crisis Line/ Crisis Assessment**- Offers a range of different crisis support services tailored to individual needs.
- ☐ **Inpatient Care (Acute Ward or Intensive Care Unit)** - Provides care to patients admitted to the acute ward or Intensive Care Unit with ongoing needs.
- ☐ **Emergency department for mental health**- Provides emergency care to patients with acute mental health needs.
- ☐ **Specialist mental health services** such as eating disorders, perinatal, memory service, learning disabilities - please state
- ☐ **Community Mental Health Support** ( community organisations like Lambeth and Southwark Mind and Southwark Wellbeing Hub, Others-please specify below)
- ☐ **Local general practitioner** (GP) or other health professional at your GP practice
- ☐ **Peer Support**
- ☐ **I could not access any mental health services**
- ☐ Other (please specify)

**\* 2. Please tell us about the challenges/ issues you experienced. (examples: what made it difficult to access services? translation issues, inability to get a timely appointment, staff behaviour etc. Provide as much details as possible, letting us know which service/s you are talking about)**

Challenge/Issue 1

Challenge/Issue 2

Challenge/Issue 3

**\* 3. What improvements would you like to see to make your experience better (your suggestions for improving the services you used)?**

**4. What additional support can the NHS provide to help people struggling with mental health access?**

## **Appendix 3- Participant Information Sheet**

We are excited to invite you to participate in our upcoming research study. Your involvement will provide valuable insights and contribute significantly to advancing knowledge in our field. We assure you that your participation is entirely voluntary, and all information collected will be kept confidential. Your informed consent and ethical treatment are our top priorities.

The focus of this project will be on non-clinical and community-based mental health interventions, as these services can prevent people from reaching crisis point, alleviate stigma and hesitancy surrounding mental health support, and can provide culturally appropriate support.

### **What is the purpose of the study?**

#### **Project aims:**

- To develop relationships and partnerships with residents from Black African and Caribbean communities in Southwark,
- To provide a platform for these groups to voice their views and represent their own voice,
- To find out the key issues, needs and priorities of the community so that we can share them with decision makers (services providers/ stakeholders/ commissioners) to raise awareness and drive change,
- To help them develop direct links with these senior representatives, empowering them to influence services on their own terms.

### **Why have I been invited?**

We are particularly keen to engage with **men from Black African and Caribbean backgrounds**.

### **Do I have to take part?**

The answer is 'No', taking part is entirely voluntary.

Participant can withdraw if they later change their mind, without giving a reason;

Withdrawal will not affect accessing any use of services.

### **What will happen to me if I decide to take part?**

You will be joining a focus group, sharing your experiences of mental health services and ways to improve them. The sessions will last an hour and you will be provided with refreshments during the sessions. Each session will be recorded to ensure an accurate reflection of the discussion is written up.

### **Will my General Practitioner/family doctor (GP) be informed of my participation?**

No.

**Will my taking part in the study be kept confidential?**

We will ensure that information is kept secure and that participants will not be identified by study report. We will keep identifiable data should participants wish to withdraw their data; we can easily remove the information provided.

**What if something unexpected happens or I feel uncomfortable?**

We have trained and qualified mental health first aiders on hand for you to speak to if you need additional support during the session. You will receive a goody bag of signposting services and self-help information to support your wellbeing.

**Will I be reimbursed for taking part?**

You will be compensated for your time, £20 Love2Shop vouchers will be issued at the end of each session electronically or by your preferred method

**What happens at the end of the study?**

Once we have completed all engagement, we will analyse the information provided to compile a report. Participants will not be identified from any report or publication placed in the public domain (for instance, with images of faces). Reports will be published on our website as well as provided to stakeholders who will respond to the outcome recommendations of our study.

- o Publishing research findings;
- o Presenting your findings at conferences, in health and social care decision maker meetings.
- o Feeding back findings to participants themselves.

**What if there is a problem?**

If you wish to complain, or have any concerns about any aspect of the way you have been approached or treated during the course of this study, you should contact Ruman Kallar via email: [ruman@healthwatchsouthwark.org](mailto:ruman@healthwatchsouthwark.org) or call on 07599653479

**Participation in future research:**

If you have provided personal details for this study such as your email address and phone number, you will be added to our email list database to be kept up to date with the work of Healthwatch Southwark. Please note this does not oblige you to take part in future research.

**Further information and contact details:**

Towards Inclusive Healthcare: Rethinking mental health services for Black African and Caribbean communities | Healthwatch Southwark | January 2025

Please contact Healthwatch Southwark

Main Office Number: 020 3848 6546 / 020 3848 6540

11 Market Place, Bermondsey, SE16 3UQ

Web: [www.healthwatchsouthwark.org](http://www.healthwatchsouthwark.org)

General Email: [info@healthwatchsouthwark.org](mailto:info@healthwatchsouthwark.org)

## **Appendix 4- Participant Consent Form**

Name of Research:

If you agree, please initial box

1. I confirm that I have read the information sheet for this study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

☐

3. I understand that relevant sections of my data collected during the study may be looked at by individuals where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.

☐

5. I agree to audio recording and the use of anonymised quotes in research reports and publications.

☐

6. I agree to take part in this study.

☐


---

Name of Participant

Date

Signature

---

Name of Person taking

Date

Signature

consent

## **Appendix 5- Focus Group Guide (2023)**

- 1.a) What do you think about using mental health services?
- 1.b) How is using mental health services viewed in your community?
  
- 2.a) Who is the first person you turn to if you are struggling with your mental health?
- 2.b) Have you used any mental health services if so which ones?
  
3. How was your experience using the service?
  
4. Are mental health services culturally appropriate to your needs?
  
5. Did you experience any challenges/ barriers to accessing and or using the services? If so, can you describe them?
  
6. Are there any improvements you would like to see made to these services? If so, can you describe them?

## Appendix 6– Focus Group Guide (2024)

Research Question:

How can non-clinical mental health support be optimised to meet the needs of Black men in Southwark?

### Understanding and Awareness

1. What kind of mental health support services are you aware of?

If no non-clinical services are mentioned, ask follow up:

2. Are you aware of any support services for mental health that do not involve diagnosis and medication?

### Preferences and Experiences

3. Have you or anyone you know relied on activities within your community to support your mental health? (for example, faith groups, a sports group, arts and music groups)

Prompt 1: If so, what was the experience like?

Prompt 2: If no, what do you do, if anything, to support your wellbeing?

4. Would you be interested in using a non-clinical mental health service?

Prompt: If yes, what type of services would you like to use? (e.g. peer support groups, art sessions, talking therapies, exercise)?

### Access and Barriers

5. As a Black man, have you experienced challenges in finding and using non-clinical mental health support?

Prompt: If so, can you explain those challenges?

### Engagement and Impact

6. How effective do you think services are at improving Black men's mental wellbeing?

Prompt: In your opinion, what should be done to make them more effective?

7. Do you think that non-clinical mental health services meet the cultural needs of Black men in Southwark?



Prompt 1: How so? / Can you tell us more about why you think that?

Prompt 2: What do you think needs to be done so that non-clinical mental health services better meet the needs of Black men in Southwark?’

8. Some non-clinical mental health services are trying to become more accessible to Black men. For example, they might provide Anti-Discrimination and Race Equality training to staff or run specific talking groups for Black people.
  1. What do you think about these sorts of anti-discrimination activities?
  2. What else could services do to become more accessible and inviting for Black men in Southwark?
9. How would you like Healthwatch to keep you informed about the outcomes of this project?

<b>Meeting Name:</b>	Health & Wellbeing Board
<b>Date:</b>	13 March 2025
<b>Report title:</b>	Annual Public Health Report
<b>Ward(s) or groups affected:</b>	All
<b>Classification:</b>	Open
<b>Reason for lateness (if applicable):</b>	Not applicable
<b>From:</b>	Director of Public Health - Southwark Council

## RECOMMENDATION(S)

1. That the Health and Wellbeing Board note the findings of the Annual Public Health Report (APHR) 2024-25 and support the recommendations.

## BACKGROUND INFORMATION

2. Each year, Directors of Public Health in local authorities across England fulfil a statutory requirement to produce an annual report on the health of their population. The report is used to inform partners and residents about the health of Southwark's communities, as well as provide evidence on key health and wellbeing needs.
3. The report is shared with partners across the Council and external partners, including the voluntary and community sector and residents. This report is published on the council website, accessible via:  
[www.southwark.gov.uk/insight-hub](http://www.southwark.gov.uk/insight-hub)

## KEY ISSUES FOR CONSIDERATION

4. The Director of Public Health chose inequalities as the theme of this year's report.
5. Health inequalities are avoidable, unfair, and systematic differences in health between different groups of people. Health inequalities can take many forms, from the ability to access services, to the experience of services and the health outcomes that are achieved. They are driven by inequalities in wider society and the conditions in which we are born, live and age.
6. Health inequalities are not inevitable. They can be reduced and removed through coordinated and sustained effort to improve the social and economic conditions in which we live. If we are to significantly reduce the inequalities in our borough, such action needs to be taken at scale and be proportionate to the needs of different communities.

7. The report sets out examples of key health inequalities in the borough, between neighbourhoods and population groups. The report also highlights key populations groups in Southwark that experience some of the greatest inequalities.
8. There are many examples of good practice of work to tackling inequalities across Southwark, being delivered by the Council, NHS and community & voluntary sector. These cover not only initiatives to identify and improve health conditions, but to address the social and economic conditions in which our residents live.
9. Further work to build on these examples is required if we are to significantly reduce inequalities in the borough. The report makes 10 recommendations that aim to improve the health of all residents in Southwark and reduce the inequalities that too many face.
10. The final section of the report outlines progress against the recommendations contained in the Annual Public Health Report 2023-24, which focused on Air Quality.

## **Community, equalities (including socio-economic) and health impacts**

### **Community impact statement**

11. The Annual Public Health Report emphasises the need to involve communities in action to improve health and reduce inequalities. It highlights examples of work which has taken place in the last year which has involved residents and community organisations in developing and delivering programmes to tackle inequalities. It concludes with recommendations on collective action, using your voice, involving communities in decision-making, and ensuring action is equitable.

### **Equalities (including socio-economic) impact statement**

12. The Annual Public Health Report provides an overview of health inequalities in Southwark. It identifies population groups who are most at risk of poor access, experience, and outcomes, and recommends that interventions take this into account when prioritising and targeting measures.

### **Health impact statement**

13. The Annual Public Health Report focuses on ways to improve health and wellbeing, and to reduce the inequalities which exist in the borough. The report concludes with recommendations for all partners to help reduce these inequalities and improve health for all residents.

### **Climate change implications**

14. The report provides an update on action to improve air quality and reduce the health impacts of poor air quality and climate change in Southwark. Climate change implications of initiatives highlighted in the report are address through the relevant governance processes.

**Resource implications**

15. There are no direct resource implications of the Annual Public Health Report.

**Legal implications**

16. There are no direct legal implications of the Annual Public Health Report.

**Financial implications**

17. There are no direct financial implications of the Annual Public Health Report.

**Consultation**

18. The Annual Public Health Report was developed through conversations with internal and external partners to understand how Southwark is acting on inequalities, and to inform the recommendations section. There was no formal consultation.

**SUPPLEMENTARY ADVICE FROM OTHER OFFICERS****Assistant Chief Executive, Governance and Assurance**

19. None sought.

**Strategic Director of Resources**

20. None sought.

**Other officers**

21. None sought.

**APPENDICES**

No.	Title
Appendix 1	APHR 2024-25 Tacking Health Inequalities

**AUDIT TRAIL**

<b>Lead Officer</b>	Sangeeta Leahy - Director of Public Health		
<b>Report Author</b>	Tom Seery and Chris Williamson		
<b>Version</b>	Final		
<b>Dated</b>	26/02/2025		
<b>Key Decision?</b>	No		
<b>CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER</b>			
<b>Officer Title</b>		<b>Comments Sought</b>	<b>Comments Included</b>
Assistant Chief Executive, Governance and Assurance		No	No
Strategic Director of Resources		No	No
<b>Cabinet Member</b>		Yes	Yes
<b>Date final report sent to Constitutional Team</b>			4 March 2025

# A Fairer Future: tackling health inequalities in Southwark

*Southwark's Annual Public Health Report 2024*

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# 1. Introduction

This year's Annual Public Health Report highlights work across our borough to both improve health and reduce inequalities. With examples from the Council, NHS and the Community & Voluntary Sector, it is clear that we all have a role to place in tackling the inequality faced by our communities.

While there are many great projects and programmes in Southwark aimed at improving health and wellbeing, there is much more to do. Many of our residents continue to face inequalities in their access and experience of services that should be supporting them. This is contributing to the large inequalities we see in health outcomes in the borough. This is both unjust and avoidable.

Locally we have a strong focus on embedding approaches to tackle health inequalities across all policy making, services and delivery. This is the founding principle of our plans to improve health in the borough. However, if we are to truly improve the lives for all our residents, and provide a fairer future for everyone in Southwark, partners must work together and redouble their efforts to reduce inequality. This will require a continued commitment to listen and work with our communities to design services that address their needs. We must also ensure that tackling inequality is embedded in our core services and programmes, and not just addressed through targeted initiatives. Only by ensuring tackling inequality is embedded in everything we do, can we truly narrow the gap.

This report shows that tackling inequality is everyone's business and we must go further in our efforts if we are to close the gap. A fairer future is possible if we work together.



**Cllr Evelyn Akoto**

**Cabinet Member for Health & Wellbeing**



Where we live can impact our health, including how long we can expect to live. Health inequalities are unfair and avoidable differences in health that exist because of differences in the conditions in which we are born, grow, live, work and age and due to inequalities in distribution of power, money and resources. These differences are not evenly distributed, leading to unequal access to support and the burden of ill health.

The life expectancy for Southwark's general population has increased since the early 2000's, with the gap between that of the average resident and people living in the rest of London and England narrowing considerably during these past decades. However, these improvements are not experienced equally across our neighbourhoods and communities. People living in more socio-economic disadvantaged areas and those from Black, Asian and minority ethnic backgrounds are living shorter lives and spend more of their lives in ill-health.

To help tackle the complexities of local health inequalities, we need to redouble our efforts, using the strength of all partners to develop programmes that put health inequalities at the forefront of their agenda. This report aims to provide an overview of health inequalities in Southwark, approaches used to better understand our communities, and highlight examples of good practice across the local system that aim to reduce health inequalities.



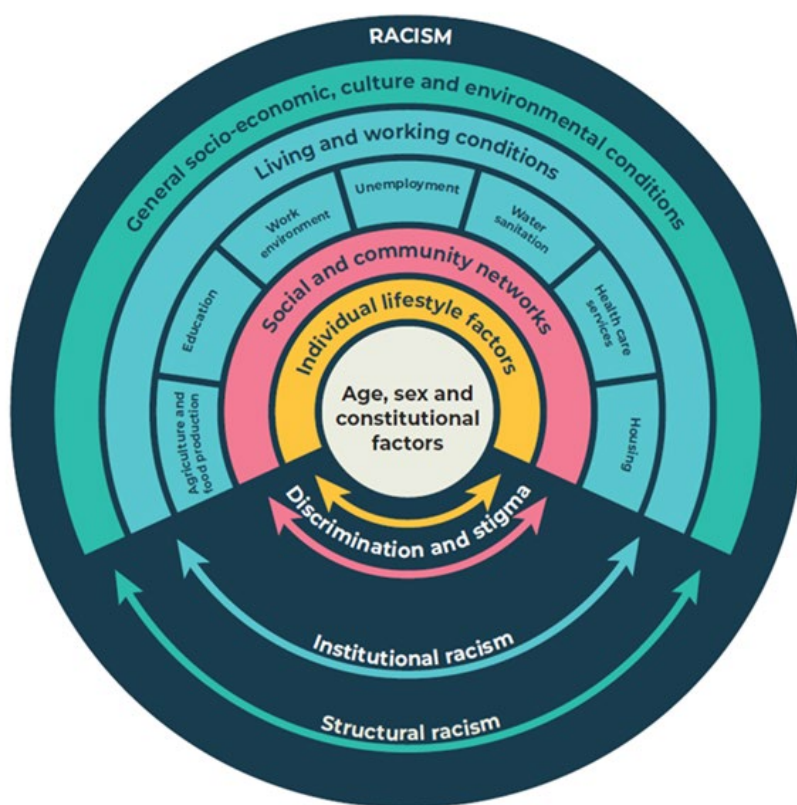
**Sangeeta Leahy**

**Director of Public Health**

## 2. Understanding Health Inequalities

### What are health inequalities?

Health inequalities are avoidable, unfair and systematic differences in health between different groups of people. Health inequalities can take many forms, from the ability to **access** services, to the **experience** of services and the health **outcomes** that are achieved. They are driven by inequalities in wider society and the conditions in which we are born, live and age.

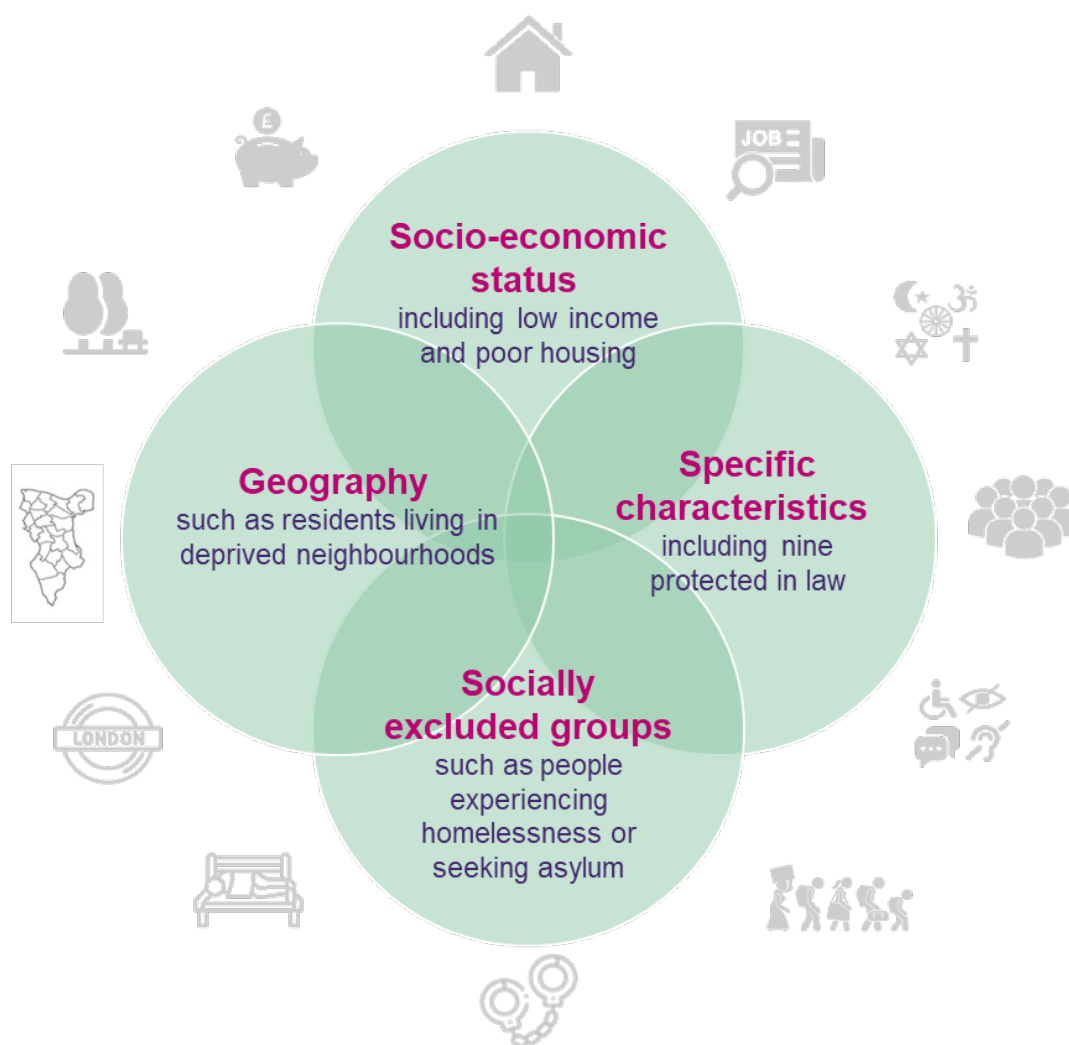


It is these social and economic factors, such as income, employment and housing, which have the largest impact on our health, and health inequalities. Furthermore, many of our residents continue to experience stigma, racism and discrimination, exacerbating inequalities still further.

The impact of health inequalities can build and accumulate throughout life. For example, adverse childhood experiences can impact educational attainment, and lead to poorer quality employment. This can lead to poorer health as a result.

**Figure 1.** The wider determinants of health (adaptation of Dahlgren & Whitehead model)

Health inequalities are often viewed through the lens of their personal characteristics and the circumstances in which they live. We know that people with specific characteristics experience greater inequalities than others, such as those from minority ethnic communities, or socially excluded groups such as those which are seeking asylum. We also know that certain communities and neighbourhoods are impacted by significant social and economic disadvantage, and poorer housing. The complex interplay of these factors, or **intersectionality**, can magnify the inequalities experienced by residents. This is where our greatest effort is required.



**Figure 2.** Dimensions of health inequalities

## Describing health inequalities

It is important to recognise that health inequalities can be exacerbated by the way in which we talk about them.

When conversations about health inequality link poorer outcomes with individual identities, groups and communities can be left feeling that they have poor health because of who they are, rather than the circumstances in which they live. This can encourage unfair bias, stigma, and discrimination. It can also lead members of stigmatised groups to expect poorer health experiences and outcomes, simply because of their identity. Such fears and expectations are disempowering, stressful, and can limit people's desire to seek support from health and care services, all of which can worsen health outcomes.

Evidence shows that health inequalities are largely caused by unfair social and economic systems imposed on people, rather than individual factors such as genetic make-up or lifestyle choices. Therefore, the words used in health inequality conversations and reports need to clearly indicate that **unfair social systems are the root cause of health inequality, not individual factors**.

When terms such as “homeless” or “ethnic minority” are used to label people, the identities of individuals are reduced to a single characteristic or experience, ignoring the other roles and attributes that they may have. For this reason, it is important to use phrases such as “people from minoritised ethnic groups” and “people experiencing homelessness” to communicate that the inequality is unfair social systems, not the individual characteristics of the people affected.

## Ways to reduce health inequalities

**Health inequalities are not inevitable.** They can be reduced and removed through coordinated and sustained effort to improve the social and economic conditions in which we live. If we are to significantly reduce the inequalities in our borough, such action needs to be taken at scale, and be proportionate to the needs of different communities.



Improving social and economic outcomes will have the most significant impact on health inequalities in the borough.



Universal interventions have the greatest impact, but must be proportionate, with those most in need receiving the greatest support.



Increasing focus on early intervention and prevention is the most cost-effective way to tackle inequalities, and leads to better outcomes for residents.



Programmes should be designed, implemented and reviewed with residents and communities for them to be most effective.



Effective monitoring is crucial to ensuring services are reaching those most in need and delivering successful outcomes.

## 3. Health Inequalities in Southwark

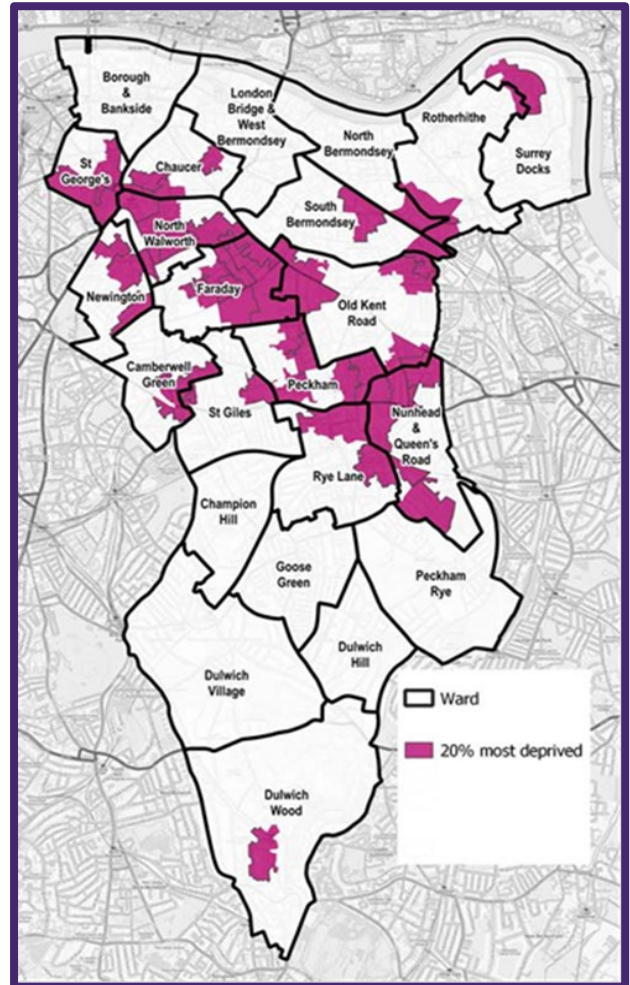
### Inequalities between neighbourhoods

Health inequalities in Southwark vary between each community and neighbourhood. We know that there are geographical differences in life expectancy across the borough, and that the influences on life expectancy can differ depending on the social, economic and physical environment. Understanding the relationship between the influences at the neighbourhood level is essential. To tackle inequalities we must give special consideration to parts of the borough and neighbourhoods that are most disadvantaged and to those groups with the greatest needs.

Within Southwark the greatest levels of social and economic disadvantage are seen across the centre and north of the borough. However we also see pockets of disadvantage in the south.

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 these neighbourhoods.

Faraday ward has the highest level of socio-economic disadvantage in Southwark, with Dulwich Village ward having the lowest. The gap in life expectancy between the two neighbourhoods is 5 years for females and over 8 years for males.



**Figure 3: 2019 Index of Multiple Deprivation quintiles.** Source: Ministry of Housing, Communities and Local Government 2019. English Indices of Deprivation. © OS crown copyright and database rights 2024. Ordnance Survey (0)100019252.



## Our poorest outcomes are concentrated in neighbourhoods experiencing the greatest levels of socio-economic disadvantage

### Faraday

has the highest level of socio-economic deprivation



### Dulwich Village

has the lowest level of socio-economic deprivation

**64%**

from Black or other minoritised ethnic groups



**33%**

of children under 16 live in poverty



**10%**

of adults are unemployed



**7% above**  
average London crime rate



**46%**

of Year 6 pupils overweight or obese



**4% above**  
average national emergency hospital admission rate



**78.8**  
male life expectancy  
**84.5**  
female life expectancy



**21%**

from Black or other minoritised ethnic groups

**5%**

of children under 16 live in poverty

**3%**

of adults are unemployed

**30% below**  
average London crime rate

**17%**

of Year 6 pupils overweight or obese

**45% below**  
average national emergency hospital admission rate

**87.1**  
male life expectancy  
**89.5**  
female life expectancy

**Figure 4:** Geographic health inequalities in Southwark infographic

## Inequalities between people

There are key population groups in the borough which face significant inequalities in not only health outcomes, but also in their access and experience of services which should be there to support them. Many of these population groups also live in our most disadvantaged neighbourhoods, magnifying the inequalities they face.

- **Residents from a Black ethnic background are more likely (22%) to ‘sometimes or often’ experience unfair treatment when compared to residents from a White ethnic background (16%).**
- **Women report a higher level of difficulty (45%) accessing services when compared to men (36%).**
- **Disabled residents are more likely (44%) to report their health as ‘bad’ when compared to the overall population (11%).**

We require a more joined-up approach to identify and tackle health inequalities within population groups in the borough. A place-based approach which identifies residents living in poor health, and tailors support for them can help reduce the large inequality that we currently see in the borough.

Notwithstanding existing efforts to support population groups at greater disadvantage for ill-health, we still lack a co-ordinated, system-wide approach that prioritises interventions for those in greatest need. We have identified 6 key population groups which partners across the system should focus on when tackling health inequalities.



Carers	Residents with disabilities	LGBTQIA+	Asylum Seekers & Refugees	Rough Sleepers	Black & Ethnic Minorities
Those providing unpaid care are more likely to report poor health than those not providing care. They are also more likely to experience loneliness and social isolation. The number of cared-for people is increasing and surviving longer but with more health issues, so carers' burden and duration of care are growing.	Residents with physical and/or learning disabilities are more likely to experience a range of health conditions and have a lower life expectancy than the general population. Those with disabilities often experience barriers when accessing services, from transport through to the understanding of staff.	Key health challenges disproportionately impact those identifying as LGBTQIA+, with higher levels of smoking, alcohol use, incidence of some cancers and mental ill-health. LGBTQIA+ individuals also experience discrimination and homophobia when accessing services.	Asylum seekers and refugees have multiple, complex health and wellbeing needs. They often experience trauma-related mental health issues and challenges with social integration. They often have poor access to services as a result of language barriers, difficulty navigating an unfamiliar health system.	Those sleeping rough are much more likely to die young, with an average age of death of 47 years of age, compared to 77 amongst the general population.  People who experience homelessness often struggle to access quality health and care and often attend emergency care.	Residents from minority ethnic backgrounds are more likely to live in disadvantaged communities, develop a greater number of long-term conditions, have poorer mental health, and experience discrimination and racism when accessing services.
Over 18,000 residents provide some level of unpaid care, equivalent to 6% of the population  Nearly a quarter provide over 50 hours of care a week, equivalent to nearly 5,000 residents.	Over 42,000 residents recorded a disability at the time of the 2021 Census  Old Kent Road, South Bermondsey and Nunhead & Queen's Road, have the highest levels  Of those in Southwark who were disabled at the time of the Census, half were aged 50 or over.	Approximately 21,000 residents identify as gay, lesbian, or bisexual – 4th largest in England.  Approximately 3,200 residents identify as trans or non-binary - 5th largest in England.  The Burgess Park area has the largest LGBTQIA+ community.	By September 2022 the asylum seeking population in Southwark increased to almost 2,000  In addition there are hundreds of Afghan and Ukrainian refugees in the borough.	In 2022/03 Southwark had the 6th largest rough sleeper population in London, with 549 individuals identified.  The majority were male (86%) and more than half were from a minority ethnic background (56%).	Around half of residents identify as from a Black, Asian or minority ethnic background. The largest single group is Black African (16%). There is a significant Latin American community in the borough, with 9,200 residents.  Around 40% of people living in the borough were born outside the UK.

**Figure 5:** Key population groups experiencing inequalities in Southwark.

## 4. Local Action on Health Inequalities

Our Joint Health & Wellbeing Strategy sets out the health priorities for the borough, and emphasises that tackling inequalities is everyone's business. We recognise that in too many areas, inequalities are either static or even increasing. Only by embedding a focus on prevention and reducing inequalities in everything we do as a borough can we effectively improve health outcomes for all.

There are many great examples of services and programmes that are working to improve the health and lives of our residents, and narrow the inequalities we see in Southwark. While this section highlights examples of work being undertaken across the borough, we know there are many more.

### Outreach: Southwark Health Promotion Van



Our health promotion outreach service brings free blood pressure and healthy weight checks, plus advice on vaccines, diabetes prevention, smoking, alcohol, mental health, cancer screening and more to events in Southwark. Combining health professionals from Guy's and St Thomas' NHS Foundation Trust and Primary Care, Public Health and Community Health Ambassadors, the outreach van aims to empower individuals to make healthier lifestyle choices, as well as address health inequalities.

Since the service began at the end of May 2023 through to August 2024, the outreach service has visited over 100 locations across the borough, including the Southwark Eid festival, Cost of Living roadshows, Millwall FC, local churches and Peckham mosque. Through such events the team have conducted over **3,500 Vital 5 checks**.

Feedback from residents has been positive, with words such as **friendly**, **efficient**, **informative**, **accessible**, and **welcoming** being used by service users to describe the outreach van in a recent survey. Furthermore, 53% of those surveyed agreed that they



learned something from the event about health that they didn't know previously, and 85% stated that the outreach helped them have a better understanding of health services provided in Southwark. So far, the outreach service has picked up at least 268 cases of high blood pressure, who were subsequently signposted to visit their GP for further investigation and management. Ways in which the service has made a difference can be demonstrated in the following real example:

### **Case Study - Resident A**

A male in his 40s attended one of our recent wellness events. He was from a Black ethnic background, a smoker, slightly overweight and had a raised blood pressure. He also had alcohol and drug addiction. He wasn't registered with a GP. Since the event, this man has attended a Southwark pharmacy for follow up twice. He has also registered with a GP and is now on treatment that has reduced his blood pressure. A referral to Stop Smoking and Drug and Alcohol services has also been made.

Further work is now required to make sure those residents receiving a Vital 5 check access the tailored support they need to improve their health outcomes.

## **Tenant Health & Wellbeing Programme**

Not only is housing a key local priority, it is an important factor which influences our health and wellbeing. A new Tenant Health & Wellbeing Programme has been established which brings together teams from across the Council and NHS to understand and address long-term impacts of COVID-19 amongst social housing residents, whose health inequalities were particularly exacerbated by the pandemic. Working with the community and citizens it aims to design place-based interventions to meet these needs, focusing on health and wellbeing implications in the home environment. Outcomes for residents are expected to include:

- **Improvements to residents' personal and community health and wellbeing**
- **Improved community connectedness**
- **Better understanding of environmental and personal stressors, and identifying ways of addressing them**
- **Improved and transferable skills and confidence in residents**
- **Improvements to existing services as well as creation of new ones**
- **Improved awareness of, and access to, available services and support e.g. employment support offers**
- **Stronger and more trusted relationships with services**

## Improving our Outdoor Spaces: School Superzones

To lead a lifestyle conducive to good mental and physical health, children and young people must feel safe and welcomed in their local surroundings. Improving outside spaces near to schools has been a key part of Southwark's **School Superzones Programme**.



Superzones are place-based interventions around schools that aim to protect children's health and enable healthy behaviours through initiatives around community safety, active travel, local advertising and others.

Southwark Council have played a key role in the development of the School Superzone programme across London. There are now six Superzone schools across the borough: Ark Walworth, Bird in Bush, St Francis, Bacon's College, Surrey Square and Keyworth.

To understand local views on open spaces, engagement workshops have taken place alongside students and parents from Superzone schools. In some cases, this has led directly to improvements to the built environment.

One example of this is street improvements that are taking place on Shorncliffe Road, which have been co-designed by students at Ark Walworth School alongside the Council's Highways team. Parent's feedback from these consultations have also influenced the creation and extension of three school streets, which transforms roads so that pedestrians and cyclists are prioritised. The impact of these streets was clear outside one school, when a community event was held on the street to celebrate Clean Air Day in June.





## Addressing the Cost-of-Living

Jobs and financial security are important to achieve good mental and physical health. The Southwark Cost of Living Fund was extended into 2024, aiming to provide support for vulnerable or low-income households at risk of hardship due to the higher cost of food, energy, and other essentials.



The fund has been used to finance a number of projects and interventions aimed at helping residents with the cost of living. Families with children at Southwark primary schools who are eligible for benefits-related free school meals can receive financial support to help pay for their meals during school holidays. Furthermore, the **Food and Fun holiday clubs programme** provides free nutritious food combined with fun physical activity sessions to children and young people aged between four and 16 receiving benefits-related free school meals in Southwark during the summer holidays. For households migrating from Housing benefit to Universal Credit between April and September 2024, a one-off payment of £250 will be provided from the cost-of-living fund to help with the transition.

Additional support for some pregnant women and families with young children exists through the **Rose Vouchers for Fruit and Veg** project and the National Healthy Start programme. Rose vouchers can be exchanged at East Street and Peckham markets, and The Blue Istanbul Supermarket for fresh fruit and vegetables by pregnant women and families with young children living in SE1, SE5, SE15, SE16 and SE17. The scheme is targeted at those who already receive healthy start vouchers, are on a low income and not in receipt of benefits or are refugees or asylum seekers.

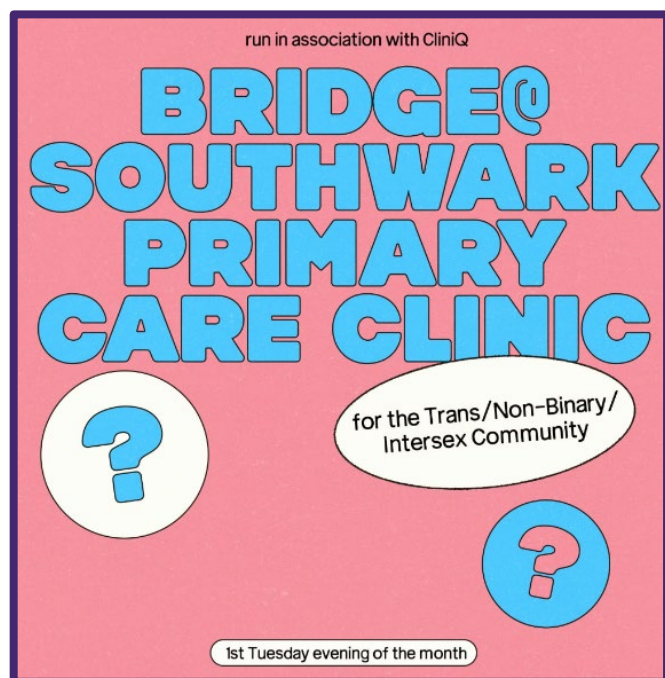


A series of cost-of-living roadshows have been held between 2022 and 2024. Bringing together a wide range of partners including charities, rights organisations, credit unions, citizen's advice, Southwark council and the health promotion van, the roadshows aim to provide advice to those worried about rising living costs, with information addressing benefits, debt, housing, energy and employment.

Interventions aimed to support residents with the cost-of-living especially over the winter months included training for front-line staff on cost of living and winter signposting and the design of communications for residents such as cold weather leaflets and a **cost-of-living guide** which additionally includes signposting on health and warm spaces. Additional training has been given to our volunteer community health ambassadors in Southwark, which aims to empower community groups to be able to sign-post those experiencing hardship to the right place for support.

**Cost of living crisis:**  
A guide to some of the support available in Southwark

## The Bridge Clinic



**The Bridge Clinic** is a dedicated primary care service for transgender and gender non-confirming residents in South Southwark.

The Trans community are more likely to face discrimination and bureaucratic barriers to care access resulting in an increased risk of developing serious health issues and receiving low quality care. Data from the national 'Trans Lives Survey 2021' shows that 57% of trans people reported avoiding going to the GP when unwell. Furthermore, it found that 45% of Trans respondents, and 55 per cent of non-binary respondents said that their GP did not have a good understanding of their needs. Crucially, 70% reported being impacted by transphobia when accessing healthcare services.

The Bridge Clinic aims to provide routine general practice services as well as care unique to the Trans/nonbinary community, such as prescriptions and monitoring of hormonal therapy and referrals to NHS Gender Identity Clinics, while maintaining a gender affirming environment. Bringing together clinicians with the relevant training and experience, which might not be consistently available at other GP practices, the clinic aims to provide a 'hub' service for Trans people.

Between September 2023 and June 2024, the clinic delivered a total of 119 appointments with an average patient age of 30. With a patient satisfaction score of 100%, the clinic has been met with positive feedback from users as well as an increasing level of demand.

## Thriving Neighbourhoods Project

Bringing together Community Southwark, Partnership Southwark and The United St Saviour's Charity, The Thriving Neighbourhoods Project is an initiative financed by the NHS. The project allocated £100,000 of funding to Voluntary and Community Sector (VSC) groups in Southwark, devolving decisions on how to spend funding to representatives from VSC groups themselves.

To be eligible for the funding, not-for-profit organisations have to be focused on the most disadvantaged areas of the borough, have an annual income of less than £50,000, and support people with disabilities and/or mental health needs as part of what they do. Two rounds of funding took place, with 21 organisations receiving £5,000 each. Groups who received grants included Art in the Park, Peckham Soup Kitchen and Southwark Refugee Communities Forum.

The decision on which organisations should receive the grants was made by a panel consisting of VSC representatives of Southwark based organisations independent of those who applied. Organisations who received grants said that the funding gave them greater financial security, allowing them to focus more on service delivery rather than fundraising. This innovative approach to funding whereby the decision is shared with the VSC groups themselves has received positive feedback - ***"The model is exceptional – it gives power back to the community; it was inspiring to see how much is going on in the community"***

## Rebuilding Trust in the Health System

Impact on Urban Health and NHS South East London Integrated Care Board (SEL ICB) have partnered to fund an ambitious new way to improve the experience and health outcomes among residents from Black ethnic backgrounds.

People from Black and other minoritised communities in London experience significant inequalities when it comes to their health – for a combination of social, economic and environmental reasons. Alongside this is a growing distrust and apathy towards the healthcare system. The reasons expressed for this distrust are diverse and include experiencing discriminatory practices in healthcare settings, being misdiagnosed, being prescribed the wrong medication and having traumatic experiences.



At the heart of this project is a new way of working to build trust in the health service. In collaboration with Black-led organisations, community-led insights will be used to shape and design improvements in health services. The partnership has two areas of work:

- **Black maternal healthcare**
- **Experiences of Black people receiving mental healthcare**

In each area of this work, project groups are made up of a range of stakeholders including residents, frontline staff delivering services, researchers and advocacy organisations. They will reimagine how healthcare services can be made more relevant, appropriate and accessible to people from Black communities by building on existing work and innovation in maternal care and designing prototype care pathways that are dedicated to improving patient experience and health outcomes.



## Southwark Maternity Commission

The Southwark Maternity Commission was established to understand the health inequalities in maternity care in the borough, especially amongst Black and Brown women and people who give birth. Since January 2024, it has engaged with and heard from over 750 residents and frontline professionals through a series of public meetings in the community, targeted surveys and specially-commissioned insights research.

Five key themes have emerged from the commission's work, including:

- **Tackling discrimination**
- **Ensuring women are listened to and supported to speak up**
- **Providing women with the right information at the right time**
- **Improving the integration of Council and NHS services**
- **Supporting the workforce to provide compassionate, kind and high quality care.**

Working with a broad stakeholder group, these themes have been used to develop recommendations for the Council, local NHS Trusts, Local Maternity and Neonatal System, Integrated Care Board and Central Government. The commission's report was launched in September 2024, after which the recommendations were presented to the Health and Wellbeing Board to support action planning and implementation.



## Community Engagement

As we develop plans and services to improve health and wellbeing, it is crucial that we work in equal partnership with our residents, taking account of the views and experiences of all who live, work, study, and volunteer within the borough.

In collaboration with Community Southwark and Healthwatch Southwark, the Council support an active network of **over 180 Community Health Ambassadors**. Ambassadors come from all corners of the borough, from a range of socioeconomic backgrounds, with different personal and professional experience in health and social care. They represent the cultural diversity of our borough, with over 70% from Black, Asian or other minoritised ethnic backgrounds, and around 50% involved with local faith groups.

The Ambassadors are an important part of our outreach into neighbourhoods across the borough, and also share insights and feedback to inform and improve services. Ambassadors are offered training in:

- **Mental Health First Aid**
- **Making Every Contact Count**
- **Cancer screening awareness**
- **Vaccine uptake**
- **Health and wellbeing coaching**
- **Other accredited courses**

Their skills support the Council through attending and promoting a variety of activities, including health advice and education, signposting to services and support, and promoting events and opportunities for health improvement.

The **Southwark Insights and Intelligence Programme (SIIP)** is a new three-year cross-Council initiative. The programme aims to help improve how the Council uses data and evidence so that we can design better services that improve health and reduce inequalities. The programme has three connected workstreams that will be delivered from 2024 to 2027 with partners including universities, voluntary and community organisations, and the NHS.

A key component of SIIP is the community research and co-production workstream. Through this, we aim to train residents and members of our voluntary and community organisations to become community researchers. Together with service providers and other partners, the community researchers will collaboratively investigate complex problems affecting health and wellbeing, and co-produce solutions and interventions for action.

## 5. How we Close the Gap

While we see some long-term improvements in the health of Southwark residents the gap between our most disadvantaged neighbourhoods and population groups remains wide. These inequalities are unfair and avoidable. Reducing inequality is the responsibility of us all, and requires a combination of dedicated and targeted interventions, along with improvements in the design and accessibility of core services. These interventions must be designed in collaboration with our residents if they are to be truly effective in meeting their needs and improving their outcomes.

Below, we have set out a series of recommendations for partners across the borough with the aim of improving the health of all residents and communities in Southwark.

1. Refresh the Joint Health & Wellbeing Strategy action plan alongside Southwark 2030 and other key system plans, ensuring sufficient action and resources are focused on improving the wider determinants of health, not just the health & care system.
2. Embed a culture of co-design with residents, utilising community research and opportunities such as the Southwark Insight & Intelligence Programme to spread good practice.
3. Implement policies and guidelines to ensure services across the health and care system are welcoming, inclusive, and affirming environments, such as Safe Surgeries and Pride in Practice.
4. Develop and implement cultural competency training and certification for staff across the health and care system.
5. Secure long-term, mainstream investment in targeted outreach services that focus on disadvantaged and marginalised communities in the borough.
6. Develop integrated service models that address the diverse needs of residents, including physical, mental, and social well-being.
7. Develop clear guides on navigating the health and care system, particularly aimed at residents born outside the UK, whilst also seeking opportunities to simplify accessibility of services.
8. Ensuring the consistent availability of reliable translation services and increasing the number of bilingual service providers.
9. Collaborate with trusted community and voluntary organisations to both engage residents and to deliver advice and support.
10. Improve and enhance data collection for marginalised communities across all health and care services, so that we can monitor improvements in access, experience and outcomes.

## 6. Update from last year's Annual Public Health Report

The 2023 [Annual Public Health Report](#) entitled 'Cleaner Air, Heathier Lives', focused on Air Quality as a public health concern, particularly highlighting the situation in Southwark. The report outlined recommendations for action relating to individuals, businesses and organisations and wider stakeholders. Updates on recommendations relating to wider stakeholders are outlined below:

**1. Integrate action on air pollution and climate. Focus on actions that provide a win-win scenario for both. For example, encourage active travel and prioritise green spaces.**

The Climate Change team and Public Health work closely together, collaborating on projects and strategies including the Climate Resilience and Adaptation Strategy.

The Streets for People Board holds cleaner air and less traffic at its core, benefitting both air quality and climate mitigation.

The Environmental Protection Team are contributing to air quality information in the Climate Change team's schools sustainability guide.

**2. Involve communities in project planning and decision-making. Use culturally aligned human stories to engage and represent the community in any air quality information that is produced or shared.**

The Environmental Projection Team and Public Health have been undertaking community research to determine how to best deliver air quality information to the community. From this research, one future route may be through air quality champions, and the research will investigate which messages and approaches are welcomed most by communities.

**3. Ensure interventions do not reinforce existing inequalities and sources of ill health.**

The Air Quality JSNA provides demographic, environmental, and health data at a local level. This helps colleagues to understand potential impacts of interventions. Public Health also dedicate time to supporting a range of projects and strategies across the council, ensuring a focus on inequalities.

**4. Target interventions towards places where people who are more vulnerable to the health effects of air pollution spend their time, for example schools, health services, and care homes.**

Interventions are frequently targeted towards children, older people, and those with certain health conditions. For example, Public Health provided funding for air filter units to be installed in care homes and schools and undertook an evaluation of the project which will be released shortly.

Other projects include asthma awareness projects targeting schools, and a Clean Air Day event which promoted active travel and other initiatives. There are also starter grants provided to schools for air quality, and Superzones include air quality as a focus area.

**5. Trial innovative pilot projects. Share learnings and invite others to take on similar work. Engage with researchers to continue to build the evidence base, especially around indoor air quality.**

A schools asthma awareness project is working alongside academic researchers. This project aims to better understand air quality in schools and homes of pupils with asthma, as well as to create a support package for families.

A team of academic researchers evaluated the air filters in schools and care homes pilot, with findings to be published shortly. The project aimed to improve air quality by using air purifiers.

**6. Enforce existing regulation to ensure that policy translates into practice.**

The Council is reviewing new powers under the Clean Air Act, operating the permitting system under Local Air Pollution Prevention & Control.

With Impact on Urban Health and Imperial College, training materials were developed for construction compliance officers. Once recruited, these officers would be responsible for supporting construction sites to improve air quality.

**7. Make use of available data and evidence on air quality, for example LAQN, Breathe London, and airTEXT.**

A project is underway to enhance the capabilities and reach of airTEXT, which provides data on air pollution levels.

Breathe London air quality monitors were installed in school Superzones, and a number of assemblies were held to introduce pupils to them alongside active travel.

**8. Provide information about and raise awareness of the health effects of air pollution, how to protect ourselves from it, and how to reduce sources.**

The schools asthma awareness raising project will provide information on air quality and raise awareness of how to reduce its impact. It will also help to facilitate the NHS asthma friendly schools program.

Coffee mornings are being held in school Superzones, which include a stall run by the repairs/damp and mould team who are able to support residents with indoor air quality.

**9. Pursue partnerships to accelerate progress and share skills. Strengthen collaboration with local health partners.**

Collaborations with health partners include Asthma Friendly Schools, and the South East London Children and Young Persons Asthma Forum.

**10. Focus on particulate matter emissions, in particular, because NO2 is trending down. Include interventions related to construction, commercial cooking, and domestic wood burning.**

A Construction Monitoring Officer is being recruited who will focus on air quality impacts of construction sites.

The Council is part of a pan-London project on domestic wood burning, and contributed to a poster and local radio media campaign last winter, and expect to do so again this autumn/ winter.

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<b>Meeting Name:</b>	Health and Wellbeing Board
<b>Date:</b>	13 March 2025
<b>Report title:</b>	Southwark Joint Health and Wellbeing Strategy action plan 2025-27
<b>Ward(s) or groups affected:</b>	All
<b>Classification:</b>	Open
<b>Reason for lateness (if applicable):</b>	Not applicable
<b>From:</b>	Public Health – Southwark Council

## RECOMMENDATION(S)

1. That the Health and Wellbeing Board approves the Joint Health and Wellbeing Strategy action plan for 2025-27, outlining any changes required as conditions of approval.
2. That members of the Board review the actions whereby their respective teams and organisations are named as action owners or partners, ensuring that these actions are specific, measurable, achievable and ambitious.
3. That the Health and Wellbeing Board agree the 14 actions that have been selected as “drive” actions, and comments on the appropriateness of this selection.

## BACKGROUND INFORMATION

4. The Southwark Joint Health and Wellbeing Strategy 2022-27 was approved by the Board in November 2022.
5. The original Strategy was published alongside an action plan that covered the first three years of the Strategy (2022-24). The Board received updates on progress against the original action plan in November 2023 and November 2024.
6. In November 2024, the Health and Wellbeing Board agreed that a new action plan and outcomes framework should be developed and presented to the Board in March 2025, with actions:
  - That are fewer in number but larger in potential for impact
  - That are ambitious and innovative, instead of business as usual
  - That are focused on partnership working in order to address the wider determinants that impact health, ability to lead healthy lifestyles and access to services



- That align with Southwark's vision for 2030 and other borough-wide strategies
7. This paper is presented alongside the draft Joint Health and Wellbeing Strategy action plan 2025-2027 (Appendix 1).

## KEY ISSUES FOR CONSIDERATION

### Approach to action plan development

8. Since November we have engaged key stakeholders across the organisations represented on the Health and Wellbeing Board, and the broader voluntary and community sector (VCS), to understand where work was needed to build on actions in the previous action plan and further progress against the Strategy's original aims. Stakeholders were engaged through one-to-one discussions, the Partnership Southwark forums, other relevant steering and working groups, and small group workshops.
9. To ensure actions are evidence-based and responsive to the needs and priorities of our population, we utilised a wealth of recent local needs assessments and community-based research, working with stakeholders to identify the actions that would address recommendations from these pieces of work.
10. The draft report has been presented to Partnership Southwark Delivery Executive, and sent to senior officers across the Council, NHS and wider system for comment prior to its formal presentation at the Board.

### Meeting the criteria for the action plan refresh

11. **Actions are fewer in number but larger in potential for impact:** The action plan contains 44 actions, in comparison to 53 in the previous plan. Partners were challenged to ensure that only the most impactful and specific actions were included. With the breadth of the Strategy's priorities and aims, it was challenging to restrict the number of actions further. To enable the Board to prioritise and focus its efforts, the authors have identified 14 actions for the Board to take additional responsibility for driving forwards.
12. **Actions are ambitious and innovative, instead of business as usual:** All actions relate to new pieces of work that are being delivered from this year onwards, or are planned for the future. Although some actions were already planned prior to action plan development, they have been included in the plan on the basis that the input or oversight from the Board would strengthen delivery and ensure alignment with the Board's strategic aims.
13. **Actions are focused on partnership working in order to address the wider determinants that impact health, ability to lead healthy lifestyles and access to services:** The actions are owned by 15 different Council divisions and organisations, including Council Housing, Planning, Highways and Local Economy teams. This demonstrates the Board's commitment to address health inequalities by tackling the wider determinants of health.

14. **Actions align with Southwark’s vision for 2030 and other borough-wide strategies:** Pages 11-14 of Appendix 1 outline the purpose of the Joint Health and Wellbeing Strategy within the strategic context of Southwark 2030, the South East London Integrated Care System (SEL ICS) Strategic Priorities, the Partnership Southwark Health and Care Plan, and Southwark Stands Together. Effort has been made to establish the role of the Joint Health and Wellbeing Strategy in preventing ill-health, promoting wellbeing and reducing health inequalities. The Board should note that actions related to improving efficacy, accessibility and equitability of our health and care services are largely covered by the Partnership Southwark Health and Care Plan, and not duplicated within the Joint Health and Wellbeing Strategy.

### **Vision statement, priorities, aims and actions**

15. The vision for 2025-27 is that people in all our communities have good health and wellbeing, living healthier as well as longer lives.
16. The key priorities of the 2022-27 Strategy are:
1. A healthy start in life
  2. Healthy work and lives
  3. Support to stay well
  4. Healthy communities
17. In recognising the establishment of SEL ICS and Partnership Southwark, the previous priority regarding “integration of health and social care” is now covered by the Partnership Southwark Health and Care Plan.
18. The aims of 2025-27 action plan are largely the same as the overarching Strategy, with some changes to reflect changing needs and priorities since the start of the Strategy (for example, the addition of an aim related to special educational needs and disabilities as recommended by the Health and Wellbeing Board in November 2024).
19. All actions have been agreed with the corresponding action owners, with the exception of Action 3.5: “Commission a review of link workers across the NHS and Council, including Social Prescribers and Community Health Ambassadors, considering their capacity and capabilities with a view to developing a more integrated approach”. The inclusion of this action was agreed at Partnership Southwark Delivery Executive, and we are currently in discussion with the Partnership Southwark regarding ownership of this action.
20. To support prioritisation and enable the Health and Wellbeing Board to focus its efforts, 14 actions have been identified as “drive” actions for the Board. These are actions that will require additional attention to facilitate partnership working across the agencies represented on the Board to achieve effective delivery. These actions will be a key focus of future Board meetings and development sessions.

### **Governance and delivery**

21. Responsibilities of the Health and Wellbeing Board and Partnership Southwark Delivery Executive are defined on page 23 of Appendix 1.

22. Preliminary feedback from the Health and Wellbeing Board development work with the Local Government Association has indicated that members would like to see the Board have a clearer focus and priorities. Public Health will support the Board to have a clearer focus towards delivering this action plan by developing new processes, such as using the action plan to inform the forward plan of the Board and improving clarity of the link between Board items and actions with the plan.
23. In addition, it has been agreed with the Partnership Southwark Delivery Team that the Partnership Well groups will provide advisory support to action owners as part of their established role as “collaboration groups to support wider system work”. Owners of actions that could benefit from input from health and care partners will be encouraged to attend Well group meetings to test ideas, solve problems and identify opportunities for collaboration.

### **Monitoring impact**

24. We propose that the Health and Wellbeing Board monitors progress against the action plan through:
  - a. **A Health and Wellbeing Outcomes Report:** A document tracking our short-term and long-term outcome measures, which will be updated every six months. The long-term outcome measures have been selected on the basis that they will help the Board to monitor inequalities in population health outcomes. Where possible, we will track our metrics over time and measure success by comparing against London averages. A paper demonstrating the structure of this report and our baseline measures will be presented to the Board in June 2025.
  - b. **Our JSNA Annual Report**, which will focus on progress against our long-term outcomes and inequalities.
  - c. **Health and Wellbeing Board meetings**, the forward plan for which designed around drive actions.
  - d. **An impact report** at the end of the Strategy period (March 2027).

### **Next steps for action plan delivery**

25. The next steps for action plan delivery, to be overseen by Public Health, are:
  - a. Development of the Health and Wellbeing Board forward plan based on the action plan and drive actions.
  - b. Development of guidance for action owners, that specifies the responsible officers for each action, partnership groups that should have oversight of each action, and information about how to report progress and outcome measures.
  - c. Presentation of the Health and Wellbeing Outcomes Report structure and baseline measures to the Partnership Southwark Delivery Executive and Health and Wellbeing Board in June 2025.
  - d. Presentation of the one-year progress update to Partnership Southwark

Delivery Executive and Health and Wellbeing Board in March 2026, alongside a plan for developing Southwark's Joint Health and Wellbeing Strategy for 2027-32.

### **Policy framework implications**

26. 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.
27. The action plan has been designed to align with Southwark 2030, the Partnership Southwark Health and Care Plan, and Southwark Stands Together, as described in point 14.
28. Several actions in the action plan directly contribute to commitments within the Council Delivery Plan for 2025-26, across the six goals of Southwark 2030.
29. Public Health will work with the Council Strategy & Communities Division to ensure the Joint Health and Wellbeing Strategy outcomes framework aligns with that of Southwark 2030.

### **Community, equalities (including socio-economic) and health impacts**

#### **Community impact statement**

30. Community empowerment and co-production is a key principle for the Strategy and corresponding action plan. Page 22 of Appendix 1 explains how this principle has been embedded in action plan design and plans for delivery.
31. The following aim has been added under priority 4 (healthy communities): "Support our thriving voluntary and community sector to deliver impactful programmes and services that contribute to reducing health inequalities". This aim was added to reflect feedback from the VCS.

#### **Equalities (including socio-economic) impact statement**

32. A key purpose of the Joint Health and Wellbeing Strategy is to establish how the Board will work in partnership to tackle health inequalities in the Borough. On pages 19-21 of Appendix 1, we describe how the action plan has been developed, and how it will be delivered, in a way that is focused towards addressing inequality.

#### **Health impact statement**

33. A key purpose of the Joint Health and Wellbeing Strategy is to establish how the Board will work in partnership to improve the health of the Borough. The focus of the Strategy is on prevention of ill-health, improving wellbeing and

reducing health inequalities.

### **Climate change implications**

34. The Health and Wellbeing Board recognises the impact of the climate emergency on population health and health inequalities in Southwark. As described on page 21 of Appendix 1, several actions within the plan were prioritised due to the co-benefits of reducing carbon emissions or mitigating against the impacts of climate change.

### **Resource, legal and financial implications**

35. By committing to be action owners, Council Divisions and partner organisations recognise that resource, legal and financial decisions that relate to the delivery of individual actions will need to be taken separately and considered through the appropriate budget, monitoring and governance processes of the relevant organisations.

### **Consultation**

36. The process that was followed in developing the action plan is outlined in points 8-10.
37. The action plan aligns with the priorities and aims that were established in the overarching Strategy, which was originally shaped by extensive community engagement, including listening and engagement exercises conducted through Southwark Stands Together, South London Listens and the 'Understanding Southwark' research.
38. The action plan was developed in collaboration with partners representing the VCS, including but not limited to Community Southwark and Healthwatch Southwark. The majority of actions were informed by community-based research conducted through Southwark's Joint Strategic Needs Assessment, and by external partners including Healthwatch, Impact on Urban Health and Centric.

## **SUPPLEMENTARY ADVICE FROM OTHER OFFICERS**

### **Head of Procurement**

39. None sought.

### **Assistant Chief Executive, Governance and Assurance**

40. None sought.

### **Strategic Director of Resources**

41. None sought.

### **Other officers**

42. None sought.

## BACKGROUND DOCUMENTS

Background Papers	Held At	Contact
<a href="#">Southwark Joint Health and Wellbeing Strategy 2022-27</a>	Public Health, Southwark Council	Rosie Dalton-Lucas <a href="mailto:rosie.dalton-lucas@southwark.gov.uk">rosie.dalton-lucas@southwark.gov.uk</a>
<a href="#">Southwark Joint Strategic Needs Assessment Annual Report 2024</a>		
<a href="#">Southwark Joint Health &amp; Wellbeing Strategy Progress Report: November 2023</a>		
<a href="#">Southwark Joint Health and Wellbeing Strategy 2022-27 – Progress Report: November 2024</a>		

## APPENDICES

No.	Title
Appendix 1	Southwark Joint Health and Wellbeing Strategy - Draft Action Plan 2025-27

## AUDIT TRAIL

Lead Officer	Rosie Dalton-Lucas, Head of Programme (Place & Partnerships), Public Health		
Report Author	Alice Fletcher-Etherington, Programme Manager (Place & Partnerships), Public Health		
Version	Final		
Dated	13 March 2025		
Key Decision?	No		
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER			
Officer Title		Comments Sought	Comments Included
Assistant Chief Executive, Governance and Assurance		No	No
Strategic Director, Finance		No	No
Cabinet Member		Yes	N/A
Date final report sent to Constitutional Team			4 March 2025

# Southwark's Joint Health and Wellbeing Strategy 2022-2027

## Action Plan 2025-2027

**People in all our communities have good health and wellbeing, living healthier as well as longer lives**

**Priority 1**



**A Healthy  
Start in Life**

**Priority 2**



**Healthy Work  
& Lives**

**Priority 3**



**Support to  
Stay Well**

**Priority 4**



**Healthy  
Communities**



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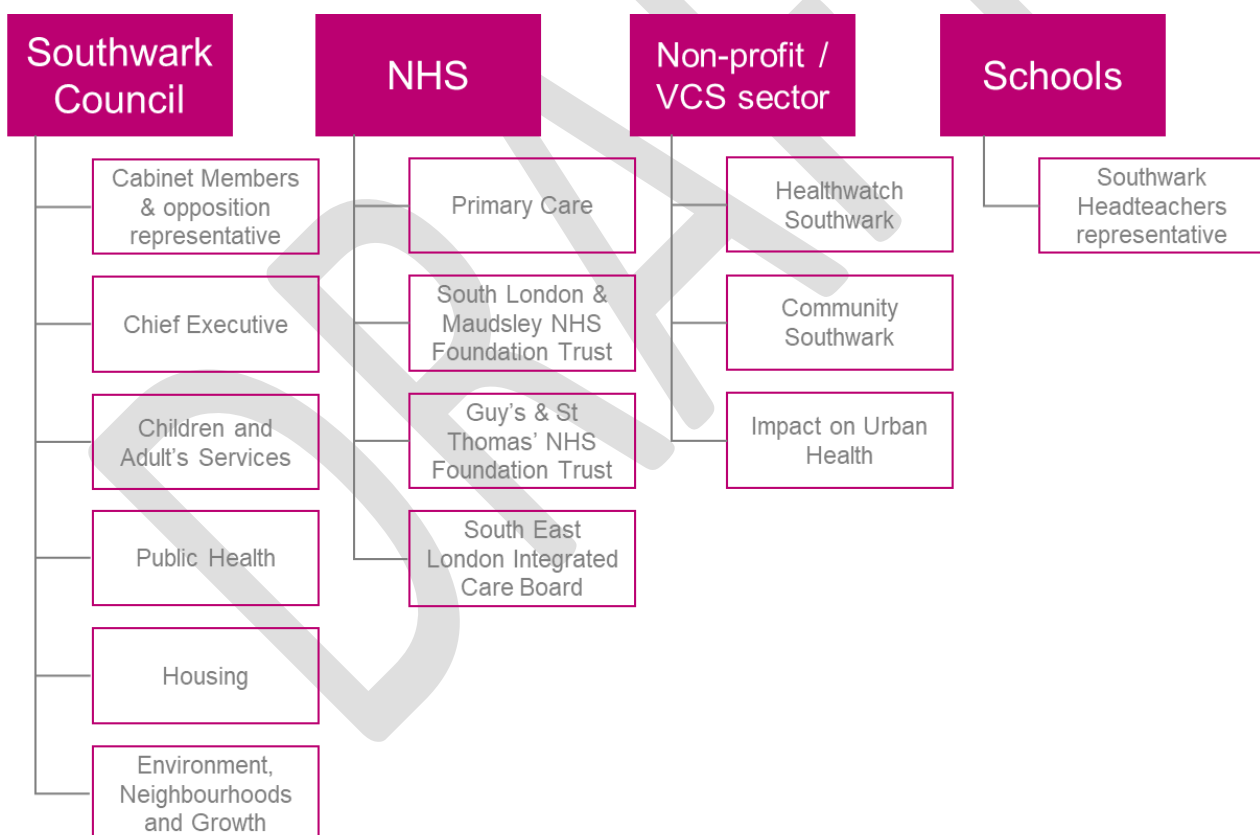
DRAFT

## Background

### Southwark Health and Wellbeing Board

The Health and Wellbeing Board is a statutory partnership between the Council, NHS, and community, voluntary and learning organisations in Southwark (Figure 1). The Board provides a place for partners to come together to take strategic decisions with the aim of:

- Improving the health and wellbeing of the population of Southwark from pre-birth to end of life
- Reducing inequalities in health and wellbeing for Southwark residents
- Ensuring the local community is fully involved in the above



**Figure 1.** Organisations represented on Southwark's Health and Wellbeing Board

There is a statutory responsibility for the Board to produce a Joint Health and Wellbeing Strategy that addresses the health needs of our population, as outlined in Southwark's Joint Strategic Needs Assessment (JSNA).<sup>1,2</sup>

## Southwark's Joint Health and Wellbeing Strategy 2022-2027

Southwark's Joint Health and Wellbeing Strategy sets out how the Health and Wellbeing Board will work together to **prevent ill health, promote wellbeing** and **reduce health inequalities** in Southwark.<sup>3</sup>

The current iteration of the Strategy runs from 2022 to 2027. The original report included an action plan containing actions that were to be delivered in the first two years of the Strategy. In 2024, progress against the original action plan was reviewed,<sup>4</sup> and the Board decided that a new action plan was required to establish how partners will build on this momentum and ensure further progress against the aims of the Strategy through to 2027.

### Priorities

The Strategy outlined five priority areas that were identified as being important to people in Southwark and requiring all agencies to work together to achieve change.

For the 2025-2027 action plan, we have simplified the language used to describe these priorities, to improve communication of the Board's areas of focus.

#### Priority 1: A healthy start in life

We will aim to ensure all families in Southwark receive access to good quality maternity care and support through the early years, reducing differential outcomes between population groups. We want to improve mental health for the whole family and reduce inequalities in outcomes by providing support for families at risk of adverse childhood experiences and children with special educational needs and disabilities (SEND).

<sup>1</sup> Department of Health (2012). [Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies](#)

<sup>2</sup> Southwark Council (2024). [Joint Strategic Needs Assessment Annual Report 2024](#)

<sup>3</sup> Southwark Council (2022). [Southwark's Joint Health and Wellbeing Strategy 2022-2027](#)

<sup>4</sup> Southwark Council (2024). [Southwark Joint Health and Wellbeing Strategy 2022-27 – Progress Report: November 2024](#)

## Priority 2: Healthy work and lives

We want to increase access to good quality jobs that support and promote health and wellbeing. We will enable and empower adults to lead healthy lifestyles, for example by maximising access to leisure, physical activity and creative and cultural activities.

## Priority 3: Support to stay well

We want to provide accessible and effective services that focus on prevention to keep people well through the life course. We recognise the role that unpaid carers play in keeping our residents safe and well, and therefore want to ensure that carers themselves are well supported and able to live healthy lives.

## Priority 4: Healthy communities

We will build resilient communities by supporting our voluntary and community sector (VCS) and creating healthy places, environments and homes that promote wellbeing and social connection.

## Priority 5: Integration of health and social care

Following the creation of South East London Integrated Care System (SEL ICS) and our local care partnership, Partnership Southwark, we are working to provide joined-up care, explore where care can be delivered at a neighbourhood level, and strengthen how we involve local people in health and social care delivery. **This priority is now covered by the Partnership Southwark Health and Care Plan, and so does not feature in this iteration of the action plan.**

## The state of health and inequalities in Southwark

Southwark is a densely populated, diverse and rapidly growing borough with large numbers of young adults and residents from a wide range of ethnic backgrounds. Across the range of health and wellbeing measures that we review through our annual Joint Strategic Needs Assessment, there have been many significant improvements in recent years that should be celebrated:

- Levels of relative social and economic disadvantage in the borough continue to reduce.
- Child vaccination rates are generally comparable to or better than the London average.
- Key risk factors such as smoking, alcohol and physical inactivity are comparable or better than the national average.
- Preventable mortality has reduced by more than 40% between 2001 and 2022, narrowing the gap with England.

**Life expectancy** and **healthy life expectancy** are our overall measures of the quality of population health in Southwark, while the corresponding gaps between people living in places with the lowest and highest levels of deprivation are our overall measures of health inequality.



**Figure 2.** Life expectancy and number of years spent in good health (healthy life expectancy) at birth, in Southwark, regardless of sex by level of deprivation of area of residence.<sup>5</sup> Level of deprivation is defined by most deprived (IMD-19 deciles: 1–4) and least deprived (IMD-19 deciles: 5–10).<sup>6</sup>

<sup>5</sup> NHS Digital (2023). Primary Care Mortality Data Set (2021-2023); Office for National Statistics (2024). [Population and household estimates, England and Wales: Census 2021](#)

<sup>6</sup> This data analysis uses the Index of Multiple Deprivation (IMD) from 2019. Ministry of Housing, Communities and Local Government (2019). [English indices of deprivation 2019](#).

**Life expectancy:** The average number of years that would be lived by babies born in a given time period if mortality levels at each age remain constant.

**Healthy life expectancy:** An estimate of the average number of years babies born this year would live in a state of 'good' general health if mortality levels at each age, and the level of good health at each age, remain constant in the future.

The average life expectancy in the borough is 82.7 for people living in our most affluent communities and 79.4 for those living in our most disadvantaged communities (a gap of 3.3 years) (Figure 2). It is important to note that improvements in life expectancy have stalled locally and nationally, with no notable increases over the last decade.

Not all of these years are spent in good health, with healthy life expectancy at birth being 69 for those living in our most affluent communities and 62.6 for those in our most disadvantaged communities (a gap of 6.4 years) (Figure 2). Of note, female healthy life expectancy reduced by 8.8 years in the 3 years up to 2020, and increases in healthy life expectancy are being prevented by the increasing prevalence of long-term conditions such as cancer, chronic kidney disease and mental health conditions.<sup>7</sup>

Significant inequalities in other health outcomes remain, which are both avoidable and unfair. Below, we set out some key challenges in relation to our four priority areas. These figures demonstrate why taking action in these areas is crucial to strengthening the health of Southwark and highlights the outcomes we want to improve upon.

<sup>7</sup> Southwark Council (2024). [Joint Strategic Needs Assessment Annual Report 2024](#)

<b>A healthy start in life</b>	<p><b>Stillbirth</b> disproportionately affects women and people born outside of the UK</p> <ul style="list-style-type: none"> <li>Between 2021-22, 64% of stillbirths in Southwark were to women and people not born in the UK, despite this cohort making up 54% of the maternal population<sup>8</sup></li> </ul> <p><b>Mental health in childhood</b> is an important determinant of health outcomes in later life</p> <ul style="list-style-type: none"> <li>In 2023/24, 67% of year 4 and 6 children in Southwark said they were “fairly happy” or “very happy” with their life<sup>9</sup></li> </ul>
<b>Healthy work and lives</b>	<p>People with <b>long-term health conditions or learning disabilities</b> are less likely to be in <b>employment</b> and those in work earn less than average</p> <ul style="list-style-type: none"> <li>The gap in employment rate between adults in receipt of long-term support for a learning disability and the overall employment rate is 69 percentage points<sup>10</sup></li> </ul> <p>If every Londoner <b>walked or cycled</b> for 20 minutes a day, we would prevent 1 in 6 early deaths and save the NHS £1.7 billion over 25 years</p> <ul style="list-style-type: none"> <li>In 2023, 45.4% of Southwark residents reported cycling or walking, for any purpose, at least five times per week<sup>11</sup></li> </ul>
<b>Support to stay well</b>	<p><b>Smoking</b> is the leading cause of preventable premature death in the UK</p> <ul style="list-style-type: none"> <li>Smoking prevalence in adults in Southwark increased from 11.6% to 13.7% between 2022 and 2023.<sup>12</sup> Levels increase to 27% among routine and manual workers.</li> </ul> <p><b>Carers</b> providing care for longer are more likely to report poorer health outcomes</p> <ul style="list-style-type: none"> <li>Southwark has a higher percentage of unpaid carers reporting to not be in good health and living with a long-standing illness when compared to London<sup>13</sup></li> </ul>
<b>Healthy communities</b>	<p><b>Poverty</b> impacts the lives of children and families with children significantly, yet child poverty is rising across the borough</p> <ul style="list-style-type: none"> <li>8,080 Southwark children live in relative poverty and 4,119 children live in a household unable to afford food, fuel and water<sup>14</sup></li> </ul> <p><b>Poor air quality</b> is thought to contribute to one in five deaths globally and to have cost the NHS and social care at least £1.6 billion between 2017 and 2025 in England</p> <ul style="list-style-type: none"> <li>The fraction of mortality attributable to particulate air pollution in Southwark is 7%<sup>15</sup></li> </ul>

<sup>8</sup> Southwark Council (2024). [Joint Strategic Needs Assessment: The First 1001 Days](#)

<sup>9</sup> Southwark Council (in preparation). Supporting the Health and Wellbeing of CYP in Southwark Primary Schools

<sup>10</sup> Department of Health and Social Care (2024). [Fingertips: 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](#)

<sup>11</sup> Department for Transport (2024). [Walking and cycling statistics](#)

<sup>12</sup> Office for National Statistics (2023). [Annual Population Survey](#)

<sup>13</sup> Southwark Council (in preparation). Joint Strategic Needs Assessment: Carers

<sup>14</sup> Southwark Council (in preparation). Joint Strategic Needs Assessment: Poverty factsheet

<sup>15</sup> Department of Health and Social Care (2025). [Fingertips: Fraction of mortality attributable to particulate air pollution](#)

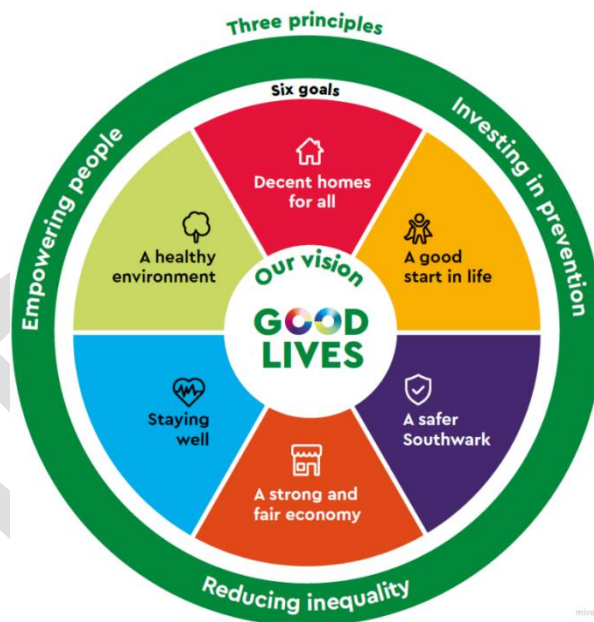


## Strategic context

The Joint Health and Wellbeing Strategy does not stand alone and must be considered alongside the accompanying strategies, action plans and evolving workstreams that are being delivered across the borough to improve health and wellbeing.

## Southwark 2030

The Southwark 2030 strategy outlines how local partners will work together to build a fair, green and safe Southwark where everyone can live a good life as part of a strong community.<sup>16</sup> This vision will be delivered by focusing on six goals underpinned by three guiding principles (Figure 3).



**Figure 3.** Principles and goals of Southwark 2030

The Joint Health and Wellbeing Strategy provides a delivery mechanism for Southwark 2030, with the action plan for 2025-27 containing multiple actions that support Council Delivery Plan commitments across all six of the goals. The three principles, investing in prevention, reducing inequality and empowering people, are reflected in the key principles of the Strategy (described on page 19) and throughout the action plan.

<sup>16</sup> Southwark Council (2025). [Southwark 2030 strategy](#).

## South East London Integrated Care System Integrated Care Strategic Priorities 2023-28

South East London Integrated Care System (SEL ICS) is a partnership that brings together the organisations responsible for publicly funded health and care services, including the Integrated Care Board (ICB), NHS health services, the six local authorities in the region and organisations from the voluntary, community and social enterprise sector. The SEL ICS Integrated Care Strategic Priorities outline how the partnership will help people stay healthy and well, deliver more joined-up, convenient care, and better support people from marginalised communities.<sup>17</sup>

The priorities are:

1. Prevention and wellbeing
2. Ensuring a good start in life
3. Children and young people's mental health
4. Adult's mental health
5. Primary care and people with long-term conditions

## Partnership Southwark Health and Care Plan 2023-28

Partnership Southwark brings together SEL ICB, Southwark Council, Primary Care Networks, Guy's and St Thomas' (GSTT), Kings College Hospital (KCH) and South London and Maudsley (SLaM) NHS Foundation Trusts, voluntary and community sector representatives, Healthwatch and care providers, to collectively design and implement plans to improve health and care services for Southwark residents and patients. The Partnership board has formally delegated responsibilities from the ICB.

Partnership Southwark's Health and Care Plan sets out how health, care and voluntary and community services in Southwark will work together with residents and communities to improve health and wellbeing outcomes for people of all ages.<sup>18</sup> It describes a set of strategic priorities that align with wider system goals, with a focus on meeting the needs of Southwark residents:

- Children and young people's mental health
- Adult mental health

<sup>17</sup> South East London Integrated Care System (2023). [Integrated Care Strategic Priorities for 2023-28](#)

<sup>18</sup> Partnership Southwark (2023). [Health and Care Plan 2023-2028](#)

- Integrated frailty pathway
- Integrated neighbourhood teams
- Prevention and health inequalities

The focus of the Health and Care Plan is on utilising strong partnership working to improve the efficiency, efficacy, accessibility and equitability of our health and care services and the role of the sector in prevention of ill-health and reducing health inequalities. In doing so, the Plan provides a means to deliver elements of the “Staying Well” goal of Southwark 2030 and Joint Health and Wellbeing Strategy, replacing the “Integration of health and social care” priority of the 2022-2027 Strategy.

## Southwark Stands Together

Southwark Council “Southwark Stands Together” is long-term programme of positive action, education and initiatives to tackle racism, injustice and inequality.<sup>19</sup> The programme was the Council’s response to the murder of George Floyd and the resulting Black Lives Matter movement, as well as the disproportional impact of the COVID-19 pandemic on Black, Asian and minority ethnic communities.

The recommendations resulting from this work that apply to the health and social care sector are:

1. Develop a **strong partnership approach** across the whole health sector addressing the wider health inequalities that disproportionately impact Black, Asian and minority ethnic communities, and their physical, mental and emotional wellbeing.
2. Recognise that discrimination can occur in many different ways, from front line to backroom functions; **adopt and embed organisation-wide approaches** to improve the experience of Black, Asian and minority ethnic communities.
3. Work with key partners to **ensure health services and initiatives are culturally appropriate and accessible** for Black, Asian and minority ethnic residents.
4. Increase uptake of **preventative programmes** such as screening, health improvement and education (i.e. myth busting and health literacy) amongst Black, Asian and minority ethnic communities.
5. Commission and **co-produce health services and interventions** with Black, Asian and minority ethnic communities.

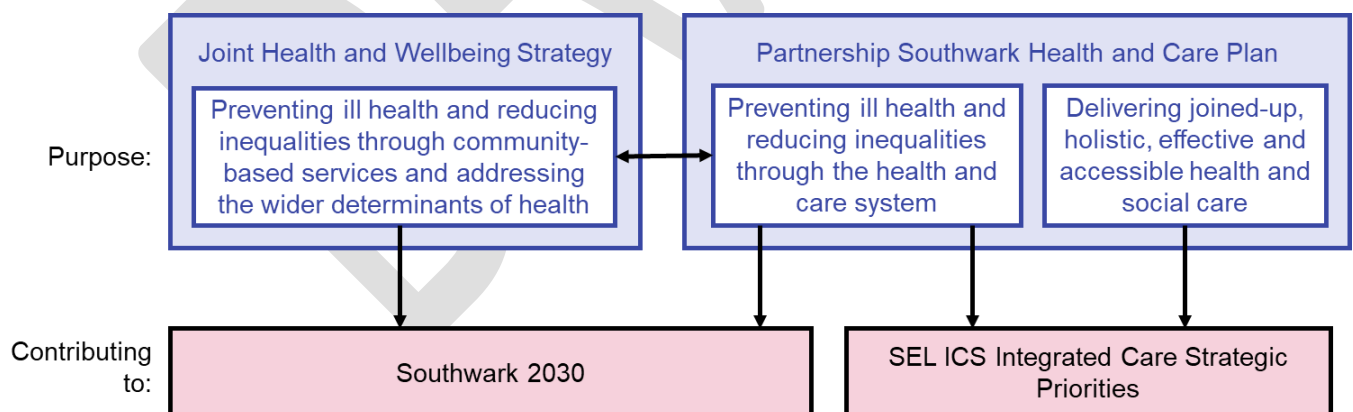
<sup>19</sup> Southwark Council (2020). [Southwark Stands Together](#)

The actions within our new action plan have been developed with the aim of meeting these recommendations.

## The role of the Joint Health and Wellbeing Strategy in the strategic landscape

The Joint Health and Wellbeing Strategy sets the strategic direction of the borough in relation to prevention of ill-health, promotion of wellbeing and reduction of health inequalities. Other local plans and strategies are required to follow its direction and reflect its aims.

The Partnership Southwark Health and Care Plan defines the role of partners in supporting the health and care system to deliver joined-up, effective and accessible care, prevent ill health and reduce inequalities. This allows the Joint Health and Wellbeing Strategy to focus on the role of a broader range of partners in prevention and reducing inequalities through settings outside of the health and social care system (Figure 4). This requires coordinated action to tackle the wider determinants of health, such as housing, employment, financial circumstance, education and environmental factors. Our action plan therefore contains actions owned by partners across the Council, including Housing, Environment, Leisure, Local Economy and Planning teams. Health and social care partners still have a vital role to play in delivering the Joint Health and Wellbeing Strategy, with actions for these partners focusing on how they work with stakeholders outside of health and care to tackle wider determinants of health.



**Figure 4.** Remit of the Joint Health and Wellbeing Strategy and Partnership Southwark Health and Care Plan, and their connection to broader system-wide and regional strategies

## Action plan 2025-2027

Our vision for 2025-2027 is that **people in all our communities have good health and wellbeing, living healthier as well as longer lives.**

The action plan and outcomes framework can be found in **Appendix 1**. The framework contains the following fields:

Aim	Action	✓	Owner	Partners	Output	Achieved by	Short-term outcome measures/targets	Long-term population health targets
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**Aim:** Each priority area contains a series of aims which set out our ambitions for the remainder of the Strategy.

**Action:** What we will do to achieve our aims.

✓: The Health and Wellbeing Board's "Drive" actions. The Board will be responsible for overseeing the delivery of all actions in the action plan. However, there are some actions that will require additional focus and strategic direction from the Board to ensure these actions are delivered. These are indicated with a "✓".

**Owner:** Every action has a designated owner – a team or organisation who is responsible for delivering the action and accountable to the Health and Wellbeing Board.

**Partners:** The purpose of the Strategy is to identify where partnership working is required to achieve change, and so all actions have designated partners who will support delivery of the actions.

**Output:** What will be delivered.

**Achieved by:** When the outputs will be delivered by.

**Short-term outcome measures/targets:** Outcomes and targets related to the specific service or programme that is the subject of the action, which will help us quantify impact and track progress.

**Long-term population health targets:** These define the progress we would like to see in our population health metrics, and the inequalities that exist within these metrics, over the long-term. The outcomes corresponding to these targets are influenced by a complex range of factors, and so we will not be assessing the success of specific actions according to how these outcomes change. Instead, these targets are designed to allow us to assess how we are performing as a whole system, for example by comparing ourselves against regional averages.

## Aims for 2025-2027

The aims for 2025-2027 largely follow the aims of the overarching five year strategy, but have been updated to address recently identified needs and to align with the strategic context.

By delivering the action plan, the Health and Wellbeing Board will aim to:

<b>A healthy start in life</b>	<ol style="list-style-type: none"> <li>1. Ensure all families in Southwark benefit from access to good quality <b>maternity care</b> and holistic support during the <b>first years of life</b>, reducing differential outcomes for Black women and families</li> <li>2. Provide early interventions and support for children with <b>early developmental needs and special educational needs and disabilities</b></li> <li>3. Promote good <b>mental wellbeing</b> and prevent mental illness in children, young people, and families</li> <li>4. Accelerate the reduction in <b>childhood excess weight and obesity</b></li> <li>5. Ensure the sustained uptake of life-saving childhood <b>vaccinations</b></li> </ol>
<b>Healthy work and lives</b>	<ol style="list-style-type: none"> <li>6. Increase access to <b>good quality jobs</b>, providing support to those facing systemic inequalities and barriers to employment, including Black, Asian and ethnic minority residents, older people, women and disabled people</li> <li>7. Support good health and wellbeing across our <b>workforce and commissioned services</b></li> <li>8. Support people to lead <b>healthy lifestyles</b> that keep them well, working with population groups and communities where risk factors are clustered</li> <li>9. Maximise access to <b>leisure, daily movement and physical activity</b>, ensuring that financial circumstance does not limit access</li> </ol>
<b>Support to stay well</b>	<ol style="list-style-type: none"> <li>10. Ensure that there are effective and accessible <b>services that prevent illness and promote wellbeing</b>, including measures to tackle “The Vital 5”</li> <li>11. Reduce admissions to hospital for <b>falls</b></li> <li>12. Support <b>carers</b> and families to look after their own wellbeing</li> </ol>
<b>Healthy communities</b>	<ol style="list-style-type: none"> <li>13. Work together to mitigate the impacts of the <b>cost of living</b> crisis for people in Southwark</li> <li>14. Promote good <b>mental health</b> and reduce <b>social isolation</b> and loneliness by focusing on prevention and creating connected communities</li> <li>15. Support our thriving <b>voluntary and community sector</b> to deliver impactful programmes and services that contribute to reducing health inequalities</li> <li>16. Ensure Southwark residents have access to good quality <b>homes, streets and environments</b> that promote good health and wellbeing</li> </ol>

## Drive actions

Out of the 44 actions in the action plan (Appendix 1), 14 will receive particular attention from the Board – the “Drive” actions. These are actions whereby partnership working across the agencies represented on the Board is particularly vital for action delivery. Owners of these actions will be required to give more regular updates to allow the Board to monitor progress and shape delivery.

Action	Owner
<b>A healthy start in life</b>	
<b>1.1:</b> Develop and implement an action plan to address the recommendations of the Southwark Maternity Commission	SEL ICS (Strategic Director for Integrated Health and Care)
<b>1.4:</b> Develop an evidence-based and integrated early intervention offer through the SEND Children and Family Hub, providing support to children with early developmental needs prior to diagnosis	Southwark Council (Children’s services)
<b>1.12:</b> Expand and extend the role of Local Child Health Teams to deliver interventions and signposting to tackle the wider determinants of child health, linking the teams with a broader range of children and family services	GSTT (Child Health Integrated Learning and Delivery System)
<b>Healthy work and lives</b>	
<b>2.1:</b> Embed employment support within primary care, secondary care and community health services through the Connect to Work programme	Southwark Council (Local Economy)
<b>2.9:</b> Expand the offer of affordable leisure activities in community settings and promote a wider range of physical activities	Southwark Council (Leisure Services)
<b>2.10:</b> Design and deliver zone-by-zone or borough-wide programmes and initiatives that address the financial, social and cultural barriers to active travel through the Streets for People strategy	Southwark Council (Highways)
<b>Support to stay well</b>	
<b>3.1:</b> Establish Southwark Hubs for Health as part of our ‘Health in the High Street’ programme, to increase access to Vital 5 checks and health promotion advice amongst groups at risk of ill health and our Black, Asian and ethnic minority communities	Southwark Council (Public Health)
<b>3.3:</b> Recommission the Southwark Wellbeing Hub with a focus on improving the outreach offer to ensure underserved populations can access the support they need in their local area	SEL ICS (Integrated Commissioning)
<b>3.4:</b> Establish a new Women’s Safety Centre that is integrated with wider health, employment, housing and financial support services	Southwark Council (Community Safety)
<b>3.8:</b> Improve access to support for carers by developing digital forms of carer assessment delivery, increasing awareness of carers assessments and improving data linkage	Southwark Council (Adult Social Care)



<b>Healthy communities</b>	
<b>4.1:</b> Develop a cross-borough anti-poverty plan, informed by resident engagement, to understand and tackle poverty and its impact on our residents	Southwark Council (Strategy and Communities)
<b>4.7:</b> Work in partnership across the Council and ICS to strengthen air quality monitoring and develop shared approaches, building on the work of the Air Pollution Footprint Partnership at a local level	Southwark Council (Environmental Protection)
<b>4.11:</b> Establish sites for co-located housing and health and wellbeing support, including at the Housing Options Service, Family Hubs and health outreach hubs	Southwark Council (Housing Needs)
<b>4.12:</b> Embed Public Health priorities within the revised Local Plan by reviewing existing policies that impact wider determinants of health	Southwark Council (Planning and Growth)



## Meeting our key principles

Across the five priority areas, the 2022-2027 Strategy defines five overarching principles that are central to meeting the aims of the Strategy:

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

We have strived to ensure that these principles are embedded within the new action plan, and in the way in which the actions will be delivered.

### Principle 1: Embedding an approach to tackling health inequalities across all our policy making, services and delivery

Reducing health inequalities is everyone's business. Southwark's Annual Public Health Report for 2024, "A Fairer Future", outlines the status of health inequalities in Southwark and highlights the work ongoing across our borough to address these inequalities.<sup>20</sup>

#### A targeted approach

If we are to reduce inequalities, the actions we take must be implemented proportionately to the needs of different communities, with those most in need receiving the greatest support. We therefore need a coordinated, system-wide approach that helps stakeholders to prioritise interventions for those in greatest need. In identifying "target groups", we recognise that these communities are at risk of poorer outcomes because of unfair social systems and the circumstances in which they live, not because of who they are or individual factors.

One mechanism for supporting proportionate delivery is Core20PLUS5, an NHS approach to reducing healthcare inequalities. The approach defines a target population, with the "Core20" being

<sup>20</sup> Southwark Council (2025). [A fairer future: Tackling health inequalities in Southwark. Southwark's Annual Public Health Report 2024.](#)

the most disadvantaged 20% of the population and “PLUS” groups being defined according to local need.

In our Joint Strategic Needs Assessment, we define six key population groups that partners across the system should focus on when tackling health inequalities: Carers, residents with disabilities, LGBTQIA+ residents, asylum seekers and refugees, rough sleepers and Black, Latin American and minoritised ethnic groups.

### **Tackling wider determinants**

Social, economic and environmental factors, such as income, employment and housing, have the largest impact on health, with inequalities in these factors leading to inequalities in health. The 2024 Annual Public Health Report recommends that to tackle health inequalities, the Joint Health and Wellbeing Strategy should revitalise its focus on influencing these wider determinants of health. This iteration of the action plan therefore has an extended reach across the public sector, with action owners and partners including the Council's Housing, Planning, Environment, Exchequer Services, Education and Community Safety teams.

### **Addressing systemic bias in service design and commissioning**

Many of our actions relate to how we will deliver or improve the services we are responsible for. To address inequalities in access to and experience of services, the Southwark systemic bias toolkit was developed to commissioners to reduce systemic bias in service design and commissioning processes. This toolkit can be used by action owners to ensure actions related to service design and commissioning contribute towards our goal of reducing health inequalities.

## **Principle 2: Targeted place-based approach and population groups**

The Joint Health and Wellbeing Strategy formalises the system and borough-wide actions that are required to improve population health, and so largely does not detail actions that are specific to certain geographies or populations. However, all actions will be delivered in a proportionate matter, with a view to meeting the specific needs of our priority populations. Recent population-based needs assessments that make recommendations to be addressed through delivery of this action plan focus on the following populations:

- Latin American residents<sup>21</sup>
- Carers<sup>22</sup>

<sup>21</sup> Southwark Council (2024). [Southwark's Joint Strategic Needs Assessment: Latin American Health](#)

<sup>22</sup> Southwark Council (in preparation). Southwark's Joint Strategic Needs Assessment: Carers

- Children and young people with special educational needs and disabilities<sup>23</sup>
- LGBTQIA+ residents<sup>24</sup>
- Asylum seeker and refugees<sup>25</sup>

Many actions will be delivered using targeted place-based approaches. Partners across the Council and ICS are increasingly using innovative hyperlocal approaches to delivering services and programmes, focusing on defined localities. Some examples include:

- **Integrated Neighbourhood Teams (INTs):** INTs will bring together staff across health, social care and the VCS to work as a single team to deliver coordinated and person-centred care to individuals within a defined neighbourhood. The next phase of this programme will involve defining neighbourhood footprints and mapping local needs.
- **Intermediate Care Southwark:** The service is being delivered across five Southwark “patches”, allocating specific staff to each patch who will use insights on demographics, local need and community assets to provide tailored interventions with the aim of reducing inequalities.
- **Resident Health and Wellbeing Programme:** This programme aims to identify and address health and wellbeing needs in specific social housing settings, involving the co-production of place-based interventions with residents to meet the identified needs. The pilot of the programme has focused on three Council housing estates and will be evaluated in 2025.

### Principle 3: 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 and responding to climate change is therefore an integral part of our approach to reducing inequalities.

Several actions within the plan were prioritised due to the co-benefits of reducing carbon emissions or mitigating against the impacts of climate change, such as those that aim to reduce air pollution, promote physical activity or increase resilience against the health impacts of hot weather.

<sup>23</sup> Southwark Council (2024). [Southwark's Joint Strategic Needs Assessment: Children and young people with special educational needs and disabilities](#)

<sup>24</sup> Southwark Council (in preparation). Southwark's Joint Strategic Needs Assessment: LGBTQIA+

<sup>25</sup> Southwark Council (2024). [Southwark's Joint Strategic Needs Assessment: Asylum seekers and refugees](#)

## **Principle 4: Community empowerment and co-production**

Individuals are experts in their own lives and their local communities. Community-based research and engagement was the source of several actions in this plan. We are working in partnership with our communities to deliver the actions, utilising expertise from Community Southwark, Healthwatch Southwark and Impact on Urban Health.

The Board recognises the vital contribution of our voluntary and community sector in delivering interventions that prevent ill-health and reduce health inequalities and is committed to supporting the VCS to perform this function. Actions describing how the Board will support the VCS are outlined on pages 44-46.

The new Southwark Insights and Intelligence Programme (SIIP) is helping to embed a culture of co-design with residents across the Council and wider community.<sup>26</sup> Projects being led by SIIP over the next couple of years will facilitate the effective and equitable delivery of actions in this plan, with a focus on age-friendly practices, preventing child poverty, making homes resilient to overheating and early help for families affected by youth violence. In addition, through its community research and co-production workstream, residents and members of VCS organisations are being trained to become community researchers who can support monitoring of outcomes and co-production of interventions.

## **Principle 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. Although priority 5, "Integration of health and care", is now covered by the Partnership Southwark Health and Care Plan, provision of high quality, joined-up and person-centred care is at the heart of many of our actions, and we aim to extend this ethos to all our services beyond the health and social care system.

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<sup>26</sup> Southwark Council (2024). [Southwark insights and intelligence programme](#).

# Delivery and monitoring impact

## Governance and delivery mechanisms

The Health and Wellbeing Board are responsible for the strategic oversight of the action plan, with individual action owners being accountable to the Board for delivery of their actions. For some actions, the Board will have a more direct role to play in providing strategic direction and a driving force behind the action, as marked by a “✓” in the framework. These actions will receive greater attention at Board meetings, with action owners being asked to present updates and identify support needed from the Board at regular intervals.

The Partnership Southwark Delivery Executive will support this oversight function by providing strategic direction and leadership in relation to relevant parts of the Strategy and actions that relate to or impact health and social care.

## Monitoring impact

The Health and Wellbeing Board will monitor progress against the action plan through:

- **A Health and Wellbeing Outcomes Report**, a live document tracking our short-term and long-term outcome measures that will be updated every six months. The long-term outcome measures have been selected on the basis that they will help the Board to monitor inequalities in population health outcomes. Where possible, we will track our metrics over time and measure success by comparing against London averages.
- **Our JSNA Annual Report**, which will focus on progress against our key long-term outcome measures and inequalities in the borough.
- **Health and Wellbeing Board meetings** that will be designed around the priorities of the Strategy, with deep dives on the drive actions (page 17) throughout the year.
- **An impact report** at the end of the Strategy period to determine the efficacy of partnership working to deliver the action plan and reflect on learnings, to support development of the next five-year Strategy.

# Appendix 1: Action plan framework

## Priority 1: A healthy start in life

Aim	Action	Drive action	Owner	Partners	Output	Achieved by	Short-term outcome measures/targets	Long-term population health targets
							#: number    %: percentage	
Ensure all families in Southwark benefit from access to good quality maternity care and holistic support during the first years of life, reducing differential outcomes for Black women and families	<b>1.1:</b> Develop and implement an action plan to address the recommendations of the Southwark Maternity Commission	✓	SEL ICS (Strategic Director for Integrated Health and Care)	Public Health Partnership Southwark (all Start Well partners)  Local Maternity and Neonatal System  VCS partners  GSTT  KCH  SLaM	Action plan developed and presented to Health and Wellbeing Board  Action plan implemented	June 2025  2027	<i>Short-term outcome measures will be defined within the action plan</i>	Reduction of the gap in % of stillbirths to mothers born outside of the UK compared to mothers born in the UK  Reduction in infant (< 1 year) mortality rate
	<b>1.2:</b> Work with the VCS to fund and run culturally appropriate and inclusive workshops on maternity rights for pregnant people and new families		Southwark Council (Public Health)	VCS partners  GSTT  KCH  SLaM  Children's services	Community-based sessions delivered	Regular delivery by March 2027	<b>Outcomes:</b> # of sessions held # of attendees  <b>Targets:</b> % of participants from Black, Asian or ethnic minority	

							groups matches or is greater than that of the Southwark population
	1.3: Promote engagement with the Baby Buddy app, focusing on ensuring pregnant people are informed of the app at points of contact with the NHS and community services		Southwark Council (Children's services)	Public Health Partnership Southwark (Start Well Clinical Care Professional Leads (CCPLs)) VCS partners	Information about Baby Buddy features on appointment booking confirmations  Learning sessions or awareness campaign targeted at primary care and maternity staff  Information on app on GP practice websites	April 2025  December 2025  December 2025	<b>Outcomes:</b> # of health care staff reached through awareness raising activities  <b>Targets:</b> Increase in # of residents using Baby Buddy app  % users from Black, Asian or ethnic minority groups matches or is greater than that of the Southwark population
Provide early interventions and support for children with early developmental needs and special educational needs and disabilities	These actions focus on early intervention for SEND. Actions related to diagnosis, treatment, management and services for children with neurodevelopmental disorders are outlined in the Partnership Southwark Health and Care Plan "Children and Young People's Mental Health" delivery plan.						
	1.4: Develop an evidence-based and integrated early intervention offer through the SEND Children and Family	✓	Southwark Council (Children's services)	Public Health Partnership Southwark (Delivery Team and Start Well CCPLs)	Consideration of development of a version of the Portsmouth approach to whole system change in relation	December 2025	<b>Outcomes:</b> # of children/families receiving support through SEND Family Hub
							Increase in % of children with free school meal status achieving a good level of development at the end of Reception in Southwark  Reduction in the gap in average Key

Hub, providing support to children with early developmental needs prior to diagnosis			<p>Start Well Integrated Commissioning</p> <p>VCS partners</p> <p>GSTT (Community Paediatrics)</p> <p>London South Early Years Stronger Practice Hub</p> <p>SEND Designated Clinical Officer (DCO) team</p>	<p>to meeting needs prior to diagnosis</p> <p>SEND Children and Family Hub established</p> <p>Needs assessment with qualitative insights from engagement with families</p> <p>Evidence of best practice relating to SEND early intervention built into antenatal parenting education programmes</p> <p>Promotion of parenting education programmes with a focus on improving equitable access for families of Black, Asian or minority ethnic heritage</p>	<p>March 2026</p> <p>March 2026</p> <p>March 2027</p> <p>March 2027</p>	<p><b>Targets:</b></p> <p>% of children/families receiving support through SEND Family Hub and parenting education programmes from Black, Asian or ethnic minority groups matches or is greater than that of the Southwark population</p> <p>Decrease in # of referrals to Family Early Help and community paediatric services</p>	Stage 4 attainment between all pupils and pupils with SEN support
<p><b>1.5:</b> Deliver a consistent programme of drop-in sessions at Family Hubs, Children and Young People's Development Centres and special needs schools to provide support around common issues for children</p>		GSTT (Community Paediatrics)	<p>Children's services</p> <p>VCS partners</p> <p>SEND DCO team</p>	<p>Deliver pilot drop-in sessions focused on sleep and toileting</p>	<p>December 2025</p>	<p><b>Targets:</b></p> <p>Increase in parent satisfaction and confidence following drop-in sessions</p> <p>Decreased number of referrals to Family Early Help and community paediatric services</p>	



	with early developmental or additional needs						
	<b>1.6:</b> Develop a joint commissioning strategy for speech and language therapy, with the aim of addressing local needs and increasing provision of evidence-based interventions		SEL ICS (Integrated Commissioning)	Speech and language services Children's services Schools Childcare settings SEND DCO team	Speech and language needs assessment Commissioning strategy developed	All July 2025	<b>Targets:</b> Decreased average age of speech, language, and communication diagnosis
Promote good mental wellbeing and prevent mental illness in children, young people, and families	<b>These actions focus on mental health prevention. Actions related to community and NHS children's mental health services are outlined in the Partnership Southwark Health and Care Plan "Children and Young People's Mental Health" delivery plan.</b>						Increase in % of Year 4 and 6 children who are very happy or happy with their life  Reduction in rate of hospital admissions as a result of self-harm (10-24 years old)
	<b>1.7:</b> Review and widen access to and uptake of existing parenting intervention services, as part of a community-based offer to prevent adverse childhood experiences (ACEs)		Southwark Council (Children's services)	Start Well Integrated Commissioning VCS partners GSTT (Child Health Integrated Learning and Delivery System and Health Visiting service)	Market review of providers offering evidence-based parenting interventions Costed commissioning plan Widen uptake of parenting interventions through Children and Family Hubs and Youth Justice System	December 2025  December 2025  April 2026	<b>Targets:</b> Increased # of self-referrals  Increased % of parents showing increase in confidence in parenting/goals met

				Agree data sharing protocol with partners, to allow mechanism to flag risk factors for ACEs on healthcare records	March 2027	
<b>1.8:</b> Review the current mental health offer in schools and other educational settings to ensure quality, equity and consistency of programmes and identify gaps in coverage and provision		Southwark Council (Children's services)	Schools Improving Mental Health and Resilience in Schools (IMHARS) Champions Network Start Well Integrated Commissioning Public Health VCS partners	Schools and Students Health Education Unit (SHEU) survey adapted to give insight into mental health needs  Lancaster model delivered and informing wider support offer to children and families  Cross-system group for attendance and inclusion to consider recommendations including how to take forward the IMHARS Champions Network	All March 2026	<b>Outcomes:</b> Number of children completing SHEU and Lancaster model questionnaires
<b>1.9:</b> Develop a programme of support for schools to prevent and respond to child death and self-harm, working in partnership with the aim of addressing local needs		Southwark Council (Public Health)	Schools Child Death Overview Panel  Children's services  IMHARS Champions Network	Programme of support and resources developed	December 2025	<b>Outcomes:</b> # of schools engaging with or using resources

				Start Well Integrated Commissioning				
Accelerate the reduction in childhood excess weight and obesity	<b>Actions related to this aim are now covered in the Southwark <a href="#">Healthy Weight Strategy 2022-2027</a> and corresponding annual action plans</b>							Reduction of the gap in % Year 6 children with excess weight between white and Black, Asian and ethnic minority children
Ensure the sustained uptake of life-saving childhood vaccinations	<b>1.10:</b> Deliver a new programme to develop the role of health visitors in engaging with families around childhood vaccinations, targeting population groups with the lowest uptake		SEL ICB (Southwark Primary and Community Based Care)	Public Health Integrated Commissioning  Public Health GSTT 0-19 service  Children's services	Pilot of new health visitor vaccination engagement service  Programme of targeted engagement in Children and Family Centres/Family Hubs  Vaccine training delivered to health visitors	All December 2026	<b>Outcomes:</b> # of engagement sessions held  # of children/families engaged with  # of children offered targeted support  # of health visitors trained	Reduction in the gap in 6 in 1 vaccine coverage at 12 months between white and Black, Asian and ethnic minority children
Cross-cutting (all aims)	<b>1.11:</b> Review development and skills needs of early years workforce (across childcare, community services, healthcare and education) in relation to topics such as		Southwark Council (Children's services)	London South Early Years Stronger Practice Hub  Integrated Commissioning  Public Health	Review of current training offer and workforce needs  Early years-specific Making Every Contact Count training offered to early years staff on a regular basis	December 2025  Ongoing	<i>Outcomes for monitoring coverage and quality of training to be determined through the review</i>	<i>As outlined for the aims above</i>

	perinatal mental health, neglect, identification of ACEs, early response to developmental issues and maternal obesity, and embed a joined-up training offer			<p>VCS partners</p> <p>GSST (Health Visiting service)</p> <p>Schools and childcare settings</p> <p>Perinatal and parent-infant relationships steering group</p> <p>Safeguarding Children Partnership</p>				
	<p><b>1.12:</b> Expand and extend the role of Local Child Health Teams to deliver interventions and signposting to tackle the wider determinants of child health, linking the teams with a broader range of children and family services</p>	✓	GSTT (Child Health Integrated Learning and Delivery System)	<p>Children's services</p> <p>Public Health</p> <p>Primary Care Networks and social prescribers</p> <p>SLaM</p> <p>Health visiting and school nurse services</p> <p>Partnership Southwark (Start Well CCPLs)</p>	<p>Local needs and causes of child health inequalities at a neighbourhood level reviewed</p> <p>Partnerships required at a neighbourhood level to address needs identified</p>	All December 2025	<p><b>Outcomes:</b></p> <p># of children receiving child health checks</p> <p>% of children/families being signposted to wider forms of support</p>	

## Priority 2: Healthy work and lives

Aim	Action	Drive action	Owner	Partners	Output	Achieved by	Short-term outcome measures/targets	Long-term population health targets
							#: number    %: percentage	
Increase access to good quality jobs, providing support to those facing systemic inequalities and barriers to employment, including Black, Asian and ethnic minority residents, older people, women and disabled people	<b>2.1:</b> Embed employment support within primary care, secondary care and community health services through the Connect to Work programme	✓	Southwark Council (Local Economy)	Partnership Southwark  Live Well Commissioning  Department for Work and Pensions  North Primary Care Network  South Primary Care Network	Live Connect to Work delivery plan developed  Employment support offer embedded within healthcare services (e.g. Integrated Healthy Lifestyle Service)	December 2025  March 2027	<b>Outcomes:</b> # of individuals with long-term conditions or belonging to Core20PLUS groups who receive support through Connect to Work	Reduction of the gap in the employment rate between those with a long-term health condition and the overall employment rate  Reduction of the 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
	<b>2.2:</b> Pilot a creative and cultural skills programme to support residents from disadvantaged backgrounds and/or facing barriers to employment to pursue a career in the creative and cultural sector and		Southwark Council (Local Economy)	Public Health Culture  Skills partners, including Southwark Works  Local creative and cultural organisations	Online and/or physical hub offer, integrated with the borough's Creative Health offer	March 2027	<b>Outcomes:</b> % of clients (including those with long-term conditions) progressing to employment and/or further learning  <b>Targets</b>	

	support their health and wellbeing			VCS partners			% of clients from target groups matches or is greater than that of the Southwark population
Support good health and wellbeing across our workforce and commissioned services	<b>2.3:</b> Build key performance indicators relating to wellbeing and fair employment into the new home care and reablement service specifications, aligning with Southwark's Ethical Care Charter (ECC)		SEL ICS (Integrated Commissioning)	Quality, Performance and Transformation (Commissioning) Adult Social Care	Service specification with clear workforce wellbeing key performance indicators  Contract monitoring to review compliance with the ECC and associated benefits (e.g. staff retention.	March 2025  Quarterly through to 2030	<b>Targets:</b> 100% of providers compliant with the ECC  100% of staff paid at least the London Living Wage  Improvement in job satisfaction and other wellbeing indicators
	<b>2.4:</b> Use the new Southwark Council Social Value Framework to ensure all Council divisions can evaluate, monitor and measure commitments to staff health and wellbeing within the procurement of commissioned services and		Southwark Council (Local Economy)	All Council divisions	Social Value Framework and Measurement System developed  Review of phased introduction of Social Value Framework	April 2025  March 2026	<b>Outcomes:</b> Contract resources donated in creative and cultural events or projects and community health interventions  # of contracts with organisations that provide staff physical and mental health programmes

	contract management						# of long-term unemployed people from priority cohorts recruited  <b>Targets:</b> Increase in # of London Living Wage employers	
	2.5: Deliver and evaluate programmes to support the wellbeing of primary and social care staff		SEL ICB (People and Culture)	Partnership Southwark Integrated Commissioning GSTT SLaM	Pilot programmes aiming to support staff following incidences of violence and aggression evaluated  Repository of best practice and system wide framework for dealing with violence and aggression developed  Engagement with staff to co-produce solutions to stress caused by dysfunctional systems	March 2027  March 2027  March 2027	<b>Outcomes:</b> # of staff attending wellbeing activities  # of staff reached through engagement work	
Support people to lead healthy lifestyles that keep them well, working with population groups and communities	<b>A range of actions supporting this aim can be found within other strategies that are overseen by the Health and Wellbeing Board: <a href="#">Southwark’s Air Quality Action Plan 2023-2027</a>, <a href="#">Healthy Weight Strategy 2022-2027</a>, <a href="#">Sustainable Food Strategy 2023-2026</a> and <a href="#">Tobacco Control Strategy 2024-2030</a></b>							Reduction in the % of residents experiencing food poverty
	2.6: Evaluate the implementation and impact of		Southwark Council (Public Health)	Planning and Growth Culture	Evaluation plan agreed by Public Health and Planning Divisional Management Teams	December 2025	<b>Outcomes:</b> # of advertisements or event sponsorship  Increase in the % of residents satisfied with “services and	

where risk factors are clustered

Southwark's Healthy Advertising Policy			Communications Highways			<p>applications rejected on the basis of the Healthy Advertising Policy</p> <p><b>Targets:</b> Decrease in % of school children reporting having seen adverts for products high in fat, salt, or sugar on the way to school</p>
<p><b>2.7:</b> Use a Health in All Policies and evidence-based approach to develop a targeted Leisure Service, Parks and Culture offer</p>		Southwark Council (Leisure)	Public Health	<p>Health in All Policies workshop delivered and implementation plan developed</p> <p>Mechanisms for collecting, monitoring and reporting service user data established</p> <p>Development and roll-out of targeted offers</p>	<p>June 2025</p> <p>March 2027</p> <p>March 2027</p>	<p><b>Outcomes:</b> # of Leisure Service, Parks and Culture activities and programmes that target specific population groups</p> <p><i>Other outcome measures will be defined alongside work to develop data collection processes and will include metrics related to demographics of service users</i></p>

support to help you and your family live a healthy lifestyle"

*Other outcomes relevant to this aim (such as those relating to physical activity, mental health and prevalence of long-term conditions) are listed against other aims*



2.8: Expand the Rose Voucher healthy food scheme to different populations and delivery locations based on local need		Southwark Council (Public Health)	Local Economy	Review of current policy, operations and population need	April 2025	<b>Outcomes:</b> # of residents belonging to new target groups receiving vouchers  # of individuals signposted to other health and wellbeing support services through the scheme  <b>Targets:</b> Increase in # of low-income residents and pregnant people receiving vouchers  % of people receiving vouchers from Black, Asian or ethnic minority groups matches or is greater than that of the Southwark population  Increase in # of businesses registered with the scheme selling culturally appropriate food
			Exchequer Services			
			Southwark Food Action Alliance	Strategic options analysis	April 2025	
			Contracted partners	Onboarding of new voucher collection and distribution support hubs	June 2025	
			Southwark Children and Family Centres	Staff/volunteer training (including Making Every Contact Count and Dignity Principles)	March 2026	
			Markets and Street Trading			
			VCS partners			

							Increase in voucher utilisation	
Maximise access to leisure, daily movement and physical activity, ensuring that financial circumstance does not limit access	<b>2.9:</b> Expand the offer of affordable leisure activities in community settings and promote a wider range of physical activities	✓	Southwark Council (Leisure Services)	Parks Culture Public Health Schools VCS partners Children's and Adults' Services Highways Climate Change and Sustainability	Leisure offer within community venues such as Parks, Libraries, schools, faith settings established  Southwark "Move" campaign delivered, including assets that promote the benefits of active travel	March 2027  December 2025	<b>Outcomes:</b> # of leisure activities delivered outside of leisure centres  <i>Other outcome metrics to be defined as part of work to review data collection across Leisure Services (action 2.7)</i>	Increase in % of residents walking or cycling at least 5 times per week  Reduction of the gap in resident satisfaction in the "Council's work to encourage cycling and walking in the borough", between economically active and inactive groups
	<b>2.10:</b> Design and deliver zone-by-zone or borough-wide programmes and initiatives that address the financial, social and cultural barriers to active travel through the Streets for People strategy	✓	Southwark Council (Highways)	Climate Change and Sustainability Public Health Leisure Communications Environmental Protection	Targeted engagement work with communities facing barriers to active travel to support design of programmes  Targeted promotion of cycle schemes such as "Try a Bike"  Pilot of JUST Streets co-production approach to redeveloping streets and outdoor space	Ongoing  Ongoing  March 2027	<b>Outcomes:</b> # of residents engaging with programmes	

## Priority 3: Support to stay well

Aim	Action	Drive action	Owner	Partners	Output	Achieved by	Short-term outcome measures/targets	Long-term population health targets
							#: number    %: percentage	
Ensure that there are effective and accessible services that prevent illness and promote wellbeing, including measures to tackle “The Vital 5”	Actions outlining the role of the health and social care system in achieving this aim are outlined in the Partnership Southwark Health and Care Plan “Prevention and Health Inequalities” delivery plan.							Reduction of smoking prevalence in adults
	3.1: Establish Southwark Hubs for Health as part of our ‘Health in the High Street’ programme, to increase access to Vital 5 checks and health promotion advice amongst groups at risk of ill health and our Black, Asian and ethnic minority communities	✓	Southwark Council (Public Health)	Partnership Southwark GSTT QHS GP Federation IHL GP Federation Community Southwark Healthwatch Southwark VCS organisations Leisure Local Economy	Implementation of the Southwark Hubs for Health, with specific focus on reaching Core20PLUS groups	March 2026	Outcomes: Qualitative feedback on satisfaction with the service amongst Core20PLUS groups  Targets: Increase in the % of Vital 5 check participants from Core20PLUS groups	Reduction in the gap in obesity prevalence in adults by ethnicity

<p><b>3.2:</b> Commission a new Healthy Lifestyle Service with a single point of access that integrates health improvement and outreach programmes, ensuring it is well-placed to support residents with wider determinants impacting their health and to contribute to ongoing behaviour change support</p>		<p>Southwark Council (Public Health)</p>	<p>Leisure Local Economy Integrated Commissioning Partnership Southwark Customer and Exchequer Services Housing Healthwatch Children's Services</p>	<p>Service recommissioned</p> <p>Development of practitioner portal to enable direct referrals from Southwark Health Kiosks</p> <p>Network of commissioners and providers established to support integration and co-location of Healthy Lifestyle Service with wider local services</p>	<p>October 2025</p> <p>December 2025</p> <p>December 2025</p>	<p><b>Outcomes:</b></p> <p># of residents who have used the single point of access</p> <p># of residents accessing wider health and wellbeing initiatives through the single point of access</p> <p><b>Targets:</b></p> <p>% of people engaging with single point of access from Core20PLUS groups matches or is greater than that of Southwark population</p> <p>Increase in % of service users supported to have a higher level of physical activity</p> <p>Increase in % of stop smoking service users achieving a 4-week quit</p>
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<p><b>3.3:</b> Recommission the Southwark Wellbeing Hub with a focus on improving the outreach offer to ensure underserved populations can access the support they need in their local area</p>	✓	SEL ICS (Integrated Commissioning)	<p>VCS organisations</p> <p>Primary Care Networks</p> <p>SLaM</p>	<p>New Southwark Wellbeing Hub service launched</p>	April 2026	<p><b>Outcomes:</b></p> <p># of residents accessing the service</p> <p><b>Targets:</b></p> <p>% of service users from Core20 and Black, Asian and ethnic minority groups matches or is greater than that of the Southwark population</p>
<p><b>3.4:</b> Establish a new Women's Safety Centre that is integrated with wider health, employment, housing and financial support services</p>		Southwark Council (Community Safety)	<p>SEL ICB</p> <p>King's Health Partners</p> <p>SEL ICB (Southwark Primary and Community Based Care)</p> <p>GSTT</p> <p>SLaM</p> <p>Integrated Commissioning</p> <p>Customer and Exchequer Services</p> <p>Local Economy</p>	<p>New Women's Safety Centre established</p> <p>Public health data used to identify local areas of need to enable delivery of preventative programmes and outreach</p> <p>Training and resource needs identified (to support the health and care system to identify and support women and girls at risk of violence and increase awareness of public space forms of violence)</p>	All December 2026	<p><b>Outcomes:</b></p> <p># of service users</p> <p># of service users accessing wider forms of support (e.g. housing support)</p> <p># of interventions in public spaces to address hotspots</p> <p># of health and social care staff receiving training</p>

			Housing Public Health VCS partners			
<b>3.5:</b> Deliver a review of link workers across the NHS and Council, including Social Prescribers and Community Health Ambassadors, considering their capacity and capabilities with a view to developing a more integrated approach		Partnership Southwark Delivery Team	Public Health Healthwatch GP federations Primary Care Collaborative	Review of link worker roles with recommended next steps	March 2026	<i>Outcomes to measure efficacy of an integrated approach to be defined during the review process</i>
<b>3.6:</b> Deliver and evaluate an inclusive surgeries programme across GP practices in Southwark		Southwark Council (Public Health)	GP federations SEL ICB (Southwark Primary and Community Based Care)	Adoption of programme with completed 6-month action plans for each GP practice  Evaluation of the programme	February 2027  July 2027	<b>Outcomes:</b> # of practices implementing an inclusive surgeries programme  <b>Targets:</b> Improved staff awareness of health inequalities and how practices can better meet need of residents

							Residents and carers have improved experience of primary care  Increased uptake of preventative care and early diagnosis amongst target populations	
Reduce admissions to hospital for falls	<b>This aim is supported by the Partnership Southwark Health and Care Plan “Integrated Frailty Pathway” delivery plan.</b>							Reduction in rate (per 100,000) of emergency hospital admissions due to falls in people aged 65 and over in Southwark
	<b>3.7:</b> Map the falls prevention exercise provision in Southwark to identify tailored forms of support for specific communities, enable personalised signposting, and to identify gaps in the support offer		GSTT (Integrated Care Transformation Team)	Leisure Services Adult Social Care Age Well Integrated Commissioning VCS organisations Public Health	Mapping of activity and exercise provision  Guide for frontline staff/referrers  Guide for residents	All March 2026	<b>Outcomes:</b> # of people attending falls prevention classes  <b>Targets:</b> 10% increase in referrals to Community Rehab and Falls service  % of people attending falls prevention classes from Core20 and Black, Asian and ethnic minority groups matches or is greater than that of Southwark population	

Support carers and families to look after their own wellbeing	<b>3.8:</b> Improve access to support for carers by developing digital forms of carer assessment delivery, increasing awareness of carers assessments and improving data linkage	✓	Southwark Council (Adult Social Care)	Age Well Integrated Commissioning  Contracted organisations  Primary Care Networks  SEL ICB VCS organisations	Digital carers assessments with Mobilise explored  Awareness sessions with adult social care and healthcare staff delivered  VCS and faith organisations identified and engaged with  Linkage of cared-for person support plans and carer data across social services and NHS systems, including the London Care Record	March 2026  March 2026  March 2026  March 2027	<b>Targets:</b> Increased take up of carers assessments  Increased take up of support for carers  Improved satisfaction of services amongst carers	Reduction in the % of unpaid carers reporting a mental health condition or long-standing illness
	<b>3.9:</b> Commission a new Carers Centre providing a comprehensive support offer for Southwark		SEL ICS (Integrated Commissioning)	Adult Social Care Public Health VCS organisations	New centre commissioned	June 2026	<b>Targets:</b> Increased take up of support for carers  Improved satisfaction of services amongst carers	



## Priority 4: Healthy communities

Aim	Action	Drive action	Owner	Partners	Output	Achieved by	Short-term outcome measures/targets	Long-term population health targets
							#: number    %: percentage	
Work together to mitigate the impacts of the cost of living crisis for people in Southwark	4.1: Develop a cross-borough anti-poverty plan, informed by resident engagement, to understand and tackle poverty and its impact on our residents	✓	Southwark Council (Strategy and Communities)	Public Health	Poverty JSNA factsheet published	April 2025	Short-term outcomes to be defined within the anti-poverty plan	Reduction in % of children living in relative poverty in Southwark
				Exchequer Services	Mapping of Council work to tackle poverty	July 2025		
				Community Engagement	Resident engagement exercise delivered	December 2025		
				Children’s Services	Cross-Council plan presented to Health and Wellbeing Board	December 2025		
				Policy and Public Affairs				
Southwark Insights and Intelligence Programme								
VCS partners								
Promote good mental health and reduce social isolation and loneliness by focusing on prevention and creating	Actions supporting this aim can be found in <a href="#">Southwark’s Suicide Prevention Strategy 2023-2028</a> . Actions relating to mental health treatment, management and services can be found in the <a href="#">Partnership Southwark Health and Care Plan “Adult’s Mental Health” delivery plan</a> .							Reduction in the percentage of adults who feel lonely often or always
	4.2: Launch a new 5 ways to wellbeing campaign in Southwark to		Southwark Council (Public Health)	Leisure Communications Housing	Theory of Change for campaign co-produced Map local provision/ opportunities against each of the five ways to	May 2025  July 2025	Outcomes: # of people accessing information about services related to	Reduction in gap in prevalence of depression

connected communities	promote the Leisure Services, Parks and Culture offer amongst the Core20PLUS and those at risk of poor mental health			Adult Social Care Exchequer Services Local Economy VCS partners	wellbeing and develop or sponsor initiatives to meet any identified gaps  Develop campaign resources and launch an online media campaign to promote the five ways to wellbeing and related services  Deliver MECC training to support campaign	July 2025      March 2026	the 5 ways to wellbeing through the Southwark Council website  <b>Targets:</b> Annual increase in visits to the mental health pages on the Southwark council website  Increase in # of residents, and those belonging to Core20PLUS groups, accessing relevant services	between white and Black residents
Support our thriving voluntary and community sector to deliver impactful programmes and services that contribute to reducing health inequalities	<b>4.3:</b> Support a consortium of VCS organisations promoting good mental health to pilot a collaborative commissioning approach, with the aim of identifying lessons learned that can inform expansion of this approach to different areas of		Community Southwark	VCS organisations Partnership Southwark	Analysis of funding landscape  Consortium established  Embed learning and opportunities from SEL ICB work on Creative Health	All March 2027	<b>Outcomes:</b> # of successful joint bids  Amount of funding received	Increase in % of VCS organisations who report having secure funding for the next 12 months

	health and wellbeing							
	<b>4.4:</b> Establish an approach for identifying and tracking localised funding opportunities for VCS organisations providing health and wellbeing support, starting with youth services		Community Southwark	VCS organisations Children's services Local funders	Shared map of funding opportunities for youth services in a defined area	March 2026	<b>Outcomes:</b> Funding received by youth services  <i>Other metrics to establish impact of collaborative approach will be identified during delivery of the project</i>	
	<b>4.5:</b> Support the VCS to influence policy and practice that impacts health inequalities by building skills and capacity in community research		Southwark Council (Public Health)	People and Organisational Development  Community Southwark  Community Engagement  London South Bank University  VCS partners	Training on research methods, co-production and Participatory Action Research approaches delivered to VCS and Council staff  Community Researcher programme delivered and evaluated	All March 2027	<b>Outcomes:</b> # of staff trained  # of community researchers  <i>Other outcome measures will be defined within the SIIP evaluation plan</i>	
	<b>4.6:</b> Develop Trust and Health Creation Partnerships and fund capacity building and skills		SEL ICS (Voluntary Sector Collaboration and Partnerships)	SEL Voluntary, Community and Social Enterprise Strategic Alliance	Trust and Health Creation Partnerships established  Community interventions trialled	April 2025  2027	<b>Outcomes:</b> Funding invested in Southwark VCS groups through the Trust and Health Creation	

	support to help VCS partners co-produce community interventions to tackle the vital 5, improve uptake of vaccinations and reduce health inequalities			Community Southwark VCS partners Partnership Southwark (Delivery Team, Live Well group and prevention and health inequalities working group) King's Health Partners SEL ICB (Southwark Primary and Community Based Care) Public Health	Interim evaluation findings, frameworks and lessons learned from Trust and Health Creation Partnerships shared with local partners  Frameworks adopted by local partners  Skills and capacity building support delivered to micro "By and For" VCS groups through Community Southwark	2027  2027  2027	Partnerships and capacity building and skills funding (£)  # of Southwark VCS groups receiving skills and capacity building support  Qualitative measures of the impact of capacity building and skills support  <i>Impact measures for the Trust and Health Creation Partnerships will be co-developed upon programme initiation</i>	
Ensure Southwark residents have access to good quality homes, streets and environments that promote	Further actions related to air quality can be found within <a href="#">Southwark's Air Quality Action Plan 2023-2027</a>							Increase % of residents satisfied in the Council and partners' work towards decent homes for all  Reduction in fraction of mortality
	4.7: Work in partnership across the Council and ICS to strengthen air quality monitoring and develop shared	✓	Southwark Council (Environmental Protection)	SEL ICB (Corporate Team) GSTT KCH SLaM	Review of shared data to identify opportunities for further joint working  All partner institutions using Ricardo air quality monitoring tools	March 2026  March 2027	<b>Outcomes:</b> # of local organisations (including health and care partners) signed up to use the Air Pollution	

good health and wellbeing

approaches, building on the work of the Air Pollution Footprint Partnership at a local level			Impact on Urban Health Climate Change and Sustainability Local Economy Public Health			Footprint Partnership tools	attributable to particulate air pollution in Southwark
<b>4.8:</b> Use insights from the Amplifying Voices programme to develop a programme of community engagement that will shape delivery of Southwark's Air Quality Action plan		Southwark Council (Environmental Protection) and Impact on Urban Health	Public Health	Insights from Amplifying Voices shared with Southwark Council  Established community engagement programme (e.g. a Citizen's Assembly) that has embedded learnings from Amplifying Voices	Ongoing, quarterly  March 2026	<i>Outcomes to be defined as the plan for community engagement is developed</i>	
<b>4.9:</b> Deliver and evaluate a behaviour change campaign and a pilot of moisture alleviation measures to prevent ill health from damp and mould within Council housing		Southwark Council (Housing - Responsive Repairs)	Public Health Housing (Planned Maintenance)  Academic institutions	Behaviour change campaign delivered  Moisture alleviation measure piloted and evaluated	All March 2026	<b>Targets:</b> Reduced # of call-outs for damp and mould	
<b>4.10:</b> Adopt a data-driven approach to		Southwark Council (Housing	Public Health	Mechanism for data-driven prioritisation of	Both 2027	<b>Outcomes:</b>	

prioritise damp and mould interventions, combining insights from the stock condition survey to identify vulnerable properties and primary care data to identify high-risk residents		- Planned Maintenance)	Housing (Responsive Repairs)	damp and mould interventions in place  Integration of primary care data with Council asset management systems		# of vulnerable residents and properties identified  % of residents identified receiving proactive interventions  <b>Targets:</b> 60% of stock condition data collected by 2027  Reduced # of call-outs for damp and mould
<b>4.11:</b> Establish sites for co-located housing and health and wellbeing support, including at the Housing Options Service, Family Hubs and health outreach hubs	✓	Southwark Council (Housing - Housing Needs)	Public Health Children's Services  VCS organisations, including local foodbanks  No Recourse to Public Funds  GP federations	Co-location feasibility assessments  Co-location sites established	December 2025  December 2026	<b>Outcomes:</b> # of sites established  # of individuals receiving housing support at outreach sites
<b>4.12:</b> Ensure the revised Local Plan helps to address health inequalities	✓	Southwark Council (Planning and Growth)	Public Health	Public Health review of the current Local Plan and Healthy Advertising Policy	December 2025	<i>Planning policies will be monitored using indicators</i>

through the spatial consideration of land uses such as open space, design considerations and the transport and movement network				Local Plan reflecting local public health priorities out for public consultation	2027	<i>agreed as part of the new Plan</i>
<b>4.13:</b> Develop a cross-Council action plan to limit the impacts of hot weather on health		Southwark Council (Public Health)	Climate Change and Sustainability Emergency Planning Southwark Insights and Intelligence Programme	<p>Action plan developed</p> <p>Pilot initiatives to better understand and address 'hot homes'</p> <p>Extreme heat emergency preparedness and response exercise</p> <p>Enhanced provision to support rough sleepers and other health inclusion groups during hot weather delivered</p>	<p>March 2026</p> <p>March 2027</p> <p>March 2027</p> <p>March 2027</p>	<b>Outcomes:</b> Qualitative metrics of heat-related wellbeing

<b>Meeting Name:</b>	Health and Wellbeing Board
<b>Date:</b>	13 March 2025
<b>Report title:</b>	Delivery of Connect to Work in Southwark
<b>Ward(s) or groups affected:</b>	All
<b>Classification:</b>	Open
<b>Reason for lateness (if applicable):</b>	Not applicable
<b>From:</b>	Assistant Director of Economy

This item relates to **action 2.1** in the draft Joint Health and Wellbeing Strategy action plan 2025-27.

## RECOMMENDATIONS

1. That the Health and Wellbeing Board note the plans for embedding employment support within primary care, secondary care and community health services through the Connect to Work programme, which will contribute to the delivery of the revised Health and Wellbeing Strategy action plan.
2. That the Health and Wellbeing Board provide feedback related to how the implementation and delivery of Connect to Work in Southwark can support the borough's ambitions in respect of health and wellbeing and in particular:
  - How best to encourage genuine integration of employment support, health and wellbeing services in Southwark;
  - How Connect to Work can best support wider developments in health and wellbeing service delivery including the move to Neighborhoods working and the recommissioning of the Integrated Healthy Lifestyle Service; and
  - Who else should be involved in this work to ensure we collectively maximise impact.

## BACKGROUND INFORMATION

3. Connect to Work is a Department for Work and Pensions (DWP) funded programme of supported employment to be delivered over five years from April 2025 to financial year 2029/30. It will be a voluntary programme whose primary objective is to support people with health and disability related barriers into good quality, sustainable employment using tested models of supported employment known as Individual Placement and Support (IPS) and the Supported Employment Quality Framework (SEQF).



4. According to DWP modelling, Southwark is anticipated to have the highest number of Connect to Work participants of all central London boroughs, with up to 700 starts per year when the programme is at full capacity. Over the five-year delivery period, over 2,000 people are expected to benefit from support. The total funding available for delivery in Southwark is £8.7 million.
5. Connect to Work is among the first initiatives linked to the Get Britain Working white paper published by DWP in November 2024. The white paper sets out an overarching commitment to closer integration between health and employment services, introducing a requirement to develop new work, health and skills plans for the economically inactive, led by mayors and local areas.
6. Connect to Work is a devolved programme that encourages local approaches to its design and delivery and responds to the needs of local populations and labour markets, making use of the knowledge and partnership networks that local authorities hold within their areas.
7. In January 2025, the Cabinet Member for Climate Emergency, Jobs and Business agreed to adopt a mixed approach to the delivery of Connect to Work in Southwark. The selected approach includes a commissioned service working alongside an in-house delivery team.
8. This approach was chosen to offer strong local direction over programme design and delivery, enabling local flexibility and responsiveness in the model and driving integration with health, care and wellbeing services across the borough. It follows that this approach has the potential to deliver the service in a way that can be best aligned with residents' needs.
9. A new in-house team is being established alongside the commissioning of the contracted elements of the service. Both elements are due to go live in October 2025 when the first residents will receive support.

## **KEY ISSUES FOR CONSIDERATION**

10. The development of the Connect to Work delivery model in Southwark has involved extensive engagement with council and NHS teams to map services, raise awareness of the offer and co-produce an approach to delivery that fits with the local landscape of provision. Key services have been engaged across Public Health and Partnership Southwark, Primary Care delivery, Children's Service, Adult Social Care, Communities and Housing Solutions.
11. Connect to Work will add to an existing portfolio of employment support provision for Southwark residents facing health, disability-related and other significant barriers to employment. These include:
  - Services provided under the Southwark Works framework funded by the council.
  - Employability support provided to residents through council services such as corporate parenting and SEND.
  - IPS support for people with drug and alcohol dependency issues funded by the Office for Health Improvement and Disparities.

- IPS support for people with severe mental illness funded by the NHS.
- Employment advisers for people engaging in talking therapies funded by DWP.

12. Connect to Work will add significant additional capacity to these existing programmes. However, enhanced coordination will be essential to avoid confusion or disconnection between elements of support aimed at people with similar needs. Effective service integration will range from outreach and strong referral relationships, to joint case-working, to co-location of support.
13. To address this, a programme lead will be employed within the council's Local Economy Team who will take the lead in building relationships and referral networks across the existing and new services, while establishing the new supported employment resource across health and wellbeing services.
14. To move this work forward, we welcome the Board's contribution to shaping the proposed approach to integrating employment support with health and wellbeing services, with a particular focus on how we can maximize what we already do well and build the right relationships to innovate and deliver what works for local people.

### **Policy framework implications**

15. The purpose of this discussion paper is to seek opportunities to align the development of Connect to Work with the existing strategic policy framework, including new national government policy, Southwark 2030, Economic Strategy and the Health and Wellbeing Strategy 2022 – 2027.

### **Community, equalities (including socio-economic) and health impacts**

16. The focus of this discussion paper is to seek ideas and to influence the further development of Connect to Work to ensure it maximizes the potential to impact positively on health of local people and reduces health inequalities. Full community, equalities and health impact statements will be completed as part of the programme's ongoing development.

### **Climate change implications**

17. There are no climate change implications from this discussion paper. Any climate implications will be managed as part of the further development of Connect to Work.

### **Resource implications**

18. There are no resource change implications from this discussion paper. Any resource implications will be managed through the decision-making process as part of the development of Connect to Work.

### **Consultation**

19. Consultation has taken place across council and NHS teams as set out in paragraph 10. Consultation has also taken place with potential delivery partners

in preparation for the procurement of elements of Connect to Work delivery.

## **SUPPLEMENTARY ADVICE FROM OTHER OFFICERS**

None required for this discussion paper.

### **Head of Procurement**

20. There are no procurement implications arising from this discussion paper.

### **Assistant Chief Executive, Governance and Assurance**

21. There are no legal implications arising from this discussion paper.

### **Strategic Director of Resources**

22. There are no financial implications arising from this discussion paper.

### **Other officers**

23. None required.

## **BACKGROUND DOCUMENTS**

<b>Background Papers</b>	<b>Held At</b>	<b>Contact</b>
<a href="#">Southwark Health and Wellbeing Strategy 2022 - 2027</a> and 2025-2027 action plan (see meeting papers)	Public Health Southwark Council, 160 Tooley Street	Chris Williamson chris.williamson@southwark.gov.uk
<a href="#">Connect to Work IDM</a>	Local Economy Team, Southwark Council, 160 Tooley Street	Nick Wolff Nick.wolff@southwark.gov.uk

## **APPENDICES**

<b>No.</b>	<b>Title</b>
Appendix 1	Connect to Work delivery in Southwark – Presentation for Health and Wellbeing Board

## **AUDIT TRAIL**

Lead Officer	Danny Edwards, Assistant Director of Economy		
Report Author	Nick Wolff, Employment and Skills Manager		
Version	Final		
Dated	28 February 2025		
Key Decision?	No		
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER			
Officer Title		Comments Sought	Comments Included
Assistant Chief Executive, Governance and Assurance		No	
Strategic Director, Finance		No	
Date final report sent to Constitutional Team			3 March 2025



# Connect to Work delivery in Southwark

Health and Wellbeing Board  
13 March 2025

Nick Wolff, Employment and Skills Manager

# The Connect to Work programme

- First initiative implemented under the Get Britain Working white paper.
- DWP-funded programme of supported employment to be funded over five years from April 2025 to March 2030.
- Aims to address 'hidden unemployment' – **people who would like to work but are not currently participating in the labour market.**
- Delivery devolved to local areas, within the national programme framework.



# Who it is for

Primarily to support people with **physical and mental health and disability** related barriers into good quality, sustainable employment.

Uses tested models of support known as Individual Placement and Support (IPS) and the Supported Employment Quality Framework (SEQF).

**Integration of health, wellbeing and employment support** at the core of this approach.

- Wider eligible cohorts include:
  - Offenders and ex-offenders.
  - Carers and ex-carers.
  - Homeless people.
  - Former armed forces members and their partners.
  - People with drug or alcohol dependency, including a history of dependency.
- Care experienced young people and care leavers.
- Refugees, resettled Afghans, people on the Ukrainian scheme.
- Victims/survivors of domestic abuse.
- Young people involved or at risk of being involved in serious violence.
- Victims of modern slavery.

# Southwark volumes

- DWP modelling has Southwark with the highest number of participants of all central London boroughs.
- Scale is comparable with existing Southwark Works framework provision.
- 50% are expected to achieve ‘first earnings’ following support.

	2025/6	2026/7	2027/8	2028/9	2029/30	Total
Starts on programme	252	672	700	504	63	2191



# Opportunity for Southwark

Further integrate employment, health and social care / wellbeing services across council teams, supporting and developing Southwark 2030, Health & Wellbeing Strategy and Partnership Southwark Health & Care Plan objectives.

Use local knowledge, networks and partnerships to deliver a programme that best meets needs of residents and local employers.

Demonstrate capacity to deliver DWP programmes at borough level.

Develop and test new models of delivering integrated employment support, including through an in-house team where this offers potential for best outcomes.

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# Delivery

30% in house

New team of up to 8 caseworkers within Local Economy.

Emphasis towards links with council and primary care directly delivered support for eligible residents.

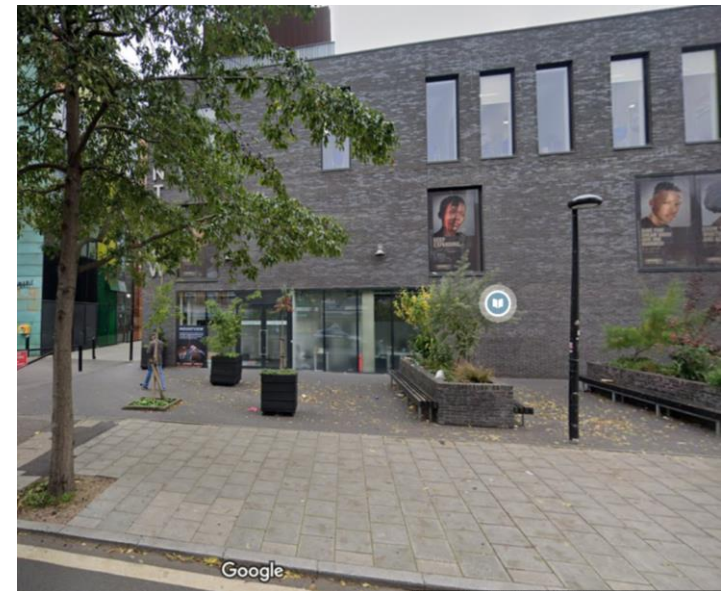
70% commissioned

Council-commissioned providers. May include existing Southwark Works providers and other specialist health and employment services with capacity to integrate with local partners.

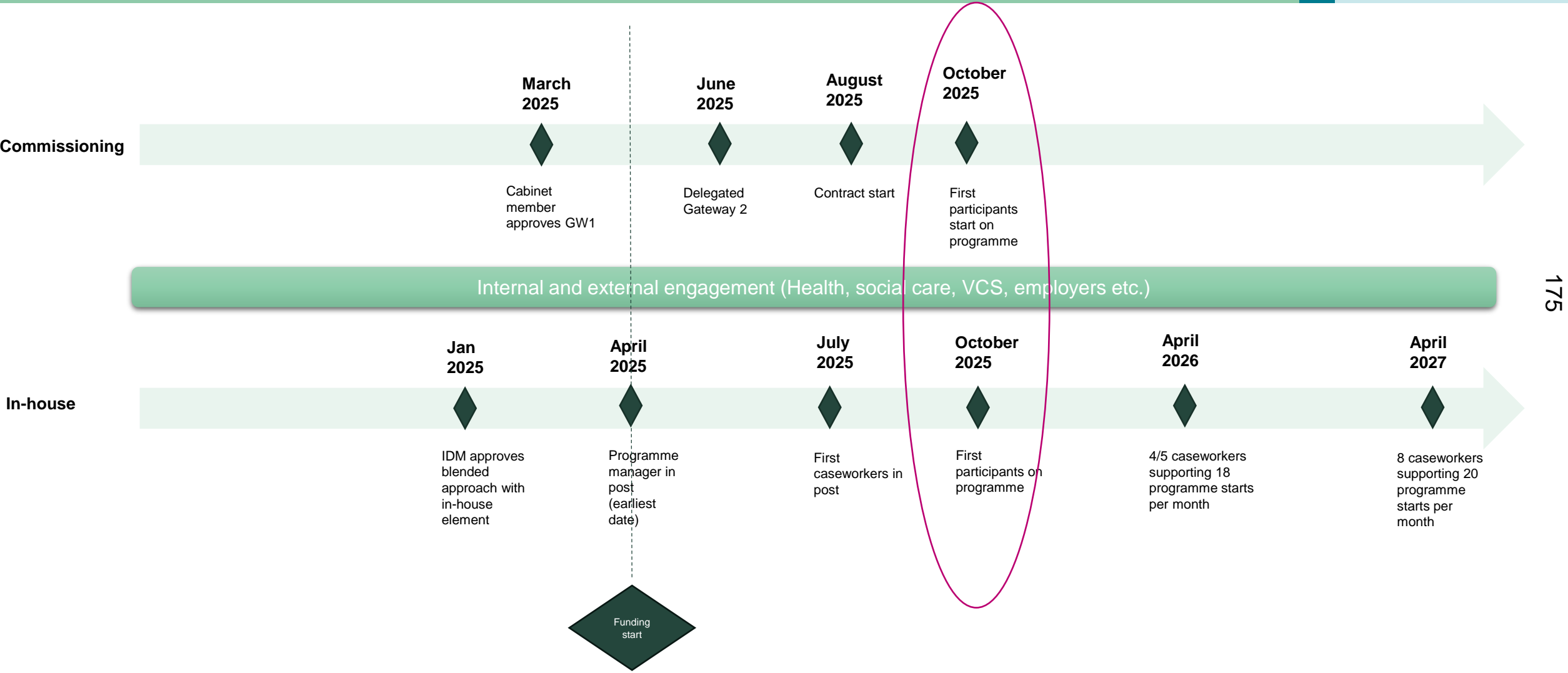
Emphasis towards streamlining relationships across key commissioned services.

Integrated with Southwark Works for consistent resident and employer offer.

New high street hub next to Peckham Library.



# Southwark blended delivery – mobilisation timeline



# For discussion

## **1, Integration**

Engagement works best when new support is introduced alongside services people are already working with. How can we best encourage genuine integration of employment, health and wellbeing services in Southwark?

## **2, Strategic alignment**

How can Connect to Work best support wider developments in health and wellbeing service delivery such as the move to Neighborhoods working and recommissioning of the Integrated Healthy Lifestyle Service?

## **3, Networks**

Who else should be involved in this work to ensure we collectively maximise impact?

<b>Meeting Name:</b>	Health and Wellbeing Board
<b>Date:</b>	13 March 2025
<b>Report title:</b>	JOINT FORWARD PLAN – 2025/26 REFRESH
<b>Ward(s) or groups affected:</b>	All
<b>Classification:</b>	Open
<b>Reason for lateness (if applicable):</b>	Not applicable
<b>From:</b>	Strategic Director for Integrated Health and Care Southwark Place Executive Lead

### RECOMMENDATION(S)

1. That the Health and Wellbeing Board notes the draft NHS South East London Integrated Care Board Joint Forward Plan refresh for 2025/26.
2. That the Health and Wellbeing Board confirms that it considers that the refreshed Joint Forward Plan continues to take proper account of the priorities and actions outlined within the Southwark Joint Health & Wellbeing Strategy.

### BACKGROUND INFORMATION

3. The Health and Wellbeing Board received a report on 20/07/23 setting out the details of the first Joint Forward Plan of NHS South East London Integrated Care Board (SEL ICB). This is a 5 year strategic plan for 2023/24 to 2028/29 setting out how the health needs of the population will be met. The Board confirmed that the Joint Forward Plan was considered to take proper account of Southwark's Joint Health and Wellbeing Strategy - such agreement from local health and wellbeing boards being a national condition for the ICB to meet before finalising and publishing its plan.
4. It is also a statutory requirement for the ICB to refresh the Joint Forward Plan on an annual basis and seek agreement from local Health and Wellbeing Boards that it continues to take proper account of the latest local Health and Wellbeing Strategies. The Board received a report on the 2024/25 refresh at its meeting of 14/04/2024.
5. The purpose of this report is to present the 2025/26 Joint Forward Plan refresh to the Board for comments and endorsement before it is finalised and published on 31/03/25.

6. The overall approach to the refresh of the plan, which covers all NHS services at South East London level as well as local care partnership plans, has been to reduce the size and complexity of the documents and focus on key priorities, objectives and outcomes. The Southwark section of the refreshed plan (see **appendix 1**) has been modified to reflect work undertaken during the current year by Partnership Southwark to refresh the priorities of the Southwark Health and Care Plan, which is closely aligned to the Southwark Health and Wellbeing Strategy.
7. The Health and Wellbeing Board received a report on 14/11/24 on the refreshed strategic priorities of the Southwark Health and Care Plan and how they align to the Joint Health and Wellbeing Strategy.
8. It should be noted that it is anticipated that the Joint Forward Plan is likely to require a significant further refresh upon the publication of the next NHS Long Term Plan which was recently subject to a national consultation process and is expected to be issued later this year.

## **KEY ISSUES FOR CONSIDERATION**

### **Key points of Joint Forward Plan**

9. The Joint Forward Plan provides a strategic overview of key priorities and objectives for the next 5 years at SEL and borough level, and a summary of short term actions to deliver these. The full plan covers a wide range of planning requirements to ensure that services are being developed that:
  - Meets the needs of our population
  - Make progress in addressing the core purpose of our wider integrated care system - improving outcomes in health and healthcare, tackling inequalities in outcomes, experience and access, enhancing productivity and value for money and helping the NHS support broader social and economic development
  - Delivers national NHS Long Term Plan
  - Meets the statutory requirements of our Integrated Care Board
10. The plan builds on the work been done as a wider system and is driven by:
  - The SEL Integrated Care Partnership integrated care strategy (as presented to the Health and Wellbeing Board on 17<sup>th</sup> November 2022)
  - Borough based Local Health and Wellbeing Plans
  - Local Care Partnerships plans
  - SEL-wide pathways and services transformation work such as acute, urgent and emergency, cancer, primary care and enablers such as digital, workforce, medicines optimisation, mental health and estates

11. The refresh of the plan brings an additional focus on:
  - Identifying clearly our key priorities and the actions to be taken
  - Setting out how actions will support population health and inequalities
  - Contributing to financial sustainability
  - Clarifying impact measures
12. The full Joint Forward Plan is a very large document and is more easily viewed in a navigable format on the ICS website [www.selondonics.org/joint-forward-plan](http://www.selondonics.org/joint-forward-plan)

### **Southwark borough section of the refreshed Joint Forward Plan**

13. The Southwark section (**appendix 1**) sets out the 5 key strategic priorities Partnership Southwark has agreed to focus on:
  1. Children and Young People's Mental Health
  2. Adult Mental Health
  3. Frailty
  4. Prevention and Health Inequalities
  5. Integrated Neighbourhood Teams
14. These priorities were approved by the Partnership Southwark Strategic Board following a review of the relevant strategic plans and strategies of Southwark Council and the Southeast London Integrated Care Board, including the Joint Health and Wellbeing Strategy and Southwark 2030, to ensure commonality of priorities across the plans and strategies.
15. Consideration was also given to the national context, specifically The Next Steps for Integrating Primary Care – The Fuller Stocktake Report, the Labour Party manifesto and the King's Speech. The findings from the Darzi investigation had not been published at the time of the review although the priorities proposed support the recommendations of the review.
16. Focused delivery plans have been developed for each strategic priority and these are summarised in the Joint Forward Plan.
17. It should be noted that the Southwark section of the Joint Forward Plan is not intended to cover the full range of operational priorities of the ICB in Southwark. A range of common priorities across boroughs are covered in the generic ICB-wide sections of the plan covering key services and enablers. For example, primary care access is covered in the Primary Care section of the plan.

### **Policy framework implications**

18. The requirement for a Joint Forward Plan arises from NHSE planning requirements established for Integrated Care Boards.

19. Health and Wellbeing Boards remain responsible for producing both joint strategic needs assessments and joint local health and wellbeing strategies which future iterations of the Joint Forward Plan are required to take into account.

## **Community, equalities (including socio-economic) and health impacts**

### **Community impact statement**

20. The core purpose of the Joint Forward Plan underpinning the detailed workstreams is “improving outcomes in health and healthcare, tackling inequalities in outcomes, experience and access, enhancing productivity and value for money and helping the NHS support broader social and economic development”.

### **Equalities (including socio-economic) impact statement**

21. The plan aims to tackle health inequalities that lead to differences in health and life expectancy within the borough. The strategy takes a community and place focus, which involves providing additional support to the population groups that have the poorest outcomes and focusing on the most disadvantaged neighbourhoods.

### **Health impact statement**

22. As stated within the plan the key population health and inequalities challenges it seeks to address are:
  - High levels of health need, with a clear link across to the relatively high levels of deprivation and population diversity found in south east London.
  - Life expectancy for south east Londoners is below the London average for all boroughs except Bromley.
  - Differences in life expectancy are more marked for those born in the least and most deprived areas across south east London.
  - These factors drive significant inequalities, with a variance across boroughs including higher levels of need, challenge and opportunity across our inner south east London boroughs, but with clear inequalities and an inequalities gap evident within each of our six boroughs.
  - Known risk factors that drive poor health outcomes plus drive inequalities.
  - Inequalities evident in terms of access, experience and outcomes.

## **Climate change implications**

23. As set out in the Sustainability section of the full plan, the ICB Green Plan underpins actions for making progress towards NHS carbon neutral targets.



24. The stated ambition is to have made clear progress towards the NHS targets of a net zero carbon footprint by 2040 and the interim target of 80% reduction by 2028, and the council's climate change plan and target for a carbon neutral Southwark by 2030. This will be measured in part through progress on key domains of the ICS Green Plan including workforce and system leadership, air quality, travel and transport (staff and patients), estates and facilities, sustainable models of care (including prevention and lean service delivery), digital, medicines (20% of NHS carbon footprint), supply chain and procurement, food and nutrition, adaptation, green spaces.
25. Specific sustainability opportunities will be considered within the individual workstreams underpinning the delivery of the five Southwark objectives.

### **Resource implications**

26. Officer time from all partners may be required to support the continued development and delivery of the multi-agency workstreams delivering the priorities of the Joint Forward Plan.
27. Any new projects/initiatives that arise through the action plan that require additional or reallocation of funding would need to be considered through the appropriate budget, monitoring and governance processes.

### **Legal implications**

28. The production of the Joint Forward Plan and its annual refresh fulfils one of the statutory obligations of the Integrated Care Board.

### **Financial implications**

29. Any financial decisions that relate to the delivery of the action plan will be taken separately through the relevant partner governance mechanisms.

### **Consultation**

30. The five objectives of the Joint Forward Plan refresh for Southwark are based on the outcome of a series of Partnership Southwark prioritisation discussions during 2024/25 in which all partners actively engaged.

## BACKGROUND DOCUMENTS

Background Papers	Held At	Contact
<a href="#">Joint Forward Plan 2024/25</a>	South East London Integrated Care Board	<a href="mailto:partnership.southwark@selondonics.nhs.uk">partnership.southwark@selondonics.nhs.uk</a>

## APPENDICES

No.	Title
Appendix 1	Southwark section of Joint Forward Plan refresh, South East London ICB 2025/26

## AUDIT TRAIL

<b>Lead Officer</b>	Darren Summers, Strategic Director for Integrated Health and Care/Southwark Place Executive Lead		
<b>Report Authors</b>	Rebecca Jarvis, Director of Partnership Delivery and Sustainability (Southwark), NHS South East London South East London Integrated Care System  Adrian Ward, Head of Planning, Performance and Business Support, Southwark, NHS South East London South East London Integrated Care System		
<b>Version</b>	Final		
<b>Dated</b>	28/02/2025		
<b>Key Decision?</b>	No		
<b>CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER</b>			
<b>Officer Title</b>		<b>Comments Sought</b>	<b>Comments Included</b>
Assistant Chief Executive Governance and Assurance		No	No
Strategic Director, Finance		No	No
List other officers here			
<b>Cabinet Member</b>		No	No
<b>Date final report sent to Constitutional Team</b>			28/02/25

# **South East London 2025/26 Joint Forward Plan Refresh Partnership Southwark**

draft 27.02.2024

# PARTNERSHIP SOUTHWARK - PLAN ON A PAGE

<b>Our vision is:</b>	<b>Our vision is to enable every part of the health and care system in Southwark to make the borough an amazing place to be born, live a full healthy life, and spend one's final years.</b>				
<b>Our priority areas are:</b>	<b>Children and young people's mental health</b>	<b>Adult mental health</b>	<b>Frailty</b>	<b>Integrated neighbourhood teams</b>	<b>Prevention and health inequalities</b>
<b>In 2025/26, we will:</b>	Reduce waiting times for children and young people who need help with their mental health. The support will be easy to access and coordinated around their needs.	Reduce waiting times for adults who need help with their mental health. The support will be easy to access and co-ordinated around their needs.	Pilot an integrated neighbourhood team for the frailty pathway in the Walworth Triangle. Use the learning from the pilot to inform spread and scaling to other neighbourhoods.	Launch a new model of care for Integrated Neighbourhood Teams (INTs) in Southwark.	Work in partnership so that Core20Plus5 communities will be more easily able to access tailored support for the five leading causes of poor health (the Vital 5).
<b>This will support population health and inequalities by:</b>	Enabling earlier access to mental health support and interventions and reduce escalation to crises and more costly acute health and social care intervention, with a focus on harder-to-reach young people.	Bringing together existing services and increasing the involvement of the VCSE to streamline and increase capacity, providing a more holistic and accessible service for all residents.	Utilising outreach to identify vulnerable and hidden cohorts prone to health inequalities, alongside a population health based targeted approach to mild, moderate and severe frailty.	Providing proactive joined up health and care services focused on local inequalities, improving outcomes by providing services at an earlier stage before deterioration leads to hospital admission.	Tackling the leading causes of death; and driving a focus on residents most at risk of poor health outcomes in our local communities.
<b>This will support system sustainability by:</b>	Reducing demand on acute services, modernising pathways, improving system navigation, and improving the use of resources (staffing, training and estates).	Adults who need help with mental health will not have to wait as long. The support will be easy to access and co-ordinated around their needs.	Promoting independent health and wellbeing for mild frailty to focus on prevention and providing coordinated care closer to home.	Shifting the balance of care from acute to community and from treatment to prevention through efficient integrated neighbourhood care.	By early identification of high-risk residents and preventing crisis stage, it will reduce demand on high-cost acute sector services.
<b>We will measure our impact by:</b>	Increase in % achievement of a system wide 4 week wait standard.	Increase in % achievement of a system wide 4 week wait standard. Reduction in number of patients waiting 72 hours in ED..	Improved proactive care reducing need for Emergency Care. Patient outcomes – Experience and Quality of Life. Improved proactive care meeting unmet needs	Metrics to be confirmed but will focus on reducing the rate of avoidable hospital and care home admissions.	Increase in uptake of Vital 5 checks by people from Core20Plus5 communities and increase in uptake of interventions.

# Partnership Southwark

## Vision

Our vision is to enable every part of the health and care system in Southwark to make the borough an amazing place to be born, live a full healthy life, and spend one's final years

## Deliverables / Improvements since 2023/24

**Start Well:** 1001 days project completed, and learning being taken forward in Family Hubs programme. Improvements in CYP Mental Health access and support for patients on waiting lists.

**Live well:** Vital 5 hypertension targets and health checks improvements, including via health promotion van. Community Mental Health Transformation programme complete and mainstreamed.

**Age Well:** Lower Limb Wound Care pilot successfully implemented - to be mainstreamed in 2025/26. Frailty workstream initiated focusing on an integrated pathway.

**Clinical Care and Professional Leads** recruited across all priorities.

**Partnership Southwark plans refreshed** and rationalised to focus on 5 key priorities by the newly established partnership team.

**Integrated Neighbourhood Teams** programme established to further develop integrated MDT working in line with expected government plans.

## Key Challenges / Opportunities Remaining

**Embedding system sustainability, prevention and health inequalities:** Budget pressures impact significantly on the potential to invest in community based preventative care models and address health inequalities.

**Mental health:** Too many children and adults are still waiting far too long to access mental health services. Escalating costs in the provision of complex adult mental placements remains a barrier to the joint commissioning of more appropriate local services.

**Capacity for change:** The capacity of partners to fully engage in transformation workstreams due to immediate delivery pressures remains a barrier to progress towards integrated solutions. System complexity adds to the challenge.

**Data:** there remain challenges with lack of robust data and analytics capacity impacting on development of comprehensive outcomes frameworks and population health approaches including Core20Plus5. Shared care records also perceived as too limited for efficient integrated working.

**Integrated Neighbourhood Teams:** the local and national drive towards the development of more integrated neighbourhood teams provides a key opportunity for addressing system challenges.

**Financial challenge:** significant shortfall in the budget means that there is limited scope for investment in growth and development opportunities.

## What are our priority areas for 2025/26

## Why has this been identified as a priority areas?

1

### Children and young people's mental health

The growing, local and national, mental health crisis for children and young people, with demands for mental health services continuing to exceed availability. Unacceptable long waits for Children and Adolescent Mental Health services (CAMHS), including for diagnostics of neurodevelopment disorders such as hyperkinetic disorders and attention deficit hyperactivity disorder (ADHD).

2

### Adult Mental Health

Waiting times for community mental health services are a challenge, with over one third of adults waiting over a year to receive treatment in 2024. We know that a significant proportion of these are referrals for neurodevelopmental problems.

3

### Frailty

Almost half of Southwark's residents over 65 report that they are not in good health, with this cohort of residents having poorer healthy life expectancy than the national average. Frailty is not an inevitable part of ageing, but it is highly prevalent and frailty healthcare costs an estimated £5.8 billion a year. The ageing population in Southwark amplifies these pressures and highlights the need for coordinated care.

4

### Integrated Neighbourhood Teams

The development of integrated care at a local level has long been recognised as a key priority for improving outcomes. However, the complexity of systems has limited progress in establishing a consistent agreed neighbourhood model. Partners have agreed that now is the time to prioritise this in the wider context of system level programmes for neighbourhood team development in line with national priorities.

5

### Prevention and health inequalities

Prevention and health inequality forms a critical part of national and local policy, with the NHS calling for systems to update plans for the prevention of ill-health and incorporate them within Joint Forward Plans, with a particular focus on improving outcomes for the Core20Plus5 populations and NHS England's high impact interventions for secondary prevention.

# Partnership Southwark

## Priority Area:

**Children and young people's mental health**

## What are the actions we will deliver in 2025/26

- Work with the Nest to identify what investment is needed to reduce waiting times.
- Use recommendations from the evaluations of the Nest and the Well Centre in Lambeth to inform how to make services easier to navigate and to improve access for less engaged groups.
- Carry out focused engagement and co-design with adolescents and early adulthood to inform future service developments.
- Work with SEL to develop the pathway for Neuro Developmental Disorders.

## Population Health and Inequalities Impact

- An aim to improve the equity of access through an integrated community offer and to reduce long waits for CYP, especially for Neurodevelopment disorders, will help to tackle health inequalities.

## System Sustainability Impact

- Likely to include a shift in investment from acute, intensive and costly health and social care, to preventative strategies through modernised pathways, co-location of services, improved navigation, and improving the use of resources such as staffing, training, facilities, and estates.

## Priority Area:

**Adult Mental Health**

## What are the actions we will deliver in 2025/26

- Improve access to community mental health services by developing a coordinated, easy-access mental health service, with input from primary care, VCSE organisations, SLAM and social care.
- Reduce waiting time for Neuro Developmental Disorders (NDD) and develop support to those whilst waiting.
- Enhance the mental health offer in neighbourhoods.

## Population Health and Inequalities Impact

- An aim to improve the equity of access through an integrated community offer and the enhancement of mental health offering at neighbourhood level will help to tackle health inequalities.

## System Sustainability Impact

- Moving to a neighbourhood approach likely to lead to improvement in system to sustainability.

# Partnership Southwark

<b>Priority Area:</b>  <b>Frailty</b>	<b>Priority Area:</b>  <b>Prevention and health Inequalities</b>
<b>What are the actions we will deliver in 2025/26</b> <ul style="list-style-type: none"> <li>• Pilot an integrated neighbourhood team for the frailty pathway in the Walworth Triangle. This will involve: <ul style="list-style-type: none"> <li>○ Identifying and developing datasets to define frailty groups</li> <li>○ Testing case finding tools</li> <li>○ Developing mild, moderate and severe frailty pathways at local level</li> <li>○ Ongoing evaluation and monitoring of success</li> </ul> </li> <li>• Use the learning from the pilot to inform spread and scaling to other neighbourhoods.</li> </ul>	<b>What are the actions we will deliver in 2025/26</b> <ul style="list-style-type: none"> <li>• Deliver a review of link workers across the NHS and Council, including Social Prescribers and Community Health Ambassadors, considering their capacity and capabilities with a view to developing a more integrated approach</li> <li>• Co-design with residents and health and social care partners interventions for people from Core20Plus5 groups with risk factors identified through a vital 5 check</li> <li>• Pilot the intervention(s) in targeted areas based on population health data.</li> <li>• Apply iterative learning for future scaling and spread.</li> <li>• Align with and support the SEL Vital 5 initiative.</li> </ul>
<b>Population Health and Inequalities Impact</b> <ul style="list-style-type: none"> <li>• Using a population health based approach and a range of different data sources to support identification of mild, moderate and severe frailty will allow inequalities to be tackled.</li> </ul>	<b>Population Health and Inequalities Impact</b> <p>Using a population health-based approach and a range of different data sources to support hard-to-reach communities.</p>
<b>System Sustainability Impact</b> <ul style="list-style-type: none"> <li>• Promoting healthy living and a focus on preventing frailty through moving care closer to home and earlier identification of frailty.</li> </ul>	<b>System Sustainability Impact</b> <ul style="list-style-type: none"> <li>• Early detection and management of high-risk residents closer to home, will reduce demand on high-cost acute sector services.</li> </ul>



# Partnership Southwark

## Priority Area:

**Integrated Neighbourhood Teams**

## What are the actions we will deliver in 2025/26

- Define population needs and services to include in Core INT
- Agreed Southwark INT model and defined neighbourhood footprints
- Agree INT Integrator Function within the Southwark lens
- Gap analysis from current working and shape high level 12 to 18 month Implementation Plan
- Engagement and socialisation of INT model and implementation plan to build momentum and engagement and further refine and shape a detailed implementation plan, building on existing examples of neighbourhood working and lessons learnt
- Organisational Development to organise existing staff and services into Teams and build joint visions and ways of working
- Recruitment of team managers to support each INT
- INTs launch, under a programme of iterative testing and learning

## Population Health and Inequalities Impact

Working in Southeast London to agree a population health management (PHM) approach and PHM functions and tools to address health inequalities through neighborhood working.

## System Sustainability Impact

Shifting the balance of care from acute to community and from treatment to prevention through an efficient model of integrated neighbourhood care.

# Partnership Southwark

Priority Area	What are the outcomes we are aiming to achieve?	How are we measuring our impact?
<b>Children and young people's mental health</b>	For CYP who need help with their mental health to not have to wait for so long. Support will be easy to access and co-ordinated around their needs.	<ul style="list-style-type: none"> <li>• Increase in % achievement of the 4 week wait standard</li> </ul>
<b>Adult mental health</b>	For adults who need help with their mental health to not have to wait for so long. Support will be easy to access and co-ordinated around their needs.	<ul style="list-style-type: none"> <li>• Increase in % achievement of a system wide 4 week wait standard</li> <li>• Reduction in number of patients waiting 72 hours in ED</li> </ul>
<b>Frailty</b>	For older people living with frailty to have their needs identified sooner, to receive treatment and support at a neighbourhood level tailored to their individual needs.	<ul style="list-style-type: none"> <li>• Reduce the rate of avoidable hospital and care home admissions from identified at risk cohorts.</li> <li>• Reduction in unplanned / emergency appointments (GP)</li> <li>• Reduction in ambulance conveyances</li> <li>• Reduction in outpatient appointments</li> <li>• Patient experience – quality of life</li> </ul>
<b>Prevention and health inequalities</b>	Core20Plus5 communities to have easier access to support for the five leading causes of poor health.	<ul style="list-style-type: none"> <li>• Increase in uptake of Vital 5 checks by people from Core20Plus5 communities</li> <li>• Increase in uptake of people from Core20Plus5 communities taking up interventions</li> </ul>
<b>Integrated Neighbourhood Teams</b>	To implement an agreed model of Integrated Neighbourhood Teams that helps improve outcomes across a range of outcome metrics linked to improved prevention and management of long term conditions.	<ul style="list-style-type: none"> <li>• Reduce the rate of avoidable hospital and care home admissions from identified at risk cohorts.</li> </ul>

# Partnership Southwark

## What do we need from enablers and partners to deliver?

- **Data and digital:** improved access to timely data in accessible formats which supports the development of the neighbourhood model and our population health management approach, including Core20Plus5. Solutions to data sharing to support multi agency working and the development of innovative digital approaches to support efficient health and care provision.
- **Workforce:** development of an ICS workforce strategy that supports integrated team models and improves recruitment and retention in key front-line roles.
- **Estates:** further develop our collaborative estates strategy to support integration, including the development of neighbourhood team facilities options.
- **Finance:** development of the system sustainability work to enable a shift to investment in neighbourhoods and preventative services.
- **Communications & Engagement:** support in developing our comms strategy to support the five priority workstreams.

## How will we work in collaboration with our system?

- **Wells Leadership:** develop diverse and proactive groups, impactful collaboration.
- **Community Networks:** grow these networks around each priority.
- **Professional Networks:** grow these networks around each priority.
- **Planning and delivery:** establish robust communications and engagement plans, influential working groups, and fully co-designed approaches.

We will also seek to obtain input from Health Innovation Network, Applied Research Collaborations, Kings Health Partners.

## How will we engage with our population?

- **Engagement:** build on recent community engagement (including Southwark 2030) and agree next steps as we scope and develop delivery plans.
- **Lived-experience and community panels:** establish fully co-designed approaches, embedding lived-experience and community voices in design and delivery.
- **Partnership:** work with Community Southwark and voluntary sector organisations as key partners in engaging with residents.

## How will we monitor and share progress?

- **Governance and reporting:** regular monitoring and reporting via governance structures and wider stakeholders, around a timeline and a set of agreed quantitative and qualitative measures, evidencing codesign approaches, and short-term and long-term outcomes (including for example community surveys and feedback mechanisms).
- **Communications and engagement:** establish robust plans to promote and communicate ambitions and achievements.

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**NOTE:** Amendments/queries to Maria Lugangira, [maria.lugangira@southwark.gov.uk](mailto:maria.lugangira@southwark.gov.uk)

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