# Greenwich Local Care Partnership (1/7)

South East London Integrated Care System

## Vision

To improve lifelong outcomes for Greenwich residents by reducing risks and strengthening protective factors, with a focus on neighbourhood-level delivery.

## Deliverables / Improvements since 2023/24

**Start Well**
- **Local Care Plan** consolidates key priorities in one document.
- Enhancing **ADHD and autism pathways** in line with SEL and NICE guidelines.
- Strengthened **parenting and infant feeding support**, with improved breastfeeding recording.

**Be Well**
- Increased **number of play streets**.
- Expanded **interventions for food insecurity support**.

**Feel Well**
- CYP: Mental health teams now in **50% of schools.**
- Adults: Training staff to prevent unnecessary **restrictive admissions**, ensuring the right intervention at the right time.
- Addiction: Fully implemented **drug and alcohol treatment funding.**

**Stay Well**
- **UTC run by the GP Federation**, enabling feedback for primary care improvements.
- **Connecting Greenwich** provides a strong neighbourhood framework at the practice level.
- **Cancer screening improvements** underway.

**Age Well**
- **Virtual wards** continue to improve.
- Advancing the **transfer of care hub** to support UEC.

## Key Challenges / Opportunities Remaining

**Start Well**
- Developing **shared ownership** across the system instead of placing all accountability on one service.
- Reducing **waiting times for Autism and ADHD assessments**.
- Shifting to a **needs-led approach** for neurodiversity rather than relying solely on diagnosis.
- Strengthening **partnerships with primary care**, including data sharing.

**Be Well**
- Assessing the impact of **neighbourhood food environments** on health and developing an action plan.
- Addressing the **gap in the team** to progress the physical activity pathway.

**Feel Well**
- CYP: Further reducing **waiting times for specialist mental health and wellbeing services** and evaluating the impact of the Integrated Clinical Team.
- Adults: Addressing **misconceptions about ED settings**, ensuring residents access the right support.
- Addiction: Embedding **Very Brief Advice (VBA)** into all pathways and practitioner contracts.

**Stay Well**
- Improving **front-door intelligence**, understanding practice-level patient presentations.

**Age Well**
- Enhancing understanding of **intermediate care services**, ensuring they meet demand and capacity needs.
- Developing the **transfer of care hub**, with live dashboards and clear role awareness.

# Greenwich Local Care Partnership (2/7)

| | What are our priority areas for 2025/26 | Why has this been identified as a priority areas? |
|---|---|---|
| 1 | Start Well: Ensuring Children & Young People get the best start in life and can reach their full potential | Our priorities span a resident's life course. Working together on our shared priority areas will produce better outcomes for Greenwich residents throughout their life. Adopting the life course approach means identifying key opportunities for minimising risk factors and enhancing protective factors through evidence-based interventions at key life stages, from preconception to early years and adolescence, working age, and into older age.<br><br>Whilst these priorities remain the same as in previous years, they support delivery of our Health & Wellbeing Strategy 2023-2028 and the HGP executive see these areas as pertinent to improving lives for people in Greenwich. |
| 2 | Be Well: Everyone is more active and can access nutritious food | |
| 3 | Feel Well: Effective integrated neighbourhood community teams provide the right support when & where needed | |
| 4 | Stay Well : Fewer residents are affected by poor mental health | |
| 5 | Age Well: Health and Care Services support people and their carers to live fulfilling and independent lives | |

# Greenwich Local Care Partnership (3/7)

South East London Integrated Care System

| Priority Area: | Priority Area: |
| --- | --- |
| Start Well: Ensuring Children & Young People get the best start in life and can reach their full potential | Be Well: Everyone is more active and can access nutritious food |
| **What are the actions we will deliver in 2025/26** | **What are the actions we will deliver in 2025/26** |
| • Review existing universal provision for opportunities for improvement and continually responding to changing need<br>• Develop and improve the accessibility of the Family Information Directory and Local Offer and engage with key stakeholders and service users within the community to improve understanding of the local support offer.<br>• Improving the core offer with service users knowing where to go for what and developing a whole system approach to supporting ASD and ADHD. | • Revise and implement the Royal Greenwich Get Active Strategy, prioritising physical activity inequalities and community-level solutions.<br>• Enhance the food environment at neighbourhood, high street, and organisational levels through integrated commissioning. |
| **Population Health and Inequalities Impact** | **Population Health and Inequalities Impact** |
| Ensuring early identification and intervention for developmental needs, improving access to information and support for families, and enhancing the quality and timeliness of services, particularly for ASD and ADHD, which disproportionately affect underserved groups. | Promoting equitable access to physical activity and nutritious food, targeting disparities at the community level, and creating healthier environments through strategic, integrated approaches. |
| **System Sustainability Impact** | **System Sustainability Impact** |
| Enhancing early intervention, streamlining access to services, and reducing long-term demand on resources through quicker diagnoses and effective support, ultimately improving outcomes and preventing future challenges in service delivery. | Addressing the root causes of health inequalities, promoting healthier lifestyles through physical activity and improved food environments, and reducing future healthcare demand by fostering long-term community well-being. |

# Greenwich Local Care Partnership (4/7)

South East London Integrated Care System

| Priority Area: |
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| Age Well: Health and Care Services support people and their carers to live fulfilling and independent lives |

| What are the actions we will deliver in 2025/26 |
| --- |
| • To ensure we provide preventive, proactive care which prevents or delays needs escalating, identify the core focuses and approach to begin testing the neighbourhood model of care including integrated teams.<br>• Increased use of Assistive Technology Enabled Care where it is embedded in to how people receive care and support.<br>• Deliver the home first communication strategy and staff training.<br>• Procurement of carer trusted assessor service alongside identification of carers |

| Population Health and Inequalities Impact |
| --- |
| Fostering preventive, proactive care through neighbourhood models and integrated teams, promoting early intervention. Expanding the use of Assistive Technology ensures accessible, personalised care, while the "Home First" strategy and staff training empower individuals to remain in their homes longer with appropriate support. |

| System Sustainability Impact |
| --- |
| Focusing on prevention and early intervention, which helps reduce future care costs and service demand. The use of Assistive Technology and the "Home First" strategy ensures that care is delivered efficiently in the most suitable settings, while integrated teams enhance coordination and resource use, leading to long-term system resilience. |

| Priority Area: |
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| Stay Well: Fewer residents are affected by poor mental health |

| What are the actions we will deliver in 2025/26 |
| --- |
| • Rollout Making Every Opportunity Count (MEOC) across the Partnership.<br>• Connect neighbourhood development work to existing service footprints.<br>• Rollout newly developed Social Prescribing and Live Well integrated model.<br>• Develop neighbourhood working in End of life & frailty pathways (case finding, action planning).<br>• Start where we can with data that is already accessible. |

| Population Health and Inequalities Impact |
| --- |
| Integrating holistic, community-focused approaches like MEOC and Social Prescribing to address individual and systemic needs. Connecting neighbourhood development to service footprints and enhancing end-of-life and frailty pathways ensure coordinated, accessible care, while leveraging existing data enables targeted, impactful interventions. |

| System Sustainability Impact |
| --- |
| Promoting integrated, community-based care models that improve efficiency and reduce duplication of services. By connecting neighbourhood development with existing service structures, enhancing social prescribing, and focusing on proactive care for end-of-life and frailty pathways, they ensure resources are used effectively and that care is tailored to local needs, ultimately reducing long-term strain on the system. |

# Greenwich Local Care Partnership (5/7)

South East London Integrated Care System

## Priority Area:

Feel Well: Effective integrated neighbourhood community teams provide the right support when & where needed

## What are the actions we will deliver in 2025/26

**CYP**

- Appoint Single Point of Access Partner / develop SPA for MH & EWB.
- Develop a coordinated and enhanced MH offer for schools
- Develop a shared understanding of Thrive, a needs led approach across the system for MHEWB
- Develop Waiting Well initiatives and run focus groups with staff, CYP and families and reduce waiting time delays.

**Adults**

- Conduct a mental health and LD needs analysis
- Re-promote LIVE WELL, MH Hubs, BE WELL, and broader support services
- Develop resources and communications ensuring staff can effectively signpost

**Addiction**

- Develop a plan for embedding Very Brief Advice (VBA)
- Comms about the new strategy and the less well-developed gambling aspects of the strategy.

## Population Health and Inequalities Impact

Improving access to mental health services for children, young people, and adults through coordinated, inclusive initiatives like the Single Point of Access and school-based mental health programs. They address gaps in care with "Waiting Well" initiatives, empower staff to provide effective signposting, and promote prevention through addiction-focused interventions such as Very Brief Advice. Enhanced communications and strategies ensure underserved groups receive tailored support, including addressing emerging issues like gambling.

## System Sustainability Impact

Creating more efficient and coordinated mental health services across age groups, improving early intervention, and reducing long-term service demand. By enhancing access to mental health resources, supporting staff with effective signposting, and addressing emerging issues like addiction and gambling, they contribute to a more resilient, responsive system that can better meet ongoing and future needs.

# Greenwich Local Care Partnership (6/7)

South East London Integrated Care System

| Priority Area | What are the outcomes we are aiming to achieve? | How are we measuring our impact? |
|---|---|---|
| Start Well | • Families, children, and young people actively shape services, improving outcomes through universal and targeted support.<br>• Communities and services work together to enhance awareness and access to resources, ensuring timely and appropriate support.<br>• Beyond Diagnosis for ASD & ADHD: A needs-led, holistic approach delivers comprehensive care and support across the pathway for children and young people. | • Reach of information to intended communities<br>• Diagnosis waiting times |
| Be Well | • Higher physical activity levels for children and adults, improving health, air quality, community safety, and reducing social isolation.<br>• Reduced inactivity levels, resulting in fewer long-term conditions and more effective treatment for those at higher risk..<br>• Consistent access to evidence-based food advice, with effective referrals and signposting to healthy eating services.<br>• Greater access to safe, affordable, and culturally appropriate healthier food at the local level. | • Activity levels |
| Feel Well | • Design a Single Point of Access for children's mental health and wellbeing designed for implementation.<br>• Better system-wide understanding of available children's mental health and wellbeing support.<br>• Enhanced experience for children awaiting specialist mental health care, with reduced delays and more preventative, holistic interventions.<br>• Increased access to drug, alcohol, and tobacco treatment services, reducing harm to individuals, families, and communities.<br>• Widespread adoption of the Addictions & Harms Strategy, with a focus on communicating new gambling-related recommendations.<br>• Quicker progression to independence, reducing the average length of service engagement.<br>• Lower mental health escalations by addressing root causes like debt, housing, unemployment, and social isolation.<br>• Improved self-management skills for people with mental health needs and learning disabilities.<br>• Clear service expectations for residents, ensuring timely access to appropriate support and an improved experience.<br>• Promote the uptake of physical health checks for residents with serious mental illness (SMI) and learning disabilities | • Drug and alcohol treatment sign-ups<br>• Community interventions for mental health support |
| Stay Well | • Integrated public sector services address social determinants of health, reducing disparities and improving outcomes for vulnerable populations.<br>• Higher referral and participation rates in frailty, end-of-life care, and long-term condition pathways.<br>• Effective Population Health Management, with all practices using HealtheIntent to drive data-informed strategies and interventions. | • Vaccination rates<br>• Long-term conditions (LTCs) diagnoses |
| Age Well | • Neighbourhood home care model embedded, enhancing localised, personalised care with integrated health and care teams.<br>• Digitally enabled workforce, equipped with high-quality technology and confident in using digital solutions to support sustainable care services.<br>• Strengthened Home First approach, embedding relationship-based services, seven-day working, and virtual wards.<br>• Carers acknowledge progress in completing actions outlined in the Joint Carers Strategy. | • Reablement rates<br>• High-intensity care pathway activity |

# Greenwich Local Care Partnership (7/7)

South East London Integrated Care System

## What do we need from enablers and partners to deliver?

- Digital: Good data underpinning Population Health Management approaches across the system using tools such as Cerner – HealtheIntent, EMIS and other national and local datasets
- Estates: Utilisation of the 'One Public Estate' and other opportunities, especially within areas of growth, to ensure residents have access to app
- Workforce: A clinical model of care which transcends the traditional boundaries of primary and secondary care to allow more patients to be cared for at home by appropriately skilled clinicians
- Finance: Shared system view on shifting resources to prevention and community

## How will we work in collaboration with our system?

- To prioritise efforts, the HGP Board reviewed all proposed HIAs and voted on those most suited for a partnership-driven approach. These selected activities are organised within each key "Well" area and will form the basis for discussions at HGP executive meetings, where progress will be reviewed, and challenges unblocked.
- The plan leverages the strength of the partnership's collaborative approach, aiming to enhance the effectiveness of identified activities by providing targeted support and addressing challenges as they arise.
- It is important to note that while some HIAs were not prioritised for partnership escalation, this does not diminish their importance. These activities remain critical and will require significant time and effort from delivery leads, though they are expected to involve fewer partners.
- Delivery leads may request ad hoc support for specific HIAs not originally identified for a partnership approach, reflecting the flexible and collaborative ethos of the HGP.

## How will we engage with our population?

- Two public forums have been held with the public in January 2025 to test priorities with local people and agree on how best to deliver these priorities with communities
- Residents will be kept up to date with progress of the LCP through the Healthier Greenwich Board in Public

Further ongoing engagement to be agreed.

## How will we monitor and share progress?

- Progress of the detailed plan will be monitored through various boards that span the different 'Well' areas (governance map has been developed previously)
- Progress of activities prioritised for having a partnership approach to delivery will be monitored at the HGP Executive and will form a standing agenda item
- Progress will be shared via the HGP board in Public, Greenwich Staff Briefings and Public Forums.

Further mechanisms to share progress to be discussed and agreed.