Partnership Southwark Strategic Board

Health & Care Plan 2023-2028

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Version Control

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Document Review Control Information

Version	Date	Reviewer (s)	Author	Change/amendment
V0.1	2/3/23	PSSB	Annie Norton	Initial draft – required significant development with content and format
V0.2	6/7/23	PSSB	Wendy McDermott	Approved - specific reference to men's health to be made more explicit within the plan
V0.3	2/11/23	PSSB	Wendy McDermott	Plan updated with appropriate additional references to men's health made

Contents

Partnership Southwark

Working together to improve health and wellbeing for the people of Southwark

Part 1

Partnership Southwark

Partnership Southwark – who we are

Partnership Southwark is a partnership of the voluntary and community sector, the NHS and Southwark Council, focused on improving health and wellbeing and reducing inequalities for people in Southwark.

You can read more about the partnership and our leadership, including our Board members here.

- The partnership was established in 2017 to improve ways of working across our organisations and with our communities to meet health and care needs across our borough and to plan and coordinate services focused on our local population. In the summer of 2022, we formally became part of the South East London Integrated Care System (ICS), which has been formed in response to the Government's Health and Social Care Act 2022. This was an important milestone in our evolution as a partnership, as we continue to work together to plan and manage the services for which we are responsible
- Working together, we coordinate care across our borough to remove unhelpful divides between hospital and community-based services, physical and mental health, and health and social care. Making services more joined-up, easier to access and better suited to people's needs will help people get the right care and support in the right place, as early as possible and help our population achieve better health in the decades to come
- Our partnership is important to help us move away from divisions between hospitals and family doctors, between physical and mental health and between NHS and Council services that have meant that too many people experience disjointed care. By joining together locally, we can better support people's health and wellbeing and their experience of care
- Integrating care also makes sense for services that are facing growing pressures. We are all living longer, so people are more likely to need help for illness, or several illnesses, over their lifetime. Southwark also has a young population, so it's important to invest in prevention as much as management so that less people will need to be dependent on our health and care services in future
- Helping people with their own health and wellbeing, so they stay well for longer, is better for everyone. Ensuring people have easy access to care when they need it, benefits residents, staff and carers. Having teams that work together across organisations to understand what matters most to people also transforms our staff's experience, enabling them to focus on each individual in a unique way

Our principles for working together

Recognise and embrace the need for partnership working **for the benefit of our local population**

Develop and maintain **trust,** healthy and constructive challenge, **commitment** to the partnership, and **collective accountability**

Create clear, purposeful and robust partnership arrangements, **minimising duplication**

Ensure **engagement and involvement** with key stakeholders across our borough, **including voluntary organisations and local communities, service users and carers**

Monitor, measure and learn through continuous improvement

Align budgets where possible to ensure money is spent wisely and **make the best use of the 'Southwark pound'**

Responding to local challenges and needs

- Partnership Southwark partners come from a diverse range of organisations, with different system and workplace cultures, we recognise its important to work in a similar way as much as possible
- We will design and deliver culturally-appropriate services that are joined-up, with easy access for all, where input from local communities is valued and people genuinely feel that they have a high level of autonomy over their lives
- We will build system connectivity and new alliances that bring together our partners and people with lived experience to plan, develop, co-ordinate and implement the Health & Care Plan priorities, through a community-led and iterative co-production approach, that will join up services, improve outcomes and address inequalities
- We will take an Asset Based Community Development (ABCD) approach, including other approaches such as Appreciative Inquiry (AI), which is a proven, collaborative, strengths-based approach to optimise opportunities for positive change and building community resilience and capacity
- By working with communities at a neighbourhood level, we can make sure that:
    - Local communities take the lead in shaping what is needed to address the inequalities that exist
    - Services are more consistent and responsive to the needs of service users, carers, and families

Neighbourhood working - our aims:

- Continue to develop neighbourhood networks to connect people and services as close to their home as possible
- Make best use of the skills, resources and energy in local communities - building relationships and empowering resilient communities
- Bring together voluntary and community partners, GPs, community physical and mental health, social care, wider council services (e.g. housing, leisure and education) to better support people's needs and improve health and wellbeing
- Target those populations where we know there is greatest inequality in experience and outcomes
- Pay attention to measuring what matters to people as part of our performance management and success measures

Our approach to learning together

We will evaluate, learn, reflect and refine as we go

We will review our plan every year, by reflecting on our activities and impact, and asking ourselves:

- Are things working? Can we do more? Do we need to change course?
- We have delivered what we said we would, what's next?
- We have met that target, should we aim higher?
- We have different data now, so should we review this measure or target?
- What is our community telling us?
- What is research evidence telling us?
- What lessons have we learnt and how will we apply these going forward?

Our approach to our plan

Partnership Southwark's Health & 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, over the next five years.

- We recognise that Southwark is diverse and not all of our residents are experiencing the health and care system in the same way. We have faced exceptionally challenging times in recent years - significant cuts to public services, Brexit, the Covid-19 pandemic, and the ongoing cost of living crisis. The impacts are not felt equally, and poverty, racism and inequality have worsened health outcomes for many in our community. Together, we must respond to these challenges and be bold in how we work together to overcome them – embracing new ways of working to support our residents, patients, partners, carers and workforce
- We can do better by working together in partnership to transform how we support our patients, carers, and residents. Through Partnership Southwark, we will use strengths-based approaches and work to improve health and care outcomes by building on our success and strong relationships, co-designing programmes of work to address all health and care activity in Southwark, and prioritising fairness and equity in all we do. We have lots of great work to build upon, but we can and must go further
- We are committed to improving the lives of every Southwark resident. The key to this will be supporting a range of positive and action-focused approaches that seek to remove unfair and avoidable differences experienced by people with characteristics protected by the Equality Act. In Southwark this includes fighting for LGBTQI+ equality and inclusion, also taking an anti - racist approach to build trust and confidence in our communities. Our plan responds to the priorities, developed by residents and communities, set out in the Southwark Health and Wellbeing Strategy and the Southwark Borough Plan and is aligned with the South East London Integrated Care System's Strategic Priorities.
- We have developed our plan from the intelligence presented in the Southwark Health and Wellbeing Strategy, the lived experience of residents from across our diverse communities and the learned experience of our workforce. We have set out the changes we want to make, what we need to do to achieve them and what help we need, over the next five years. Our plan is ambitious. We recognise that we will need to learn from our experiences and adapt to changing circumstances as we go, using research and evidence to continue to understand and act on the causes of inequity in Southwark

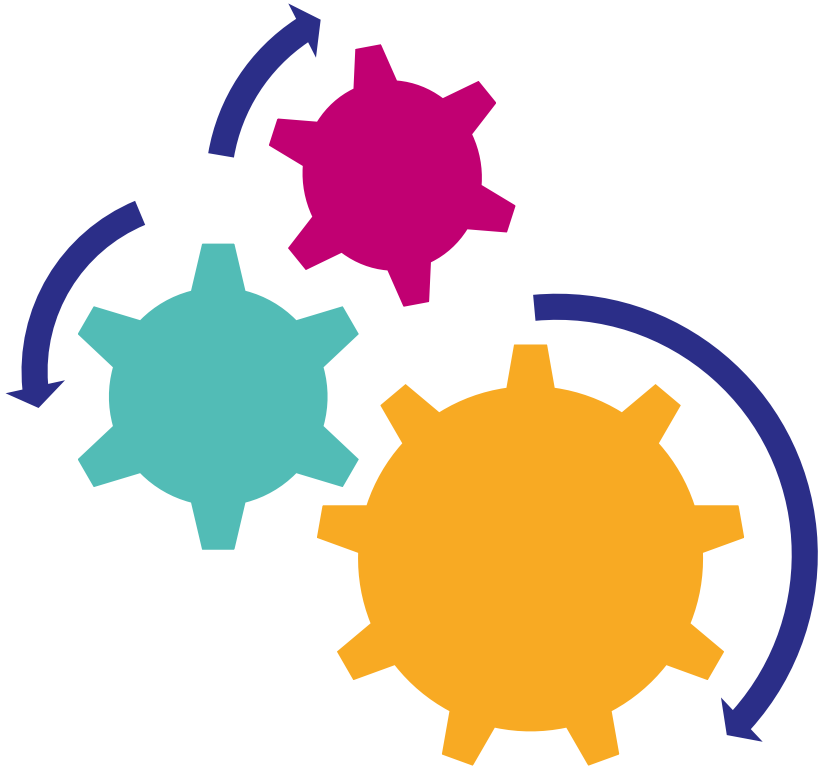
We have identified 6 priority areas across a person's lifespan - we will work together on these to improve health and wellbeing, including how we plan and manage services

Our plan

Our Health & Care Plan sets out how health, care and voluntary and community services in Southwark will work together to improve health and wellbeing outcomes over the next 5 years, with a focus on delivery for the next 2 years in the first instance.

Our health and care plan:

- Focuses on supporting people to lead healthy lives, improving prevention and early intervention, and making sure that people have access to and positive experiences of health and care services that they trust and meet their needs. We know that the key to this will be delivering in different ways, supported by a positive and action-focused approach to equity for our communities
- Is ambitious - we know we can do better by working together to transform how we work, to deliver for our patients and residents
- Responds to the priorities developed by residents and communities as set out in the Southwark Health and Wellbeing Strategy and the Southwark Borough Plan and is aligned with the South East London (SEL) Integrated Care System Strategic Priorities
- Sets out our aspirations for the borough, our residents, and patients and those who care for them, including what we want to happen, change or improve (our outcomes), the principles of how we will work, what we need to deliver the plan and how we will know if we are making a difference



Our delivery framework

Start Well	Live Well	Age Well & Being Cared for Well
		 
Children & Young People	Working Age Adults	Older Adults in the community Older Adults in residential settings

Delivered through population-based workstreams in the community and residential settings

Priorities that span a person's life course

Working together on shared priorities will produce better outcomes for Southwark communities throughout people's lives

Support Southwark residents to **Start Well:**

- Families receive the right care that works for them, including during pregnancy and the 1001 days of a child's life
- Children get the best start in life and can reach their full potential
- Fewer children and young people are affected by poor mental health

Support Southwark residents to **Live Well:**

- For adults to access the support they need around the Vital 5 areas to promote good health and wellbeing on an equitable footing
  - hyper-tension
  - mental health
  - smoking cessation
  - alcohol intake
  - healthy weight
- People have access to and positive experiences of health and care services that they trust and meet their needs holistically - with fewer adults affected by poor Mental Health (MH)

Support Southwark residents to **Age Well & Being Cared for Well:**

- Integrated health and care services support people to live fulfilling and independent lives, where carers are also supported
- A coordinated and integrated Frailty pathway to maximise mobility and function, reduce crisis and avoidable and unnecessary hospital admission and support timely discharge from Acute care to community
- A holistic model of practice for lower limb wound care

Key Enablers

Workforce - Quality - Data - Digital - Buildings - Finance - Sustainability - Medicines optimisation - Safeguarding - Communication & Engagement - Communities - Cllrs/Elected Officials - Leadership & Governance

Key enabler activities (1 of 4)

Our Workforce:

- As a partnership our aim is to continue to develop innovative roles and ways of working that support integration and make best use of our constrained resources. We also have an ambition to explore areas of staff development that might benefit from doing more together, for example apprenticeships, where each partner has a successful programme
- Support our workforce and their wellbeing, including developing and retaining our staff, and supporting fair pay for care staff
- Explore areas of staff development that might benefit from doing more together and harness opportunities to resource services differently
- Have a workforce that, at all levels, can relate to people's lived experience, is representative of and supports our diverse and intersectional communities
- Have a workforce that has capacity, is trusted and supported, so communities receive a consistent and reliable service
- Different workforce models: Enable our workforce to work together, across organisational boundaries, in an integrated way, including through our Clinical and Care Professional Network
- Workforce more flexible and to offer more flexibility to staff groups to reduce vacancy rates and improve retention rates
- Sharing expertise and planning workshops to look at the issues and develop more MDT approaches in neighbourhoods
- Workforce engagement to understand the issues and barriers that result in people leaving their roles
- Work with local schools and colleges to attract more local people into NHS roles or into education that will lead to NHS employment.

Data / Intelligence:

- Develop a culture and infrastructure that prioritises data-driven decision-making and approaches to understanding the unique needs of Southwark residents, especially those who are facing health inequalities. Our goal is to make a positive impact on specific populations within our community, such as those from different ethnic backgrounds, sexual orientations, and those living in deprived areas. Data that provides quality outcomes rather than purely performance
- Access to data to support targeted population approaches to support reduction in inequalities, early risk identification, detection and intervention and proactive planned care support

Quality:

Our ambition is to build a community of learning and shared focus on quality that takes full advantage of the experience and skills of our diverse partners, so that quality improvement and clinical effectiveness drives our programme of integration and to support shared accountability for the wellbeing and experience of the population in their interactions

Key enabler activities (2 of 4)

Our Communities:

- Involving people from a broad range of communities in all engagement activities
- Have residents and communities within the partnership at every level to support involvement at the Strategic Board and Executive team to ensure we are able to listen to and learn from lived and learned experience as we develop, maintain and monitor services
- Having dedicated resource and time for public engagement to work towards a co-production approach will be vital in securing the best services for people and communities in the borough
- Use the information from this meaningful engagement to inform our work to provide health and care services
- We acknowledge and commit to further investment in the skills and experience of our community and voluntary sector leaders to help us to learn and achieve meaningful co-production opportunities and develop partnerships to achieve meaningful and sustainable and local development and solutions

Communications & Engagement:

- Ensure people and communities are represented at every level within Partnership Southwark and are supported and enabled to share their voice and the issues raised in the borough
- Lead the communications function for Partnership Southwark to facilitate the flow of pertinent information between partners, ensure the consistency and correct usage of the Partnership Southwark brand, and coordinate communications messaging and activity across the partnership
- Provide projects and programmes within Partnership Southwark with communications and public engagement advice and support

Councillors / Elected Officials:

- Engage local communities in trusting relationships with meaningful 2-way dialogue
- Sense checking at the local level, hearing directly from residents on areas of concern
- Key partner in deciding what are the important areas of focus, which supports informed planning and decision making

Key enabler activities (3 of 4)

Finances:

Partnership Southwark has an ambition to have an integrated financial plan and a strong financial standing that will enable us to deliver our collective priorities. Ensuring a collaborative approach to planning and contracting, as well as delivery, the Partnership recognises the very real challenges the local health and care economy faces and the need to work together to find solutions to jointly manage these issues across the Local Care Partnership.

Enhanced collaboration:

Partnership Southwark have a strategic ambition to develop formal collaboratives, where we look to pool or share funding to reduce siloed working and deliver the best outcomes for Southwark residents.

Buildings:

- Encourage all health and care partners to work together in the same buildings to transform service delivery and improve access to care, delivered from high quality premises
- This includes making the best use of the opportunities presented by the Tessa Jowell Health Centre, where a Lead Integrator is being appointed
- Opportunities with Children and families centers and looking at neighbourhood opportunities and future planning with estates

Digital:

- Developing a single view of the digital estate, with aligned governance and data sharing arrangements which will enable partners to work in a more integrated way
- Replacing outdated digital infrastructure to enabling our workforce to access a person's health and care record, and other data and information, with ease and from any location
- Ensuring that residents have access to digitally enabled care across health and care settings that are easily accessed, consistent and ensures the right service for their needs
- Identifying shared workforce training opportunities

Key enabler activities (4 of 4)

Sustainability:

- All partner organisations have signed up to an ambitious sustainability to achieve the NHSE targets of a net zero carbon footprint by 2040 and the interim target of 80% reduction by 2028
- Partnership Southwark has committed to ensuring that sustainability implications are systematically considered in all decision making
- Halve the council's carbon emissions again by 2026, staying on track to cut emissions from the council's operations and vehicles to net-zero by 2030
- Make the council's pension fund zero carbon by 2030 at the latest and earlier if more zero carbon funds become available sooner, while ensuring we protect the pensions of our staff
- Roll out an ambitious programme to upgrade insulation and heating of our council homes

Medicines optimisation:

Medicines prevent, treat and manage many illnesses and conditions and are the most common intervention in healthcare.

Shared-decision making between the residents in Southwark and all partners involved in medicines to ensure patient safety, optimise adherence and reduce waste.

Incorporating sustainability into medicines optimisation:

All partners have agreed locally that by the end of March 2024, 95% of all existing patients on inhalers will be to switched over to powder inhalers and from September 2023, all new patients will be prescribed powder inhalers in the first instance.

Safeguarding:

Work collaboratively and restoratively with our partner agencies to 'Think Family' and protect all those at risk of harm, abuse or neglect, ensuring this approach is embedded across all our services in line with strength based approaches.

What we want to hear from our communities and workforce

For people and communities

- I want to live longer and have a more rewarding life
- I want to receive culturally appropriate services that are joined-up and easy to access
- I want to feel valued with my own degree of autonomy
- I want equitable access to services, that are “family friendly”
- I want to experience integrated care that is timely, with joined-up care records and fewer onward referrals
- I want to feel empowered and responsible for my own self-care
- I want to be a partner in the on-going cycle of community development

For workforce

- I feel part of an integrated and connected workforce fit for the future
- I see there are opportunities for flexible and creative recruitment approaches that go beyond traditional practices
- I have opportunities to work within other organisations in Southwark to develop my knowledge and skills - via placements & secondments
- I experience a different and sustainable workforce model, rooted in our community
- I enjoy greater job satisfaction and understand where I fit and how I work as part of a broader multidisciplinary team and contribute to good outcomes for people
- We have better staff retention and stability in teams and across pathways
- We have genuinely integrated teams for supporting people in local neighbourhoods
- We value working with our communities, and sharing power

Other work that sits alongside the Health & Care Plan

These pieces of work also focus on population groups or communities and cross-cutting health and care issues where we will bring together partners and people with lived and learned experience to plan and manage initiatives that will join up services, improve outcomes and address inequalities:

Asylum Seeker & Refugee Health & Wellbeing
Oversees the delivery of the Health Core Offer (e.g. health assessments and mental health support) for Initial Accommodation Centre (IAC) asylum seekers and Ukrainians; and to support asylum seekers & refugees to register with a GP

Homelessness
A wide range of services, including a nurse-led primary care and specialist care service that provides community healthcare for people experiencing homelessness, those with addictions, asylum seekers and refugees and other groups who have difficulties in accessing health services

Vaccinations Strategy
Joint group to continue developing the borough approach to adult and childhood immunisations in light of the decline in uptake rates after the pandemic

Combating Drugs Partnership
Programme to reduce the harms caused by substance misuse and support those using substances to access the right help to meet their needs

Start for Life & Family Hubs Partnership
Supporting children, young people and families in Southwark to have the best start in life and reach their full potential. The programme's objective is to join up and enhance services delivered through transformed family hubs in local authority areas, ensuring all parents and carers can access the support they need when they need it

Sexual Health Programme
A South East London programme to improve people's sexual and reproductive health and enabling people with HIV to live and age well

Safeguarding
Developing integrated approaches to ensure the right procedures are in place, information is shared, expert advice is on hand, staff are trained to recognise people at risk, timely appropriate decisions are taken and lessons are learned and shared

Integrated Neighbourhood Teams
To enable all Primary Care Networks (PCNs) to evolve into integrated neighbourhood teams, supporting better continuity, preventive healthcare and access

Learning Disabilities & Autism Programme
National programme to improve services and reduce avoidable hospital admissions for people who are autistic or have a learning disability: a focus on making reasonable adjustments.

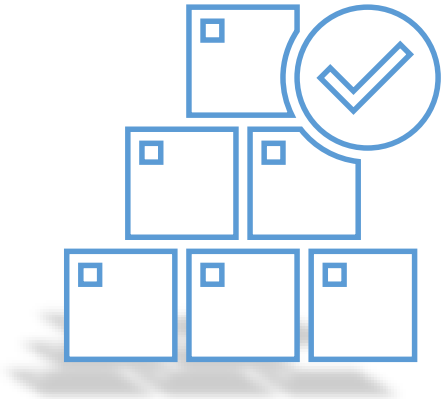
Primary Care Programme
Leading the implementation of the recommendations from the Fuller Review to improve primary care outcomes and access to primary care across the borough

Governance

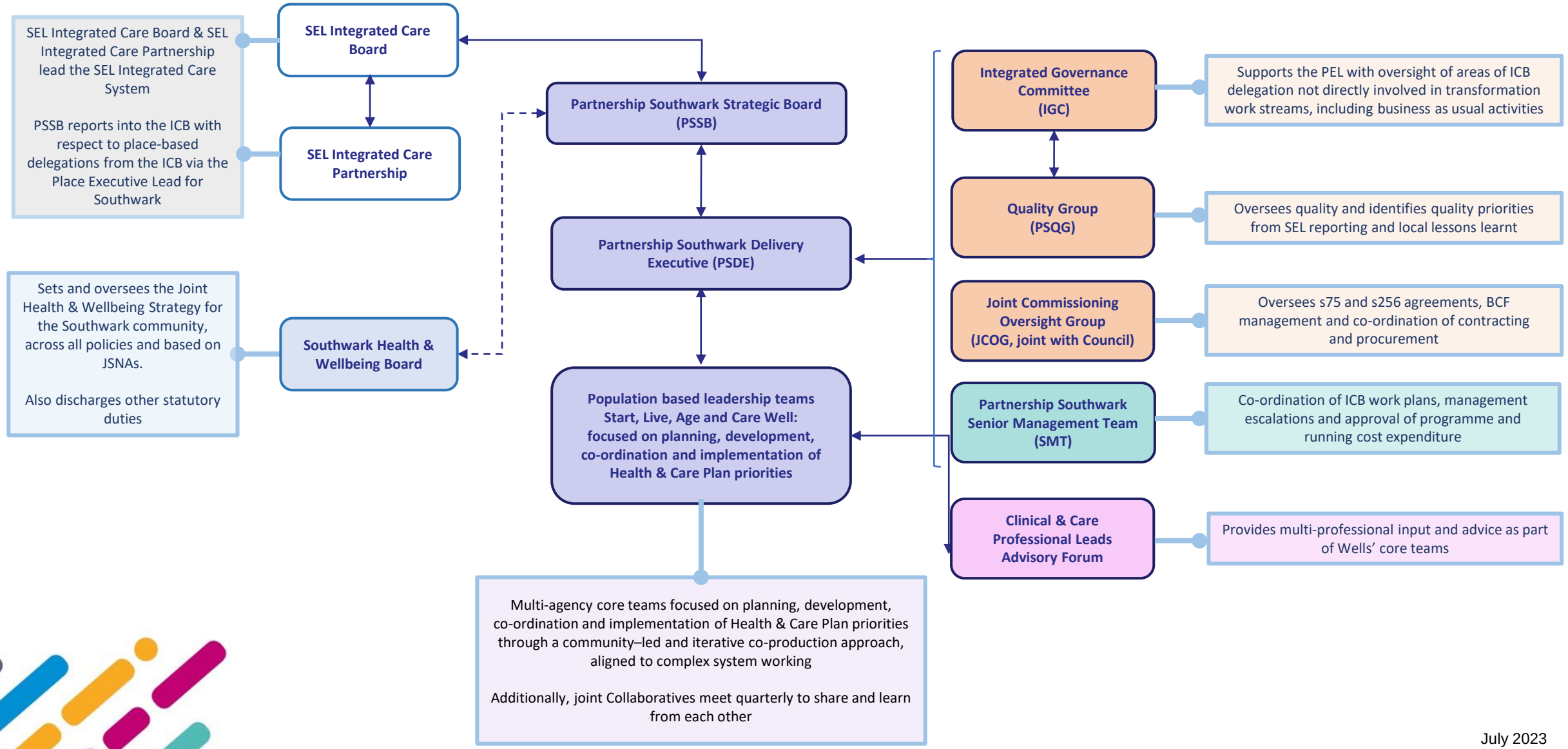
- We recognise that over the course of this five year plan things will change. National health and care directives will evolve, and the amount and quality of data, intelligence and insights will improve over time - to be able to adapt to these changes, we have designed a governance process to regularly review the measures we use to monitor success and to adjust, improve and refine them as necessary so that they continue to be fit for purpose

- Design, delivery and evaluation of Health & Care Plan will be integrated within the Partnership Southwark structure with delivery aligned to population based leadership teams: Start Well, Live Well, and Age & Care Well. The workstreams will hold detailed delivery plans for the identified priorities including milestones, measurable impacts and relevant plans for risk management. Each workstream will be expected to provide, at a minimum, quarterly updates to the Partnership Southwark Delivery Executive and six-monthly updates to the Partnership Southwark Strategic Board.

- Partnership Southwark will also use existing professional groups to inform the development of work, including the Primary Care Group, Community Southwark networks and the Clinical & Care Professional Leads Advisory Forum.



Governance structure



July 2023

Partnership Southwark

Working together to improve health and wellbeing for the people of Southwark

Part 2

Our Health & Care Plan

London Borough of Southwark (1 of 2)

Our population[1,2,3]

We have 307,000 residents. Our population is comparatively young, with the average age (32.4 years) almost two years younger than London, and almost seven years younger than England. 39% of our residents are aged 20-39, compared to 26% in England. We have a large LGBTQI + population – over 8% of our adults compared to 4% in London and 3% nationally. Latest estimates indicate that 51% of people living in Southwark have a white ethnic background compared to 81% nationally. Our diversity is greater among our children and young people, with roughly equal proportions of young people from white and black ethnic backgrounds. The latest population projections suggest that our population will continue to grow, with over 17,000 additional people living in the borough by 2030. Population growth is set to take place across almost all parts of the borough, but the largest increases are expected in redevelopment areas around Old Kent Road, Canada Water, and Elephant and Castle.

Achievements[4,5,6]

Across the borough there have been significant improvements in health and wellbeing in recent years, and there are many areas of success that should be celebrated:

- Our residents are living longer lives than ever before, with life expectancy comparable or better than the national average
- Levels of relative deprivation in the borough continue to reduce.
- Around 9 in 10 children in Southwark achieve a good level of development at 2-2 1/2 years.
- Key risk factors such as smoking, alcohol and physical inactivity are comparable or better than the national average.
- Preventable mortality has reduced by almost half since 2001, narrowing the gap with England.

London Borough of Southwark (2 of 2)

Wider determinants of health and wellbeing

- Around 16,000 households in Southwark are classed as overcrowded, with more overcrowding that is seen across London and England[7]
- However, Southwark continues to have a higher proportion of households with fewer bedrooms than required that is seen across London and England[7]
- Around 51,800 (40%) households in Southwark are deemed to be under-occupied and have more bedrooms than is required[7]
- Lack of affordable and, in some cases decent, housing is a significant issue in Southwark[7]
- At the start of 2020 Southwark was thought to have at least 25,700 unpaid carers with numbers expected to increase in the future[8]
- 25% of 0-16s are estimated to be food insecure (75,000) with a similar percentage for people >16 (16,000), with prevalence higher in central and northern parts of the borough and for those who are Black, in social rented housing or with dependent children[9]
- Local community organisations, parks and green spaces are seen as valuable assets by residents. Local people have told us how important it is that their voices are used to shape change in their local area and services
- The median (average) household income in Southwark in 2022 was £43,769 broadly comparable to the national average of £38,984. There is a wide range of income in Southwark with around 1 in 10 households in the borough having a total income of <£15,000 per year[10]

Inequalities within our borough

- Approximately 21% of Southwark's population live in communities ranked within the most deprived nationally. This increases to 23% among those aged under 18[5]
- Across a wide range of health, social and economic measures, from child poverty through to obesity, hospital admissions and life expectancy, outcomes are poorer in central and northern parts of Southwark particularly communities in Faraday and Peckham wards
- Residents from a Black African and Black Caribbean background are more likely to live in communities with high levels of deprivation, develop a greater number of long-term conditions, have poorer mental health, and experience discrimination and racism when accessing services[5]
- Southwark has the fourth highest LGBTQI+ population in the country, and we know that this group can suffer discrimination for access to services, as well as poorer health outcomes[3]
- Southwark has the highest number of asylum seekers in accommodation centres in SEL.[11] The population may have experienced conflict, violence, multiple losses, torture, sexual assaults, and/or risk of exploitation, as well as experiencing issues accessing health and care services. Population inequalities: often mirror those nationally with Black, Asian and minority ethnic people seeing poorer outcomes than for white people, especially Black African /Caribbean. Other populations affected are Latin American, LGBTQI+, those with learning disabilities, carers, rough sleepers and asylum seekers & refugees.
- For 2018-20, life expectancy in Southwark was: males 79.6 years and females 84.1 years - better than the national average and linked to areas of socio-economic deprivation.[4]
- However, years in good/poor health are equal at 64 years for men and women, so women are living longer but in poorer health.[4]

Start Well – picture in Southwark

Data	Relevance to programmes
In Southwark 1 in 4 children in reception are overweight or obese, the highest prevalence being in Camberwell Green. Obesity is higher than London levels: 1 in 4 in reception, rising to >40% in year 6, correlates to more deprived communities (mid / north of borough), worse for black children.[12]	1001 days programme Start for life and family hubs
The over-35 birth rate in Southwark (35 per 1000) is significantly higher than that for England (23 per 1000) (2020/21) and there is increased risk of complications with age.[13]	Start for life and family hubs
4.5% of women were known to be smokers at time of delivery (2020/21).[13]	Start for life and family hubs and link with Vital 5 (Live well)
16.6% of women are obese in early pregnancy, a figure below the regional (17.8%) and national percentage of 22.1% (2018/19). Babies born to obese women have a higher risk of foetal death, stillbirth, congenital abnormality, shoulder dystocia, macrosomia and subsequent obesity.[13]	1001 days Start for life and family hubs
15,000 emergency attendances per year by children under 5s for accidental injury or minor illnesses that could have been treated in primary care (higher in north of borough). Attendances are significantly higher than national average and increasing but admissions are comparable with London levels and below national average.[13]	1001 days programme Start for life, family hubs and links with child health teams
10% (2000) children 0-4 years have experienced >= 4 ACEs and around 25,700 children living in poverty in the borough.[13]	1001 days programme Start for life, family hubs and links with child health teams
2771 Children in Need, which is higher than London levels, of which 47% relates to abuse or neglect.[14]	Start for life and family hubs
There are inequalities in breastfeeding prevalence at 6 weeks post-birth, by level of deprivation. Exclusive breastfeeding coverage decreases with increasing level of deprivation. 16% of mothers living in Camberwell Green do not breast feed at all, with 31% partially breast feeding.	1001 days programme Start for life and family hubs

Live Well – picture in Southwark

Data	Relevance to programmes
Top 3 factors re poor health: smoking/obesity/poor diet, comparable with national picture, higher in men than in women.[6]	Vital 5, healthy weight
Long Term Conditions (LTCs) represent: 50% of GP appointments, 70% inpatient bed stays and 70% acute and primary care budget expenditure – 2400 emergency care admissions, significantly higher than national average and not changing much over time. Top 3 LTCs: hypertension, depression and diabetes (20/21). This is more likely within Black, Asian or other minority ethnic communities, particularly with higher socio-economic deprivation, age at which people have LTCs is getting younger.[17]	Coordinated holistic care - Vital 5
Cardiovascular disease is the second largest causes of preventable deaths both locally and nationally, accounting for around 25% of all deaths.[18]	Vital 5
Smoking, obesity and poor diet have the biggest impact on quality of life (morbidity) in our population, with smoking resulting in 11% of years of life lost prematurely, and high Body Mass Index (BMI) resulting in 8% lost prematurely. However, smoking among adults in Southwark continues to decline.[19]	Vital 5
Despite a fall in average alcohol consumption over recent years, Southwark has the second highest rate of alcohol dependency in South East London for those aged 35 and over.[6]	Vital 5
Around 55,000 adults in the borough have a common mental health condition[20] MH: 1 in 5 in London, c 48,700 adults locally, more prevalent in women SMI c 4,100 diagnosed, more likely if male, older or from a Black, Asian or other minority ethnic communities	Community Mental Health Transformation
Southwark has the fourth highest LGBTQI+ population in the country, and we know that this group can suffer discrimination for access to services, as well as poorer health outcomes.[3]	Inequalities funding – targeted work in primary care

Age Well & Being Cared for Well – picture in Southwark

Data	Relevance to delivery workstreams
Adult social care: rates of people needing services are lower locally than for London average (rising), broadly equally split between 65 + years and working age – personal care is most common support needed. ASC provides support to 1500 unpaid carers.[21,22]	Links to supporting people to be Cared for Well in residential settings
Falls: emergency admissions consistently higher than national/regional levels and Southwark is the highest in SE London. Those who are 80 years or over are >4 times the number of those <80 years.[4]	Frailty and Falls Prevention
Dementia: 1,178 people, which is comparable with London and England levels. In Southwark, 2/3 of people thought to be affected have received a diagnosis. Highest rate of emergency admissions for dementia in London.[4]	Frailty pathway
Geographic inequalities: poorer in central and northern parts of the borough, especially Faraday, Peckham wards but also Kingswood and Downtown estates which are in more generally affluent areas in the South.	(part of neighbourhood working)

What have we heard from people and communities?

We have been talking with people and communities through a variety of initiatives and partners. These include south London Listens, Southwark 2030, Southwark Stand Together and the work led by Social Finance and Centric. From these we have heard:

- Mental health and wellbeing for children, young people and adults is a priority
- People can struggle to access services, such as GP appointments; due to demand, or because they feel excluded, unsure of where to go or unable to interact with services
- Services need to be culturally-appropriate and accessible for all
- Discrimination and structural racism are impacting access and experience of services
- Vulnerable people are falling through gaps in support
- Concern regarding rising cost of living, food poverty and affordable housing
- Local communities and community autonomy is highly valued
- People want to be meaningfully involved and for their voices, insight and experience to be valued
- People want to be able to access as much as possible in their neighbourhoods

Start Well | First 1001 Days of a child's life

Target Population: Mothers, Families and Babies under 2 years

Closely aligned to the development of the start for life and family hubs programme, a specific programme focused on the first 1001 days of life (conception to 2 years old) has been identified as a priority within Southwark. The programme is specifically targeted at families in the Camberwell Green area and is utilising an asset based approach to support community development and allow for tailored and creative approaches to meeting need in this area. Camberwell Green has been selected as the initial area of focus as it is an area of high deprivation (most of the area is in the second most deprived quintile nationally) and:

- evidence shows that socioeconomic deprivation increases the risk of maternal perinatal mental illnesses
- 16% of mothers living in Camberwell Green did not breast milk feed at all, 31% partially breast fed compared with 11% and 24% respectively for mothers in the second least deprived quintile (maternal population in the least deprived quintile is very small)
- Camberwell Green has the highest prevalence of obesity in Reception aged children in the borough. Camberwell is also a community asset rich area with strong, well embedded, and trusted community groups and leaders making this an ideal area to trial the resident led, neighbourhood targeted programme approach

Proposed focuses for the programme are perinatal, parental and infant mental health; workforce development; and breast feeding and infant nutrition.

Links have been established with Local Maternity & Neonatal System (LMNS) SEL and we are exploring which strands of work would be beneficial to join up, e.g.. co-production, pre-conception care.

How we will secure delivery

Actions for 23/24

- Plan and deliver in collaboration with start for life offer and family hubs
- Develop and deliver a coproduction plan to shape the future of the programme: double diamond methodology
- Set up core multi-agency programme group with sub workstreams as required to focus on key areas
- Asset mapping of Camberwell Green area in collaboration with residents and partners
- Continue to expand the delivery group membership as necessary to ensure all relevant partners and teams are part of the programme. Continue to build relationships with residents and community groups in Camberwell Green and across system partners
- Undertake local workshops/meetings that connect people to unlock the potential in the local area
- Coproduce outcomes framework with residents and system partners
- Establish opportunities and solutions for data sharing between system partners
- Link in with existing planning around workforce development to align programme plans
- Produce a report to capture approach – learning – activity and outcomes and use the learning from this to spread/scale to other parts of the borough (**Camberwell is a starting point**)
- Scope and develop a collaborative maternity partnership group within Southwark to oversee the ambition

Actions for 24/25

- Development of n action plan on tackling local inequalities based on recommendations on maternal access, outcomes and experiences
- Further plans and actions to be coproduced with residents and partners as the programme develops
- Established pooled funding arrangements

Strategic priority:	**Start Well – First 1001 days of life (1 of 2)**
Ambition:	**An integrated networked approach to understand issues and co-produce solutions in Camberwell for Families with Children under 2 years, specifically to support mental health, breast-feeding and nutrition with a focus on workforce development**

Five-year vision statement

By 2027, all women and their partners who live in Southwark will feel equipped and empowered to provide the best start in the first 1001 days of their children's lives through the provision and access of family-centred, integrated support and services that meet their specific needs.

Core inputs and Activity	Resident health & wellbeing outcomes	Impact indicators	Resources and Core delivery partners
1. Work with local community, voluntary sector, primary care and other partners and residents to understand current picture around access to breastfeeding and weaning advice and support: which is culturally appropriate – co produce solutions to issues 2 Deliver workshops and community events to bring people together in Camberwell to build community connections, develop local ideas and build opportunities together which support families 3. Improve the links between services and at a practice level look for opportunities to integrate workforce via co- location, training, 'warm' referrals, interprofessional practice and data collection 4. Recruitment of clinical and care professional lead from VCS to co-lead as part of the 1001 days programme team – and help us build a community network to build trust, learn and co – produce solutions 5. Map funding arrangements and explore opportunities to pool funding that improves integration – align with start for life offer & family hubs 6. Explore access to information for local people – what works well and where might improvements be made to reduce apparent inequalities and support prevention	• Local residents access breast feeding support in a timely way with appropriate steps undertaken to ensure those whose first language is not English do not experience discrimination • Mothers, Fathers families and babies are supported to access a range of services when required - having received the input they need , improving trust , satisfaction and experience	• Residents report increased satisfaction in accessing relevant/flexible opportunities for breast feeding support, with language not being a barrier – increased numbers breastfeeding in Southwark • Reduction in wait times between key services through improved interdisciplinary practice/systems and processes to be baselined) • Increased evidence of MDT approaches with 'warm handovers' (linked to above) • Reduction in crisis presentation to A&E from families with children under 2 years in the Camberwell area (currently not separated from under 5s) • Pathway for MH support – employing both qualitative and quantitative measurement for the effective management of the whole process from all perspectives (service users/staff/system) • A reduction in referral rates into crisis mental health services (to be baselined) • Increased publicity of community resources and activities – ensure there are well publicised and local knowledge of the diverse and personalised range of services and interventions for families with babies under 2 years • Increase in investment in community and voluntary sector to support a sustainable network of meaningful services and offers that are appropriately adapted to the needs of the local community • Increase the number of people using the community pharmacy consultation service for support and help with common ailments (to be baselined)	Programme team and Start Well <u>Core 1001 days team members:</u> • London Borough of Southwark • Southwark ICB • SLaM • Primary Care • GP • GSTT • King's College Hospital • Community & Vol Sector Partners • KHP • Community Pharmacy • Comms and engagement <u>Links with wider programmes:</u> 1. LMNS - SEL 2. Asylum seekers 3. Start for life and family hubs 4. Safeguarding (as appropriate) 5. Council Neighbourhoods programme

Strategic priority:	**Start Well – First 1001 days of life (2 of 2)**
Ambition:	**An integrated networked approach to understand issues and co-produce solutions in Camberwell for Families with Children under 2 years, specifically to support mental health, breast-feeding and nutrition with a focus on workforce development**

Five-year vision statement

By 2027, all women and their partners who live in Southwark will feel equipped and empowered to provide the best start in the first 1001 days of their children's lives through the provision and access of family-centred, integrated support and services that meet their specific needs.

Core inputs and Activity	Resident health & wellbeing outcomes	Impact indicators	Resources and Core delivery partners
7. Capacity to support review of Mental health pathway in the neighbourhood, including information sharing, joint working arrangements, family approach 8. Capacity to support review of A&E activity for under 5's to understand the data for those under 2 years and themes/neighbourhood – link with safeguarding 9. A programme of communication with local population to allow a greater understanding of the differing healthcare roles, the range of health and wellbeing and social services available for babies under 2, and how they can have direct access to the right service for their need, including to protect a child's wellbeing and safety 10. Explore opportunities for weighing and monitoring weight in children under 2 years old in Camberwell to support healthy weight 11. To establish a Maternity Commission to review action to tackle inequalities in access, experience and outcomes in maternity care.	• Increased self-management skills for people experiencing problems with their mental health and wellbeing • Increase access to and recovery rates for Southwark Talking Therapies for Black African and Caribbean residents to ensure they are as least as good as those of British White residents. • Mothers, Fathers, families and babies are supported to access services when required - having received the input they need thus improving the person's experience • Better peri-natal and maternal mental health outcomes, offered through a range of flexible opportunities and a clear pathway	• Reduction in crisis presentation to A&E from families with children under 2 years in the Camberwell area (currently not separated from under 5's) • Pathway for MH support – employing both qualitative and quantitative measurement for the effective management of the whole process from all perspectives (service users/staff/system) • A reduction in referral rates into crisis mental health services (to be baselined) • Increase in investment in community and voluntary sector to support a sustainable network of meaningful services and offers that are appropriately adapted to the needs of the local community. • Increase the number of people using the community pharmacy consultation service for support and help with common ailments (to be baselined). • Pooled funding arrangements that support children aged 2 years and under e.g. children centres, PACT, CAMHS, for perinatal care, Parental Mental health, Pause. Expand the current agreement between the Council & SLaM to be widened and include the ICB, Evelina and others NHS bodies. (Principles for pooling funding to be agreed) • Maternity commission action - review completed by 03/24.	Programme team and Start Well <u>Core 1001 days team members:</u> • London Borough of Southwark • Southwark ICB • SLaM • Primary Care • GP • GSTT • King's College Hospital • Community & Vol Sector Partners • KHP • Community Pharmacy • Safeguarding leads <u>Links with wider programmes:</u> 1. LMNS - SEL 2. Asylum seekers 3. Start for life and family hubs 4. Safeguarding (as appropriate) 5. Council neighbourhood development

Start Well | Children and young people's mental health

Target Population: Children & Young People

Southwark Partnership is known to serve a population at elevated risk of mental health issues: PHE data shows Southwark young people are at higher risk than the national rate of being first time entrants into the Youth Justice system, of homelessness, and of attendance at A&E. More recent data from the Children's Commissioner indicates that the modelled prevalence of children 0-17years at risk of experiencing adult mental health, domestic violence, alcohol/substance abuse in LBS is 229.5 per 1000 placing it as one of the highest risk rates in the country. The modelled prevalence of children 0-17y at risk of ALL of above factors is given as 12.9 per 1000 again one of the highest rates in the country.

Intended outcomes in 5 years' time

1. Young People are able to access holistic services which are structured around need rather than age
2. Southwark system can demonstrate seamless, system wide collaboration in a joined-up vision and clear, sustainable investment through transparent decision making and collective accountability
3. Families are able to access support for their mental health and wellbeing in a way that supports improved family outcomes
4. Resilient and representative groups able to improve service users experience
5. Improved connectivity and pathways between SEL commissioned services and local services to increase uptake
6. Improve the mental health and wellbeing of families, children and young people, ensuring 100% of children and young people who need support can access emotional wellbeing or mental health services
7. Keep children and young people safe through early identification and support for families at risk of adverse childhood experiences
8. Each neighbourhood in Southwark has a local integrated child health team that meets the holistic needs of children, including their mental health

How we will secure delivery

Actions for 23/24

- A pilot to test the dedicated and regular support to child health teams, from CAMHS staff
- Improving equality of access and reducing waiting lists
- Supporting 16-25 year olds to access the right support
- Improving parental mental health to keep families strong
- Support for Southwark schools – universal and targeted offer for pupils, staff and parents
- Supporting children responding to trauma and distress and crisis stepdown
- Supporting the emotional and mental wellbeing of young offenders (including prevention)
- Develop a seamless pathway for children and young people with eating disorders
- Ensure that the mental health needs of those attending Accident and Emergency are better met
- Improving the responsiveness of perinatal mental health support
- Increasing the number of mental health support teams in schools

Actions for 24/25

- Waiting list reduction continues with the following actions:
  - October 24 – no longer than 36 week wait
  - April 25 – no longer than 30 week wait

  Identify opportunities to strengthen how data on adverse childhood experiences is shared between relevant services.

Strategic priority:	**Start Well – Children & Young people's mental health (1 of 2)**
Ambition:	**Fewer children and young people are affected by poor mental health**

Five-year vision statement

Our aim is for all children, young people and families in Southwark to have the support needed to be mentally and emotionally healthy. This includes being empowered to know how we can help ourselves. Where more help is needed, children, young people and families have a choice of support, provided by someone families can trust, in a suitable environment which is welcoming, safe, without discrimination and easy to access.

Core Inputs and activity	Resident health & wellbeing outcomes	Partnership Impact indicators	Core delivery partners
Development of an iThrive and preventative system approach to children's mental health and wellbeing including a new Single Point of Access and Schools offer.	Improved knowledge and understanding from practitioners and schools on supporting children's mental health and wellbeing. As part of a single point of access • Improved referral triage decision making • Improved and more timely access to CYPMH services	• New Single Point of Access pathways co-developed with children and young people and professionals. • New online digital single point of access for access to mental health and wellbeing resources and support. • Co-ordinated mental health offer for Southwark schools	• SLaM NHS Foundation Trust • London Borough of Southwark • SEL Integrated Care Board • Voluntary and community sector partners • Schools
Continued delivery of the following initiatives: • Kooth digital mental health platform for CYP • Nest Open Access • Fantastic Fred – interactive MH performance within 11 primary schools • PACT community led support service to improve parental mental health • Mental Health Support Teams in Schools (36 schools by end of 24/25) • Develop and implement a person-centred model for community mental health, based on primary care networks and neighbourhoods, in which primary care, secondary care VCSE organisations and local authority staff work together to deliver practitioners to be embedded in communities and neighbourhoods through Be Well hubs.	• Improved support for mental health and wellbeing needs for children being supported by Children's Services. • Improved early intervention support for children and young people preventing potential escalation to specialist mental health provision. • Improved MH/ADHD service transition to adult • Improving parental mental health to keep families strong • Support for Southwark Schools, universal and targeted offer for pupils, staff and parents • Improving the responsiveness of perinatal mental health support	• Development of new Integrated Clinical Health Team structure • New Integrated Clinical Health Team posts fully recruited	• SLaM NHS Foundation Trust • London Borough of Southwark • SEL Integrated Care Board
	• More timely and specialist child and adolescent mental health assessment and support • Reduce assessment waits to eliminate: • over 52 week by October '23 and 44 week wait by April '24. • October 24 no longer than 36 week wait • April 25 no longer than 30 week wait • April 26 consistent delivery of all care within 18 weeks	• Recruitment of additional staffing capacity to reduce assessment times in 23/24. 52 week wait reduction: 1 x WTE B7 - 0.5 WTE B6 44 week reduction: 1 x WTE B7 - 1 x WTE B4 - 1 x WTE B7, 0.5 WTE B7 • Reduction in waiting times for specialist child and adolescent mental health services	• SLaM NHS Foundation Trust • SEL Integrated Care Board

Strategic priority:	Start Well – Children & Young people's mental health (2 of 2)
Ambition:	Fewer children and young people are affected by poor mental health

Five-year vision statement

Our aim is for all children, young people and families in Southwark to have the support needed to be mentally and emotionally healthy. This includes being empowered to know how we can help ourselves. Where more help is needed, children, young people and families have a choice of support, provided by someone families can trust, in a suitable environment which is welcoming, safe, without discrimination and easy to access.

Core Inputs and activity	Resident health & wellbeing outcomes	Partnership Impact indicators	Core delivery partners
Each neighbourhood in Southwark has an integrated local child health team, who have: a weekly **triage** meeting, a monthly in-reach **clinic** a monthly **MDT** 18-20% of referrals were for mental health or functional presentations. **In response approaches are to be piloted to increase MH input to the child health teams, to better meet the needs of these children**	Children's Mental health needs are met in a timely way with the recommended right evidenced based treatment	• Measurement of impact on health inequalities • MH outcomes • Measuring demand – assuming high levels for pilot • Patient/family reported outcomes • MDT learning and growth in expertise and confidence to manage children's MH needs • Monitor demand an capacity in CAMHS as a by product of the Primary care enhanced service	• Child health teams, including GP • CAMHS Psychiatrist (SLaM) • B7 CAMHS Practitioner • GSTT – Programme manager • Health visiting • Children's community Nursing • Therapists Physiotherapists, SALT, Occupational Therapists)
Bolstering the Child health team with integrated MH expertise from SLaM CAMHS to form a holistic offer and pathways for treatment and support GP's, Paediatricians and Health visitors have said they would like to learn more about Psychiatric support for children through: • Case reviews • Guidance on referral process and how to refer effectively • How to manage children in primary care who are on the waiting list for CAMHS – safety plans and practical advice. • More MH worker involvement in neighbourhoods	Feeling supported through the process and whilst waiting for some assessments and treatments Feeling like you are working with one team and not having to tell your story more than once Building relationships and trust with practitioners in a neighbourhood.		

Live Well | Adult Community Mental Health Transformation

Working Age Adults

The Prevention Concordat for Better Mental Health provides a frame and focus for our cross sector plan and is underpinned by an understanding that taking a prevention-focused approach to improving the public's mental health has been shown to make a valuable contribution to achieving a fairer and more equitable society. Working collaboratively with residents, VCSE's, NHS, and local authorities, expand the provision of prevention and early intervention and community-based mental health support offers for adults through both statutory and non-statutory organisations, and across health and care services.

Intended outcomes in 5 years' time

- Each neighbourhood in Southwark to have a fully established integrated community mental health teams bringing together health and social care and VCSE providers
- Contacts through community mental health to have increased 5% on average every year, with contacts representing the demographics and need of the local population
- Reduction in the inequality of service users' access, experience and outcomes around CMH services. In particular, Southwark's Black, Asian and minority ethnic communities and other groups that have previously been underserved
- Care is continuous: service users have an 'easy in, easy out' experience when stepped up/down between primary and secondary care and vice versa
- Mental health care is largely preventative and reduces the number of residents experiencing a mental health crisis
- Links with the VCSE are improved, service-users are able to get support with wider issues such as housing
- Improved mental and physical health and reduction in mortality, particularly among residents with SMI

Actions for 23/24

Actions for 24/25

How we will secure delivery

Delivery of year 3 of the adult community mental health transformation programme:

- Embed service user and carer involvement into service design and review across the system e.g.. through the launch of a Service Users Network
- Neighbourhood team structures designed, tested and implemented, incorporating multi-disciplinary teams and capitalising on the combined resource of MH professionals across primary care, secondary care and local VCSE professionals
- Review of referral processes between CMH services and secondary care with a view to streamline and reduce rates of unsuccessful referrals. Work with service users and residents with lived experience to ensure simple points of access across the system from other professionals and self-referrals
- Develop improved relationships and systems for SMI health checks to take place with the most appropriate health care team
- Finalise a proposal to measure outcomes across the system using the national outcomes framework metrics and existing system measures
- Link with CYP Emotional, Wellbeing & Mental Health Steering and Delivery Groups to join up work around young people's transition from CAMHS to adult services
- Current funding until end of March 2024
- ADHD – understand needs of this population, current mapping of services, consider local solutions for assessment and ongoing management. Develop guidelines for the community
- MH practitioners to be embedded in communities and neighbourhoods through Be Well Hubs
- Complete system-wide scoping activity to identify opportunities to integrate mental health in all policies, to improve the social determinants of poor mental health

Strategic priority:	Live Well | Maximising the impact of our services on prevention and early intervention
Ambition:	Deeper Integration in our local health and care systems

Five-year vision statement

The London Borough of Southwark are improving mental health and wellbeing by working across these key areas: Primary care and community-based support, Primary/Secondary care interface, developing our core offer for SMI. We are collaborating with service users, carers and the voluntary sector to tackle mental health stigma and discrimination towards more personalised services; ensuring that there are effective mental health services available when and where needed with focus on there being 'no wrong door'. Performance measures are being developed for specific recommendations within the Transformation Delivery Group Plan against our National Roadmap.

Core inputs and activity	Resident health & wellbeing outcomes	Partnership impact indicators	Core delivery partners
• Develop a diverse and personalised range of interventions to people experiencing mental health problems within the community setting considering psychological, physical, and social needs – including partnerships with Primary Care Networks, IPS employment, Shared Lives, Southwark Wellbeing Hub, MIND and Black Thrive	• Reduced average length of engagement as people are supported to quickly move through the service having received the input they need • Reduced escalation of mental health problems as a result of unaddressed issues such as debt, housing, drug/alcohol use, unemployment and social isolation • Increased self-management skills for people with mental health problems • Ensure there is active monitoring of the vital 5 risk factors when residents engage with our services	• Reduction in hospital admissions • Delivery of first contact with 28 days for adult community mental health services currently at 87% but with these actions to achieve 95% by 2024. • Reduction in presentations to A&E of service users known to mental health services • Workstream/pathway outcomes to be measured against National Roadmap • Increased use of Wellbeing Hub and Mental Health Practitioners	• SLaM Trust • Southwark Local Authority • Southwark ICB • Primary Care Networks • VCSE – Mind & Black Thrive • Public Health • Southwark Wellbeing Hub • Kings/GSTT
• Work with people with lived experience to develop effective communications and engagement to help tackle stigma and provide a sense of belonging to a community of people with similar experiences	• Increased connectivity with local communities and services, better self-management skills for people with mental health problems • Reduced health inequalities, in particular, for people from our black and minority ethnic communities	• Increased engagement in community resources and activities including via self-directed support • Decreased Community Mental Health Team caseloads to achieve target 24 cases per staff member • PCREF data/governance and patient/carer feedback	• SLaM Trust • VCSE – Mind & Black Thrive • Southwark ICB • Southwark Wellbeing Hub • Southwark Local Authority • Police
• Neighbourhood working. Build relationships between Primary and Secondary Care to continue to develop services in the community and hospitals, including talking therapies, to provide the right level of care for people with common or severe mental illnesses. Development and implementation of evidenced based clinical care pathways	• Residents are supported to receive the right care and the right time, in the right place' thus improving patient experience • Better mental health outcomes • Increased availability of evidenced based treatment and intervention • Wellbeing Hub neighbourhood outreach support workers pilot providing additional 1:1 support to residents	• Reduction in the number of delayed transfer of care patients by 20% by 2024 • A reduction in referral rates into mental health services • Reduction in waits to access support capped at 28 days by 2024 from 87% to 95%	• SLaM Trust • Primary Care Networks • Southwark ICB • ICS • Southwark Local Authority • VCSE – Mind & Black Thrive • Public Health

Live Well | Prevention, Vital 5 (hyper-tension, healthy weight, alcohol intake, smoking, mental health)

Working Age Adults

We know that focusing on prevention and early detection in these five areas is an effective way of improving outcomes for our population. Our plan has included the Vital 5 as we know that identifying, recording, and sharing the Vital 5 data between all relevant partners and our patients, and acting on the results across our population, would make the biggest difference to people's health and wellbeing and to the sustainability of health and social care**.** The starting focus of the Live Well programme is hypertension as this cuts across and impacts all the other Vital 5 areas and is also one of the five clinical areas within the Core20Plus5. Hypertension is the most important risk factor for premature cardiovascular disease, being more common than smoking, dyslipidaemia, and diabetes and accounting for an estimated 54% of all strokes and 47% of all ischemic heart disease events globally. Evidence also suggests there are significant numbers of residents with undiagnosed hypertension. Our aim is to ensure residents have the best possible blood pressure, and 80% of those with high blood pressure are detected and treated to recommended guidelines, in line with the national ambition.

How we will secure delivery

Actions for 23/24

- Lead the aims and objectives of the vital 5 programme within the Live Well workstream and ensure alignment at borough level with SEL Vital 5 programme
- Incorporate awareness and screening of the Vital 5 in the public health promotion and campaign
- Conduct a review of local intelligence regarding the prevalence and management of hypertension including transfer of information between organisations and analysis on health inequalities across Southwark identifying future opportunities and actions
- Extending screening of the Vital 5 to other healthcare groups
- Establish how to better target existing incentive schemes to improve data recording of Vital 5 in underserved groups
- Develop pathways that mean hypertension data collection can be translated into meaningful interventions that lead to better outcomes
- Evaluation of digital health kiosks in the community, also map intervention pathways from the mobile van approach, also targeted test and learn activity within primary care for hypertension
- Increase uptake of NHS health checks by those with greater risks along with risk reduction interventions
- Extend the Community Health Ambassadors programme, empowering more people to increase update of vaccinations, cancer screenings and health improvement opportunities in their communities, focusing on areas with poorer health and higher levels of deprivation.

Actions for 24/25

- Conduct an equivalent review approach for the other Vital 5 areas (smoking, alcohol intake, mental health, obesity) once work on hyper-tension begins to advance, building on the iterative and developmental model of working
- Building on previous year's work, lessons learnt and round up
- Use the Population Health Management contract to encourage general practice to deliver the Vital 5
- Working with Council leisure services to utilise space in health environments to encourage residents to optimise opportunities

Intended outcomes in 5 years' time

Southwark system in collaboration with SEL providing a seamless, system wide approach to a joined-up approach to delivery to screening and interventions, risk factor documentation and communication between services.

Local ambition:

- All residents in Southwark to be aware of what the Vital 5 is, and what their own measurements are
- A minimum of 50% of NHS Health Checks are undertaken by residents from Black, Asian and other ethnic minority backgrounds
- Fully embedded "Making Every Contact Count" approach to maximise interactions with patients across health and care system
- To provide culturally sensitive services for residents, offering easily accessible and exciting options for improving individual and family health

National ambitions:

- 80% of the expected number of people with high BP are diagnosed by 2029
- 80% of the total number of people diagnosed with high BP are treated to target as per NICE guidelines by 2029

Strategic priority:	**Live well – Vital 5 (1 of 2)**
Ambition:	**All residents in Southwark are aware of what the vital 5 is, and what their own measurements are.**

Five-year vision statement

Through the areas of focus that have been proposed, our aim in Southwark is to ensure residents are able to lead the healthiest and longest life possible. The Vital 5 programme will enable residents to know their Vital 5 status through accessible screening, having access to pathways of care and intervention that proactively meets their needs, reducing variation and inequity.

Core inputs and activity	Resident health & wellbeing outcomes	Partnership impact indicators	Core delivery partners
• Develop a range of opportunities to strengthen the Vital 5 programme including improved data recording, engagement and interventions • Complete a mapping exercise that identifies the current pathway, opportunities and challenges for the Vital 5 across Southwark with a focus on reducing health inequalities • Carry out a review of all tier 2 weight management services commissioned at place by Public Health and the Health Populations team with a view to pooling budgets and commissioning new, culturally appropriate services for 24/25 • Working with Council leisure services to utilise space in health environments to encourage residents to take up free gym and swim offer available	• Option to attend alternative locations to primary care to have Vital 5 screening completed including out of hours locations • Access to pathways of care and interventions that proactively meet their needs, reducing variation and inequity • Reduced health inequalities particularly for people from our black and Latin American communities • Better health outcomes • Better communication between services and sharing of Vital 5 measurements thus improving patient experience and confidence in services • Residents feel enabled to self manage their health and stay well • Residents at risk of deteriorating ill health are identified earlier • Reduced stigma to mental health and improved patient experience	• Reduction in respiratory diseases, liver transplants, diabetes, renal dialysis, amputations and other comorbidities associated with obesity, high alcohol intake and smoking • Reduction in the prevalence of hypertension and associated CVD • Increased detection and control of hypertension. • Increased number of people with known hypertension whose target blood pressure is achieved and maintained • Improved mental and physical health outcomes through improved self-management and treatment adherence • Improved and timely identification of co-morbid depression/anxiety • Increased publicity and engagement in community resources and activities • Improved access to care pathways to prevent and manage Vital 5 related conditions • Increase in the number of locations available for people to complete their Vital 5 screening • Improved collection and sharing of Vital 5 data across all services. • A whole system pathway developed in conjunction with SEL/KHP Vital 5 programme to allow results to be acted on appropriately, the person supported, and data flows implemented to support the programme • Standardised pathway and tools for recording and sharing of the Vital 5 measures with patients and professionals across primary, community and secondary care • Pooled budget arrangements for healthy weights • Increased uptake in free gym and swim offer	<u>Led by Partnership Southwark programme team</u> <u>Core Live Well team members from</u> • Primary care • London Borough of Southwark • SEL Integrated Care Board - Southwark • SLaM NHS Foundation Trust • GSTT • Community & Vol Sector Partners (e.g.. ITAV, Bede House) **In collaboration with SEL/KHP Vital 5 Delivery Group**

Strategic priority:	**Live well – Vital 5 (2 of 2)**
Ambition:	**All residents in Southwark are aware of what the Vital 5 is and what their own measurements are.**

Five-year vision statement

Through the areas of focus that have been proposed, our aim in Southwark is to ensure residents are able to lead the healthiest and longest life possible. The Vital 5 programme will enable residents to know their Vital 5 status through accessible screening, having access to pathways of care and intervention that proactively meets their needs, reducing variation and inequity.

Inputs and activity	Resident health & wellbeing outcomes	Partnership impact indicators	Core delivery partners
• Roll out our community outreach and early prevention initiatives such as our 'community outreach' to promote awareness of the Vital 5, offer screening, health and wellbeing information and signpost to interventions and support services with a focus on reaching those with higher risk of poor health	• Increased self-management skills for people experiencing long term conditions • Reduced health inequalities and in particular for people from our black and Latin American communities • Improve access to services to support good health, well-being and connection for local residents • Empower residents and communities to choose healthy behaviors and make changes that reduce the risk of developing chronic diseases and other morbidities	• Increase the number of residents completing a Vital 5 screen by engaging directly with residents • Deliver 24 community events with the Vital 5 offer and information as a key component for each event • Improve access to services for inclusion health groups, in line with the Core20 PLUS5 approach • Engagement with a wider range of stakeholders and partners to inform and co-produce the outreach programme delivery • Tangible feedback from residents regarding their experiences	• London Borough of Southwark • SEL Integrated Care Board – Southwark • Primary care • Healthwatch • Community & Vol Sector Partners • Providers

Age Well & Being Cared for Well | Frailty (incl. Falls)

Older Adults and Carers

Identifying people who are living with frailty offers an important opportunity to identify those people who are at the greatest risk of deterioration in their health and wellbeing and ability to live independently. The early recognition and timely management of frailty syndrome is vital. There are interventions that can improve independence and the quality of life for people living with frailty. Whilst recognising much work is underway to manage frailty, we don't have a recognised frailty strategy and integrated pathway and approach in Southwark. This frailty programme for older adults has interdependencies with Virtual wards and links with the lower limb wound care programme.

How we will secure delivery	Intended outcomes in 5 years' time
Actions for 23/24 • Scope other Local strategies and approaches in SEL to learn about what is working well and where there may be gaps and opportunities • Set up a task and finish group to review findings and best evidence and scope Southwark to understand our local system at place - Present findings to Del Executive as to what is being proposed/recommended by Well Collaboratives - a case for change – • Draft a business case as per direction by Del Executive • Develop an integrated strategy – including digital interoperability • Deliver education and training on falls risks and availability of local services for community healthcare, social care and primary care workers • Develop an inclusive apprenticeship programme within the social care workforce, focusing on staff who have the ambition to join the registered workforce and may have been excluded from traditional university routes. • Implementation of Workforce Race Equality Standard in Adult Social Care as an early adopter local authority	• Southwark system is operating in accordance with our agreed strategy, with a common understanding of what frailty means • Those with frailty are supported and cared for at home (link to virtual wards, rehab and Reablement services) • A reduction in falls rates in all settings – a training offer in place from an MDT perspective • Aligning with Care Well around the Health Innovation Network initiative to deliver bespoke Leadership Support programme to care home managers across South London • Carers are recognised as part of the core team, kept informed • A digital solution explored as part of the strategy • Effective information sharing and data capture to compliment an outcomes framework which measures the effectiveness of the integrated strategy and quality of individualised care
Actions for 24/25 • Commissioning and delivery response in line with above • The creation of an accessible and holistic pathway to avoid hospital admission when clinically appropriate • A "pull" pathway out of hospital so post-acute care does not happen in an acute hospital - neighbourhoods • Agree an approach to sharing information effectively across agencies and within neighbourhoods around an individual's care and support needs	

Strategic priority:	Age Well & Being Cared for Well
Ambition:	An integrated Frailty Pathway to support people to live fulfilling and independent lives, where carers are also supported

Five-year vision statement

This priority brings together key agencies with a role in improving health and wellbeing in Southwark, who will jointly develop a model which aligns to delivering our neighbourhood approach. The opportunities to deliver better outcomes for Southwark residents will be optimised through strengthening joined up care, exploring where care can be delivering at a neighbourhood level and strengthening how we involve local people in planning and delivery of our work.

Inputs and activity	Resident health & wellbeing outcomes	Partnership impact indicators	Core delivery partners
Build on what is already working well. Working with colleagues across SEL and in Southwark to understand good practice around integrated frailty pathways and develop recommendations for piloting an approach/neighbourhood pathway locally, linked to the local falls work. • Gain consensus as to a starting point for the model with clear definitions and understanding as to what we mean by frailty and where the assessment points are and tools to support practice • Provide holistic care to our population bridging the gap between primary, secondary care, social care and wider community and voluntary sector offers • Address longer-term care planning with people that is person centred and promotes activity and independence within their functional limits – building resilience • Provide a first point of contact for people experiencing a rapid deterioration or crisis	• People don't have to tell their story more than once and the physical, psychological, spiritual and cultural needs of people are incorporated into the holistic and person-centred assessment and care plan • Accessible care co-ordination: Referrals to other organisations are simple transfers that support health and wellbeing in a prompt and person-centred way • Reduced A& E attendances/crisis and number of attendances per individual – data to be sourced • people can be supported at home by various members of the virtual ward team/community services • Staying well and independent with optimum resilience to remain active and enjoy meaningful activities • A meaningful impact on independence, enabling people to live and die well as part of a community • Increased specialist advice & support available to enable people to make choices about their care • People have access to meaningful activity and are able to feel well and active for as long as possible • A reduction in hospital attendances and admissions (particularly for >1 day), reducing the risks of protracted periods of recovery • A meaningful increase in the wellbeing of patients receiving multi-factorial frailty support • Enabling patients to die in their usual place of residence, where this is their preferred place of death	• Joint planning and closer collaboration with Live Well • Supporting GP practices and primary care to deliver alongside existing workforce - bringing service closer together • A model of care which prevents deterioration and restore health and independence where possible and at earliest point • Provide rationalisation of medicines and correct usage/procedures • Social prescribing activity • Falls referrals and reduced attendance to A&E and admissions • Reduced fractured NoF • Digital opportunities optimised and increased to prevent falls and monitor – via Telecare • Shared assessment information and data to support outcome measurement holistically rather than episodically • Delivering capacity for patients simultaneously by the virtual wards in Southwark • Reducing ED attendances and admissions (compared to the 6 months pre-intervention) for frailty MDT • Reduction in the median length of stay at GSTT and Kings on frailty wards • Admissions avoided due to referrals to alternative care pathways	**Led by Partnership Southwark programme team** Core lower limb wound care team members from • London Borough of Southwark • Southwark ICB • Community & Voluntary Sector Partners e.g.. Link Age & Southwark Carers • GSTT • Kings • SLaM • Primary care • Medicines Optimisation team • Providers, incl hospice, care home, home care • Comms and Engagement • Quality • Hospice care • Telecare service
• Co-design, development and delivery of community-based support model for those with care and support needs and their carers	• Service is designed in partnership and therefore it is more meaningful in meeting broder needs that support the prevention agenda • Choice and control and a partner in the care they receive and where they receive it	• Work with carers strategy group - Support and education for carers undertaken (formal and informal) • Aligning with other priorities within Age and Care Well including falls and dementia	As above Carers' strategy group

Age Well & Being Cared for Well | Lower Limb Wound Care

Older Adults and Carers

This project will design a new, holistic service model to transform lower limb wound care, including faster healing of wounds, improved quality of life for patients, reduced likelihood of wound recurrence, more effective use of health & care resources. Opportunities will be sought to improve the quality of chronic wound care through innovative solutions that will improve wound healing, prevent harm, increase productivity of staff, and produce financial savings in line with the requirements of the recent NHS Long Term Plan. The project will bring together key agencies with a role in improving health in Southwark, who will jointly develop a model by a partnership approach, which aligns to development of our neighbourhood approach and align to our approach to frailty. The opportunities to deliver better outcomes for Southwark residents will be optimised through strengthening joined up care, exploring where care can be delivered at a neighbourhood level and strengthening how we involve local people in delivery of our work. By bringing NHS, council and voluntary and community organisations together, we can define the shared outcomes we want for our population and ensure the right leadership, accountability and oversight to support our work.

How we will secure delivery

Actions for 23/24

- Set up multi-agency Task & Finish Group to build on the initial project work carried out in Age well
- Identify spend on staffing and prescribing across the system
- Desk top review of intelligence & data gathered to date from numerous sources
- Stakeholder engagement with all relevant parties
- Work with an external provider to carry out a deep dive needs analysis of wound care delivery in the borough and agree parameters and methodology with the group and wider ICB partners
- Test case examples to design a proposed integrated model - across health and social care and focuses on early identification – assessment – treatment – maintenance/further prevention
- Develop business case in 2 phased approach i) model development ii) analysis element
- stakeholder engagement activity with wider stakeholders, including carers forums and patients to test out initial thinking
- Develop the signposting to Ageing Well Southwark to ensure that a greater number of
- carers know how to access support
- Support model of social prescribing that helps to connect local residents to relevant services that can tackle loneliness and social isolation, focusing on factors associated with severe loneliness
- Set out how budgets can be aligned and or pooled under the Health and Care Plan
- Establish a new approach to embedding community voices in shaping and implementing health and care priorities

Actions for 24/25

- Further aligning programmes to build on the connections that are already happening across projects/programmes in Age Well - frailty/falls/hospital admissions/discharge/wellbeing
- Strategic planning and closer collaboration with Live and Care Well
- Working with PS delivery Executive to support development, as appropriate
- Enhanced focus on communities and neighbourhoods with poorer health to ensure better uptake of prevention and services to manage long-term conditions

Intended outcomes in 5 years' time

- Overall increase in quality of leg ulcer care delivery
- Reductions in no. of unscheduled hospital attendances for routine leg ulcer care
- Reduction in clinic wait times
- Number of patients being seen by social prescribers or accessing/being referred to additional preventative/support services
- Improved use of technology for research & reporting
- Improved outcomes for people with leg ulcers and decrease recurrence rates and increase healing rates
- Better awareness among patients and carers of risk reduction for leg ulcers
- Better access to specialist wound care in the community
- Improved patient experience and satisfaction
- Better coordination of care & patient outcomes
- Increase in staff skills and knowledge around leg ulcer treatment, with clear career pathway progression
- Increased productivity of staff and job satisfaction
- Less frustration & improved work satisfaction as currently unable to provide adequate care
  Release of non-specialist staff time

Strategic priority:	**Age Well & Being Cared for Well**
Ambition:	**To develop a holistic service model which will transform lower limb wound care, including faster healing of wounds, improved quality of life for patients, reduced likelihood of wound recurrence, more effective use of health & care resources.**

Five-year vision statement

This priority brings together key agencies with a role in improving health in Southwark, who will jointly develop a model by a partnership approach, which aligns to development of our neighbourhood approach. The opportunities to deliver better outcomes for Southwark residents will be optimised through strengthening joined up care, exploring where care can be delivered at a neighbourhood level and strengthening how we involve local people in delivery of our work.

Inputs and activity	Resident health & wellbeing outcomes	Partnership impact indicators	Core delivery partners
Design a new service model to radically improve: • the quality of life of older people, engagement in activities that may otherwise have been compromised due to pain and reduced mobility • holistic person-centred approaches, with an opportunity for service users to codesign a model • innovative solutions that will improve wound healing and prevent harm • increased productivity of staff and job satisfaction • integration of existing pathways and practice between health, care and the voluntary & community sector • financial savings in line with the requirement of the recent NHS Long Term Plan • potential joint working with diabetes clinics • Appointment data shows Black or Black British Caribbean patients, will have more overall appointments than other ethnicities, potentially demonstrating delayed or longer healing rates in these patient populations	• People receive a timely, holistic assessment via a single point of referral into a multiagency hub • Moves away from being an entirely medical model lens to a holistic health care and broader social model which acknowledges social activities and leisure • Healing rates are predominantly affected by good initial assessment (14 days) including doppler (blood flow ultrasound), followed by appropriate compression therapy applied by a trained clinician. An aim of the proposed model is to ensure both of these whether within a hub setting, by neighbourhood nursing or in a care home etc. • Health and wellbeing of patients are foremost in service delivery, encompassing links with drug and alcohol services and mental health support all available in one place, meaning less travel and separate appointments for patients • Linked to a prevention pathway which takes in consideration meaningful activity that is culturally relevant	• National target = % of patients with a lower leg ulcer receiving initial full assessment within 14 days of initial presentation. Current position is 28 days for neighbourhood nursing and 47 days for Tissue Viability Nurse • Developing a system to record healing rates to enable an accurate healing rate to measure against the national target and then identify options to address any slippage • National target = % of people diagnosed with venous leg ulceration healed within 12 weeks of initial presentation. Current position is 22.5 weeks for clinic via a proxy Length of Stay (LoS) measurement and 31.4 weeks for housebound LoS • E-Learning will be available and the hub will become the practical training space for all clinicians • Increased utilisation of social prescribing within new service model facilitating holistic, person centred assessment and interventions helping to address the wider social determinants of health (including mental health, food banks, housing support and other advice and support for patients & carers) – based on previous year • Monitoring and reviewing the prescribing of wound dressings to identify trends in ordering and reduce waste in bulk ordering	<u>Led by Partnership Southwark programme team</u> <u>Core lower limb wound care team members from</u> • London Borough of Southwark • Southwark ICB • Community & Voluntary Sector Partners e.g.. Link Age & Southwark Carers • GSTT • Primary care • Medicines Optimisation team
• Co-design, development and delivery of community-based support models for those with care and support needs and their carers	• Improved offer including choice and control over the care they receive and where they receive it • Offering a hub model providing single point of referral to community service and offering holistic well-being support • Carer able to support with low level wound care	• Support and education for carers	As above

Age Well and Being Cared for Well | Frailty (incl. Falls) - Metrics

Health and Care Plan - draft metrics scorecard - illustrative example of approach to be developed with all workstreams					
Partnership Impact domain	**Metric**	**Baseline 2022/23**	**Target 2023/24**	**Performance 2023/24***	**source**
Falls - reduced attendance to A&E and admissions	Emergency admissions due to falls in over 65's	1940	1843		BCF, HWB Strategy Outcomes framework
Falls - telecare	Telecare call outs for falls, where specialist lifting equipment is used as an alternative intervention to an LAS call.	tbc	tbc		Local measure
Admissions avoided due to referrals to community response	2 hour Urgent Community Response (UCR) first care contacts (GSTT) - number, %	tbc	tbc		Operating Plan
Reduced A&E attendance and admissions	Admissions for ambulatory care sensitive conditions rate (e.g. COPD, Diabetes)	872	829		BCF
Support at home, staying well and independent Healthy aging and timely intervention	Permanent admissions to care homes (rate) Frailty rates and Quality of life score **(early detection of frailty to intervene early and optimise function and impact**)	499	540		BCF
Enabling people to live and die well as part of a community	Death in usual place of residence	30.3% (SEL)	tbc		PHE end of life care profile
Carers are supported	Proportion of adult carers who have found it easy to find information and advice about support, services or benefits	tbc	tbc		Carers survey, HWBS Outcomes framework
Dementia diagnosis	Dementia diagnosis rate for 65+ years old (recorded/ % expected)	tbc	tbc		QOF, HWBS Outcomes framework
Dementia care	Percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months	tbc	tbc		QOF
Effectiveness of reablement and rehabilitation after discharge	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services	92%	90%		BCF, HWBS Outcomes framework
Discharge and Community rehabilitation: Length of Stay in hospital	% of patients with a Length Of Stay of 21+ Days	6.6%	tbc		ICB BI team/ NHSE
Polypharmacy: Identify and undertake patient centred medication reviews that include Shared Decision Making (SDM) in patients 65 years and over, and prescribed 10 or more medicines	Show ANY reduction in % of patients 65 years and over, prescribed 10 or more unique medicines. Prescription data for Quarter 4 23/24 vs. Q3 22/23 (baseline)				

*__Note:__ metrics to align with neighbourhoods and ethnicity where possible

Risks, issues and opportunities (1 of 2)

	Risks/Issues	Description	Opportunities and Mitigations
1	**Workforce**	Reduced ability to recruit, retain and support staff.	Respond to national NHS workforce strategy – opportunities with new roles, potential cross organisational arrangements, bringing resources together. Build on existing apprenticeships, creative role design/incl. non registered roles. Partnership recruitment approach and potentially campaign to attract new employees, Joint training arrangements where beneficial to delivery, interdisciplinary training/development opportunities, strong, supportive leadership & teams.
2	**Data & intelligence**	Insufficient or poor-quality data results in an inability to track the progress and evaluate our interventions and impact. Incomplete, outdated, or inaccurate data hinders the effectiveness of our decision-making and analysis.	Invest in how we collect and record data to improve the richness of our data, making information more timely, accurate and complete. Building on existing relationships between the analytical teams across the partnership. Develop an assurance mechanism to review, monitor and evaluate progress and to enable scrutiny of the validity of data quality and intelligence. Build into our governance process the mechanism to periodically review the plan and to adjust, improve, and refine how we monitor delivery and adjust performance indicators as data quality improves.
3	**Outcomes & Evaluation**	Ensure there is a framework for each programme – to assess the progress in the outcomes that the program is to address (e.g. effectiveness, efficiency, impact, sustainability).	Optimise partnership resources and links with SEL expertise. Work to develop system level approaches (potentially with Cordis Bright). Clinical Care & Professional Leads to support through links and contacts. Make a clear distinction between what we need for broader partnership working and requirements for the Health & Care Plan.
4	**System-wide Demand**	Demand on the health and care system impacts Partnership Southwark to the extent that it constrains partner ability to prioritise transformational delivery.	PSDE to review system pressures regularly and consistently, alongside transformation work, and encourage operational information sharing and solution-focused partnership working. PSSB kept informed, with escalations where appropriate.

Risks, issues and opportunities (2 of 2)

	Risk	Description	Opportunities and Mitigations
5	**Resources and expertise to ensure co-production**	Adequate resources , skills and expertise to lead programmes that build trust through use of Asset Based Community. Development or strength based approaches - focus on assets, opportunities and see people as citizens and co-producers rather than seeing them as clients.	The Board demonstrates the appetite for this approach, recognising the additional time implications. Invests in co-production and this sits at the centre of how the health and care system learns and embeds change in Southwark.
6	**Financial pressures**	Partnership Southwark partner organisations need to make financial savings and/or face significant budget pressures.	Partner organisations continue to provide a stable financial environment that supports improvement and investment in healthcare and outcomes. The commitment to financial sustainability will be vital to ensuring a robust and effective delivering of core responsibilities, secured through approaches that demonstrably improve productivity, efficiency, and value through making the best possible use of funding available.
7	**Lack of enabling factors**	In developing our plan, we have reflected on and agreed the ways we need to work and what conditions we need to succeed. If these enabling factors are not present, this will impact our ability to meet our outcomes.	Ensure existing working groups are aligned to and delivering on our Enablers. Where our Enablers need dedicated improvement, we will bring together the right people to do this. We will pay attention to the Enablers in the same way we do our outcomes and build oversight of these enablers into our governance and ways of working.
8	**Changes to national priorities / political landscape**	Legislative changes or changes in national priorities impacts upon local priorities. Local elections dictate changes to local context and position.	Ensure Partnership Southwark periodically review the plan and to adjust, improve, and refine as necessary so that the plan continues to be fit for purpose. Formally review the plan annually and propose changes to be agreed by the Partnership Southwark Strategic Board.

References

The demographic and health data presented in the Health & Care Plan is drawn from the Southwark JSNA Annual Report 2022, and topic-specific needs assessments, available via www.southwark.gov.uk/jsna.

The primary sources of the data used are referenced below:

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