Healthier Greenwich Partnership (in public)

Date: Wednesday 22 January 2025
Time: 12.30 – 14.30
Venue: MS Teams Click here to join the meeting
Chair: Iain Dimond

AGENDA

	Item	Page no.	Presented by	Time
Opening Business				
1.	Welcome, introductions and apologies.	Verbal	Chair	12.30
2.	Questions from the public related to today's agenda – to be submitted in advance	Verbal	Chair	12:35
3.	Declarations of interest	Verbal	Chair	12:45
4.	Minutes of the meeting held 24 July 2024 and 11 December 2024 (Part One).	1	Chair	
5.	Action Log and Matters Arising	15	Chair	
6.	Positive Partnership Story – Connecting Greenwich	Verbal	Maria Howdon/Clare Simpson	12:50
Public Engagement: Delivering our Healthier Greenwich Plan				
7.	Update on process of HGP refresh	16	Gabi Darby	13:05
8.	Feedback from Public Forums	23	Russell Cartwright	13:15
9.	Update on Greenwich Neighbourhood planning	44	Nick Davies/Gabi Darby	13:25
10.	Live Well: MSK Procurement update	54	Lisa Wilson/Jane Thurston	13:35
11.	Healthier Greenwich Charitable Funds update	66	Daniella Finch	13:50
Items for Noting				
12.	Healthier Greenwich Partnership – Quarterly Partner Update	72	Gabi Darby	14:05
13.	Performance Report	90	Gabi Darby	14:10
14.	Risk update	112	Chair	14:15
Closing Administration				
15.	HGP Forward Planner	115	Chair	14:20
16.	Any Other Business	Verbal	Chair	14:25
17.	Next Meeting in public: 23 April 2025		Chair	
Meeting closes at 14:30				

Healthier Greenwich Partnership
Meeting In Public
Minutes of the meeting held on Wednesday 24 July 2024
MS Teams

Members	
Iain Dimond	Chief Operating Officer, Oxleas NHS Foundation Trust (ID) (Chair)
Nayan Patel	PCN Clinical Director (NaP)
Tuan Tran	Greenwich LMC (Local Medical Committees) Chair (TT)
Chris Dance	Associate Director of Finance, Greenwich, SEL ICB (CD)
Kate Heaps	Chief Executive, Greenwich and Bexley Community Hospice (KH)
Kate Anderson	Director of Corporate Affairs, LGT (KA)
Lisa Thompson	Director of Children & Young People's Services, Oxleas (LT)
David Borland	Integrated Commissioning Director for Children and Young People – RBG/ICB (DB)
David James	Chief Executive, Greenwich Health (DJ)
Steve Whiteman	Director of Public Health, RBG (SW)
Lisa Wilson	Integrated Commissioning Director, Adults (LW)
Nick Davies	Adult Social Care director (ND)
Jessica Arnold	Director of Primary Care and Neighbourhoods, Greenwich (JA)

In Attendance	
Jo Hawkes (minutes)	Personal Assistant, Royal Borough of Greenwich (JH)
Shanna Martin	Business Support Lead, SEL ICB Greenwich (SM)
Elizabeth Howe	Governance Lead, SEL ICB (EH)
Pauline O'Hare	Metro Charity (standing in for Mark Delacour) (PH)
Joy Beishon	CEO, HealthWatch Greenwich (JB)
Chahak Basra	Comms & Engagement Assistant (CB)
Chris Dance	Associate Director of Finance, SEL ICB Greenwich (CD)
Eugenia Lee	
Schola Muhror	Deputy Chief Executive, Age UK Bromley and Greenwich
Daniella Finch	Programmes Officer (Grants), Groundwork London (DF)
David James	Chief Executive, Greenwich Health
Jose Garcia	Clinical Care Professional Lead Greenwich, GP, Pall Mall Surgery (JG)
Maria Howden	Assistant Director of Primary Care, SEL ICB Greenwich (MH)
Carmel Britto	
Members of Public	1

Apologies

Sarah McClinton	Place Executive Lead, Greenwich (SMc)

Nupur Yogarajah	Clinical Lead for Population Health & Inequalities, Greenwich (NY)
Julie Mann	Business Support, SEL ICB Greenwich (JM)

1.1	**Introductions and Apologies for Absence**
1.1	The Chair welcomed everyone to the meeting. The Chair noted this was a meeting in public and explained the ground rules for effective conduct of the meeting. This was followed by introductions.
2	**Questions from the public related to today's agenda – to be submitted in advance**
2.1	No questions were submitted in advance or raised at the meeting
3.	**Declarations of Interest**
3.1	The Chair asked if anyone had any interest to declare relating to any of the agenda items. No declarations of interest were noted
4.	**Minutes of the Previous Meeting in Public Held on 24 April 2024**
4.1 4.2 4.3	The minutes of the meeting held on 24 April 2024 were reviewed The following amendments were advised: • TT advised correction on Page 14, Item 11.4 NMC should be LMC • LW added that it should be noted that in relation to ATEC (Item 8) further engagement with primary care still needs to be actioned. LW will follow up with JA to action • EL advised would be interested in further discussion with LW relating to engagement with GPs **Actions:** • **Minutes from 24 April 2024, Page 14 Item 11.4 – to be amended from NMC to LMC** • **LW and JA to meet to discuss primary care engagement for ATEC** • **LW and EL to meet to discuss GP engagement for ATEC**
5.	**Action Log & Matters Arising**
5.1 5.2 5.3	The action log was reviewed and updated. ID noted: • The public forum on 17 July 2024 was cancelled as no theme for the event was forthcoming. • Another forum will be planned for the near future • Any suggestions for a theme/subject matter to be shared with Russell Cartwright **Action:** • **Suggestions for theme/subject matter for next public forum to be shared with Russell Cartwright**

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6.	**Positive Partnership Story - Greenwich and Bexley Community Hospice.**
6.1	KH introduced the item, noting that the slides were not shared in advance, as the presentation includes a 'sneak peek' of the new Greenwich and Bexley Community Hospice branding which is launching on 1 August 2024. The relevance being that it demonstrates what the hospice is trying to achieve and will help people better understand what the Hospice does, and how they are trying to deliver that message.
6.2	The new brand is more vibrant and talks about community hospice for the residents of Greenwich and Bexley as opposed to Greenwich and Bexley community hospice.
6.3	The hospice sees approximately 3000 people a year, with many patients attending very late in their journeys. A key focus is on seeing these patients earlier
6.4	Thanked everyone who had been involved in the brand development as it has been shaped by members of the community, patients and many partners.
6.5	Will be using the brand work to accelerate community development work and amplify voices from marginalised groups, making sure that learnings don't just influence care the hospice provides, but influences across the system as well.
6.6	The hospice service transformation strategy that was developed a couple of years ago is focussed on listening to patients, addressing inequalities and providing personalised care at scale. The case study is an example of how this is being achieved.
6.7	A 76-year-old patient with pulmonary fibrosis was experiencing limiting breathlessness and required 24-hour oxygen was referred for the showering service. The showering service is a relatively new service to assist those who are struggling to access their bathing facilities at home. Their carers, if they have them, are expected to be there as well to help them have a shower. A self-service service as opposed to the hospice doing everything for them
6.8	The patient was assessed by the occupational therapist, who identified that the patient not only needed showering assistance and some equipment and was also concerned about forgetfulness, headaches, dizziness, fatigue and forgetfulness. The hospice arranged the following: • A review by the home oxygen team who reduced his oxygen as the patient had been receiving too high levels of oxygen • A home visit by the occupational therapist who arranged for a wet room to be installed at the home • Information provided about a taxi card to help the patient with travel arrangements • A referral to social care for personal care needs • A referral to the hospice community rehab

6.9	The patient will be attending two programmes provided by the hospice: • Living well with fatigue, to help them think about how energy levels are managed • Living well with breathlessness • Both programmes are of six-week duration
6.10	Once participation in the programme ends, there may not be any onward steps, but the patient will know more about the hospice and what support is available. If the patient needs more support, he will be less fearful and anxious about asking for help.
6.11	The patient and his family have had an introduction to the hospice with specific and tangible interventions which, when he does need end of life care, he trusts the hospice and the system to work together to ensure his needs are met. Hopefully this means that the patient will continue to be proactive, avoid crises and won't end up in hospital
6.12	A simple case study but reflects that this is not necessarily what people think a hospice is.
6.13	The following queries, comments and observations were made: • The case study was incredibly impactful and powerful • Re-branding is good • How complex was it to recognise additional needs and involve other services • How easy was it to get the other services involved • There is a need to bring all services together for proactive care and to avoid overlaps/duplication (e.g.: frailty) • A Trusted assessment model would ensure knowledge of services ensuring all practitioners across health and social care, have increased knowledge of what is available and possibly combat the perceptions and stigma about some services • Make every opportunity count – a way of making sure all practitioners are aligned as to how they can make a difference to interventions • How can we as a community help promote this valuable resource and asset • What groups might not be accessing the service • How can we collectively hep to reduce health inequality • There is a vehicle for bringing services together through partnerships in Home First which could be built on • How do we better engage with Primary Car and specific GPs through the Home First work • Home First are also exploring how to engage more with housing and other colleagues • Make our workforce and neighbourhood connections stronger
6.14	KH responded:

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	• The most impactful intervention is asking what is most important to the patient and using that as a starting point • Even one intervention will make a difference • Work to a holistic model for assessments • Weekly MDT meetings to discuss new referrals • It's important to get the knowledge of services 'out there' and to combat any stigma/perceptions about services • There are marginalised groups who don't get the same access to palliative care services as others do • Research has shown that you are less likely to die in a hospice if you are old/male/black/gay • 60% of the hospice patients are non-white, but for inpatient services it's only 30% • There are structural inequalities across the whole system • The new brand will be used as a vehicle to help people understand what hospices there are for and will show people that they are being heard and the hospice wants to provide services that are relevant to them • There is an opportunity to bring services together through the partnership working closer, co-location of services, aligning work at all levels, services working together • Trust is key - how we work together and the way we respond between the community and our patients
6.15	ID noted: • The presentation and discussion bought to life that getting palliative care right can be a life-lengthening process • There are structures in place (like Home First) that work in an aligned way with the hospice • Making hospice a formal member of this group helps us think about the role that the hospice plays in the wider system • Need to think about how we input into the Home First group and how the conversation develops – updated to be provided in the future
6.16	KH added: • For the rebrand launch there will be sessions for partners to join • New website will show a different look and feel and will be easy to navigate • Encourage people to visit the website and contact us to help with any issues
6.17	ID asked if there would be an evaluation process to ensure that all communities are being reached
6.18	KH confirmed that there will be evaluations of website traffic as well as internal measures on referrals, etc.
6.19	**Action:** • **KH to update in future on discussions with Home First**
7.	**HealthWatch Thematic Review**

7.1	ID introduced the item and advised that this is the HealthWatch Greenwich annual report that they are required to present to various key bodies in the system, as such it has already been presented at the Greenwich Health & Wellbeing Board. This is an opportunity for discussing what the review is flagging up, the findings and how we collaborate with HealthWatch Greenwich on any actions that arise.
7.2	JB presented: • HealthWatch Greenwich annual report, showing activity for the last year and what the impact has been • Mission is to gather the views of local people about their health and social care needs and experiences - a statutory duty to ensure that the voices of the Community are not only heard, but acted on • Use insights and data that is collected from local people to work with and support systems partners to ensure services are designed and delivered in ways that meet community needs • An information and signposting service, advising residents about what services are available and how to access them. • Work contributes to positive changes in local health and care services based on those Community insights • A small team of seven, not all of who are full time • Nearly 3,500 thousand people shared their experiences Over 24,000 people got advice and information on accessing services through the website and social media. • Over 100 updates, briefings, supporting campaigns and resident experiences and desired improvements • Visited 11 learning disability care homes in the borough, not all of those reports have been published • Have a large body of committed and supportive volunteers that give up their time to support on this work • Have received the Volunteering Quality mark and been awarded the Employability Award by Greenwich University • Collaboration with the SE London Maternity and Neonatal system to understand the maternity experiences of asylum seeking, seeking or recently migrated women • Supported people with finding new GP practice when Clover Health Centre closed • Working with public health, facilitated a series of workshops bringing together community leaders to co-produce a model for mental wellbeing support • Discussions about the current community champion model where a two-way dialogue would be best • Community advised that they need funding to be involved • Workshops identified the potential to link up with existing work that's taking place across SE London • Be Well hubs are being rolled out across SE London by Citizens UK and funded by SLAM

	• There were two projects focussed on understanding the needs and experiences of carers
7.3	ID curtailed the presentation, acknowledging the importance of the report and feedback, but suggesting that JB go direct to recommendations and questions on what had already been presented.
7.4	JB agreed to stop the presentation and advised that there are no specific recommendations, there is only a case study to be shared, and happy to present final part of the presentation at another meeting.
7.5	ID stated: • What is to be done with this rich, insightful material? • What structures are in place in Greenwich that can make use of it? • Balance of report to be completed at next public meeting
7.6	LW advised: • Some work relating to carers had been delayed due to restructures • Team is now working on the mental health vision • Interested to find out how the Be Well hubs could be linked in to the vision • Will introduce JB to Debora Mo as the HealthWatch work will align with the Feel Well/mental health theme
7.7	ND advised: • Ability to draw on what HealthWatch has to offer in terms of engagement is great • When preparing for things like CQC assurance of our adult social care, that's really about hearing the lived experience of people and the feedback about what our services are doing • This is rich information to feedback and it's good to see the actions are progressing • Monthly and annual reports sharing insight is very useful • Suggest a follow up to ensure that recommendations are followed – as a collective look at any particular themes in report and how we might work on them
7.8	JB added: • Always keen to highlight when things are working well and share examples of good practice • Usually, people don't come to us when things are working well • Feedback will never be representative, and it will always be biased • It will be good to understand how to work with partners to highlight when changes have been made to show that the service is listening and working hard to make services as good as they can be
7.9	ID noted: • Will discuss with SMc how to include final part of HealthWatch report on next public agenda

	• Everyone to read the report in advance to note any outputs from HealthWatch for discussion
7.10	**Actions:** • **JB to complete presentation at next public HGP and colleagues to discuss what can be done with this insightful information.** • **All to read Healthwatch report in advance of next meeting to note outputs for discussion** • **LW to link JB with Elizabeth Saunders/Debora Mo on the Be Well info and the work being done on Adult Mental Health Vision**
8.	**Operose Ownership Update – for noting**
8.1	Detailed and comprehensive papers circulated in advance.
8.2	MH highlighted: • Relates to a change in control request submitted by AT Medics who hold one contract in Greenwich, Thamesmead Health Centre. Request submitted in Nov 2023. • Committee is not being asked to make a decision on the change of control as that took place in December 2023 • The change of control had already happened before it was presented to us • Focus of the report is on the recommendations and outputs from the due diligence process, and the findings relating to seeking assurances on the quality and safety of the services • Information relating to debt and liabilities is an HSBC liability • Maintaining scrutiny of the services, particularly workforce, are monitored via ta national monitoring system • Proposal is Primary Care working group will complete the monitoring to then bring to HGP Board to update. • Operose used to be owned by a US based company, but is not UK owned • Organisational structure as highlighted in the papers is quite complex in terms of the Holdings companies involved and the relationship with HMRC • A Breach notice was served regarding this change as acted on without the commissioner consent (is a requirement of the contract). • Important to stress that the changes has not had any known impact on patient care. Monitoring of this will continue. • The Thamesmead Heath Centre site is currently out for procurement.
8.3	ID noted that as the ICB has already issued a breach notice about this, what is being noted is whether we are confident that the assurance processes are effective
8.4	JB commented/asked: • Noted when this happened it did cause concern, which has been addressed • Is there a FAQ on the practice website that people can be directed to?

8.5	MH responded: • Will check, but it was on the ICB website • Due to the procurement, whilst a separate issue, may be worthwhile having it elsewhere
8.6	TT noted that the paper was well presented, and agrees that monitoring via the primary care working group is the best option
8.7	**Action:** • **MH to share details of where to direct members of the public who have concerns and questions.**
9.	**Healthier Greenwich Partnership – Quarterly Partner Update**
9.1	ID introduced the item, advising that this report is using a different template, which has been used in other boroughs. Thanked JB for the feedback that this was a positive change.
9.2	JA made note of the following: • The main thing to highlight is the existence of the report and this being a good way forward for us to get a holistic update from across the partnership of all the good things happening between meetings • An update in there on the practice support programme that's ongoing relating to practices and geographical areas within Greenwich • Public Health mention the current preparations to re-commission a number of vital services in 2025 • An extensive update from Oxleas covering physical health, specialist children's services, CAMHS, mental health etc. • The Greenwich Healthier Communities Fund have provided an update, and it would be interesting to know more about this • There are updates from some of our PCNs and it would be good to have updates from more of them in the future • Hospice have updated about their 30th Anniversary
9.3	TT noted: • Found the template useful and a good way to focus on what should be included • The LMC submission is missing
9.4	ND added: • Template and report really good – would be useful if all partners would submit • Agree it would be good to have more information about the charity
9.5	JB advised: • Partnership report really useful • Good opportunity to see where collaborations can happen, especially for wider collaboration – e.g.: Waiting Well initiative at LGT and Kings

9.6	ID added: • Agree about collaboration – currently looking at neurodevelopmental diagnostic waits with the ICB and across SEL. Any contributions welcomed • The report is an opportunity for everyone to understand what is happening and how these actions link in to the ethos and vision of the partnership and the ICB strategy
9.7	**Actions:** • **LMC report section missing - ID to follow this up with SMc** • **Groundwork to provide update on the Greenwich Healthier Communities Fund at the October meeting**
10.	**Risk update – for noting**
10.1 10.2 10.3	ID noted that the risk register had been circulated in advance, advised: • There is one new risk relating to over-prescribing • Eight risks are being reviewed • Mitigations have been updated **All agreed to accept the risk register mitigations**
11.	**Healthier Greenwich Partnership – update to Terms of Reference**
11.1 11.2 11.3 11.4	ID noted the following amendments to the ToR (Terms of Reference): • Rotating chair arrangement • VCSE (Voluntary, Community and Social Enterprise) membership was proposed to be increased, and Greenwich and Bexley Community Hospice was included as a permanent standing member of the partnership • The membership section has been adjusted to reflect updated job titles. NP suggested the following additions: • Section 6: Rotating chairing – term should be annual • Section 7: Quorum & conflicts of interest – need to stipulate that this is 50% of voting members **All agreed to accept the revised Terms of Reference for submission to the ICB Board for ratification** **Action:** • **ToR to be updated to reflect NP suggestions** • **ToR to be submitted to ICB Board for ratification**
12.	**HGP Forward planner**
12.1 12.2	ID advised that the forward planner had been circulated which included proposed agenda items for the next meeting LW advised: • Feel Well Mental Health Vision to be added to September

	• Procurement of the MSK service update to be moved to October meeting in public • ATEC mobilisation is currently due to be presented in October, but may need to be moved to November – will advise accordingly
12.3	DB advised For SEND strategy, hoping to include the Young Peoples Plan (September) as well, so a longer period of time may be required
12.4	**Actions:** • **Forward planner to be updated to include Feel Well in September and MSK in October** • **LW to advise if ATEC mobilisation is to be moved to November** • **Agenda timings for September to be adjusted to allow for SEND strategy/Young People's Plan to be discussed**
13.	**Any Other Business**
13.1	JB raised the recent Neonatal death report where the local Trust received a red rating – should the partner be invited to attend a meeting to advise what is being done to address it. What is the role of this partnership when something like this occurs.
13.2	ID responded: A very good question, perhaps this would go through the local health scrutiny committee, although it would be presented there for different reasons. Will discuss with SMc whether it is something to consider at HGP or if it could form part of partnership report.
13.3	DB advised that there was a recent Ofsted inspection for which the results have just been published. The inspectors talk to parents, children and staff to look into how we are performing. Pleased to advise that RBG received an Outstanding award. This is a celebration not just for the team and social care but also about the partnership, as a key note related to the Corporate Parenting Partnership and how Health and Care are prioritising children in care and care leavers and the support they receive. It's a great independent assessment for us to sense check that we are on the right path.
13.4	ID responded: • A fantastic result and agree it is the basis of good partnership working and the quality of the range of services provided in the borough. • Also noted congratulations on the video reflecting two points of view.
13.5	**Action:** • **ID to discuss with SMc the Neonatal report and suitability of having it as a discussion at HGP or if it should be included in the partnership report**

Healthier Greenwich Partnership
Part One - Held in Public
Minutes of the meeting held on 11 December 2024
Via MS Teams

Members	
Iain Dimond (Chair)	Chief Operations Officer, Oxleas NHS Foundation Trust (ID)
Nayan Patel	PCN Clinical Director (NaP)
Gabi Darby	Chief Executive Officer, Greenwich (GD)
Tuan Tran	Greenwich LMC (Local Medical Committees) Chair (TT)
Sarah McClinton	Place Executive Lead Greenwich (SMc)
Samantha Bennett	Deputising for Steve Whiteman, Director of Public Health, RBG (until 12h20)
Helen Buttivant	Deputising for Steve Whiteman, Director of Public Health, RBG, (from 12h20)
Kate Anderson	Director of Corporate Affairs, LGT (KA)
Lisa Thompson	Director of Children & Young People's Services, Oxleas NHS Foundation Trust (LT)
Niraj Patel	Chair of Greenwich Health GP Federation (NP)

In attendance	
Julie Mann (Minutes)	Business Support (JM)
Russell Cartwright	AD Comms and Engagement (RC)
Cllr Mariam Lolavar	Cabinet Lead for Health, Adult Social Care and Borough of Sanctuary, Greenwich
Lisa Wilson	Integrated Director of Commissioning, Adults, RBG (LW)
Joy Beishon	Chief Executive Officer, Healthwatch Greenwich (JB)
Nicky Skeats	Primary Care Network/Neighbourhood Development Manager, SEL ICB (NS)
Chris Dance	Associate Director of Finance, Greenwich, SEL ICB (CD)
Dave Borland	Integrated Director of Commissioning, Children, RBG (DB)
David James	Chief Executive, Greenwich Health (DJ)
Jose Garcia-Lobera	Clinical and Care Professional Lead for Greenwich (JG)
Eugenia Lee	PCN Clinical Director (EL)
Nupur Yogarajah	Clinical and Care Professional Lead (NY)

Apologies	
Jessica Arnold	Director of Primary Care and Neighbourhoods (JA)
Florence Kroll	Director of Children's Services, RBG (FK)
Mark Delacour	Metro GAVS (MD)
Rachel Matheson	Associate Director – Greenwich, Adult Community Physical Health Directorate, Oxleas NHS Foundation Trust (RM)
Nick Davies	Adult Social Care Director, RBG (ND)
Steve Whiteman	Director of Public Health, RBG (SW)
Kate Heaps	Chief Executive, Greenwich, and Bexley Community Hospice (KH)

DRAFT

1	**Welcome, introduction and apologies**
1.1	• The Chair welcomed Councillor Mariam Lolavar and Nicky Skeats to the meeting. • The Chair noted that this is an extraordinary meeting in public to discuss and agree the appointment of a successful bidder for the APMS contract for Thamesmead Health Centre • No members of the public joined the meeting • Apologies as noted above
2	**Declarations of Interest - relating to agenda item**
2.1	• No conflicts of interest relating to the agenda item were declared.
2.2	• It was noted that Eugenia Lee advised that they are a partner at Gallions Reach Health Centre in the Thamesmead area, which is a neighbouring practice to Thamesmead Health Centre. Whilst there is no conflict of interest, there is interest in the results of the procurement process and who is awarded the bid.
3	**Thamesmead Procurement for approval**
3.1	Papers were circulated in advance It was noted that no questions from the public had been submitted in advance of the meeting.
3.2	NS provided an overview: • The item had previously been presented in April for full procurement as the current provider contract ends March 2025 • This is an APMS (Alternative Provider Medical Services) contract • Purpose of the item today is to gain approval from the committee to appoint the highest scoring bidder • A full procurement process was led by the Northeast procurement team • There were five bidders, who have all been reviewed and assessed • Panel consisted of leads from across the borough and Southeast London, estates, quality, the Primary Care team, finance, members of the public, patients from the practice and Healthwatch • Proposing that the highest scoring bidder, Bidder C, is awarded the contract • Anticipated that the bidder will be advised on 11 or 12 December • There will be a 10-day standstill period, followed by a three-month handover • Confident that the process has been robust
3.3	The following comments and queries were noted: • The process has been rigorous, and the weighting reflects our priorities of community working, health inequalities, digital and innovation • Page 16 question – score of 2 with minor concerns – can this be disclosed? How will these be addressed. How significant are they, are they clinical or patient-facing? • What assurance is there relating to resolving the concerns • If the proposed bidder cannot provide assurance on resolving the minor concerns, will the contract then be offered to bidder D? Would this be bought back to the Board or will it automatically happen • Clarify that the approval is for Bidder C • If the bid is to be awarded to the next bidder, will this be bought back to the committee • Is the meeting a quoracy for agreeing the decision • Will the timeline be affected if having to award to a different bidder • What is the timeline for notifying patients/the public about the new provider
3.4	NS responded: • The minor concerns raised in scoring are minimal and there is a simple remedy, the panel does not have any concerns that this cannot be resolved • Provided an explanation of the scoring:

	○ Score of four – no improvement required ○ Score of three – performing well ○ Score of two – satisfactory ○ Score of one - unsatisfactory • Of a total of 36 questions, it is typical to have one or two that only receive a score of two • The score of two is therefore within the satisfactory range, and relates to only one element of the bid, and the team will work with the bidder to improve that element • The timeline is achievable if the bid is awarded to the next bidder • Confirmed that the approval requested is for Bidder C • If the award is to go to the next bidder, this will be communicated with the committee • Have already been working with the current providers and engaging with patients and the patient group • Working on a three-month handover period, including communications • There will be a communication plan and will be working with Healthwatch on this as well as providing assurances that this will not affect patient experience
3.5	JM confirmed that the attendance met quoracy requirements
3.6	GD advised that she was content that the process had been followed correctly and is confident to recommend that this is awarded to Bidder C
3.7	ID asked the voting members of the committee to approve that the APMS contract for Thamesmead Health Centre be awarded to Bidder C • All voting members in agreement • ID noted that the approved bidder is Bidder C and that they be advised of this, and requested that once the bidder had been advised that this be confirmed in writing via JM to notify board members
3.8	**Actions:** • **Bidder C to be advised that they have been awarded the APMS contract for Thamesmead Health Centre** • **NS to provide written confirmation to JM to notify the board that the bidder has been notified of their appointment**
4	The Chair advised that this concludes the in public part of the meeting, the rest of the meeting will now be conducted in private.

DRAFT

Action Log - Open

Date of meeting	Minute reference	Action and updates	Lead	Deadline	Date closed
11/12/2024	3.8	Bidder C to be advised that they have been awarded the APMS contract for Thamesmead Health Centre	NS	12/12/2024	12/12/2024
11/12/2024	3.8	NS to provide written confirmation to JM to notify the board that the bidder has been notified of their appointment	NS	12/12/2024	
11/12/2024	4.3	Members to email JM with updates on their items on the action log	ALL	15/01/2025	15/01/2025
11/12/2204	4.3	Feel Well item to be on the agenda for February or March – JM to liaise with LW to agree date	JM/LW	31/01/2025	
11/12/2024	5.6	IS to share LCP refresh slide pack after meeting	IS	12/12/2024	12/12/2024
11/12/2024	5.6	ALL to share feedback on LCP refresh with IS	ALL	06/01/2025	06/01/2025
11/12/2024	7.3	ALL to share ideas for Positive Partnership story with ID/JM	ALL	06/01/2025	06/01/2025

AGENDA ITEM: 7

Healthier Greenwich Partnership

Date: 22 January 2025

Title	Update on process of HGP refresh	
This paper is for **noting/approval**		
Executive Summary	The report provides a summary of the HGP refresh process with a reminder of the Greenwich priorities of Start Well, Be Well, Live Well, Stay Well and Age Well	
Recommended action for the Committee	The committee is requested to take note of the refresh plan and provide feedback	
Potential Conflicts of Interest	None	
Impacts of this proposal	Key risks & mitigations	None arise directly from this report
	Equality impact	Not required for direct purposes of this report
	Financial impact	Not applicable
Wider support for this proposal	Public Engagement	Public engagement forums have been held, and will be reported on separately
	Other Committee Discussion/ Internal Engagement	Not applicable
Author:	Imogen Setter	
Clinical lead:	Not applicable	
Executive sponsor:	Gabi Darby, Chief Executive Officer, Greenwich	

Healthier Greenwich Partnership
Local Care Plan Refresh

HGP Board in Public

January 2025

HEALTHIER GREENWICH PARTNERSHIP

What is the Healthier Greenwich Partnership?

The Healthier Greenwich Partnership (HGP) is a group of organisations and individuals in Greenwich **working together to support the health, care and wellbeing** needs of the local residents.

It includes partners from the **NHS, local council, social care, and the community and voluntary sector.**

The goal is to come together to **provide excellent health and care** for our community.

Health & Wellbeing Strategy

- In 2023, we introduced a new **Health & Wellbeing Strategy** to help make Greenwich a healthier, happier place for everyone.
- This plan, developed *with residents and for residents*, sets out our priorities for the next five years, focusing on what matters most to the people who live, work, or study here.

- To bring this strategy to life, we will continue working closely with local residents and communities to ensure your voices shape the changes we make.
- Over the next year, the **Local Care Plan** will be our main way of turning these ideas into action, delivering real improvements to health and care in Royal Greenwich.

HEALTHIER GREENWICH PARTNERSHIP

Our five wells

Our priorities span a resident's life course. Working together on our 10 priority areas will produce better outcomes for Greenwich residents throughout their life.

Support Greenwich residents to **start well:**

- Children and young people (CYP) get the best start in life and can reach their full potential

Support Greenwich residents to **be well:**

- Everyone is more active
- Everyone can access nutritious food

Support Greenwich residents to **feel well:**

- There are fewer people who experience poor health as a result of addiction or dependency
- Fewer adults are affected by poor mental health
- Fewer children and young people are affected by poor mental health

Support Greenwich residents to **stay well:**

- For everyone to access the services they need on an equitable footing
- Effective integrated community teams based in neighbourhoods provide the right support when and where it is needed
- Reduce unfair and avoidable differences in health and wellbeing

Support Greenwich residents to **age well:**

- Health and care services support people to live fulfilling and independent lives and carers are supported

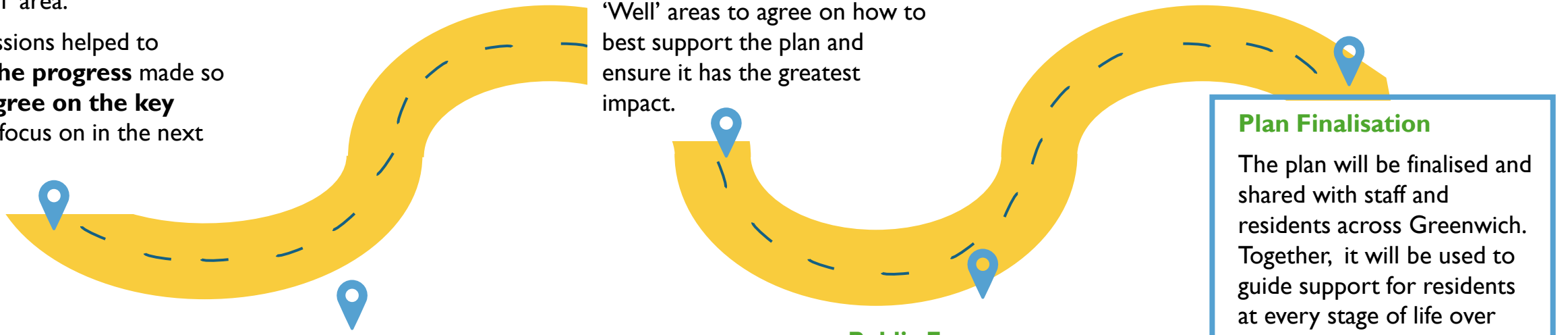
Live Well Greenwich

Refreshing our plan for the next year

Senior Leaders Meetings

One-on-one meetings with the senior leaders responsible for each 'Well' area.

These sessions helped to **review the progress** made so far and **agree on the key goals** to focus on in the next plan.



Delivery Team Meetings

Meetings with the teams working in each wellbeing area to refine the goals, plan activities that support those goals, and decide how success will be measured.

Development Workshop

Development workshop with senior leaders from across the 'Well' areas to agree on how to best support the plan and ensure it has the greatest impact.

Public Forum

This public forum is where we share ideas from teams across Greenwich, check if they match residents' priorities, and make changes to improve them based on your feedback.

Plan Finalisation

The plan will be finalised and shared with staff and residents across Greenwich. Together, it will be used to guide support for residents at every stage of life over the next year.

HEALTHIER GREENWICH PARTNERSHIP

Delivering the priorities with communities

In Greenwich, the **overall ambition is to effectively work in neighbourhoods** and with communities to deliver these priorities.

What does this mean in practice?

Personalised Care: Support tailored to your individual needs.

Proactive Help: Services reach out to you before issues grow.

Joined-Up Support: Tell your story once and get the right help quickly.

Local and Community-Focused: Access support close to home, with hospital visits only when necessary.

Shaped by You: Your feedback helps improve local services.

Staying Well Longer: Early support and clear advice keep you healthy and independent.

HEALTHIER GREENWICH PARTNERSHIP

AGENDA ITEM: 8

Healthier Greenwich Partnership

Date: 22 January 2025

Title	Update on HGP Public Forum 22/01/25 – HGP Priorities for 25/26	
Healthier Greenwich Partnership are asked to discuss the update and note the feedback from residents.		
Executive Summary	This paper summarises the discussions at the Healthier Greenwich Partnership Public Forums on 09/01/25 and 13/01/25	
Recommended action for the Committee	Members are asked to note the report and consider the feedback while agreeing partnership plans for 2025/26.	
Potential Conflicts of Interest	None arise directly from the report.	
Impacts of this proposal	Key risks & mitigations	None arise directly from the report.
	Equality impact	Demographic info from attendees has been collected
	Financial impact	None arise directly from the report.
Wider support for this proposal	Public Engagement	The paper outlines the report from one of the HGP's key engagement activities.
	Other Committee Discussion/ Internal Engagement	Not applicable
Author:	Shelley Whittaker	
Clinical lead:	Not applicable	
Executive sponsor:	Gabi Darby, Chief Operating Officer, Greenwich	

Healthier Greenwich Partnership Public Forum report

January 2025

Topic: Healthier Greenwich Partnership priorities

Healthier Greenwich Partnerhip's Public Forum is one of a number of ways we gather insights from members of the public on key topics. They usually take place ahead of Healthier Greenwich Partnership board meetings in public so that the outcomes of the public forum can feed into decision making and be considered by the board.

The first public forum of 2025 focused on the refresh of the Healthier Greenwich Partnership priorities which are organised under the banner of the five 'well' areas outlined in the Greenwich Health and Wellbeing Strategy.

Engagement has already taken place within the partnership (see roadmap below) to help to set new priorities for the coming year 2025/26 and this was our opportunity to test the emerging priorities with local residents before decisions are made. The priorities are being discussed at the Healthier Greenwich Partnership Meeting in Public on Wednesday 22 February 2025.

Event format

For the first time, we separated the public forum into two separate meetings; one face-to-face event was held at Mycenae House in the Westcombe Park/Maze Hill area of Greenwich on Thursday 9 January from 6-8pm; and an online event was held on Monday 13 January from 6-8pm. The content of both events was the same.

This approach was designed to address complex logistics of working with a face-to-face and online audience at the same time which has proved difficult in the past.

Attendance

Attendance was good considering promotion of the events straddled the Christmas and New Year period, plus the extreme cold weather experienced on the night of the face-to-face event.

Seventeen members of the public joined the online event, and 15 joined us in person at Mycenae House, making a total of 32 members of the public.

Previous events have been attended by similar numbers: eg; 11 people (four in person and seven online) to discuss cancer services; and 29 people (20 in person

and nine online) to discuss neighbourhood development. See appendix 1 for more information on attendance and evaluation.

Structure of event

The events started with an introduction by Shelley Whittaker, Engagement and Communications Manager for Healthier Greenwich Partnership, who set the context for the discussions. She talked about health and care needing to change in the context of the national Change NHS consultation which is asking for the public's ideas on what should change. The South East London Integrated Care Board events to support the national consultation were promoted and people were encouraged to attend local events and to complete the national survey online.

Iain Dimond, Healthier Greenwich Partnership Chair and Chief Operating Officer of Oxleas NHS Foundation Trust, and Gabi Darby, Chief Operating Officer for Healthier Greenwich Partnership, presented the suggested priorities for Greenwich for 2025/26.

Iain talked through the work that has gone on to date to determine priorities and shared a roadmap of the engagement to determine the suggested priorities for the coming year.

Gabi talked through the headline priorities for each of the 'well' areas:

Attendees were then arranged in breakout groups for discussions around the priorities on each 'well' area. They were asked the following questions:

1. Are these the right priorities?
2. How can local people and communities get involved to deliver the ambition?
3. What would success look like for these priorities? What would be different?

Feedback and insights

The discussions were positive, rich in content and solution-focused at both events and the key points raised are summarised below under each of the five 'wells'. Further comments are also included. While attendees agreed with the priorities, they suggested others and some solutions that would underpin success.

Start well

While these priorities were recognised as being important, some key themes emerged in the discussions about start well, and suggested additional priorities included:

- **Parents need support** to understand how best to help their child to live healthy and happy lives – the work of Sure Start was providing this and there's a huge gap.
- **Family hubs** are a vital key to building resilient communities, including support for refugee families, but are they sustainable?
- **These priorities need to focus on the whole person and whole family support rather than focusing on individual conditions.**
- There are **much wider special needs** than just ADHD and ASD including mental health of children. Putting basic support and education in place would address a much wider remit.
- **Schools are overwhelmed and underfunded** – they seem a logical place for support for the health and wellbeing of children and education of parents, but not without resource.
- **A directory** is useful, but needs to be kept up-to-date and also needs to be promoted so that everyone knows about it.

Comments included:

- Bring back Sure Start to support families and young people – and use them for additional support such as mental health, healthy living etc.
- Recognise that supporting adult mental health and wellbeing, and enabling people to be better parents will have a good knock-on effect on children and future generations.
- Invest in mental health support/counsellors within schools.
- Refugee children need better support.

- Focus more on improving child mental health and this will have a knock-on effect as they become adults.
- The whole-person support for children and young people with ADHD and ASD feels a bit limited and too narrow – it focuses on a small group of young people. Could it be broadened to include all children and young people with additional support needs?
- Timely and early diagnosis is important – lots of people are undiagnosed and there are long waiting times. An example was given of a single mother with mental ill-health who had to wait three years for a diagnosis for her child who was nervous and had communication difficulties.
- The area of focus is right but raising awareness of the conditions and the symptoms is also important, along with tips to support people as they wait for a diagnosis.
- Long wait lists for ADHD and ASD can lead to lots of other problems eg: mental health.
- Stigma can also be an issue in some communities which needs to be addressed.
- The whole-person, holistic approach is good but could it be extended to the whole family, including parents and siblings?
- There are currently huge delays in people getting a diagnosis for ADHD and ASD. This causes problems for schools because without a diagnosis they don't receive the funding they need to put in the extra support the child needs. This puts stress on schools. (from a school governor).
- It is not just ADHD and ASD. Children have a range of other special educational needs. We are seeing more arriving in reception classes with poor communication skills. This has got worse since the pandemic. These are children who get on much better with a small amount of input.
- Most schools are struggling to make ends meet so putting in extra support without the funding which follows the diagnosis is difficult.
- The earlier the support starts the more effective the intervention will be. This is particularly true for communication difficulties.
- A directory of support and services is important but only if it's up-to-date and promoted and people know about it.

<u>Suggested actions to be considered when determining and developing priorities for 2025/26:</u>

- Holistic, whole family support is vital to effect change and should be embedded into these priorities.
- Support is needed for schools and other organisations which can support these priorities and education of families to support their children to live well.
- A directory of services and family hubs need to be sustainable.
- Involve local people in the co-production of these services.

Be well

Attendees agreed that these priorities were important, and they are a golden thread that weaves through the other 'wells'. They recognised they were particularly important for helping people to live healthy and happy lives throughout the life course. Suggestions included:

Food accessibility - Access to healthy nutritious food can have a massive impact on helping people to live healthier and happier lives. More information needs to be available about how to access healthy food on a budget.

Community cohesion through food and exercise - Food could be the key to bringing communities closer together and helping people from different cultures understand one another better and support one another. *Food is a vital ingredient in building strong cohesive neighbourhoods.* Holding food events could help people experiencing food poverty, help them become more aware about nutrition, encourage them to try healthier options or food from a different culture. Many faith groups provide food in communities.

The cost of living crisis means **nutritious food and paid exercise options are becoming more and more unaffordable for many**. Consider how to address this.

Creating safer communities and spaces is important to encourage outdoor free exercise.

Possible solutions suggested included:

Free food courses/events could be run in local communities – which include information about healthy eating alongside provision of a healthy meal with recipes to take away etc, and possibly food ingredients to encourage them to try a new recipe. This would need to be done in local neighbourhoods, perhaps by GP surgeries.

- A food festival in General Gordon Square with a focus on healthy, nutritious, affordable food
- Regular food events in local communities to introduce people to food options they may not have considered and to bring communities and cultures together
- Improved information on healthy food options and foodbanks and local community offers such as the Sikh community project which provides

vegetarian food at The Tramshed in Woolwich on Mondays – food that is suitable and available for people of all faiths.

Improve safety with more community policing/security as unsafe communities prevent people from getting out in green spaces, and green spaces tend to be areas which feel unsafe. Improved visibility of community policing/safety officers would make places like General Gordon Square feel more safe and encourage them to be used as a community focal point by a wider community than people with addiction/mental health needs.

Knowing communities well is key to a better neighbourhood approach to healthy living – we need to create communities and neighbourhoods that watch out for one another. This was happening more in Covid but has been lost since.

Invest in nutrition information and support as a preventative measure.

Comments included:

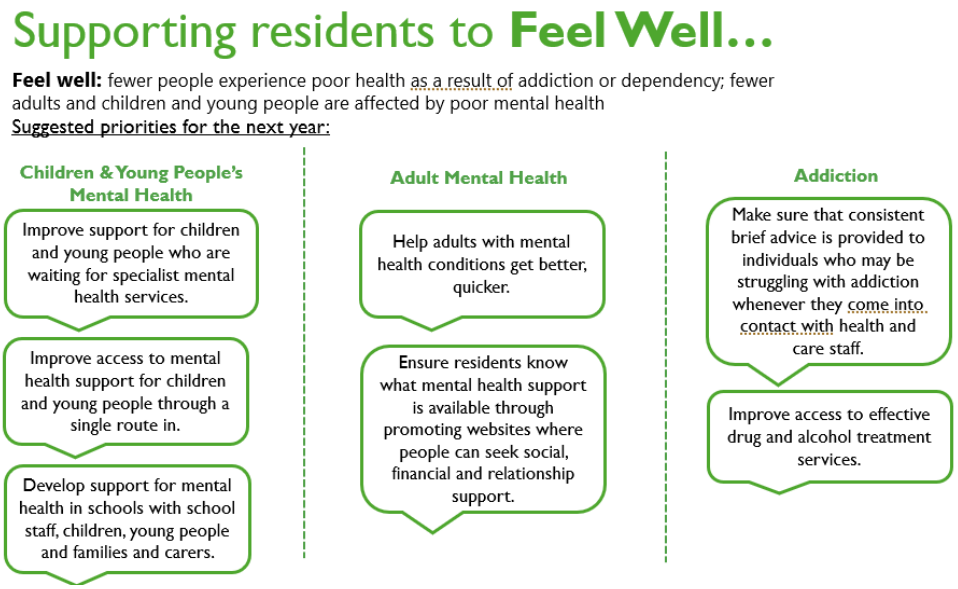
- Better information about healthy eating and exercise and making that information accessible is key.
- Understanding barriers to physical activity and healthy eating is an important to address this…eg emotional eating, feeling safe in local communities, cost, lack of information about free options such as walking groups.
- Support available needs to be communicated well.
- Planning and the council licensing department to make decision based on creating a healthy environment (less fast food): all you see when you come out of our stations is fast food and fried chicken shops, especially in some areas. This difference is contributing to inequalities.
- It's not just about telling people to eat healthily, you need to explain why it is important (education), especially for people with long term conditions.
- May need to do radical things like pay people to be healthy.
- Need to signpost people to how they can access healthy food easily and cheaply in their community, eg: the council holiday food clubs and even some of the supermarkets do things in school holidays.
- People may need help with things like budgeting.
- Council/NHS/Government should take it up with suppliers – the supermarkets sell the cheapest, most profitable items.
- Look at cooperative models – eg Foodshare as a solution.
- Bring people together around different issues (eg debt advice) and talk to them around nutrition.
- The council should look at what food is given out at food banks – often it is not healthy and is mainly processed and tinned food.
- The process of getting access to food banks puts many people off – can be difficult and doesn't always maintain dignity.
- The Community Fridge in Glyndon has no barriers or checks to people accessing food.
- Introduce activity champions who promote physical activity in communities.

- Make every contact count – eg: if someone comes into contact with a social worker they are unlikely to talk to them about physical activity.
- Buddy people up – peer support works.
- If you aren't naturally active all the info in the world won't make you active. Encourage places that people go to to include physical activity eg: at the mosque.
- Encourage activity groups to integrate healthy eating and exercise – example given of someone attending a Mindful Mums group and they did a walk.
- How do you get people who are part of groups to incorporate physical activity? Can you enable, encourage and commission VCSE organisations to keep people active as part of their responsibilities?
- Some people thought that accessing Better leisure centres is expensive. Others pointed out that you can access for £1 on weekdays between 1-4pm and that there are various schemes where people can get free access and free membership for limited times. More should be done to promote these opportunities.
- For many people confidence is also an issue when it comes to going to a leisure centre, gym or swimming pool.
- Healthy eating is not promoted in school.
- Not about how long you live but how well you live.
- Prevention is really all about the public health work and how this all links together.
- Important to focus on improving access.
- Years ago the council did cooking clubs, food stalls etc providing cheap and healthy food. What is in the plan around this?
- There is more to prevention than just food – what else is coming?
- I have type 2 diabetes and I get so frustrated when I am out and about how hard it is to get healthy food and to get information about sugar and carbohydrates contained in food in restaurants and cafes. Could the borough encourage the outlets to provide this? And encourage them to cut down on sugar?
- The key thing is around the narrative. Creating an empowering and enabling environment so people can make informed choices. Helping people to change their behaviours positively. Enabling through health coaching.

<u>Suggested actions to be considered when determining and developing priorities for 2025/26:</u>

- Improve community safety to make the borough of Greenwich a safe place to exercise
- Hold food events to improve knowledge and encourage healthy eating
- Use behaviour change approaches to understand the barriers to healthy eating and exercise for people.
- Work in local neighbourhoods and communities as an approach – perhaps at PCN level.

Feel well



Themes which emerged around mental health and supporting people to feel well included:

- **Bringing people together in their local communities** is the key to addressing loneliness and isolation which contributes to mental health issues.
- Developing a **community spirit** can solve some mental health problems; get people to care about one another.
- **The right information and signposting** is needed for community groups and volunteers to support in their communities.
- **Education through schools** is key to help people understand their mental health and coping techniques from a young age.

Comments included:

- Community awareness is important.
- A resident gave an example of a community hub and peer support groups in Kidbrooke which aren't linked in to Oxleas…and asked what can be done in communities that improve knowledge about mental health and how to access services?
- Equip community groups which are working, for instance in mental health field, to make sure they're giving the right info and signposting correctly.
- Situating hubs in the local community.
- Schools supporting children and young people…unsure what that would look like.
- More people have compromised mental health – so think how we put in support earlier on through schools.
- Sure Start and early help is vital.
- Community support – peer support groups run by social workers could help in communities.

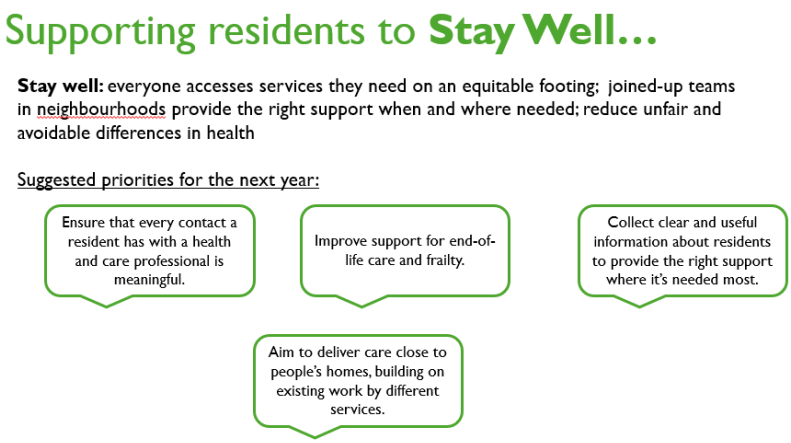
- Codesign: a platform for solutions from local people and communities is key to get lots of feedback from community hubs and organisations and people – many people have great ideas and solutions but need a platform for those ideas…empower them. Involve people from the start to shape and codesign solutions.
- Lots of responsibility is falling on families of people who are unwell…carers are affected in terms of their work/income and their physical wellbeing.
- Accessing resources is a nightmare.
- Prioritise vulnerable people.
- Provide mental health support at the GP practice.
- Target loneliness and isolation and reinvigorate a community spirit which are at the route of mental health problems for many.
- Use volunteering as a way to combat loneliness, upskill, give people a reason to get up.
- Help people to keep active and promote the benefits of exercise for mental health.
- Invest in and support befriending services.
- Understand the barriers for people from different ethnic and cultural backgrounds.
- Special consideration is needed for those in uncertain immigration status.
- Introduce a framework to help people to do some work and develop skills when they are on benefits.
- Create a skills academy/groups and teach skills such as cooking, cleaning in communities.
- Create a compassionate environment in the community.
- Enable people to help design services and support.
- Support faith groups to support people.
- Put in solutions for language barriers.

The group felt we will know if we're succeeding with these priorities because there will be fewer referrals to mental health services. Also, if we create community spaces to support health and wellbeing, success will be measured by the number of people using them.

<u>Suggested actions to be considered when determining and developing priorities for 2025/26:</u>

- Develop a community approach to tacking mental health problems – creating more caring and supportive communities.
- Invest in voluntary sector, schools and faith groups who can help improve knowledge about mental health, address loneliness and support people to know how to self-manage.
- Help children and young people develop resilience to create adults of the future who can better self-manage their mental health.

Stay well



The group felt these were important priorities but they had views on things which need to be considered alongside them. These included:

- **Better training** of staff to underpin it all and ensure people get treated as humans with multiple needs.
- **Communication** and correspondence needs to be better.
- **Accessing services**: people are finding it very hard to get through to anyone and feel abandoned. Phonelines don't always get answered and when they do the advice sometimes isn't helpful or compassionate. We need to go back to basics.
- **Accessibility** needs addressing - the health and care system is geared up for people without disabilities/hearing loss/sight impairment/language barriers/learning difficulties/neurodiversity – we should be catering for all, not the 'norm'.
- **Language is a barrier** to people accessing services and support on an equitable footing and community organisations and voluntary sector need the support of translators/advice on running events and services for people who don't speak English. An example was given of people turning up to support groups who don't speak English and that makes providing the right support difficult. So support is needed such as a translator for events in the community/voluntary sector/volunteers.
    - **Possible solutions suggested included:**
    - a database of volunteers who could support with translating at community events/groups
    - support package for voluntary organisations and community groups to help them run events.
- **Digital communication** should be part of the package but not the only solution to communicating with people about health services/booking appointments etc.
    - **Possible solutions:**

    - Make sure we **communicate in multiple formats** to enable people to access services/advice/support/information equitably - eg create printed copies/audio copies and promote and enable the ability for people to talk to a real person not just bots/digital algorithms.
- **Better support for voluntary sector and rewards for volunteers**
- Support for **a more cohesive neighbourhood/community approach** is needed with training/ongoing support for voluntary organisations and community groups.
- **Support should include financial support** through grants and help with bids for funding and advice for making services/support groups etc sustainable.
- **We shouldn't rely on goodwill and volunteers** as much as we do – a reward system is needed and that could take many forms – eg not just monetary but could include support with accessing free food/exercise groups/community support. Recognition that voluntary sector organisations and volunteers are the 'go to' people who will support…but they have a limit. Address this before volunteers/people running voluntary organisations get burnt out.
- **Neighbourhood work**: create spaces and a structure for regular dialogue in communities.
- **Look to understand the root causes of ill health** rather than just treating symptoms: eg poor housing or housing with a high cost can affect mental health/food poverty/physical health. Working in a more joined up way and understanding the needs of communities with a holistic approach will improve health ultimately.
- **Co-production** – involve people and communities from the start and through a project/development of services, rather than just a tick box exercise. Be honest with them about the challenges and enable them to help commissioners/decision makers find the solutions. Feedback to them so they understand they are being heard and that decision makers are considering their views when making decisions.
- **Better training for GP receptionists** – they could help with signposting to advice/translators and services rather than just being gatekeepers.
- **Volunteering as a solution**: encouraging volunteering could support with loneliness and isolation and the effect that has on physical and mental health. But caution is needed to avoid burnout – it's important to get the balance right for volunteers and provide a reward.
    - **Possible solution:** encourage volunteering from secondary school age to volunteer and the benefits of volunteering to support community cohesion/increase the number of people volunteering, supporting them with lifeskills to prepare for workplace, create a sense of belonging that could even help to address big issues such as gang culture. This would help to make voluntary support more sustainable.

Comments included:

- When people experience ill health, they start to doubt themselves and their abilities.

- Getting back to work can be difficult but it is important. Helping people build back their confidence.
- I love the idea of people telling their story once but how is info shared? Is there a shared care record? Important to share data in a way that makes sense to people and services.
- Importance of services reaching out to smaller community organisations and sharing data and information appropriately.
- The community organisations are likely to have a better understanding of what the person is experiencing.
- Need to empower people to help themselves. Positive self-management and behaviour change tools.
- Suggestion of the right food to help with health conditions (as in diets).
- Need to have conversations with communities about some of the ways that people can support each other.
- Community covenant – mutual aid?
- Developed resident data could help pair people to meet up with others with the same health conditions?
- Would expect there to be more in this area around prevention – eg type two diabetes.
- One participant has Parkinson's and said they regularly have to repeat their story over and over. There is no one shared record and this is frustrating for everyone.
- There have been lots of projects over the years to stop people repeatedly telling their stories – need to ensure that this one succeeds where others haven't. IT-wise there needs to be one system.
- One participant had worked as a nurse in the borough for more than 20 years (including as a District Nurse) and said delivering care closer to home has been talked about a lot.
- An example was given by a volunteer who supports a lady who lives in SE9. They have a Greenwich GP but can't access Greenwich services because they pay council tax to Bromley.
- The role of carers and work to support them is really important – many of them are on their knees. Carers themselves tend to be older and many have their own health issues.
- Technology is helpful but you need to acknowledge that not everyone uses or has access to it.
- For those who can make use of technology it is really important to make good use of it when possible. With Parkinson's I typically have conversations on the phone with the Parkinson's nurse. They would get a lot more info about me if they could see me – Parkinson's is quite a visual disease so video calls would help.
- Limitations of home care – needs to be flexible.
- Carers are in a position to do a lot and play a role in prevention. If they had more time and were able to talk to people they could do much more and help people to remain at home for longer.

- How do we connect people into things like befriending or social prescribing?
- Make smarter use of patient record databases – highlighting and sharing key info but not all.
- Need to foster a joined-up approach between the community and the council. So many gaps that could be filled this way. There are a lot of organisations working in the borough who the council aren't even aware of.
- Example given of a recent Greenwich Healthier Communities Fund event where many of the organisations present didn't know about each other and their work.

<u>Suggested actions to be considered when determining and developing priorities for 2025/26:</u>

- A solution is needed to join up care and support available – communities need support to connect.
- Improve communication and education about long term conditions and support available.
- Use behavioural science to understand the barriers to people self-managing their conditions.
- Better support for carers.
- Co-produce support to help people prevent getting ill and to self manage their conditions.

Age well

While people agreed in principle with the suggested priorities they felt there were others that underpin success. These included:

- The **importance of not relying solely on technology to access services or provide solutions.** People felt the older generation particularly would experience health inequalities if we don't provide **good support for using technology** and enable them to access services via the phone.
- They felt an additional priority should be **support and advice and training to increase digital skills** for older people so they can access the technology that others can.
- **Intergenerational learning and support** was another suggested priority, with younger people supporting older people, and older people supporting younger people. One suggestion was to put in place a programme for intergenerational learning to enable older people to get better at technology, and to impart wisdom, knowledge and life skills to others.

Comments included:

- Voluntary organisations could provide retirement advice to include healthy living on a budget.
- Promotion of volunteering to older people and the benefits of keeping active.
- Technology – there's a limit to how much you can use software and technology. Older people are not familiar with technology – and it can't pick up everything. Real people are needed to support people.
- Nutrition is a big thing and helps people and can save a lot of money in the NHS. Families need help from early on to prevent ill health. Invest in nutrition information and support as a preventative measure.
- Stop providing meals for older people which aren't good nutritionally…microwave meals aren't the answer.
- How can education around nutrition address inequities? People might need support to know how to make a cheap nutritious meal. It's deeper than just telling people to change their diet. Skills needed as well as information.

- We need to consider nutrition for older people instead of microwave processed meals with salt etc – how do we address this when talking about how people can be well?
- Introduce multigenerational cooking groups to share skills.
- Enable patient groups at GP surgeries to support older people with signposting and help to access services/social prescribing.
- Consider setting up wellness groups for older people like an example in Bromley..this would help with health, signposting, health checks, loneliness and mental health.

Suggested actions to be considered when determining and developing priorities for 2025/26:

- Ensure we don't rely on digital technology for older people but provide non-tech options, while also promoting and offering digital skills courses.
- Co-produce community cohesion solutions
- Consider an intergenerational programme of support.

Conclusion

The public forum events were incredibly useful to get insights from local residents about how we can implement these priorities, as well as consider other elements which could contribute to their success.

Communication, co-producing solutions with local people, community cohesion, working within neighbourhoods, and increasing information to enable people to live healthy lives while understanding their barriers to change were all key themes.

Next steps include:

- Consideration of this report as part of the decision making process around 2025/26 priorities.
- Feeding back to people who participated in the public forum events, including on decisions made as a result.
- Supporting coproduction.
- Considering feedback when planning future public forums.
- Continued communication on priorities and progress.

Shelley Whittaker

Engagement and Communications Manager

Healthier Greenwich Partnership

20 January 2025

Appendix 1: Analysis of attendance and evaluation

Promotion

The event was promoted through multiple channels including:

- Our email contacts lists (which includes interested organisations and individuals)
- Posts on X
- Posts on several community groups on Facebook
- Lets Talk Health and Care in South East London website
- Royal Borough of Greenwich resident bulletin
- Community Champions WhatsApp and bulletin
- Request to share sent to all HGP partners

We also ran paid for ads on social media which created 37,497 impressions, reaching 20,863 people, of which 233 clicked on the link.

Registration and attendance:

Online event: 380 people viewed the registration page, 42 registered, 22 attended, including five members of staff/presenter = 17 members of public

Face to face: 917 views of the Eventbrite page, 31 registered, 15 attended.

A total of 32 people actively engaged by attending the events.

Evaluation

8 people visited the online evaluation page but only three people from the online event completed the evaluation form.

10 people returned the evaluation form at the face-to-face event.

Feedback from participants

Overall, awareness of Healthier Greenwich Partnership and its priorities improved for people who attended the events. They found the venue good and of the 10 people who completed the face-to-face event evaluation, six people scored the event as excellent, and four scored it as good.

Some of the key results are included below:

Face to face event

To what extent do you agree with the following?

	Agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Definitely disagree
I could hear the speakers	**8**			**1**	**1**
I could see the slides and the people speaking	**8**	**2**			
Mycenae House is a convenient and accessible location for me	**8**	**2**			

How would you rate your knowledge of the Healthier Greenwich Partnership before and after the event?

	1. Very poor	2. Poor	3. Neutral	4. Good	5. Excellent
Before	**1**	**3**	**1**	**1**	**3**
After			**2**	**2**	**5**

Average score before = 3.2 Average score after = 4.3

How would you rate your knowledge of Healthier Greenwich Partnership before and after the event?

	1. Very poor	2. Poor	3. Neutral	4. Good	5. Excellent
Before	**1**	**3**	**1**	**1**	**2**
After			**1**	**3**	**4**

Average score before = 3 Average score after = 4.3

Overall, how would you rate your experience of the Healthier Greenwich Partnership Public Forum?

1. Very poor	2. Poor	3. Neutral	4. Good	5. Excellent
			4	**6**

What topics would you like to see included in future Healthier Greenwich Partnership Public Forum sessions?

- Mental health
- Healthy eating
- Health advice for ethnic minorities
- Knife crime
- Health inequalities and what's being done to address it
- Take the public forum out on the streets in the community

Other feedback provided
Take the public forum out on the streets in the community

Online event feedback

To what extent do you agree with the following?

	Agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Definitely disagree
I could see the video and slides	**3**				
I was able to participate fully by joining online	**3**				

Please tell us your experience of joining online for this event and if you experienced any of the following:

Connections issues	1
I didn't experience any technical issues	1
Poor sound quality	
Unable to use chat function	
Unable to raise my hand via the reaction function	
Poor visual quality	
Other, please specify	

How would you rate your knowledge of the Healthier Greenwich Partnership before and after the event?

	1. Very poor	2. Poor	3. Neutral	4. Good	5. Excellent
Before	**2**	**1**			
After		**1**		**2**	

Average score before = 1.3 Average score after = 3.3

How would you rate your knowledge of Healthier Greenwich Partnership priority areas before and after the event?

	1. Very poor	2. Poor	3. Neutral	4. Good	5. Excellent
Before	**3**				
After			**1**	**1**	**1**

Average score before = 1 Average score after = 4

Overall, how would you rate your experience of the Healthier Greenwich Partnership Public Forum?

1. Very poor	2. Poor	3. Neutral	4. Good	5. Excellent
			2	**1**

What topics would you like to see included in future Healthier Greenwich Partnership Public Forum sessions?

Progress report pros and cons of interventions taken.

How to make it easier and more consistent patients accessing services across neighbouring and improving the current difficulties. The public would be able to give examples of the difficulties this currently creates. I know a countrywide issue but a more holistic approach again with patient care.

Feedback and suggestions:

- Not sure where this event was advertised, I learned about from a friend
- Advertise these more extensively. You may advertise in these places already but if not I suggest: on surgery notice boards, supermarket notice boards, library, SE9 Magazine, with various local groups and organisations.
- Consultants talking more to each other more across specialisms and hospitals, referrals through different disciplines and not always returning the patients back through the GP to be referred on. This often slows the process for the patient.
- Flexibility for patients to discuss more than one issue when they visit a GP, currently talking about only one issue when a patient has more, risks missing related symptoms and therefore could slow full and concise diagnosis. Give Greenwich residents the chance to discuss this and feed back not only to GPs but MPs.
- Moving hospital administration and appointment booking back in house, for many reasons:- understanding of the procedures and appointments being booked, liaison between staff especially medical staff and easier and more joined-up for patients. There is so much time and money wasted in this area because the standard currently is not consistently good enough.

- Ensure all hospital administration/appointment/enquiry phone lines manned at least 9-5 Monday to Friday and if weekend appointments these phones are manned then. Ensuring there is always some covering staff leave. A chance for people to give their thoughts on how this could be improved.
- How to make people feel happier - a tricky and huge one but happier people are often healthier people because they tend to care about themselves, others and their environment more. Finding ways to make everyone feel they matter, and more so in tough times and difficult circumstances.
- Do more show not tell, no one wants to feel they are being lectured or criticised, especially if they feel it could be by others who may have no experience of their lives or circumstances.
- Discuss how to get various messages across in ways people can relate to more, want to participate in and enjoy doing so. Non-traditional ways. For example cooking demonstrations in the middle of a park or shopping centre with food tastings, getting people to hold these who make food fun. and 'doable'.
- Discuss ideas for cross-generations events. This interaction between ages groups had been seriously reduced with the progression of technology. Young and old have much to gain from each other. I know this has worked well between pre-school age children and seniors but this could also work with for example teens and seniors.
- Discussions on Men's health, I feel a much neglected area and this is from a woman. Men have traditionally had a reluctance to address both their physical and mental health. There should be more men only forums for those who would find that easier. Generate ideas how this problem of men not taking up on wellness checks at GP surgery and prostate checks etc can be addressed. For example perhaps very well advertised walk-in days at weekends, evenings or even really early mornings for those who work shifts. advertising at local sports events, pubs, gyms, local clubs. Even incentives if necessary it would save money in the long-run with the prevention and early detection that could be achieved. Walk-in 'Time - To-Talk' days/sessions at non-medical venues, that could also offer referral to a mental health team and GP support.

AGENDA ITEM: 9

Healthier Greenwich Partnership

Date: 22 January 2025

Title	Update on Greenwich Neighbourhood planning	
This paper is for **noting**		
Executive Summary	South East London (SEL) has previously committed to working in a more integrated way at neighbourhood level, and as part of that, develop Integrated Neighbourhood Teams (INTs) to help balance the provision of consistent access and standards of local care with the variation required to improve population health and address long-standing inequalities, with differing local resources and assets. Greenwich has been developing neighbourhood working over recent years, particularly manifested through the Connecting Greenwich programme with primary care and local communities, and place-based strategy work in the Council	
Recommended action for the Committee	This item is for noting	
Potential Conflicts of Interest	None arise from directly from the report.	
Impacts of this proposal	Key risks & mitigations	None arise directly from the report
	Equality impact	Integrated Neighbourhoods will help improve and reduce inequalities
	Financial impact	Not applicable
Wider support for this proposal	Public Engagement	Stakeholder discussions have started with primary care, social care, public health, community care, and acute care, as well as the Healthy Greenwich Partnership Exec. No major issues or concerns have been raised. Further work is being undertaken on

		relative population needs of each neighbourhood in the proposed models. Further consideration being given to opportunities for children's services and alignment of family hubs
	Other Committee Discussion/ Internal Engagement	Not applicable
Author:	Imogen Setter	
Clinical lead:	Not applicable	
Executive sponsor:	Gabi Darby, Chief Executive Officer, Greenwich Nick Davies, Acting Director of Health and Social Care, Royal Borough of Greenwich	

Healthier Greenwich Partnership Local Care Plan Refresh

Public Forum

January 2025

HEALTHIER GREENWICH PARTNERSHIP

DRAFT

The case for neighbourhood working

- **South East London (SEL) has previously committed to working in a more integrated way at neighbourhood level,** and as part of that, develop Integrated Neighbourhood Teams (INTs) to help balance the provision of consistent access and standards of local care with the variation required to improve population health and address long-standing inequalities, with differing local resources and assets.
- **Greenwich has been developing neighbourhood working over recent years,** particularly manifested through the Connecting Greenwich programme with primary care and local communities, and place-based strategy work in the Council.
- **Without this shift, any improvements in the funding or delivery of individual services across health, local government and wider partners will continue to be overwhelmed** by growth in activity and demand
- **Neighbourhood working is a continuation of local, regional and national initiatives** across successive governments that have aimed to improve the co-ordination and person-centredness of care within the community, to address the following drivers for change:

Social

- Many services are working in isolation, and there is a need for more joined-up, proactive care, which is flexible and able to respond to local needs.
- A consistent approach, clear understanding of what self care and proactive support is available and a strong message that service delivery in partnership with communities is required.
- Recognition that statutory services alone cannot provide all the support people need, particularly with regards to addressing inequalities and reaching underserved communities.

Political

- Government priority to transform the NHS into a 'Neighbourhood Health Service' and shift from hospital to community and sickness to prevention.
- Access issues in primary, community and mental health care, and delays in Emergency Departments and diagnostics.
- Increasing wider social determinants and underinvestment in public health has led to the deterioration of the overall health of the nation.

Economic

- There are significant costs associated with the failure to prevent ill health, to detect and intervene and to mitigate complications.
- Strong and shared economic case especially for the working age adult population – to prevent people becoming economically inactive and to support people back to work.
- Long term sickness is contributory factor to economic activity.

Technological

- One of the shifts planned for health and care services nationally – analogue to digital.
- Investment is required to build and maintain effective infrastructure outside of hospitals.
- Finding effective and practical solutions to co-ordinate and share data for planning, delivery and evaluation purposes.
- Utilising technology at scale to improve efficiency and effectiveness.

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Progress to date in Greenwich

Summary of Focus and Activities

Greenwich partners have been focussed on neighbourhood working principles as a way to; (i) better connect local communities and services, (ii)address the steep gradient of health inequalities in the borough, (iii) ensure an effective operating model for delivery of proactive care to those at risk of escalation and (iv) target collective preventative resources into local communities..

- Greenwich has been running the 'Connecting Greenwich' programme since April 2024. This programme is underpinned **by population health systems, social research, community development approaches and a commitment to continuous learning**. Two-thirds of Greenwich practices have now signed up, including two whole PCNs.
- Over November and December, the team have conducted **interviews and discussions with a diverse range of stakeholders**, including estates planners, social care professionals, PCN Clinical Directors, and acute and community trusts. These discussions have supported in **identifying strategic and operational insights across multiple areas** to what constitutes effective neighbourhood working in Greenwich.
- The team have undertaken **desk-based research to map boundaries, analyse population size and characteristics**, and enabled a clearer **understanding of the local landscape and resources**. This provides a data-driven foundation for understanding characteristics and assets that will support decisions on neighbourhood delivery footprints and initial target populations.

Key Achievements

1.65.5% of practices have signed up to the Connecting Greenwich programme within the first six months and are actively engaged in a project to **develop their neighborhood and community-based approaches** with 4 geographical test beds underway

2.Identified priorities for **integrated neighbourhood delivery** related to frailty and complex LTC management, paediatric care in the community and meeting on-the-day need across the primary and secondary interface.

3.Developed two potential neighbourhood footprints: currently under consideration, discussions have started with stakeholders from primary care, community care, and acute care to gather feedback on these options.

Connecting Greenwich

Practice development proof of concept projects:

- ✓ Triveni
- ✓ Everest
- ✓ St Mark's
- ✓ Basildon Road
- ✓ Galleons Reach
- ✓ Abbey Wood
- ✓ Plumstead
- ✓ Mostafa

Neighbourhood development geographical test-beds:

- ✓ Horn Park – health and life checks, women's health, resident activation (with Lewisham)
- ✓ Plumstead and Glyndon – social connections, digital inclusion, food, community garden, cancer awareness
- ✓ Thamesmead – social connections, health and built environment (with Bexley)
- ✓ Blackheath and Charlton – social connections, voluntary sector development, patient collaboration

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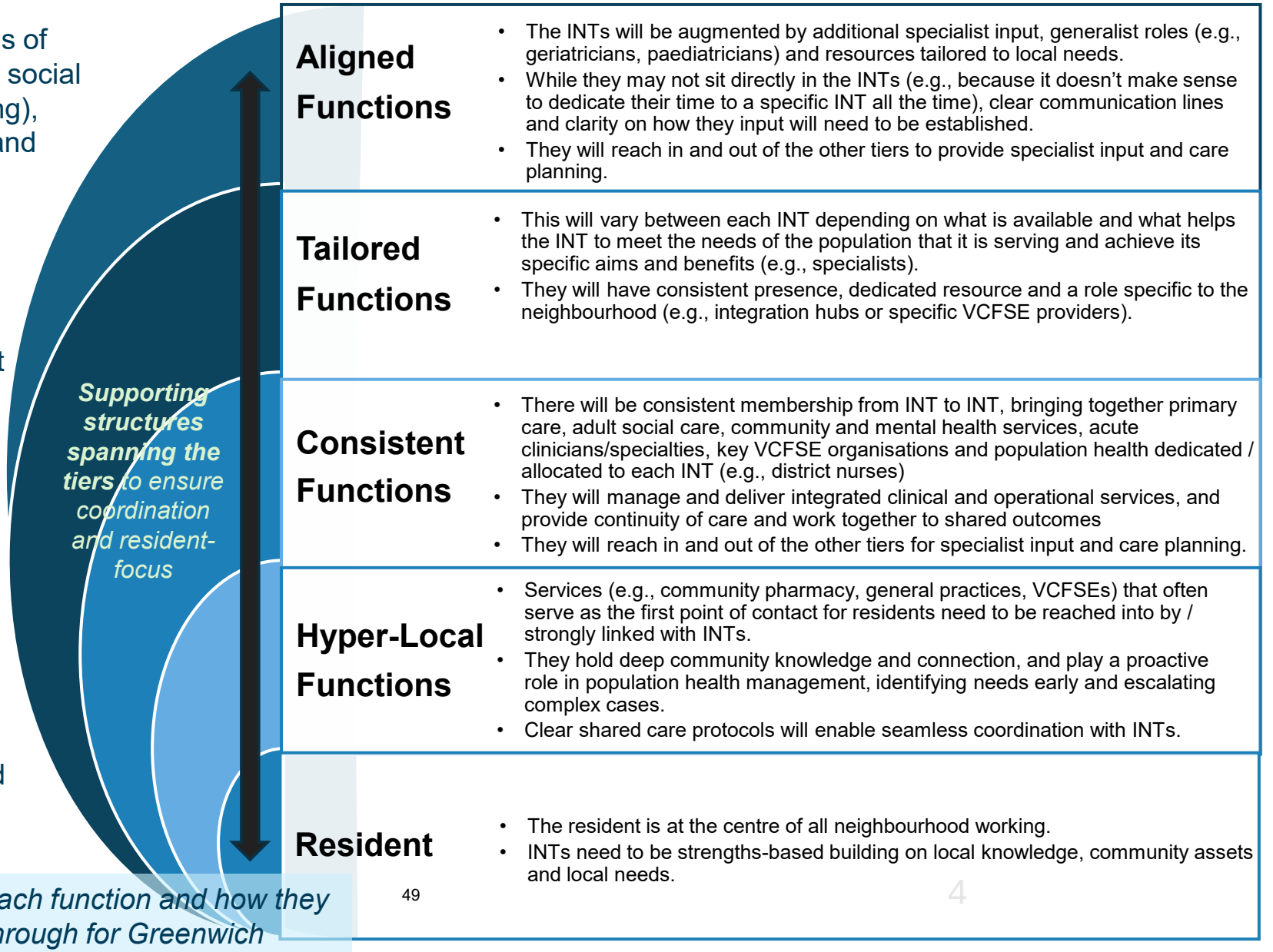
What an INT looks like

INTs will provide the structure for MDT collaboration through the creation of "teams of teams": integrating services across health, social care (including local authorities and housing), public services, and the sector to design and deliver holistic, person-centred care.

- **Our model enables local variation tailored to local needs while maintaining a consistent foundation across all neighbourhoods in SEL.** Investment levels will vary depending on each neighbourhood's starting position and specific needs.
- **Our INTs will be organised using a tiered system**, acknowledging that different functions and services are delivered to residents a range of different scales.
- **Our INTs will leverage population health data** to proactively identify individuals and populations who would benefit from support earlier and prioritising populations experiencing greatest levels of health inequalities.



***Note:** The detail required to operationalise each function and how they relate to each other will need to be worked through for Greenwich*

What we want our INTs to do

Our initial focus is to provide proactive care for higher and rising risk populations, and work with communities on prevention for growth. Based in neighbourhoods, INTs will be made up of a range of skills and expertise, including from primary care, VCSFE and social care, to meet the holistic needs of their local populations. These core teams will be able to easily draw upon specialist input as needed.

This is not about minor tweaks or layering on top of what is already in place nor is it about uprooting what is already working. Working at a neighbourhood level will require a fundamental shift in how we work together as a system, with residents and within communities.

Integrated neighbourhood working will:

- **Tackle health inequalities** by using population health data to proactively identify residents within target populations and connect them into the services that they need to reduce the risk of escalating poor health and stay well for longer. To address inequalities effectively, INTs needs to be wider than health e.g., addressing social determinants like housing and be community-based.
- **Eliminate the need for referrals and hand-offs,** through a combination of Multi-Disciplinary Team working, including regular huddles and reviews and the use of digital and knowledge management tools, that support population data analysis and enable person-based care information to be shared across services.
- **Work closely with residents and within communities,** to develop a clear understanding of what local needs are and the services that are best placed to meet these needs. They will identify and collectively respond to any gaps that may emerge as these needs change over time.
- **Support and enable cross-system leaders,** who share collective responsibility for ensuring that the infrastructure, systems and processes needed to deliver integrated neighbourhood working are in place and remain fit for purpose.
- **Provide holistic, person-centred care, closer to home** that draws upon a wide range of offers from across health, care, VCSFE, housing, and other local services. Our INTs will take a strengths-based approach, so that residents are empowered to make decisions about their health and wellbeing, access the services that are meaningful to them and receive faster and more effective support at times of crisis or increased need.
- **Ensure that all South East London residents receive the same standards of care**, wherever they live and whatever their individual needs.

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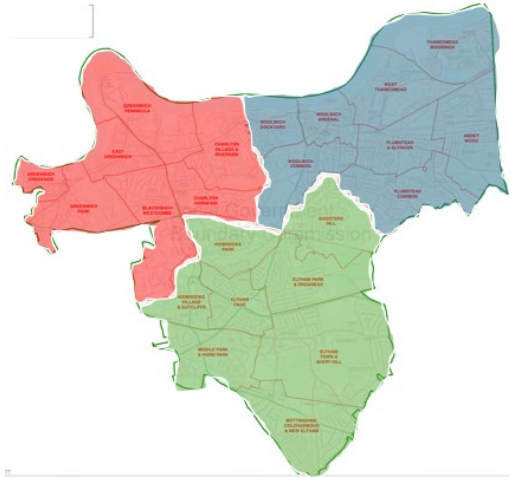
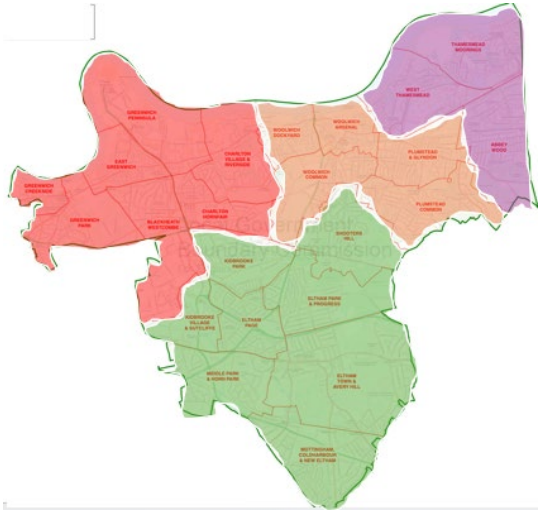
What our neighbourhood groupings could look like



Option 1: Three Neighbourhoods

- **East (Woolwich) – ~116,000**
- **South (Eltham) – ~90,000**
- **West (Greenwich) – ~86,000**



Option 2: Four Neighbourhoods (2 sub-options)

- **North East – ~42,000**
- **Central East – ~74,000**
- **South – ~90,000**
- **West – ~86,000**

Please note that these boundaries may change slightly as a result of the population segmentation exercise.

Primary care

- PCN footprints overlap, creating challenges in aligning with population-specific needs. Neighbourhood options can build on the existing PCN structure through careful planning for overlaps.

Social care

- The three- or four-neighbourhood options would be viable for adult social care but requires exploration of how current homecare boundaries and operational designs can adapt. Redesigned social care hubs aligned with three or four neighbourhood geographies could further optimise service delivery.

Acute and Urgent Care

- Currently integration between acute and community care is limited due to separate acute and community providers. There is an opportunity for better integration between services, transitioning care from acute settings to community hubs or virtual wards. The three- or four-neighbourhood options are compatible with acute and urgent care, but effective communication with frontline staff is needed to address borough-wide variation.

Community Care

- Community services, such as district nursing, align with PCNs, but areas with higher deprivation (like the East) face staffing shortages. PCN alignment causes crossover issues, requiring some residents to travel outside their local area for care. The four-neighbourhood model may better align resources to address the higher demand and deprivation areas.

The neighbourhood footprints are **not yet established**, presenting an opportunity to design a model that truly prioritises the needs of the population, while **feedback from staff across different organisations has not raised any major concerns about the proposed approach.**

The next step is to **review population segmentation data for the options**, to enable comparison of need rather than raw population numbers.

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Assessment of the two neighborhood footprint options

How well do each of these options achieve our goals?

Centre around populations and natural communities:

- *Option 1*: Aligns well with Greenwich's three town centres (Greenwich, Woolwich, and Eltham), respecting natural geographical communities and simplifying identification.
- *Option 2*: Reflects residents' perceptions more accurately by splitting the East into two areas, recognising that Thamesmead is perceived separately from Woolwich and Plumstead.

Build on existing networks and local assets

- *Option 1*: Does not directly leverage existing health or social care boundaries but indicates alignment with key local assets such as Eltham Community Hospital and Kidbrooke Community Hub.
- *Option 2:* Engages services across Greenwich, aligning more comprehensively with local health and social care boundaries.

Include population sizes between 50k–100k

- *Option 1*: The East neighbourhood has higher population density, and adjusting boundaries could create challenges, requiring additional resources.
- *Option 2*: Most neighbourhoods meet this principle, but the North East, currently smaller (42k), is projected to grow due to developments in Thamesmead, although boundaries could also be adjusted to even these up

Enable not hinder joint working

- *Option 1:* Facilitates borough-wide services and manageable travel times under 30 minutes.
- *Option 2:* Supports borough-wide and hyperlocal services, maintaining efficient travel times within 30 minutes.

Adapt footprints based on specific challenges

- *Option 1:* Faces difficulties addressing resource disparities, particularly in the East, without disrupting current structures.
- *Option 2:* Focuses on targeted interventions for high-need areas such as the East, leveraging existing structures to address population health challenges.

Engagement so far

Stakeholders discussions have started with primary care, social care, public health, community care, and acute care, as well as the Healthy Greenwich Partnership Exec. No major issues or concerns have been raised. Further work is being undertaken on relative population needs of each neighbourhood in the proposed models. Further consideration being given to opportunities for children's services and alignment of family hubs

Timing

The process to reach local agreement on neighbourhood geographies is ongoing, with a target to finalise geographies to enable implementation from April.

Next steps

Refine and Confirm Geographies

- Engage stakeholders and analyse data to evaluate the two options in relation to population needs and service priorities.
- Collaborate across primary care, community care, and acute care to refine geographies that best align with local requirements.

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Initial neighbourhood development and implementation approach

Phase 1 (now)
Scope & design

- ✓ **Have a clear shared vision, purpose and high-level outcomes** aligned to SEL and London vision
- ✓ **Build on existing work and strengths** to inform development, including Connection Greenowich and local neighbourhood test-beds
- ✓ **Pull together data** from across health, public health and social care to achieve a clear view on existing neighbourhood footprints, community assets and population needs, including inequalities
- ✓ **Agree common language** describing our population segments to facilitate integrated planning and working
- ✓ **Define geographies** for neighbourhood footprints, including how PCNs align with neighbourhood teams
- ✓ **Identify initial priority cohorts** for INTs and pull data related to this group
- ✓ **Align plans with existing** integrated neighbourhood working iniatives (e.g., existing work across PCNs)
- ✓ **Establish programme workstreams and structure –** including population health data, comms and engagement, care model design, wokforce, digital and evaluation

Phase 2 (Feb-Mar)
Refine design and set up

- ✓ **Identify and agree workforce, skills and resource requirements** of INTs to meet population needs (including integrator function)
- ✓ **Collectively allocate resources** based on identified need, exploring novel arrangements (e.g., contracts, incentives) removing historical integration barriers
- ✓ **Develop population health management** approach to enable proactive identification and management of residents across life stages, need status and different factors influencing a person's needs
- ✓ **Establish governance** to ensure clear leadership and accountability, including risk management and clinical governance
- ✓ **Agree measures of success** and monitoring approach for initial implementation
- ✓ **Facilitate neighbourhood discussions**, based on shared data and clear goals

Phase 3 (April onwards)
Test and learn

- ✓ **Develop integrated multi-organisational neighbourhood teams** for a chosen population cohort in an agreed geographic footprint, helping individual PCNs and teams better manage demand and capacity, building resilience and sustainability.
- ✓ **Embed digital tools and knowledge** that enable a shared, population-health driven approach
- ✓ **Apply a test and learn approach**, to understand key enablers and barriers to implementation including access routes, integrator functions, data, workforce and resource flows
- ✓ **Share learning, capacity and resource across neighbourhoods**, converging around best practice
- ✓ **Use established governance** to continously assess learning, progress and impact and integrate into the development of the full INT implementation
- ✓ **Based on learning from initial implementation tests,** start potentially expand population coverage and increase resource proportion supporting prevention

Underpinned by…

Ongoing engagement and meaningful participation

with partners and residents to enable cultural change and INTs being built and flexed around residents needs, making full use of the knowledge and skills of the team across organisations and ensuring learning and experience is maximised and shared to continuously improve.

AGENDA ITEM: 9

Healthier Greenwich Partnership

Date: 22 January 2025

Title	Live Well: Greenwich Community MSK recommissioning update
This paper is for **noting/approval**	
Executive Summary	This paper provides an update, 8 months on, regarding the progress to recommission Musculoskeletal (MSK) services in Greenwich. We remain committed to working collaboratively with residents and local partners to co-design a model that addresses the needs of our community. **Progress Overview** Since the initial service design event in February 2024, significant progress has been made. Through ongoing engagement and collaborative efforts, we are now approaching the final draft of the service specification document. This marks a critical milestone in the recommissioning process as we prepare to enter the procurement phase. **Key Milestones Achieved** 1. **Final Draft Service Specification Document** • Following extensive engagement with stakeholders, residents, and partners over the past 11 months, the service specification document is now near completion. Feedback from key events, such as the February service design session and the March community day event, has been incorporated into this draft to ensure it reflects the needs and aspirations of all stakeholders. • The specification emphasises holistic care, improved pathways, and enhanced patient experiences, with a focus on seamless referrals, integrated IT systems, and a preventative approach. 2. **Procurement Timeline** • The procurement process for the MSK service is scheduled to commence on **17th January 2025**, with the tender provisionally expected to go live on this date. This marks the transition from design to delivery, bringing us closer to implementing a future-fit MSK service. 3. **Stakeholder Engagement** • Engagement efforts have remained robust, with additional sessions held since the February and March events to refine the model. These sessions have supported the development of

	clear service pathways, workforce requirements, and a co-production approach that ensures the patient voice remains central. 4. **Alignment with Strategic Priorities** • The updated model aligns with local priorities, emphasising equity of access, integration across primary and secondary care, and the use of community assets to deliver care closer to home. **Next Steps** • Finalise and approve the service specification document by mid January 2025. • Launch the procurement process provisionally on **17th January 2025**, adhering to the outlined timeline. • Provide support to potential bidders to ensure alignment with the co-designed model. • Continue to engage with stakeholders and maintain communication throughout the procurement phase. • We are on track to meet the key milestones in the recommissioning process, ensuring the delivery of a high-quality, patient-centred MSK service that meets the needs of Greenwich residents. Updates will be provided as the procurement progresses and as we transition to the implementation phase.
Recommended action for the Committee	Note the update and ensure continued partner engagement as the service moves toward finalisation and procurement.
Potential Conflicts of Interest	N/A

Impacts of this proposal	Key risks & mitigations	The recruitment of additional capacity has been completed; however, this introduces a risk of a shortened timeline for service design and procurement. To mitigate this, we will prioritise efficient project management and closely monitor progress to ensure key milestones are met within the revised timeframe.
	Equality impact	Equality impacts will be considered throughout the development of the future model and procurement planning, ensuring the service meets the needs of all communities.
	Financial impact	The financial envelope for the service is defined, and efforts will focus on ensuring best value while finalising the service design and commissioning the new service.

Wider support for this proposal	Public Engagement	Ongoing stakeholder sessions with member practices, healthcare providers, and patient representatives have refined the service specification, integrating feedback to ensure the model meets local needs and aligns with strategic priorities. This collaborative approach has ensured a patient-centred service.
	Other Committee Discussion/ Internal Engagement	This paper builds on updates previously shared with the JCB and HGP Exec, which informed key decisions on procurement timelines and stakeholder engagement. These committees and other forums will continue to be updated on progress.
Author:	Jane Thurston – Strategic Change programme Lead – Community, MSK and Physical health and wellbeing	
Clinical lead:	*Rashida Pickford -Consultant MSK Physiotherapist – SEL Clinical Lead*	
Executive sponsor:	*Lisa Wilson - Integrated Director of Commissioning – Adults*	

South East London
Integrated Care System

Greenwich Community MSK Service Provision : Update

22nd January 2025

Jane Thurston
Strategic Change Programme Lead
jane.thurston@selondonics.co.uk

South East London Integrated Care System

HEALTHIER GREENWICH PARTNERSHIP

Introduction:

This report provides an update on the progress of the recommissioning of the musculoskeletal (MSK) services in Greenwich, following extensive engagement with stakeholders and the local community, resulting in significant strides being made toward finalising the service specification and preparing for procurement.

Progress Overview

Since the initial service design event in February 2024, and subsequent engagement activities, we are now nearing the final draft of the service specification document. The procurement process is provisionally scheduled to begin on **17th January 2025**, with the tender predicted to go live on this date. These developments are the result of ongoing collaboration with member practices, healthcare providers, Lived experience patient representatives, and community stakeholders.

Indicative Timeline for the Procurement

Milestones	Indicative Dates
Issue of Tender documents **Advert on Find a Tender Documents on portal**	17th January 2025
ITT Supplier Clarification Question Period (ends 12 Noon)	7th February 2025
Deadline for Submission of Bids (ends 12 Noon)	14th February 2025
Evaluation Period	24th February 2025 – 14th May 2025
Bidders Presentation and Interview (if required)	23rd April 2025-30th April 2025
Approval of Contract Award	25th June 2025
Outcome Letters to Bidders (from)	30th June 2025
Earliest Mobilisation Commencement (incl Contract)	1st October 2025 – 31st March 2026
Contract Commences	1st April 2026

Several engagement activities were conducted to align the MSK service model with local population needs and stakeholder priorities:

- **September – December 2023:** Community outreach and public engagement. Survey completed by 94 residents, discussions held at 14 community groups or events
- **Healthier Greenwich Partnership Public Forum (October 2023):** Residents were invited to join a discussion either in-person or online to give feedback on the existing service and suggestions for future provision
- **Service Design Event (February 2024):** A world café-style session involving patients, partners, and stakeholders to review current MSK pathways and gather feedback.
- **MSK Community Day Event (March 2024):** Held at Sutcliffe Park in Greenwich, patients on MSK waiting list were invited
- **Market Engagement (November 2024):**Online event presenting the vision to potential providers.
- **Primary Engagement (November 2024):** Online session with the Community of Clinical Influence to gather clinical feedback
- **Ongoing Stakeholder Sessions:** These sessions have been critical in refining the service specification and incorporating feedback to shape the future MSK service model.
- **Patient Representation in Project Group:** Patient representatives are included in the project group to ensure service design aligns with patient needs, and in the procurement process as evaluators

These activities have ensured that the service model reflects patient-centered care and the expertise of key stakeholders.

Next Steps

- **Finalisation of Service Specification:** The service specification document will be finalised by mid January 2025, based on the insights and feedback gathered from all engagement activities.
- **Procurement Process:** The procurement process is predicted to officially begin on **17th January 2025**, with the tender going live.
- **Continued Stakeholder Engagement:** Ongoing updates will be provided to the Healthier Greenwich Partnership, JCB, and HGP Exec to ensure transparency and continued collaboration throughout the procurement phase.
- **Informing Local People:** Updates will be shared through newsletters, the website, and ICB communication channels, as well as those of our partners. The online engagement platform will be kept up-to-date with progress. Additionally, we will directly reach out to individuals who have engaged on MSK and provided their contact details and consent for further communication.

Conclusion

The recommissioning of MSK services in Greenwich is progressing as planned, with key milestones on track. Continued engagement with stakeholders, including live experience service users and local partners, remains central to the process, ensuring the future service is designed to meet local needs.

South East London Integrated Care System

NHS South East London

Recommended Action for the Healthier Greenwich Partnership:

- Note the update on progress and ensure continued partner engagement as the service moves toward finalisation and procurement.
- Support ongoing collaboration to ensure successful delivery of the recommissioned MSK service.
- Monitor progress through the procurement phase to ensure objectives are met.

Importance of getting it right the first time.

Benefits: improved patient outcomes, faster recovery times, reduced readmissions.

Thank you for your time

AGENDA ITEM: 11

Healthier Greenwich Partnership

Date: 22 January 2025

Title	*Update on the Greenwich Healthier Communities Fund*	
This paper is for **noting**		
Executive Summary	• *Update will be provided on the Greenwich Healthier Communities Fund – it will cover programme aims, what has been funded so far, our recent Grantee Networking Event and the future of the fund.*	
Recommended action for the Committee	• *This update is to note only*	
Potential Conflicts of Interest	• *N/A*	
Impacts of this proposal	Key risks & mitigations	• *N/A*
	Equality impact	• *N/A*
	Financial impact	• *N/A*
Wider support for this proposal	Public Engagement	• *N/A*
	Other Committee Discussion/ Internal Engagement	• *N/A*
Author:	*Daniella Finch*	
Clinical lead:	*N/A*	
Executive sponsor:	*Gabi Darby*	

HEALTHIER GREENWICH PARTNERSHIP

GROUNDWORK CHANGING PLACES CHANGING LIVES

Greenwich Healthier Communities Fund

Greenwich Healthier Communities Fund

- Established to support organisations and communities that seek to address health inequalities in Greenwich.
- Being used to distribute approx. £6.6m from the NHS Greenwich Charitable Funds.
- Will fund work that addresses barriers faced by those affected by health inequalities, through a number of strands.
- Establish a community of successfully funded groups who will work collaboratively and share learning and best practices.

Greenwich Healthier Communities Fund

Key data:

Enabling Round 1:
- 32 applications
- Funded 8 organisations
- Totalling £57,711

Delivery Round 1:
- 67 applications
- Funded 25 organisations
- Totalling £542,189

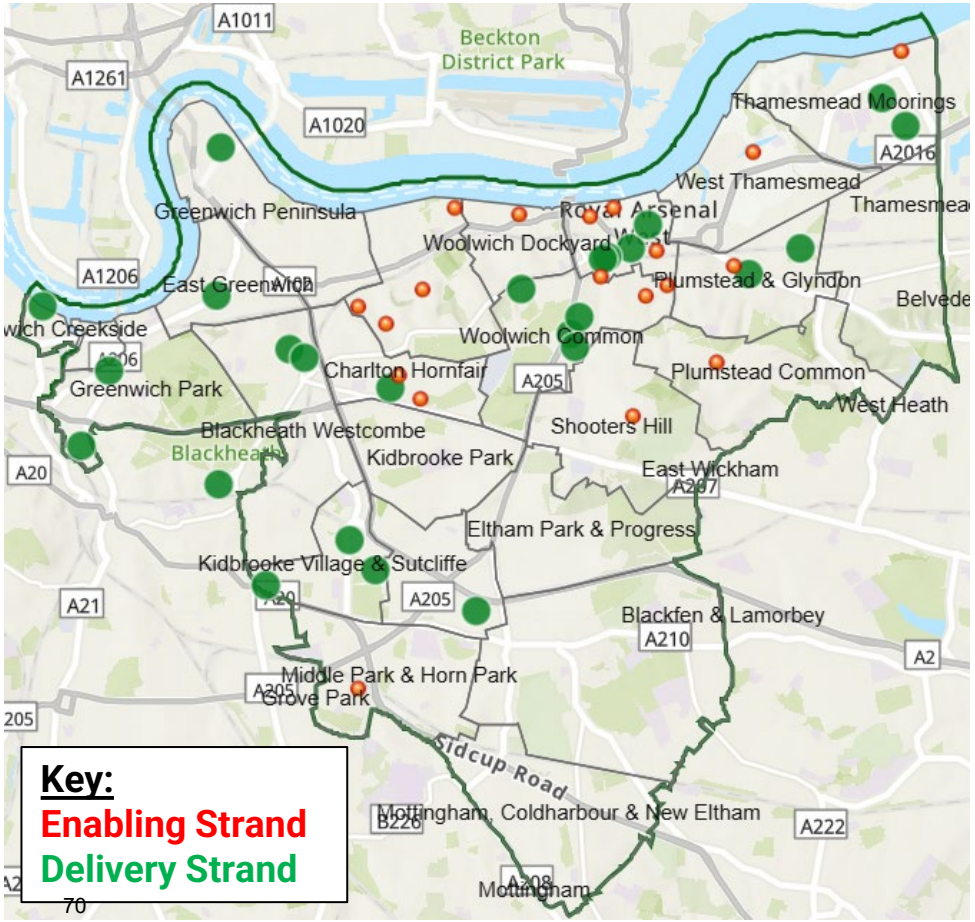
Enabling Round 2:
- 25 applications
- Funded 11 organisations
- Totalling £96,570

Enabling Round 3:
- 19 applications
- Funded 11 organisations
- Totalling ££85,604

Greenwich Healthier Communities Fund

Funded Organisations

Theme:	Organisations:
Health Access	20
Healthy Eating	9
Mental Health	16
Physical Fitness	13
SEND Support	4
Children & Young People	13



Greenwich Healthier Communities Fund

Grantee Networking Event

- 32 organisations attended, plus key stakeholders from Public Health/ VCS
- Networking opportunity for grantees to connect to organisations with a similar mission
- An opportunity for us, as the grant manager, to gain feedback on the fund

Greenwich Healthier Communities Fund

AGENDA ITEM: 12

Healthier Greenwich Partnership

Date: 22 January 2025

Title	Healthier Greenwich Partnership – Quarterly Partner Update	
This paper is for **noting**		
Executive Summary	The purpose of this report is to provide the Committee with an overview of key work, improvements and developments undertaken by partners within the Healthier Greenwich collaborative.	
Recommended action for the Committee	The committee is asked to note the report	
Potential Conflicts of Interest	None arise from directly from the report.	
Impacts of this proposal	Key risks & mitigations	Not applicable
	Equality impact	Not applicable
	Financial impact	Not applicable
Wider support for this proposal	Public Engagement	Not applicable
	Other Committee Discussion/ Internal Engagement	Not applicable
Author:	Joint Partners report	
Clinical lead:	Not applicable	
Executive sponsor:	Gabi Darby, Chief Executive Officer, Greenwich	

Partnership Report – January 2025

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1. Healthier Greenwich Partnership (HGP)

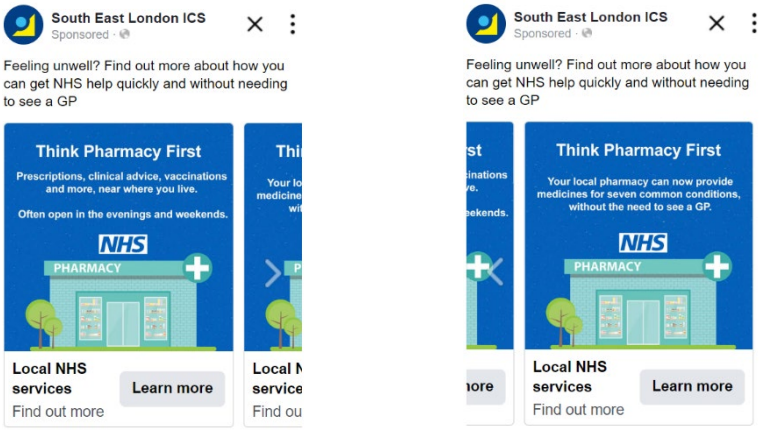
The partnership has had a busy quarter, with significant pressures on the urgent and emergency sector over the December and January period. In this context, we thank the health and care workforce across Greenwich for their dedication in meeting resident and patient needs over the period. Despite this, there has been significant progress and in programmes of work delivering service improvements, many of which are set out in this report.

There have also been changes in leadership in Greenwich over the last quarter. Sarah McClinton, Greenwich Place Executive Director across Health and Social Care in the Royal Borough of Greenwich and SEL ICB has moved on to a new national role. Nick Davies is now Acting Director of Health and Adult Services while the Chief Executive undertakes a recruitment exercise. Gabi Darby is the Chief Operating Officer for ICB in Greenwich, and the main representative for Greenwich within SEL ICB governance. Gabi and Nick will maintain the close collaboration between the NHS and Local Authority in the borough that is central to this partnership.

2. Local Communications and Engagement

Testing new communication tools to help with system pressures

To help with system pressures we have been piloting using digital programmatic advertising[1] with the main focus being on promoting Pharmacy First. This was chosen as it is felt that public knowledge of the conditions that pharmacists can provide treatment for is patchy. The adverts are targeting people based on their recent online behaviour. For example, if someone has been looking at symptoms or treatments for earache we can send them a Pharmacy First advert. This has the potential to increase impact as we are able to run adverts and minimise waste as they will be seen by the people we most want to target.



As well as adverts for Pharmacy First we are also running short video adverts explaining which service is right for people (pharmacy, primary care, NHS 111, mental health crisis line, A&E/urgent care).

For a small investment so far, we have seen very positive results. The adverts have generated over 475,000 impressions, leading to 4,000 clicks. When the data about Pharmacy First consultations is available we will have a clearer picture of the full impact.

[1] Programmatic is a form of digital advertising that uses automated technology. The automation informs when the ad is seen, who sees the ad and where they see the ad in order to best achieve the campaign objectives. This means ads are only seen by those meeting the audience criteria, thus reducing wastage and improving campaign outcomes. Audience profiles cover demographic, behaviours and interests as well as geographic criteria

Smokefree app pilot

Helping people to quit smoking is a big priority for us in Greenwich and is especially important as we aim to focus more on prevention. Our team in Greenwich are developing a campaign, led by behavioural science, which will run in all boroughs in South East London. This is a partnership with the NHS and each of the local authorities. The first step is promoting a pilot of the Smokefree App with enhanced licences available for a limited time. This enables people to access a smoking cessation service on their phone including chatting to counsellors and peers, ordering nicotine replacement therapy, ordering starter kits to enable smokers to swap vaping.

3. Primary Care and Neighbourhoods Update

Connecting Greenwich

The Connecting Greenwich programme has been running since April 2024 and is actively working with two-thirds of Greenwich's general practices, including three PCNs. The programme works holistically with practice teams to identify areas for improving how practices provide proactive, accessible care to their local communities and/or target population cohorts. Through specific projects with the practices or PCNs, long term culture change is embedded through coaching, thinking councils, data analysis and trialing innovations. Many projects within the programme include a focus on reducing health inequalities, including engaging with Vietnamese, Nepalese and Somali older generations; improving hypertension control in black men; childhood immunisations outreach; integrated same day access; piloting Local Child Health Teams; and a community wellbeing café. The programme is being evaluated by DG Cities alongside delivery.

Neighbourhoods Development

Following successes over the past year of population and community-based working models in several geographic 'test-beds' for integrated neighbourhoods in Greenwich, including Horn Park, Thamesmead, Plumstead and Glyndon and Blackheath and Charlton, momentum has gathered towards defining the key pathway/services that will be delivered by Integrated Neighbourhood Teams. These include focusing on proactive care for frailty and complex Long Term Condition patients at 'rising risk' of deteriorating health; piloting Local Child Health Teams in the community; streamlining local access to same day care; and reducing health inequalities through the Connecting Greenwich and population health management programmes. We are now moving toward defining our Neighbourhood footprints based on optimal population sizes, natural communities within the borough and the existing infrastructure of health and care provision, such as the PCNs, community services and social care teams. Healthier Greenwich Partnership have been robustly engaged and there is good system-wide commitment to integration. A priority for early 2025 is ensuring general practice is robustly engaged in shaping the move towards Integrated Neighbourhood Teams both in terms of pathways and geographies.

Flu and Covid Vaccinations

Ahead of the 2024/25 flu season, we recruited a dedicated immunisations lead to work directly with GP practices and partners to help to improve vaccination uptake and outreach. This has initially focused on flu and Covid vaccinations uptake through the winter including amongst

housebound patients and will turn attention to childhood immunisations uptake in 2025. There have been a number of outreach initiatives in progress for flu/Covid, such as homeless vaccination clinics and engaging with Nepalese residents in their own language. Up to 5th January 2025, the uptake of seasonal vaccinations in Greenwich had been:

Flu: 60% of eligible over 65s have taken up their flu vaccination and 34% of eligible under 65 at risk patients have taken up their flu vaccination
Covid: 39% of eligible over 65s have taken up their Covid vaccination and 13% of eligible under 65 at risk patients have taken up their Covid vaccination

Work is ongoing during the final months of the winter season to boost uptake of vaccinations, and we are exploring additional outreach clinics and communications on flu jabs particularly, to reduce the surge of mostly unvaccinated Greenwich patients going to hospital at QEH with flu

4. Royal Borough of Greenwich, Public Health Update

The RBG Public Health team has a number of workstreams that will continue to move forward into 2025. The following are a few examples:

The 2024-25 Annual Report of the Director of Public Health will be published in early spring and has a focus on health inequalities. The report will describe what we know about the health inequalities that affect our populations, their causes, and what the evidence suggests we should be doing to have a positive impact in addressing these inequalities. The causes of health inequalities are multiple, complex and inter-related. They include social, cultural, economic and environmental factors. Where we live, our income levels, the beliefs and behaviours of those around us, the quality of our education and training, our experience of discrimination, the quality of the health and care services we use all contribute to how healthy we are. There is no silver bullet to tackling health inequalities. Complex problems require complex solutions at a range of levels, from support for individuals through to national policy change.

Our work in partnership with HGP colleagues to develop our approach to neighbourhood working is one of the means we are implementing to improve health outcomes and tackle health inequalities, especially in our more disadvantaged areas where health is poorest. Through working in close partnership with residents, community, voluntary and faith organisations, statutory services can design services to better meet the needs of our diverse communities. This work includes a focus on better meeting the needs of more vulnerable residents, such as those living with frailty and / or multiple long term health conditions. But it also includes work to improve other factors that affect residents' mental and physical health and wellbeing, such as the physical environment, access to advice and support services, social connection and other factors that affect quality of life.

The Health and Wellbeing Board in Greenwich has been reviewing its role and priorities. It intends to structure its meetings for the next municipal year around a number of deep dives into key issues of importance to the health and wellbeing of residents in the Borough. In the March 2025 meeting, the Board will be considering whether partners round the table could make a greater contribution to support the work in Greenwich aimed at tackling the high levels of domestic violence experienced in the Borough, especially (though not exclusively) affecting female residents.

Finally, the current Director of Public Health, Steve Whiteman, has announced his intention to leave RBG at the end of April 2025. Work has begun to seek to identify a successor for Steve to lead the department into the next period.

5. Integrated Commissioning – Children and Young People

Child Health Teams Pilot

Greenwich has started a 6-month pilot in Greenwich West Primary Care Network of Local Child Health Teams. The pilot brings together a Consultant Paediatrician from Lewisham and Greenwich Trust, Lead GPs from the Primary Care Network and Community Nursing from Oxleas NHS Foundation Trust. Building off learning from Lambeth and Southwark but developed from the bottom up, the model consists of a weekly triage and monthly clinic bringing together Primary, Secondary and Community professionals to identify and provide better support to children at a neighbourhood level. An evaluation of the 6-month pilot is planned that will inform the next steps.

New Children's Wellbeing and Schools Bill

The Government has recently published its new Children's Wellbeing and Schools Bill. This proposes significant changes that will impact upon the Integrated Care Board and Health partners, such as the new Multi-Agency Child Protection Teams, Regional Care Co-operatives, Information sharing and unique identifiers and the use of accommodation depriving liberty. Ongoing discussions are taking place locally to consider the impact of the proposals and potential future developments needed.

Pan-London Development: Continuing Care and Social Care

A new Pan-London Children's Continuing Care and Social Care group is being established between Local Authority and ICB representatives. The group aims to review joint working between Local Authorities and Integrated Care Boards with respect of children being assessed for both Continuing Care by ICBs and support under the Chronically Sick and Disabled Persons Act by Social Care. The intention is to try to improve both joint working and consistency across ICBs and Local Authorities regarding assessment and support.

6. Integrated Commissioning – Adults

Organisational change and embedding our vision and approach to integrated commissioning – we are so pleased that we now have a full leadership team in place. After some time of working on our new organisational approach and structure this will enable us to ensure effective delivery of our local priorities and engagement with SEL colleagues. We still have some vacancies in key roles and continue to work on the recruitment to these. Collaboration across teams and with partners continues and we have seen some good progress with teams setting up new ways of working across adults, public health, children and young people and primary care teams. Plans are in place to ensure this continues this year including leadership development across teams and with partners. We thank our staff and teams for their continued hard work and commitment to the lives of Greenwich people.

Collaboration and partnership - we focus on improving our work with other teams and engage

them if specialist skills or knowledge is needed. We have built effective partnerships with a number of providers, VCS partners, RBG and ICB corporate services including operational, finance, procurement, change, digital and data teams, housing and regeneration and planning, communications, legal and others as well as working closely with residents. These relationships have been critical to our delivery over the last few months, and we thank colleagues for their continued leadership and support.

Market Quality and Sustainability

- **Quality Assurance –** the team continue to sustain their performance in overseeing the quality of care and support for Greenwich residents, working in collaboration with front line teams, safeguarding colleagues, CQC, ICB quality teams and care and support providers. Work has recently been undertaken to provide an overview of the quality of care and support provision to the Joint Commissioning Board. Focusing mainly on Residential and Nursing homes and support in the community including Homecare and Supported Living. Where there are any concerns about providers these are investigated and a supportive approach to quality assurance is then implemented, including the delivery of support to providers to improve on areas identified for action. The team was recently expanded through the reorganisation, and final vacant roles are being filled.

- **Sustainability –** Work continues to assess the impact of inflation, NI and other pressures which impact the sustainability of provision as well as assessing the demand for services. For NHS services, planning guidance is still expected which will inform the local decisions as well as provide direction for ICB provision. The LA budget setting process is underway with decisions in February expected to confirm an affordable uplift off for providers going into 25/26. Communications will be shared in a timely way and engagement with providers is ongoing. Commissioners are working with colleagues across the region and sub regionally to inform local decisions as well as national support offers. We know the planned NI changes are going to present significant challenges, and work will continue to ensure partnerships are maintained during challenging financial circumstances.

- **Market Position Statement –** data and insight has been gathered over the past year to inform the development of the MPS for Greenwich adult's provision. This will set out what we currently commission and where, what our strategic needs assessment tells us about new or different care provision needed and the intentions we have to secure this over the next period. There is an intention to publish this information so that prospective partners can understand what is needed and how best to engage with us. Further work is intended to progress the development of commissioning strategies which deliver against national requirements, Health and Wellbeing Strategy, Our Greenwich and Local Care Plan priorities.

- **International Recrutiment –** work continues to be undertaken in partnership with other agencies to address any issues with sponsorship licenses**,** address concerns and support impacted workers including linking them to support offers across SEL and locally

Aging Well – Early Help, Homefirst

Early Help, Homefirst and UEC:

- **Urgent and Emergency Care and winter planning –** We have continued to work alongside local partners to deliver actions outlined in our UEC recovery plan. Recognising the pressures in community capacity, work was done to identify the local gaps in provision, particularly for residential and nursing homes and support for people at home and intermediate care settings. This was also linked to recent work with LGT to enable more effective discharges. The impact of the new capacity secured will be monitored in partnership with LGT and others between January and March. The work continues to ensure our Urgent Treatment Centre arrangements are as effective as possible. Partnership meetings are regularly convened to work on key actions and monitor progress. Learning is being gained from elsewhere including from the lead CCPL to inform the work.
- **Homefirst –** homefirst priorities continue to be delivered across the partnership. Key areas of focus over the last period have been; delivery of an evaluation of pathway 0 offers, re-commissioning of the Take Home and Settle service, improvements to our Reablement offer following trials supported by the RBG Digital Team, considering options for Step Up/ Step Down solutions to meet current and future needs. Further work to embed Virtual Wards, this has included a focus on making more of this opportunity to support discharge for those who need to go home. Support for those who are at end of life continues including via the Greenwich and Bexley Community Hospice as well as virtual wards. A recent review was undertaken of this VW offer and the outcomes it delivers were highlighted.

- **Assistive Technology Enabled Care Service (ATEC)** – following the successful tender for a strategic partner, the LA as the lead commissioner is now progressing the formal governance steps to award the contract. Healthier Greenwich Partnership are receiving a full update in February ahead of the new service going live in April. Work continues to progress towards implementation at pace alongside local partners, detailed work on the operational and system and data aspects has continued. This has allowed for greater collaboration and staff will soon access the learning and development opportunities which will be available to ensure they are equipped with the knowledge and skills to ensure ATEC is offered proactively to eligible residents with health and care needs. We are excited about the launch as we believe this to be one of the most significant new services to be offered to residents. It will complement the work on developing integrated neighbourhood team approaches and ensure we are able to better deliver preventative and proactive care. Opportunities to deepen relationships between Joint Emergency Team and the current Telecare service have been progressing in readiness for go live. The telecare service will undergo some changes to enable them to provide an integrated ATEC monitoring and response service for Greenwich residents.

- **MSK –** recent work was undertaken to review the timeline for recommissioning the service. The outcome of this has meant a direct award to the current provider has been put in place to ensure service continuity over the coming year. The new service will be commissioned to be in place for April 2026. The changed timeline has meant more local engagement on the model and core requirements for the service could be undertaken, which has been welcomed by partners as well as patients. A clear programme of work is now underway to achieve the revised timeline and more stable staffing resources aligned to the work

- **Carers –** we continue to improve our offer to carers through the delivery of the Joint Carers Strategy and action plan. This includes working alongside those who are carers themselves in the Borough to improve the offers of information and advice, access to local support and to be

able to access a carers assessment in a person centred and timely way. The new carers assessment offer is currently in the process of being commissioned and the outcome will be known later in the spring before go live in April.

Feeling Well, Adults MH, LD and A and Disabilities

- **MH –**

- the community MH transformation continues with further work to embed MH Hubs and take in to account actions required as a result of the recent audit across SEL
- We continue to work across partners to ensure we utilise the available support so people can be supported locally and that we ensure this is in the least restrictive environment possible
- The MH needs assessment work continues, when this is completed we will ensure this informs the delivery of our Adults MH priorities alongside the insight from the recent work with residents and partners to hear what matters to them and develop a vision for MH in Greenwich.

- **LD –**

- Work has continued alongside Housing and Regeneration colleagues to progress a decision to secure some key buildings which provide accommodation for care and support services for those with LD. A decision is expected in late January by RBG Cabinet. Subject to the decision being approved this will enable the work required to recommission LD accommodation based support in Greenwich to be progressed over the coming 2 years.
- A new partnership Board overseeing place based work to deliver support to those with LD has been mobilised alongside the wider LD Partnership Board. This will enable effective oversight and collective action, the impact of which can then be shared with HGP and support delivery of local and SEL LDA priorities.

CHC – We continue to work on the areas of improvement which remain and have seen significant progress over the last period. We continue to focus on effective support to residents to be assessed for CHC in a timely way, enhancing partnerships with adults social care, ensuring better value care and support is commissioned, making sure outstanding reviews are completed and that we work with others across SEL to ensure consistent ways of working.

Enabling Services - A new integrated brokerage team in Greenwich was launched in 2024 and are now supporting CHC placements. The impact of the approach is hoped to be seen as we will ensure we are more aware of gaps in provision which can be supported by commissioning teams, oversight of quality can be more aligned to LA approaches and we can hopefully secure better value through enhanced negotiation and data driven approaches. The Direct Payment team was also re-organised including work with local residents in co-production which has informed the new ways of working which are emerging. This work has been recognised nationally and a visit from DHSC recently has meant we are able to influence policy and practice improvement plans at a national level. We were delighted to be asked to run a workshop on this at the National Social Care conference in Liverpool in November and the integrated nature of our local offer was recognised as one of the most forward-looking by others who shared feedback. We hope to use these new approaches to increase access to Direct Payments for those with health and social care needs. We are likely to be asked to continue to support developments at a national level alongside embedding our local improvements.

25/26 planning – local work has continued to review outcomes, actions and progress against our Health and Wellbeing Strategy and the local care plan five-year forward view. This will

support the planning process. We are ensuring alignment across projects and programmes, support of system intentions and priorities including key priorities such as Neighbourhood development, frailty model development and delivery, the sustainability programme and work to support people with long term conditions.

MTFS – a key area of focus has been on the standing up as well as delivery of MTFS priorities across ICB and RBG. Where possible these have been connected to strategic change priorities already planned or underway.

7. Update from Oxleas NHS Foundation Trust

1. Neighbourhood based care

We are working with partners to support neighbourhood-based care in each borough both through discussions at Place and at the South East London Neighbourhood Based Care Board.

Sessions with Oxleas' Board and leadership team have considered how the organisation can be best placed to support such developments.

2. Winter Pressures

Local acute sites are experiencing considerable demand with high emergency department pressure scores noted at QEH and PRUH as well as high OPEL scores. Colleagues from our Community Physical Health, Acute & Crisis Mental Health and Children and Young People's services are working alongside system partners to expedite patients through emergency departments and facilitate discharge from inpatient settings. In particular, our community physical health services have continued to support patient flow through the Home First teams. This involves sending senior staff to hospital wards to identify patients that can be cared for at home.

3. Community Physical health services

The Joint Emergency team has been continuing to work with London Ambulance Service paramedics to treat patients at home and reduce the need for a hospital visit by ambulance. This alliance is having a very positive effect. In the first four months, it has saved nearly 200 ambulance trips to hospital.

We have successfully recruited a Project Manager to support the Assisted Technology Enabled Care (ATEC) programme being led through the Royal Borough of Greenwich. This role will support implementation by working closely with the Oxleas teams through implementation and delivery. The JET team are developing close links with Telecare in preparation for ATEC to work across both health and social care.

Our specialist long-term conditions services continue to develop to support Greenwich residents. This includes the Respiratory hubs with clinics now underway as a joint service with Lewisham and Greenwich Trust for diagnosing COPD and Asthma. Also, as part of the SEL enhanced sickle cell community service we now have a Sickle Cell nurse for adults, covering Greenwich and Bexley, and are starting to receive referrals with clinics and multi-disciplinary reviews at Eltham Community Hospital.

We continue to experience a growth in demand for our District Nurse teams. We have a

workstream in place led by our Service manager to work with local partners to improve service efficiency. We have had success in recruitment campaigns and will soon be sharing a promotional video to champion the work of District Nursing.

4. Community mental health services

Physical health checks are essential for the older adults' teams, and maintaining these has been challenging due to recruitment issues. To overcome this, our Greenwich service is collaborating with our Agile Physical Health Intervention Team to improve patient care.

The Oxleas ADHD diagnostic and treatment service is based in Bromley, but covers the Boroughs of Bromley, Bexley and Greenwich. The service has been undergoing a process of rapid development to meet changing needs and increased referrals to the service. Across the UK there has been a steep rise in referrals to Adult ADHD services. There has also been a national supply problem with ADHD medication which has been changing on a weekly basis. The Oxleas team have been proactive in its efforts to address these needs. The team members are highly motivated and committed and have significantly increased capacity. In part this has been achieved by embracing new technology
to reduce the administrative burden. While waiting lists are increasing in many areas, the team have reduced the waiting time for new assessments to below two years. The team has worked closely with local pharmacies where particular medications are hard to obtain and have sent comprehensive advice to GPs and service users about alternatives. The team are also developing non-medical interventions and will soon be starting a psychoeducation group. Team members are also visiting local community groups to provide information and advice about ADHD and training to members of staff to be ADHD coaches. In November 2024 the team won the RCPsych awards 2024 in the category of the Best Working Adult team in the country.

The Bexley and Greenwich Care Home Team, established in 2022, aims to train care home staff to enhance their skills in managing residents with dementia and challenging behaviours. Their training has been well received, and the team's interventions have significantly reduced symptoms for many residents. However, future funding for the team is uncertain, and efforts are being made to secure funding for 2025/26.

5. Older People’s Conference

We are hosting our inaugural Oxleas Older People’s Conference in February 2025. It will focus on the exciting work being done trustwide to improve the health and wellbeing of people in later life. Taking place on **Wednesday 12 February 2025** at Kent County Cricket Ground in Beckenham, the event will be chaired by Chief Medical Officer, **Dr Abi Fadipe.** Keynote speakers will include **Dr Amanda Thompsell**, National Advisor of Older People’s Mental Health at NHS England and **Dr Jan Oyebode**, Professor of Dementia Care at the University of Bradford.
The conference will include presentations, posters and interactive stalls from colleagues working with people in later life and in community mental health, acute and crisis, adult learning disability, adult community health and forensic and offender services.

6. Mental Health Services for Children and Young People

The development of the Crisis Pathway has been progressing with successful recruitment and the implementation of standardised training. The CAMHS Liaison and Crisis Team (CLiC) 24/7

pilot will end, and funding for permanent posts is being sought.

The CAMHS Brief Intervention Home Treatment Team is still experiencing delays in mobilisation, with a soft launch date now likely to be end of January. The 16-25 Pathway project aims to improve mental health service pathways for 16-25-year-olds and recruitment for the Transition Worker post is planned.

Lisa Thompson, Service Director for Children and Young People's Services, will be leaving Oxleas at the end of March 2025. Jenny Ioseliani, currently Associate Director for Adult Learning Disability Services, has been appointed to take up the post on Lisa's departure.

7. Oxleas Annual Recognition Awards

Colleagues from across Oxleas took part in our annual Recognition and Long Service Awards which were held in December 2024. This event celebrated achievements of staff, lived experience colleagues and volunteers across the organisation.

8. Improvement and Innovation Conference

Oxleas quality team worked with colleagues from South London and Maudsley and South West London and St Georges to host a conference highlighting service improvement and innovation across the three organisations. Around 300 people attended the event to hear about the latest developments. The poster presentation competition was won by the Oxleas Shadow User and Carer Committee. The full list of posters and information on the speakers is available at South London Partnership Improvement and Innovation Conference 2024

8. Greenwich Healthier Communities Fund

The Greenwich Healthier Communities Fund was launched in April 2024 as a new funding programme aimed at tackling health inequalities in Greenwich.

It was established by the NHS Greenwich Charitable Funds, in partnership with the South East London NHS Integrated Care Board and the Healthier Greenwich Partnership.

The programme funds individuals, community groups and organisations that work to prevent and respond to health issues in the borough.

Since its launch, the programme has funded 55 organisations across two funding strands. The Enabling strand, which aims to increase the capacity of organisations, and the Delivery strand, which funds project work.

We held our first grantee networking event in November 2024, which brought together the organisations that have been awarded so far. This was a great opportunity to celebrate the awardees and facilitate connection and collaboration across these organisations.

The second round of the Delivery strand closed on 10th January 2025. We are currently developing the programme, based on feedback from grantees, the community and public health stakeholders. We are aiming to relaunch the fund in April 2025 with changes and improvements to ensure it remains relevant to tackling prevalent health inequalities, whilst being accessible for the communities that most need its support.

9. Primary Care Networks Update

Blackheath & Charlton PCN

1. We are starting a Community Café in the next few months- following the work in Bromley. Currently we are going through site approval requirements. We will be working with our care coordinators and social prescribers
2. We plan to be working with All Together Better – a provider that has done national work in engaging with our patient population to identify patient cohorts who can contribute to developing new ways of managing demand and supporting our patients.
3. We have worked with Arden's to develop a risk stratification tool that allows practices to classify patients according to needs and capture any inequalities they may experience in accessing healthcare interventions. A simple tool that classifies people into Red, Amber, Green
4. We have developed a continuity of care protocol that allows standardised data recording. It captures all long-term condition metrics, A & E attendance / admissions, NOK, carers, advance care planning, LPA details etc. This allows our practice MDT team to record information which can facilitate proactive care.
5. We have developed a dashboard that sits behind this that allows practices to monitor what is happening to all RAG rated patients. It is especially useful for amber and red patients.
6. We are currently trying a pilot with Oxleas for a more fluid model of proactive care. They will have access to RAG rated patients and will have a care coordinator based within the practice.
7. We have all practices signed up to GP automate as part of our PCN digital strategy.

Eltham PCN:

1. We have set up a home visiting service running since Feb 2024, which is set up with an ANP, paramedic and an HCA. They have dealt with all the acute and chronic management of all the house-bound patients and delivery of vaccinations for those patients.
2. We have a PCN-based respiratory service (asthma and COPD) that runs on Saturdays at the Eltham Community Hospital for our PCN population.
3. PCN care coordinators in each practice are involved in the smear campaign (which led to 80% uptake over the past two years), bowel & breast cancer campaign on people who failed to engage with national screening and also involved in COVID and Flu campaigns.
4. We have given the most COVID vaccinations in Greenwich and are in the top 5 within SEL for the flu campaign for the 2024 winter season.
5. We have done a few community projects, which include a community garden project at Eltham Medical Practice and a Summer PCN health fair working with the CACT team at the Roots 4 Life in Eltham doing health screening and health promotion-related work. We recently opened up an Eltham Wellbeing Cafe at the Eltham Library, where we have set up drop-in sessions for the local community on Wednesdays to help with health promotions, health screening (BMI, BP and AF screening), form filling, benefits advice, and community activities. We also had an afternoon tea charity event at the Eltham Medical Practice Garden and raised £350, which will be donated to Breast Cancer Now.

10. Update from Greenwich LMC

The recent major sporting events have provided a nice reminder of the health benefits of being active, as well as a welcome distraction from the travails of general practice created by the cyber-attack on Synnovis pathology service.

The current BMA non-statutory ballot of GP contract holders on collective action is currently active. The London LMCs umbrella organisation, Londonwide LMCs, is gathering information on what actions practices may undertake, should the outcome of the ballot is for action. The local ICB senior management team is aware of the implications of this for local general practice, and have been asked to factor this into their forward planning.

However, a new government bring fresh optimism that the perilous situation of general practice is acknowledged and understood, and negotiations will be initiated which will avoid any further action.

11. Lewisham and Greenwich NHS Trust (QEH)

The Queen Elizabeth Hospital (QEH) is facing severe operational pressures as it enters the 2025 calendar year. QEH, which provides a full range of health services, is experiencing high demand in all areas, but has particular pressure within its emergency department, which remains one of the busiest in London.

As part of its winter preparation plans QEH has implemented a Same Day Emergency Care (SDEC) and has expanded day time capacity from November 24, and extended weekday SDEC service to 12 hours per day from January and 7 days per week from March 25. In recent weeks additional escalation beds have been opened on all wards, and management has installed an additional 21 beds across two wards (wards 22/23) to improve flow out of the emergency department (ED), directly improving the safety of care within the ED.

Alongside its winter planning preparations management has continued work focusing on discharging patients as soon as they are sufficiently well and has worked with the Royal Borough of Greenwich to develop an incentive scheme in early 2025. This will fund:

- Three months additional social worker resource to reduce delays in decisions on immediate care and pathways; and
- Increased care home capacity to accommodate the numbers of patients awaiting discharge home – At The Oak (5 additional beds), Riverlee (3 additional beds) and Goldsmiths enhanced care home (4 additional beds).

Since the last partnership meeting, over the summer of 2024 the QEH benefited from a significant infrastructure upgrade, which has improved the safety and overall resilience of the site. A future site transformation plan is being developed and further bed capacity is being created by moving corporate teams. An example of this is a new ward (ward 26) ahead of next winter following the recent move of the medical records team.

The Trust's current position against key performance targets is as follows:

Referral to treatment times (RTT): Work continues to reduce the Trust's waiting lists dropped by 1,508 to 68,313 in December, the lowest value since May 2024. Key volumes for >65 week and >52-week pathways fell to 3,039 and 313 respectively.

Cancer: The Faster Diagnosis Standard (FDS) outlines that patients should not wait more than 28 days for a cancer diagnosis. Our current unvalidated position for September is 71.9% which is an improvement of approximately 2% but remains below the national planning target of 77%. The largest driver of the Trust's overall FDS position year to date has been the change in the dermatology performance position. Referrals to the QEH site at LGT have seen a significant increase in 24/25.
LGT's overall 62-day position of 55.7% is driven by Lower GI, Lung and Prostate pathways. These make up 33.5 of the 35 total breaches.

Intensive COO-led/Deputy COO-led monitoring is in place to ensure delivery of recovery actions and escalation of key risks to minimise the numbers of patients waiting for treatment.

Urgent and Emergency Care: The Trust's emergency department pathways continue to experience significant demand. Trust ED performance remains below the national average of 73%, reporting 64.6% in November. In December performance looks to have remained stable at to 65.4%

At QEH T3 performance (lower acuity patients) remained at 90% in December (for a second month running) but is very volatile on a day-by-day basis. Two rooms have been provided to the UTC team for streaming, and there is a requirement to increase physical space need for streaming but also reduce the time to streaming. A monthly partnership board is in place with Greenwich Health to work on QEH UTC performance and flow

T1 non admitted – The SDEC case approved in October is impacting performance positively by around 5% each day through 30 patients per day moving more quickly out of ED. As noted above an additional 21 beds have been made available on the site from mid-January.

A visit in December from the NHS England team highlighted key areas for action to be completed to improve flow across the QEH site within 1 week and one month. These actions have been fed into site plans.

12. Greenwich and Bexley Community Hospice

Service Transformation – Community SPC Service
The team have been working on new referral criteria and allocation process
The process is already live and is seeing a significant reduction in waiting times – referral criteria were soft launched internally before Christmas and will be shared more widely in forthcoming couple of weeks.

<u>Referrals will be accepted for any patient:</u>
1. Over the age of 18 (please contact us to discuss those that may be transitioning from children services to adult)
2. With any life limiting/terminal or progressive illness, including frailty
3. at any stage in their illness
4. Experiencing intractable problems that are not responding to routine treatment and therapeutic intervention, and which have persisted after generalist palliative care by a non-palliative care specialist (e.g. GP, Oncology, District Nursing)
5. Where their support network is/ are having difficulties in adjusting to/ coping with their disease physically, psychologically, spiritually or emotionally

6. To assess their need for further hospice services or inpatient care

Reasons for Referral include:

- Specialist multidisciplinary assessment.
- Symptom management- (please tell us what they are)
- Complex psychological/spiritual issues
- Provision of supportive care including those offered by our Rehab & Wellbeing team
- Palliative rehabilitation
- Symptom Control within inpatient setting & end of life inpatient care, where hospice is the patient's preferred place of death
- Information and signposting
- Bereavement care-for those connected to a person we have cared for

Universal Care Plan
We are seeing a steady increase in creation and updating of UCPs for hospice patients. Thanks to all involved in making sure patients have a UCP.

Discharge Criteria:
Since last autumn, we are also discharging more patients to Patient Initiated Follow Up. Palliative Care aims to help people live well and improve quality of life whilst living with a terminal illness. Patients may require episodic input from our services and will be made aware that discharge from our caseloads/services is seen as a positive step in their journey. Discharge can occur when a patient condition is stable and no longer needs the specialised input from our teams/services. Should circumstances change the individual can be re-referred by themselves, carers or another Healthcare Professional

13. Healthwatch Greenwich

1. Enter & View Visits - (13) Learning Disability Care Homes and (1) Learning Disability Respite Service

The 13 Enter and View visits carried out have led to significant, positive changes for residents and their families. Key outcomes for 1 or more homes visited include:

- Access to Essential Health Services: Recommendations resulted in better coordination with local NHS services, ensuring residents could access vital services, such as regular dental care.

- Stronger Safety Measures: Safety concerns identified during the visits, such as visitors not being asked for ID or not being logged in visitor books, were addressed, leading to improved safety for residents.

- Better Communication with Families: New practices like regular newsletters and group meetings strengthened connections between care providers and families, ensuring relatives were better informed and involved in care decisions.

- More Comfortable Living Environments: Care homes responded to our recommendations by making communal spaces more comfortable, and completing repairs and decoration, creating a more welcoming atmosphere for residents.

2. **Enter and View visit- Queen Elizabeth Hospital Urgent Treatment Centre (UTC)**

The visit involved interactions over 4 days with 107 visitors, including 12 in-depth interviews, and observations of staff-visitor interactions. Findings highlight the professionalism and compassion of the UTC staff, with visitors feeling well-supported. However, concerns were raised about waiting times, inconsistent communication regarding delays, and accessibility challenges, particularly for those with mobility issues. The report also notes the need for improvements in the waiting area's environment and facilities, such as the provision of charging stations, vending machines, and child-friendly spaces.

3. Tackling Health Inequalities in Surgical Care

We explored the challenges faced by patients waiting for elective surgery, particularly those most likely to experience health inequalities.

In collaboration with Lewisham and Greenwich NHS Trust, we facilitated seven participatory sessions with patients on the waiting list for surgery, including those from global majority backgrounds, people with living with physical or cognitive disabilities, and carers, to co-design solutions for improving preoperative health.

Key findings highlight the need to move away from generic to personalised information, a requirement for culturally sensitive information - co-designed with patients and community groups, greater proactive communication from LGT, tailored support during key touchpoints (initial referral, waiting for surgery, and preoperative appointment), and the importance of peer and community support. The report recommends greater focus on meeting NHS accessible information standards, increased use of social prescribing, and greater community and family involvement to support motivation and accountability to address health inequalities for better surgical readiness and recovery outcomes.

4. Evaluation of the Anti-Racism Community of Practice for Health Equity (CoP)

Working in partnership with Public Health, the evaluation will assess its effectiveness as a safe and reflective space for open discussions and learning leading to personal and professional development. The evaluation seeks to determine whether the CoP facilitates transformative learning and provides insight on anti-racist practices to advance health equity. It explores the clarity of the CoP's objectives, how well sessions translate into actionable outcomes, and strategies for sustaining engagement.

5. Mental Wellbeing Workshops

We partnered with Public Health to organise a series of four interactive workshops with local community leaders to identify strategies for improving mental wellbeing. As a result, Healthwatch Greenwich is now leading "Be Well Support", working with a small number of community groups to increase their capacity to promote mental wellbeing across their communities and signpost to relevant resources.

6. Befriending Service

Working in partnership with Live Well/CACT, we delivered a small pilot befriending project aiming to reduce social isolation and improve the wellbeing of vulnerable residents. The service provided emotional support through volunteer befrienders matched with clients based on their preferences and needs. 20+ residents were referred to the service from Live Well and 15 took part (our capacity was limited to 15 residents). Key findings included improvements in emotional wellbeing and reduced feelings of loneliness. The pilot also addressed broader health inequalities by supporting residents with complex physical and mental health needs by signposting to relevant statutory services.

7. HPV

Working in partnership with the South-East London Cancer Alliance, our project aims to improve health outcomes and reduce health inequalities by addressing barriers to HPV vaccination among young people aged 16-25 in Thamesmead. Our project uses a youth-led participatory approach by recruiting, training, and compensating four young people as peer researchers who will gather qualitative insights through semi-structured interviews and lead culturally sensitive outreach efforts. These include tailored awareness workshops, community events, and engagement in youth settings such as colleges, and youth clubs. Collaboration with public health, primary care, and sexual health partners will support the development of effective strategies for improving vaccine uptake while equipping stakeholders with the knowledge to promote HPV vaccination effectively.

8. Outreach Engagement

We have carried out a series of outreach sessions, working in partnership with neighbourhood and community groups, to draw attention to the challenges in accessing health and care services for residents who are:

- Digitally excluded
- Carers
- Living with disabilities
- Homeless or living in insecure housing

9. Monthly Feedback Reports

Our Monthly Feedback Reports compile insights from residents regarding their experiences with health and care services. The feedback is gathered through satisfaction surveys, meetings with local groups or advocates, outreach and engagement events, and research reports. These reports aim to highlighting where services are working well identify opportunities for improvement.

AGENDA ITEM: 13

Healthier Greenwich Partnership

Date: 22 January 2025

Title	Performance Report	
This paper is for **noting**		
Executive Summary	• The purpose of this report is to provide the Committee with an overview of local performance, and is used to form part of the local assurance processes. • The latest position against key areas of local performance is presented, highlighting achievement against national targets, agreed trajectories and other comparators. An overview of performance and wider SEL context is provide to support interpretation of the data. • Local actions and mitigations are noted in the report	
Recommended action for the Committee	The committee is asked to note the report	
Potential Conflicts of Interest	None arise from directly from the report.	
Impacts of this proposal	Key risks & mitigations	Not applicable
	Equality impact	Not applicable
	Financial impact	Not applicable
Wider support for this proposal	Public Engagement	Not applicable
	Other Committee Discussion/ Internal Engagement	Not applicable
Author:	Business Support Lead	

Clinical lead:	Not applicable
Executive sponsor:	Gabi Darby, Chief Executive Officer, Greenwich

South East London Integrated Care System

NHS South East London

Greenwich Local Care Partnership
LCP performance data report

December 2024

South East London Integrated Care System

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NHS South East London

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Overview of report

Summary:

- This report is produced by the SEL ICB assurance team and is intended to be used by LCPs as part of their local assurance processes.
- The latest position against key areas of local performance is presented, highlighting achievement against national targets, agreed trajectories and other comparators. An overview of performance and wider SEL context is provide to support interpretation of the data.
- This report is intended to be used by the responsible LCP committee/sub-committee to identify areas where performance is not in line with expectations and where members/teams may be required to provide additional explanation and assurances that issues are being addressed either locally or as part of a wider system approach.

Contents and structure of report:

- The report covers a range of metrics where LCPs either have a direct delegated responsibility for delivery or play a key role in wider SEL systems. It covers the following areas:
    - Areas of performance delegated by the ICB board to LCPs.
    - Metrics aligned to the six ICB corporate objectives that fall within delegated responsibilities LCPs.
    - Metrics requested for inclusion by LCP teams.

Structure

- A dashboard summarising the latest position for the LCP across all metrics is included on page 4.
- This is followed by a series of more detailed tables showing performance across south east London with explanatory narrative.
- Metrics are RAG rated based on performance against national targets, agreed trajectories or national comparators (where included in the tables). Arrows showing whether performance has improved from the previous reporting period is also included.

Definitions:

- Definitions and further information about how the metrics in this report are calculated can be found here.

South East London Integrated Care System

Greenwich performance overview

NHS South East London

Standard	Trend since last period	Period covered in report	Comparator	Benchmark	Current performance
Dementia diagnosis rate	↑	Oct-24	National standard	67%	65%
IAPT discharge	↑	Sep-24	Operating plan	321	355
IAPT reliable improvement	↑	Sep-24	Operating plan	67%	70%
IAPT reliable recovery	↔	Sep-24	National standard	48%	48%
SMI Healthchecks	↓	Q2	Local trajectory	66%	48%
PHBs	↑	Q2 - 24/25	Local trajectory	488	362
NHS CHC assessments in acute	↔	Q2 - 24/25	National standard	0%	0
CHC - Percentage assessments completed in 28 days	↓	Q2	Local trajectory	70%	91%
CHC - Incomplete referrals over 12 weeks	↔	Q2 - 24/25	Local trajectory	0	0
Children receiving MMR1 at 24 months	↑	Q1 - 24/25	PH efficiency standard	90%	86%
Children receiving MMR1 at 5 years	↓	Q1 - 24/25	PH efficiency standard	90%	85%
Children receiving MMR2 at 5 years	↓	Q1 - 24/25	PH efficiency standard	90%	76%
Children receiving DTaP/IPV/Hib % at 12 months	↑	Q1 - 24/25	PH efficiency standard	90%	91%
Children receiving DTaP/IPV/Hib % at 24 months	↑	Q1 - 24/25	PH efficiency standard	90%	90%
Children receiving pre-school booster (DTaPIPV%) % at 5 years	↓	Q1 - 24/25	PH efficiency standard	90%	72%
Children receiving DTaP/IPV/Hib % at 5 years	↑	Q1 - 24/25	PH efficiency standard	90%	89%
LD and Autism - Annual health checks	↑	Sep-24	Local trajectory	424	525
Bowel Cancer Coverage (60-74)	↑	Mar-24	Corporate Objective	67%	65%
Cervical Cancer Coverage (25-64 combined)	↑	Apr-24	Corporate Objective	66%	66%
Breast Cancer Coverage (50-70)	↑	Mar-24	Corporate Objective	57%	57%
Percentage of patients with hypertension treated to NICE guidance	↑	Oct-24	Corporate Objective	69%	65%
Flu vaccination rate over 65s	↑	Oct-24	Corporate Objective	54.5%	49.5%
Flu vaccination rate under 65s at risk	↑	Oct-24	Corporate Objective	20.0%	24.5%
Flu vaccination rate – children aged 2 and 3	↑	Oct-24	-	-	30%
Appointments seen within two weeks	↓	Oct-24	Operating plan	90%	94%
Appointments in general practice and primary care networks	↑	Oct-24	Operating plan	-	146140
Appointments per 1,000 population	↑	Oct-24	-	-	449

Greenwich performance mitigation actions

Standard	Trend since last period	Period covered in report	Comparator	Benchmark	Current performance
Dementia diagnosis rate	↑	**Oct-24**	**National standard**	**67%**	**65%**
Plans are in progress for 2025 to support general practice to improve rates of early dementia diagnosis and coding, and to ensure newly diagnosed patients are appropriately signposted and their carers supported in primary care.					
SMI Healthchecks	↓	**Q2**	**Local trajectory**	**66%**	**48%**
Focussed work between primary Care and Oxleas continued to ensure progress is sustained. Performance has slightly dropped however the learning from the previous actions supported by HIN activity will continue. Performance is shared with the MH Oversight and Coordination Board and collective actions agreed where required.					
PHBs	↑	**Q2 - 24/25**	**Local trajectory**	**488**	**362**
There has been a range of co production work with residents and staff over the last year to understand what's working well/ what could be improved around self- directed support offers including increasing access to PHBs. This has led to the development of action plans to improve the offer including self-directed to those who have Direct Payments and encouraging more uptake. Work will continue to embed these changes and consider where the newly developed Individual Service Fund offer may support those with both health and joint health and care needs. This includes work to increase uptake for those with MH and S117 needs.					
Children receiving DTaP/IPV/Hib % at 5 years	↑	**Q1 - 24/25**	**PH efficiency standard**	**90%**	**89%**
For all seven of these childhood immunisations metrics, we are reviewing the incentives in place for general practice to undertake enhanced recall of patients/parents and signposting to information, with the aim to provide funding to practices from April 2025 for this purpose. Our Connecting Greenwich practice development programme is intensive supporting several practices who have prioritised improving their childhood immunisations rates amongst cohorts who have low vaccination rates. From March 2025, once the flu and Covid vaccs season has concluded, our Borough Immunisations Coordinator will provide intensive focus on projects and outreach to improve childhood vaccinations. We are part of local, SEL and national communications campaigns to promote childhood immunisations.					
LD and Autism - Annual health checks	↑	**Sep-24**	**Local trajectory**	**424**	**525**
Following a roundtable with local GP leaders in December 2024, we are working across organisations and teams to address barriers to LD Health Check uptake and signposting. The details of this project are TBC and will be developed after 31st March 2025 once the data gives us a clear picture of practice performance against this metric.					
Percentage of patients with hypertension treated to NICE guidance	↑	**Oct-24**	**Corporate Objective**	**69%**	**65%**
We are developing pathways for people with multiple and complex LTCs – which very often includes hypertension as one of those LTCs – to provide proactive care for people at 'rising risk' of deteriorating health, stroke/heart attacks and associated hospital admissions and long- term healthcare usage. This is aligned to significant work across SEL to develop at pace standardised approaches to care for multi-morbidity patients, especially where exacerbating factors such as depression or deprivation exist.					
Flu vaccination rate – children aged 2 and 3	↑	**Oct-24**	**-**	**-**	**30%**
Our dedicated immunisations lead is working directly with GP practices and partners to help to improve vaccination uptake and outreach. This has initially focused on flu and Covid vaccinations uptake through the winter including amongst housebound patients and care home residents. There have been a number of outreach initiatives for flu/Covid, such as homeless vaccination clinics and engaging with Nepalese residents in their own language. Work is ongoing during the final months of the winter season to boost uptake of vaccinations, and we are exploring additional outreach clinics and communications on flu jabs particularly, to reduce the surge of mostly unvaccinated Greenwich patients going to hospital at QEH with flu.					
Appointments per 1,000 population	↑	**Oct-24**	**-**	**-**	**449**
For all of these primary care access metrics, we have been working closely with Greenwich's 29 practices and seven PCNs to ensure full delivery of the national Primary Care Access Recovery Plans. All PCNs are on target to achieve full payment against these indicators in 2024/25. Many of our practices have now adopted sophisticated management and triage tools to allow them to identify which patients need to be seen and by whom, which can be managed remote by telephone or online, and which can be redirected to other services such as community pharmacies. This is helping to provide additional appointments and sooner to the patients who need them.					

Greenwich performance mitigation actions

Standard	Trend since last period	Period covered in report	Comparator	Benchmark	Current performance
Children receiving MMR1 at 24 months	↑	Q1 - 24/25	PH efficiency standard	90%	86%
Children receiving MMR1 at 5 years	↓	Q1 - 24/25	PH efficiency standard	90%	85%
Children receiving MMR2 at 5 years	↓	Q1 - 24/25	PH efficiency standard	90%	76%
Children receiving pre-school booster (DTaPIPV%) % at 5 years	↓	Q1 - 24/25	PH efficiency standard	90%	72%
Children receiving DTaP/IPV/Hib % at 5 years	↑	Q1 - 24/25	PH efficiency standard	90%	89%

To improve the uptake of Immunisations in Greenwich, a number of new services, providers and initiatives are being established and launched:

- NHS England London region have commissioned new community providers including:
- From 1st September 2024 there was the start of the new community provider contract delivering the neonatal BCG service for babies aged 0-12 months across London. Hounslow and Richmond Community Healthcare NHS Trust (HRCH) is the new provider in Greenwich.
- From 1st September 2024, HRCH have been the new school aged immunisation services (SAIS) provider for Greenwich.
- From August 2024, Greenwich has appointed an Immunisation Coordinator, established within the ICB. They oversee the implementation of the local immunisation plan.
- GPs have been offered a new Incentive scheme, to roll out Immunisation clinics in community settings. This was launched in August 2024.
- In September 2024, SEL ICB have commissioned 2 pharmacies per borough to offer childhood immunisations, including MMR

South East London Integrated Care System

NHS South East London

Performance data

Dementia Diagnosis Rate

SEL context and description of performance

- The 2024/25 priorities and operational planning guidance identifies improving quality of life, effectiveness of treatment, and care for people with dementia by increasing the dementia diagnosis rate to 66.7% by March 2025 as a National NHS objective. Dementia diagnosis rate is defined as the diagnosis rate for people with dementia, expressed as a percentage of the estimated prevalence.
- South east London is achieving this target. October 2024 performance was 70.1%
- There is, though, variation between boroughs. Greenwich has not achieved the target in 2024/25 (or during 2023/24).

		Oct-24						
Metric	**Target**	**Bexley**	**Bromley**	**Greenwich**	**Lambeth**	**Lewisham**	**Southwark**	**SEL**
Dementia diagnosis rate*	**66.7%**	72.0%	70.7%	64.7%	76.4%	65.0%**	70.5%	70.1%
Trend since last report	-	↑	↑	↑	↓	↓	↓	↓

*Nationally reported borough-level dementia diagnosis rates are aggregated based on the postcode of individual GP practices mapped to UTLAs. This does not map exactly to NHS geographies. This means that a single Lambeth practice is included as part of the figures for Southwark, and practices that serve the wider ICB (e.g. SEL Special Allocation Practice) are allocated to an individual borough.

**Reported Lewisham performance has fallen from 69% in September. The new Lewisham Care Home Practice has not been included in the nationally reported data for October, which likely accounts for the reduction in dementia register size.

IAPT/Talking Therapies

SEL context and description of performance

- New metrics to measure performance of NHS Talking Therapies have been introduced for 2024/25. These new targets have been welcomed by services, but they will need to adjust their delivery in line with these. New targets are as follows:
  - Number of patients discharged having received at least 2 treatment appointments in the reporting period, that meet caseness at the start of treatment.
  - Reliable improvement rate for those completing a course of treatment.
  - Reliable recovery rate for those completing a course of treatment and meeting caseness.
- The number of patients having been discharged following at least two treatments has not been met since April 2024. Reliable improvement and reliable recovery targets have been achieved in September 2024, having not been achieved in August.

	Sep-24						
Metric	Bexley - MIND	BHC	Greenwich (Oxleas)	Lambeth (SLaM)	Lewisham (SLaM)	Southwark (SLaM)	SEL
Talking Therapies discharge metric	150	200	355	580	455	300	2005
Trajectory	176	261	321	585	355	406	2119
Trend since last reporting period	↑	↓	↑	↓	↑	↓	↑

		Sep-24						
Metric	Target	Bexley - MIND	BHC	Greenwich (Oxleas)	Lambeth (SLaM)	Lewisham (SLaM)	Southwark (SLaM)	SEL
TT reliable recovery	48%	51.0%	52.0%	48.0%	52.0%	43.0%	51.0%	49.0%
Trend since last report	-	↑	↑	↔	↑	↓	↑	↑

		Sep-24						
Metric	Target	Bexley - MIND	BHC	Greenwich (Oxleas)	Lambeth (SLaM)	Lewisham (SLaM)	Southwark (SLaM)	SEL
TT reliable improvement	67%	72.0%	70.0%	70.0%	71.0%	69.0%	62.0%	69.0%
Trend since last report	-	↑	↑	↑	↑	↑	↑	↑

SMI Physical Health Checks

SEL context and description of performance

- The south east London ICB board has set Improving the uptake of physical health checks for people with SMI as a corporate objective.
- There was a significant increase in the number of AHCs undertaken for people with an SMI over the last 12 months and the SEL operating planning trajectory was achieved at the end of 2023/24. All LCPs significantly improved their position and delivered health checks to over 60% of their registers. Indicative trajectories, aligning with the SEL operational plan, were met by 3 out of 6 LCPs.
- As part of the operational planning process, a trajectory to achieve 70% uptake by the end of 2024/25 has been agreed for south east London.
- SMI physical health checks is also part of the 2024/25 Quality and Outcomes Framework (QOF) with an aim to reduce health inequalities. QOF rewards practices for delivering all six elements of the check.
- Where annual health checks are being completed, quality can vary as can onward referral to other physical health services.

	Q2 - 24/25						
Metric	**Bexley**	**Bromley**	**Greenwich**	**Lambeth**	**Lewisham**	**Southwark**	**SEL**
SMI Healthchecks	52.0%	44.6%	47.5%	49.9%	43.1%	48.6%	47.4%
Trajectory	65.7%	65.7%	65.7%	65.7%	65.7%	65.7%	65.7%
Trend since last report	↓	↓	↓	↓	↓	↓	↓

***NOTE:** The above figures have been calculated based on published LCP performance for Q2: Physical Health Checks for People with Severe Mental Illness - NHS England Digital.

Personal Health Budgets

SEL context and description of performance

- As part of the Long Term Plan, annual borough level targets were submitted for the total number of PHBs to be delivered annually up to the end of 2023/24. The regional team have extended the targets into 2024/25. For SEL the target is to achieve 4,926 by the end of Q4.
- The personal wheelchair budgets offer is in place across SEL and PHBs for mental health service users. This has been introduced through the South London Partnership.
- S117 PHBs have been a 'right to have' since December 2019, but this still needs implementing through SLAM and Oxleas.
- Preventative small PHBs have been introduced, linked to social prescribing in Lewisham for people with low level mental health needs, where an immediate solution or intervention isn't available. The intention is to expand the offer to all PCNs. This is primarily offered through Age UK currently.
- There is ongoing support to LCPs to implement the personalisation agenda and expand their PHB provision. A 'Community of Practice' has been developed to support the workforce to implement personalised care across the ICS. Issues relating to DPIA and data sharing agreements have been resolved.

	Q2 - 2024/25						
Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
PHBs	760	724	362	253	132	271	2519
Trajectory	394	563	488	544	450	431	2869
Trend since last report	↑	↑	↑	↑	↑	↑	↑

NHS Continuing Health Care

SEL context and description of performance

- There are a number of national standards which systems are required to achieve consistently. Where deviating from the standard, there is an expectation that performance will be addressed as a priority. Performance standards are as follows:
  - A national target was previously set to reduce the number of CHC assessments in an acute hospital setting to less than 15%. The aim, however, is that zero assessments should be completed in an acute setting and this is the benchmark that LCP and ICB teams are measured against.
  - Complete assessments of eligibility within 28 days from the date of referral in >80% cases.
  - Reduce the number of outstanding referrals exceeding 12 weeks to Zero
- Recovery trajectories for the 28 day and 12 week metrics have been agreed with NHSE.

		Q2 - 24/25						
Metric	**Target**	**Bexley**	**Bromley**	**Greenwich**	**Lambeth**	**Lewisham**	**Southwark**	**SEL**
NHS CHC assessments in acute	0	0	0	0	0	1	0	1
Trend since last reporting period	-	↔	↔	↑	↔	↓	↔	↓

	Q2 - 24/25						
Metric	**Bexley**	**Bromley**	**Greenwich**	**Lambeth**	**Lewisham**	**Southwark**	**SEL**
CHC - Percentage assessments completed in 28 days	69%	87%	91%	56%	37%	70%	66%
Trajectory	70%	70%	70%	70%	70%	70%	70%
Trend since last reporting period	↓	↓	↓	↓	↓	↓	↓

	Q2 - 24/25						
Metric	**Bexley**	**Bromley**	**Greenwich**	**Lambeth**	**Lewisham**	**Southwark**	**SEL**
CHC - Incomplete referrals over 12 weeks	0	0	0	1	0	0	1
Trajectory	0	0	0	0	0	0	1
Trend since last reporting period	↔	↔	↔	↔	↔	↔	↔

Childhood immunisations (1 of 2)

Description of metric and SEL context

- Vaccination saves lives and protects people's health. It ranks second only to clean water as the most effective public health intervention to prevent disease. Through vaccination, diseases that were previously common are now rare, and millions of people each year are protected from severe illness and death. South East London and our 6 local care partnerships recognise this in the ICS Strategic Priorities and our Joint Forward Plan.
- South East London ICB has recently refreshed its Vaccination and Immunisation Strategy and has embedded within the six boroughs an approach to increase uptake by developing trust and confidence in the childhood immunisation programme with local communities.
- Since December 2023 there have been a number of reported cases of measles across the country resulting in a national and regional response. SEL boroughs and programme team are co-ordinating and aligning plans across the system in response to the concerns. A full report detailing the position and proposed actions was agreed at the ICB Executive Committee in February 2024. Actions include: SRO/director level attendance at the weekly London IMT meeting; production of a weekly sitrep feeding up to London IMT; A sub-group of the SEL board is meeting on a weekly basis with borough leads, public health, communications and primary care leads to co-ordinate the local response and to support local plans. Each borough has produced a local action plan and are using their local place level vaccination groups to support delivery.
- Borough plans are also in place in response to the rise in numbers of whooping cough numbers and the imperative to focus on the full range of childhood immunisations including pertussis.
- The 24/25 operational planning guidance identifies the following as a key action for systems: maximise uptake of childhood vaccinations and flu vaccinations for CYP, achieving the national KPIs in the Section 7a public health functions agreement, including reducing inequalities.
- The performance indicators have an efficiency standard of 90% and an optimal performance standard of 95% for childhood immunisations. Based on current performance for south east London (and London more widely), the 90% efficiency standard is used as the comparator for RAG ratings in the 2024/25 LCP performance below. This is a change in approach compared to previous year (which used the national average as comparator)

		Q1 - 24/25								
Metric	Efficiency standard	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL	London	England
Children receiving MMR1 at 24 months	90%	87.2%	89.1%	86.5%	79.9%	85.1%	83.2%	85.2%	82.1%	89.2%
Trend since last reporting period	-	↑	↑	↑	↓	↑	↓	↑	↑	↑

		Q1 - 24/25								
Metric	Efficiency standard	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL	London	England
Children receiving MMR1 at 5 years	90%	88.9%	89.2%	85.5%	83.6%	85.0%	86.7%	86.4%	84.2%	91.7%
Trend since last reporting period	-	↓	↓	↓	↓	↓	↓	↓	↓	↓

		Q1 - 24/25								
Metric	Efficiency standard	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL	London	England
Children receiving MMR2 at 5 years	90%	77.5%	83.4%	75.6%	75.8%	78.3%	79.7%	78.4%	71.8%	83.6%
Trend since last reporting period	-	↓	↓	↓	↓	↓	↓	↓	↓	↓

Childhood immunisations (2 of 2)

Metric	Efficiency standard	Q1 - 24/25 Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL	London	England
Children receiving DTaP/IPV/Hib % at 12 months	90%	89.5%	91.0%	91.2%	86.5%	86.8%	87.1%	88.6%	85.8%	91.0%
Trend since last report	-	↓	↑	↑	↓	↓	↑	↑	↔	↓

Metric	Efficiency standard	Q1 - 24/25 Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL	London	England
Children receiving DTaP/IPV/Hib % at 24 months	90%	90.7%	92.4%	90.0%	86.3%	87.5%	88.1%	89.1%	87.7%	92.5%
Trend since last report	-	↑	↑	↑	↓	↓	↑	↓	↑	↔

Metric	Efficiency standard	Q1 - 24/25 Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL	London	England
Children receiving pre-school booster (DTaPIPV%) % at 5 years	90%	76.4%	80.4%	72.5%	73.1%	72.9%	71.9%	74.6%	68.5%	81.8%
Trend since last report	-	↓	↓	↓	↓	↓	↓	↓	↓	↓

Metric	Efficiency standard	Q1 - 24/25 Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL	London	England
Children receiving DTaP/IPV/Hib % at 5 years	90%	86.6%	90.4%	88.6%	87.7%	85.9%	85.5%	87.6%	86.7%	92.8%
Trend since last report	-	↓	↓	↑	↓	↓	↓	↓	↓	↓

Learning disabilities and autism – annual health checks

SEL context and description of performance

- The south east London ICB board has set improving the uptake of physical healthchecks for people with LDA as a corporate objective.
- SEL achieved the 2023/24 plan with 7,104 health checks delivered against a plan of 6,018. The SEL plan for 2024/25 is to deliver a minimum of 6,600 health checks.
- All LCPs are currently delivering against the 2024/25 trajectory
- Where annual health checks are being completed, quality can vary as can onward referral to other physical health services.
- The AHC Strategic group is being reshaped to have a greater focus on boroughs sharing their learning and knowledge from their areas.

	Sep-24						
Metric	**Bexley**	**Bromley**	**Greenwich**	**Lambeth**	**Lewisham**	**Southwark**	**SEL**
LD and Autism - Annual health checks	381	367	525	655	625	510	3063
Trajectory	316	325	424	437	512	332	2258

Cancer screening

South East London Integrated Care System

NHS South East London

SEL context and description of performance

- The south east London ICB board has set improving breast, bowel and cervical screening a corporate objective. At an SEL level, bowel cancer screening coverage is currently above the nationally defined optimal level of screening of 60% for south east London. Cervical cancer screening is currently below the nationally defined optimal level of screening of 80%. Breast cancer screening is currently below the nationally defined optimal level of screening of 70-80%.
- For 2023/24, SEL set overall ambitions for improving breast, bowel and cervical screening a corporate objective. Indicative LCP level targets have now been developed for 2024/25 and shared via the six Place Executive Leads (PELs). These are based on a standard proportional reduction in the unscreened population at an LCP level for each cancer cohort. 2024/25 performance will be reported against these trajectories.
- This means that there is an expectation that all LCPs will improve uptake in 2024/25 but those with a lower current uptake will have a slightly larger stretch for the year. Thus, supporting a reduction in inequality between boroughs.
- Cervical cancer coverage is now being reported against the new 2024/25 LCP level indicative trajectories. The most recently available bowel and breast cancer screening coverage data is for March 2024 so continues to be reported against the overall SEL ambition for 2023/24.
- Screening is directly commissioned by NHS England, and delivery is through regional teams. Changes to programme, workforce, capacity etc. require NHS England to action. Given this, we rely on a joint approach with other London ICBs on common issues within these areas and advocate for regional solutions such as addressing workforce and capacity challenges within programmes, improving processes and operational pressures, and coordinating potential mutual between screening providers. Local actions for SEL require focus on improvements within the current programme structure/resource.

		Mar-24						
Metric	SEL ambition	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Bowel Cancer Coverage (60-74)	67.3%	72.8%	74.9%	64.9%	61.3%	63.2%	61.4%	66.8%
Trend since last reporting period	-	↑	↑	↑	↓	↑	↓	↑

	Apr-24						
Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Cervical Cancer Coverage (25-64 combined)	71.7%	74.0%	66.0%	63.0%	67.7%	63.9%	67.1%
Trajectory	71.9%	74.2%	66.0%	63.0%	67.8%	64.1%	67.2%
Trend since last reporting period	↑	↑	↑	↔	↑	↑	↑

		Mar-24						
Metric	SEL ambition	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Breast Cancer Coverage (50-70)	56.7%	69.8%	71.5%	57.4%	55.7%	57.0%	57.0%	61.6%
Trend since last reporting period	-	↓	↓	↑	↑	↑	↑	↑

NOTE: Due to lag in national reporting, local data from the SEL BI cancer screening dashboard is shown. This uses the same Open Exeter data source

Management of hypertension to NICE guidance

SEL context and description of performance

- The south east London ICB board has set improving the percentage of patients with hypertension treated to NICE guidance as a corporate objective. The board agreed a 'floor' level ambition of 69.7% as a minimum by March 2024 with the intention to achieve 77% (2023/24 operational plan target) as soon as possible.
- The SEL 'floor' level ambition for 2023/24 was achieved overall and by five of six LCPs individually. Significant improvement was achieved across all LCPs.
- The 2024/25 priorities and operational planning guidance identifies increasing the percentage of patients with hypertension treated to NICE guidance to 80% by March 2025 as a national objective. For 2024/25, this will remain the primary aspirational goal for SEL. SEL will also pursue a 'minimum achievement' target (which will serve as the revised SEL ICB corporate objective) to achieve 80% over a 2 year time period (i.e. by end March 2026). This approach has been agreed by the PELs.
- 2024/25 performance will be reported against straight line trajectories for each LCP to achieve the 80% target by March 2026.
- There is a significant time lag (of approximately 4 months) in the publishing of national reporting (CVD PREVENT) of this metric. To support local monitoring of performance, the SEL LTC team have used the local data as the basis for trajectories up to March 2026.
- Hypertension is predominantly managed in general practice and there is wide variation in achievement across practices, not always explained by demography. People at risk may not have sufficient support to understand the importance of detecting and managing raised blood pressure.

		Final 2023/24 position (National CVD PREVENT reporting)						
Metric	**SEL ambition**	**Bexley**	**Bromley**	**Greenwich**	**Lambeth**	**Lewisham**	**Southwark**	**SEL**
% patients with hypertension treated to NICE guidance	69.7%	71.2%	72.7%	70.3%	71.4%	65.5%	72.8%	70.7%
Trend since last report	-	↑	↑	↑	↑	↑	↑	↑

	Oct-24 (Local data reporting)						
Metric	**Bexley**	**Bromley**	**Greenwich**	**Lambeth**	**Lewisham**	**Southwark**	**SEL**
Percentage of patients with hypertension treated to NICE guidance	61.3%	64.5%	65.2%	64.4%	60.5%	64.7%	63.5%
Trajectory	66.9%	69.1%	68.7%	68.6%	64.5%	68.2%	67.7%
Trend since last report	↓	↓	↑	↓	↑	↑	↑

Adult flu immunisation (1 of 2)

SEL context and description of performance

- The south east London ICB board set improving adult flu vaccination rates as a corporate objective. The ambitions for 2023/24 was as follows: improve the vaccination rate of people aged over 65 to 73.7%, improve the vaccination rate for people under 65 at risk to 46.0%.
- Performance in 2023/24 (year 1) was significantly below ambition for both metrics and represented a decrease in performance from the previous year.
- In order to ensure that 24/25 ambitions are informed by place, their knowledge of and insights into their local population, their role in commissioning services and their strategic plans for delivery, each borough team have set their own ambitions to improve uptake for the two main adult flu cohorts for the upcoming flu season.
- The below table provides targets set at borough level
- The following slides provides the published October borough level performance and the preliminary November borough level performance vs trajectory

Year end targets for 2024/25 proposed by borough teams:

	65+ cohort vaccination target for 2024/25 season	<65 at risk cohort vaccination target for 2024/25 season
Bexley	75.0%	42.0%
Bromley	76.2%	46.5%
Greenwich	66.4%	36.9%
Lambeth	60.0%	32.9%
Lewisham	61.0%	34.3%
Southwark	61.5%	34.2%
SEL	68.1%	37.3%

Adult flu immunisation (1 of 2)

Published October Performance

Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Over 65s vaccinated	57.2%	59.3%	49.5%	41.6%	41.6%	41.2%	49.9%
Local October trajectory	50.0%	26.7%	54.5%	48.0%	57.5%	45.0%	44.6%

Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Under 65s at risk vaccinated	24.8%	27.8%	24.5%	20.0%	19.0%	20.4%	22.4%
Local October trajectory	20.0%	16.3%	20.0%	27.0%	30.0%	25.0%	23.5%

Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Children aged 2 and 3 vaccinated	25.1%	39.0%	29.8%	24.8%	26.3%	27.3%	28.9%

Provisional data to 1 December 2024*

Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Over 65s vaccinated	65.4%	68.8%	57.6%	49.3%	48.8%	50.6%	58.3%
Local November trajectory	60.0%	61.0%	63.7%	55.0%	59.0%	55.0%	59.2%

Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Under 65s at risk vaccinated	31.1%	34.7%	31.2%	25.6%	25.5%	27.3%	28.9%
Local November trajectory	30.0%	37.2%	27.8%	29.3%	31.0%	29.0%	30.7%

Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Children aged 2 and 3 vaccinated	32.4%	46.0%	36.0%	32.4%	34.7%	34.7%	32.4%

*Borough level performance has been calculated from non-mandatory automated practice level data uploads. Coverage for all borough is >95% of practices

Primary care access

SEL context and description of performance

- The 2024/25 Priorities and Operational Planning guidance identifies the following as a national objective for 2024/25:
    - Continue to improve the experience of access to primary care, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within 2 weeks and those who contact their practice urgently are assessed the same or next day according to clinical need
- The following trajectories have been agreed at an SEL level as part of the annual planning process:
    - Planned number of general practice appointments.
    - Percentage of patients whose time from booking to appointment was two weeks or less for appointment types not usually booked in advance.
- Appointments totalled 931,440 in October against the operating plan of 834,378. SEL did not achieve the planning trajectory for appointments seen within 2 weeks (89.2% vs 90.0% trajectory).

		Oct-24						
Metric	Planning trajectory	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Appointments seen within 2 weeks	90.0%	89.3%	83.9%	93.9%	91.5%	86.9%	89.9%	89.2%

		Oct-24						
Metric	Planning trajectory	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Appointments in general practice and primary care networks	834,378	133,319	175,796	146,140	194,806	135,290	146,089	931,440
Appointments per 1,000 population	-	511	489	449	431	379	403	440

AGENDA ITEM: 14

Healthier Greenwich Partnership

Date: 22 January 2025

Title	HGP Risks update	
This paper is for **noting**		
Executive Summary	The paper provides update about the latest review of some of the risks on Greenwich risk register. A range of actions are being undertaken to manage and mitigate the various risks.	
Recommended action for the Committee	HGP to note the update.	
Potential Conflicts of Interest	None	
Impacts of this proposal	Key risks & mitigations	None arise directly from the report
	Equality impact	Not required for the direct purposes of the report
	Financial impact	Not Applicable
Wider support for this proposal	Public Engagement	Not required for the direct purposes of the report
	Other Committee Discussion/ Internal Engagement	Not Applicable
Author:	Business Support Lead Greenwich	
Clinical lead:		
Executive sponsor:	Gabi Darby, Chief Executive Officer, Greenwich	

Greenwich Risk
Enterprise Risk

Risk ID	Opened Date	Risk Owner	Risk Sponsor	Risk Title	Risk Description	Initial Likelihood	Initial Consequence	Initial Rating	Controls	Gaps in Control	Current Likelihood	Current Consequence	Current Rating	Assurances	Gaps in Assurance	Target Likelihood	Target Consequence	Target Rating	Reviews Date and Comment	Next Review Due
464	13/7/23	Aideen Silke	Jessica Arnold	Risk to engagement with Greenwich communities.	There is a risk that residents will not engage with the programme and that communities will not see that they have a valuable role in this. There is a risk that there is insufficient capacity in the system to allow effective integrated teams to be developed at individual neighbourhood level. There is a risk of disconnect between patient report outcomes and community based outcomes. The impact on the HGP is potentially significant if it is not possible to achieve this priority which is also part of the Our Greenwich focus.	3	3	9	Developing appropriate communication plan that would address need of residents, ensure they feel listened to, and target the different parts of the community. This is partly included in the 100-day challenge, but would need a refined approach as part of our Neighbourhood engagement., Ensure there will be appropriate oversight for this work to ensure involvement of residents voice. This work needs to be appropriately resourced. The oversight would be provided through the Health Inclusion Steering Group and Integrated Neighbourhood Working Group., Understand and define patient outcomes that would be focused on, and making sure they are appropriately captured and reviewed. Develop a way of capturing and using appropriate data., Work to be undertaken to understand what services are operating within neighbourhoods and how they are currently working together; determine what needs to change, and what resources are required to enable an integrated neighbourhood based approach.	There are no gaps in controls	2	3	6	HGP Board has oversight of the delivery plan.	No gaps in assurance have been identified at this time.	2	2	4	19/09/2023 - 1. A Social researcher has been nominated for 6 months to work with three neighbourhood areas and to develop a a community engagement approach for Greenwich, including working with community researchers. There will be evaluation of the impact of this approach of community engagement on reducing winter pressures. Some winter funding has been set aside to facilitate this.\nNo change made to current risk rating., 17/01/2024 - The Social researcher has provided an interim report which would form the basis for next stages of the programme. The Healthier Greenwich Partnership (HGP) public forum was held on 15 January 2024 with focus on neighbourhood engagement. Community corners in GP Practices in Blackheath and Charlton PCNs being launched early 2024.Recruitment of Community Connectors planned for early 2024.Leave the risk score as 9., 20/08/2024 - Social research findings are now being applied in practice. One community connector role in place and recruitment for a second connector planned for September 24. \n\nThe community engagement approach is embedded within the connecting Greenwich programme and included in the evaluation. \n\nThe risk has been downgraded to a moderate score of 6.	18/3/25
465	13/7/23	Roneeta Campbell-Butler	Dave Borland	Risk to 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	There is a risk that we don't deliver on all areas of the high impact activity covered within this strand. This is as a result of current commissioning capacity. This has presented significant challenges to drive forward more complex large scale pieces of work. To mitigate against this risk re-prioritisation of other work is being undertaken to support delivery. The impact on HGP would be a higher risk that we don't deliver on all areas within this high impact activity. PLEASE NOTE: This is related to very major strategic projects and risk reviews should happen on six monthly basis.	4	3	12	Temporary utilisation of RBG funded commissioning capacity; alongside use of external capacity to support delivery of Single Point of Access., The establishment of multi-agency task and finish group to take forward the mental health in schools work., Establishment and maintenance of the Children's Mental Health and Wellbeing Partnership Board, Recruitment of partner to develop and implement the Single Point of Access for children's mental health and emotional wellbeing.	There are no gaps in controls	3	3	9	The Healthier Greenwich Partnership Board has oversight of the delivery plan.	No gaps in assurance have been identified at this time.	3	2	6	07/05/2024 - In relation to delivering Thrive, we have undertaken workshops and identified the key priorities with our newly established CYP Mental Health and Emotional Wellbeing Partnership.\n\nI am also engaging with Transformation Partners; who will establish the delivery / implementation plan, which we will again take back to partners for their agreement. \n\nAnother element to the Thrive model is the development of a 'Signs and Symptoms' guide which explains all of our MH provision to professionals, YP, parents and carers. \n\nWe do have a deficit in our team, where by we have roles that have not been recruited to yet; of whom would be responsible for 'operationalising' what I have just discussed above., 02/10/2024 - Meeting took place, risk owner was to go back and check wording with Risk Sponsor as this information goes to the HGP in public. \n\nStill waiting for this wording to come back from Risk owner., 05/11/2024 - iThrive - Principles of iThrive have been incorporated into the Mental Health and Emotional Wellbeing Delivery Plan; which aligns to the deliverables within the SEL Transformation plan and the 'Feel Well' element within the Healthier Greenwich Partnership Plan and deliverables from each respective partner. The delivery of this plan will overseen by the newly established Greenwich CYP Mental Health and Emotional Wellbeing Partnership Board.\n\nSingle Point of Access – The Children's Integrated Commissioning Team are in the process of commissioning a partner to support the development of a Single Point of Access for mental health and emotional wellbeing services. A presentation to endorse the initiative was provided to the Joint Commissioning Board in October. The tender is due to be released in early November. We hope to have a partner in place before the end of the financial year. Delays in this development were due to recruitment delays =to the new integrated commissioning team. \n\nSchools Offer - Greenwich was awarded additional funding to expand the number of Mental Health Support Teams from two to three. This will enable 50% of Greenwich schools to be supported by a team. The new team is currently being recruited and is expected to begin work from January 2025. Building on mapping undertaken earlier in 2024 of mental health and emotional wellbeing provision in Schools, a Greenwich headteacher has been part seconded to work to review provision in Schools and identify potential areas of development. Representation from Schools is also being identified to be part of the newly established Greenwich CYP Mental Health and Emotional Wellbeing Partnership Board.\n\nRisk Score reduced from 12 to 9.	28/1/25
466	13/7/23	Sharne McLean (RBG staff)	Dave Borland	Risk relating to Rollout of the Family Hubs programme including the Start for Life Offer on parenting, parent-infant relationships and perinatal mental health support, home learning environment and infant feeding support.	This work is on track but due to the scale and complexity is categorised as at risk. There is a risk due to the scale that elements of the programme may be delayed. The impact to the HGP would be not achieving the most from the DfE/DHSC funded programme in strengthening our universal and prevention offer. NOTE: This risk relates major projects and review on six monthly basis is preferred.	3	3	9	Establishment of Family Hubs Programme governance, including specific work strand plans and partnership oversight group., There is regular programme reporting to the Department for Education (DfE)/ Department for Health and Social Care (DHSC) ., Recruitment and retention of Family Hub programme delivery roles	There are no gaps in controls	1	2	2	The Healthier Greenwich Partnership Board has oversight of the delivery plan.	No gaps in assurance have been identified at this time.	2	2	4	11/07/2024 - Risk score has lowered to 4. Service is now up and running, mitigations in place where staffing issues. The community grants programmes to support perinatal mental health are all being delivered.	23/1/25
474	16/8/23	Rachel Matheson	Lisa Wilson	Risk to optimising and developing our Home First approaches by expanding virtual wards (including a virtual ward hub) to provide assessment, treatment and care to all patients in the place that they call home.	There is a risk that the Home First (HF), and associated social care allocations, will be insufficient to meet the needs of the programme moving forward. There is also a risk to the awareness of partners and colleagues across the system of the virtual ward provision. These risks are caused by; * The anticipated financial allocations being lower than anticipated for Virtual Wards (VW). * The shift of acute care into the community increasing costs in social care and other areas of primary and community care that do not have additional funding * The lack of a fully established dashboard tracking delivery of HF and VW and understanding impacts, the cause relates to a lack of join up and capacity related to data and performance. * The availability of skilled workforce to deliver the specialist and generalist roles needed in the community. * The lack of a communications strategy to widen awareness of the VW programme across partners and the wider workforce. The impact on the Healthier Greenwich Partnership would be challenges in understanding and demonstrating the impact and benefits of the Home First approach. This could lead to a loss of confidence amongst partners and a negative financial impact in other areas of the system.	3	3	9	Operational board overseeing delivery and meets regularly., The Strategic Board receives escalations from the Operations Board and have decision making functions about workforce and financial resources. Oversee the Home first dashboard.	There are no gaps in controls	3	3	9	The Operations Board oversees delivery of Home First, receives progress reports and escalates any concerns to the Strategic Board.	No gaps in assurance identified.	2	3	6	16/01/2024 - The Home first operational and strategic Boards are embedded. There is a Home First dashboard developed and circulated over the last 8 months for sharing data at both boards. There is also a Greenwich and Bexley (QEH System) Urgent and Emergency Care Board dashboard. This includes data relating Virtual Wards and the Urgent Community Response (UCR).For 2023-24 there was a reduction in Virtual Wards funding against the plan from the original bid. The recurrent funding for 24/25 remains at reduced level, requiring review of virtual wards pathways against funding allocation. The risk of this is that the full number of beds that were originally planned would not be available. There has been challenges for the workforce, especially in recruiting specialist roles. For example, recruiting advanced clinical practitioners to deliver the virtual wards within JET and recruitment of a palliative care consultant within the hospice. The Communications Lead does attend the Home First Strategic Group and a number of resources are in development.The Risk score should remain at 9 due to ongoing challenges regarding funding level below original modelling for virtual wards., 02/05/2024 - The Home First communications strategy is in development. The risk remains the same and all the risk issues are still relevant. The risk rating remains the same too., 07/11/2024 - The Home First Operational board and Strategic board continue to deliver the programmes and the Home First dashboard is circulated on a monthly basis. Virtual ward and UCR data is produced for the UEC board. From December 16th 2024 community providers will also be producing opel scores. A Home First communication strategy has been devised and is now being implemented by a multi provider communications group. Savings schemes have been implemented by all system stakeholders and whilst a small amount of investment was contributed to Virtual wards (£85k), this is ringfenced for standardisation and focused on data collection. Recruitment of staff has improved although specialist roles such as advanced clinical practitioners within JET remain difficult to recruit to. The model in the description of the risk has changed because there will now be a transfer of care hub rather than a virtual ward hub at QEH. All risk ratings remain the same given the lack of additional investment and impact of budget reductions across the system.	28/1/25
494	29/12/23	Deane Kennett	Gabi Darby	Risk to delivery of Greenwich delegated performance targets	There is a risk that Greenwich would not be able to deliver all the performance targets delegated to place during 2024/25. This is caused by a number of the targets not being met, those relating to IAPT access, SMI health checks, children immunisation and cancer screening. The impact on the Healthier Greenwich Partnership (HGP) would be inability to deliver all performance targets in 2024/25.	4	3	12	Oversight is maintained by Joint Commissioning Board (JCB), with monthly reviews of the performance report during JCB monthly meetings.	No gaps	4	3	12	Oversight is maintained by Joint Commissioning Board (JCB), with monthly reviews of the performance report during JCB monthly meetings.	No gaps	3	3	9	23/02/2024 - There is ongoing review of key performance indicators related to place delegated areas, working in partnership with SEL colleagues on provider wide metrics, such as SMI Health checks, ADHD and ASD waits.\nThis risk would need to be reviewed in light of 24/25 plans and trajectories., 11/07/2024 - Risk level remains the same. \n\nWork continues to improve areas of under performance. \n\nReview risk again in 3 months., 16/10/2024 - Review undertaken no changes made, 24/10/2024 - No Changes Made - Risk remains the same. Review in 3 months, 14/01/2025 - Risk reviewed - no change from last period	14/3/25
495	29/12/23	Nick Davies	Lisa Wilson	Risk relating to co-ordination of timely discharge support for residents.	There is a risk that patients who are medically fit for discharge are unable to leave hospital. This can be caused by a combination of: internal hospital processes holding discharge up as well as pressure on community and social care services and a changing demographics of the borough. This could impact negatively on Trust A&E and elective performance as well as the best outcomes for residents.	4	4	16	UEC Board has oversight of winter planning, BCF Planning Group has oversight of BCF which has main targets for discharge and admissions avoidance, including 22/23 Discharge Fund and 23/24 planning. Home First Board has oversight of TOCC review and initiatives that support discharge processes and outcomes., SEL Discharge Solutions and Improvement Group looking for sub regional solutions to common challenges such as data analysis and insight.	Impact of Discharge Activity on social care staffing and budget resources being financially unsustainable and needing a system solution. Short term and short notice nature of winter and discharge funding flows. Specific pressures on system such as industrial action, Covid-19 outbreaks, staff shortages etc.	4	3	12	Joint commissioning Board, UEC Board, SEL Discharge Solutions and Improvement Group rolling out improvement plans for acute and mental health settings. Discharge framework issued across SEL for implementation in borough	Lack of accurate and reliable data insight on delayed transfers of care and demand and capacity planning - this is however under development	3	3	9	23/02/2024 - Reviewed the risk with Chief Operating Officer, noting the risk score should be reduced to 12 as winter is nearly over., 01/03/2024 - There is continued pressure in hospital discharge pathways. There are programmes like QE Cares, the Home First operational group and the TOCC that have focus on ensuring flow. \nThere is a focused set of actions to ensure discharge is optimised called Super March running through March 2024 with all partners contributing., 11/07/2024 - Risk scoring remains the same. \n\nTimely discharge remains a key focus, the TOCC work to ensure scrutiny of any delays and mitigations ongoing. We have the oversight of the FLOW coordinator in place. Work ongoing at Home First oBard to make sure we have the appropriate capacity in services to manage timely discharge. In addition the 7 day social care working model in JET has funding confirmed until March 25., 30/10/2024 - All actions from previous update in July are ongoing. \n\nIn addition there is local work to streamline discharge pathway between the discharge coordination team and HIDT. The Live Well support is proving successful at supporting discharges. There has been a piece of work commissioned from Better Care Fund support team to review discharge data and pathways in preparation for winter.	29/1/25
565	1/4/24	Chris Dance	Gabi Darby	Achievement of Financial Balance 2024/25	During 2023/24 Greenwich delivered in line with the delegated borough budget. However given material and escalating prescribing and continuing care cost pressures, material non recurrent measures were also required to achieve financial balance. These cost pressures are on an upward trend and expected to continue into 2024/25, hence a material risk the borough will not be able to achieve recurrent financial balance in 2024/25.	5	3	15	Monthly budget meetings with budget holders to review expenditure and put in place mitigation plans, Budget holders have been engaged in the budget roll over process and have been aware of the limitations within which we need to work, Sound budgetary control to ensure expenditure trends are monitored, and delivery of QIPP is measured.		3	3	9			3	3	9	12/11/2024 - Risk has been reviewed subject to review of the efficiency saving plans as monthly monitored via SMT *& other forums. This had reflected in a reduced likelihood scoring to reflect the progress to date	3/3/25

569	11/11/24	Jessica Arnold	Gabi Darby	Primary Care GP Collective Action	There is a risk that the BMA recommendation for GP Collective Action results in reduction in primary care access and provision, and pressure on acute sector through some of the actions.		4	4	16	National Sitrep in place and daily local monitoring of impact based on situation., Use local information and understanding of key pressure points to monitor the situation. Continue to engage / contact local practices, PCNs and LMC regularly to maintain communications and provide local support as necessary to minimise patient impact. Work to improve the primary-secondary interface	Negotiations at a national level will be required to resolve issue. System plans with Trusts. Dependent on actions selected, workarounds to minimise patient impact.	3	3	9	Return to National Sitrep reporting, Borough-led communications and engagement with local practices.	Practices are not obliged to notify ICBs of any action they are taking, provided contracts are not breached. Reliance on soft intelligence gathering.	3	2	6					21/1/25

Conditional Format List

Cell	Initial Rating Between 1 And 3
Cell	Initial Rating Between 4 And 6
Cell	Initial Rating Between 8 And 12
Cell	Initial Rating Between 15 And 25
Cell	Current Rating Between 1 And 3
Cell	Current Rating Between 4 And 6
Cell	Current Rating Between 8 And 12
Cell	Current Rating Between 15 And 25
Cell	Target Rating Between 1 And 3
Cell	Target Rating Between 4 And 6
Cell	Target Rating Between 8 And 12
Cell	Target Rating Between 15 And 25

Forward Planner Greenwich Meetings	Jan-25			Feb-25		Mar-25	
HGP - Healther Greenwich Partnership	in Public	22 January 2025		26-Feb-25	Private	26-Mar	Workshop
	provisionally booked Town Hall rooms 4 & 5	Papers due 14/01 COP		Papers due 14/02 COP			
Chair - Iain Dimond **Business Support -** Julie Mann **Standard Agenda Items** -Welcome -Introductions and apologies -Declarations of interest -Minutes of previous meetings -Action Log -HGP Partner's Report.- Quarterly at public meeting -HGP sub-committee report - **Public Meeting** - HGP Development - **Private Meeting**		Board Meeting in public **(hubrid)** **Main Business /Themed Item** - sub committee assurance report - risk register for noting - quarterly partners report - ATEC - presentation or report (TBC - Lisa Wilson/Rethink) - moved to February - MSK update		Board meeing in private - HGP development - refresh- PPL (Imogen/Kate) - ATEC - presentation or report (TBC - Lisa Wilson/Rethink) - Feel Well (mental health) (Debora Mo)		Plans for 25/26	
Future Agenda items - not linked to specific meeting - Public Health Commissioning - Steve Whiteman - Primary and Secondary Interface - Jessica Arnold - Collaborative updates (acute, mental health,community) - Kate Heaps to update on discussions with Home First - Jessica Arnold to provide updated plans on neighbourhood based care - Winter planning feedback - Erica Bond							