SOUTHWARK JOINT MENTAL HEALTH AND STRATEGY – APPENDIX 1

MENTAL HEALTH & WELLBEING STRATEGY WORKSTREAM WORK PLANS 2021-2024

1. Prevention and Mental Health Promotion

What do residents experience now?	Delivery for Y1	Delivery for Y2	Delivery for Y3	How will we demonstrate delivery
In 2019/20, the Council trained 122 staff in Mental Health First Aid, so that they were prepared to support colleagues or residents they worked with in a mental health crisis. The programme was successful, and a decision was made to expand it	**At least 100 additional people will receive training between September 2021 and March 2021** The **Mental Health First Aid** training programme has been extended to more Council front line staff (i.e. Housing, Pest Control etc), as well as 50 Community Health Ambassadors.	All training will take place in FY 2021/22	All training will take place in FY 2021/22	Number of staff and Community Ambassador trained - Feedback from trained Mental Health First Aiders
Southwark Works is a service commissioned by the council aimed at supporting people to get back into employment or improve their employment situation through breaking down barriers and providing new skills. Whilst the service is open to anyone, it targets specific groups such as long-term unemployed, long-term conditions, existing mental health problems, at risk of homelessness, families and	**PHE Better Mental Health grant: Breaking down mental health barriers to employment.** The project will double the mental health support available and extend mental health support interventions to all Southwark Works clients, especially to those who are not already involved with Mental Health services but who may still have unmet mental health needs. Funding has been	The PHE grant needs to be spent by March 2022. The Local Economy Team is currently exploring options for extending this enhanced element of Southwark Works beyond FY 2021/22	TBC	Measure of wellbeing at baseline and post-intervention • Number of beneficiaries • Number of jobs, placements and/or courses completed

What do residents experience now?	Delivery for Y1	Delivery for Y2	Delivery for Y3	How will we demonstrate delivery
lone parents, NEET, care leavers and others	secured via a successful bid to PHE as part of their Better Mental Health fund 2021/22.			
Citizens Advice Southwark is already accredited by the Financial Conduct Authority (FCA) to provide debt advice and are commissioned by the Council and the Money and Pension Service to provide a general advice service to residents, which includes financial / debt advice. A report by the Money and Mental Health Policy Institute recommends debt advice be more accessible, in particular to those with existing poor mental health and wellbeing	**PHE Better Mental Health grant: A new specialist debt advisor will be recruited**. The post holder will have specialist knowledge and experience in supporting those with an existing mental health condition, those considered at risk of developing a mental health condition, or those with multiple disadvantages. This post will be able to support approximately 150-200 vulnerable people. The post will be up to 6 months, thanks to the funding received as part of our successful bid to PHE,.	The PHE grant will need to be spent by March 2022.	The PHE grant will need to be spent by March 2022	- Measure of wellbeing at baseline and post-intervention - Number of beneficiaries
Residents have access to advice and signposting information on mental health and wellbeing on the Council's website. Currently there isn't a digital wellbeing offer beyond that	Southwark Public Health is working on a **new, comprehensive digital health offer**, **which will include elements of mental health and wellbeing**. The offer will be under the banner "Take Care Southwark" and, using a series of digital tools underpinned by a behaviour change model, residents will be able to start	TBC	TBC	TBC

What do residents experience now?	Delivery for Y1	Delivery for Y2	Delivery for Y3	How will we demonstrate delivery
	their personalised digital journey to improve their health and wellbeing, assess their needs and be signposted to local resources.			

2. Wellbeing, information, advice and support in the community

What do residents experience now?	Delivery for Y1	Delivery for Y2	Delivery for Y3	How will we demonstrate delivery
Residents don't receive the full range of information, advice and support in the community that addresses needs Mental health community offer to be refreshed	Re-procurement of the Mental Health and Wellbeing Hub taking account of needs that have arisen since procurement, in particular impact of Covid-19 pandemic Task and Finish Group convened for procurement The needs of disadvantaged population groups (Black, Asian and Minority Ethnic communities; people facing multiple disadvantage) to be addressed in specification. Hub specification and procurement to involve co-production with service user and carers Success measures/monitoring arrangements clarified	Mental Health and Wellbeing Hub contract mobilised and in place. Quarterly meetings to review contract performance up and running Establish oversight group (to include operational staff Contract meetings to focus on: • Quarterly monitoring returns and formalities of contract meetings (first half) • Oversight group involvement to consider operational issues (second half)	Review community-based information, advice and support and identify priorities for future provision, including expansion	Design and development of community offer that reflects identified needs for provision based on current circumstances Service user satisfaction via surveys, case studies and co-produced success measures

What do residents experience now?	Delivery for Y1	Delivery for Y2	Delivery for Y3	How will we demonstrate delivery
(Contd) Residents don't receive the full range of information, advice and support in the community that addresses needs Mental health community offer to be refreshed	As part of community offer refresh, review all community-based mental health projects with which we have contracts, 360 degree review of current community provision to identify gaps, duplication, unmet need, to inform future commissioning intentions and reprovision	Complete 360 review of community mental health projects Use the opportunity provided by the community mental health transformation agenda to commission services that are better aligned and integrated	Review community-based information, advice and support and identify priorities for future provision, including expansion	Design and development of community offer that reflects identified needs for provision based on current circumstances Service user satisfaction via surveys, case studies and co-produced success measures
Full potential of digital mental health innovation not realised to improve access and quality of support	Building on the lessons learned during pandemic as well as availability of increasingly sophisticated technology, to maximise the benefits of digital provision. Digital provision must be aligned with other initiatives at neighbourhood level. This work to be added to remit of existing work taking place across the board in Southwark to avoid duplication	Pilot digital mental health resources within the borough Review pilot Consider how needs of digitally excluded service users are met to ensure equity in provision	Roll out digital provision across the borough taking account of lessons learned from pilot	An increase in take-up of digital solutions implemented Service user satisfaction assessed via surveys, case studies and agreed success measures that have been co-produced with residents, service users and patients (TBC)

What do residents experience now?	Delivery for Y1	Delivery for Y2	Delivery for Y3	How will we demonstrate delivery
Community based info, advice and support does not take full account of unmet need of some population groups, leading to inequity of provision	Engagement with Black Asian and Minority Ethnic communities using existing projects (SLaM BAME Community Development project, emerging PCREF projects) and appropriate tools and mechanisms for engagement (SST approach) to ensure widest possible engagement and understanding of needs Engage with residents facing multiple deprivation via *It Takes a Village* initiative	Develop innovative models of community based provision of information, advice and support that is culturally appropriate Consider workforce implications Pilot projects targeted at Black, Asian and Minority Ethnic communities, and to meeting the needs of individuals suffering multiple deprivation and social exclusion	Review pilots and roll out provision of services that meet the needs of Black Asian and Minority Ethnic communities and individuals and groups suffering multiple deprivation, **as identified by them**	Increased take up of services by targeted communities Service user feedback and satisfaction through agreed success measures
Community mental health offer is not fully integrated with neighbourhood provision	Within the context of the transformation of mental health agenda, align provision/re-provision of information advice and support services with integrated approach to health and care services developed at neighbourhood level. Identify links with neighbourhood/PCN service integration initiatives being led by Partnership Southwark and SLaM	Examine potential for co-location of services and integrated ways of working at neighbourhood level with Partnership Southwark (Live Well) and SLaM services redesign as part of transformation agenda. Consider use of estate for delivery of integration projects. Examine workforce implications	Information advice and support services integrated with neighbourhood initiatives	

3. Primary Care and Mental Health

What do residents experience now?	Delivery for Y1	Delivery for Y2	Delivery for Y3	How will we demonstrate delivery
Fragmented services that are not co-located	Establish working group to look at co-location of services at neighbourhood level, with links to estates planning	TBC	TBC	TBC
Divide between physical and mental health services	Integrate physical and mental health through neighbourhood approach bringing primary and secondary care closer alongside social care and the third sector	Upskilling and training physical health workforce to deal with mental health issues	TBC	TBC
Barriers to access	Develop integrated and clear points of access Develop open referral systems, streamlined assessment and triage processes Develop digital community channels to support multi agency working, improved shared care and access to Consultant Connect	TBC	TBC	TBC

4. Improving Access to Psychological Therapies

New referral numbers have decreased from March 2020, similar to most if not all London IAPT services– across all IAPT services. During the pandemic when people have not been out and about as much, they have had less opportunity to come across information about IAPT. Referral numbers have been increasing steadily from March 2021. IAPT activities have not decreased – more patients have been offered to start treatment.
Good look like – innovative work / effective allocation of resource / understand capacity requirement and funding implication
Recruitment – due to high turnover of staff particularly in the summer months
national targets are used to review successes – proportionally for these underrepresented groups – can be measured locally

What do residents experience now?	Delivery for Y1	Delivery for Y2	Delivery for Y3	How will we demonstrate delivery
Older adults - access; self and GP referrals; housebound services • Older Adult Positive Practice guide for IAPT – Jun 2021 • Under-represented in services – challenge is to make services more accessible; effective publicity; staff training. • There is an area of unmet need for older people -	• Publicise community groups for older people • –GP awareness of services / outcomes for older people	• run a community centre group	• Housebound older people / home visits	• Overall increase in older people seen in the services • Self-referral / GP referrals • Number of people seen; and recovery rates
University students • Not clear where they get support i.e. occupational health – • Unmet need as not registered with Swk GPs so do not have access to services • Needs to be reviewed	• Re-run the webinars in the autumn after summer holidays • Develop signposting to make self-referrals based on GP registration			• Number of people attending webinars • Feedback on the webinar

What do residents experience now?	Delivery for Y1	Delivery for Y2	Delivery for Y3	How will we demonstrate delivery
• Delivered focused groups i.e. consulted with students and uni welfare department Topics i.e. exam stress / efficiency				
Black, Asian and Minority Ethnic Communities • Lower referrals rates; higher dropout rates; lower recovery rates	• Race identity and me – BAME, depression and anxiety - 8 week group	• Develop and implement an alternative model i.e. tasters sessions / webinars sessions – one off sessions which will introduce IAPT / be culturally acceptable and accessible	• Better / updated resource file for community groups for BAME	• Access number for BAME individuals to IAPT • Feedback / impact of the webinars • Monitor attendance and recovery rate for BAME people

5. Averting Crisis and Reducing Suicide

What do residents experience now?	Delivery for Y1	Delivery for Y2	Delivery for Y3	How will we demonstrate delivery
High number of older people presenting in crisis at A&E	Data to be gathered through engagement with Guy's, King's and SLaM			Reducing number of older people presenting in crisis at A&E (dehydration/delirium from care homes)
Increase in use of alcohol related A&E attendances – injuries, suicidal ideation, liver/alcohol related illnesses, loss of access to mental health services because of substance misuse	Linking in with services to review data and develop targets, development of dual diagnosis pathways (dependence and mental health),			Referrals made by A&E to the Change Grow Live Programme Referrals made by SLaM to Change Grow Live Programme and vice versa Reduction in numbers of people with drug and alcohol problems being discharged from acute and community services

6. Recovery & Volunteering and Employment Support

What do residents experience now?	Delivery for Y1	Delivery for Y2	Delivery for Y3	How will we demonstrate delivery
12 week practical 1:1 support to help residents achieve their personal goals and promote recovery delivered by the Wellbeing Hub	100	150	200	Feedback shows that this has remained one of the most popular offers at the WBH and has made a real positive impact on the people served by the WBH.
Southside Rehabilitation Ltd (SRA) has been commissioned by SEL CCG Southwark to support people with severe mental health problems recover and become active members of their community including accessing adult education, voluntary work and open employment.	Fund 20 places	Fund 25 places	Fund 30 places	Up to 30 people with severe mental health problems supported into accessing adult education, voluntary work and open employment.
Continue the Southwark Council commissioned **Southwark Works** for Access to training courses, apprenticeships, volunteer positions and internships across diverse industry sectors. Southwark Works - Employment Services for Southwark Residents	TBC	TBC	TBC	Total number of people supported into volunteering and employment

What do residents experience now?	Delivery for Y1	Delivery for Y2	Delivery for Y3	How will we demonstrate delivery
IPS Model -supported employment intervention based on the 'place-then-train' approach for people with severe mental health problems.	No of adults accessing IPS services = 175	No of adults accessing IPS services=239	No of adults accessing IPS services =297	No of adults accessing IPS services (per year)
Workforce requirements to assist Partnership Southwark with the recruitment and expansion plans for IPS	IPS Employment Specialists (WTE)=4 IPS Team Leaders (WTE)=1	IPS Employment Specialists (WTE)=6 IPS Team Leaders (WTE)=1	IPS Employment Specialists (WTE)=7 IPS Team Leaders (WTE)=2	Full workforce plan implemented by year 3 meeting employment targets
Support into employment for those with serious mental health problems through the continued commissioning of Southside Rehabilitation by SEL CCG Southwark	fund places for about 20 places	funds places for about 25 places	funds places for about 30 places	Up to 30 people with severe mental health problems supported into employment

7. **Older People and Dementia**

What do residents experience now?	Delivery for Y1	Delivery for Y2	Delivery for Y3	How will we demonstrate delivery
Southwark People with Dementia are asking for more post diagnostic support	• Test out co-location of Dementia Advisor role to the Southwark and Lambeth Memory Service to support timely post diagnostic support from Alzheimer's Society. Identify match funding for year 2	• Task and Finish group established • Embed the Dementia Advisor co location role for post diagnostic. • Plan for review and continue to progress projects	• Embed the Dementia Advisor co location role for post diagnostic and spread to co-location at Kings Hospital Dementia Ward • Plan for review and continue to progress project	• To provide targeted support for people living with various forms of dementia following diagnosis to remain as independent and connected as possible within their local communities.
Families affected by Dementia need to be empowered through care planning and agreeing advance directives using a user friendly platform.	• Delivery will be agreed as part of the Dementia Action Plan Delivery group. • Priorities agreed through workplan to include stakeholder engagement with a proactive and planned approach to working with our harder to reach communities • Key stakeholders to support in the design, development and roll out of the device identifying our priority populations including work with Care Homes (initially) to test a Dementia Friendly approach through social	• Task and Finish group in place • Work with the Dementia Action Delivery group to Prioritise other settings/priority populations who would benefit from this approach and scope plans to expand the test and learn. • Start to monitor metrics to analyse project expansion. • Plan in place to deliver agreed care planning and technology	• Ageing Well programme to oversee delivery of plans • Evaluate test and learn utilising collation of metric data identified. • expand usage of platform to other priority groups on a rolling basis, identify a lead within the Dementia Action Delivery group to own the project and oversee delivery. • Deliver Dementia friends interventions across multiple settings (residential, extra care) support patients, their carers and families. Identify Place lead to oversee delivery.	• Process: % Increase of patients diagnosed with dementia whose care plan has been reviewed by an MDT team • Process: % Increase of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (B2H&W) • Include analysis of patient satisfaction and carer satisfaction

What do residents experience now?	Delivery for Y1	Delivery for Y2	Delivery for Y3	How will we demonstrate delivery
	and environmental interventions • Work with the Dementia Action Delivery group and people with lived experience to scope options for a care planning platform. (e.g. using an app such as Beth which has been procured by SLaM) • Deliver test and learn of new platform working with identified population Monitor/analyse activity to capture impact on health and experiences of care. • Develop a set of metrics to monitor and analyse device and inform test and learn evaluation.			
Residents with Dementia and their families would like a Dementia friendly Southwark	• Delivery will be agreed as part of the Dementia Action Plan Delivery group. • Priorities agreed through workplan –to include stakeholder engagement with a proactive and planned approach to	Plan in place to work in Southwark to support delivering a Dementia friendly community including task and finish groups	• Ageing Well group to oversee delivery of plans, • Review and continue to progress projects	• Workforce are trained, • Dementia Friendly Training in place • More Southwark Dementia Friendly Champions.

What do residents experience now?	Delivery for Y1	Delivery for Y2	Delivery for Y3	How will we demonstrate delivery
	working with our harder to reach communities			
More Support for Carers to Care (multiagency)	• Establish a patient and professional Carer Partnership Forum (led by the council with multiagency input) • Establish multiagency Carers Delivery Group to set priorities and deliver an integrated work programme working with the forum • Map system pathways and set improvement plans to streamline processes to create a shared offer. • Create awareness, training and development for patients and professionals on Carer expectations and support available.	• Carers Delivery Group in place to oversee priorities. Task and finish groups set up to progress projects agreed. • Priorities reviewed and refined in partnership with the Carer Partnership forum.	• Carers Delivery Group in place to oversee priorities. Task and finish groups set up to progress projects agreed.	• Improved Carer identification • Outcome: Improve carer wellbeing (ASCOF 1D national Survey) (B2H&W • Shared partnership culture and approach • Carers shape and develop the offer through a person-centred approach
Improving Dementia Diagnosis rates	Partnership registry for people diagnosed with Dementia (New/Existing). Partnership agreement of how to identify (early), track, monitor and support new/existing cases.	Improving diagnostic rates and early detection working on a shared partnership registry. Monitoring will remain in place to ensure learning and improvement on Diagnosis rates.	Improving diagnostic rates and early detection working on a shared partnership registry.	• Outcomes: Improve Dementia Care (measure tbc) • Process: % increase in diagnosis rate (B2H&W) • Process: Number of patients on the registry

What do residents experience now?	Delivery for Y1	Delivery for Y2	Delivery for Y3	How will we demonstrate delivery
				• Meet NHSE/I 67% Diagnosis target each quarter.

8. Community Mental Health Transformation

What do residents experience now?	Delivery for Y1	Delivery for Y2	Delivery for Y3	How will we demonstrate delivery
Service users are not always seen by the most appropriate clinical service	Pilot enhanced step-down model as part of community teams redesign	Review enhanced step-down pilot and finalise redesign proposal Workforce planning to upscale and move to new structure	Transition to new structure and embed	TBC
Services not as integrated as they could be and people don't always have access to timely assessments, interventions and treatments to achieve the outcome they want for themselves	Develop integrated neighbourhood services Pathway development and asset mapping	Review with partners		TBC
People don't receive the right interventions at the right time in the right time. People are sometimes cared for within specialist settings when they don't need to be	Implement community based eating disorders service Launch new early intervention service	Review with partners	Manage impact of SLAM teams restructure	TBC
Services are not informed by a recovery focused strength based culture	Recruit to new third sector roles Contract process for third sector roles	Staff in post and training and development	Initial review and develop plans for future investment	TBC

What do residents experience now?	Delivery for Y1	Delivery for Y2	Delivery for Y3	How will we demonstrate delivery
The mental health needs of the Black Asian and Minority Ethnic Communities are not met they aren't confident in accessing services; don't feel services meet their needs in line with their cultural norms; and are over-represented in acute clinical services as a result of not being able to access appropriate support in the community	Recruit Black Asian and Minority Ethnic community outreach workers Plan quarterly oversight group with partners	Patient and Carer Race Equality Framework competency framework agreed Implement PCREF improvement projects and manage alignment with local work	Evaluate impact and agree priorities for future	TBC

9. Autism and Learning Disabilities

What do residents experience now?	Delivery for Y1	Delivery for Y2	Delivery for Y3	How will we demonstrate delivery
Lack of access to Personal Health Budgets (PHBs) for people with Learning Disabilities.	Deliver PHBs to people with Learning Disabilities, so that the offer is accelerated. Work out the offer to the residents and model the uptake and subsequent resource implications. Work out the pathway with all stakeholders. Communicate the offer to the residents.	Review and evaluate the offer. Evaluate residents' satisfaction with the PHB offer.	Accelerate the rollout.	People with Learning Disabilities will be in receipt of a Personal Health Budget where appropriate.
People with Learning Disabilities are not experiencing universal access to smoking cessation services.	Work with Public Health colleagues with newly procured stop smoking service, which aligns to Ottawa. Will ensure people with Learning Disabilities are offered a service and uptake is monitored. Ensure GP aware of service and offer as part of Annual Health Checks.	Evaluate people with Learning Disabilities satisfaction with the service. Monitor activity to ensure equity of access.	Evaluate the outcome. Continue to publicise the service with primary care at scale.	new universal smoking cessation offer will also be available as part of specialist mental health services for long-term users of specialist mental health and learning disability services.
Poorer health outcomes for people with Learning Disabilities and higher number of preventable deaths in people with a Learning Disability and autistic people	Work with Public Health to produce a population outcome measure. Evaluation and research of causes of death and poor health outcomes. Identify resources/stakeholders for pilot intervention.	Design a pilot (based on identified need), to test intervention. Evaluate pilot and determine resources to enable roll out	Design a new model of care. Either accelerate or mainstream the learning from the pilot across the borough.	Health outcome and morbidity rates for people with a Learning Disability and Autistic people are improved.

What do residents experience now?	Delivery for Y1	Delivery for Y2	Delivery for Y3	How will we demonstrate delivery
Limited understanding of the needs of people with learning disabilities and autistic people in mainstream health services.	Understand and influence plans of SEL NHS Providers to implement mandatory Oliver McGowan LDA awareness training. Support local implementation of the mandatory training.	Understand the impact of the training on service improvement. Monitor CCG Southwark borough staff uptake.	Continuously review the outcome and publicise how this has impacted positively on service delivery.	Improved understanding in mainstream health services of the needs of people with learning disabilities and autistic people and work together to improve their health and wellbeing.
Residents currently have got access to an autism diagnostic service, but the referral process for adults is complex and there are barriers, also waiting times are long at *1-2 years. *Waiting times to be verified as part of the review.	SEL CCG are carrying out a review of SEL Adult Autism diagnostic services across 6 boroughs.	Pending outcome of 2021 adult review. SEL plan to carry out review of SEL CYP autism diagnostic services across 6 boroughs.	Pending outcome of 2021 Adult review Pending outcome of 2021 CYP review	Waiting times will be improved. Simpler pathway to adult autism diagnostic assessment will be available

10. Personalised Care Including Personal Budgets for Mental Health

What do residents experience now?	Delivery for Y1	Delivery for Y2	Delivery for Y3	How will we demonstrate delivery
Lack of awareness of personal health budgets	Working with mental health provider trusts to increase workforce knowledge of personalised care budgets, and resident awareness of right to have (S117) Patients to receive that care plan Collect robust data to inform development of the work programme. Develop a comms plan for wider engagement through PCNs and community services	Through coproduction develop a plan to expand the PHB offer to people outside of S117 who require support in the community. Identify some transformational funding to explore possibility of small preventative budgets through social prescribing. Identify at least 2 people with lived experience who can join the wider personalised care coproduction group &/or are willing to sign up for the NHS Peer Leadership Development Programme	Trial the small budgets and shape this with feedback from people with lived experience. Use Peer support to develop language and understanding amongst staff and service users	1000 people with MH needs accessing personal health budgets
Lack of collaboration between health and social care	Make links with LA to discuss a way of jointly funding and supporting people in Southwark. Outline governance arrangements or link to existing panels. Agree a joint system for processing of payments and monitoring	Test out a system of joint funding and look at support needed for people who decide to opt for a direct payment. Agree funding for the support service, could be in conjunction with other cohort groups who will be using PHBs or Integrated PB. Use spot purchasing arrangements for any Direct payment support needed	Agree a formula for joint funded package and outline a tender for a DP support service	Evidence of jointly funded support through Integrated Personal Budgets (not sure what the stats are on this). Evidence of local direct payments support service working for LA and NHS service users to provide the level of support needed in the individual case.
90% of service users said that they would like to use a PHB if given the option (SEL wide), although they don't have access to a PHB currently	Work with MH commissioner to expand the use of PHBs in Southwark. Implement the right to have offer for S117 aftercare.	Expand use of PHB to jointly funded packages with the LA and identify transformation work where PHBs could form part of a service users	Work with providers to work up a model where funding for PHB can be released for all MH service users in secondary care and look for opportunities to use PHBs for preventative care	All users have access to a PHB, for some or part of their community support

11. **Hoarding** (AWAITED)

What do residents experience now?	Delivery for Y1	Delivery for Y2	Delivery for Y3	How will we demonstrate delivery

12. Mental Health Medicines Optimisation

What do residents experience now?	Delivery for Y1	Delivery for Y2	Delivery for Y3	How will we demonstrate delivery
More than 90% of people with dementia experience behavioural and psychological symptoms of dementia (BPSD). Antipsychotics are overprescribed for the treatment of BPSD. In 70% of people with BPSD, antipsychotics can be discontinued without worsening symptoms.	Review, and where appropriate, revise prescribing of low dose antipsychotics in people with dementia, in accordance with NICE/SCIE guidance and the NICE Quality Standard on dementia.	Identify and address staff training needs.		Percentage of patients on the dementia register prescribed antipsychotic drugs without a psychosis diagnosis.
Psychotropic drugs are prescribed to reduce frequency of challenging behaviours in the LDA community. Prescription cascade and polypharmacy are common in LDA due to reduced communication (non-verbal patients) and general low awareness of LDA.	Facilitate multidisciplinary team discussion to reduce unnecessary psychotropic drugs and acute hospital admissions through STOMP (Stopping over medication of people with a learning disability, autism, or both).	Identify and address staff training needs.		Number of STOMP patients reviewed.
Anxiolytics and Hypnotics are drugs that are prescribed for short-term treatment of conditions such as anxiety and sleep problems. The Royal College of Psychiatrists states that "around 4 in every 10 people who take them every day for more than 6 weeks will become addicted" and therefore they should not be prescribed for longer than 4 weeks.	Review prescribing of hypnotics and anxiolytics and facilitate the stopping of the treatment if necessary.	Identify and address staff training needs.		Number of average daily quantities (ADQs) for benzodiazepines (indicated for use as hypnotics) and "Z" drugs per Hypnotics (BNF 4.1.1 sub-set) ADQ based STAR-PU.

13. Housing and Complex Care and Support

What do residents experience now?	Delivery for Y1	Delivery for Y2	Delivery for Y3	How will we demonstrate delivery
Lack of advance care planning and collaboration between health and social care	• Delivery and priorities will be agreed as part of establishing the Housing and Complex care group, learning from work previously undertaken • Identifying stakeholders and working through an engagement plan) with representation from across the system to support the development of the work which will include a proactive and planned approach to working with our harder to reach communities	• Task and Finish group established • Engagement plan in place • Project plan in place • Work plan agreed with system partners to increase knowledge and awareness of advance care planning	• Agreed systems in place for advance care planning • Review process agreed and overseen through Housing and Complex care group and Care Well programme	• An increase in the number of clients with advanced care planning in place. • Systems in place to ensure health and social care professionals are aware and able to access the care plans.
Limited focus on physical health	• Delivery and priorities will be agreed as part of establishing the Housing and Complex care group, learning from work previously undertaken • Identifying stakeholders and working through an engagement plan) with representation from across the system to support the development of the work which will include a proactive and planned approach to working with our harder to reach communities	• Task and Finish group established • Consistent approach to addressing physical needs of people residing in supported accommodation agreed • Engagement and project plans in place	Agreed processes in place to support physical health	Review of data NHSE/I data detailing Serious Mental Illness Health checks.

What do residents experience now?	Delivery for Y1	Delivery for Y2	Delivery for Y3	How will we demonstrate delivery
Unclear Pathway	• Delivery and priorities will be agreed as part of establishing the Housing and Complex care group, learning from work previously undertaken • Identifying stakeholders and working through an engagement plan) with representation from across the system to support the development of the work which will include a proactive and planned approach to working with our harder to reach communities	• Task and Finish group established • Engagement and project plans in place • Map current services in place and co design pathway with system partners, service users and carers	• Agreed pathway in place • Agreed process/outcomes for reviewing Ensure communication and engagement plan delivered (including servicer users front line workers, voluntary sector	Frontline staff are aware of and understand the pathway.
Lack of awareness and understanding of rehabilitation and services that are available	• Delivery and priorities will be agreed as part of establishing the Housing and Complex care group, learning from work previously undertaken • Identifying stakeholders and working through an engagement plan) with representation from across the system to support the development of the work which will include a proactive and planned approach to working with our harder to reach communities	• Task and Finish group established • Engagement and project plans agreed • Mapping of services to support the increase in awareness and understanding of rehabilitation and services that are available • To develop with system partners an operation guide that clearly states what rehab is and what therapeutic interventions should be available to those in supported accommodation	• Deliver with system partners the operation guide. • Ensure communication and engagement plan in place (including servicer users front line workers, voluntary sector)	For staff in the system to be able to describe the therapeutic interventions that people need to support rehab.

What do residents experience now?	Delivery for Y1	Delivery for Y2	Delivery for Y3	How will we demonstrate delivery
Residents and their families have a varied experience of Supported Housing in Southwark.	• Delivery and priorities agreed as part of establishing the Housing and Complex care group, learning from work previously undertaken • Identifying stakeholders and working through an engagement plan) with representation from across the system to support the development of the work which will include a proactive and planned approach to working with our harder to reach communities	• Priorities agreed through workplan • Service review • Task and Finish group established • Recommissioning year 1 to be confirmed	• Implementation of services-contracts and pathways	Will engage with service users and families on their experience of the supported housing.

14. Children's and Young People's Services

1. Improving Access and Wait Times

What do residents experience now?	Delivery for Y1	Delivery for Y2	Delivery for Y3	How will we demonstrate delivery
There is limited support for those with behaviours that challenge, pathways are reliant on a mental health diagnosis to receive support from Tier 3 CAMHS. Pathways have been developed based on diagnosis rather than the need to manage and support the behaviours.	Increased capacity in the Early Help CAMHS for NDT Identified open access support for those with ADHD, ADHD or behaviours that challenge SLAM led quality improvement project for Conduct Disorder provision GSTT and SLAM review of neuro-disability diagnosis pathways to increase joint clinics	Advisory panel for CYP who have experienced exclusion, development of screening tool for schools	Agreed established pathways for conduct disorder	Early intervention, improved outcomes for those experiencing late diagnosis, open access support for LDA needs.
For families with children over 5, and without an allocated social worker who are experiencing challenges due to parental mental health are required to access support via adults' provisions which is not facilitative to supporting family based or taking into consideration support a child might currently be receiving.	Workshop with CYP, Families and current VCS providers to understand experiences of current provision Adults post in Hope Project to facilitate think family approach Understand and demonstrate the effectiveness and impact of Kids Time / Our time.	Using learning from year 1, clearly identify areas of transformation across AMH to inform whole Family Approach		Families can access support for their mental health and wellbeing in a way that supports improved family outcomes

What do residents experience now?	Delivery for Y1	Delivery for Y2	Delivery for Y3	How will we demonstrate delivery
Under 5's was a new and developing area for Southwark, a pathway was introduced in 2019/20. The pathway provides an opportunity to develop the system-wide offer to under 5's and parents	Increased SLAM Capacity within the IAPT under 5 programme enhancing access to specialist interventions for this age group Improved awareness and universal workforce capabilities through the SUSI programme of training for Children and Family Centres, family early help and early years settings "Top 10" 50 things before you are 5 app identified for those who might be at risk of poor mental health The Nest roll out of provision for 0–11-year-olds.			
Over the last 12 months CYP have waited 9.3 weeks for a first contact and 17.22 for a second contact. Following COVID waiting times for the second contact are increasing (current time of writing July 2021),	Increased access to core CAMHS, reducing waiting times and crisis in line with the LTP. Learning from the 4 –week waiting time pilots across SEL.	To be determined as part of Local Transformation plans	To be determined as part of Local Transformation plans	Reduced waiting times.

Children and Young People (Contd)

2. School Provision

What do residents experience now?	Delivery for Y1	Delivery for Y2	Delivery for Y3	How will we demonstrate delivery
The schools-based offer across Southwark is rich (IMHARS, New Youth Deal - the Nest, SLAM, school nurses and school selected provisions) however, the equity of spread and access across Southwark's schools is unknown	• Mapping of all emotional wellbeing and mental health provisions in schools across Southwark • Widen engagement with schools, CYP, Place 2 Be national provision, worker in schools, drop ins and counselling sessions to inform future service delivery • MHST will be delivered from Jan 2022 and should look to improve equity of access and mitigate against worsening outcomes in targeted population groups • Roll out of the New Youth Deal, provided by the Nest to: • Supporting people at risk of fixed term exclusions and their families. Awareness raising with schools. • Learning from the School Nurse Pilot, Digital Health Questions and COVID clinics to inform future delivery	Roll out of Wave 8 MHST	Roll out of Wave10 MHST	Evidenced activity in schools through shared outcome reporting of council and CCG commissioned services operating in schools Commissioned school-based offer is clear and equitable

Children and Young People (Contd)

3. 0 -25 Transformation

What do residents experience now?	Delivery for Y1	Delivery for Y2	Delivery for Y3	How will we demonstrate delivery
There is a lack of continuity of care for those who experience transition from CAMHS to AMH, for those presenting for the first time in this age group accessing the right provisions can be difficult due to different models of care, thresholds, structures and arrangements between CAMHS and AMH.	Expansion of the 16-25 young People workers, service to host dual trained workers, 50/50 across AMH and CAMHS. Target groups to include: • Individuals who are seen by the open access service The Nest that require additional support but do not mee AMH thresholds • Individuals that are being held by CAMHS but are over 18 • Cases which are discussed in the 0-25 advisory panel • Care Leavers Development of a Personal Behavioural Support offer • Target group those who are red on the Dynamic Support Risk Register (links to LDA actions)	Continued roll out of young people's teams, expanding on lessons learnt in year 1 Service development plans which respond to learning and gaps identified in the advisory panel	Ongoing service development	Young People can access holistic services which are structured around need rather than age. CAMHS and AMS work flexibly across age groups

Children and Young People (Contd)

4. Communications and Co-production

What do residents experience now?	Delivery for Y1	Delivery for Y2	Delivery for Y3	How will we demonstrate delivery
Residents and system partners often do not clearly understand what is available to them	Develop strategic plan for Comms & Engagement, inc. a time table for engagement and consultation Partnership arrangement with the VCS agreed, meeting map shared and relevant representatives invited.	Directory of services is updated twice a year, with CYP involved in the co-design of the future format (i.e. app)		There is equitable and meaningful involvement and participation of children, young people and their parent/carers, which drives the transformation of services so they improve equity of access
There is disproportionate representation within services, including under representation of those who are black, Asian and minority ethnic, further specific groups are at increased risk of poor mental health	Working with specialist VCS providers, development of a youth ambassador group which can create a dialogue across the system to aid un-learning and new learning. This should be representative of high risk groups, or seldom heard groups	Ongoing recruitment and support for the youth ambassador Group	Ambassador groups form a wider networked across Southwark and SEL (i.e. New Youth Deal Parliament, SLAM Peer Support groups)	There is equitable and meaningful involvement and participation of children, young people and their parent/carers, which drives the transformation of services so they improve equity of access
Peer support programmes and engagement activities are led by individual organisations with limited learning across the system from the events. In order to maximise the recent increase in peer support activities the learning from recent activities will be reviewed and brought together to inform future developments and sustainability	SLAM to deliver a clear programme of activities in response to Southwark Pledge as part of Southwark / SEL Listens request for grass root peer lead activities SLAM, CCG and Local Authority review current commissioned and delivered peer groups to ensure sustainability and long term commitment to grass roots activities.			Learning will be shared across the system, CYP, parents and carers will be able to engage with the system in a more systemic way so learning is translated into continuous improvement of services

Children and Young People (Contd)

5. Outcomes

What do residents experience now?	Delivery for Y1	Delivery for Y2	Delivery for Y3	How will we demonstrate delivery
Outcomes are not always developed a reported on at a CYP level or clinical level. System wide outcome reporting is limited.	• Development of a data dashboard so that all services can to contribute to 100% Southwark Target • In house clinical service • SEL wide contracts • The Nest • IMHARS • School Nursing • Core SLAM CAMHS • MHST in schools • All services set up and to contributing to the MSHDS	All new services set up and to contributing to the MSHDS	All new services set up and to contributing to the MSHDS	"100% of Southwark children and young people [who need support] get access to emotional wellbeing or mental health services so that the need (and waiting times) for specialist services is reduced; and to ensure that children and young people (and their families) who must wait for specialist services are well supported. " Outcomes drive commissioning and service development at a strategic and operational level. Routine Outcome Measures (ROMs) are used in clinical practice to identify needs, interventions, evaluate the efficacy of treatment and help determine endings

15. **Substance Misuse and Mental Health** *(AWAITED – recently added Strategy priority)*

What do residents experience now?	Delivery for Y1	Delivery for Y2	Delivery for Y3	How will we demonstrate delivery

16. **Mental Health Needs of Refugees and Asylum Seekers** *(AWAITED: recently identified Strategy priority)*

What do residents experience now?	Delivery for Y1	Delivery for Y2	Delivery for Y3	How will we demonstrate delivery