Healthier Greenwich Partnership in Public

Date: Wednesday 28 September
Time: 13.00 – 15.00
Venue: Novotel Greenwich, 173-185 Greenwich High Rd, London SE10 8JA
Virtual link: Click here to join the meeting
Chair: Nayan Patel

AGENDA

	Item	Page no.	Presented by	Time
Public section – questions from members of the public & feedback from the public forum held on 21 September – 20 mins				
Opening Business				
1.	Welcome, introductions and apologies	Oral	Chair	13.20
2.	Declarations of interest	Oral	Chair	
3.	Minutes of the meeting held 20 July 2022 & 7 September	3-9 10-12	Chair / Neil Kennett-Brown	
4.	Action Log and Matters Arising	13-14	Chair	
Items for Discussion				
5.	ICS Update	-	Andrew Bland	13.25
6.	Mental Health Update: • Primary update • Mental Health elements of the delivery plan • Draft CYP Transformation Plan	15-65 66-69 70-71	Lisa Wilson / Iain Dimond	13.45
7.	Winter Planning	72-88	Gemma O'Neil	14.05
Items for Decision				
8.	Refresh of the Health and Wellbeing Strategy	89-137	Steve Whiteman	14.20
9.	Eltham Update	138-158	Neil Kennett-Brown / Russell Cartwright	14.35

For information				
10.	LCP ICB Delegation MoU	159-172	Sarah McClinton	-
11.	“Collaborate” SEL Programme	173	Sarah McClinton	-
12.	Forward Planner	174-176	Alex Harris	-
Closing Administration				
14.	Any Other Business	Oral	Chair	14.50
15.	Next Meeting: 26 October 2022	Oral	Chair	
Meeting closes at 15:00				

Healthier Greenwich Partnership
Minutes of the meeting held on Wednesday 20 July 2022, 13:00 – 15:00

Members	
Nayan Patel	Healthier Greenwich Partnership Chair & PCN Clinical Director
Atul Sharma	PCN Clinical Director, Greenwich
David James	CEO, Greenwich Health Ltd.
Florence Kroll	Director of Children's Services, Royal Borough of Greenwich
Iain Dimond	COO, Oxleas NHS Foundation Trust
Joy Beishon	CEO, Greenwich Healthwatch
Lisa Wilson	Integrated Commissioning Director, Royal Borough of Greenwich
Maria Howdon	Assistant Director of Primary Care (Greenwich), SEL ICS
Naomi Goldberg	Director of Strategy, METRO GAVS
Neil Kennett-Brown	Place Based Director, Greenwich, SEL ICS
Nick Davies	Deputy Director Health and Adult Services, Royal Borough of Greenwich
Robert Shaw	Director of System Development – Greenwich, SEL ICS
Sandra Iskander	Deputy Director of Strategy, Lewisham & Greenwich NHS Trust
Sarah McClinton	Executive Place Lead, Greenwich
Tuan Tran	Local Medical Committee Chair, Greenwich

In Attendance	
Alex Harris	Governance Lead (Greenwich), SEL ICS
Andrew Scriven	Head of Business Strategy & Performance, Royal Borough of Greenwich
Claire Kennedy	Co-Founder and Managing Partner, PPL
Joanne Hare	System Development Project Manager, SEL ICS
Robert Goodwin	Primary Care and Public Health Development Manager, Royal Borough of Greenwich
Russell Cartwright	Head of Communications & Engagement – Greenwich, SEL ICS
Sarah Burchill	Director Adult Health Services Bexley Care at Oxleas NHS Foundation Trust
Victoria Stanway	Senior Consultant, PPL

Apologies

Ify Okocha	Chief Executive, Oxleas NHS Foundation Trust
Jackie Davidson	Integrated Commissioning Director (Prevention, Primary Care, Population Health), Royal Borough of Greenwich & SEL ICS
Lisa Thompson	Director of Children & Young People's Services, Oxleas NHS Foundation Trust
Steve Whiteman	Director of Public Health, Royal Borough of Greenwich

1.	**Introduction**
1.1	**Introductions and Apologies for Absence**
1.1	The Chair welcomed the attendees. Apologies were noted as above.

1.2	The Chair canvassed opinion on holding a Healthier Greenwich Partnership away day, provisionally on 29 September 2022.
2.	**Declarations of Interest**
2.1	Attendees were asked to declare any new or existing interests in the context of agenda items.
2.2	The Chair noted that an email had been sent around last week, asking HGP members to update their declarations of interest. Members were asked to contact Alex Harris if they had any questions about how to complete their declarations.
2.3	Neil Kennett-Brown noted that Primary Care clinicians were conflicted on Item 8 in relation to PC Enhanced Access.
3.	**Minutes of the previous meeting**
3.1	The minutes of the previous meeting were approved as an accurate record of the proceedings.
4.	**Action Log & Matters Arising**
4.1	There were no open actions on the log.
4.2	Neil Kennett-Brown provided an update on the Eltham Community Hospital. He noted that we were looking at consolidating intermediate care, and we would be circulating an engagement document on this item next week.
4.3	Robert Shaw provided an update on the community diagnostic centres. He noted that the proposal was currently making positive progress. We would have additional CT, MRI, X-Ray, ultrasound, ECHQ and phlebotomy in place at the Eltham hospital. We were looking to secure slightly over £9m for a four-year run rate. A formal business case was also currently in progress. Naomi Goldberg noted that the site was difficult to access for some in the borough. Robert Shaw responded that accessibility had been considered but this could be given more development in the second phase of work.
Items for Decision	
5.	**Bids and Prioritisation: Inequalities Group**
5.1	The item was introduced by Neil Kennett-Brown and Robert Goodwin. Neil Kennett-Brown noted that the steering group had been set up and had met a total of four times. He noted that whilst we had not received the whole funding we asked for, we expected we would still be able to deliver on our priorities.
5.2	We also had access to the population health management tool (Healthy Intent) which LGT had developed. This had been rolled out to us for a relatively small amount of money in comparison to the cost of initial development of the tool.
5.3	Neil Kennett-Brown also noted that we would be further developing the terms of reference for the Health Inequalities Oversight and Governance Group, and these would be brought back to HGP. ➢ **ToR for the Health Inequalities, Oversight and Governance Group to be added to HGP forward planner. Action for Jackie Davidson & Robert Goodwin.** ➢ **Sandra Iskander noted that she would be happy to arrange a demonstration of the Healthy Intent for anybody who was interested.**
5.4	Florence Kroll noted that there were many inequalities which intersected with each other and we

	needed to make sure we didn't apply our approach too broadly. Neil Kennett-Brown agreed, and noted that part of the work we were doing was to define what inequalities existed in Greenwich and how we tackled them.
5.5	Neil Kennett-Brown noted that the workforce group would look at how population health approaches impacted on our workforce, and was time-limited for this reason.
5.6	Naomi Goldberg added that we had received three years' funding to establish a hub to support representation and voice, in order to better engage local communities and the VCS. **Resolved**
5.7	The Healthier Greenwich Partnership: • Agreed to progress the Tackling Health Inequalities submission recommendations from the Task and Finish Group. • Agreed to the de-establishment of the Healthier Greenwich Partnership Health Inequalities Task and Finish Group. • Agreed to the establishment of a Health Inequalities Oversight and Governance Group which will report to Healthier Greenwich Partnership. • Agreed to the Oversight and Governance Group establishment of three subgroups, namely, Data Subgroup, Community Infrastructure and Assets Subgroup and a (time limited) Work-force Development Subgroup.
6.	**SEL ICS Strategy**
6.1	Neil Kennett-Brown introduced the item. The SEL ICS had developed a strategy which was a national requirement of all 42 ICS in the county. He noted that the chief question for the HGP was what this work meant for Greenwich and how we would create our own narrative. This would also further encompass working with the Health and Wellbeing Board, and developing our Health and Wellbeing Strategy and Joint Strategic Needs Assessment. Our system plan would need to be in place by the end of March next year. **Resolved**
6.2	The Healthier Greenwich Partnership noted the report.
7.	**Primary Care Enhanced Access**
7.1	Maria Howdon introduced the item, noting that the main difference between this and the NHS England offer was that London had for some time had a 7-day offer. We needed to give further consideration to the extent to which we offered a service (if any) on Sundays and bank holidays.
7.2	Joy Beishon asked what the impact would be on service users, and further asked what engagement has been taking place. Maria Howdon responded that the current specification did not make Sunday opening a requirement, nor did it require bank holiday opening. At the moment, the majority of access provided were GP and nurse appointments. All PCNs were currently on the same page with regard to what we offered in order to access the totality of the population. Joy Beishon asked if there was potential for there being a postcode lottery, as it could be luck-based as to whether patients were served by practises with more resources. Maria Howdon responded that currently it was not possible to answer this question.
7.3	Robert Shaw asked that we give consideration to the work currently being done around urgent care re-procurement, and we needed to make sure this fed into the PC enhanced access work. Atul Sharma also noted that PCNs needed to be involved in every aspect of this work. Robert Shaw responded that Sabah Salman was the nominated clinical lead in terms of the work so far. There was a paper currently due to be brought to the Greenwich Joint Commissioning Board on

	UTC Procurement. ➢ **Robert Shaw to clarify how PCN CDs would be involved in the UCC Development.**
7.4	Tuan Tran noted that we needed to make sure the correct infrastructure was in place as this could represent a significant change in the ways practises worked. We also needed to think about what was doable in a safe way. He also added that this represented an opportunity to increase practise resilience. General practice was the bedrock of the NHS and we needed to make sure that this was not allowed to deteriorate due to the current resourcing crisis.
7.5	Maria Howdon responded that the offer was based around what PCNs could deliver but also what the population needs were. With regard to IT infrastructure – this was an ongoing issue. We may need to look at a phased approach, however this was likely to be kept under review. This work would proceed from the premise that clinical safety was of utmost importance.
7.6	Sandra Iskander noted that it was well-understood that primary care was under significant pressure. Even small changes were likely to have considerable impact. She therefore asked what the mechanism was to make sure trusts were contacted in advance about any changes. Maria Howdon responded that there was work being undertaken around enhanced service specification. We also needed to identify what impacts were likely to be, and this would need to be done in conjunction with relevant partners. ➢ **Primary Care Advisory Group to review and recommend membership of the task and finish group.**
7.7	Atul Sharma added that the presentation didn't seem clear enough on supporting the assurance process. He also noted that the paper was very GP Federation-heavy and should be more supportive of practises themselves.
7.8	Neil Kennett-Brown noted that the timescales for this were very tight, with an expected go-live date of October 2022. ➢ **Extraordinary HGP meeting to be set up in the first week of September. To include all voting members of the HGP aside from those who are conflicted (Nayan Patel, Tuan Tran, Atul Sharma, Niraj Patel & David James).**
7.9	Nayan Patel added that we were lucky as a borough to have six days a week GP provision back on the table. We needed to be mindful, when discussing these items, of the need for consistent language. We also needed to focus on how we were working on provision going forward. **Resolved**
7.10	The Healthier Greenwich Partnership: • Approved the assurance and governance process proposed in this paper • Noted the wider briefing, recognising that primary care access is a high priority for our population
8.	**Developing our Health and Care Partnership Arrangements**
8.1	Sarah McClinton introduced the item. She noted that a lot of the work going forward would be based on developing relationships and trust, which was the theme running throughout this work.
8.2	Claire Kennedy also added that this item was heavily focused on the practicality of delivering our prioritised outcomes. We needed to work on having a shared narrative and shared identity. Furthermore, we needed to think about the key projects and pieces of work we needed to develop

	in order to realise our outcomes.
8.3	Neil Kennett-Brown added that we would be arranging a series of 1:1 meetings in advance of our September workshop.
8.4	Nayan Patel expressed the concern that the detail in the slide pack was comprehensive but lacking clarity of simple message, and further emphasised the need for us to bring a wide range of partners on board who may be overwhelmed by the detail.
8.5	Florence Kroll added that there was a wider workforce that we needed to engage with, who were not just the usual people around the table who had a high degree of familiarity with this work. ➢ **Victoria Stanway & Claire Kennedy to take the presentation away and work on simplifying the language for members of the public and other partners. Russell Cartwright to also assist.** **Resolved**
8.6	The Healthier Greenwich Partnership noted the presentation.
9.	**Briefing on the Fuller Report**
9.1	Maria Howdon introduced the item. She noted that the Fuller Report was focused on system-wide change to deliver population-based care, and in aiding the whole LCP to deliver, rather than just placing the burden on General Practice.
9.2	Neil Kennett-Brown noted that Neighbourhoods were multi-faceted and might mean different things for children as they do for adults. There was a real opportunity here to co-design work and create a borough-led approach of how we implement the Fuller Report. This would not be top-down, and there would also be areas of commonality across the SEL ICS where we could share learning across boroughs. If we wanted to tackle things in Neighbourhoods, we needed to have detailed conversations at a much closer level to our communities. We needed to further develop our delivery mechanism, and there was great opportunity here.
9.3	Lisa Wilson added that we needed to work out how we would join-up the strategic work on this.
9.4	Nayan Patel also noted that the Fuller neighbourhood concept needs to fit in with the neighbourhood work currently being undertaken by RBG and the PCN footprint of population of 30-50k. We will also need to agree that this is the footprint as opposed to having several different meeting of neighbourhoods as we will not make any movement
9.5	Sarah Burchill highlighted a number of exciting examples which we could build on in the borough, including the frailty model in Riverview PCN. Furthermore, we needed to think about how we would wrap around support to develop a prevention-based model.
9.6	Sandra Iskander also noted that the discussions felt intuitively correct. She stressed the importance of practicalities as we worked out how to action some of this goodwill. Nayan Patel noted that conversations last week had discussed the infrastructure required in order to set up and implement Fuller. These new ways of working were likely to be disruptive (in a positive sense), as this was the only way in which change was achieved. Neighbourhoods would need a strong geographical emphasis.
9.7	Neil Kennett-Brown drew the conversation back to the questions highlighted in the paper. He noted that we may be able to release capacity in our system through more efficient ways of working.
9.8	David Borland also added that there would be further work to be undertaken on highlighting the

	healthy tensions in the system, and common principles we shared. Florence Kroll added that a lot of this could be developed at the forthcoming away day. ➢ **Florence Kroll & David Borland to provide HGP with an update on the SEND Green Paper.** ➢ **Lisa Wilson to provide an update to HGP on social care reforms.**
9.9	Robert Shaw also noted that Greenwich was quite well-developed as a system. Oftentimes, however, there were governance issues that arose when working together. Nayan Patel noted that we needed to tie together all the elements of Neighbourhoods that worked well together. Neil Kennett-Brown added that there was an opportunity provided by remote working that enabled greater collaboration without need for co-location. ➢ **All partners to consider and reflect on the Fuller Report and the questions posed. Action for Neil Kennett-Brown & Integrated Commissioning directors.** **Resolved**
9.10	The Healthier Greenwich Partnership noted the report.
10.	**Governance**
10.1	Alex Harris provided an update on the terms of reference attached to the agenda, noting that these had previously been seen by the board and were approved by the ICB Transition Group on 1 July 2022. Joy Beishon noted that Healthwatch Greenwich was not a core member of the HGP and requested this be changed. She also requested that the quorum be amended to include Healthwatch and METRO GAVS. Neil Kennett-Brown added that Healthwatch was not a decision-maker, which is why they were not in the core membership. ➢ **Healthier Greenwich Partnership terms of reference to be added onto the next agenda in order to address the status of Healthwatch.**
10.2	Maria Howdon also introduced the Primary Care Delegation item, noting that this was a primarily update on the governance of the delegation, and the ToR were being refreshed for the group. The board approved the Primary Care Working Group reporting into the HGP. ➢ **Maria Howdon to report back to the HGP on the Primary Care Working Group Terms of Reference.** **Resolved**
10.3	The Healthier Greenwich Partnership noted the governance items submitted.
11.	**For information items**
11.1	The following items were submitted for information: ➢ Summary feedback from Integrated Care Board & Executive ➢ Public Health Update (Covid / Monkeypox) ➢ Virtual War Governance Update ➢ Forward Planner
11.2	There was no action for the Board.
12.	**Any Other Business**
12.1	➢ **Atul Sharma requested that papers be sent out two weeks, as opposed to one week in advance. Alex Harris stated he would look into this.**

13.	**Date of Next Meeting**
13.1	The next meeting will be an extraordinary meeting of the HGP held in early, September, date TBC.
14.	**Meeting close**
14.1	The meeting ended at 15:02.

Healthier Greenwich Partnership
Minutes of the meeting held on Wednesday 7 September 15.00-16.00

Members	
Neil Kennett-Brown	Chief Operating Officer – Greenwich, SEL CCG (Acting Chair)
Ben Travis	Chief Executive, Lewisham & Greenwich NHS Trust
Christopher Dance	Associate Director of Finance (Greenwich), SEL ICS
David Borland	Integrated Commissioning Director, Children & Young People, Greenwich – SEL ICS / Royal Borough of Greenwich
Jackie Davidson	Integrated Commissioning Director, (Prevention, Primary Care, Population Health) - SEL ICS / Royal Borough of Greenwich
Joy Beishon	Chief Executive, Healthwatch Greenwich
Lisa Thompson	Director of Children and Young Peoples' Services – Oxleas NHS Foundation Trust
Lisa Wilson	Integrated Commissioning Director – SEL ICS & Royal Borough of Greenwich
Naomi Goldberg	Director of Strategy, METRO GAVS
Nick Davies	Adult Social Care Director, Royal Borough of Greenwich

In attendance	
Gemma O'Neil	Deputy Director of System Development (Bexley and Greenwich), SEL ICS
Maria Howdon	Assistant Director of Primary Care (Greenwich), SEL ICS
Rachel Matheson	Associate Director, Adult Community Services, Oxleas NHS Foundation Trust
Russell Cartwright	Head of Communications and Engagement (Greenwich), SEL ICS

Apologies	
Atul Sharma	PCN Director
Florence Kroll	Director of Childrens' Services, RBG
Iain Dimond	Chief Operating Officer, Oxleas NHS Foundation Trust
Ify Okocha	Chief Executive Officer, Oxleas NHS Foundation Trust
Sarah McClinton	Executive Place Lead, Greenwich

1.	**Introduction**
1.1	**Introductions and Apologies for Absence**
1.1	The Chair welcomed the attendees. Apologies were noted as above.
2.	**Declarations of Interest**
2.1	There were none.
3.	**Primary Care Enhanced Access**
3.1	The item was introduced by Maria Howdon. She noted that we are only able to assure our PCN plans against the national specification. The Board today was being asked if it was assured on this point.

3.2	All six PCNs had submitted their plans following engagement with their patients. As a result, there were a high level of take-up.
3.3	As this was a new service, engagement with patients would continue and services were likely to evolve. Similarly, we would continue to work alongside PCNs to support delivery and mobilisation.
3.4	Joy Beishon asked if enhanced access had led to a reduction in service. Maria Howdon responded that all PCNs would need to meet the requirements of the specification and there was further requirements built back into the EA based on feedback received.
3.5	Naomi Goldberg asked what flexibility we had in terms of times and days, as there would likely be certain times (Friday evenings, Sunday mornings, for instance) when people may not want to attend general practice. Maria Howdon responded that feedback we had received indicated that most people wanted appointments on Monday – Friday in the evenings after work.
3.6	David Borland asked how representative the surveys had been. Maria Howdon responded that there had been questions around preferences for access in relation to equalities and in addition to this a variety of questions relating to respondents' diversity had been posed.
3.7	Sandra Iskander expressed confusion as to what the HGP was being asked. She noted that unless we had full cognisance of the context surrounding the paper, this would be a difficult decision to take. Jackie Davidson noted that there were to processes going on – one was about the system impact, the other was an assurance piece around adherence to the national specification. The latter was what was being signed-off today.
3.8	Lisa Wilson noted that during the pandemic different modes of delivery had been enacted and we needed greater understanding of how EA would affect this. Maria Howdon noted that there had been paper copies of the surveys in General Practises. She did not have a full breakdown of all of the respondents, however the model would continue to evolve and did not represent a significant departure from the previous model.
3.9	Nick Davies noted that work was being done to understand the impact of urgent care system pressures. Neil Kennett-Brown further noted that there were ongoing conversations as to whether the GP Federation would be commissioned to run a bank holiday / Sunday service. We had also funded Greenwich Health to do additional front door work.
3.10	Sandra Iskander asked when some of the more substantive decisions would be made, and whether the existing provision would end at a specific date. Neil Kennett-Brown responded that 1 October is when the new EA service would go live.
3.11	Jackie Davidson added that one thing we would need to consider in September would be understanding how this would work in practise. This could potentially be considered a change in existing service provision which may require a specific type of engagement.
3.12	Sandra Iskander highlighted the need for a collective conversation on this closer to winter, as this would impact on winter planning.
3.13	Christopher Dance asked how this would be brought together with UTC procurement. Neil

	Kennett-Brown responded that one of the potential bidders for UTC Procurement could include HGP members. We would be publishing a PIN on the service specification to avoid concerns about unfair advantage being bestowed on HGP members.
4.	**Any Other Business**
4.1	Neil Kennett-Brown noted that the engagement process for Eltham had begun.
4.2	Neil Kennett-Brown further noted that next week we would be running a public forum on the 14 September which would invite members of the public to ask questions of members of the partnership.

Action Log for the Healthier Greenwich Partnership – September 2022

Updated 23 September 2022

OPEN ITEMS						
Meeting date	**Minute Ref**	**Action no**	**Action**	**Action Owner**	**To be Completed**	**Comments**
20 July	5.3	001	ToR for the Health Inequalities, Oversight and Governance Group to be added to HGP forward planner.	Jackie Davidson	October 2022	Re-scheduled for October.
20 July	5.3	002	Sandra Iskander noted that she would be happy to arrange a demonstration of the Healthy Intent for anybody who was interested.	Sandra Iskander	September 2022	Closed. Regular meeting set up.
20 July	7.3	003	Maria Howdon to link in with Sandra Iskander & Sarah Burchill on the setting-up of the Task and Finish Group.	Maria Howdon	September 2022	Closed. This has been set up.
20 July	7.8	004	Extraordinary HGP meeting to be set up in the first week of September. To include all voting members of the HGP aside from those who are conflicted (Nayan Patel, Tuan Tran, Atul Sharma, Niraj Patel & David James).	Alex Harris	September 2022	Closed. Meeting has been held.
20 July	8.5	005	Victoria Stanway & Claire Kennedy to take the presentation away and work on simplifying the language for members of the public and other partners. Russell Cartwright to also assist.	Victoria Stanway / Claire Kennedy / Russell Cartwright	September 2022	Closed. Meeting has taken place.
20 July	9.8	006	Florence Kroll & David Borland to provide HGP with an update on the SEND Green Paper.	Florence Kroll / David Borland	September 2022	On forward planner for November.
20 July	9.9	007	Lisa Wilson to provide an update to HGP on social care reforms.	Lisa Wilson	November 2022	On forward Planner for November.

OPEN ITEMS						
Meeting date	**Minute Ref**	**Action no**	**Action**	**Action Owner**	**To be Completed**	**Comments**
20 July	9.9	008	All partners to consider and reflect on the Fuller Report and the questions posed. Action for Neil Kennett-Brown & Integrated Commissioning directors.	Jackie Davidson	September 2022	Closed. Task and Finish group has been set up.
20 July	10.1	009	Healthier Greenwich Partnership terms of reference to be added onto the next agenda in order to address the status of Healthwatch.	Alex Harris	September 2022	Closed. Have re-drafted ToR to refer to “voting” and “non-voting” members, removing reference to “core”.
20 July	10.2	010	Maria Howdon to report back to the HGP on the Primary Care Working Group Terms of Reference.	Maria Howdon	September 2022	On forward planner for November.
20 July	12.1	011	Atul Sharma requested that papers be sent out two weeks, as opposed to one week in advance. Alex Harris stated he would look into this.	Alex Harris	September 2022	Closed. This would be a difficult timescale to adhere to as it would not give sufficient time in between meetings for papers to be drafted.

AGENDA ITEM: 6

Healthier Greenwich Partnership

Date: 28 September

Title	MH Update Paper including key updates to Reset and Recovery Plan	
This paper is for **noting**		
Executive Summary	The paper is being shared with the partnership to provide key updates in relation to MH related activity which impacts on our local population. Mental Health and Wellbeing remains a key priority for the ICB and locally. Attached are three documents – the primary mental health presentation (pages 15-65), followed by a version of the delivery plan which highlights just the mental health elements of the plan (pages 66-69) and finally a draft CYP transformation plan (pages 85-86). The latter two documents are provided primarily for information and the partnership is invited primarily to comment on the main presentation.	
Recommended action for the Committee	The partnership are asked to note the key priorities shared within the paper for the coming period. The updates to the Reset and Recovery Plan are provided to ensure continuity of information between the previous updates provided in relation to the delivery plan.	
Potential Conflicts of Interest	No conflicts arise directly from this report	
Impacts of this proposal	Key risks & mitigations	Further work is required to understand the full impact of the pandemic on the MH and Wellbeing of the local population. There is a risk that increased demand may outweigh the range of support available however the MH Oversight and Coordination Board will continue to monitor this risk and highlight to the partnership any key issues that may arise. The planned needs assessment referenced in the paper will help to understand current and future demand and needs of the local population

		Workforce constraints are still impacting on recruitment and retention across the workforce. Planned activity includes ways to mitigate these impacts
	Equality impact	The delivery of the priorities outlined are intended to have a positive impact and address inequalities in access to MH and Wellbeing Support
	Financial impact	Increased demand could present increased fincnial impacts. These are being monitored. Current inflation and cost of living pressures are also being understood locally in order to asses impact
Wider support for this proposal	Public Engagement	As detailed in the papers, co production and engagement is intended to underpin all our work across our priorities
	Other Committee Discussion/ Internal Engagement	NA
Author:	Lisa Wilson - Integrated Director of Commissioning (Adults) Dave Borland - Integrated Director of Commissioning (CYP)	
Clinical lead:	Neil Kennet – Brown	
Executive sponsor:	Sarah Mc Clinton	

South East London Integrated Care System

Healthier Greenwich Partnership

Mental Health Update

September 2022

Paper contents:

- **Purpose**
- **June 2022 Mental Health System Wide Workshop** – key actions and priorities
- **Lived Experiences -** Insights
- **Reset and recovery plan** – key updates
- **Key Priorities 6-12 months**
  - ❑ MH alliance
  - ❑ Community MH transformation
  - ❑ CYP MH transformation
  - ❑ Oxleas and South London Partnership - key updates and data and insight showing trends
  - ❑ Prevention & Public Health Mental Health related activities

Purpose of the update to HGP

South East London Integrated Care System

- Improving the MH and Wellbeing and tackling inequalities in relation to access and support remain a key priority for the place and partnership

- Since the pandemic, we have seen a growing demand for support in our population, from those impacted by the effects of the pandemic, those who already had MH and Wellbeing needs and have seen a deterioration of these and those who face inequity in relation to the current offers available

- The full impact is not yet known, as a system we need to better understand our population needs as we continue to make progress on our priorities to improve our offers in relation to MH and Wellbeing for our local population

This paper provides an update on key priorities already established in our Reset and Recovery Plan as well as new priorities which have since emerged as a result of new insight and collaboration across system partners and those in our communities including people with Lived Experiences

June 2022 Mental Health System Wide Workshop – key actions and views on priorities

South East London

Key Actions – next 3-6 months

1) **Promoting Person Centred Practices**

- Promote Personal Budgets (PBs) – ensure more people are offered choice and control and make progress on all forms of PBs for MH
- Pay parity and focus on recruitment and retention
- Recognise VCS (including small organisations)

2) **Agree shared values for place based workforce strategy** – ahead of development of joined up workforce strategy, develop set of values for each org to agree and use

3) **Raise awareness of community based offers** - Each service to provide a service description – brief outline of 2 key functions and key contacts. This can then be developed in to a resource and support updates to existing directories etc. Supports IAG and knowledge of partners and workforce

4) **Look at where we are and are not co producing and engaging -** ensure user voice, do the same for VCS representation and agree gaps / address them

5) **Ensure primary care and housing are engaged partners -** work to ensure opportunities for collaboration and more joined up support for people are realised

6) **Revisit MH vision** – re co produce the MH system wide vision and commit to deliver it

Top Priorities 22-24

Ensure Co-production and lived experiences underpin all we do

1)

- Simplify access – strive for one point of access and a more joined up system and workforce
- Invest in Early Help / Early intervention
- Ensure integration is not just on paper

2)

- Development of Greenwich Mental Health and wellbeing HUB (CMH transformation)
- Deliver more and better PBs and Integrated PB's (Health and Social Care) – inc making sure diverse local solutions are available
- Reduce isolation through delivery of the Social connection strategy

3) **Prioritise CYP MH and parents/carers/families** and Funding early help/intervention for all ages

4) **Development of system wide Workforce Strategy for MH** (ensure diversity and explores future workforce models)

5) **Ensure a Person centred approach** across all we do with lived experiences at the heart

6) **Build on mapping and data and insight work** – have a true tool that is interactive/understandable and serves the people of Greenwich well alongside organisations and the workforce. Build on the data work and ensure key measures for the local place are developed that are regularly reviewed

7) **Linked to workforce strategies** - Flex for workforce to move with the need, look at gaps in workforce such as Navigator roles and peer support

Progress on key outputs agreed

Following the workshop the MH Oversight and Coordination Board members reviewed the set of actions and priorities discussed on the day and established areas to progress on initially whilst recognising some of the priorities were already underway across the MH range of activity. Key updates on Progress are provided below:

Revisit MH vision – re co-produce the MH system wide vision and commit to deliver it

***Progress**: Lead identified, working group established, scope of work agreed and specification developed to commission a partner with experience in facilitation of co production of Vision and system design work. Next Steps: agree final scope and approach and kick off work. New Vision to be co produced and agreed by Spring 2023, to include how it will be used to drive MH activity across the system and ensure ownership and buy in from all*

Build on service mapping - have a true tool that is interactive/understandable and serves the people of Greenwich well alongside organisations and the workforce

***Progress**: Lead identified, work to build on mapping produced ahead of workshop, meetings with key stakeholders to build in key changes and updates, discussions as to how the tool could be developed further to be interactive and also built in to Community Directory development. Service descriptions and key contacts established*

Data and Insight work - Build on the data work and ensure key measures for the local place are developed which are regularly reviewed for impact/to identify where improvements are needed in local offers

***Progress**: Lead to be identified, scope discussed and agreed at MH Oversight and Coordination Board to include; development of theory of change to identify key measures, ensure links to ICS development of MH dashboard approach. Include in scope a refreshed MH needs assessment for the Borough, this would also inform the refresh of the Health and Wellbeing Strategy. Public Health agreement to support this work. Next steps to convene working group to progress key actions*

A key priority established at the workshop in June was to ensure lived experiences and co production approaches underpin all we do

Lived experience insights

Quotes are taken from various sources and include Volunteer to work service evaluation participants and staff feedback surveys, peer engagement facilitators, lived experience practitioner post training feedback survey, volunteer annual survey, workshops, service user and carer engagement groups for the MH transformation programme, Oxleas strategy survey and Carers support network groups

*"My journey through local services has been a frustrating one, it felt as though I was just another statistic to be processed and reported on before being passed onto the next team. The main theme embedding itself throughout my life back then was **disconnection"***

*"Then there was the distinct feeling that I couldn't connect to those delivering my care, they were "healthy", and I remember thinking that this was **just** a job to them, so how could they possibly understand me? I felt like a patient, a RiO number, rather than a person or fellow human being. I was, **I am**, full of potential"*

*"Which is why we need to develop a culture of pro activity rather than being reactive, if we **are truly person-centred** then we have to rebuild our systems to reflect this and ensure everyone involved in our patients care is delivering on that promise, including our patients. Call out the compassion fatigue for what it is, remind ourselves why we're here, and know that we're not so different from our patients"*

Recommendations:

Peer support - inject some more humanity into mental health services - be prepared to fully integrate them into our service delivery

Give our residents a voice, is by creating a borough-wide pool of clients, patients, service users and carers alike that we could tap into for support or advice when making changes in our services

Invest in partnerships and Alliances. Champion recovery

Ensure that we are supporting each other across this sector, instead of operating in silos. There are already examples of joint-working cropping up, and it's brilliant, but we need more.

We have to look at educating the wider teams around the benefits of lived experience, and what a powerful concept it can be.

Things that are working well

"I don't know where to begin, from the volunteer to work scheme, to the Lived experience practitioner programme. I have always felt supported in everything". – written feedback from a service user on the lived experience practitioner programme.

"Never thought I would be able to be a receptionist and put it on my CV. I have more chances of having an interview now"!- Volunteer

"Presence of a female volunteer assisting the running of a male dominated group is making new female members feel less uncomfortable"- Oxleas staff member

"*I can see the other side of the fence and how hard the staff work to keep us well"*- Peer engagement facilitator

Quotes from existing insight

Things that are not working so well

"I was trying to assist another Turkish speaker accessing a crisis service, he was told that they have booked an interpreter but it could take up to 6 hours for this to be organised, they couldn't do the assessment, I did my best to help. But ultimately the person left in a worse state than when he had arrived. I felt helpless and so did the staff". – *Service user and carer equalities reference group*

"Listen to family members, involve the patients in treatment options".- *Oxleas Service user and carer survey , 2019*

Things that are not working so well

Concerns shared by carers

- No information of changes - Care Co-ordinators, Psychiatrist, Medication.
- No direct telephone number or email for Care Co-ordinators.
- Not taken seriously
- Being seen as an obstruction
- Not given information they ask for - Care Plan Reports, Dates of Meetings with Client

Carers recommendations

Information is key to carers, working together helps the care for your client to be more holistic.

A conversation with the carer before meeting with your client may give you more of an insight into what is really happening with the client.

Get to know the carers, this can only help with the care and support you provide. A carers assessment will help with this process.

Remember the carer knows your client best.

What do Carers Bring to Oxleas and the wider system

Carers bring a wealth of knowledge and experience regard caring for someone with Mental Health and other disabilities.

Skills of navigating other agencies outside of Oxleas NHS Trust

Knowledge of how services could be improved when working in partnership with carers

Reset and Recovery Plan updates

South East London Integrated Care System

- The accompanying document sets out the key priorities in relation to MH and Wellbeing which where included in the Reset and Recovery Plan
- During the pandemic some activity was impacted due to the need to divert resources to ensure our population were supported to keep safe and well. This has meant some key priorities have had to be delayed or re-phased in terms of how and when they can be delivered
- As we learn more about the impacts of the pandemic and other social and economic factors on our local population and expected future demands and needs, priorities and delivery approaches will be reviewed. This will also be informed by plans to delegate aspects of financial and operational delivery and quality oversight to local places from the ICS
- Workforce constraints continue to impact on commissioners, providers and partners and therefore the offer we have in the local borough. A range of work is already underway to address workforce challenges and this was identified as a key joined up piece of work to progress from the MH workshop in June.
- HGP are asked to note the key updates provided in the accompanying paper as well as some key areas of focus from the plan on the following slides

Mental Health Alliance

First Phase

The first phase of a Greenwich Mental Health Alliance model is focused on Support and Accommodation (Supported living and visiting support)

An Alliance works in a different and collaborative way across member organisations which is aimed at improving outcomes for individuals

A second phase Alliance is planned to include community services as well as Support and Accommodation

An Alliance Agreement has been signed off by the participant organisations – which are those with contracts for support and accommodation or RBG and SEL ICB Commissioning

Multi agency assessment through Alliance providers and clinical partners have enabled better outcomes for individuals and production of themes to aid development of the Alliance model

Mental Health Alliance

First Phase

Work on involving people with lived experience (LXP) who has been through or are using support and accommodation services

This involves an organisation providing external facilitation in a sequence of workshops – content and outcomes aimed to be produced with people LXP

An aim of the workshops is to get feedback on the service model for the Support and Accommodation phase of the Alliance

However, there are clear expectations that this work will lead to greater sustainable and repeatable involvement of people with LXP

Governance and Procurement timelines for the Mental Health Alliance are being revised in line with completion of this key engagement work and will be confirmed

Community Mental Health Transformation Programme

Lorraine Regan, Director of Community Mental Health and ALD, Oxleas NHS Foundation Trust

Beth Towle – Community Transformation project Manager, Greenwich

Context pre transformation

High demand for services

Service fragmentation and duplication, e.g. repetition of assessment

Multiple entry points which are confusing

Services not integrated- especially crisis support

Reducing resources

Inequalities

Lack of focus on outcomes

Culture change

Over usage of acute pathway

Core Offer in South East London

Aim

- A diverse and personalised range of interventions to people experiencing mental health problems within the community setting
- Enable earlier access to support; to support people to recover and stay well; to prevent mental ill health and crisis intervention.
- To reduce inequality in access and experience of mental health and physical health care for people with severe, moderate and mild mental illness across South East London.

Who for

- Adults in South East London, over 18 years of age, experiencing mental health problems. This will include people with severe mental illness (SMI) as well as individuals with mild mental health illness who require care and intervention.

Underpinning Principles

- Community services with clear access points and providing flexible care that considers both mind and body (i.e. mental and physical health).
- Targeted and measurable outcomes to assess and evaluate benefits for residents in South East London and across the wider health and care economy.

BLG Mind – Initial involvement

- Joint delivery began in 2018 with the Primary Care Mental Health Service in Lewisham working with SLaM
- Early example of integrated team working to deliver community mental health provision. BLG Mind roles work alongside SLaM staff to jointly assess needs and deliver holistic support
- Teams have now been developed across the whole borough expanding their reach as a result of Community Transformation Funding
- New initiatives to increase access, including the Culturally Diverse Communities Peer Support programme
- Learning from this experience has informed the development of work in Bromley and Greenwich

Community Wellbeing Hub

Principles (drawing on those agreed at SEL) that underpin the proposals in Bromley and Greenwich:

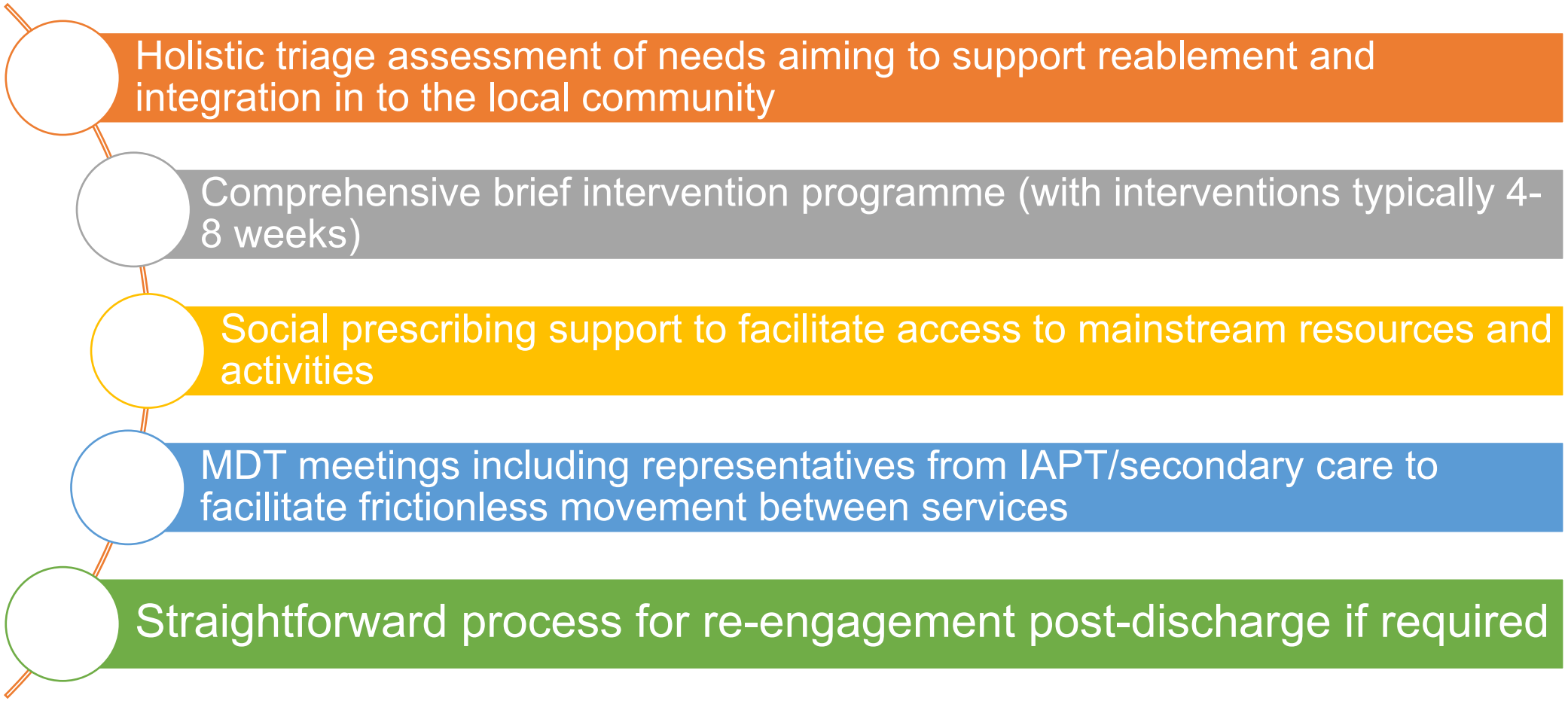
Bridging the gap across Primary and Secondary Care

No wrong door into services and frictionless movement between them

Holistic approach to assessing and meeting needs

Integrated, multi-disciplinary team providing clinical and non-clinical support

Key components of the Hubs



Greenwich Hub

NHSE Transformation funding: £1.2m in 2021/22

Integrated team of approx. 25-30 people

Partnership between Bridge Support, Oxleas and BLG Mind	**Expertise & Lived Experience:** - Oxleas staff; current PCP and new staff -BLG Mind & Bridge; Service Manager, Mental Health Advisors, Peer Support Workers, Benefits Specialist, Inequality Worker	Project Manager employed by BLG Mind

Current status:

- Initial joint recruitment complete. Ongoing recruitment for Y2 and 3
- Service model delivery Operational Policy in process of development.
- Initial joint working protocols in place and operating
- Team base identified and works being undertaken

Outcomes


Reduced waiting times and ensure individuals receive the appropriate support in a timely manner so length of engagement in services is reduced
Increase self management skills, engagement in community resources and activities
Reduced escalation of mental health problems as a result of unaddressed issues such as debt, housing, unemployment and social isolation
Reduced health inequalities, in particular for people from BAME communities, as a result of tailored support to improve accessibility, experience and equity

GREENWICH DIRECTORATE MENTAL HEALTH UPDATE

SEPTEMBER 2022

South London Partnership (SLP UPDATE)

A data set has been agreed between partners which details all cost per case placements - 100% health and those funded jointly between health and the Local Authority.

A priority matrix has been coproduced which supports the identification of people prioritised for review. Priority is given to people who have not received a timely review, are out of area, are in poor quality accommodation as determined by CQC, and those in high cost placements.

16 people have been reviewed by the integrated virtual review team which comprises of joint assessment between OXLEAS, CCP Clinical Assessment Team, VCS organisations. This work forms part of the data group within the Greenwich Alliance

16 people have been reviewed by the integrated virtual review team which comprises of joint assessment between OXLEAS, CCP Clinical Assessment Team, VCS organisations. This work forms part of the data group within the Greenwich Alliance

AMHP UPDATE

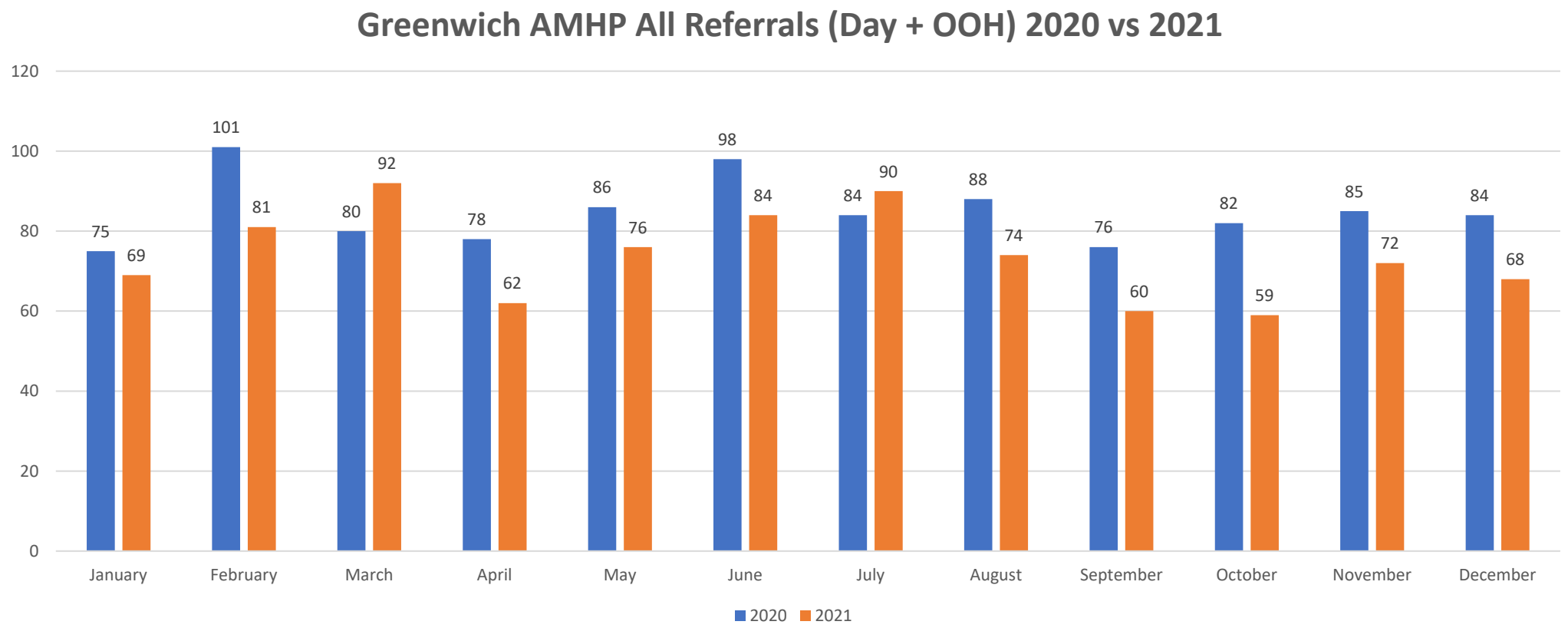
Greenwich MH Social Care Structure

The currently there are 18 wte posts of Mental Health Practitioners (AMPHs) in Greenwich. The wte in the CAT are currently 5. There is a Team Manager (TM) in the CAT team and a Lead Social worker (LSW). In addition, The CAT team has 7 seasonal AMPHS who are doing Bank / sessional work for the service. The CAT team also has 4 locums employed to support the function of the service.

Referrals Trends

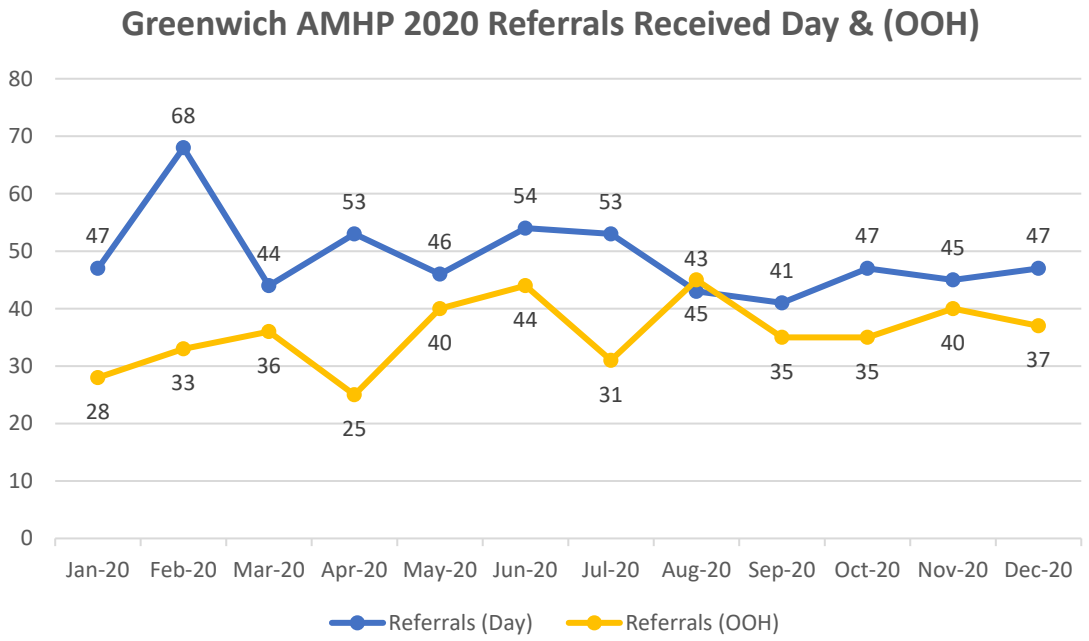
The Central team has received from January 2020 – December 2020 was 1,005 and from January 2021 to December 2021 were 892. Most referrals to the Central AMPH service are known service users (73%).

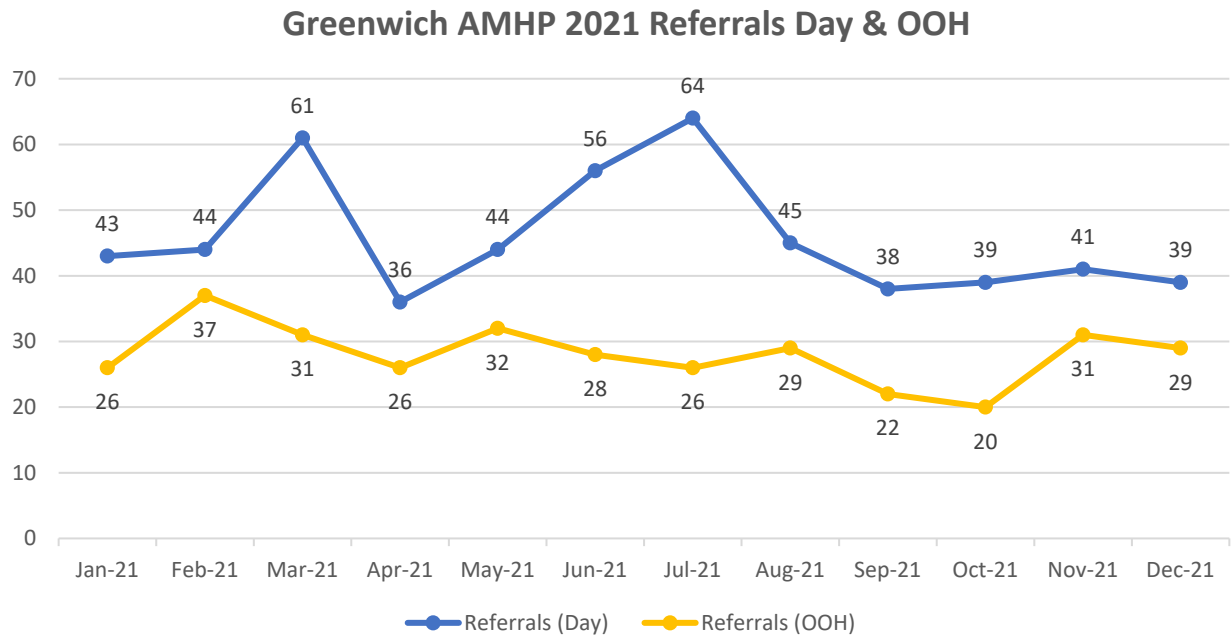
REFERRAL TRENDS



****OOH = Out Of hours

REFERRAL TRENDS CONT.





****OOH = Out Of hours

WAITING TIMES

INITIAL CONTACT TO MENTAL HEALTH ACT ASSESSMENT 2020							
DAY SERVICE				OUT OF HOURS SERVICE			
Month	Average Wait Initial contact to Assessment	Shortest Wait (Days)	Longest Wait (Days)	Month	Average Wait Initial contact to Assessment	Shortest Wait (Days)	Longest Wait (Days)
Jan-20	3.53	0	21	Jan-20	3.14	0	38
Feb-20	5.72	0	31	Feb-20	1.74	0	13
Mar-20	4.61	0	24	Mar-20	0.59	0	6
Apr-20	2.86	0	16	Apr-20	1.09	0	5
May-20	5.34	0	26	May-20	0.86	0	8
Jun-20	3.68	0	14	Jun-20	0.93	0	6
Jul-20	3.6	0	21	Jul-20	0.79	0	7
Aug-20	2.52	0	19	Aug-20	1.8	0	12
Sep-20	3.4	0	22	Sep-20	0.66	0	3
Oct-20	2.65	0	15	Oct-20	1.68	0	24
Nov-20	4.73	0	28	Nov-20	0.63	0	2
Dec-20	4.1	0	28	Dec-20	1.35	0	32
Av.	**3.90**		**22.**	Av.	**1.27**		**13**

0 = Same Day MHA Assessment

Reasons for delay: Court applications, obtaining warrants, police involvement and scheduling

Trends: OOH service has the lowest waiting times for MHAs

Longest wait times: anomalies were investigated and have since been rectified and found some to be errors. OOH services usually see clients on the same day or within 24hrs.

WAITING TIMES CONT.

INITIAL CONTACT TO MENTAL HEALTH ACT ASSESSMENT 2021							
DAY SERVICE				OUT OF HOURS SERVICE			
Month	Average Wait Initial contact to Assessment	Shortest Wait (Days)	Longest Wait (Days)	Month	Average Wait Initial contact to Assessment	Shortest Wait (Days)	Longest Wait (Days)
Jan-21	6.12	0	23	Jan-21	1.7	0	24
Feb-21	6.9	0	78	Feb-21	1.11	0	5
Mar-21	7.76	0	154	Mar-21	1.3	0	6
Apr-21	5.45	0	49	Apr-21	1.93	0	28
May-21	4.18	0	49	May-21	1.15	0	15
Jun-21	11.68	0	78	Jun-21	1.3	0	5
Jul-21	8.93	0	135	Jul-21	3.23	0	41
Aug-21	12.25	0	113	Aug-21	1.52	0	12
Sep-21	7.3	0	40	Sep-21	4.16	0	40
Oct-21	2.91	0	19	Oct-21	1.1	0	4
Nov-21	3.41	0	23	Nov-21	0.87	0	11
Dec-21	7.41	0	64	Dec-21	2.48	0	21
Av.	**7.025**		**68.75**	Av.	**1.82**		**17.66**

0 = Same Day MHA Assessment

Reasons for delay: Court applications, obtaining warrants, police involvement and scheduling

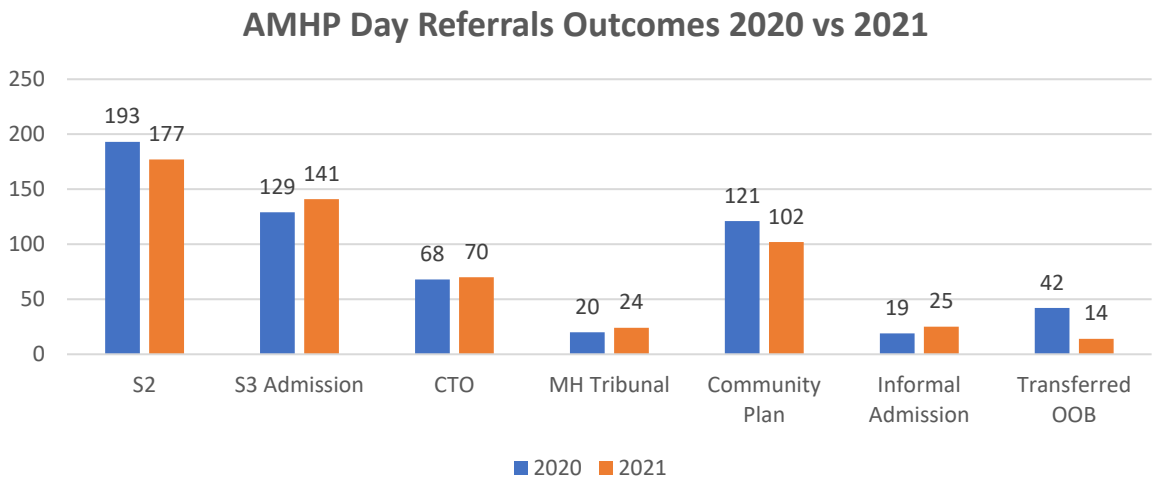
Trends: OOH service has the lowest waiting times for MHAs

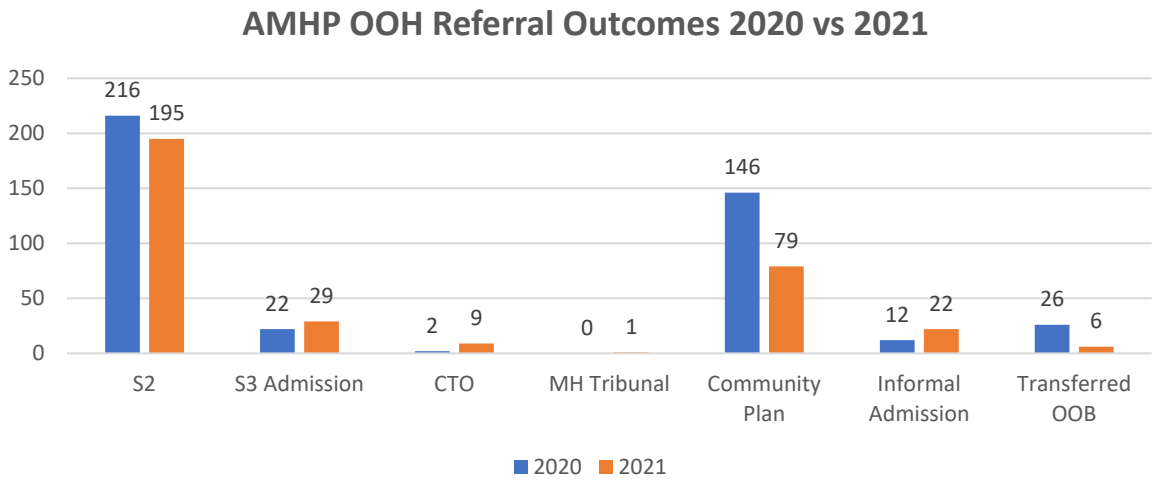
Longest wait times: anomalies were investigated and have since been rectified and found some to be errors. OOH services usually see clients on the same day or within 24hrs.

ADMISSION TRENDS

Greenwich AMHP 2020 & 2021 Admission Types
Day & Out of Hours (OOH) combined

ADMISSION TYPE	2020	2021
S2 Admission	249	372
S3 Admission	22	170
CTO	2	79
Informal Admission	22	47
Community Plan	188	181
Transferred OOB & Absconded	26	20





ADMISSION TRENDS CONT.

Greenwich AMHP Service S136 Referral Outcomes Day

Year	Section 136	S2 Admission	S3 Admission	Informal Admission	Community Plan	Transferred OOB	Absconded
2020	79	33	0	5	43	2	0
2021	65	38	1	3	24	0	1

Greenwich AMHP Service S136 Referral Outcomes Out of Hours (OOH)

Year	Section 136	S2 Admission	S3 Admission	Informal Admission	Community Plan	Transferred OOB	Absconded
2020	182	82	2	7	91	1	1
2021	138	64	3	14	57	0	0

COMMUNITY MENTAL HEALTH UPDATE

GREENWICH PCP

WAITING TIME (%) - REFERRAL TO ASSESSMENT <14 DAYS

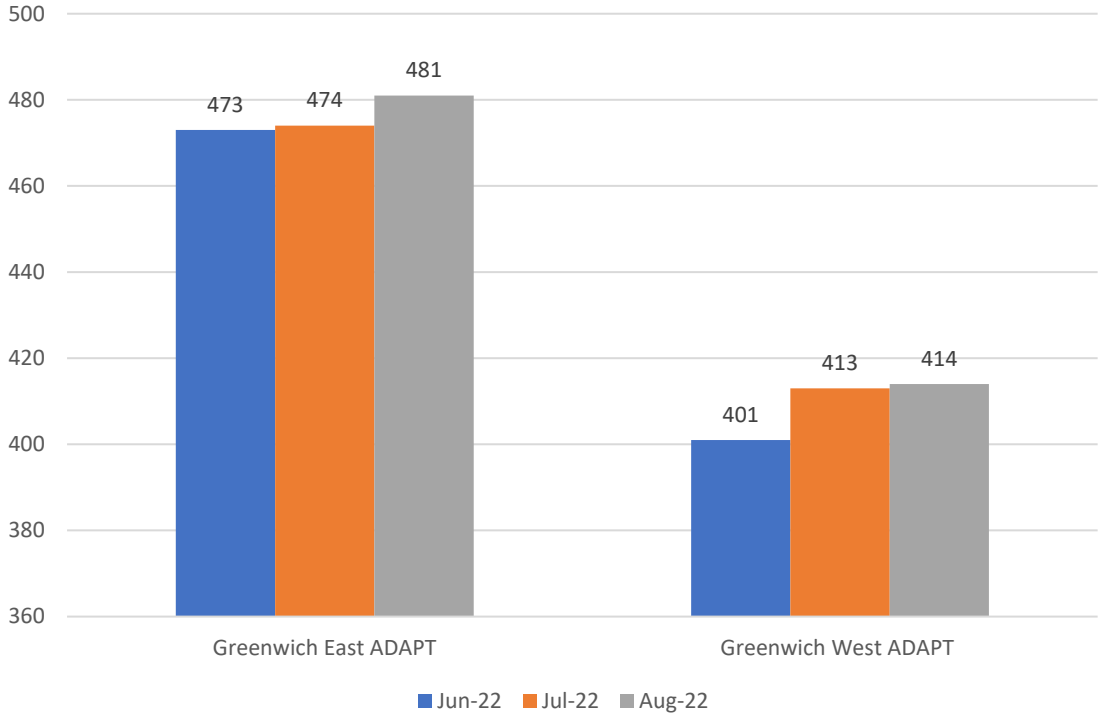
- **JUNE 22** = 97.2%
- **JULY 22** = 92.7%
- **AUGUST 22** = 91.5%

AVERAGE WAIT (DAYS) REFERRAL TO 1ST OFFERED APPOINTMENT

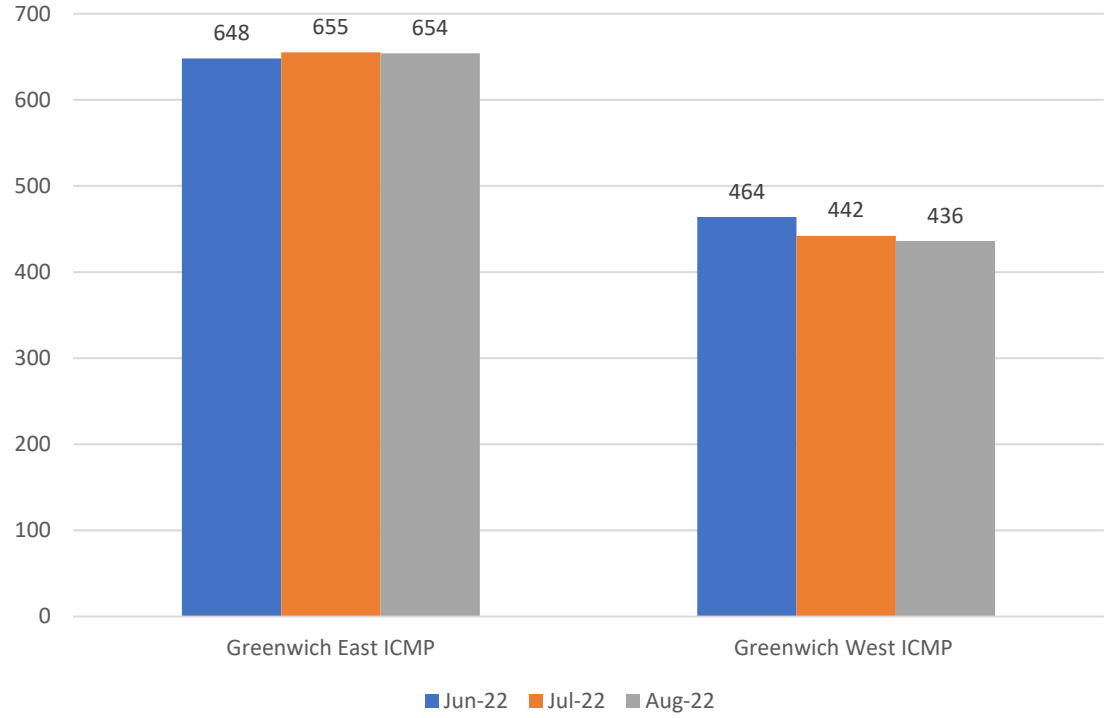
- **JUNE 22** = 23
- **JULY 22** = 21
- **AUGUST 22** = 14

CMHT UPDATE CONT.

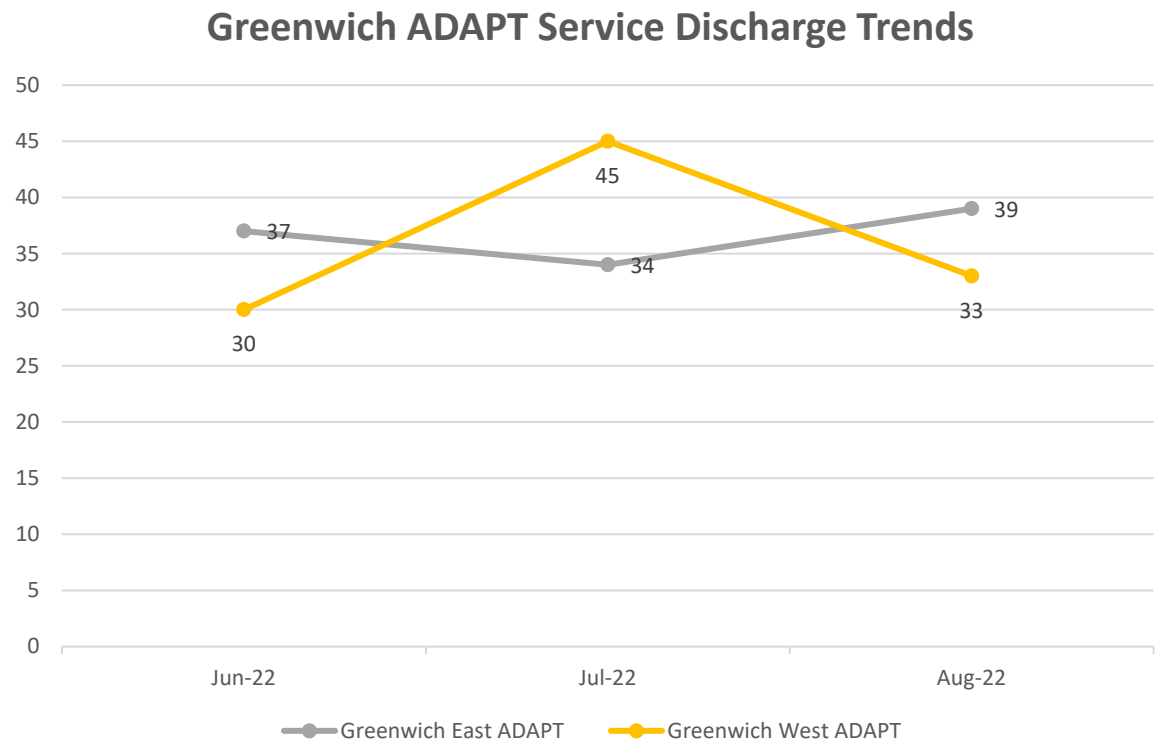
GREENWICH ADAPT SERVICE CASELOAD TRENDS

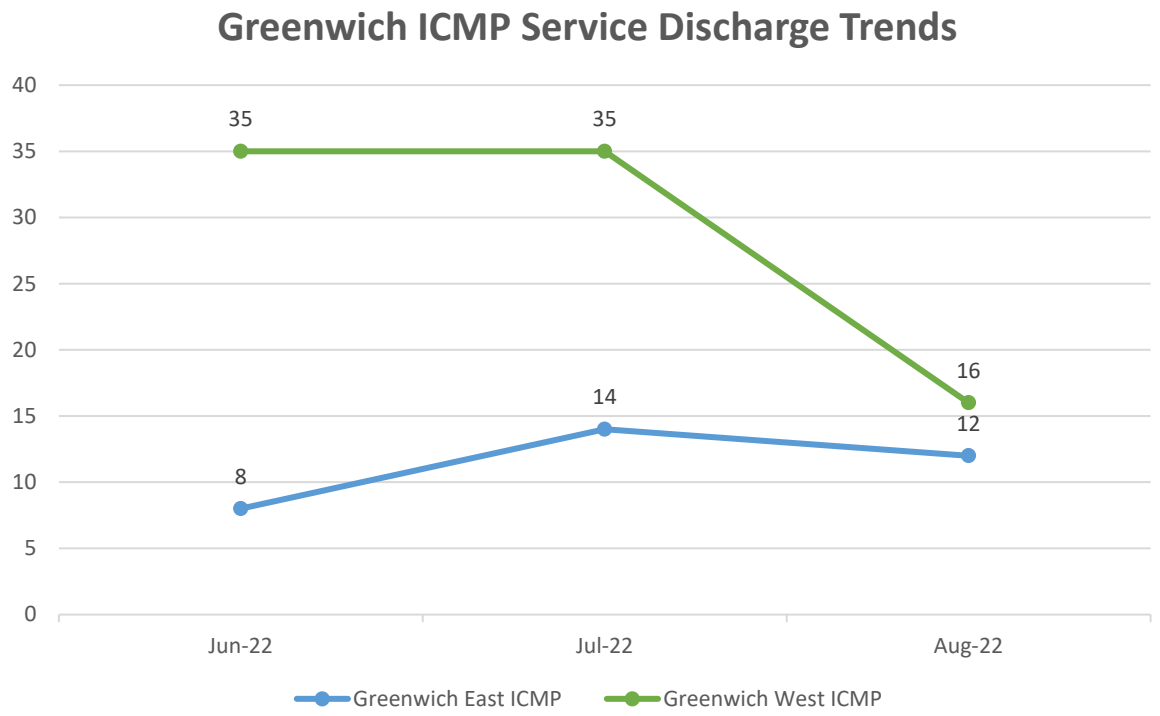


GREENWICH ICMP SERVICE CASELOAD TRENDS

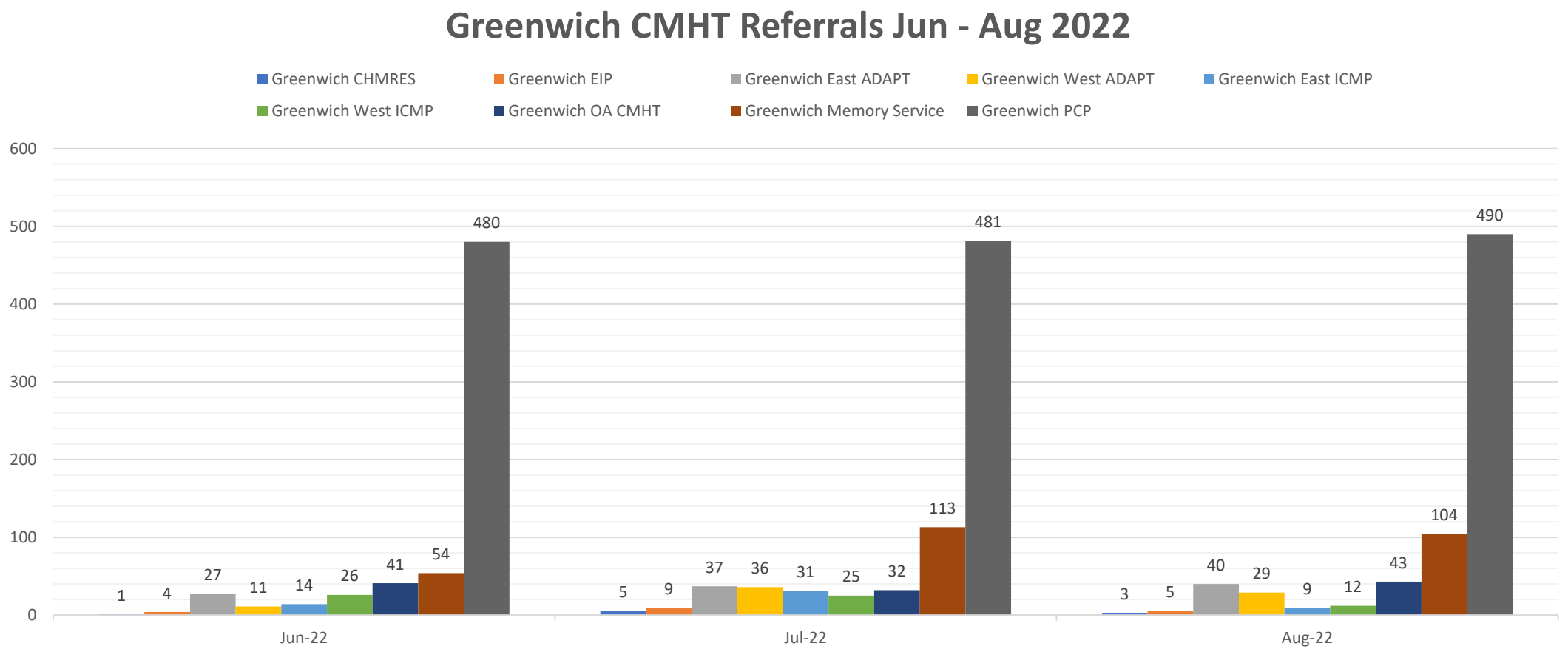


CMHT UPDATE CONT.

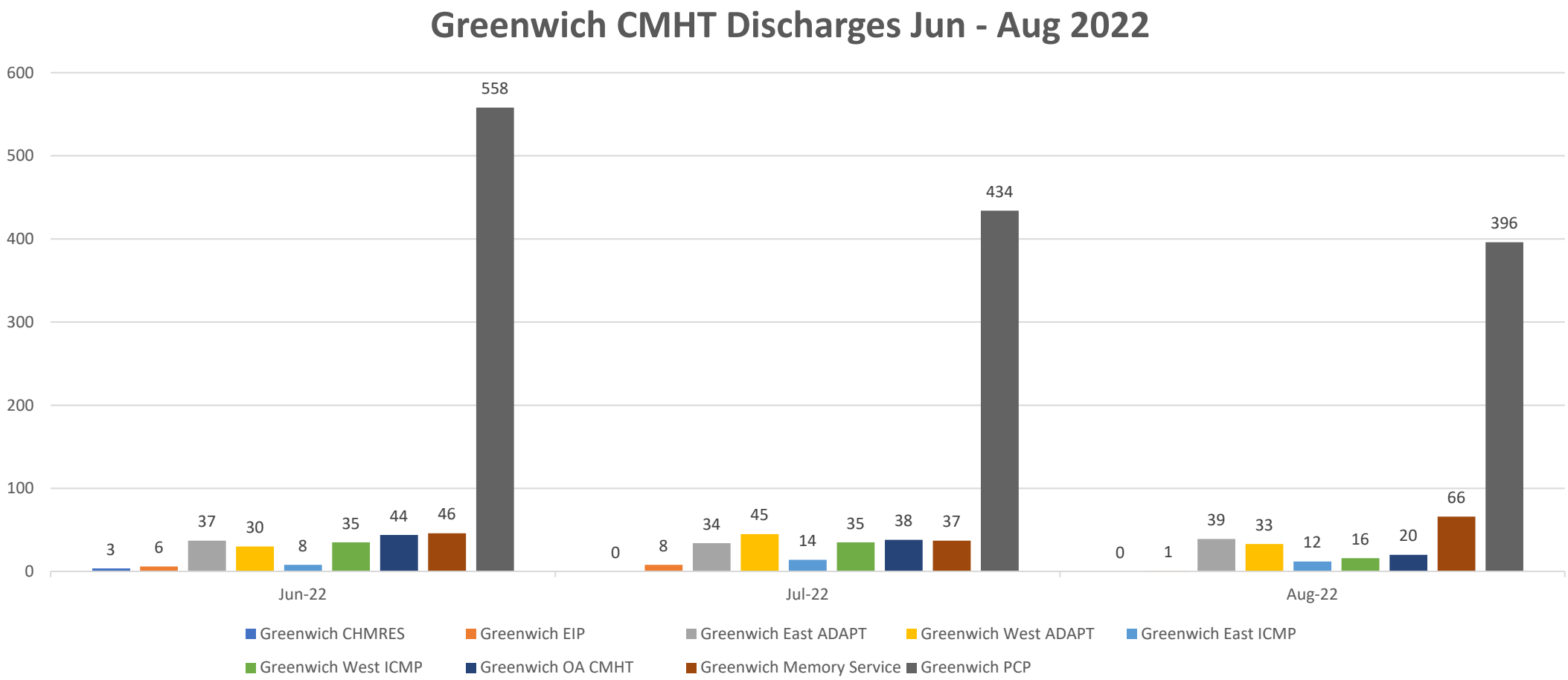




CMHT REFERRAL TRENDS

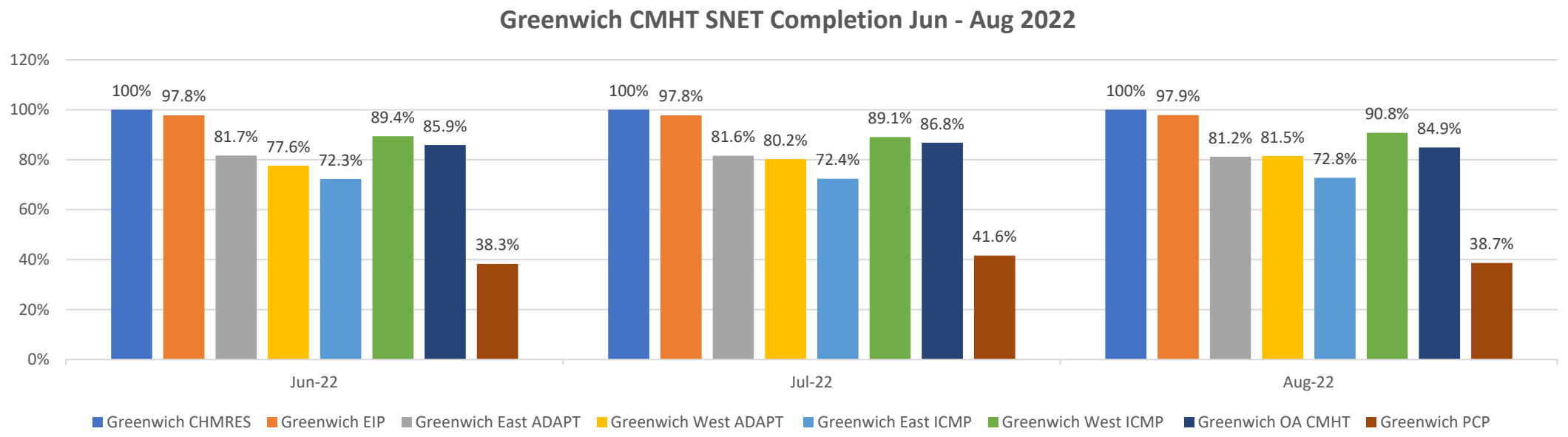


CMHT DISCHARGE TRENDS

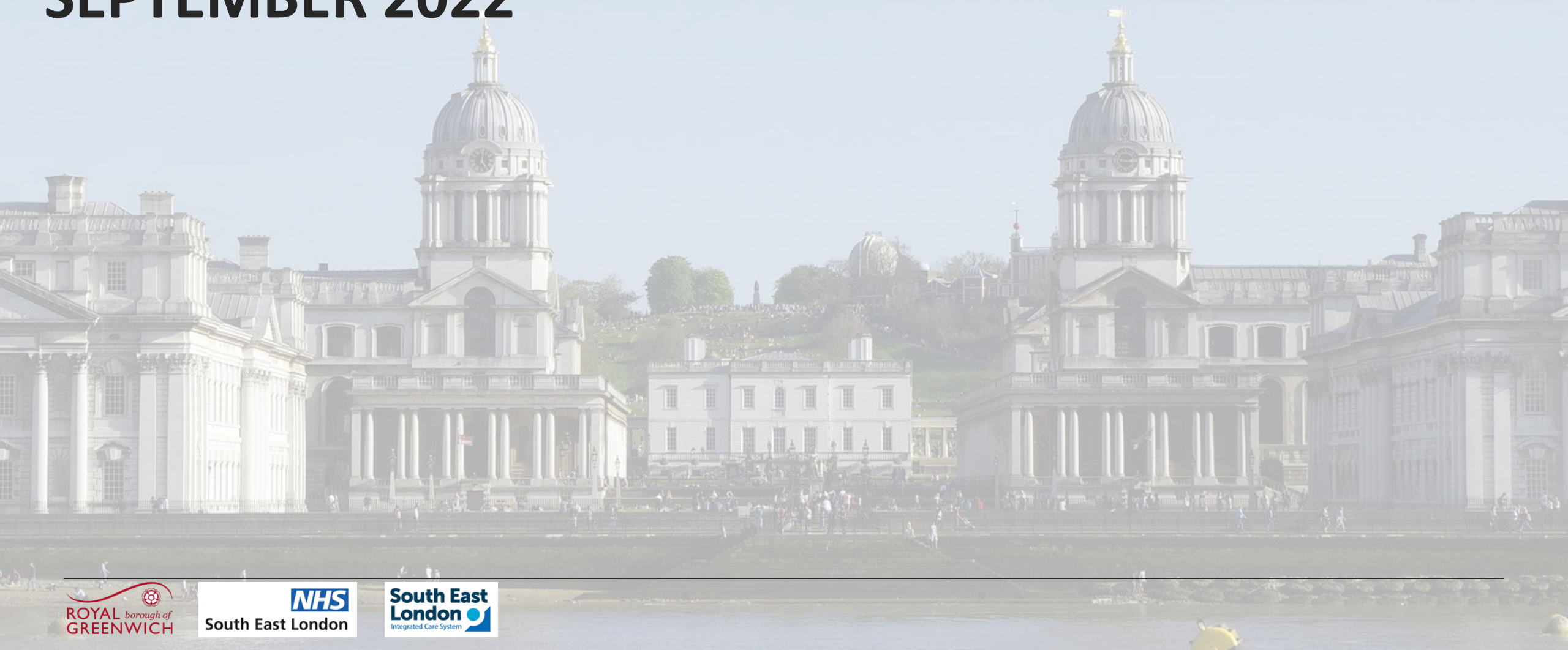


CMHT PATIENT EXPERIENCE

Greenwich Directorate	Target	Jun-22	Jul-22	Aug-22
FFT; overall patient experience - % "Good" and "Very good" responses (MH and CAMHS)	> 90%	64.6%	61.5%	64.6%
FFT; overall patient experience - % "Poor" and "Very poor" responses (MH and CAMHS) <10%	<10%	17.1%	15.4%	17.1%



CYP MENTAL HEALTH AND EMOTIONAL WELLBEING SEPTEMBER 2022



ROYAL borough of GREENWICH

NHS South East London

South East London Integrated Care System

CHILDREN'S MENTAL HEALTH AND WELLBEING – LIVED EXPERIENCE

From the most recent **CHI-ESQ** data, communication and experience of staff had the highest number of positive responses.

Waiting lists had the most negative responses.

Example: Waitlist / Appointments

"Sometimes it has taken a long time to get help, particularly when changing therapists"

Example: Experience of Staff

"I felt comfortable talking to my CAMHS worker and felt listened to a majority of the time. My worker was very helpful when it came to suggestions with home life"

Examples: Communication

"I felt that I was listened to & not made to feel that my problems or questions were silly or invalidated"

"I felt confident and comfortable speaking, I felt I were listened to and understood, very happy with the care I receive."

You Said, We Did

A young person said that their questionnaire had not been looked at prior to their appointment and so the session felt repetitive. Training was delivered to clinicians on how best to use the tool and use it to prepare for upcoming sessions.

- All Children/Young People (CYP) aged 9+ and their parents/carers are invited to complete the CHI-ESQ (Experience of Service Questionnaire) at review and at discharge from Greenwich CAMHS. This data relates to questionnaires completed in Greenwich from 1st October 2021 – 31st March 2022
- 139 responses were collected, 90 from parents/carers and 65 from CYP.

CHILDREN'S MENTAL HEALTH AND WELLBEING – NATIONAL CONTEXT

Three in four mental illnesses start in childhood
Three quarters of life-long mental health problems in the UK start before the age of 25.*

Mental Health and Physical Health: Children with a mental health disorder were more likely to have poor general health, a limiting long-term illness, a physical or developmental problem or a special educational need. Nearly three-quarters (71.7%) had a physical health condition or developmental problem.*

Probable mental disorder: Rates increased between 2017 and 2021; in 6 to 16 year olds from one in nine (11.6%) to one in six (17.4%), and in 17 to 19 year olds from one in ten (10.1%) to one in six (17.4%). Rates in both age groups remained similar between 2020 and 2021. **

Change in mental health: Looking at individual-level change, 39.2% of those aged 6 to 16 years in 2021 had experienced deterioration in mental health since 2017, and 21.8% experienced improvement. Among those aged 17 to 23 years in 2021, 52.5% experienced deterioration, and 15.2% experienced improvement. **

School absence: Overall, 10.6% of 6 to 16 year olds missed more than 15 days of school during the 2020 Autumn term. Children with a probable mental disorder were twice as likely to have missed this much school (18.2%) as those unlikely to have a mental disorder (8.8%) **

* NHS Digital Mental Health of Children and Young People in England 2017
** NHS Digital Mental Health of Children and Young People in England 2021 mhcyp_2021_rep.pdf (digital.nhs.uk)

CHILDREN'S MENTAL HEALTH AND WELLBEING – LOCAL CONTEXT

Referrals: Referrals into Greenwich CAMHS have remained at a mostly consistent level over the past two years however increased acuity has continued to adversely affect capacity across all pathways.

Caseload Sizes: Rates of discharges across CAMHS pathways having reduced by 42.5% since 2019 leading to increased caseload sizes.

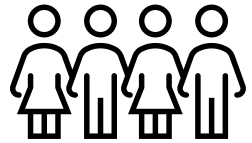
In July 22, caseloads in Greenwich had grown by 26% in the previous 2 years.

Waiting Times: Numbers of CYP waiting have increased in recent years with Greenwich just below the national average for those waiting for 1st appointment (as of July 22) and above the national average for 2nd appointments.

Crisis Presentations: 55% increase in crisis presentations for CYP in Greenwich from 19/20 to 21/22 with further increase forecast for the current year.

In July 22, there were 88 crisis referrals. 56 (64%) did not have an open referral to any CAMHS team.

RESET AND RECOVERY



Children and Young People Mental Health

- **MHST –** 24 primary schools; 7 secondary schools and 1 sixth form. The team continue to work with schools to expand the reach.
- **Young Greenwich** – Parenting programmes being delivered supporting parents of adolescents.
- **Discharge Protocol** – best practice protocol developed, implemented and reviewed that has improved relationships and join up on discharge. Further work needed to quantify the impact.
- **Tellmi** – Peer to peer online support for children and young people commenced in 2022.
- **Kooth** – In 2021/22 - 4,526 new logins to the service and high levels of positive user feedback
- **Tramshed** – pilot project to support children and young people's mental health through drama, provided a service for up to 30 children in 21/22 and will continue to do so through NHS funding in 2022/23
- **Mental Health and Wellbeing fund for schools** – Joint RBG and NHS funding agreed for Mental Health and Wellbeing initiatives delivered through education settings. Application process released this month.

OUR CYP MENTAL HEALTH AND EMOTIONAL WELLBEING TRANSFORMATION PLAN

- The transformation plan focuses on delivery and improvement over the next two years.
- The focus is on CYP mental health and emotional wellbeing (and not just CAMHS).
- The transformation plan priority areas need to align to the 10 key areas identified as part of the Phase 3 CYP Mental Health Inequalities Report as well as the national KLoEs.
- The transformation plan needs to have clear actions (with delivery dates) identified for each of the key areas. The plan should be integrated including actions underway both through health and local authority funded services.
- Place and Trusts complete a template setting out priorities/actions, which are then combined to create an overall SEL Plan.
- The plans are subject to resources available with SEL and Place working together on prioritisation.

DEVELOPING OUR CYP MENTAL HEALTH AND EMOTIONAL WELLBEING TRANSFORMATION PLAN

Date	Task
9th September	First draft of proposed Place and Trust plans to be collated.
15th September	First drafts to be reviewed by the CYP Mental Health Network with a view to agree the actions/pieces of work that need to be done once, SEL-wide.
16th September	Update to be provided on the development of the transformation plan at the ICS Mental Health Board
28th September	**Healthier Greenwich Partnership Update**
30th September	Final transformation plan developed.
21st October (no later than)	Local Care Partnerships endorsement of final transformation (and endorsement of both Place-based actions and SEL-wide actions).
28th October (no later than)	Mental Health Board endorsement of transformation plan.
16th November	SEL ICB endorsement of the transformation plan (through the public board meeting)
2nd December	Final transformation plan to be published on SEL ICB website

HIGHLIGHTED KEY PRIORITY AREAS – FULL PLAN IN APPENDIX

Ten Mental Health and Wellbeing priorities for change emerged from the ICS commissioned PPL report on addressing inequalities in CYP Mental Health. These have formed the structure of the mental health and wellbeing transformation plans.

- Parental Mental Health
- Crisis Step Down
- Managing Waiting Lists
- A&E Presentations
- Young Offenders
- Inequalities in Access
- Transition to Adult Services
- Supporting Children responding to Trauma and Distress
- CYP Eating Disorders
- Schools

ROYAL borough of GREENWICH

NHS South East London

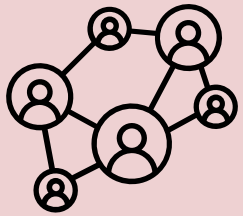
South East London Integrated Care System

*some proposals cut across multiple boroughs but impact on Greenwich

HIGHLIGHTED KEY PRIORITY AREAS – FULL PLAN IN APPENDIX

Thrive Implementation

- Approaching Mental Health and Wellbeing as a whole system
- Prevention and early intervention
- March 2023



Single Point of Access

- Single point for all mental health and wellbeing referrals
- Multi-agency
- Digital front door
- June 2023

Crisis Care

- Extend crisis service to 24/7 - initially as 2yr pilot
- Additional capacity for emergency assessment and brief interventions
- Early 2023 (recruitment dependent)

Prevention and population mental health

Recent work

- Delivered £491k Mental Health and Inequalities Innovation Grants to grassroots organisations and residents from May 2022
- Promoting universal ZSA Suicide Prevention training to staff and community groups.
- Delivering targeted suicide prevention training to social care, health and schools staff.
- Launched a Suicide Bereavement Service, including practical and emotional support, with direct outreach linked to London-wide Real Time Suicide Surveillance system.
- Promoting mental health and wider determinants support through the Live Well Line, Live Well Coaches and Greenwich Community Directory
- Investing in and promoting “Good Thinking” (pan-London digital mental health resources), including faith specific resources
- RBG corporate priority to help residents with Cost of Living through Greenwich Supports, including Live Well Line
- Increased the counselling service in secondary schools for an extra day per week
- Delivered self-belief and motivational workshops for pupils in secondary schools

Prevention and population mental health

Key deliverables next 12 months

- Making ~£850,000 Mental Health Innovation Grants available for schools and nurseries
- Improving responsiveness of suicide prevention activities – developing cluster surveillance and response around deaths, and exploring opportunities re self-harm
- Exploring roll-out of pilot SEL self-harm in Emergency Departments work to Greenwich settings
- Mapping social connection assets across the borough, and enabling effective support into meaningful connection opportunities.
- Supporting effective and sustainable Community Involvement in design and delivery of MHWB activity, building on engagement through COVID, Community Champions Programme, G-HIVE and influencing future thinking around Neighbourhood-based working.
- Completing Mental Health and Wellbeing Needs Assessment
- Exploring sign up to Prevention Concordat for Better Mental Health which would include delivering 12-month plan for improving population mental health

Challenges next 12 months

- Impact of Cost of Living Crisis, climate crisis and Ukraine war on burden of mental health
- Ensuring the best oversight and partnership co-ordination around population mental health and wellbeing
- Improving partnerships around Suicide Prevention, particularly with University and Prison settings, and Port of London
- Ensuring engagement is consistent and residents' contribution is recognised/rewarded
- Establishing best way to incorporate MH anti-stigma activity into community collaboration work

Each of the priority areas in our Delivery Plan will seek to actively address health inequalities

1. IMPROVING MENTAL HEALTH AND WELLBEING					
Priority Area	**Priority Description**	**Key Milestone/s**	**Lead**	**Delivery Group**	**Progress Update**
Establish the Mental Health Alliance	To develop and launch a Mental Health Alliance to improve outcomes for service users, address, address health inequalities and develop the mental health system. Initially the focus will be around accommodation based services.	• First Alliance Agreement signed August 2022 • Extensive engagement work with LXP individuals underway from September/October 2022 • Alliance Data Sharing Agreement in place since January 2021 and joint assessments taken place • Ongoing assessment work that helps develops themes for future development • Revised procurement planning to take account of LXP views and design • Agreement for a Pathway Coordinator – decisions to be taken which organization hosts the role	Integrated Director of Commissioning -Adult's Services (RBG/ICB)	• Alliance Board	• Throughout the development of the Alliance, consideration has been given on how best to engage with clients in supported accommodation, this is now an integral thread in the Alliance work. To date this has taken the form of interviews, surveys, reviews. This work has formed the basis upon which we are now progressing to forms of co-design via workshops, and to the establishment and a platform for better, more coherent and longer-term engagement practices across the system • Comprehensive Alliance model of joint assessments across voluntary sector are taking place • Co design and externally facilitated lived experience work across October and November 2022 • Planning already underway for decisions on the new model following the design work which will lead to a procurement exercise in 2024
Managing acute and community placement pressures	To work collaboratively to manage acute bed pressures, problem-solve, place and review patients in the community.	• Developing partnerships with Providers through spot contracts – future work required • Regular meetings in place to collaboratively review areas for improvement which are preventing access to suitable placements in the community – forum to review progress convened every 6 weeks • Community Mental Health Transformation project delivery – now in Year 2 and having delivered key requirements in the first year to design a Hub model is now progressing towards formal launch of the new MH Hub in the Autumn	Integrated Director of Commissioning -Adult's Services (RBG/ICB) Integrated Commissioning Unit (RBG/ICB) Oxleas – Crisis and Inpatient and Community Teams	• Section 75 Meeting with Oxleas • Bed Management Meeting – including Part 2 partnership forum (Oxleas led) • Provider and Commissioner Forum	• Continued work required with spot purchase providers, work will need to be factored into future market shaping strategies, cost of care and sustainability work with providers – subject to commissioning capacity. • The Community MH Transformation Programme of work is underway. A new Community MH Hub has been developed between partners from BGL Mind, Bridge Support and Oxleas. • Principles (drawing on those agreed at SEL) that underpin the Hub are • Bridging the gap between primary and secondary care • There is a no wrong door service with frictionless movement between them • Holistic approach to assessing and meeting needs • Integrated, MDT providing clinical and non-clinical support
Improving partnership working and service user engagement	To engage with service users, the voluntary and community sector and Providers to collaborate and improve the mental health system.	• Further develop effective user/resident engagement from across our communities, particularly those who do not normally have a voice – From November 2020 and ongoing • MH System wide workshop held in June 22 to aid collaboration and connections across the system – attended by people with lived experiences, VCS, LA, NHS, providers, front line staff and leaders – agenda included reflecting on lived experiences, agreeing positive ways of working between partners, review of data and insight, mapping of a range of services in communities, project updates, review of MH vision and agreement to key next steps • Insights gained from community based activity during the pandemic including deep engag • Undertake a range of user/resident engagement of individuals in accommodation-based services – this	Integrated Director of Commissioning -Adult's Services (RBG/ICB) and other place based system leaders focusing on MH	• MH Oversight and Coordination Board • Greenwich Mental Health Development Collaborative (Voice and Engagement Subgroup)	• User/resident engagement of individuals in accommodation-based services has happened and informing work around MH Alliance and other commissioning services. • Actions from June MH workshop prioritized and initial actions to be progressed agreed at MH Oversight and Coordination Board • Greenwich Mental Health Development Collaborative is exploring the future work of the collaborative ad how the group can contribute to the development and implementation of MH services in the borough. • A review of service user engagement continues to be an ongoing priority with user voice now represented in the MH Oversight and Co-Ordination board which was established in Autumn 2021

Each of the priority areas in our Delivery Plan will seek to actively address health inequalities

		was progressed in 2021/22 after some delays due to pandemic impacts • GAIN (Greenwich Area involvement Network) have appointed a new Voice and Engagement Officer. This officer is now a member of the MH Oversight and Coordination Board which oversees the range of MH activity across the Borough. This is to ensure links are maintained between the work of GAIN and Voice and Engagement Subgroup. • Representatives of the community with an experience of MH are now formerly on the MH oversight and Coordination Board and actively involved in both shaping and delivery of activity across our MH projects and programmes			
Developing improved crisis pathways	To review and develop crisis pathways in collaboration with statutory and non-statutory services.	• Supporting Bridge Support and Bromley, Lewisham and Greenwich Mind Mindline service extension following successful funding bid – On-going co-design • Service User engagement around Crisis pathways – on-going – aim to finish by 2021	Assistant Director – Public Health (RBG)	Mental Health Crisis Pathways Group	• BLG Mindline has been delivering on the increased hours. COVID has delayed Bridge Support work • Service user stories are being gathered to support the development of the pathway led by GAIN
Improving mental health and well-being	To work with partners to create a more seamless community mental health and well-being offer with up to date and diverse information and advice.	• Joint work on the Community Mental Health Transformation Programme. This had previously included establishing the Mental Well-Being, BAME, LGBTQ+, Voice & Engagement and Bereavement workstreams – these have now progressed as part of the CMH transformation work including the development of the MH Hub approach • Supporting the Greenwich MH Hub multi-agency meetings, linking to neighbourhood development and linking to primary care initiatives – Ongoing work to embed newly designed approach • Serious Mental Illness (SMI) Physical Health Checks – work continues in partnership between Oxleas and primary care colleagues to address the low uptake of SMI physical health checks • Appointment of Clinical and Care Professional Lead role for MH and LD – successful appointment of newly established CCPL role, initial focus on improving take up of SMI Physical health checks and supporting work to embed MH practitioner roles as part of CMH transformation	Integrated Director of Commissioning - Adult's (RBG/ICB) and other place based system leaders focusing on MH	MH Oversight and Coordination Board CMH Transformation Project group	• MH Oversight and coordination Board has been meeting monthly to oversee this and other key activity, jointly chaired by Oxleas and Integrated Commissioning • The scope of the work overseen by the Board has now widened to ensure an all age approach as well as covering activity related to prevention and public health led activity related to MH and Wellbeing • Live Well MDT meeting weekly with good engagement from Oxleas, explore further input from Health and Adult Services (non-mental health) and review specific cases with integrated commissioning unit to identify possible pathway and service improvements • Community Champions programme, building on COVID engagement, has been delivering key Mental Health and Wellbeing signposting and communications. • Social prescribing infrastructure (LW Line, Community Directory, Live Well Coaches) supports residents towards mental health and wellbeing information, resources and services, • £491k Mental Health and Inequalities Innovation Grants to grassroots organisations and residents.
Children and Young People Have Positive Mental Health and Wellbeing	Development of the priority under the Children and Young People's Plan. Re-commissioning of CAMHS looking at whole system mental health and wellbeing for children and young people. This includes tackling areas of inequality in access to provision.	• Mental Health and Wellbeing Group – December 2020 • Other actions and timescales to be delivered in line with the Children and Young People's Plan when finalised due by December 2020 • Safeguarding Children Partnership provide Sign Off for Multi-Agency Discharge Protocol - January / February 2021 • New CAMHS contract – April 2021 • Development and mobilisation – From April 2021	Interim Integrated Commissioning Director Children's Services – (RBG/CCG) David Borland	Mental Health and Wellbeing Group Multi-Agency Protocol Group	• Multi-Agency Discharged Protocol in place and 1 year review undertaken. Improvements identified in joint working across CAMHS, Social Care and Hospital. Further work needed to quantify the impact. • New pilot of Tellmi – peer to peer online support for children and young people • The CAMHS contract is now operating on the annual NHS contracting cycle. Re-commissioning development work identified as part of the wider SEL Mental Health and Wellbeing

Each of the priority areas in our Delivery Plan will seek to actively address health inequalities

					Transformation Plan – to be finalised and published by December 2022. • New Mental Health and Wellbeing Fund to support the delivery of school-based projects. • Increased the counselling service in secondary schools for an extra day per week • Self-belief and motivational workshops delivered for pupils in secondary schools
Anti-stigma	Engage communities on their own terms to find ways to improve openness and tackle stigma around mental health and wellbeing, developing universal and targeted communications, creating mentally healthy public and domestic spaces	• Recruit Time to Change Champions • Co-design and deliver a variety of communications, universal and targeted • Continue to deliver Play Streets • Review approach in light of pandemic impacts on Time Change roles and create sustainable ways to still address this priority	Health and Wellbeing Strategist (RBG)	Mental Health and Wellbeing Partnership Board	• National Time to Change no longer receives funding (as of April 2021), but Greenwich Time to Change Hub Champions can use branding until November 2022. Local initiatives by Champions include Just Another Illness (https://justanotherillness.com/). • Events held to coincide with World Suicide Prevention Day (10th September 2022) • Through COVID-19 community engagement, residents requested community training in relation to mental health. • Pilot Advice in Community Settings funded by the GLA which will brought financial, housing and immigration advice into community settings to schools in Thamesmead. Learning informing future approaches. • New brand identity for champion-led anti-stigma work has been developed (replacing Time to Change), however during COVID period many lived experience champions have moved away from these roles, and we need to look at the most effective and sustainable ways to continue to address this priority.
A happy, healthy and productive workforce	Identify and implement effective approaches to engaging local employers around tackling stigma and discrimination, working with employers to provide mentally healthy workplaces	• Employers signing Time to Change Pledge. • Experts by experience supporting workplaces around mental health and wellbeing. • Health and Wellbeing Board partners modelling mentally healthy workplaces. • Supported Employment approaches for those with MH needs are in scope of the newly launched VCS commissioning programme within RBG	Health and Wellbeing Strategist (RBG)/Healthy Workplace Programme Manager (RBG)	Employee Health and Wellbeing Strategic Group/Mental Health and Wellbeing Partnership Board	• RB Greenwich has achieved re-accreditation from the London Healthy Workplace Award in 2021, which recognizes support for employee mental wellbeing. • Continued support for businesses and organisations to achieve accreditation or re-accreditation for the London Healthy Workplace Award from Public Health and the GLA
Suicide prevention	Improving information and intelligence to tackle suicide, supporting higher risk and vulnerable populations and improving communication and support around suicide	• Deliver regular suicide audits, develop sources of suicide intelligence such as Coroner's reports. • Improve suicide prevention training for staff across the system • Respond to evidence of local risk factors, including collaborating with the "Improving information and intelligence" task and finish group. • Improve the support available to people who have been bereaved by suicide.	Health and Wellbeing Strategist (RBG)	Suicide Prevention Steering Group	• Joint SEL work has led to a support service for people bereaved by suicide, offering practical and emotional/clinical support. • Work underway to refresh the Greenwich Suicide Prevention Strategy for 2022. • Promoting universal ZSA Suicide Prevention training to staff and community groups. • Delivering targeted suicide prevention training to social care, health and schools staff. • Developing a Suicide Bereavement Service, including practical and emotional support, with direct outreach linked to London-wide Real Time Suicide Surveillance system.

Each of the priority areas in our Delivery Plan will seek to actively address health inequalities

		• Work underway to refresh the Greenwich Suicide Prevention Strategy for 2022.			• Community Engagement event around Suicide, co-delivered between RBG, Oxleas and grassroots BAME mental health group Nous organization for World Suicide Prevention Day • Suicide Prevention Strategy is being revised to properly respond to dramatic changes in wider context (Cost of Living Crisis, impact of war and international situation) • Early planning will commence for World Mental Health Day in 2023
Enabling and improving social connection	Promote social connection for everyone, prevent people becoming isolated or lonely and restore social connection for people who have become isolated or lonely	• Provide social isolation/loneliness support from Live Well Greenwich • Continued work to develop interventions to improve social connections and improve mental health for Thamesmead residents through Shaping Thamesmead	Head of Public Health Development (RB)/Public Health Strategist (RBG)	Mental Health and Wellbeing Partnership Board	• The Shaping Thamesmead bid development (October 2019 – August 2021) provided rich insights around social connection, community connection, social isolation, loneliness and mental health, particularly through community researchers. Funding for interventions being identified through Greenwich Public Health and Bexley Integrated Commissioning – now Connecting Thamesmead. • Funding has been identified for mapping of and engagement with social connection opportunities/assets at neighbourhood level and possible training for relevant groups. Ambition is to enable social prescribers and peer champions to identify and address social connection needs, by supporting people who are socially isolated and lonely to access existing social assets in the borough. • Procurement of provider to deliver mapping of social connection assets across the borough has been progressed with successful bidder identified. • Engagement event with Health and Adult Services frontline professionals around design of work to enable effective support of residents to meaningful and sustainable social connection opportunities. • Peabody has been commissioned to co-ordinate implementation of a cross-borough partnership action plan focusing on interventions to improve social connection and mental health in Thamesmead, called Connecting Thamesmead, linking to mental health transformation work in Bexley and Greenwich

Our aims is for all children and young people and families in Greenwich to have the support needed to be mentally Healthy. This includes being empowered to know how we can help ourselves. Where more helps is needed, children, young people and families have choice of support, provided by someone families can trust which is welcoming, withough discrimation and easy to access.

KEY:
Oxleas/SLaM: Trust-wide | Individual Borough | Multiple Boroughs

Key Priority Area	Action (What will we do?)	Deliverable/Outcome (What will we achieve?)	Delivery Date (When will we achieve this by?)	Monitoring Delivery (How will we monitor delivery?	Nominated LCP Lead (Who will lead this work?)
Managing Waiting Lists	**Neurodevelopmental & Learning Disability pathways** - increase early access to evidence-based interventions (e.g. PBS) for CYP with neurodevelopmental and co-morbid mental health difficulties to reduce long-term need for psychopharmacology. Expand access to support within primary care through shared care arrangements for young people with neurodevelopmental needs, through direct clinical care and consultation/support.	(A) Increase access to evidence-based interventions for CYP with neurodevelopmental and co-morbid mental health difficulties (B) Reduce waiting time for assessment and treatment for CYP in CAMHS Neuro pathways in accordance with NHSE access/wait standards (C) Reduce pathway LOS and increase rate of discharge for CYP in CAMHS Neuro pathways (D) Increase in number of CYP supported in primary care setting with neurodevelopmental and pharmacological needs.	(A) Apr-23 (B) Jan-24 (C) Jan-24 (D) Sep-24	Oxleas CAMHS Leadership Group C&YP Directorate	Oxleas CAMHS
	iTHRIVE Transformation - transformation of community CAMHS services to achieve greater alignment with iTHRIVE framework, with aims of improving user/pathway flow and staff experience, in addition to embedding focus on user outcomes, a culture of continuous improvement and use of processes and data. The framework emphasises needs-led decision making and, therefore, the development of relationships with community partners (inc. Third Sector/VCS) will be critical.	> Alignment to THRIVE framework > Improve user/pathway flow, service responsiveness and access > Improve staff experience, reduce vacancy rate > Improve consistency in service processes/practice	Jun-23	Oxleas CAMHS Leadership Group C&YP Directorate	Oxleas CAMHS
	'Keeping in Touch' programme - pilot of assessment waiting list management programme, including CYP/parent support groups, digital and psychoeducation interventions (e.g. sleep hygiene)	(A) Increased access to psychoeducation for common mental health difficulties and support for CYP on assessment waiting lists (B) Greater oversight and management (inc. gatekeeping) of CYP on assessment waiting lists (C) Reduction in number of CYP requiring assessment following KIT programme intervention (D) Expansion of digital offer	(A) Programme pilot to commence by Jan-2023 (B) Review of pilot by Jul-2023	Oxleas CAMHS Leadership Group C&YP Directorate	Oxleas CAMHS
	Developing Clinical Skills, Capacity & Workforce - further implement Oxleas CAMHS Workforce Strategy to reduce vacancy rate, retain staff and expand capacity to provide evidence-based interventions. Aims include: > Diversifying clinical workforce through investment in new clinical roles such as CWPs and CAPs > Reinforcing support for CAMHS Social Work and Nursing staffing groups through establishment of Practice Development roles > Investing in Art/Music Therapy posts to achieve greater alignmtnet with NICE guidance for LAC, EIP and Complex Trauma, providing foundations for development of new Complex Trauma pathway.	(A) Reduction in vacancy rates and increase in staff retention, enabling greater consistency in clinical capacity and consequent reduction in waiting times for a range of interventions (B) Increase CYP access to evidence-based interventions across pathways (C) Greater diversity in skillset within MDT	Jan-24	Oxleas CAMHS Leadership Group C&YP Directorate	Oxleas CAMHS
	Integrated Clinical team: Create an Integrated Clinical Team based within RBG social care team; recruit the lead post first (for Oct/Nov) and then work with colleagues to develop the model/learn and then recruit additional posts.	Embed the systemic and CFT Pyschological practice model within Social Care and the Family Support Service (Front Door) thereby reducing referrals to CAHMS services; Fewer inappropriate referrals to specialist CAMHS	Oct-22	Children Children and Families Safeguarding and Social Care Clinical Oversight Group	RBG
	VCS Support: Delivery of " Whatever Makes You Happy" Drama programme by Tramshed	The proven effectiveness of the Safe Space/Drama workshop structure ensures that social interaction time is balanced with social interaction, therapy, and drama-based activity to help the young people: >Build confidence & self-esteem >Develop communication skills & ability to express themselves >Work with others & develop social skills >Improve resilience & manage emotions	Mar-23	Contract monitoring meetings quarterly	Head of CYP Integrated Commissioning
	Preceptorship Programme - expand preceptorship programmes to all CAMHS Psychological Therapist roles. This will support newly qualified clinicians to progress (e.g. Band 7 to Band 8a) following completion of a 2yr period in post (assuming core competences are met)	(A) Greater retention of staff across community CAMHS (B) Reduction in vacancy rate (C) Increase CYP access to evidence-based intervnetions across pathways, maintain MDT balance	Jan-23	Oxleas CAMHS Leadership Group C&YP Directorate	Oxleas CAMHS
Transition to Adult Services	**16-25yrs Clinical Pathway** - develop and mobilise tri-borough specialist 16-25yrs clinical pathway (with support of recently appointed Darzi Fellow), supporting young people who often do not meet criteria or disengage from AMH services, including Care Leavers.	(A) Develop 16-25yrs clinical pathway in partnership with AMH and other stakeholders (B) Mobilise 16-25yrs clinical pathway More young people receive appropriate care >Improved transition experience >Fewer young people go on to need support for adult specialist mental health services. >Fewer hospital admissions >More children and young people from under-represented groups access appropriate support >More children and young people accessing social pre-scribing/community opportunities	(A) Jan-23 (B) Sep-23	Oxleas CAMHS Leadership Group C&YP Directorate Oxleas AMH Directorate	Oxleas CAMHS - Dominic Leigh, Sabitha Sridhar, Darzi Fellow Oxleas AMH - TBC
	Perinatal Care - pilot of specialist perinatal pathway within newly developed 16-25yrs clinical pathway in response to local evidence suggesting disproportionately high number of young mothers presenting to AMH services.	> Increase access to specialist perinatal MH care for young mothers within 16-25yrs pathway > Address local inequalities in access	Sep-23	Oxleas CAMHS Leadership Group C&YP Directorate Oxleas AMH Directorate	Oxleas CAMHS - Dominic Leigh, Sabitha Sridhar, Darzi Fellow Oxleas AMH - TBC
	Partnership Development - continue to develop links with local Third Sector partners (e.g. Recovery College, MIND, Bromley Well) to improve access to MHWB services for young people aged +18yrs.	> Increase access to community MHWB services for young people aged +18yrs > Improve links and joint working practice between NHS and Third Sector organisations	Apr-23	Oxleas CAMHS Leadership Group C&YP Directorate	Oxleas CAMHS
Inequalities In Access	**Outcome/Population Analysis** - increase level of clinical outcome and population data analysis, focussing on inequalities in clinical outcomes and access across community CAMHS, and further embedding clinical outcome practice across teams.	(A) Improved insight and data analysis regarding inequalities in clinical outcomes and access (B) Achieve NHSE LTP clinical outcome measure (paired measure) targets (GBOs)	(A) Apr-23 (B) Mar-24	Oxleas CAMHS Leadership Group C&YP Directorate	Oxleas CAMHS
	Integrated Single Point of Access/Front Door - pilot integrated SPA for all local MHWB referrals in accordance with Kaleidoscope progamme and in partnership with Third Sector and other stakeholders, including Bromley Y and RB Greenwich. Development will include creation of 'digital front door' and will help achieve SEL commitment to 'virtual waiting room'.	(A) Improve referral triage decision making (B) Fewer inappropriate referrals (C) Improve gatekeeping of specialist services (D) Increase in access to CYPMH services;	Mar-23	Oxleas CAMHS Leadership Group C&YP Directorate (and others as indicated)	Oxleas CAMHS (and others as indicated)

	Access Teams - pilot new 'Access Teams' to improve management and processing of referrals within community CAMHS. The team will also seek to engage with user groups in CAMHS and reinforce co-production agendas (w/ People Participation Lead), whilst also engaging with underrepresented communities (e.g. LAC, 0-5s, Youth Offending, cultural and religious groups) through targeted interventions as MHWB champions and in helping referrers and users navigate systems/pathways.	(A) Increase access to CAMHS from underrepresented groups (B) Meet NHSE CAMHS access targets (C) Reduction in number of declined referrals/increase in referral acceptance rate (D) Improve relationships with referrers/other partners	Mar-24	Oxleas CAMHS Leadership Group C&YP Directorate	Oxleas CAMHS
Parental Mental Health	**Family Connections** - expand 12-week Family Connections group programme across community CAMHS (evidence-based programme for relatives of CYP with problems with emotion dysregulation)	> Increase access to Family Connections programme > Increase numbers of clinicians trained to deliver intervention > Increase numbers of parents trained to co-facilitate programme	Increase group capacity by Apr-23	Oxleas CAMHS Leadership Group C&YP Directorate	Oxleas CAMHS
	NVR Leadership - establish clinical leadership for tri-borough community CAMHS evidence-based Non-Violent Resistance treatment pathway	> Establish sustainable clincal leadership role for NVR pathway, with a view to expanding access to evidence-based intervention for families across services	Jan-23	Oxleas CAMHS Leadership Group C&YP Directorate	Oxleas CAMHS
	Introduction of EPEC in Greenwich to undertake work with families from Global Majority Groups who are often under represented in Mental Health provision	Increased access, and reduced health inequalities for CYP often under represented in CAMHS service	Apr-23	SEL CAMHS Network/RBG	SLaM/ICB NHS Body
Schools	**MHST Clinical Leadership Pilot** - increase clinical leadership within MHST pathways through additional Band 8b post (working across Bexley and Greenwich) and continued delivery of Wave 6	> Establish sustainable clinical leadership role within MHST pathways, supporting development of clinicians and the clinical pathway in accordance with emerging evidence base; Improve mental health outcomes for CYP and reducing inequalities by providing mental heal support in schools ; promoting the programme to improve access.	Jan-23	Oxleas CAMHS Leadership Group C&YP Directorate	Oxleas CAMHS
	Art Therapy/Music Therapy Pilot - expand current MHST staff mix to include Art and Music Therapy roles, in accordance with evidence base for school-based interventions (working across Bexley and Greenwich)	> Increase access to evidence-based interventions for CYP in school settings > Develop clinical skill mix in MHST pathway > Diversify workforce, continue commitment to CAMHS Workforce Strategy	Jan-23	Oxleas CAMHS Leadership Group C&YP Directorate	Oxleas CAMHS
Supporting Children Responsing to Trauma and Distress	**Edge of Care** - develop targeted CAMHS pathway for CYP who are on the edge of care, working in close partnership with Local Authority colleagues to address any mental health difficulties experienced by the CYP and to support the professional network to keep families together. The clinical resource will be integrated within existing CAMHS LAC pathways.	> Improved understanding of mental health difficulties amongst Staying Together/EOC teams within Las > Greater access to specialist care for CYP who are EOC with mental health difficulties	Jan-23	Oxleas CAMHS Leadership Group C&YP Directorate	Oxleas CAMHS
	RB Greenwich Pilot/Review - review of existing clinical in-reach service to enable greater integration of CAMHS/CSC services and help staff to improve confidence and practice in working with CYP with mental health difficulties.	> Targeted support for staff in CSC working with CYP with mental health difficulties > Improve confidence/understanding amongst CSC staff in working with CYP with mental health difficulties > Improve understanding of CYPMH pathways amongst CSC staff and access to services for CYP	Dec-22	Oxleas CAMHS Leadership Group C&YP Directorate RBG DMT	Oxleas CAMHS RB Greenwich
Young Offenders	Mobilise **Violence Reduction Vanguard j**ointly with Bexley (CACT and SLAM)	Targeted support for YP at risk of exploitation and reduced risk of trauma, resulting in exposure to, or participation in community based violence	Apr-23	SEL CAMHS Network/RBG	Head of CYP Integrated Commissioning
	Integrated Clinical team: See row 13 for further detail	Embed the systemic and CFT Pyschological practice model within Youth Justice System/Youth Offending service thereby reducing referrals to CAMHS services; Fewer inappropriate referrals to specialist CAMHS	Oct-22	Children Children and Families Safeguarding and Social Care Clinical Oversight Group	RBG
CYP Eating Disorders	**Review Demand & Capacity** for routine and urgent referrals	Adherence to national standards and sustainable workload for staff	Mar-23	monthly monitoring	SLaM
A&E Presentations	**24hr Crisis & Liaison Team** - expand Crisis Team to provide 24hr rapid response service (in accordance with NHS Long Term Plan) and increase multi-disciplinary representation.	> Reduce number of delayed discharges in ED > Reduce time between DTA and transfer to inpatient unit > Meet 1hr F2F emergency referral response time target (24/7)	Apr-24	Oxleas CAMHS Leadership Group C&YP Directorate	Oxleas CAMHS
	24hr Crisis Line - evaluate mobilisation of 24hr SLP Crisis Line and effectiveness in reducing number of A&E presentations	> Reduce number of A&E presentations	As per SLP timelines	South London Partnership Exec	South London Partnership
Crisis Stepdown	**Intensive Outreach Team** - develop intensive outreach team within Crisis pathway, offering alternative to admission, MDT assessment and treatment to CYP in mental health crisis within a community setting, including group and social prescribing interventions. Service will also provide urgent response to CYP presenting in crisis within the community (4hr).	> Reduce number of admissions to psychiatric inpatient units > Reduce number of delayed discharges in ED > Meet 4hr urgent community referral response time > Reduce number of A&E presentations	Apr-24	Oxleas CAMHS Leadership Group C&YP Directorate	Oxleas CAMHS
	24hr Intensive Outreach Team - expansion of above team to provide 24/7 service to CYP in mental health crisis within community setting	> 24/7 service for CYP presenting in mental health crisis within community setting	Dec-24	Oxleas CAMHS Leadership Group C&YP Directorate	Oxleas CAMHS

AGENDA ITEM: 7

Healthier Greenwich Partnership

Date: 28 September

Title	Winter Plan Discussion Document	
This paper is for **noting/approval**		
Executive Summary	• Winter is traditionally a challenging time for the health and social care system, with the number of people requiring hospital treatment or admission rising sharply. This year feels different; the system moves towards winter without having experienced the traditional summer dip in demand and with the anticipated cost of living crisis expected to have an additional impact on health and care services. • Staff across the system have worked tirelessly to balance priorities over the last two years. It is thanks to their efforts and professionalism that NHS and social care services in Greenwich remain something of which we are proud. Supporting staff and acting together to make changes where we know there is challenge or opportunity, is central to our plan for winter. • The performance of the emergency department serving to signify whether the system as a whole is working effectively to support people in need of urgent or emergency treatment. This winter plan goes beyond beds in line with our Home First principle – where the provision of care can take place outside hospital this will be enabled, preserving hospital beds for those requiring specialist input. • The winter plan is being developed collaboratively with partners from across the Greenwich Wellbeing Partnership, bringing together a summary of the changes that we will make ahead of, and during winter, to safeguard our collective resilience and ensure residents continue to receive a high-quality service.	
Recommended action for the Committee	To note the report.	
Potential Conflicts of Interest	• *None.*	
Impacts of this proposal	Key risks & mitigations	*Listed within the report.*

	Equality impact	*None from this paper as it is a discussion document related to proposed plans.*
	Financial impact	*None from this report – winter pressures will have a financial impact but this is report has no costs associated with it.*
Wider support for this proposal	Public Engagement	• *The HGP in September is being held in public.*
	Other Committee Discussion/ Internal Engagement	• *Greenwich Joint Commissioning Board – 22 September.*
Author:	*Gemma O'Neil, Deputy Director of System Development*	
Executive sponsor:	*Neil Kennett-Brown, Chief Operating Officer, Greenwich*	

The Greenwich Winter Plan

Version 1

13th September 2022

Draft / discussion document

Winter is traditionally a challenging time for the health and social care system.

This year feels different.

Introduction

- Winter is traditionally a challenging time for the health and social care system, with the number of people requiring hospital treatment or admission rising sharply. This year feels different; the system moves towards winter without having experienced the traditional summer dip in demand and with the anticipated cost of living crisis expected to have an additional impact on health and care services.

- Staff across the system have worked tirelessly to balance priorities over the last two years. It is thanks to their efforts and professionalism that NHS and social care services in Greenwich remain something of which we are proud. Supporting staff and acting together to make changes where we know there is challenge or opportunity, is central to our plan for winter.

- The performance of the emergency department serving to signify whether the system as a whole is working effectively to support people in need of urgent or emergency treatment. This winter plan goes beyond beds in line with our Home First principle – where the provision of care can take place outside hospital this will be enabled, preserving hospital beds for those requiring specialist input.

- This plan, developed collaboratively with partners from across the Greenwich Wellbeing Partnership, brings together a summary of the changes that we will make ahead of, and during winter, to safeguard our collective resilience and ensure residents continue to receive a high-quality service.

Funding award and bed targets

- A winter funding allocation has been awarded to SEL and divided between the respective acute trusts and six boroughs. The table below presents the funding and associated bed increases expected.

	GST	KCH	LGT	Borough	Total
	£'000s	£'000s	£'000s	£'000s	£'000s
Wider Discharge Initiatives	£559	£1,118	£1,118	£2,795	£5,590
Acute Pathway Improvement	£400	£800	£800	£0	£2,000
Total	£959	£1,918	£1,918	£2,795	£7,590
			Per Borough	£466	
Bed target	8	16	16	36	76
			Per borough	6	

Our winter story – What will winter look like in Greenwich this year?

- The difficulties staff and residents are experiencing as the cost of living rises, along with the sustained high level of demand we are seeing across all of our service and threat of an increase in covid and flu cases, means that we expect this winter to be as challenging as ever.

Sustained high levels of demand across all parts of the health and care system	ED attendances at QEH in its worst summer were higher than winter 2021 Social care teams are receiving record levels of referrals Community services do not have the capacity to meet the levels of demand
Additional impact of cost of living crisis	More than half of British people (55%) feel their health has been negatively affected by the rising cost of living (Royal College of Physicians, 2022)
Limited opportunity to flex demand (elective recovery programme)	The uncharacteristically cold weather, high rates of emergency admissions, and a lack of capacity in an already overworked and overstretched system have led to cancellations of elective activity in previous winters – this is not included as an option in the Winter plan for this year in order to continue to support elective recovery
Changes to primary care – enhanced access DES	Implementation of the new EA DES will increase the proportion of core PC provided by GPs with full access to patient records however is expected to impact on the availability of same day primary care
Vaccination programme – flu / covid / polio	The winter vaccination programme delivered by Primary Care will this year include the traditional flu campaign, plus the covid booster and for those indicated Polio and Monkey Pox. This adds an additional risk to the already stretched Primary Care workforce

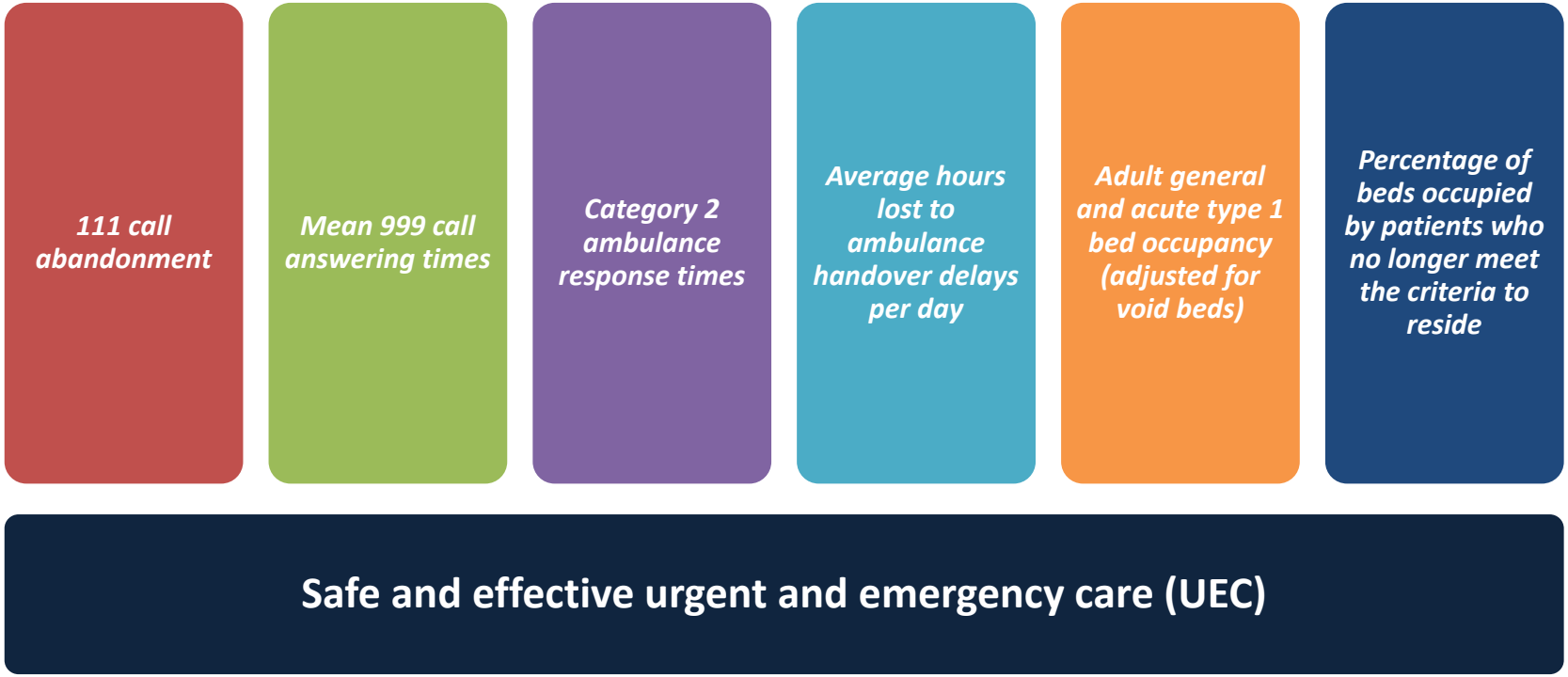
National winter resilience objectives

- **In a letter to ICB executives nationally, the following objectives were set out to increase capacity and operational resilience in urgent and emergency care:**

1. **Prepare for variants of COVID-19** and respiratory challenges, including an integrated COVID-19 and flu vaccination programme
2. **Increase capacity outside acute trusts**, including the scaling up of additional roles in primary care and releasing annual funding to support mental health through the winter
3. **Increase resilience in NHS 111 and 999 services**
4. **Target Category 2 response times and ambulance handover delays**, including improved utilisation of urgent community response and rapid response services and the new digital intelligent routing platform
5. **Reduce crowding in A&E departments** and target the longest waits in ED
6. **Reduce hospital occupancy**, through increasing capacity by the equivalent of at least 7,000 general and acute beds, through a mix of new physical beds, virtual wards, and improvements elsewhere in the pathway.
7. **Ensure timely discharge**, across acute, mental health, and community settings, by working with social care partners and implementing the 10 best practice interventions through the '100 day challenge'.
8. **Provide better support for people at home**, including the scaling up of virtual wards and additional support for High Intensity Users with complex needs.

National Performance Metrics

- Six specific metrics have been identified nationally which are seen as key to the provision of safe and effective urgent and emergency care. NHS England and ICBs will use these to monitor performance in each system through the Board Assurance Framework:



Key challenges linked to national priority areas

Impact of cost of living – all providers, partners, service users and staff

Vaccine programme

Impact of multi-vaccine (covid, flu, polio) delivery model on core system capacity.

Primary Care

Core primary care capacity and impact of extended access.

Community and urgent response

Growing demand for community services such as CHRT, Diabetes and District Nursing.

Front door attendances

Demand at the front door far exceeds the physical and staffing capacity (now consistently exceeding pre-covid levels)

Hospital flow

Demand throughout the hospital far exceeds the physical and staffing capacity (now consistently exceeding pre-covid levels)

Workforce

Wellbeing of current staff, vacancy levels, ability to recruit additional staff for winter

Increase in aggressive and abusive behaviour from patients towards staff across all sectors

System flow and discharges

Growing demand for social care as more people receive care out of hospital, and complexity increases. Significant staffing shortages in most areas.

Changing landscape of service provision during winter (GP enhanced access, UTC model, discharge programme)

Mental health demand in both community and bedded services have grown across London but is especially high in Greenwich and Greenwich

Public perception of open access as normal to health and social care services, when our Infection Prevention Control protocols place different restrictions.

Funding – short termism of discharge funding will demonstrably impact social care ability to resource care and recurrent funding levels not enough to reflect community pressure

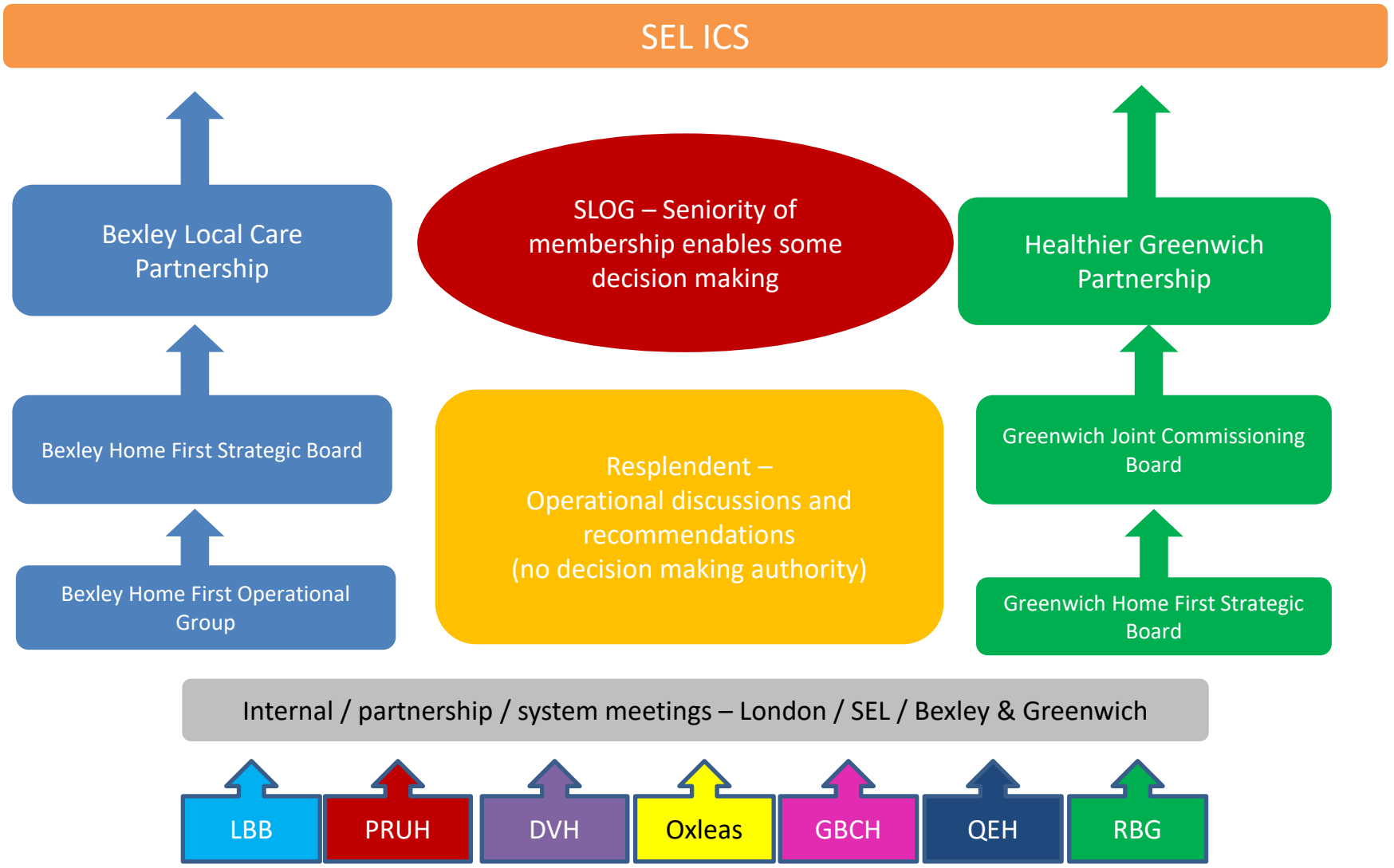
Local planning principles

Our plan is based on what we can do to deliver efficiency and aid resilience across the system within existing resources, and additional allocated winter funds. The focus is on delivering the right outcomes for residents by optimising responsiveness and flow throughout the system. Where the need for beds arises, this should be targeted and be out of hospital where appropriate

Our winter plans are based on a number of key principles:

1. **Maximising capacity** through investment in existing provision as opposed to creating new services.
2. **Supporting prevention** through targeted vaccination and enhanced access to urgent primary care
3. **Support effective system flow** through action to improve discharge planning, social work assessment, provide interim care and increase access to care in a range of community settings
4. **Considering mental health, alongside physical health, as a core driver of demand**
5. **Basing decisions on data and system intelligence and acting in the interest of improved outcomes**
6. **Supporting staff wellbeing** by ensuring that staff can continue to work safely and effectively with access to timely physical, practical and emotional wellbeing support
7. **Focusing on access and equity –** aiming for a consistent approach with a focus on closing gaps in provision
8. **Deploying our finite workforce smartly –** ensuring that we deploy capacity in the areas with the greatest need and potential to impact on the highest volume of patients.

Winter planning - system engagement & governance framework

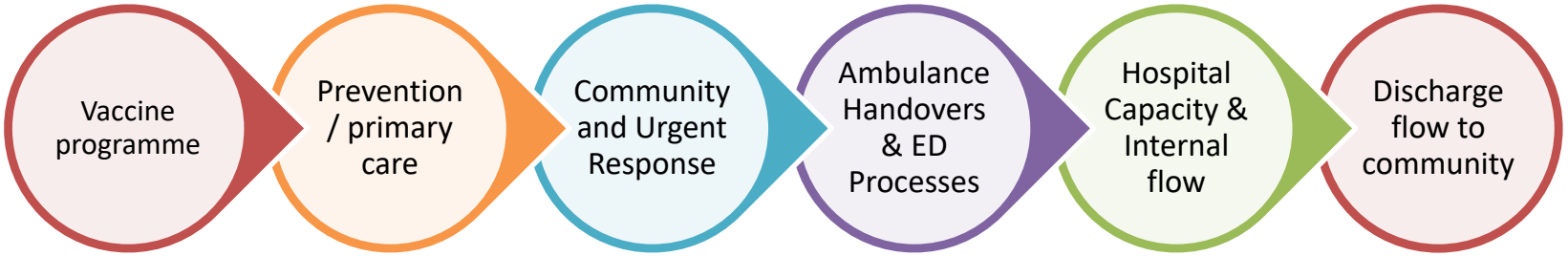


Greenwich Winter Schemes – Initial Ideas

- The opportunities outlined below are those developed by the Home First Board, with support from Resplendent. Work is ongoing to work up the resource, cost impact and feasibility of these opportunities. The intention is to use the winter funding of £466 to fund a sub-set the developments listed below which (based on initial analysis) will fund the additional beds (at a cost of circa £250k) and three/four additional opportunities. To deliver change over and above this, additional funding will need to be explored.

Apps - Scheme Proposals – Being considered through Home First Strategic Board
▸ 6 additional Winter Beds (location being discussed) – A total of 26 Greenwich beds = eleven more beds for winter (Community Beds – 10 Langton Way (Housing needs – at least until March 2023), 10 D2A (Permanent - all cohorts. Dependent on success of procurement) – This reflects an increased position on current 15 beds)
▸ Additional Social Care resource to manage patient flow – Social Workers
▸ Additional Social Care resource to manage patient flow – POC
▸ Additional DN capacity to support patients at home – alternative resource to complete Care Home Physical assessments (currently being completed by DNs)
▸ Additional Reablement / Therapy for more urgent access (also included within virtual ward plans).
▸ Care Home Trusted Assessor role – Possible conversation with Greenwich colleagues re efficiencies
▸ Single Point of Access for community services – Triage nurse in CAT team (clear and consistent criteria)
▸ Voluntary sector – Focus on pathway ‘0’ support / Cost of living scheme / winter warmth scheme
▸ Primary Care Access – GP Front door scheme
▸ Staff wellbeing – Schwartz round for staff
▸ Mental health – rapid access team to community placements / supported accommodation scheme.

System Preparedness Planning Priorities



- Flu / Covid booster / Polio / Monkey Pox – to protect against ill health

- Extended access DES - Same day access to Urgent and Emergency Care
- Prevention in conjunction with RBG Livewell services - Support for cost of living crisis, befriending, food parcels

- Maximise direction of appropriate patients to Rapid team
- Additional resource in community teams – particularly therapy and district nursing

- Fully implement SDEC pathways
- Co-locate MH crisis team at front door

- Provide 10 additional acute beds for winter
- Review of site team roles and responsibilities
- More hospital specialist palliative care (seven days)

- 11 additional Winter D2A beds to provide 26 total Greenwich beds
- Additional social care resource to support hospital discharge planning – social workers and packages of care

Workforce Initiatives – System Wide Actions

Key system risks / mitigations

Risk Description	Mitigation / response strategy
Insufficient health and social care staffing to support required interventions	Joined up recruitment/ sharing of workforce/rotational roles. Work more closely with voluntary sector. Recruit substantive roles at risk
Social care unable to meet demand for levels of discharge – POC and D2A	Continued review to prioritise need and manage risk. Continue to engage at a London and National level re funding solutions together with SEL ICS opportunities for funding
Community Health services unable to meet existing demand	Continued review to prioritise need and manage risk. Continue to engage at a London and National level re funding solutions together with SEL ICS opportunities for funding
System-wide lack of capacity to respond to peaks in demand	Continue to work in partnership to support the whole system to flex together during significant peaks in demand. Continue to engage at a London and National level re funding solutions together with SEL ICS opportunities for funding
Limited physical space / options to reconfigure space to respond to peaks in demand at QEH and to expand community services requiring	Constant review of opportunities to reduce demand, decompress ED, optimise use of space. Exploration of all elements of NHS / healthcare space including general practice and social care.

Winter Plans Key Dates

Date	Action	Committee
12/09/22	Review early draft with SEL colleagues	SEL UEC Board
12/09/22	Submission of self-assessment checklist	Acute Trusts
14/09/22	Submit estimated costs of six months of scheme, anticipated impact and likelihood of success	Members of GW Home First Programme Board
16/09/22	Presentation of winter schemes and 'story' for progression to HGP / BLCP / LGT boards	System Leaders Oversight Group
22/09/22	Socialisation of Winter Plan – principles and high level intentions (agreement to virtual approval or Chair's action of detailed plan prior to 27th October meeting to enable presentation at 19/10/22 HGP)	GW Joint Commissioning Board
22/09/22	Winter Plan – Detailed planning discussion (Recommendation to proceed to HGP)	GW Home First Programme Board
26/10/22	Approval of Winter Plan	Healthier Greenwich Partnership
End October	Next submission of assurance framework action log	SEL Team on behalf of the system
04/11/22	Presentation of Greenwich winter plan by system leaders	Greenwich OSC
November	Mobilise winter schemes	All
01/12/22	Winter Beds in Place	All

Greenwich virtual ward – plan on a page

Our biggest opportunity to reduce hospital stays for those most at risk of harm of admission
= frail, elderly and dementia

Frailty – 60 beds	IV antibiotics – 20 beds (10 adult & 10 children)	Dementia – 10 beds	Respiratory – 10 beds	End of Life Rapid Response – 5 – 7 beds	Reablement – Physiotherapy / OT – 5 beds
Expansion of Frailty MDT to identify moderately frail to support admission avoidance Focused short- term intervention to support people to reorientate and recover at home following hospital stay	IV antibiotics to support patients in own homes following hospital stay 5 patients currently reported through virtual ward data collection (5 further Gw patients per week currently using Homelink Service from QEH, also opportunities at ED for avoidance) Children's Hospital at Home service	Introduce Admiral nurses for crisis intervention and case finding Focused short-term intervention to support people with delirium or other related conditions to reorientate and recover at home following hospital discharge	Expansion of existing service to support admission avoidance To support patients on the COPD caseload who are experiencing an acute deterioration in symptoms to prevent ED attendance and admission where clinically appropriate	Proposal for new service provision by GBCH Rapid Response service model for end-of-life patients to support admission avoidance at points of crisis and enable more people to die in their place of choice	Expansion of existing service to support readmission avoidance A safe, timely response and on-going therapy review post discharge. Ensure carers are trained where needed and equipment is reviewed in the home environment.

Plus Programme Management support to mobilise and monitor

Greenwich virtual ward – plan on a page

Pathway	Potential number of virtual ward beds	Lead Provider	Summary of service	Staffing Model	Cost 22/23 £000s (six months)
Consultant Led Frailty Virtual Ward	60	QEH / Oxleas / PCN	1 Expansion of Frailty MDT to identify moderately frail to support admission avoidance 2 Focused short- term intervention to support people to reorientate and recover at home following hospital stay	Consultant (Geriatrician) GP Pharmacist Case co-ordinator Health Care Assistant Occupational Therapist Advanced Care Practitioner Case navigator nurse Virtual ward clerk Additional Social Care / Night Sitting	£798
Dementia / Delirium Virtual Ward	10	PCN / Oxleas	Focused short-term intervention to support people with delirium or other conditions to reorientate and recover at home following hospital discharge	2 x Admiral Nurses Additional social care / night sitting	£253
IV antibiotics (children and adult)	20 (10 children & 10 adult)	Oxleas	IV antibiotics to support patients in own homes following hospital stay	2 additional WTE DNs (Adults) – already reporting five virtual ward beds Team of nurses for Children's service	£245
End of Life Rapid Response	5 – 7	GBCH	Rapid Response service model for end-of-life patients to support admission avoidance at points of crisis	4 WTE Band 6 nurses	£133
Respiratory Virtual Ward	10	Oxleas	To support patients on the COPD caseload who are experiencing an acute deterioration in symptoms to prevent ED attendance where possible	1 additional Band 7 Respiratory CNS 1 Band 4 HCA (for tech monitoring) – already reporting six virtual ward beds	£66
Reablement – Greenwich CR-STAT – Community Care Plus	5	Oxleas	A safe, timely response and on-going therapy review post discharge. Ensure carers are trained where needed and equipment is reviewed in the home environment.	1 additional Band 7 Physiotherapist - already reporting four virtual ward beds	£46
Total	***112***				***£1541***

AGENDA ITEM: 8

Healthier Greenwich Partnership

Date: 28th September 2022

Title	Refresh of the Greenwich Health and Wellbeing Strategy	
This paper is for **approval**		
Executive Summary	1.1. The current Health and Wellbeing Strategy was agreed by the Health and Wellbeing Board shortly before the start of the pandemic. 1.2. Much has changed in our understand of key public health challenges since that time, especially in relation to the inequalities that our communities experience related to wider social, economic, cultural and environmental inequalities. 1.3. In light of the pandemic, lessons learnt and the need to redouble our efforts to tackle unjust health inequalities, the Board has agreed to a review and refresh of the current Health and Wellbeing Strategy to ensure it is fit for the future. 1.4. The Board is looking to the HGP to play a lead role in reviewing the strategy and proposing updated priorities and actions for the Board's consideration. 1.5. The current version of the strategy (to be reviewed) is attached as a reminder for HGP members of the priorities it identifies.	
Recommended action for the Committee	The HGP is asked to agree to take a lead role in reviewing and refreshing the strategy and to consider a suitable timeframe for achieving this.	
Potential Conflicts of Interest	• No potential COI identified in the decision to be taken at this meeting. • There may be COI considerations during the process of reviewing and refreshing the strategy.	
Impacts of this proposal	Key risks & mitigations	• There is a risk of duplication with strategies at Borough level that may be required by the ICB. It will be important to seek to align any such strategies and to be clear about what actions need to sit at SEL level and what at borough / place level • The refresh will be dependant upon an update

		of the Joint Strategic Needs Assessment (JSNA). The Public Health Team will lead a rapid update of the JSNA headlines to support the identification of priorities for the strategy refresh.
	Equality impact	• Addressing health inequalities will need to be a central thread running through the updated strategy. • Specific equalities considerations and actions to address them will be developed as the strategy is refreshed.
	Financial impact	The development of the refreshed strategy will be primarily resourced within existing staff costs within partner organisations. The implementation of the strategy will require resource assessments once the priorities and actions have been identified.
Wider support for this proposal	Public Engagement	• There will need to be a public engagement and consultation process as part of the refresh of the strategy
	Other Committee Discussion/ Internal Engagement	• The Health and Wellbeing Board considered this issue at its meeting of 7th July 2022. • It is proposed to establish a task and finish working group to oversee the process for the refresh of the strategy and to develop the public engagement and consultation process
Author:	Steve Whiteman, Director of Public Health, RBG	
Clinical lead:	*Name of the Lead Executive*	
Executive sponsor:	*Name of clinical lead*	

Royal Greenwich Joint Health and Wellbeing Strategy

2019-2024

ROYAL borough of GREENWICH

ITEM NO: 9 (Appendix A)

Contents

ITEM NO: 9 (Appendix A)

Foreword

The Royal Greenwich Health and Wellbeing Strategy 2019-2024 sets out our shared ambition for the borough. It describes how we as the strategic leaders for the health and social care system will work together with people who live, work or study in the Royal Borough of Greenwich over the next five years to create a happier, healthier place to live.

The Royal Borough of Greenwich is a diverse borough, with a rich cultural and historical heritage. International historical sites like the Cutty Sark, Royal Observatory and Royal Park sit alongside iconic modern landmarks such as the O2 Arena, and the borough has been the focus of unprecedented regeneration over recent years. The borough is home to nearly 290,000 people, speaking over 150 languages.

For many years, statutory agencies and community partners have been working together to improve the health and wellbeing of our residents and have had some remarkable successes. Our focus, for example, on improving the lives and outcomes for children has seen a significant improvement in relation to the educational attainment of our children, with 52% of Royal Greenwich students progressing to higher education in 2016, compared with 30% in 2013. Smoking continues to be the biggest avoidable cause of early death, ill health and health inequalities in the UK. Adult smoking rates in the Royal Borough of Greenwich have fallen from 20.9% in 2011 to 16.9% in 2017.

As well as being a borough with many assets and achievements, the Royal Borough of Greenwich is also a place of great contrasts. Life expectancy in the borough remains lower than average compared to London or England; rates of childhood obesity are among the highest in London, and one in five children are living in a low income home. Our population is expected to continue getting older, while local public services continue to operate within challenging financial constraints.

This strategy places a focus on two key aspects of health – mental health and wellbeing, and healthy weight. These were also priorities in the previous health and wellbeing strategy (2015-2018), chosen both because they are important to all sections of our community in their own right, and because by making progress in these areas we can build resilience and help prevent or delay the onset of wider health problems in our residents.

continue overleaf

We also focus on two vital ways that we are changing how we work in the Royal Borough of Greenwich to best support the health and wellbeing of our residents. By developing and improving the Live Well Greenwich system, our approach to 'prevention at scale', we can bring all of the assets in our borough together to help our residents live healthier, happier lives.

Secondly, we are committed to developing a more integrated and co-ordinated system of health and social care in the Borough. We aim to improve the way our residents experience our services, streamline and modernise our processes and gain the best value for money for every pound we spend on our health and social care offer. These changes in our approach to working together across the South East London health and care economy will ensure the robust implementation of the NHS Long Term Plan and new national Government plans dealing with social care and prevention.

This strategy sets out our high-level ambitions and direction of travel for the next five years. We will develop detailed annual action plans against each of our key priorities, with a robust approach to evaluation to ensure that our strategy remains effective and responsive to changing evidence and the changing context.

Signed

Cllr Danny Thorpe
Leader of the Royal Borough of Greenwich and Chair of the Health and Wellbeing Board

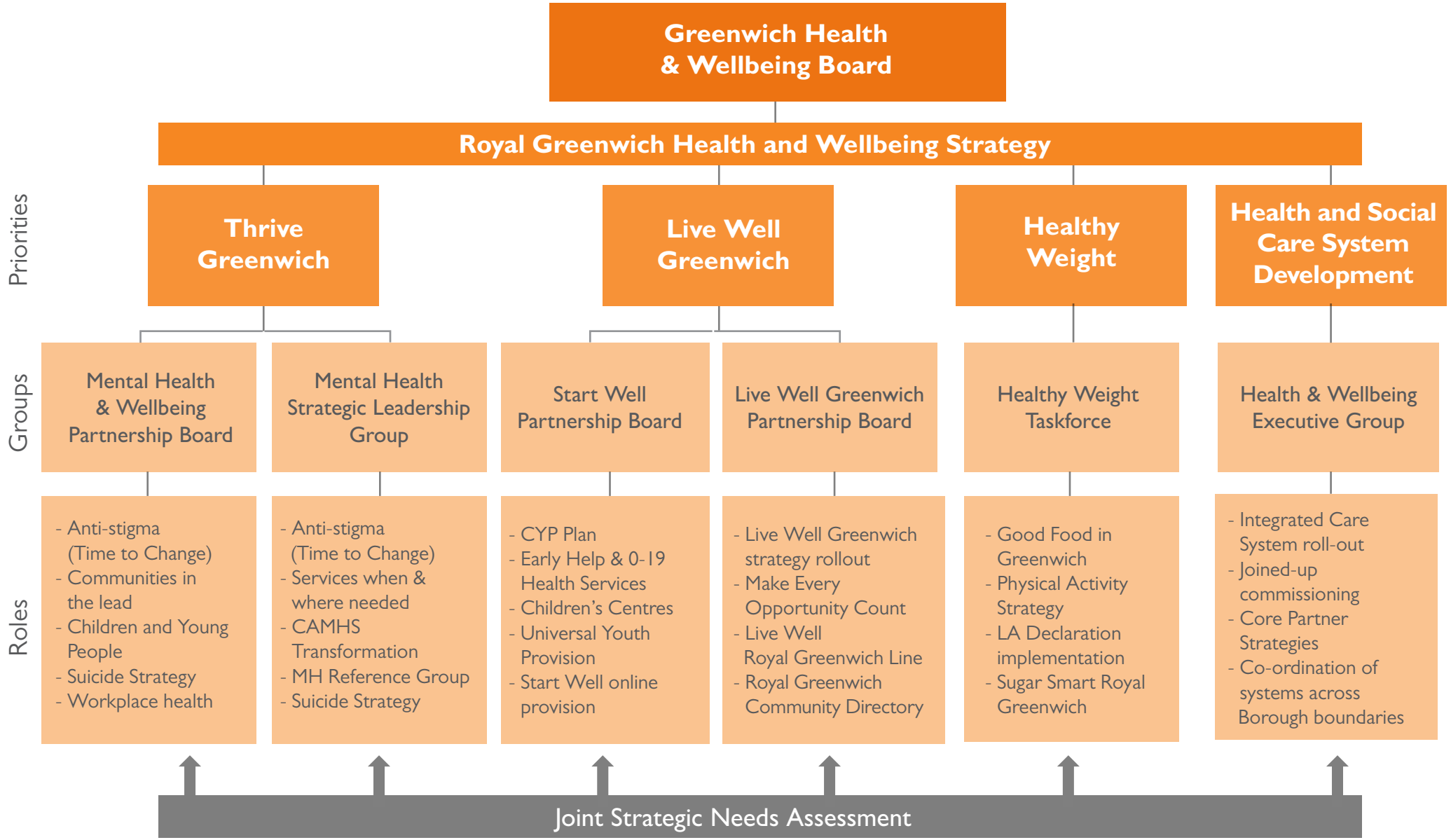
Dr Krishna Subbarayan
Chair of NHS Greenwich CCG and Vice-Chair of the Health and Wellbeing Board

Introduction and executive summary

This strategy sets out the high level priorities and key actions to improve health and wellbeing in the Royal Borough of Greenwich across the five years to 2024. These priorities have been identified by the Health and Wellbeing Board as the areas where we can most benefit from working together. We will work across agencies and sectors, and in partnership with our diverse communities, to ensure we draw on all the knowledge, insight and talent in Royal Greenwich to create a happier, healthier borough.

The Health and Wellbeing Strategy will be implemented by lead groups overseeing each of the priorities. These groups are multiagency partnerships with professionals and local people working together to implement the ambitions set out in this strategy.

Figure 1: Health and Wellbeing Strategic Leadership



ITEM NO: 9 (Appendix A)

A summary of the Health and Wellbeing Strategy approach to each of the four priorities is set out below.

Improving mental health and wellbeing

The Royal Borough of Greenwich is adopting the Thrive LDN approach to improving mental health and wellbeing, working across six key areas: individuals and communities taking the lead, tackling mental health stigma and discrimination, maximising the potential of children and young people, a happy, healthy and productive workforce, mental health services available when and where needed, and working towards zero suicide.

- To support individuals and communities to take the lead, and to tackle stigma and discrimination around mental health, we will work through the 'Time to Change' Royal Greenwich programme to challenge misconceptions and ignorance around mental health; engage community leaders to understand the best ways to improve mental health literacy in different parts of the borough; and develop a multi-agency Social Isolation and Loneliness Strategy that addresses this major driver of ill-health and unhappiness. We will also link with the Royal Greenwich Social Mobility Delivery Plan, and the ongoing collaboration between health and wellbeing and planning officers, to support improvements in the physical and socio-economic environment which profoundly impact on residents' ability to live happy healthy lives.
- To help children and young people to maximise their potential, we will engage and work with Children and Young People (including those who are not in education, employment or training, home-schooled or attending alternative provision), to identify and implement ways in which to promote positive mental health and wellbeing, and reduce the potential negative impacts of social media. We will work with children, young people and their parents to support them in improving their mental health and wellbeing and to improve access to and the quality of mental health and wellbeing services. We will also work with schools to support them to become mentally healthy places.
- Improving mental health and wellbeing in workplaces in the Royal Borough of Greenwich requires working with a wide variety of organisations, as the borough has only a small number of large employers, and a large proportion of diverse small and medium enterprises. We will work with employers to identify the right approaches to becoming mentally healthy places for different types of workplace. This will include finding ways for employers to contribute to tackling stigma and discrimination around mental health.
- To deliver the right mental health services for the Royal Borough of Greenwich, we need to ensure that local services connect and work together smartly, improving co-ordination, and linking in with the wider system to deliver consistent and effective care. Through the life of this strategy we will look at the way that our services are commissioned, to help support more integrated and innovative ways of working, and fully draw on the contribution of all stakeholders, including mental health service providers, the community and voluntary sector, patients and experts by experience.
- Our approach to suicide prevention will work across three key areas: improving information and intelligence to tackle suicide; supporting higher risk and vulnerable populations, with a focus on training; and improving communication and support around suicide. We will continue to collaborate with experts by experience, including our ongoing work with a community group of parents bereaved by suicide who have made invaluable contributions to local work so far.

Improving Healthy Weight

Over the last few years, we have been pursuing a whole systems approach in the Royal Borough of Greenwich involving strategic efforts to address healthy weight across 10 key areas. These areas have been identified through a London wide sector-led improvement process facilitated by the Association of Directors of Public Health (ADPH) and are based on the original 'Foresight' map of influences on obesity. The key areas are outlined below and cover a wide range of health, education and community-based interventions with a focus on food, physical, economic and social environments, planning and community approaches:

- Increase breastfeeding rates and support parents and carers to establish a healthy diet for their children from a very early age. Focus on providing the right support to our families, developing an infant feeding strategy that helps families establish a healthy diet.
- Increase the range and accessibility of healthier meals, snacks and drinks that are available to buy locally. Work with businesses and partner organisations to ensure improved access to healthy food and drinks.
- Support and enable people to be more active and less sedentary in their everyday lives. Improve the physical environment to enable people to achieve and maintain a healthy weight and increase the proportion of journeys that are made on foot or by bicycle.
- Support schools to promote healthy eating and physical activity.
- Support public and community settings to promote healthy choices and support people to achieve and maintain a healthy weight.
- Deliver health services that promote healthy choices and support people to achieve and maintain a healthy weight.
- Increase the proportion of employers and workplaces that promote healthy choices and support people to maintain a healthy weight.
- Increase engagement and commitment to tackle child obesity among partners and residents.

Live Well Greenwich— embedding a prevention approach

Live Well Greenwich is our approach to 'prevention at scale'. It aims to unite efforts across all local organisations to maximise opportunities to improve health and wellbeing for everyone in the Royal Borough of Greenwich.

Live Well Greenwich is working across three levels to create a systematic approach to prevention:

- Working at the population level, Live Well Greenwich focuses on embedding health in all policies across agencies and sectors, tackling the wider determinants of health, delivering wide scale social marketing campaigns and engaging and training the workforce around health and wellbeing through the 'Make Every Opportunity Count' programme.
- Working at the community level, Live Well Greenwich focuses on engaging and empowering communities, building social networks, increasing participation, improving understanding and skills, developing community assets, building community capacity to address wider determinants of health and increasing resilience.
- Working at the individual level, Live Well Greenwich focuses on supporting individuals to make positive changes, by providing the infrastructure needed to increase access to services and resources and improve navigation between services.

Health and Social Care Development

The Health and Social Care services available to people in the Royal Borough of Greenwich seek to achieve a range of important outcomes for our population. They seek to:

- help people to live long, healthy lives, and to stay active and independent throughout their lives.
- provide care, support and effective treatment for people who experience illness or injury, be that sudden and unexpected or a longer term health problem or disability.
- support people needing specific medical care at particular times in their lives, for example maternity care for pregnant women and care for newborn babies.
- provide home care, rehabilitation, residential and nursing care when people need additional support.
- provide compassionate, dignified and tailored care to people nearing the end of their lives and their friends and families.

The NHS has setout a series of new commitments and improvements for healthcare services through its NHS Long Term Plan, a 10-year plan which was published early in 2019. The Government is publishing two Green Papers during 2019, one on Social Care and one on Prevention.

In addition, the Greenwich Clinical Commissioning Strategy sets out a local framework for changes to the health and care system, identifying a number of priorities:

- priority 1: to prevent illness and help our population to Live Well.
- priority 2: to strengthen local support for people with mental illness, including children and young people.
- priority 3: to better meet the needs of frail people with care closer to home, an integrated urgent care system and stronger community based care.
- priority 4: to improve the prevention, detection and treatment of cancers for our local population.

In Royal Greenwich, we plan to work increasingly closely together across our organisations to improve the integration and co-ordination of our services, including prevention, primary care, community care, acute, mental health and social care services in the borough. We will work together to respond to national policy in a locally appropriate way, improving the way our services wrap seamlessly around local people in ways that meet their needs effectively and provide a positive experience of care.

We will change and strengthen the way that health and care services are both commissioned and provided, adopting increasingly collaborative and integrated approaches to designing and managing the system.

Much of our work will remain organised at a very local level and within the borough boundary, but we will also work increasingly closely with neighbouring boroughs in South East London where it makes good sense to do so as part of the wider health and care economy in this part of London.

Priority 1:
Improving Mental Health and Wellbeing in the Royal Borough of Greenwich

Why is it important?

There is a growing understanding and recognition that mental health is more than the absence of mental illness and that good mental health underpins everything we do - how we think, feel, act and behave. Good mental health and wellbeing is profoundly important to growth, development, learning and resilience and can be understood as 'how people feel and how they function, both on a personal and a social level, and how they evaluate their lives as a whole'.

Evidence is increasingly demonstrating that good mental wellbeing protects the body from the impact of life's stresses and traumatic events, and enables the adoption of positive health behaviours and the management of long term illness.

Having good mental wellbeing is a valuable resource for individuals, families and communities. It is associated with better physical health, positive interpersonal relationships and socially healthier societies. It helps people to achieve their potential, realise ambitions, cope with adversity, work productively and contribute to their community and society.

We also know that people from different backgrounds and communities can have very different experiences around mental health and wellbeing. For example, black and ethnic minority young people are not accessing our Child and Adolescent Mental Health Services (CAMHS) in the numbers we would expect, but are more likely to experience a mental health crisis and receive emergency care later on.

We know that LGBTQ people are likely to have poorer mental health, while men are much more likely to die by suicide, and women experience higher rates of depression and other common mental health problems.

The interplay of social, financial and cultural inequalities with mental health is complex, with inequalities both contributing to the risk of mental health problems, and people with mental health problems facing additional inequalities and discrimination.

What have we been doing?

Improving mental health and wellbeing across the population was one of the key priorities for the Greenwich Joint Health and Wellbeing Strategy 2015-2018, and has been an area of significant focus and partnership working in the borough. As new evidence and guidance has emerged during this period, we have drawn on it to ensure that we continue to work as effectively as possible.

In 2017, the Mayor of London and London Health Board launched Thrive LDN, a citywide movement to improve the mental health and wellbeing of all Londoners, comprising work across six key priorities.

In Royal Greenwich, we responded to the London call to action by realigning our mental health and wellbeing work to the Thrive LDN approach, and creating 'Thrive Greenwich'. It was agreed that the structure of Thrive would shape the mental health and wellbeing element of our Joint Health and Wellbeing Strategy 2019-2024. Figure 2 sets out the six priority areas for Thrive Greenwich.

Figure 2: Thrive Greenwich priorities

Thrive Greenwich

Our approach to improving mental health and wellbeing across the population

A city where individuals and communities take the lead

In England only 27% of people feel they can influence local decisions about their area - 51% say they want to.

Feeling lonely increases the risk of depression and even early death (comparable to smoking and obesity).

A city with a happy, healthy and productive workforce

Almost 1 in 6 people of working age have a diagonsable mental health condition.

19% of long term sickness absense is attributable to mental ill-health.

A city free from mental health stigma and discrimination

60% of people with a mental health problem say that stigma and discrimination are as damaging or more damaging than symptoms of their mental health problems.

A city that maximises the potential of children and young people

50% of mental health problems are established by the age of 14, 75% by the age of 24.

It is estimated that nearly 4000 children and young people have a mental health disorder in The Royal Borough of Greenwich.

A city with services that are there when and where needed

The Royal Borough of Greenwich has higher levels of recorded serious mental illness (1.18%) compared to England (0.9%).

In 2016/17 4110 people were in contact with mental health services. 13,823 local people have been reported as experiencing depression at some point in their lives.

A zero suicide city

On average 15 people die from suicide every year in The Royal Borough of Greenwich.

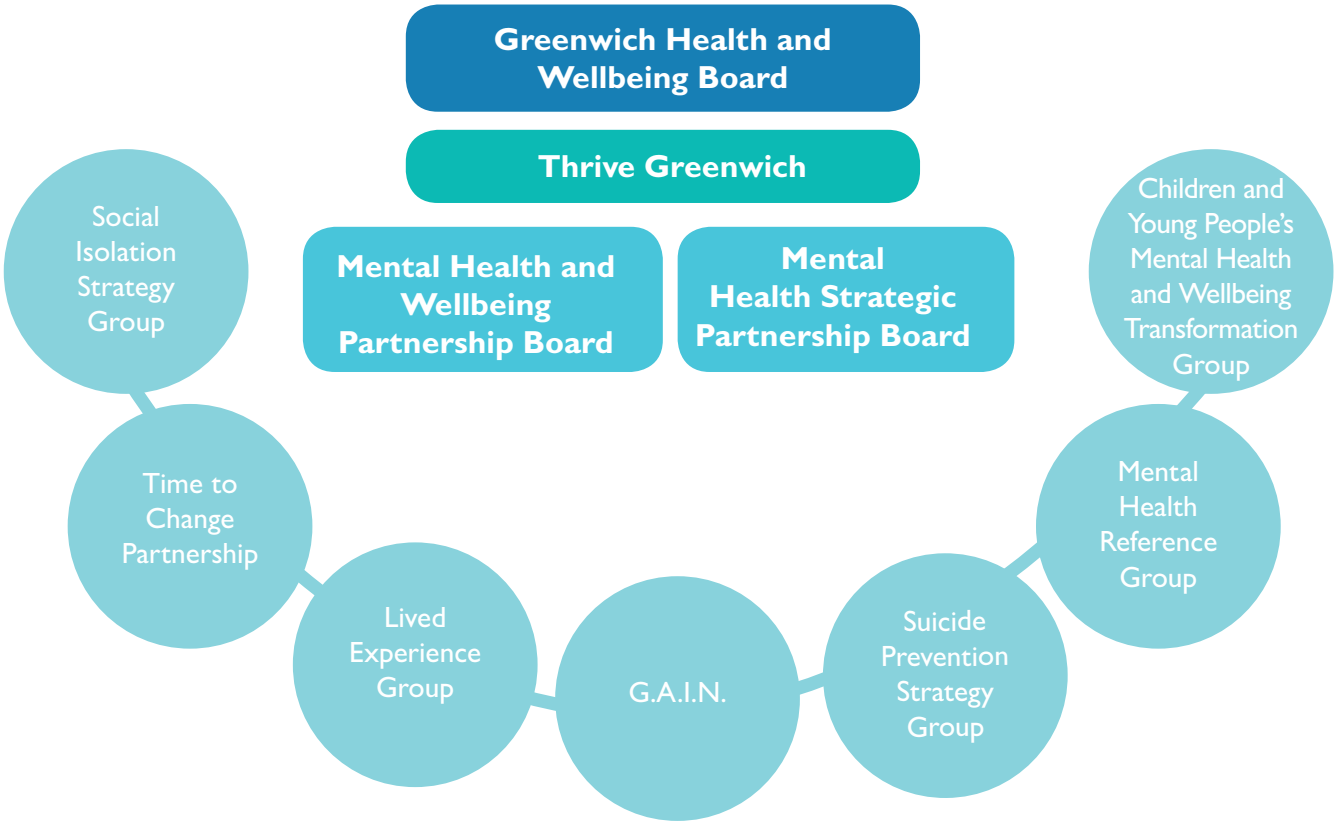
6 times more people die by suicide than from all traffic accidents put together.

ITEM NO: 9 (Appendix A)

Who has been involved?

Work on this area has required a partnership approach, and Figure 3 illustrates the high level groups contributing to leadership around mental health in the Royal Borough of Greenwich. The membership of these bodies reflect the wide expertise needed to improve mental health and wellbeing across the borough, crucially including people with lived experience of mental health problems.

Figure 3: local leadership for improving mental health and wellbeing



We have sought to involve and engage local people with lived experience of and interest in mental health problems to help shape the Thrive Greenwich approach. People with lived experience of mental health problems are key members of groups working across mental health and wellbeing issues, including the Mental Health and Wellbeing Partnership Board and Suicide Prevention Strategy Steering Group. Mental health service user input has been drawn on through G.A.I.N. (Greenwich Area Involvement Network - a group of local mental health service users), as well as Royal Greenwich Time to Change Champions.

The identification of key areas for action around children and young people has been informed by ongoing participation work, including with the Royal Greenwich Young Mental Health Ambassadors, ACE (a forum for children with disabilities), and Royal Greenwich Young People's Council.

What needs to happen in the Royal Borough of Greenwich?

To inform delivery approaches to our six Thrive Greenwich priorities, we have drawn on a range of intelligence, evidence and guidance. This included engaging with our residents to understand their views, and the challenges and opportunities that they experience around mental health and wellbeing.

The Mental Health Foundation and Faculty of Public Health have a produced a comprehensive overview of evidence around public mental health, which underlines the importance of working to address protective and risk factors across the life course, as well as improving the physical and social environments that people live and grow up in.

The factors identified in this review strongly support the Thrive framework approach, and the specific interventions and recommended actions are being used to inform the detailed implementation plans that will sit under this strategy.

Academic research and evidence is very useful when deciding where we need to concentrate our work – but it only tells part of the story. People with different backgrounds in different parts of the country may not have the same experiences and challenges, so it is important that we engage with our communities to ensure that what we do is responding to the needs of people living in the Royal Borough of Greenwich.

To help understand the views and priorities of local people, we conducted a survey in October 2018 looking at the issues affecting people's mental wellbeing. 162 people responded, and results showed that:

- the three biggest barriers to being happier that people highlighted were money (23% of issues mentioned), community, connection and loneliness (15%) and having a safe and pleasant environment (13%).
- in terms of what needed to change locally, people wanted to see improvements in services (30%), additional support such as self-help groups, mindfulness and safe spaces (17%) and community and equalities (17%).

This feedback from the community supports the Thrive Greenwich approach, highlighting the broad range of issues which impact on people's mental health and wellbeing, while emphasising the importance of good services that meet the needs of local people. Issues raised by our residents were broadly similar to those found in a nationwide survey in 2015. However, in the national survey money was the fourth most commonly cited issue, while in Royal Greenwich it emerged as the single most frequently mentioned problem.

The huge effect of financial worry in the Royal Borough of Greenwich is very clear, and this strategy adds to the Thrive London approach in very clearly acknowledging the central role that money plays in people's wellbeing.

Figures 4 and 5 below show word clouds of the most frequently cited issues in the survey.

Figure 4: What do you think are the things that stop people feeling happier and can help people to be happier?

Figure 5: What do you think we should be focusing on to improve mental health and wellbeing in Royal Greenwich?

Source: October 2018 survey of Royal Greenwich residents

For different aspects of Thrive Greenwich, we have looked at the best work being done across the country, and engaged with key organisations and programmes leading on these issues, to provide a foundation for an informed local approach.

The national Time to Change campaign, which has been working to tackle mental health stigma and discrimination since 2008, has been invaluable in providing an evidence-based roadmap to changing attitudes around mental health problems. Time to Change have not only identified effective ways of addressing these issues, but provide hands-on support for local people to lead the work.

We are drawing on this for our Time to Change Royal Greenwich hub, while also pursuing local engagement to explore how to raise the profile of mental health and wellbeing in our diverse communities. Mental health stigma is an enormous challenge, and while Time to Change provides evidence-based approaches to tackling this issue, progress will require concerted effort and commitment from all local partners.

Resident feedback underlined how important community, connection and loneliness are in individual and social wellbeing. A separate Social Isolation and Loneliness Strategy is being developed following a significant engagement with a range of local stakeholders. This engagement identified barriers and opportunities for increasing social connectedness in the borough, and the strategy will also reflect the early thinking being developed nationally as part of the national strategy "A connected society - a strategy for tackling loneliness".

There is increasing recognition that there is a big role for the urban environment to play in improving mental and physical wellbeing. This understanding is reflected in the National Planning Policy Framework (NPPF), the London Plan and the Royal Greenwich Core Strategy which help us in using local levers to create places that support people's wellbeing. Health Impact Assessments, through the Mental Wellbeing Impact Assessment Toolkit, provide a way of assessing the effects new developments will have on mental wellbeing, and how they can be improved.

We are drawing on the principle of Lifetime Neighbourhoods, which seeks to reduce social isolation by ensuring that neighbourhoods provide all the services needed on a day-to-day basis within easy walking distance and create public spaces that encourage social interaction.

We are building on the work of the local Dementia Information Hub to inform policy-makers and designers on how to improve accessibility for those with dementia, including looking at opportunities for intergenerational housing. There has been work in other cities to ensure young people are not excluded from the public realm, and we are exploring how these approaches can be applied in the Royal Borough of Greenwich to create public spaces that make all users feel welcome and included.

There has been growing concern around the mental health of children and young people in recent years. Nationally it has been recognised that not enough is done to help young people before issues become more serious and entrenched, in the context of what the Children's Commissioner for England has described as a "children's mental health epidemic".

Locally the number of young people dying by suicide has risen in south east London. Evidence around the causes of this decline in young people's mental health is still developing, however the impact of early trauma and Adverse Childhood Experiences on mental health, and how services and settings respond to these, is emerging as a significant factor.

The NHS Five Year Forward View highlights the importance of improving the mental health services available to young people, and the 'Future in Mind' report from March 2015 set out how local areas should proceed in transforming children and young people's mental health services. Local work is being carried out to understand more about how young people can be supported when they have a mental health concern but do not meet the criteria for our Child and Adolescent Mental Health Services.

Our two-yearly School Health Education Unit survey of primary and secondary school children also provides useful insight into the experiences of children in the Royal Borough of Greenwich. Our plans over the next five years will build on our current and developing evidence base to protect and improve the mental health of all our children and young people.

Workplace mental health and wellbeing has been an area of increasing national focus in recent years, and a range of tools to help employers have been developed. The Time to Change Employer Pledge sets out an ambitious approach for larger organisations to both improve wellbeing and tackle stigma, while Public Health England has worked with Business in the Community to produce a toolkit for small and medium enterprises. Rethink Mental Illness and Mind also provide toolkits and frameworks to support workplaces to improve their policies and environments. These resources provide a wide menu of options, meaning we are able to build an offer to employers that is responsive to their circumstances and needs.

There is a broad range of services working around mental health in the Royal Borough of Greenwich, from acute clinical care, innovative mental health support provided by community and voluntary organisations such as Mind, Bridge Mental Health and Metro to vital services like CGL, Her Centre and GLLaB working around key drivers of mental health and wellbeing.

The Five Year Forward View for Mental Health (2016) set out key ambitions for mental health services in England, including 24/7 NHS crisis care, an integrated approach to physical and mental health, and focusing on promoting good mental health and prevention. In order to achieve these goals, we need our local services to connect and work together smartly, improving co-ordination, and linking in with the wider system to deliver consistent and effective care.

The involvement of voluntary sector services, housing providers, local authority social care and housing provision in designing this approach is essential. During the life of this strategy, we will take opportunities to look at the way that our services are commissioned, to help support more integrated and innovative ways of working, and fully draw on the contribution of all stakeholders, including mental health providers, the community and voluntary sector and patients and experts by experience.

Around 15 people die by suicide in the Royal Borough of Greenwich each year, each one of which is a tragedy with devastating effects on those close to the victims. Our approach to suicide prevention, and help for people bereaved by suicide, has been greatly informed by the Public Health England and National Suicide Prevention Alliance Local Suicide Prevention Planning Practice Resource. This brings together evidence for interventions, high risk groups and recommended priorities for local action.

The six key planks of this national framework are picked up through the three high level priorities of our Suicide Prevention Strategy. We are working with key experts, from national organisations such as The Samaritans and Papyrus UK, and with those who are expert through experience, to ensure that our activity is effective and sensitive.

What we are going to do next

Table 1 sets out the high level delivery approach to each of our Thrive Greenwich priorities over the next five years, the key groups who will oversee work and lead further development and implementation, and the indicators which will allow the Health and Wellbeing Board to monitor the progress of these areas of work.

Some of these ambitions are already being taken forward by existing strategies, such as the Social Isolation Strategy and the Suicide Prevention Strategy, while others represent significant new areas of work.

As we move forward in the implementation of the strategy, the lead groups will produce annual action plans which set out the detail of our approach. These will include how we target work at our most vulnerable populations, embed engagement and co-production, and set out a monitoring and evaluation across the strategy.

Table 1: Improving Mental Health and Wellbeing actions

Thrive Greenwich ambitions	Action	Who will take this forward?	Measuring success
 **A city where individuals and communities take the lead**	Engage communities on their own terms to find ways to improve openness and tackle stigma around mental health and wellbeing.	Mental Health and Wellbeing Partnership Board.	Number of Time to Change Champions recruited and active in the Royal Borough of Greenwich Number of community groups engaged and working around mental health and wellbeing.
 **A city free from mental health stigma and discrimination**	Work with people with lived experience to develop universal and targeted communications to help tackle stigma and discrimination in the Royal Borough of Greenwich.		Number and type of communications and engagement activities.
	Work with planners, developers and residents to create mentally healthy public and domestic spaces.	Cuts across a range of strategic groups.	Number of Play streets delivered Resident access to green space. Improvement in quality of Health Impact Assessments included as part of planning applications. Better, more effective and inclusive consultation and engagement between developers and local communities.
	Reduce the level and impact of social isolation and loneliness.	Social Isolation Strategy Group.	Number of residents receiving social isolation/loneliness support from Live Well Greenwich.
	Work through the Social Mobility Delivery Plan to address the wider socio-economic factors that affect mental health and wellbeing in our communities, including by better supporting people to access financial advice services	Social Mobility Board.	Performance measures are being developed for specific recommendations within the Social Mobility Delivery Plan.

A city that maximises the potential of children and young people

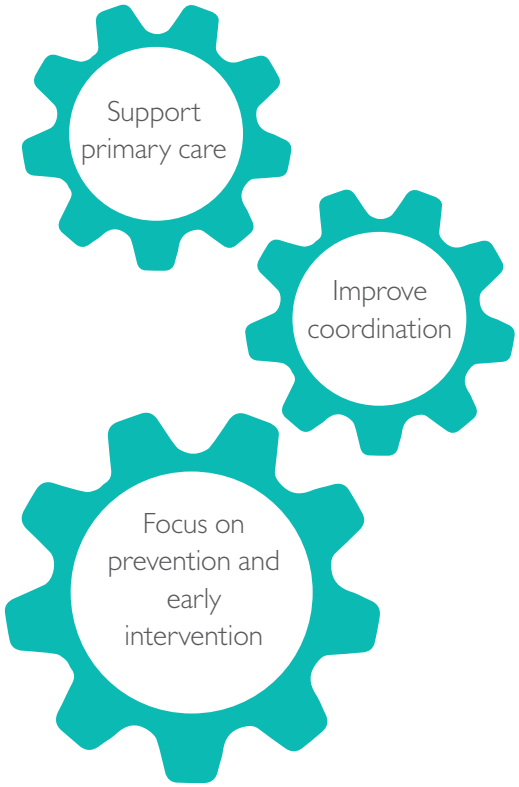
Engage and work with Children and Young People (including those who are NEET, home-schooled or attending alternative provision), to identify and implement ways in which to promote positive mental health and wellbeing, and reduce the negative impact of social media.	Children's Mental Health and Wellbeing Transformation Group and Joint Commissioning Group. Start Well Partnership Board.	Children and young people's self-reported wellbeing. Children and young people reporting negative impact of social media in SHEU local schools survey. Schools with a Health Education and RSE curriculum in place by 2020.
Work with schools to support them to become mentally healthy settings.	Children's Mental Health and Wellbeing Transformation Group and Joint Commissioning Group. Start Well Partnership Board.	Schools with Healthy Schools Bronze award. Schools engaging in support through the Mental Health in Schools Network and/or bespoke support. Engagement with Mental Health in Schools conference. Participation in School Health Education Unit local schools survey.
Work with children, young people and their parents to support them in improving their mental health and wellbeing and to improve access to and quality of mental health and wellbeing services, including through Start Well Greenwich and developing new approaches to managing transitions between CAMHS and adults services.	Children's Mental Health and Wellbeing Transformation Group and Joint Commissioning Group. Start Well Partnership Board.	Young people reporting being aware of local services. Children and young people, families and professionals reporting improved outcomes for children and young people. Improved access to support (percentage of CYP who require treatment, accessing support within 12 weeks). Percentage of children and young people accessing specialist CAMHS with recorded goals showing improvement. Numbers of children and young people attending A&E due to self-harm.

A city with a happy healthy and productive workforce

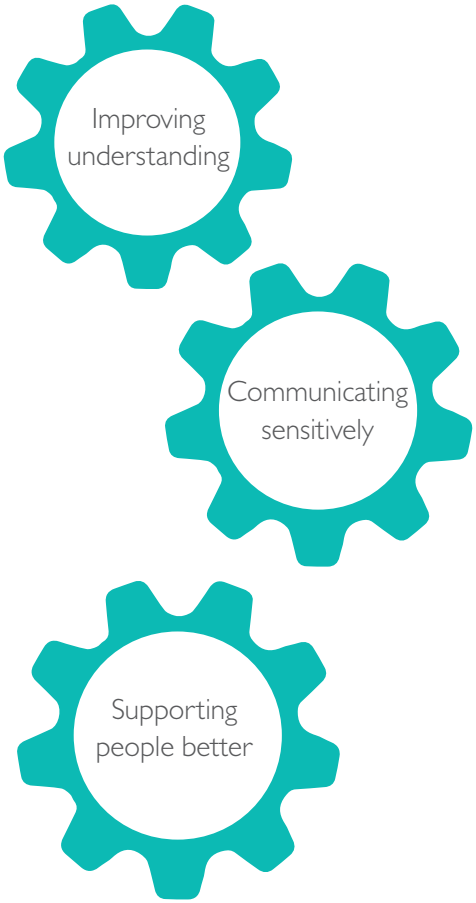
Identify and implement effective approaches to engaging local employers around tackling stigma and discrimination.	Mental Health and Wellbeing Partnership Board. Mental Health Strategic Leadership Group.	Employers signing Time to Change Pledge. Experts by experience supporting workplaces around mental health and wellbeing. Health and Wellbeing Board partners modelling mentally healthy workplaces.
Work with employers to provide workplaces that support good mental health, and with people who are self-employed, drawing on the expertise and skills of people with lived experience.		

<table>
<tr>
<td rowspan="2"> 

A city with services that are there when and where needed

 
</td>
<td>Develop Mental Health Alliance.
Improve co-ordination of mental health provision – no wrong door, information sharing. Services that are responsive to the needs of individuals.
Develop a community support service that brings together service users, voluntary and community sector, Primary Care and mental health providers to provide a prevention and early intervention support to avoid the need for Crisis services.
Work with Primary Care so that they are better informed of the services and support that is available for people with Mental Health conditions.
Develop the accommodation pathway for people to go back into the community after a crisis experience which provides a coherent and flexible support package.</td>
<td>Mental Health Strategic Leadership Group.
Developments will be informed by the Mental Health Reference Group and opportunities for co-production will be taken up.</td>
<td>Reduction in Crisis.
Substance misuse or crisis admissions.
Establishment of the Alliance.
More informed Primary Care.
Established Accommodation Pathway.</td>
</tr>
<tr>
<td>Work with wider services, including services with risks of exacerbating mental health problems (such as DWP or tenancy enforcement teams), to make their provision more supportive and sensitive to people living with mental health problems.</td>
<td>Mental Health and Wellbeing Partnership Board.</td>
<td>Adoption of safeguarding alert in key services.
Uptake of mental health awareness training in key services.</td>
</tr>
</table>

A zero suicide city



Improving information and intelligence to tackle suicide.	Suicide Prevention Strategy Steering Group.	Rate of local deaths by suicide. Coroner data shared with Children and young people Royal Greenwich. Frontline staff undergoing suicide prevention training. Level of self-harm reported in schools survey. Key contact points stock Help is at Hand/postvention resources. Support in place for parents bereaved by suicide.
Supporting higher risk and vulnerable populations, with a focus on training.		
Improving communication and support around suicide.		

Priority 2:
Improving Healthy Weight

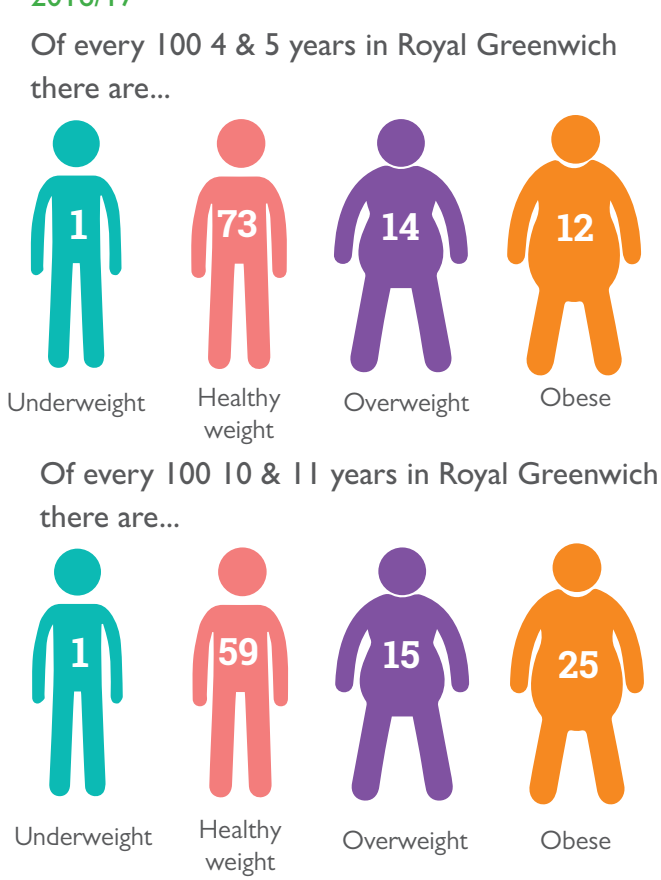
Why is it important?

Overweight and obesity are significant health issues for children and adults across the life course. In London 3.8 million people are identified as overweight or obese and it is still the case that more than1 in 3 children are an unhealthy weight by the time they start secondary school.

Carrying excess weight can have significant implications for an individual's physical and mental health and is linked to a wide range of diseases, including type 2 diabetes, hypertension, some cancers, heart disease, stroke and liver disease. Obesity is also associated with poor psychological and emotional health, and poor sleep. Obese young people and adults may also be more likely to suffer from stigma which can impact on their self-esteem.

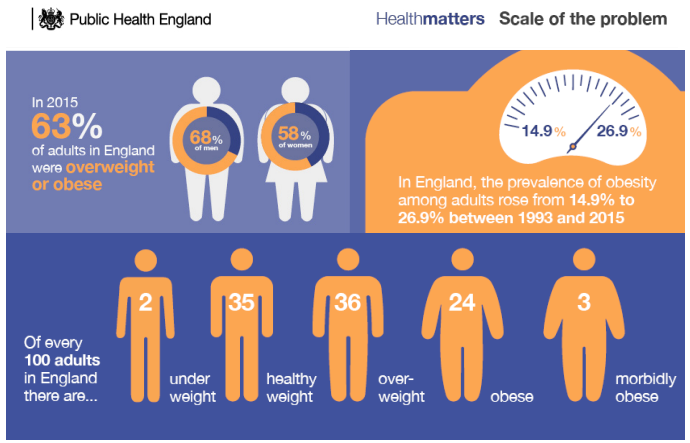
Figures 6 and 7 outline the scale of overweight and obesity in the Royal Borough of Greenwich with 40% of 10 -11 year olds and nearly 60% of the local adult population recognised as an unhealthy weight in 2016/17.

Figure 6: Prevalence of weight classifications among primary school pupils in Royal Greenwich, 2016/17



Source: National Child Measurement Programme

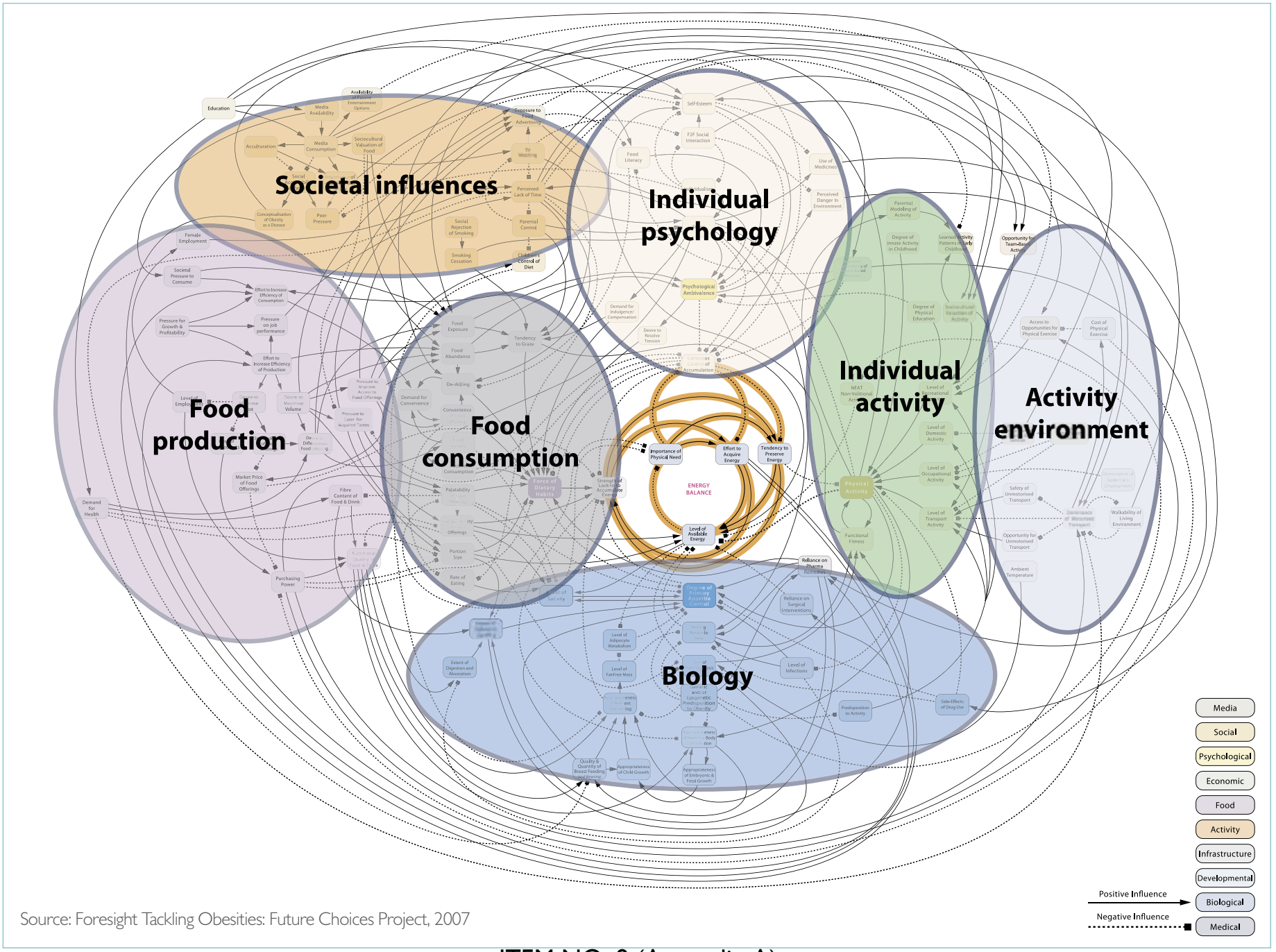
Figure 7: Prevalence of weight classifications in England and Royal Greenwich, 2016/17



Source: Public Health Outcomes Framework

Current research identifies obesity as a complex problem with multiple causes and profound inequalities by ethnicity, socioeconomic status, geography, and disability. As such, there is no single intervention that can tackle obesity on its own. The Government's Foresight reports (Foresight, 2007) provide causal maps that illustrate a systemic problem whose causes are complex, manifold and interdependent. This complexity demands a whole systems approach if we are to reduce prevalence, give children a healthy start in life and support adults to maintain a healthy weight.

Figure 8: Obesity causal map



Source: Foresight Tackling Obesities: Future Choices Project, 2007

ITEM NO: 9 (Appendix A)

What have we been doing?

As for mental health, improving healthy weight was one of the key priorities for the Greenwich Joint Health and Wellbeing Strategy 2015-2018, and has been an area of significant focus and partnership working in the borough.

Figure 9 demonstrates the range of specific interventions that are currently in place across the borough.

Figure 9: Royal Greenwich Healthy Weight Map

In September 2018 a new Councillor-led Healthy Weight Taskforce was established in Royal Greenwich to mirror the London Childhood Obesity Taskforce at a local level. The Taskforce has refreshed the RBG Healthy Weight action plan in line with the Foresight domains. Figure 10 highlights the focus of the work.

Figure 10: Royal Greenwich healthy weight priorities

Healthy Weight - Priorities for action

- Increase breastfeeding rates and support parents and carers to establish a healthy diet for their children from a very early age.
- Increase the range and accessibility of healthier meals, snacks and drinks that are available to buy locally.
- Increase the proportion of journeys that are made on foot or by bicycle.
- Improve the physical environment to enable people to achieve and maintain a healthy weight.
- Support schools to promote healthy eating, physical activity and health and wellbeing.
- Support public and community settings to promote healthy choices and support people to achieve and maintain a healthy weight.
- Support and enable people to be more active, and less sedentary in their everyday lives.
- Deliver health services which promote healthy choices that support people to achieve and maintain a healthy weight.
- Increase the proportion of employers and workplaces that promote healthy choices and support people to maintain a healthy weight.
- Increase engagement and commitment to tackle child obesity among partners and residents.

The specific priorities for action have evolved from a London wide obesity review, which aimed to translate the complexity of the obesity picture into measurable actions. The priority areas include a mixture of environmental improvements to increase access to healthier food and help the local population be more active, raising awareness of the issue and key messages relating to healthy weight and support for skills development to act on healthy weight messaging.

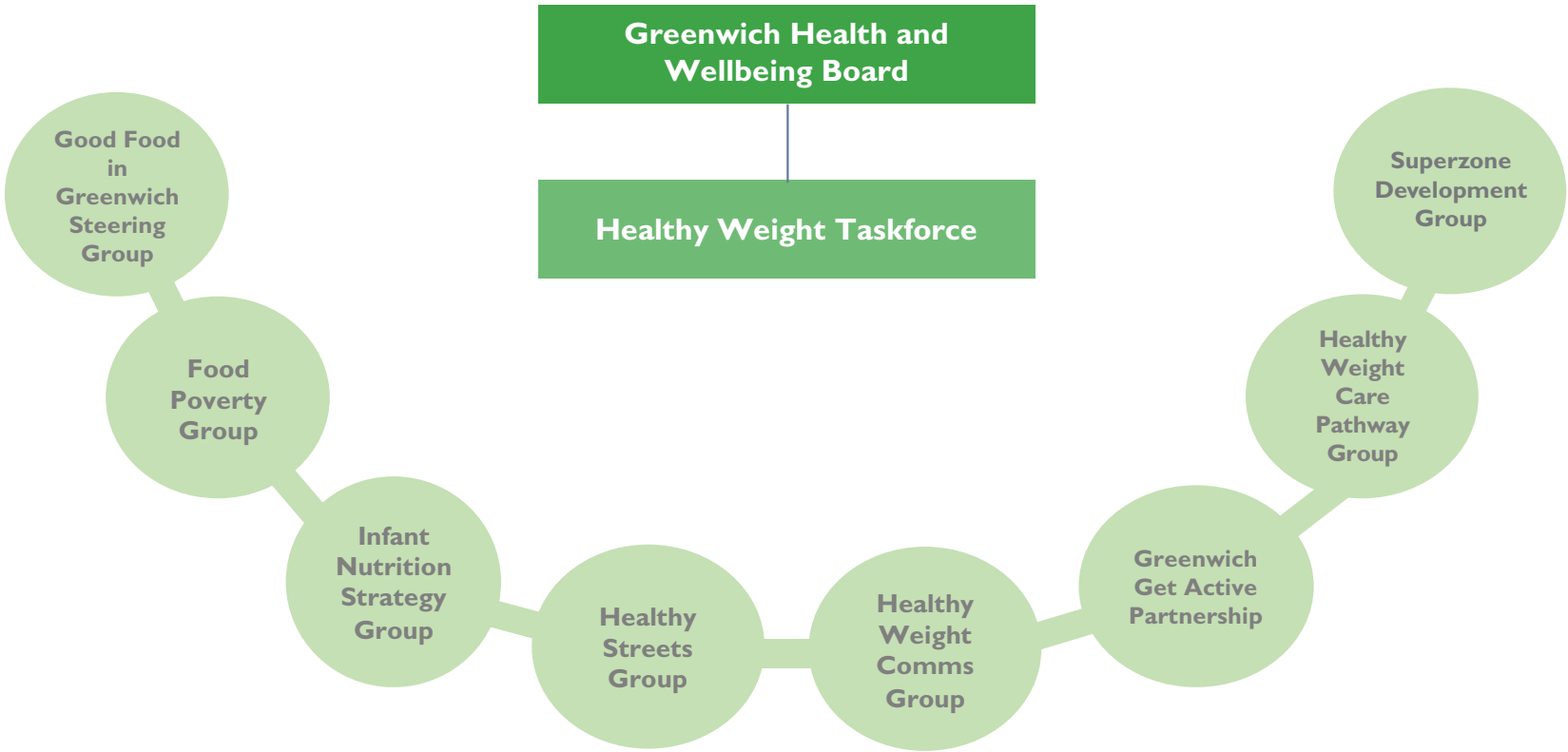
Some of the early commitments made by the Taskforce include:

- Identifying cross departmental and cross agency opportunities to address healthy weight in the Royal Borough of Greenwich.
- Developing a multi-agency communication plan for stakeholders about healthy weight and messages relating to healthy weight.
- Fully implementing the Local Authority declaration to reduce sugar and promote healthier food including delivering the Good Food in Greenwich action plan and working towards mirroring the TfL advertising ban at a local level.
- Linking the Food Poverty action plan to the Social Mobility strategy.
- Maintaining UNICEF Baby Friendly accreditation status and committing to the achievement of Baby Friendly Initiative Gold standard.
- Developing a Physical Activity and Sports strategy for the borough.
- Developing a care pathway specifically for healthy weight which encourages stakeholders to raise the issue of weight and refer to specialist weight management programmes such as the Xplore programme.

Who has been involved?

Figure 11 illustrates the high level groups contributing to the leadership of this agenda in Royal Greenwich. These groups are made up of a wide number of stakeholders across the borough. They represent the various elements of the system working to improve healthy weight at an individual and population level.

Figure 11: local leadership around healthy weight and reducing obesity



What needs to happen in the Royal Borough of Greenwich?

To inform our approach to healthy weight, we have drawn on a range of evidence and guidance. The Council has strong links to regional healthy weight groups and networks such as the London Childhood Obesity Taskforce, enabling local leads to respond effectively to new policy and research. Engaging with our residents to understand their views and the challenges and opportunities that they experience around healthy weight is also key to our approach.

The Great Weight Debate 2016 was a large scale London wide 'conversation' which enabled Londoners to give their views about the obesity crisis in our City. Our residents cited too much unhealthy food and fast food outlets and a lack of safe places for children to play as the main barriers to maintaining a healthy weight.

To understand the views of our residents a local consultation took place with residents across the borough in October 2018. 162 residents responded to a series of questions about obesity and the environment and results showed that:

- The biggest perceived barriers to maintaining healthy weight were availability to unhealthy food and the relative cost of healthy food
- In terms of what needed to change locally, people wanted to see education and support and improvements to the physical environment

These barriers were also prioritised at ward level through the insight gathered for the new Superzone (a health zone 400m around a school) which took place locally in Thamesmead in Spring of 2019. 120 parents responded to the Superzone insight questionnaire, again highlighting food access and safe places to play as key priorities for action.

This feedback from the community supports what we know from other research and has been considered as part of the borough response to improving healthy weight.

What we are going to do next

Table 2 below sets out the high level actions for the key themes of the Healthy Weight action plan, the lead groups who will oversee work and lead further development and implementation and the measures which will be considered alongside the activity.

The lead groups will work to agreed action plans and be accountable to The Healthy Weight Taskforce and ultimately the Health and Wellbeing Board.

Figure 12: What makes eating well easy or difficult?

Figure 13: What needs to change in order for people to eat well and be more physically active in Royal Greenwich?

Source: October 2018 survey of Royal Greenwich residents

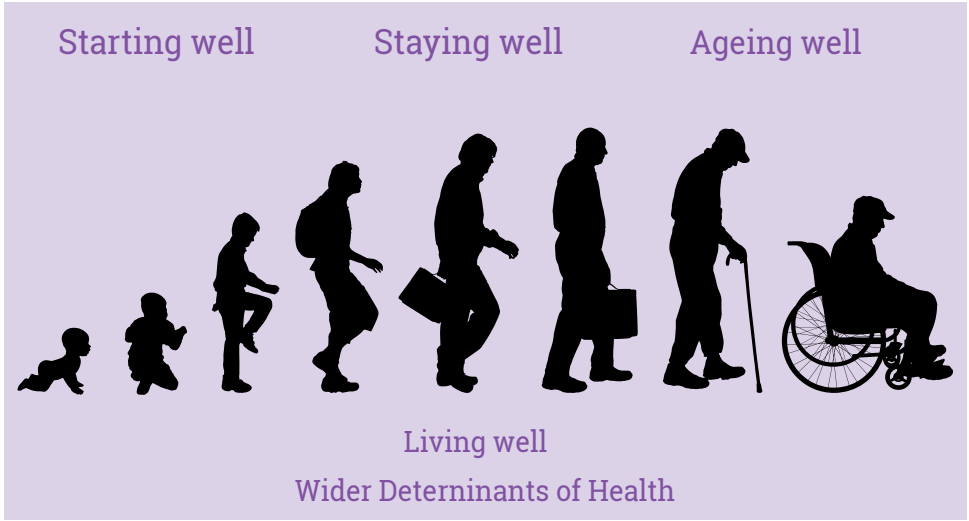
Table 2: Supporting Healthy Weight actions

Healthy Weight ambitions	High level actions	Who will take this forward?	Measuring success
Increase breastfeeding rates and support parents and carers to establish a healthy diet for their children from a very early age. 	Maintain UNICEF Baby Friendly Initiative status and achieve Gold level accreditation within the next 2 years. Work with employers to develop policies which support breastfeeding mothers return to work.	Infant Nutrition Strategy Group. Healthy Early Years Steering Group. Start Well Board and operational groups.	Breastfeeding rates. Healthy Early Years accreditation. Healthy Start uptake.
Increase the range and accessibility of healthier meals, snacks and drinks that are available to buy locally. 	Implement the Good Food in Greenwich (GFiG) action plan and roll out GFiG charter; promote Sugar Smart, support food business engagement, food growing and healthier food offer at events. Deliver the food poverty action plan. Ensure all new fast food outlets engage with GFiG and Healthier Catering Commitment. Develop a healthy retail strategy.	Good Food in Greenwich Steering Group. Food Poverty Group. Food environments contract.	Greater healthy food offer across the borough. Number of sign-ups to GFiG Charter, Sugar Smart and Healthier Catering Commitment. Food Poverty measure. Healthy Start uptake.
Increase the proportion of journeys that are made on foot or by bicycle. 	Deliver cycle training and promote active travel plans. Develop streetscape design. Initiate insight about car dependency.	Healthy Streets Group.	Number of bikeability sessions delivered. Number of schools with TfL stars accreditation. Development of robust local data on people's attitudes toward car dependency.

Improve the physical environment to enable people to achieve and maintain a healthy weight. 	Enhance existing off-street leisure/transport assets such as the Thames Path, the green chain walk and continue roll out of Play Streets, Play Estates and School Streets initiatives. Agree local response to TfL advertising ban. Implement the Local Implementation Plan (LIP). Consider healthy weight in major regeneration developments.	Healthy Streets Group.	Local Implementation Plan (LIP) measures: air quality and modal shift indicators. Parks Usage. Numbers of Play Streets, School Streets, Healthy Catering Commitment outlets. Sugar Smart sign ups. Reduction of unhealthy food advertised on council owned advertising estates. Number of food growing sites.
Support schools to promote healthy eating, physical activity and health and wellbeing. 	Increase the use of the curriculum and extra-curricular activities to develop children's skills and knowledge around healthy eating, physical activity, and health and wellbeing. Increase numbers of schools taking part in Healthy Schools, Food for Life, TfL Active Stars and Sugar Smart. Pilot the Co-create youth engagement programme (working with the London School of Hygiene and Tropical medicine). Increase referrals into children's weight management programme weight management service. Deliver the National Child Measurement Programme (NCMP).	Schools Health and Wellbeing Network. Food in schools group. NCMP Operational Group.	Number of Healthy Schools. Food for Life accredited schools. Food for Life Served Here status. Sugar Smart sign ups. Schools with TfL Stars. Free school meal and school meal uptake. Schools taking part in The Daily Mile. Number of referrals to Xplore weight management service.
Support public and community settings to promote healthy choices and support people to achieve and maintain a healthy weight. 	Deliver the food skills programme. Develop sustainable plan for Holiday Hunger/ enrichment programmes through the Social Mobility Strategy action plan.	Food skills contract. Social Mobility Group.	Community based food skills attendance. Numbers attending OCN 'How to run a cookery club' training. Number of Holiday Meals provided each school holiday.

Support and enable people to be more active and less sedentary in their everyday lives. 	Design and implement adult physical activity pathway, which includes families - targeting behaviour change support and activity programmes at those who face the biggest barriers to getting more active. Implement Royal Greenwich Get Active Physical Activity and Sports Strategy.	Physical Activity and Sports Strategy Group.	Reducing inactivity levels. Activity levels measured as part of the Active Lives, School Sports and Royal Greenwich School Health Education Unit (SHEU) surveys.
Deliver health services which promote healthy choices that support people to achieve and maintain a healthy weight. 	Develop and implement a care pathway for healthy weight (children, young people and adults). Embed healthy weight and weight management service offer within the Start Well commissioning process.	Healthy Weight Care Pathway group. Children's Weight Management. Programme Contract. Start well contract.	Development of healthy weight Care Pathway and take up of related training. Number of children and young people attending Xplore programme.
Increase the proportion of employers and workplaces that promote healthy choices and support people to maintain a healthy weight. 	Develop and implement the Good Work Standard. Promote Sugar Smart and Breastfeeding Friendly initiatives through workplace health.	Breastfeeding Strategy Group.	Healthy Workplace Charter sign ups. Healthy Early Years status. Healthy Schools status. Make Every Opportunity Count sign ups. Sugar Smart sign ups.
Increase engagement and commitment to tackle child obesity among partners and residents. 	Develop and implement multi agency communication plan. Implement training programme as part of care pathway roll out. Deliver the National Child Measurement Programme (NCMP).	Healthy Weight Communication Group.	Activity monitoring of social media activity, website traffic, e-newsletters, PR coverage, campaign execution, product development, roadshow/outreach interventions, as well as direct and wider partner engagement with the strategy.

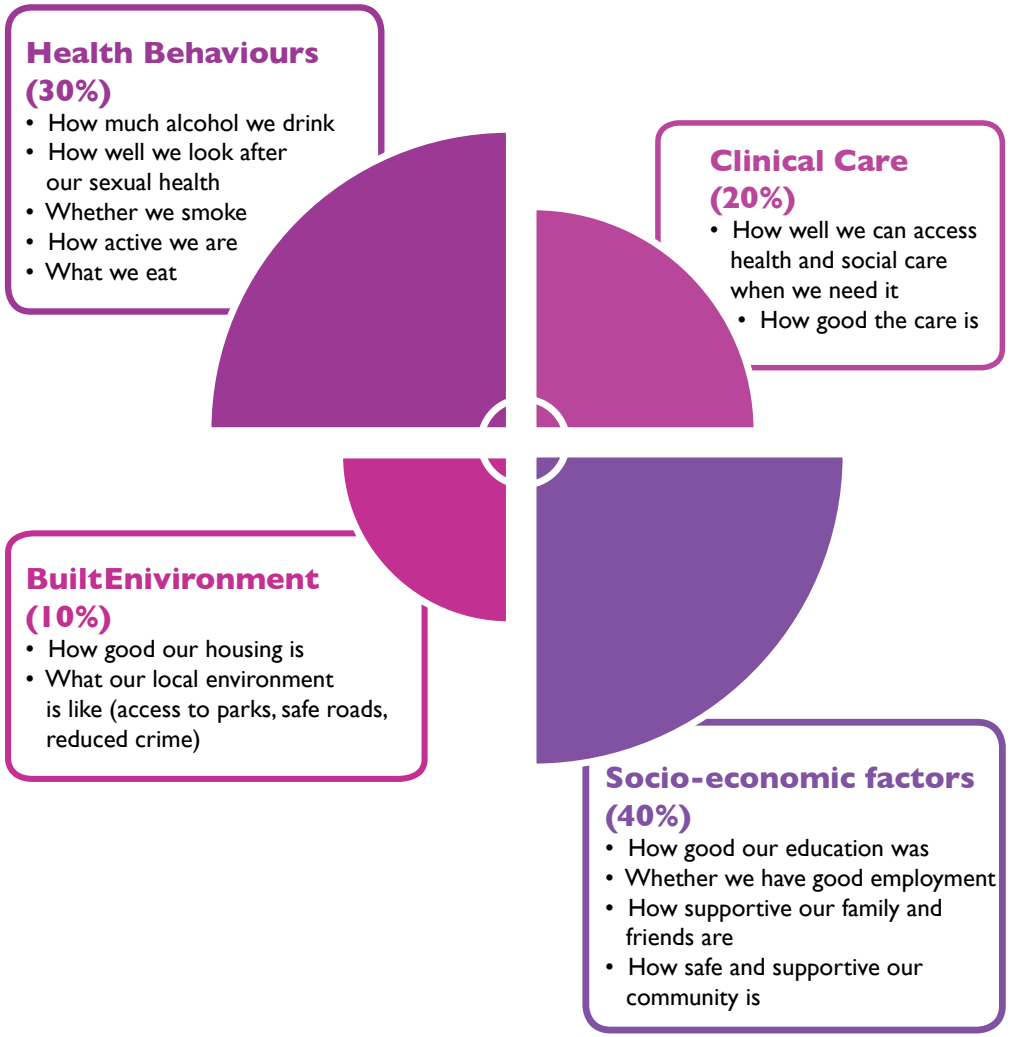
Priority 3: Live Well Greenwich – embedding a prevention approach



Why is it important?

In the Royal Borough of Greenwich people are living longer, but, an increasing number of the extra years are spent living in poorer health, often with multiple chronic diseases. Good or bad health is not simply the result of individual behaviours, genetics or access to medical care. A substantial part of differences in health is down to social, economic and environmental factors (figure 14). Changes in lifestyle and behaviour can improve people's health and reduce their risk of poor health, and supporting people to make these changes is an important part of a population approach to improving health. However, the underlying circumstances within which unhealthy choices are made are complex and varied, and the physical and social environment in which people live can affect their ability to make healthy choices. In addition, the physical and social environment itself can also directly affect people's health and wellbeing, through, for example the effect of damp homes or poor air quality.

Figure 14: What makes us 'healthy'?



Diseases such as cancer, heart disease, diabetes and chronic lung conditions cause a significant burden to people, communities and society. In order to help prevent poor health and the development of chronic diseases we need to support individuals, but at the same time address negative impacts of the environment and social circumstances. Live Well Greenwich's approach to prevention operates at population, community and individual levels to seek to address some of these broader factors.

Community life, social connections and having a voice in local decisions are all factors that have a vital contribution to make to health and wellbeing. These factors help people build confidence and resilience, helping to reduce the risk of disease and influence positive health-related behaviour. Community-centred approaches are important for health and social care services.

The NHS Five Year Forward View and Long Term Plan sets out how our health services need to change and argues for a new relationship with patients and communities. The National Institute for Health and Care Excellence (NICE) guidance reiterates the importance of community engagement as a strategy for health improvement, particularly as it leads to services that better meet the community members' needs.

Recognising the wider social factors that affect people's health means that as well as supporting their medical needs we also need to focus on supporting people to address their social circumstances, working with the assets they have.

'Social prescribing' involves supporting people to improve their health, by focusing on wellbeing and social welfare (e.g. employment, lifestyle, finance, housing or social isolation) connecting them to a range of local, non-clinical community facilities (figure 15). The aim of social prescribing is to deliver holistic, person-centred approaches to improve confidence, independence and resilience to reduce the need for healthcare services through non-medical solutions.

Figure 15: Social Prescribing

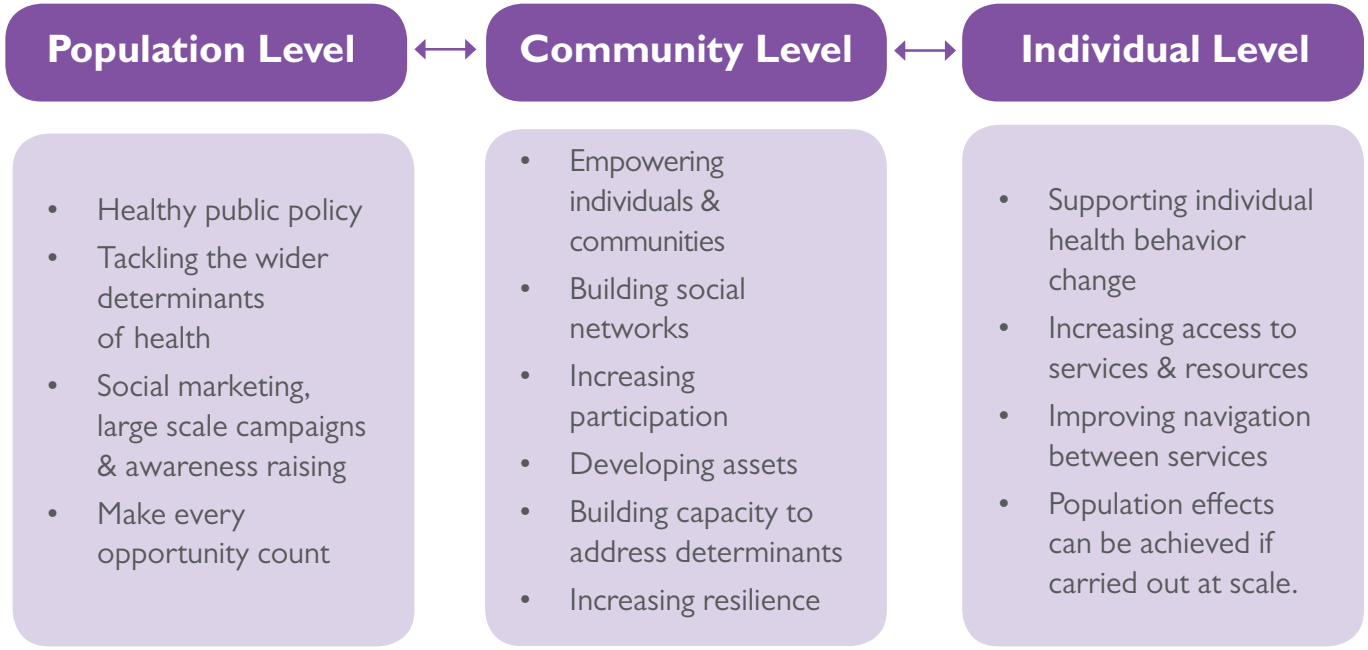
Source: Public Health England

Understanding that good healthcare is only part of the solution to achieving good health for the Royal Borough of Greenwich means we need a new way to tackle the problem of chronic disease. To effectively prevent complex chronic health problems in the long term, we need to recognise the role of social, economic and environmental factors and how these interact. This requires the whole system working together to deliver prevention at scale to maximise opportunities to embed a preventative approach in the broader work of the Council and its partners, making improving health an important part of all that we do.

What have we been doing?

Our partnership approach to prevention, Live Well Greenwich, officially launched in November 2017. It aims to unite efforts across all local organisations to maximise opportunities to improve health. Live Well Greenwich seeks to ensure existing strategies, infrastructures and services work together in a single comprehensive approach at individual, community and population levels, to make health everybody's business. This approach is summarised in figure 16 below.

Figure 16: Prevention approach to delivery of Live Well Greenwich



Working at a population level

At a population level, Live Well is focusing on embedding health in all policies across the Council and partners, and creating a population approach to tackling the wider factors affecting health. This includes working with transport, planning and regeneration stakeholders to create healthy public places; with employment skills stakeholders to improve employment, and with businesses to create healthy workplaces. By taking a population approach to delivery of large scale campaigns through our roadshows and campaigns, we can further contribute to this population approach to preventing poor health.

Working at the community level

The United Nations defines community development as "a process where community members come together to take collective action and generate solutions to common problems." It is a broad term given to the practices of civic leaders, activists, involved citizens and professionals to improve various aspects of communities, typically aiming to build stronger and more resilient local communities.

People in Royal Greenwich - and the communities in which they live - have resources, connections and ability to influence locally. We can harness, develop and join up these assets in order to maintain and improve health and wellbeing: this 'asset-based approach' has the potential to lead to substantial gains. Assets within the community include individuals, their skills and the passions of local residents that give them the energy for change, the networks and connections including friendships and neighbourliness, local informal groups, official statutory, private and third sector organisations, physical spaces such as parks or buildings, businesses, and even social bonds and knowledge about the area that enhance wellbeing.

By strengthening and linking these assets, we are improving the community's capacity to ensure sustainable health benefits in the long-term. We apply an asset-based approach at all stages: from mapping assets and needs within a community, to planning and delivering an intervention and even evaluating what has been done. The assets approach values the capacity skills, knowledge, connections and potential in the community - it does not only see the problems that need fixing and the gaps that need filling.

We have been working for many years with communities across the Royal Borough of Greenwich and over 1000 local people have been trained as health champions (the most of any London borough) through the Royal Society for Public Health (Understanding Health Improvement – Level 2 training). This includes members of community, churches, professionals and volunteers.

These individuals roll out key Live Well messages to their own communities and some have become volunteers supporting Live Well Coaches and even become Live Well Coaches. This is an ongoing programme to support Live Well and create active communities. This network of Live Well Champions is seen as co-producers of health and wellbeing rather than recipients of services.

They are a valuable asset which promotes community networks, relationship building and friendships which supports individuals' health and wellbeing through self-esteem, coping strategies, resilience skills, knowledge and personal resources. These principles often lead to new kinds of community-based working and help to refocus some existing services.

Working at an individual level

Using insight led engagement within local communities we have developed an infrastructure to empower people and communities to improve health and wellbeing, including through social prescribing. The insight research identified that social isolation, housing and financial worries were the most frequently expressed additional needs for which people contacted services and for which additional support was required.

This infrastructure comprises: the Royal Greenwich Community Directory, an online resource that signposts people to assets in the community that may help; the Live Well Line, telephone support that provides a more detailed support helping guide people to the right support for their needs; and Live Well Coaches, a more intensive level of individual support (social prescribing). The aim of the telephone and face to face coaching is to build confidence and help people recognise the assets they have that can help them address their needs.

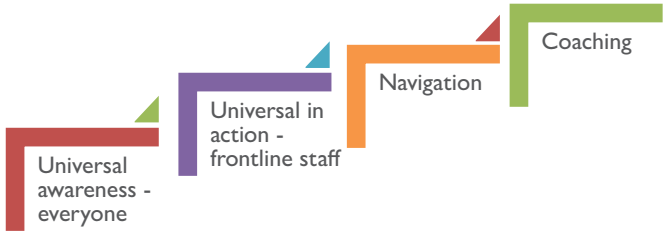
Additionally, the NHS Plan sets out its commitment for link workers (social prescribers) within primary care networks to work with people to develop tailored plans and connect them to local groups and services. We will work with the Primary Care Networks to support the extension of social prescribing within the Borough.

Implementing the system

To achieve the aim of Live Well Greenwich to make improving health everyone's business, we need people and communities to recognise how they can help others and themselves, and to be aware of the support that is available. We have developed training, at different levels, to support the infrastructure. Universal training 'Make Every Opportunity Count' (MEOC) helps people know when, where and how to best signpost local people to Live Well Greenwich. Since December 2018, over 600 people have been trained across the Royal Borough of Greenwich and we continue to roll out to both front line staff and the community and are developing further training to help more people across the borough.

A key target for this training is the Primary Care workforce. Facilitated by Greenwich CCG funding, the Council's Public Health team have developed a stepped training programme to embed navigation and coaching skills within existing staff as outlined in figure 17. This model of training may provide opportunities for the Council to roll out to other workforces, both paid and volunteer.

Figure 17: Live Well Training pathway



We have been working with partners to embed the Live Well Greenwich infrastructure into broader pathways. This includes Health and Adult Services' Adult Customer Journey, Greenwich CCG Diabetes pathway and End of Life Pathways to date. We have also embedded Live Well Greenwich as part of the VCS Commissioning Process where provider commitment to Make Every Opportunity Count Training and signposting to Live Well was considered as part of the selection criteria.

In July 2018, the Royal Borough of Greenwich commissioned the development of four Primary Care Live Well Centres, managed through the GP Federation, Royal Greenwich Health. These centres now provide a range of open access public health services; these are expected to grow in size and scale as they develop as centres of excellence targeting those in most need.

A life course approach to prevention

Taking an early approach to prevention is important for the health and wellbeing of borough residents. The Royal Borough of Greenwich has a number of key challenges related to our population of children and young people. Working in partnership, the Public Health team and Children's services have a joint commissioning plan to remodel children and young peoples' wellbeing services including: Health Visiting, School Nursing, Universal Youth and Children's Centres.

This has given us an opportunity to develop a programme Start Well Greenwich which is aligned with the wider Live Well Greenwich prevention system. In a similar way to Live Well Greenwich, Start Well Royal Greenwich, aims to empower children, young people and their carers/parents to build confidence and resilience, making the most of their community assets.

Who has been involved?

Live Well Greenwich is steered by the Live Well Partnership Board, chaired by the Cabinet Member of Adults, Older People and Anti-Poverty. Figure 18 below sets out the wider range of partners contributing to the Live Well programme.

Figure 18: local leadership for Live Well Greenwich

We work closely with and support the Live Well Champions groups through regular meet ups and events, as well as co-producing an action plan.

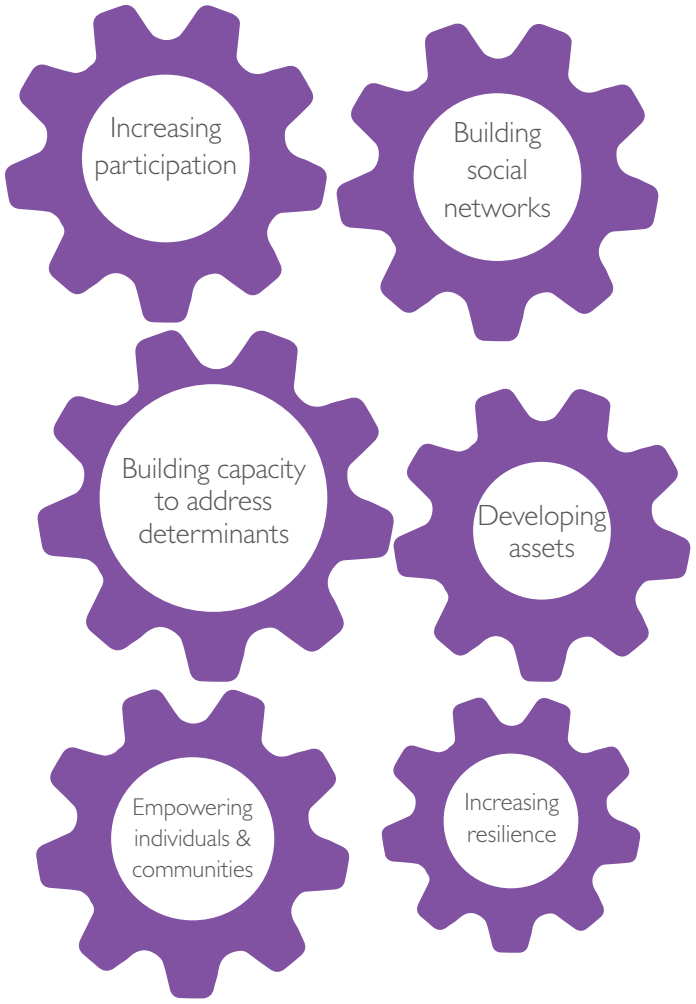
What we are going to do next

Table 3 sets out the high level delivery approach to each of the core areas of Live Well Greenwich priorities over the next five years, the key groups who will oversee work and lead further development and implementation, and the indicators which will allow the Health and Wellbeing Board to monitor the progress of these areas of work. The leadership of this action plan sits with the Live Well Greenwich Partnership Board. Core elements of the Live Well Greenwich prevention at scale programme are below:

- Delivery of the Live Well Infrastructure with partners to ensure a multi-layered and integrated service for the borough.
- Co-produce an action plan with the Live Well Champions and jointly work with volunteers to deliver this.
- Ensure broad uptake of Making Every Opportunity Counts across the borough
- Embed the health in all policies approach.
- Maximise opportunities to embed Live Well in other pathways or commissioning approaches.
- Work alongside the Primary Care Networks to develop our systematic approach to social prescribing in primary care.

Table 3: Live Well Greenwich actions

Live Well Greenwich ambitions	Action	Who will take this forward?	Measuring success
Live Well in all policies (population level action)  	Population awareness raising campaigns including a call to action. Start Well Greenwich aligned with the wider Live Well Greenwich prevention system. Utilise partner support and communications mechanisms to reach a wider audience e.g. business. Integration of the adults and children's directories.	Multi-agency Communications group. Live Well Partnership Board/Start Well Board. Live Well Partnership Board. All Services Hub.	Local representation of Public Health England and other national campaigns. Revised integrated Royal Greenwich Community Directory.
	Local representation of Public Health England and other national campaigns. Revised integrated Royal Greenwich Community Directory.	Live Well Training and Development Group.	Uptake of Make Every Opportunity Count training – aim for 500 completers per year.
	Work with planners, developers and other place makers to create healthy public and domestic spaces. Work with VCS orgs whose remit relates to wider determinants such as employment readiness, advocacy, confidence building etc. to create environs and opportunity for living well. Build VCS capacity to support social prescribing	Health and Wellbeing Board. Wider Determinants Group.	Play streets created. Proximity to green and open spaces. Engagement with planners. No VCS organisations engaged with Live Well.

Live Well in the community - community level action 	Engage communities on their own terms to understand how to engage and support them. Seek to engage with diverse range of communities that are not currently represented.	Live Well Partnership Board. Community Development and Engagement Workers Forum. Live Well Delivery Teams.	No of targeted 'deep dive' community reviews. Evaluation of targeted outreach. Number of community groups engaged and working around Live Well. No of community organisations supported by the programme.
	Increase the numbers of Live Well Champions within the local community. Work with local community leaders and Volunteer Centre Royal Greenwich to recruit residents to be Live Well Champions.	Live Well Training and Development Group. Live Well Champions group.	Numbers completing RSPH Understanding Health Improvement 2 day training – aim 100 per year. Number of active volunteers (in primary care). Number of community-based interventions supported. Number of community meals per year. Live Well Champions action plan co-produced with volunteers.
	Reduce the level and impact of social isolation and loneliness. Work with community centres on specific initiatives related to tackling social isolation and loneliness.	Social Isolation Strategy Group.	Number of residents receiving social isolation/loneliness support from Live Well Royal Greenwich.
	Increase added value of community development programme.	Live Well Partnership Board.	Social value measures.

Live Well as individuals and families 	Deliver Live Well Infrastructure at scale and as a single service, supported and enabled by community approaches. Continue to engage with Advice services and Strategic Equalities services to further enhance reach to groups listed under Protected Characteristics. Work to align Live Well Greenwich including social prescribing and Make Every Opportunity Count with core frontline services. Work with the new Primary Care Networks to support the development of and implementation of a borough wide plan for social prescribing.	Live Well Partnership Board. All Services Hub Steering Group. NHS Greenwich CCG Governing Body.	Integrated adults and children's directories. Live Well Line – 5000 contacts per month. Number of individuals supported by a Live Well Coach – 2000 per year. Develop special interest Live Well Coaches e.g. employment, housing, energy. Implementation of DH funded programme; number of referrals from primary care; number of coaching sessions based in primary care. Range of Protected Characteristics that are supported.
	Design and deliver a Live Well training and development programme; this will include staff development especially in primary care as well as volunteer development in conjunction with Voluntary and Community Sector.	Live Well Primary Care Training group.	Live Well Primary Care training, training pathways for development of volunteers.
	Programme addresses the core needs of the clients – social isolation, employment, housing, financial concerns and lifestyle changes.	Live Operational Group/Live Well Partnership Board.	Clients by need. Client outcomes – WEMWBS (mental wellbeing measurement tool), self-efficacy tool. GAVS Needs assessment.
Evaluation and Development	Robust evaluation and monitoring system in place. Develop with VCS pathways of navigation to seamlessly connect services.	Live Well Partnership Board.	Quarterly reports. Royal Greenwich Action for Voluntary Services Needs Assessment.

Priority 4:
Health and Social Care System Development

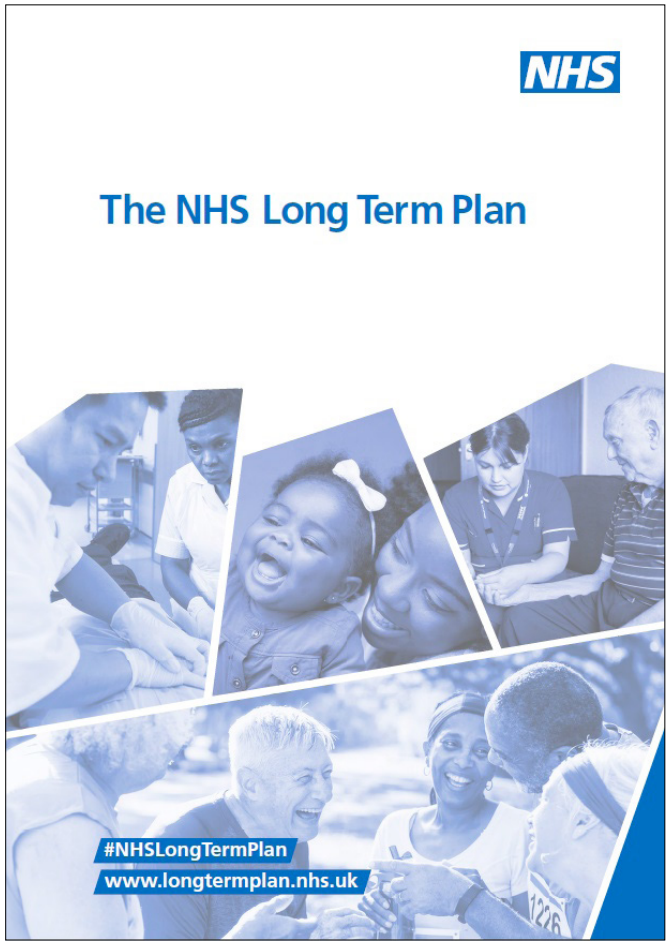
The Health and Social Care services available to people in the Royal Borough of Greenwich seek to achieve a range of important outcomes for our population. They seek to:

- Help people to live long, healthy lives, and to stay active and independent throughout their lives.
- Provide care, support and effective treatment for people who experience illness or injury, be that sudden and unexpected or a longer term health problem or disability.
- Support people needing specific medical care at particular times in their lives, for example maternity care for pregnant women and care for new born babies
- Provide home care, rehabilitation, residential and nursing care when people need additional support.
- Provide compassionate, dignified and tailored care to people nearing the end of their lives and their friends and families.

The NHS Long Term Plan (10 year plan from 2019)

The NHS has set out a series of new commitments and improvements for healthcare services through its NHS Long Term Plan, a 10 year plan which was published early in 2019. Government is also planning to publish two Green Papers during 2019, one on Social Care and one on Prevention. The following are some of the key features of the Long Term Plan.

- Primary and community services get a major boost as part of a drive towards integrated care and population health. This includes the setting up of Primary Care Networks covering populations of circa 30-50,000 people, and the funding of new roles, including clinical pharmacists and social prescribers. The concept of the Integrated Care System (ICS) is also set out by the Long Term Plan, which in Royal Greenwich will involve all key partners working together on the Borough footprint.
- There is a major focus on a range of clinical priorities. These priority areas include children and young people, cancer, cardiovascular disease, stroke, diabetes, respiratory disease and mental health. Each priority has specific ambitions and will require their own implementation plans. For example, by 2019 the NHS will roll out the Saving Babies' Lives Care Bundle to every maternity unit; and by 2028, the NHS will diagnose 75 per cent of cancers at stage 1 or 2.
- Workforce issues receive a high priority. A new Workforce Implementation Plan, supported by a new national workforce group drawing the various stakeholders together, is promised.
- Digital developments are in the spotlight. For example, over the next five years every patient will get the right to telephone or online consultations with their GP practice; and for outpatients, technology will be used to redesign services to avoid up to a third of outpatient visits.
- Prevention and health inequalities. The plan commits the NHS to a greater focus on prevention and on health inequalities but quite rightly recognises that even at its best, the NHS is only part of the answer to better, fairer health. As the plan says, we cannot 'treat our way out of health inequalities' – national and local government and other partners are fundamental to making broader progress. In Royal Greenwich, our priorities in relation to healthy weight, mental health and Live Well Greenwich are all important components of our local approach to tackling health inequalities and preventing ill health.



The Royal Greenwich Clinical Commissioning Strategy (2018-2022)

Locally, the Royal Greenwich Clinical Commissioning Strategy sets out a local framework for changes to the health and care system, identifying a number of priorities:

- Priority 1: to prevent illness and help our population to Live Well
- Priority 2: to strengthen local support for people with mental illness, including children and young people
- Priority 3: to better meet the needs of frail people with care closer to home, an integrated urgent care system and stronger community based care
- Priority 4: to improve the prevention, detection and treatment of cancers for our local population

In the Royal Borough of Greenwich, we plan to work increasingly closely together across our organisations to improve the integration and co-ordination of our services, including prevention, primary care, community care, acute, mental health and social care services in the borough. We will work together to respond to national policy in a locally appropriate way, improving the way our services wrap seamlessly around local people in ways that meet their needs effectively and provide a positive experience of care.

We will change and strengthen the way that health and care services are both commissioned and provided, adopting increasingly collaborative and integrated approaches to designing and managing the system.

Much of our work will remain organised at a very local level and within the Borough boundary, but we will also work increasingly closely with neighbouring Boroughs in South East London where it makes good sense to do so as part of the wider health and care economy in this part of London.

Our work will therefore operate effectively at a range of levels:

- Very local level – the development of primary care networks across the Borough, involving multi-agency teams of health and care professionals providing joined-up, co-ordinated preventive, treatment and social care services for local communities based on a good understanding of local need
- Borough level – the commissioning and provision of services through an Integrated Care System approach for Royal Greenwich residents, where the Borough footprint makes the most sense
- South East London level – the commissioning and provision of services for residents across the six Boroughs in South East London, where these are best delivered for a larger population

The Royal Greenwich Clinical Commissioning Strategy sets-out the challenges we face in Royal Greenwich, the plans we have to transform services, our top priorities for action and the impacts we are seeking to achieve for the health and wellbeing of our populations.

Figure 19 sets out the 'Plan on a Page' for the Royal Greenwich Clinical Commissioning Strategy.

Figure 19: Royal Greenwich Clinical Commissioning Strategy (2018-2022)

Our challenges	High levels of deprivation, inequality and unemployment	High prevalence of mental health issues and learning disability – mental health the biggest cause of poor health in Royal Greenwich and gaps in service provision	Fragmentation of planned care. GP workforce shortagesand estate not fit for purpose. Financial challenge across the system – savings of more than £14m needed	Cancer is one of the main causes of premature death and living with ill-health
Our plans	To prevent ill-health and increase health and wellbeing, intervene early to avoid hospital admissions,and to streamline service provision • To develop an **integrated care system** for Royal Greenwich, in collaboration with social care, public health, providers and community and voluntary sector organisations • To provide the wrap-around health and social care needed by people living with a physical and mental health condition • To invest in a wide range of **primary care services, working at scale**, across four Local Care Networks, which are responsive to local people • To engineer shifts away from expensive hospital services to primary and community-based care close to home. A frailty care pathway, better end of life care, integrated care hubs, and the highest quality urgent care should all help in reducing unnecessary hospital attendances			
Our four priorities for the next three years	To **prevent illness** and help our population to live well	To strengthen local support for people with **mental illness**,including children and young people	To better meet the needs of **frail older people with care closer to home**, an integrated urgent care system, and stronger community-based care	To improve the prevention, detection and treatment of **cancers** for our local population
The impact of our plans by 2022	Children get the best possible start in life • Improvement in life expectancy, particularly for women • Reduction in alcohol consumption and smoking • Increase in children and adults who are a healthy weight • Better mental health and wellbeing, and early identification of children's educational and communication needs • Reduction in diabetes and other long-term conditions	We see better mental health and wellbeing for both children and adults • Decrease in A&E attendances for mental health issues • Reduction in out of area treatments • Services are joined up and well-coordinated • Unnecessary hospital admissions and inappropriate discharges fall • Fewer people with learning disabilities in the justice system	Frail people receive safe, high quality interventions in the community • Fewer hospital attendances and admissions for frail people • Hospital interventions only when necessary and for the shortest periods • Royal Greenwich population benefits from enhanced community provision and improved access • More people nearing the end of life can die at home or in the community with multidisciplinary support	Uptake of screening for cancers • Improvements in the factors associated with an increased cancer risk (e.g. smoking, alcohol, diet) • Increased public awareness of cancer symptoms and the need for early diagnosis • Consistent access to high quality care, timely diagnosis and treatments • Increase in cancer survival rates from one to five years • Improved patient experience scores

Implementing the Joint Health and Wellbeing Strategy 2019-2024

The lead groups overseeing each of these priorities will continue to work on a multi-agency partnership basis with professionals and citizens to implement the ambitions set out in this strategy.

Working through the relevant Partnership Boards, we will develop a reporting framework and schedule to update the Health and Wellbeing Board on the progress of action plan development, and the key measures of success relating to these priorities. We will bring regular progress and performance reports to the Health and Wellbeing Board regarding each priority area.

The lead groups will continue to monitor and respond to the changing local and national context, to ensure that our approach remains relevant and impactful throughout the five years of this strategy.

ITEM NO: 9 (Appendix A)

ROYAL borough of GREENWICH

21150 August 2019

ITEM NO: 9 (Appendix A)

AGENDA ITEM: 9

Healthier Greenwich Partnership

Date: 28 September

Title	Eltham Community Hospital – summary of proposals and engagement activity	
This paper is for **noting,** with a further paper with recommendations for approval to follow.		
Executive Summary	• The paper summarises proposals to reconfigure intermediate care and develop a new Community Diagnostic Centre at Eltham Community Hospital. • The report includes a summary of the proposals and the work completed to communicate and engage with Greenwich residents about them, plus the materials produced for this purpose. • The engagement was extended due to national period of mourning. When it is completed and has been analysed a further paper summarising the feedback will be circulated with recommendations for HGP to approve at the meeting on 28/09/22.	
Recommended action for the Committee	• At this stage members are being asked to note but a further paper will follow prior to the meeting with recommendations for approval.	
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	• Equality Impact Assessments have been completed for both the proposed consolidation of the intermediate care beds and the Community Diagnostic Centre
	Financial impact	The Community Diagnostic Centre is expected to bring in funding to Greenwich from NHSE&I of £13m capital investment and £9m revenue funding for the next three years.
Wider support for this proposal	Public Engagement	• The paper outlines the engagement activities and the materials used. Analysis of the activities will follow.
	Other Committee Discussion/	• Healthier Greenwich Partnership 08/06/22, 20/07/22

	Internal Engagement	• Healthier Communities and Adult Social Care Scrutiny Committee 22/09/22
Author:	Russell Cartwright	
Clinical lead:	Rachel Matheson	
Executive sponsor:	Neil Kennett-Brown	

South East London Integrated Care System

Healthier Greenwich Partnership

Proposals for changes to services at Eltham Community Hospital

Summary of proposed reconfiguration of intermediate care and a new Community Diagnostic Centre

September 22

Eltham Community Hospital

Background

- Since it opened in 2015 we haven’t been able to get the most out of Eltham Community Hospital
- Currently on the site are based:
  - two GP practices
  - musculo skeletal services (MSK)
  - phlebotomy (blood tests)
  - X-ray services
  - intermediate care beds

Community Diagnostic Centre - the proposal

- NHS England and Improvement have agreed to fund Community Diagnostic Centres (CDCs) across the country

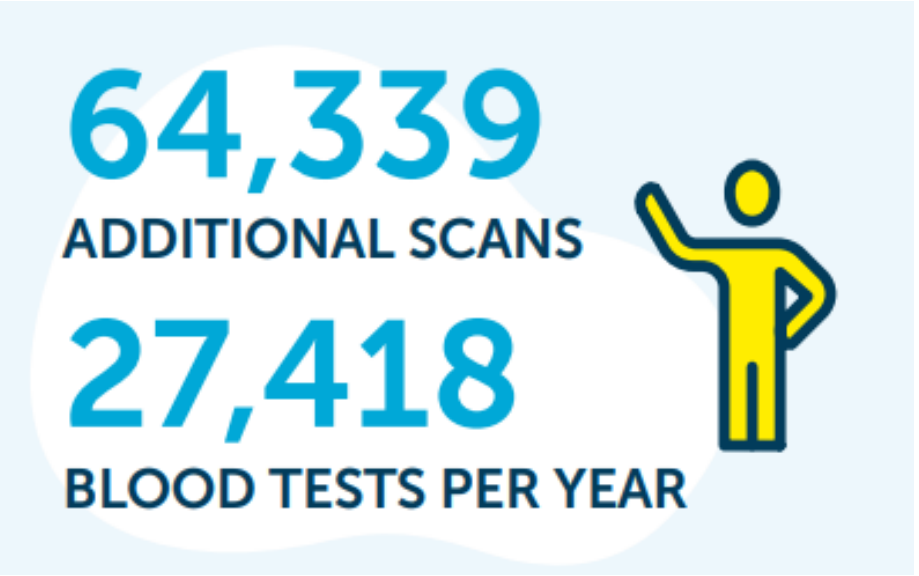
- **Eltham Community Hospital** has been identified as an ideal space for a CDC which would
  - provide local residents access to life saving checks closer to home
  - enable rapid diagnosis of a range of conditions without the need to travel to an acute hospital

- This would be a massive benefit to the local communities of Greenwich meaning health conditions can be diagnosed earlier, faster and more accurately with easier access to tests

Community Diagnostic Centre – benefits of the proposal

The proposed Community Diagnostic Centre will provide:

- up to 64,339 additional scans
- 27,418 blood tests per year
- increase existing capacity for ultrasound scans, blood tests and X-rays
- create new capacity for CT scans, MRI scans, respiratory and cardiac diagnostics



£13m capital investment and £9m revenue funding for next 3 years

Community Diagnostic Centre – benefits of the proposal

- Significantly increase diagnostic capacity
- Provide improved access to blood monitoring testing and 24-hour tape monitoring which will free up clinical space at QEH to develop acute services
- Improve waiting times
- Reduce the numbers of patients at the Queen Elizabeth Hospital and University Hospital Lewisham sites for diagnostic testing, helping reduce onsite pressures across the two acute sites

- Support reducing health inequalities by providing a broad diagnostic service in the community to improve the health and wellbeing of local residents
- Support faster diagnosis of cancers and other illnesses

Home first initiative

Local people should receive the highest quality care in the safest environment – wherever possible this should be the home

Healthier Greenwich Partnership

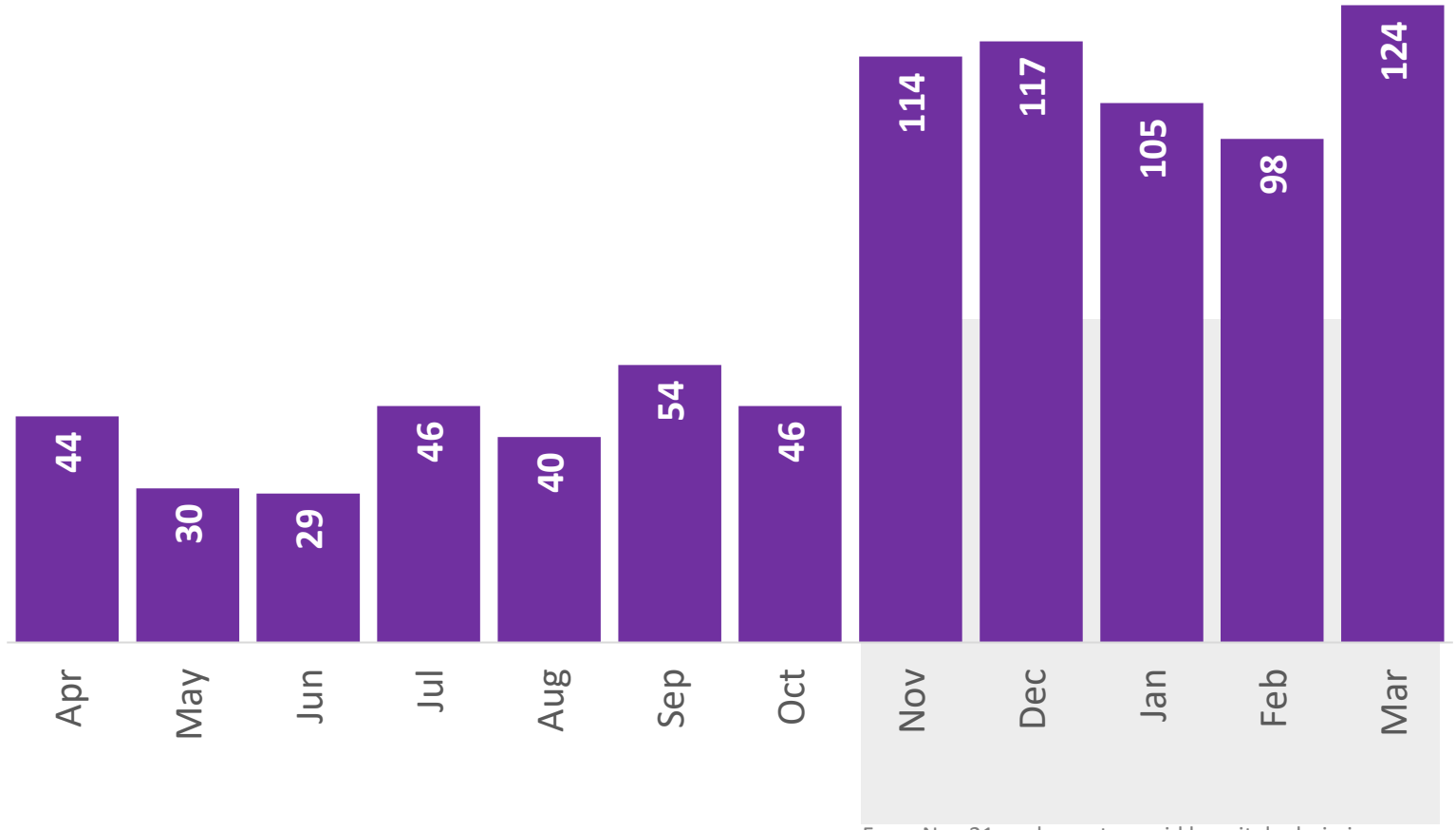
Aims:

- Identify people at risk of a hospital admission and provide care that prevents their condition from worsening
- Enable people to receive a high level of care in their own homes instead of being admitted unnecessarily to hospital
- Enable advanced discharge from hospital so that people can recuperate in the comfort of their home while receiving high quality care
- Preferred place of death - give people real choice to die in their preferred place of residence without unnecessary admissions to hospital

£1.9 million investment across teams and organisations including the following:

- Expansion of Rapid Response teams
- Additional medical support – consultant leadership and GP sessions
- Improved interface with ambulatory care and NHS 111
- Increase in therapy staff to aid faster access to rehabilitation
- Development of a delirium pathway

Pathway 1: Discharge to the community with a new package of care



From Nov 21 packages to avoid hospital admission were included

788 Greenwich residents supported April 21 to March 22

What do patients think of Home First?

The table below shows the recent patient experience report from some of the teams who are part of the Home First initiative. The percentages shown are patients who scored the team ‘good’ or ‘very good’ in the Friends and Family test.

FFT % - Good or Very Good		
ServiceName	June	July
Joint Emergency Team	**75%**	**91%**
Greenwich COPD Team	**84%**	**85%**
Community Care Plus	**100%**	**100%**
Community Rehabilitation and Short-Term Assessment Team (CRSTAT)	**100%**	**82%**
Greenwich Falls Prevention Team	**100%**	**100%**
Greenwich Frailty Team	**100%**	**100%**

Planned virtual wards

Investment to reduce hospital stays for those most at risk of harm with admission: People who are frail, elderly or have dementia

Virtual wards will enable people to receive high quality care in their own home

Frailty – 60 'beds'	IV antibiotics – 20 'beds' (10 adult & 10 children)	Dementia – 10 'beds'	Respiratory – 10 'beds'	End of Life Rapid Response – 5 – 7 'beds'	Reablement – Physiotherapy / OT – 5 'beds'
Expansion of Frailty multi-disciplinary team (MDT) to support admission avoidance Focused short-term support to help people to reorientate and recover at home following a hospital stay	IV antibiotics to support patients in their own homes following a hospital stay Children's Hospital at Home service	Introduce Admiral nurses for crisis intervention and case finding Focused short-term support to help people with delirium or other related conditions to reorientate and recover at home following hospital discharge	Expansion of existing service to support admission avoidance To support patients with COPD caseload who are experiencing an acute deterioration in symptoms to prevent Emergency Department attendance and admission	Proposal for new service provision by Greenwich and Bexley Community Hospice Rapid Response service model for end-of-life patients to support admission avoidance at points of crisis and enable more people to die in their place of choice	Expansion of existing service to support readmission avoidance A safe, timely response and on-going therapy review following discharge. Ensure carers are trained where needed and equipment is reviewed in the home environment.

£1.4 million investment over the next six months

Intermediate Care

Intermediate care is a period of care and rehabilitation between the hospital and home, designed to help patients regain their independence and enable them to return to normal life as smoothly as possible.

- Currently at Eltham Community Hospital there is provision for two wards of 20 intermediate care beds
- One of these wards is not in use, the other is rarely full
- Currently intermediate care for Greenwich and Bexley residents is provided mainly at home - *96% of all patients are discharged to their own home*
- Both services are run by Oxleas NHS Foundation Trust
- Meadow View is also rarely at full capacity

Intermediate Care – the proposal

The proposal is that Oxleas will provide intermediate care beds for both Bexley and Greenwich patients at Meadow View, Queen Mary's Hospital with a total of 36 beds.

- *This number is based on a thorough review of need over the past few years in Greenwich and Bexley boroughs.*

Intermediate Care - benefits of the proposal

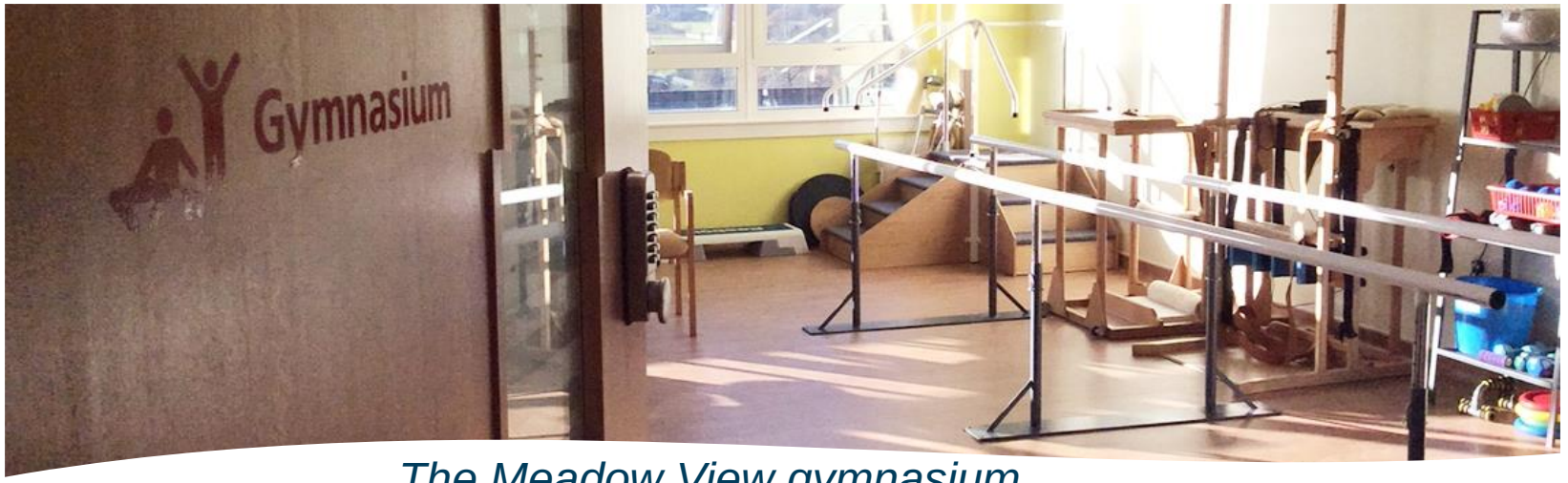
- The proposed intermediate care bed service at Meadow View will provide a better, more resilient service for patients
- Better rehabilitation outcomes for patients and enable them to return home quicker
- At Queen Mary's there are a number of clinical benefits including other wards staffed 24 hours a day and an urgent care centre on site
- The environment at Queen Mary's Hospital offers a better experience for patients and relatives using intermediate care beds with a café, shop, gardens and parking on site
- The Home First model enables more patients to receive intensive health and care support in their own home

Currently at Eltham Community Hospital	Proposed new service at Meadow View
0.2	0.3
Therapists to each patient	Therapists to each patient

Meadow View ward

Intermediate Care - benefits of the proposal

- Staff will be working in a team with a greater skill mix than present
- There will be a simplified process for professionals referring patients to the service at Meadow View
- Better use of the space will enable other investments including the proposed Community Diagnostic Centre and other opportunities which will be explored with the Healthier Greenwich Partnership
- The proposals are aligned to plans to meet anticipated future demand and create additional acute hospital beds at Queen Elizabeth Hospital



The Meadow View gymnasium

South East London Integrated Care System

Healthier Greenwich Partnership

Proposed changes to Eltham Community Hospital

Summary of Communications & Engagement Activity

August 22

Audiences

- Recent intermediate care patients
- Carers and relatives of recent intermediate care patients
- Voluntary and community sector organisations working with the above
- Greenwich residents
- MPs, Councillors

Activities

- Oxleas NHS led engagement with intermediate care staff
- Press release
- Publish summary on Let's Talk Health and Care digital engagement platform with survey and forum questions
- Printed summary and longer version of the proposals
- Send out to Community Champions and through partner communication channels
- Promotion on social media
- 2x Focus group discussions at Eltham Community Hospital
- 1x Healthier Greenwich Partners Public Forum discussion
- Healthwatch Greenwich facilitated discussion on CDC
- Attendance at existing community meetings
- Meetings – updates on the Eltham Community Hospital with MPs, Councillors

Timetable of main activities

Date	Activity
16 Aug 22	Staff engagement started
18 Aug 22	Patient/resident engagement starts
18 Aug 22	Press release issued and article published on ICS website
18 Aug 22	Email to all contacts (including engagement list, partners, VCS, Deep engagement, Healthwatch, councillors and MPs)
19 Aug 22	Digital summary published on Let's take health and care in SE London
19 Aug 22	Social media promotion commences
19 Aug 22	Community Champions email and Whatsapp messages
25 Aug 22	First patient/resident focus group (at Eltham Community Hospital)
1 Sep 22	Community Champions email and Whatsapp messages
2 Sep 22	Email to Patient Participation Groups, engagement list, faith groups, VCS, deep engagement, comms partners
7 Sep 22	Community Champions email and Whatsapp messages
8 Sep 22	Second patient/resident focus group (at Eltham Community Hospital)
13 Sep 22	Staff engagement ends
~~14 Sep 22~~ 21 Sep 22	Healthier Greenwich Partnership Public Forum
~~15 Sep 22~~ 26 Sep 22	Discussion at Oxleas NHS Council of Governors
22 Sep 22	HCASC Scrutiny Meeting
28 Sep 22	Healthier Greenwich Partnership meeting
Jan to Mar 23	Further patient/resident engagement on CDC

Evaluation and reporting

- The engagement activities are being measured on an ongoing basis and plans adapted to reflect the learnings
- Outputs are being measured by the numbers of responses and the quality of the feedback received
- A summary of the feedback and actions taken in response to it will be published and shared with participants
- Outcomes from the engagement will be reported to the Healthier Greenwich Partnership (28th Sept) and the Health Scrutiny Committee (22nd Sept)

South East London Integrated Care System

NHS South East London

Engagement materials

Digital engagement

https://letstalkhealthandcareselondon.org/elthamhospital

Home / Healthier Greenwich Partnership / Proposals for changes to services at Eltham Community Hospital

Your session expired, please sign in again to continue.

Proposals for changes to services at Eltham Community Hospital

Proposed reconfiguration of intermediate care and a new Community Diagnostic Centre

Introduction

We are proposing some changes to the services currently at Eltham Community Hospital

Proposal for changes to Eltham Community Hospital.pdf (745 KB) (pdf)

Complete our short survey on the proposals

NHS
South East London

SOUTH EAST LONDON INTEGRATED CARE SYSTEM

MEMORANDUM OF UNDERSTANDING - INTEGRATED CARE BOARD DELEGATION AGREEMENT

BETWEEN THE SOUTH EAST LONDON INTEGRATED CARE BOARD AND GREENWICH LOCAL CARE PARTNERSHIP

FOR THE PERIOD 1 JULY 2022 TO 31 MARCH 2023

1. Introduction

The South East London Integrated Care Board (ICB) has agreed a principle of subsidiarity in determining respective roles and responsibilities across its system of systems to support the delivery of the ICB's core objectives. This commitment has driven an agreed approach to year 1 delegation to the ICB's six place based Local Care Partnerships, its Acute Provider Collaborative, South London Partnership Collaborative for SEL Mental Health and Community Provider Network.

This Memorandum of Understanding sets out the governance and scope of the agreed year 1 delegations, recognising that the ICB will further develop its approach to and the scope of delegation for future years and also that year 1 arrangements will need to be tested and iterated over 2022/23 as we establish, test and develop our wider ICB governance and working arrangements.

2. 2022/23 delegation arrangements

The ICB has agreed an approach to delegation that is complimentary across its Local Care Partnerships, Provider Collaboratives and Provider Network, thereby differentiating the respective role and responsibilities of each.

In discharging these responsibilities all parties are committed to working inclusively within their partnerships and with the wider ICB, Committees, Boards and Partnerships.

In addition all parties will ensure associated ICB agreed commitments and priorities are demonstrably addressed, be they related to national planning guidance or local strategic and operational plans alongside working to further the four core national objectives of ICBs. This includes delivery of the ICB's inherited 2022/23 operational plan and associated commitments.

This will include reporting to the ICB in line with agreed governance arrangements, recognising the required separation of responsibility and accountability with the ICB remaining the accountable body for the delivery of agreed ICB functions, requirements and commitments.

Local Care Partnerships, Provider Collaboratives and the Provider Network will further work as part of an Integrated Care Partnership, Board and system ensuring a full contribution from the Partnership/Collaborative/Network to the ICB's strategic and

operational planning and delivery processes, Transformation and Enabler Boards and wider ICS development.

The ICB will work inclusively and collaboratively with its places, collaboratives and networks in the development of strategic and operational plans, thereby reflecting agreed ways of working and SEL's system of systems approach. In agreeing plans all parties will give due consideration to the resourcing, infrastructure and support required to enable effective delivery.

2.1. Governance

The ICB delegation to Greenwich Local Care Partnership is made in line with the agreed nominated leads across the system, as follows:

Bexley Local Care Partnership - Stuart Rowbotham, Place Lead
Bromley Local Care Partnership - Angela Bhan, Place Lead
Greenwich Local Care Partnership - Sarah McClinton, Greenwich Place Lead
Lambeth Local Care Partnership - Andrew Eyres, Place Lead
Lewisham Local Care Partnership – Ceri Jacob, Place Lead
Southwark Local Care Partnership - James Lowell, Place Lead
Acute Provider Collaborative – Clive Kay, Lead CEO
South London Partnership, SEL Mental Health – David Bradley, Lead CEO
Community Provider Network - Ify Okocha, Lead CEO (an advisory delegated responsibility recognising overall LCP delegated responsibility for community services).

Place Leads will be expected to discharge their delegated responsibilities through the wider Local Care Partnership, through the Local Care Partnership Committee, which will operate as a formal committee of the Integrated Care Board in 2022/23. Specifically decisions related to delegated responsibilities should be made by the wider partnership, inclusively and collectively. The agreed Terms of Reference for the ICB's Local Care Partnership Committees is attached as Appendix 1 to this Memorandum of Understanding.

Provider Collaborative/Network leads will be expected to discharge their delegated responsibilities through the wider Collaborative/Network governance arrangements that have been agreed and established by the Provider Collaborative/Network. Specifically decisions related to delegated responsibilities should be made by the wider Collaborative/Network, inclusively and collectively. The Provider Collaborative/Network governance will operate on a stand-alone basis, with accountability to the ICB through the Lead CEO and to the constituent organisations comprising the Collaborative or Network in line with agreed Committee in Common or equivalent agreed arrangements.

2.2 Delegated responsibilities

Local Care Partnerships

The ICB's Local Care Partnerships (LCPs) have agreed delegated responsibility for 'out of hospital services', defined as covering the following areas of provision - primary care, primary care prescribing, community service for physical and mental health, continuing

Health Care and client groups. This includes delegated budget responsibility for these same out of hospital services. In managing the budget the Place lead/LCP will act in a way that is consistent with the ICB's financial framework and ensure that financial management approaches do not have funding implications or shift financial risk elsewhere in the system, without these being addressed and agreed with relevant partners.

In undertaking these delegated responsibilities the LCP commits to ensuring the delivery of national requirements and agreed local objectives and outcomes as set out in the ICB's 2022/23 operational plan and within Local Care Partnership Plans, including applicable agreed common standards and outcomes to be secured locally, adherence to the ICB's allocation framework and the management of spend in line with the LCP's delegated budget, inclusive of taking action to address variation against these commitments and plans.

2022/23 delegation has a prime focus on delivery, through the implementation of locally designed solutions to meet agreed ICB objectives and outcomes, with a commitment and expectation that delivery approaches and solutions optimise the scope for integrated solutions across community based health and care services.

In delivering these delegated responsibilities the LCP and ICB will reflect and adhere to the agreed operating model agreed across the ICB's planning, delivery, monitoring and management functions.

The LCP will support the ICB in the discharge of its statutory functions, including those related to quality and safeguarding and the delivery of agreed local responsibilities and actions as part of the ICB's discharge of its functions.

The LCP will convene the local system and take a lead responsibility in managing local interfaces and interactions through for example their Health and Well Being Boards, borough based Local Medical Committees and Overview and Scrutiny Committees.

2.3. Financial delegation

The ICB has agreed that the principle of subsidiarity will apply to finance, with financial delegation driven by agreed delivery responsibility.

In the future the ICB will receive a financial allocation to meet the costs of NHS services for which the ICB has overall responsibility. The ICB will determine, on the basis of full partnership discussion and agreement, a strategy driven delegation of this financial allocation in line with an agreed financial framework and any national requirements (e.g. by area uplifts such as the Mental Health Investment Standard). For 2022/23 the ICB will inherit a budget for the year alongside the agreed SEL operational plan and associated financial targets and commitments.

In the event that additional recurrent or non-recurrent funding is made available to the ICB in year a system approach will be taken to the agreeing the deployment of that funding, consistent with the roles and responsibilities agreed as part of our overall operating model and any national or regional requirements. This will include clarity as to non-recurrent and recurrent handling and carry forward assumptions.

The approach to financial delegation for 2022/23 mirrors pre ICB arrangements with delegated financial responsibility to place, through the Executive Place Lead working with Local Care Partnerships, for out of hospital services and to the South London Partnership for fully funded ICB mental health complex care placements.

We are committed to developing our financial delegation approaches for the future in terms of increasing existing scope and considering the impact of national changes to commissioning responsibilities for specialised services, direct commissioning and primary care. The financial delegation model will therefore evolve to reflect allocation and responsible commissioner changes and national guidance more generally such as the expected policy shift to allow for financial delegation to Provider Collaboratives in the future.

For all agreed financial delegation delegated responsibilities encompass the following expectations:

- Ensuring adherence to the ICB's financial framework.
- Collectively agreed deployment of the delegated budget to meet agreed outcomes and deliverables, within and consistent with the agreed financial framework, national requirements, agreed contracts and financial commitments.
- Managing spend in line with the agreed allocation.
- Managing risk and any associated risk/gain share approaches to support delivery of the overall plan and ensure spend is in line with the delegated budget.
- Ensuring that in managing budgets actions do not impact on, shift costs or increase risk in other parts of the system without the involvement and agreement of impacted partners.

Local Care Partnerships

A 2022/23 budget delegation of the out of hospital budget in line with the agreed ICB final operating plan, aligned to all areas of delegated responsibility. These budgets include assumed efficiency savings to be secured by the Local Care Partnership over 2022/23. The budgets further include the contractual funding included in the ICB's contracts with SEL providers for community services (across physical and mental health), noting the contracts further include provision for acute services as part of single integrated contract agreements. The community services funding included within these contracts and LCP budgets represent pass through payments for 2022/23 as part of agreed fixed contracts with providers for the year.

3. Delegation within an overall ICB operating model and framework

In broad terms the agreed SEL operating model assumes the Integrated Care Board is responsible for:

- Ensuring an effective NHS contribution to the ICB integrated care strategy
- Ensuring NHS delivery of the Integrated Care Partnership integrated care strategy and the delivery of the four aims of ICSs. This will include the agreed articulation of strategic and operational objectives, outcomes and standards to improve health and reduce inequalities and an agreed supporting investment strategy and financial allocation framework, articulated through an agreed system wide ICB strategic and operational plan.

- Ensuring supporting infrastructure and enablers are in place and further developed
- Overall system management and oversight.

The key responsibilities of the ICB's LCPs, Provider Collaborative and Network are to contribute to the design and development of the ICP integrated care strategy and the ICB's associated strategic and operational plans, inclusive of agreed objectives and outcomes, investment and allocation approaches to best meet the needs of the population. They will then be responsible for:

- Undertaking the detailed planning to support the delivery of these agreed ICB objectives and outcomes, inclusive of local and system wide priorities and commitments, for areas of agreed delegated responsibility.
- Ensuring the effective and timely implementation of agreed plans, ensuring the required care pathway and service changes are secured.
- Monitoring and managing the delivery of agreed objectives and outcomes, including reporting to the ICB through agreed ICB governance arrangements.
- Ensuring that remedial action is identified and implemented in a timely manner and that recovery actions are communicated to the ICB.
- Any serious service or delivery failure, or national/regional intervention or requirement, will be subject to system wide discussion and agreement in terms of required next steps.

In taking forward their delegated responsibilities LCPs and the Provider Collaboratives/Network will be expected to take due account of and reflect in local delivery planning and implementation agreed system wide priorities, be they driven by national guidance, local strategic and operational priorities or agreed ICB 'core offer' expectations.

ICB teams will work collaboratively and inclusively with Local Care Partnerships, Provider Collaboratives and Network in taking forward its planning responsibilities.

2.5. Ways of working

In undertaking delegated responsibilities and more generally in terms of ways of working with the wider ICB, its Committees, Transformation and Enabler Boards, the ICB's Local Care Partnerships, Provider Collaboratives and Network commit to:

- Convening the Local Care Partnership, Provider Collaborative and Network to support the effective discharge of agreed responsibilities and an effective contribute to wider ICB strategic and operational planning plus ICP/B development processes.
- Working inclusively within their Partnerships, Collaborative and Network to ensure their processes, outputs and decision making are inclusive and demonstrate collective, partnership and system focussed approaches.
- Working inclusively with the wider system in the discharge of delegated responsibilities, with a particular focus on ensuring effective relationships and interfaces across the ICB's Local Care Partnerships, Provider Collaboratives and Network and with the ICB's Committees, Transformation and Enabler Boards to support effective joined up care pathways and approaches.
- Ensuring that agreed ICB commitments are demonstrably taken forward and secured.

- Ensuring an open and transparent approach to feeding back on the work of the Local Care Partnership, Provider Collaborative and Networks, inclusive of monitoring and reporting on the delivery of agreed commitments.
- Providing support to the ICB in managing up in terms of responding to Regional and system oversight arrangements as required.

2.6. Developing delegation approaches for the future

This Memorandum of Understanding covers the period 1 July 2022 to 31 March 2023 only.

- All parties are committed to reviewing the MoU and the effectiveness of the delegation approach and agreements in place for the year, with a commitment to making any in year changes required, by collective agreement, to support a fit for purpose delegation.
- All parties are further committed to reviewing these arrangements for 20023/24 onwards in the context of local experience, future ambition, national guidance and flexibilities.

Signed

……..
Andrew Bland
Chief Executive – Integrated Care Board

……
Sarah McClinton, Greenwich Executive Place Lead

NHS
South East London

Appendix 1 Local Care Partnership Terms of Reference

Integrated Care Board

Greenwich Local Care Partnership Committee (Healthier Greenwich Partnership)

Terms of Reference

Approved 1 July 2022, amended 14 September 2022

1. Introduction

1.1. The NHS South East London Integrated Care Board (ICB) Local Care Partnership committee [the "committee"] is established as a committee of the ICB and its executive powers are those specifically delegated in these terms of reference. These terms of reference can only be amended by the ICB Board.

1.2. These terms of reference set out the role, responsibilities, membership, and reporting arrangements of the committee under its terms of delegation from the ICB Board.

1.3. All members of staff and members of the ICB are directed to co-operate with any requests made by the Local Care Partnership committee.

2. Purpose

2.1. The committee is responsible for the effective discharge and delivery of the place-based functions[1]. The committee is responsible for ensuring:

a. The place contribution to the ICB's agreed overall planning processes including the effective planning and delivery of place based services to meet the needs of the local population, with a specific focus on community based care and integration across primary care,

[1] As defined by the South East London Integrated Care Board

community services and social care, managing the place delegated budget, taking action to meet agreed performance, quality and health outcomes, ensuring proactive and effective communication and engagement with local communities and developing the Local Care Partnership to ensure it is able to collaborate and deliver effectively, within the partnership and in its interactions with the wider ICS.

b. The Local Care Partnership can secure the delivery of the ICS's strategic and operational plan as it pertains to place, and the core objectives established by the LCP for their population and delegated responsibilities.

c. The Local Care Partnership plays a full role in securing at place the four key national objectives of ICSs, aligned to ICB wide objectives and commitments as appropriate.

d. The representation and participation of the Local Care Partnership in the wider work of the ICS and Integrated Care Board, contributing to the wider objectives and work of the ICS as part of the overall ICS leadership community.

3. Duties

3.1. **Place-based leadership and development:** responsibility for the overall leadership and development of the Local Care Partnership to ensure it can operate effectively and with maturity, work as a collective and collaborative partnership and secure its delegated responsibilities with appropriate governance and processes, development and relationship building activities and meaningful local community and resident engagement. This will include developing relationship with other parts of the system that may operate at place including the acute provider collaborative, the mental health collaborative and community networks to ensure the join up of services at place. The LCP also needs to support the Place Executive lead to ensure they are able to represent LCP views effectively whilst also considering the needs of the wider ICS.

3.2. **Planning:** Responsibility for ensuring an effective place contribution to ICP/B wide strategic and operational planning processes. Ensuring that the Local Care Partnership develops and secures a place based strategic and operational plan to secure agreed outcomes and which is aligned with the Health and Wellbeing strategic plan and underpinned by the Joint

Strategic Needs Assessment (JSNA) and a Section 75 agreement. The LCP must ensure the agreed plan is driven by the needs of the local population, uses evidence and feedback from communities and professionals, takes account of national, regional and system level planning requirements and outcomes, and is reflective of and can demonstrate the full engagement and endorsement of the full Local Care Partnership.

3.3. **Delivery:** Responsibility for ensuring the translation of agreed system and place objectives into tangible delivery and implementation plans for the Local Care Partnership. The LCP will ensure the plans are locally responsive, deliver value for money and support quality improvement. The LCP will develop a clear and agreed implementation path, with the resource (both financial and workforce) required whilst ensuring the financial consequences are within the budget of the LCP and made available to enable delivery.

3.4. **Monitoring and management of delivery:** Responsible for ensuring robust but proportionate mechanisms are in place to support the effective monitoring of delivery, performance and outcomes against plans, evaluation and learning and the identification and implementation of remedial action and risk management where this is required. This should include robust expenditure and action tracking, ensure reporting into the ICS or ICB as required, and ensure local or system discussions are held proactively and transparently to agree actions and secure improvement where necessary.

3.5. **Governance:** Responsible for ensuring good governance is demonstrably secured within and across the local Care Partnership's functions and activities as part of a systematic accountable organisation that adheres to the ICB's statutory responsibilities and adheres to high standards of public service, accountability and probity (aligned to ICB governance and other requirements). Responsibility for ensuring the LCP complies with all legal requirements, that risks are proactively identified, escalated and managed.

4. Accountabilities, authority and delegation

4.1. The LCP Committee is accountable to the Integrated Care Board of the SEL Integrated Care System.

4.2. The LCP Committee will provide regular updates to the Health and Wellbeing Board ensuring the alignment of work.

5. Membership and attendance

5.1. Voting members of the committee will include representatives of the following

a. Chair

b. 1 x Local Care Partnership Place executive lead Deputy CEO and Director of health and Social Care, RBG

c. 1 x Local authority adult social care - Director of Adult Social care, RBG

d. 1 x Local authority children's services, Director of Children's Services, RBG

e. 1 x Local authority public health -, Director of Public Health, RBG

f. 1 x Primary care (Nominated PCN Director) - TBC

g. 1 x Community services provider –Director of Children & Young People's Services, Oxleas

h. 1 x Mental health services provider, Chief Operating Officer- Oxleas

i. 1 x Acute services provider –Chief Executive, LGT

j. 1 x VCSE sector –Director of Strategy, METROGAVs

5.2. In addition to the voting membership, the following members of the Healthier Greenwich Partnership will also be in attendance

a. 1x ICB - Chief Operating Officer, Greenwich (SEL ICB)

b. 1 x Healthwatch –Chief Executive

c. 1 x VCSE provider - nomination by the VCSE sector

d. 1 x Acute services provider- Deputy Director of Strategy, LGT

e. 1 x LMC Representation (Greenwich)- Chair LMC

f. 1 x GP Federation Representative - , Director, Greenwich Health

g. 1 x Adult Social Care Provider - TBC

h. 3 x Integrated Commissioning Directors - joint postholders RBG/SEL ICB.

i. 1 x Director of System Development, SEL ICB/Oxleas/LGT

j. Lay member (to be confirmed)

6. Chair of meeting

6.1. The meeting will be chaired by Dr Nayan Patel, and the deputy chair will be appointed by the committee.

6.2. At any meeting of the committee the chair or deputy chair if present shall preside.

6.3. If the presiding chair is temporarily absent on the grounds of conflict of interest, the deputy chair shall preside, or, in the case that they also may not, then a person chosen by the committee members shall preside.

7. Quorum and conflict of interest

7.1. The quorum of the committee is at least 50% of members of which the following must be present (or their nominated deputies):

- Chair
- Two of:
  - Place Executive Lead,
  - Director of Adult Social care, RBG
  - Director of Children's Services, RBG
  - Director of Public Health, RBG
- 1 x Primary care (Nominated PCN Director) - TBC
- One of:
  - Director of Children & Young People's Services, Oxleas
  - Chief Operating Officer- Oxleas
- Chief Executive, LGT
- Director of Strategy, METROGAVs

7.2. In the event of quorum not being achieved, matters deemed by the chair to be 'urgent' can be considered outside of the meeting via email communication.

7.3. The committee will operate with reference to NHS England guidance and national policy requirements and will abide by the ICB's standards of business conduct. Compliance will be overseen by the chair.

7.4. The committee agrees to enact its responsibilities as set out in these terms of reference in accordance with the Seven Principles of Public Life set out by the Committee on Standards in Public Life (the Nolan Principles).

7.5. Members will be required to declare any interests they may have in accordance with the ICB Conflict of Interest Policy. Members will follow the process and procedures outlined in the policy in instances where conflicts or perceived conflicts arise.

8. Decision-making

8.1. The aim of the committee will be to achieve consensus decision-making wherever possible. If a vote is required, the core members and the Chair are the voting members of the Local Care Partnership. Core members are expected to have a designated deputy who will attend the formal Local Care Partnership with delegated authority as and when necessary.

9. Frequency

9.1. The committee will meet once every two (or three) months (in public) with ability to have closed session as Part B in addition to this.

9.2. All members will be expected to attend all meetings or to provide their apologies in advance should they be unable to attend.

9.3. Members are responsible for identifying a suitable deputy should they be unable to attend a meeting. Arrangements for deputies' attendance should be notified in advance to the committee Chair and meeting secretariat.

9.4. Nominated deputies will count towards the meeting quorum as per the protocol specified in the ICS constitution, which means individuals formally acting-up into the post listed in the membership shall count towards quoracy and deputies not formally acting-up shall not.

10. Reporting

10.1. Papers will be made available five working days in advance to allow members to discuss issues with colleagues ahead of the meeting. Members are responsible for seeking appropriate feedback.

10.2. The committee will report on its activities to ICB Board. In addition, an accompanying report will summarise key points of discussion; items recommended for decisions; the key assurance and improvement activities undertaken or coordinated by the committee; and any actions agreed to be implemented.

10.3. The minutes of meetings shall be formally recorded and reported to the NHS ICB Board and made publicly available.

11. Committee support

11.1. The LCP will provide business support to the committee. The meeting secretariat will ensure that draft minutes are shared with the Chair for approval within three working days of the meeting. Draft minutes with the Chair's approval will be circulated to members together with a summary of activities and actions within five working days of the meeting.

12. Review of Arrangements

12.1. The committee shall undertake a self-assessment of its effectiveness on at least an annual basis. This may be facilitated by independent advisors if the committee considers this appropriate or necessary.

Email sent from Sarah McClinton re: Collaborate launch

We are excited to launch 'Collaborate', which is about developing our collectively system leadership capability in Greenwich and across within South East London ICS. Please take time to have a look at the attached information, and we are keen that we put forward some Greenwich leaders into this. This is targeted at two groups of leaders :
1. Leaders with potential: Those new to leadership roles who show potential to be some of the best leaders within the system
2. Existing leaders: Those in leadership positions with existing leadership capability, leading at a system level for the first time

Please note that :

- There are 30 available places on the programme for the first group of leaders
- Duration of this programme is approximately 7 months
- Expected time commitment per month is 2-3 days
- Majority of the learning modules adopt an in-person format
- The programme is set to start at the end of October 2022

Applications for this are due by 25th September.

Final application form link: https://forms.office.com/r/9a7EqMFfKU
Community website link: https://www.kscopehealth.org.uk/project/collaborate-systems-leadership-programme-launch

If you want to discuss this opportunity further, then please get in touch with myself or Neil

Kind regards,

Sarah

Healthier Greenwich Partnership Forward Planner 2022/2023

Date	Standing Items	Main Business/Themed Item	Items for Information
September 2022	• Welcome • Introductions and apologies • Declarations of interest • Minutes of previous meetings • Action Log	• ICS Update from Andrew Bland • Eltham Update – Neil Kennett-Brown • Refresh of the Health and Wellbeing Strategy – Steve Whiteman • Mental Health Update – Lisa Wilson • CCPL Update – Robert Shaw • Mental Health & Wellbeing for CYP – David Borland	
October 2022	• Welcome • Introductions and apologies • Declarations of interest • Minutes of previous meetings • Action Log	• Homecare: New Integrated Model – Lisa Wilson • Split workshop session – HWBB / HGP • The London 'Every Child a Healthy Weight' Delivery Plan – Steve Whiteman • JSNA Update – Steve Whiteman • Annual Public Health Report 2022 – Steve Whiteman • Primary Care Plan – Maria Howdon • Medicines Optimisation Committee ToR – Jin On	

Date	Standing Items	Main Business/Themed Item	Items for Information
		• Adults and Childrens Safeguarding Annual Report Headlines and Next Steps / Priorities – Nick Davies	
November 2022	• Welcome • Introductions and apologies • Declarations of interest • Minutes of previous meetings • Action Log	• Clinical waste briefing – Jackie Davidson • Primary Care Working Group ToR – Maria Howdon • Health Inequalities, Oversight & Governance Group Terms of Reference – Jackie Davidson • Update on SEND Green Paper – David Borland / Florence Kroll • ASC Reforms Update – Lisa Wilson	
December 2022	• Welcome • Introductions and apologies • Declarations of interest • Minutes of previous meetings • Action Log	• Review of HGP Terms of Reference	
January 2023	• Welcome • Introductions and apologies • Declarations of interest • Minutes of previous meetings • Action Log	•	
February 2023	• Welcome • Introductions and apologies • Declarations of interest • Minutes of previous meetings	•	

Date	Standing Items	Main Business/Themed Item	Items for Information
	• Action Log		
March 2023	• Welcome • Introductions and apologies • Declarations of interest • Minutes of previous meetings • Action Log	•	