Healthier Greenwich Partnership (in public)

Date: 23 July 2025
Time: 12.30 – 14.30
Venue: MS Teams Click here to join meeting
Chair: Kate Heaps

AGENDA

	Item	Page no.	Presented by	Time
Opening Business				
1.	Welcome, introductions and apologies.	Verbal	Chair	12.30
2.	Questions from the public related to today's agenda – to be submitted in advance	Verbal	Chair	12:35
3.	Declarations of interest and Conflicts of Interest relating to agenda items	Verbal	Chair	12:40
4.	Minutes of the meeting in public held on 23 April 2025 and the extraordinary meeting in public held on 22 May 2025	1	Chair	
5.	Action Log and Matters Arising	15	Chair	
Public Engagement: Delivering our Healthier Greenwich Plan				
6.	Be Well	16	Sam Bennett	12:45
7.	Integrator Identification - decision to endorse proposal	42	Gabi Darby	13:30
8.	UTC Re-procurement	52	Deane Kennett/Erica Bond	14:00
Items for Noting				
9.	SEL Aging Well Frailty Framework	58	Gabi Darby	14:10
10.	Healthier Greenwich Partnership report, including performance report	142	Gabi Darby	
11.	Risk update	167	Chair	
Closing Administration				
13.	HGP Forward Planner – for noting	171	Chair	14:15
14.	Any Other Business		Chair	
15.	Next Meeting in public: 22 October 2025		Chair	
Meeting closes at 14:20				

Healthier Greenwich Partnership
Held in Public
Minutes of the meeting held on 23 April 2025
MS Teams

Members		**Voting member**	**Apologies**
Iain Dimond (Chair)	Chief Operating Officer, Oxleas NHS Foundation Trust (ID) (Chair)	Yes	
Nayan Patel	PCN Clinical Director (NaP)	Yes	
Niraj Patel	Chair, Greenwich Health (NiP)	Yes	
Gabi Darby	Chief Operating Officer, SEL ICB Greenwich (GD)	No	
Tuan Tran	Greenwich LMC (Local Medical Committees) Chair (TT)	No	
Florence Kroll	Director of Children's Services (FK)	Yes	Yes
Kate Heaps	Chief Executive, Greenwich, and Bexley Community Hospice (KH)	Yes	
Kate Anderson	Director of Corporate Affairs, LGT (KA)	Yes	
Nupur Yogarajah	Clinical and Care Professional Lead for Greenwich (NY)	Yes	
David James	Chief Executive, Greenwich Health (DJ)	No	
Steve Whiteman	Director of Public Health, RBG (SW)	Yes	
Nick Davies	Director of Health and Social Care, Royal Borough of Greenwich (ND)	Yes	
Jenny Ioseliani	Director of Children & Young People's Services, Oxleas NHS Foundation Trust (JI)	No	
Mark Delacour	Metro GAVS (MD)	Yes	
Joy Beishon	Chief Executive Officer, Healthwatch Greenwich (JB)	No	
	Adult Social Care Provider	No	
Lisa Wilson	Integrated Director of Commissioning, Adults, RBG (LW)	No	
Dave Borland	Integrated Director of Commissioning, Children, RBG (DB)	No	
Jessica Arnold	Director of Primary Care & Neighbourhoods, SEL ICB, Greenwich (JA)	No	

In attendance	
Julie Mann	Business Support (Minutes) (JM)
Russell Cartwright	AD Comms and Engagement (RC)
Shelley Whittaker	Engagement & Communications Manager (SW)
Daniella Finch	Programmes Officer (Grants), Groundwork London (DF)
Imogen Setter	Senior Consultant, PPL (IS)
Cllr Mariam Lolavar	Cabinet member for Health, Adult Social Care & Borough of Sanctuary, Royal Borough of Greenwich (ML)
Erica Bond	Bexley & Greenwich Programme Lead (EB)
Chris Dance	Assistant Director of Finance, SEL ICB (CD)
Nupur Yogarajah	Clinical Care and Professional Lead (NY)
Samantha Bennett	Assistant Director Public Health, Health & Adult Services, Royal Borough of Greenwich (SB)
Eugenia Lee	
Johnson D'Souza	PCN Clinical Director (JdS)
Members of the public	**0**

Apologies	
Sarah Burchell	Service Director Adult Community Physical Health Services, Oxleas (SB)
Rachel Matheson	Associate Director – Greenwich, Adult Community Physical Health Directorate, Oxleas (RM)
Florence Kroll	Director of Children's Services, RBG (FK) – voting member

1	**Welcome, introduction and apologies**
1.1	• The Chair welcomed all attendees and noted the attendance of Jenny Ioseliani, Director of Children & Young People's Services, Oxleas NHS Foundation Trust who has replaced Lisa Thompson who previously held the same position at Oxleas, but has now retired
1.2	• Apologies as noted above
2.	**Questions from the public related to today's agenda**
2.1	• No questions were received
2.2	• The Chair invited attendees to note any questions relating to the agenda items in the meeting chat function
3	**Conflicts of Interest - relating to agenda items**
3.1	• Joy Beishon, Healthwatch Greenwich, noted a potential COI relating to funding awards for Greenwich Charitable Funds as the organisation have submitted a bid for funding • It was noted that as the information being shared about the charitable funds relating only to the new funding streams, there is no official COI for Healthwatch Greenwich, as the paper is for noting only
3.2	• No other Conflicts of interest were noted
4	**Minutes of the meeting held 22 January 2025**
4.1	• The minutes of the meeting held on 22 January were accepted and approved as a true record of the meeting
5	**Action Log and Matters Arising**
5.1	• Chair requested that updates are emailed to JM
5.2	Matters arising • RC advised that there is an engagement forum on 24 April 2025 and will report back in due course.
5.3	**Actions:** • **Action Log updates to be emailed to JM** • **Engagement Forum 24/04/2025 to be reported on at another meeting**
6.	**Chair Rotation**
6.1	The Chair noted: • This is his last meeting as Chair • Previously agreed chair would rotate annually • He has enjoyed the position and thanked all for their support The Chair advised: • The new Chair will be Kate Heaps, Chief Executive Bexley and Greenwich Community Hospice • The new Chair will start their role from May 2025 GD shared:

	• Gratitude on behalf of the partnership, residents, and community for the chairing • Excited to welcome Kate as the new chair and first VCSE representative. Additional thanks were noted by TT, LW, NiP, JA, JB, EL and KH
7	**HGP Refresh and Joint Forward Plan**
7.1	CD provided a recap of the HGP refresh • Papers were shared in advance • Final JFV pack is currently being reviewed for publishing and will be circulated once approved • Provided a reminder of the 5 pillars (The Wells), highlighting each of the key activities • High impact activities for 25/26 were listed • There has been extensive engagement with all concerned • How should we move forward collectively with delivery of the plans • Once the 10-year plan is published – may be asked to provide a more comprehensive plan
7.2	The following comments and observations were made: • Stay Well – are the finances available for delivery, have funds been identified • There will be a need for further investment • Have trajectories been set up to show funding streams • Where is funding for primary care, wider neighbourhood systems • Not about maintaining status quo • Pleased to see focus on data driven approach • Good to see the maturation of the document • Already seeing some good practices arising • Need to be more transparent about funds that are available • Need to measure impact via data but also from communities - do communities recognise the impact • How to measure successes and outcomes • Building on each plan each year • Workforce suggestions are crucial especially to ways of working • Will be judged on delivering outcomes, but need to be aware that additional funding will be required • Need to start thinking about 26/27 now to plan ahead for funding • Need to learn from other boroughs in SEL – comparisons mat be useful • If spending on resource, workforce need to be made aware that this is what is being focussed on – needs to be uniformly communicated • Importance of understanding impact of experience • Must not lose sight of micro community/VCSE groups who can also be used for feedback • Must manage residents' expectations – they must know what they can expect • Comprehensive and agile plane with the public
7.3	The following responses were noted: • Financially challenged system • Maximise opportunities in all areas • Funds have been identified, caveat that this is contingent on efficiency savings • Considering PMS premium for some funding

	• Some funds already available within the system– need to work across all areas to make efficient use of funds • May need additional resource – e.g.: how to use estates for communities • Constant discussions will continue • Have worked hard on finances within a constrained budget • This is a multiyear plan • System sustainability group are working on collating information about how to maintain plans • Need to have a detailed plan and discussion about comms at a future meeting
7.4	Additional comments: • Delivery of plan will continue to be delivered by the partners • Each Well has a nominated SRO and existing forums will be overseeing delivery • HGP Exec must have a deeper dive into each well at meetings to ensure delivery
7.5	**Actions** • **Need to have a detailed plan and discussion about comms at a future meeting**
8	**Neighbourhood Next Steps**
8.1	GD shared an overview of the neighbourhood geographies and the integrator function: Four neighbourhood areas in Greenwich, which include population analysis for each area Goals are split into two areas:
8.1a	Universal goals • These apply to all neighbourhoods, with the opportunity for provider organisations to consider alignment in the neighbourhoods, recognising that the opportunities will differ between organisations. • To support this, we need to build on Public Health work and existing community activation projects, also building on the Greenwich Healthier Community Fund (refer to agenda item 10) to leverage and encourage collaboration amongst VCSE organisations • A revision to incentives to GPs via the PMS premium to support risk stratification approach and engagement in NDTs for each neighbourhood • Initial target cohort is frailty, but need to be more specific in our definition of this • Organisations use different tools to identify patients • Need to converge and agree a common approach • Expand the proactive care approach across long term conditions • Need to build on the existing frailty service in Greenwich, doing more to establish a coordination function across all neighbourhoods • Map out core members for each neighbourhood • Continue to develop the same day access offer • Review the Estates offer
8.1b	Areas that need a ‘deeper dive’ before rolling out across the borough • How heath and care data is used to identify populations where we can most effectively intervene and reduce escalation of need How data is fed through to neighbourhood teams, recognising that it is currently difficult for clinicians working on different systems to access accurate data How to use a London data service as the main source of population and health data across London • District nursing home care – reablement and workforce that interfaces closely with the team and how to use the combined workforce Recognising that there could be some residents who have visits from multiple people, with no view of how the resource could be more effectively deployed • Review the outcomes of the current Children’s pilot and determine next steps

8.1c	Comments and observations: • Goals for year one seem realistic and good for building foundations • Universal goals – different organisations have different ways of stratifying people • Current method is a common-sense way of doing this • The right people/manageable cohort will be required so that both the practise and its community partners can then target and manage, etc. • What is ARF • Should consideration be given to a deeper dive on data tools for population health
8.1d	Response: • ARF is the Accelerator Reform Fund used to reform social care • There is a workstream on population health data looking at tools in use and what will be used in the future
8.2	**Concept of an integrator** • Functions of an integrator included in the paper • There are some areas of duplication • Recent announcement of 50% reduction of corporate costs, providers also asked to reduce costs by 50% has an impact • Must look at how efficiencies are achieved not just within individual organisations, but across the partnership working together to maximise our collective workforce • Need to deliver on integrated working • There have been long standing discussions over the years on a strategic commissioning model and integrated provider organisations accountable for population health • There have been changes to procurement legislation and ability to use data to measure outcomes • Need to consider how this affects Greenwich • There are some challenges that are shared across South East London, but there are also some differences • Greenwich have both Oxleas and LGT in the area, whereas other boroughs have one trust covering community and acute services • Greenwich has strong relationships across the partnership • We don't have a pre-identified integrator • Need to consider how we evolve and what the future options might be for a place based provider organisation • The provider organisation could support on operational delivery of neighbourhoods and in undertaking some functions that are currently undertaken by ICB teams at present • As partners we need to think about what success looks like and what the requirements would be for evolving the partnership • Employ some legal expertise to discuss different ways to achieve this, providing options on different ways to form partnerships, pool budgets or delegate functions between organisations Proposal: To commence work on this over the next three months and then review at HGP Question to all partners: Is everyone in support of the initiation of this work and is each partner prepared to input into the work thinking about what the requirements would be and what the success factors would be
8.2a	Comments and observations: • This is an important but complicated piece of work • In terms of scope – is this a conversation for the HGP member organisations or are there other key commissioned organisations that should be included

	• Could the functions of the integrator be changed to bullet points for better understanding • This is about taking the time to get it right and not rush to conclusions • The approach is coherent with how we have tried to operate as a partnership • Other options may arise from this concept • May be concerns around procurement rules and competition – assuming that some things could be achieved in-house rather than going to procurement • Suggest a workstream as there may be tensions when commissioners become strategic • There are functions and then the form and then how you get to that form in terms of securing a partnership • An integrated function is a facility to enable everyone to deliver a successful integrated neighbourhood working model • This is about aligning ourselves and harnessing a collective resource to delivery the priorities that have been set for neighbourhoods
8.2b	**All in support – next steps to be discussed at next quarterly meeting**
8.3	**Actions:** • Integrator appraisal to be discussed at next quarterly meeting
9	**Positive Partnership Story – Partnership working to improve acute flow during Super March**

9.1	EB advised:
	• This was an initiative throughout March and involved several system partners
	• There were four overarching initiatives:
	  ○ Working on admission avoidance and flow from ED, SDEC and Wards one and two at QEH
	  ○ Series of themed mini made events focussing on Pathways one and two
	  ○ Discharge from hospital into the community aiming to reduce length of stay and clients that do not meet criteria to reside
	  ○ Additional streaming resource for UTC to reduce four-hour breaches and improve streaming targets
	JS advised:
	• Improved 4-hour performance by 6.5% in comparison to March 2024
	• Increased working with local partners contributed to this both at front door and back door
	• Input of teams on site was beneficial
	• Developed relationships which helped with understanding, empathy, shared frustrations and understanding why some things can't happen the way they should
	• Created a lot of enthusiasm, recommendations and ideas, and actions for more that can be done to improve
	• Big learning to focus on pathways one and two and how to continue building trust between organisations to move patients along those pathways better
	• Also had a trial of Transference Care Hub with daily meetings, people being clear on responsibilities and next actions in a particular pathway
	• The Transference Care Hub was very successful, now aiming to continue this in a way that not only works but is beneficial
	• Happened in context of financial announcements from NHSE
	• Focussing results builds into the Winter Plan and improvement plan for UEC overall

9.2	Comments and observations: • There is a link between Super March and longer-term approaches being built by the partnership • This is the second Super March, but this one felt significantly different this year in terms of outcomes and relationship aspects which created a sense of excitement and will be a platform for the future

- As we try to build, change and transform our system we must develop relationships at every opportunity
- How do we improve understanding – shouldn't have to wait to be prompted to work better together or use situations like Super March to build empathy on the challenges we all face
- There was a tangible impact on admissions
- Repositioning the system to work better together would apply to elective care as well
- Suggest having a Super June focussing on planned care
- How do you improve on the potential of SDEC
- Has the hospital considered outreach into PCNs as part of neighbourhood working looking at high intensity users, finding a way to help reduce this

10 **Healthier Greenwich Charitable Funds update – Funding Awards and Funding Themes**

10.1 DF Advised:

- The Greenwich Healthier Communities Fund was relaunched on 22 April 2025
- It was initially launched in April 2024, so now in its second year of funding
- The fund is being used to distribute approximately £6.6million over a 5-year period
- Funding goes towards VCS organisations that are preventing or responding to health inequalities
- Funded and awarded 79grants with a value of £1.3million in the first year
- There have been some project visits where the positive work of the fund is being seen
- There are now new funding opportunities, everyone is asked to share the opportunity with VCS organisations

	Enabling - open	Micro - open	Delivery		
			Small - open	Medium - open	Large – opens September 2025
Aim	To fund capacity building and one-off purchases i.e. training, equipment, infrastructure improvements	To fund the continuation or pilot of small projects, focusing on innovation	To fund the continuation, expansion or pilot of small projects	To fund the continuation, expansion, or new medium projects that address a "theme", with collaborative projects encouraged	To fund the continuation, expansion, or new large projects that address a "theme", with partnership working required
Grants	£500 to £5,000	£500 to £5,000	£5,001 to £20,000	£20,001 to £50,000	£50,001 to £200,000
Location	Whole of Greenwich	Whole of Greenwich	Whole of Greenwich	Whole of Greenwich / Targeted in alignment with theme	Whole of Greenwich / Targeted in alignment with theme
Application process	Always open, until budget is spent Light touch application form	Always open, until budget is spent Light touch application form	Open twice a year Simple application form with proportional level of detail	Open twice a year Detailed application	Open once a year Two-stages: (1) Detailed application, (2) Interview
Suggested Delivery	Up to 6 months	Up to 6 months	Up to 12 months	Up to 18 months	Up to 24 months

- Each strand has different aims:
  - Enabling strand – to fund capacity building within the borough
  - Micro grants – to fund small targeted projects that work to focus on innovation
  - Delivery strand – to fund project work that tackles health issues in the borough
  - Small awards – keeping this broad so any type of project can apply for funds that work to tackle health inequalities
- Have added themes to the delivery strand medium and large awards, meaning that grants will be for tackling inequalities based on themes
- Themes are:
  - Improving Health Outcomes for People with Learning Disabilities and/or Autism
  - Tackling Isolation
  - Long Term Conditions
  - Active Healthy Living for Children and Young People
- Large awards require compulsory partnership and collaboration working, making a maximum impact especially within key neighbourhoods

	• Themes were selected following community and stakeholder consultation Themes were submitted for consideration before being approved by the fund committee • Themes were submitted for consideration before being approved by the Fund committee • Grantees also suggested themes • Stakeholder that submitted themes included RBG Public Health team, RBG CYP team and Oxleas • Applicants will have to clearly demonstrate how their project aligns with one of the themes to be considered for funding • Themes will be relevant for 2025 into 2026, at which time the fund will pause and be redeveloped and new themes will be selected
10.2	Comments and observations: • A phenomenal success so far • A great sense of direction for the future • Is there specific material that could be shared so partners can share with their networks • How would we find out who has received funds that we could be in contact with to link up with them on existing work that aligns with the themes
10.3	Response: • DF will share document for circulation with JM • DF will advise JA when grants have been awarded so approaches can be made to organisations
10.4	**Actions:** • DF to send document for circulation to JM • JM to circulate document to all partners • ALL to share across their groups and networks • DF and JA to liaise once grants awarded
11	**Healthier Greenwich Partnership Report – Chief Operating Officer report**
11.1	The partnership report was circulated in advance GD advised: • Trying to iterate the way we do the partnership report to reduce and writing and producing separate materials for the report • Collating latest existing board reports for organisations • Need to reach a balance where we are being transparent with the public who want to understand what the partnership has been doing and how they find the information • Shorter more succinct reports with links to website accessible documents with greater detail that the public can read
11.2	Comments and observations: • A more pragmatic and streamlined approach • Any suggestions can be directed directly to GD
11.3	**Actions:** • New partnership report to be pared down with links to organisations web pages • Updates to be provided at each quarterly public meeting • Updates to be noted on forward planner by JM
12	**Performance report**
12.1	This item is for noting • The Chair noted that mitigations are noted on pages 32 and 33
13	**Risk update**
13.1	This item is for noting

13.2	The Chair noted: • This report provides an update on the most recent review of risks on the Greenwich risk register • The report includes a range of actions that are being undertaken to manage and mitigate risks • Risks are updated monthly • There are currently eight risks that have been reviewed and mitigations update
14	**HGP Forward Planner**
14.1	• This item is for noting
14.2	The Chair noted that if anyone wants items included at future meetings, these should be emailed to JM
14.3	**Actions:** • ALL to email JM with any future agenda items
15	**AOB**
15.1	The Chair advised that this would be the last meeting attended by Steve Whiteman who is retiring as Director of Public Health for the Royal Borough of Greenwich on 21 April 2025 The Chair thanked SW for both his immense contribution to the partnership and also to Greenwich over the years SW added that Samantha Bennett and Helen Buttivant, Assistant Directors of Public Health for the Royal Borough of Greenwich, will be job- sharing the role of Director of Public Health until a permanent replacement is appointed.
	Next meeting in public: 23 July 2025

Healthier Greenwich Partnership
Held in Public
Minutes of the Extraordinary meeting held on 22 May 2025
MS Teams

Members		Voting member	Apologies
Kate Heaps (Chair)	Chief Executive, Greenwich, and Bexley Community Hospice (KH) (Chair)	Yes	
Iain Dimond	Chief Operating Officer, Oxleas NHS Foundation Trust (ID)	Yes	
Nayan Patel	PCN Clinical Director (NaP)	Yes	
Niraj Patel	Chair, Greenwich Health (NiP)	Yes	
Gabi Darby	Chief Operating Officer, SEL ICB Greenwich (GD)	No	
Tuan Tran	Greenwich LMC (Local Medical Committees) Chair (TT)	No	
Florence Kroll	Director of Children's Services (FK)	Yes	Yes
Kate Anderson	Director of Corporate Affairs, LGT (KA)	Yes	Yes
Jo Sutcliffe	Deputy Chief Operating Officer, LGT (JS)	Yes	
Nupur Yogarajah	Clinical and Care Professional Lead for Greenwich (NY)	Yes	Yes
David James	Chief Executive, Greenwich Health (DJ)	No	Yes
Samantha Bennett	Interim Director of Public Health, RBG (SB)	Yes	
Nick Davies	Director of Health and Social Care, Royal Borough of Greenwich (ND)	Yes	
Jenny Ioseliani	Director of Children & Young People's Services, Oxleas NHS Foundation Trust (JI)	No	
Mark Delacour	Metro GAVS (MD)	Yes	
Joy Beishon	Chief Executive Officer, Healthwatch Greenwich (JB)	No	
	Adult Social Care Provider	No	
Lisa Wilson	Integrated Director of Commissioning, Adults, RBG (LW)	No	
Dave Borland	Integrated Director of Commissioning, Children, RBG (DB)	No	
Jessica Arnold	Director of Primary Care & Neighbourhoods, SEL ICB, Greenwich (JA)	No	

In attendance	
Julie Mann	Business Support (Minutes) (JM)
Elizabeth Howe	Corporate Governance Lead, SEL ICB (EH)
Nicky Skeats	Primary Care Commissioning Manager (Greenwich), SEL ICB (NS)
Eugenia Lee	
Johnson D'Souza	PCN Clinical Director (JdS)
Members of the public	**0**

Apologies (other apologies noted in members list)	
Sarah Burchell	Service Director Adult Community Physical Health Services, Oxleas (SB)
Rachel Matheson	Associate Director – Greenwich, Adult Community Physical Health Directorate, Oxleas (RM)

1	**Welcome, introduction and apologies**
1.1	• The Chair welcomed all attendees and noted that this is an Extraordinary meeting relating to the Thamesmead APMS contract award that had been approved at the HGP Meeting in Public on 11 December 2024
1.2	• Apologies as noted above
3	**Update on the Thamesmead APMS Contract Award**
3.1	Item is for approval Papers were circulated in advance
3.2	JA advised: • The Thamesmead Medical Centre operated under an APMS contract • The contract is not perpetual and is typically for a five-year period before re-procurement • The decision to re-procure was agreed and a full procurement process was conducted up to the point of contract award • After notifying the highest scoring bidder (Bidder C) that they had been awarded the contract, advice was received during the standstill period notifying previously unknown breach notices to the Bidder C, which had not previously been declared • The standstill period was paused to investigate the accuracy of the notification, procurement questions and legal options • A representation panel which included members from the ICB, North East London commercial hub, and procurement experts from South East London • The investigation confirmed the accuracy of the notification, revealing multiple breach notices had been issued to Bidder C which had not been declared • Bidder C was provided an opportunity to provide additional information which was not forthcoming • Legal advice was sought to determine appropriate actions based on the procurement selection regime rules • The Primary Care Commissioning Board recommended revoking the contract award to Bidder C due to their failure to meet tender criteria • The Primary Care Commissioning Board recommended that the procurement process be rewound to the point of contract award and remaining bidders who met the criteria would be reconsidered • The outcome of the rewound procurement will be bought back to the committee for final approval
3.3	• The members were asked to approve that the procurement process for Thamesmead Medical Centre APMS contract be rewound to the point of contract award. **All agreed**
3.4	Comments and observations: • Concern was raised that there was short notice given for the meeting, which would not inspire confidence by local residents • It was acknowledged that this was not ideal and is not the usual practice, but the Comms and Engagement team did reach out to local communities to advise of the extraordinary meeting and its subject matter • It was confirmed that papers for the meeting were published five days in advance on the website to ensure transparency in the decision making process
3.5	**Actions** • The contract award to Bidder C will be revoked and the procurement process rewound to the point of contract award

	• Outcome of the procurement process will be presented at a future HGP meeting in public
	Next meeting in public: 23 July 2025

Action Log - Open

Date of meeting	Minute reference	Action and updates	Lead	Deadline	Update/Date closed
22/05/2025	3	Outcome of Thamesmead Medical Centre APMS contract to be presented at future HGP meeting in public	JA		Noted on forward planner
22/05/2025	3	Contract award for Thamesmead Medical Centre APMS contract to revoked and procurement process rewound to point of contract award	JA	30-May	In progress, bidder advised and reprocurement process started
23/04/2025	11	Next partnership report to be pared down with links to partner organisations web links	JM	23-Jul	New format used for July meeting in public
23/04/2025	10	DF and JA to liaise once grants awarded	DF/JA	TBC	
22/01/2025	15.3	All to advise JM of future agenda item requests	ALL	Ongoing	
22/01/2025	5.3	Members to email JM with updates on their items on the action log	ALL	Ongoing	

AGENDA ITEM: 6

Healthier Greenwich Partnership

Date: 23 July 2025

Title	*Be Well Update – verbal presentation*	
This paper is for **noting** and **discussion**		
Executive Summary	This item will provide an update on key pieces of work taking place within the Be Well Priority of the Local Care Plan; with a particularly focus on engagement work around the development of the physical activity and sport strategy as well as supporting residents to have better access to safe, affordable, sustainable, culturally appropriate healthier food at a local level.	
Recommended action for the Committee	• *Members are asked to note the work being delivered under the Be Well Strand of the HGP Plan; to discuss and ask questions* • *To consider and share any actions by partners which could support the delivery of these pieces of work*	
Potential Conflicts of Interest	*None arise from directly from the report; however it should be noted that due to the breadth of the work undertaken under this priority it is possible that future conflicts could arise because of the areas of work.*	
Impacts of this proposal	Key risks & mitigations	*While there are risks associated with each specific area of work contained with the update. There are no specific decisions requested as part of this report and therefore no specific decision related risks.*
	Equality impact	*There are different equalities implications in respect of each of the pieces of work as they develop and these are factored into the respective areas, including where relevant equalities impact assessments. • As there is no specific decisions requested as part of this report there are no equalities impacts associated with the report itself*
	Financial impact	*There are no decisions as part of this report and therefore no financial impact.*

Wider support for this proposal	Public Engagement	*Information is included within the update on the different public engagement that has taken place as part of the work*
	Other Committee Discussion/ Internal Engagement	Not Applicable
Author:	*Aideen Silke, Head of Public Health Programmes* *Laura Wood, Senior Public Health Manager – Everybody Active* *Claire Bennett, Senior Public Health Manager – Food and Health*	
Clinical lead:	*Dr Nupur Yogarajah, Care and Clinical Professional Lead*	
Executive sponsor:	*Nick Davies, Director of Health and Adult Services, RBG* *Samantha Bennett, Interim Director of Public Health RBG*	

Healthier Greenwich Partnership
Be Well Update
July 2025

PPL

HEALTHIER GREENWICH PARTNERSHIP

Our five Wells

Our priorities span a resident's life course. Working together on our ten shared priority areas will produce better outcomes for Greenwich residents throughout their life. Adopting the life course approach means identifying key opportunities for minimising risk factors and enhancing protective factors through evidence-based interventions at key life stages, from preconception to early years and adolescence, working age, and into older age.

Setting our direction for 2025/2026: Be Well

To refresh our Local Care Plan for 2025/2026, we started with a reflection on our wins and improvement opportunities from the past year.

What has gone well

Number of play streets has increased.

Activity has increased around interventions and opportunities for people to get support around food insecurity

More work to do…

Better understand the influence of neighbourhood food environments on physical and mental health and create an action plan

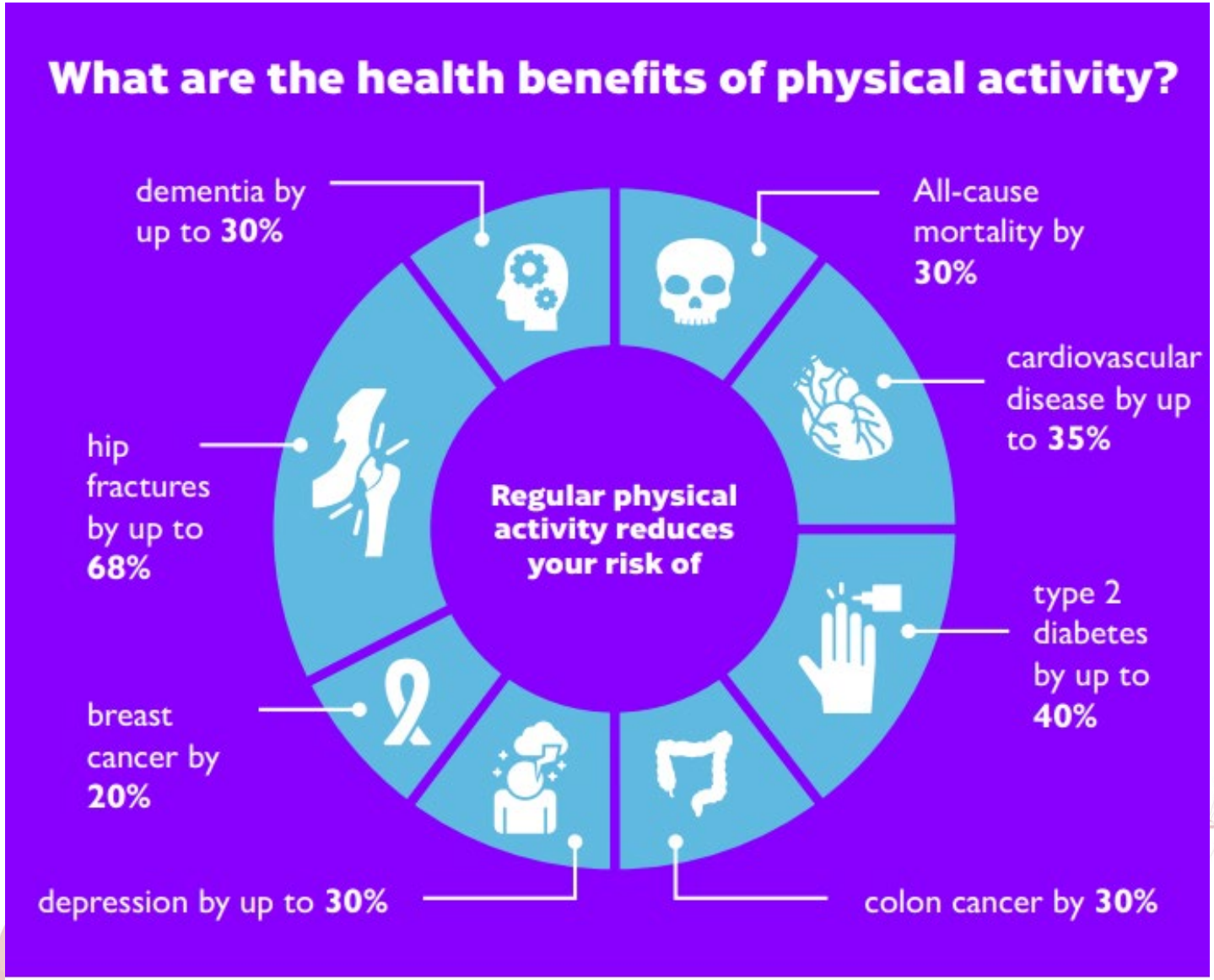
Play streets are more commonly occurring in certain areas of the borough, highlighting the need for broader development and accessibility across all communities.

Physical activity pathway not progressed due to a gap in the team.

Planning for the year ahead was informed by logic models, drafted by delivery teams, summarising actions required to bring us closer to our 'Well' ambition. At a Board level we identified those where there is the greatest added value from a partnership approach. As a result, we commit to **delivering 3 HIAs, with the support of the Healthier Greenwich Partnership:**

Ambition(s)	
Everyone is more active; Everyone can access nutritious food	
High Impact Activity	**Outcome Statement**
Review, update and implement Royal Greenwich Get Active Physical Activity and Sports Strategy with a focus on understanding inequalities in physical activity and how to address this at community level; learning from community research.	Increased physical activity for children and adults, with co-benefits for air quality, community safety, and social isolation, leading to better health and wellbeing.
	Reduced inactivity levels, resulting in fewer long-term conditions and more effective treatment for those at higher risk.
Develop an approach to ensure food and nutrition is included in all diet-related disease care pathways.	Residents receive consistent, evidence-based and relevant food advice and information, and are referred and signposted to services that support healthy eating.
Improve the food environment at a neighbourhood, high street and organisational level, with contributions from all Healthier Greenwich partners organisations, working with planning levers, e.g Thamesmead Superzone and through integrated commissioning for neighbourhoods	Residents have better access to safe, affordable, sustainable, culturally appropriate healthier food at a local level.

Be Well – Everyone is more active


What are the health benefits of physical activity?
dementia by up to 30%
All-cause mortality by 30%
cardiovascular disease by up to 35%
hip fractures by up to 68%
Regular physical activity reduces your risk of
type 2 diabetes by up to 40%
breast cancer by 20%
depression by up to 30%
colon cancer by 30%


Social Connections
Increased opportunities to feel connected to others in your community
Community Cohesion
Diverse people coming together, a greater sense of community safety
Family relationships
Spending time together and problem solving
Economic development
Volunteering and employment opportunities
Active travel
Cleaner less polluted air, safer streets, reduced costs
Enhanced learning and attainment
Mental wellbeing
Stress reduction, relaxation, improved confidence
Value of nature
Increased usage of green spaces, increased vitamin D levels

Engagement to support strategy development

Community engagement 2024

Delivered by Community & Economic Regeneration Consultants Ltd (Community Regen)
July – October 2024.

1. Resident survey with a particular focus on:

- *children and young people;*
- *people with physical, sensory, and learning disabilities and long-term conditions;*
- *neuro-divergent people;*
- *black and minoritized communities with low activity levels;*
- *older people;*
- *low-income residents; families*

2. Survey of key partner organisations

3. One to one semi-structured interviews with stakeholders

HEALTHIER GREENWICH PARTNERSHIP

Greenwich residents

364 completed the survey:
42% were under 25, 60% female, 24% African and 27% white, 10% have a disability and 19% carers.

How was this delivered:
- Resident community researchers including young people.
- Attending community events and activities and using Whatsapp groups.
- Sharing through networks i.e community champions, GGA networks and Metro GAVS.

Results:

Priorities: affordability, information accessible and visible, and use activity to bring together different people from different ages and communities.
Effective ways to increase activity: better facilities in parks, community based sport and physical activity, and incentives.
Barriers: lack of money, time and motivation.
Motivators: physical health, fun, improve mental health.

HEALTHIER GREENWICH PARTNERSHIP

Greenwich partners

38 completed survey and 14 one-to-one semi structured interviews were conducted.
Oxleas, Community fitness charity, youth service, GLL, sports clubs, black swim association, disability sport charity, musilim womens group, peabody, CACT and MENCAP.

How was this delivered:

- Key stakeholders identified by the team and completed by partners from Greenwich Get Active Network, Community Grants Networks and from word of mouth.
- Semi Structured interviews with a diverse range of partners.

Results:

Priorities: work with least active, use activity for different ages and communities to come together, information is accessible and visible to everyone.
Effective ways to increase activity: community based programmes, specific target audiences, and public awareness campaigns.
Barriers: Lack of money, time and confidence.
Motivators: Social interaction and enjoyment.

HEALTHIER GREENWICH PARTNERSHIP

The Results - what are the strengths

- Partnerships
- Committed staff
- Strong sports organisations
- Spaces and facilities
- Leadership

The Results What is the Need

- Affordability - carers and length of incentives
- Leisure centres – desire and intimidation
- Community sport and physical activity – convenient for variety of people
- Enhance park facilities – safety and access
- Fun and wellbeing -marketing
- Accessibility -marginalised communities, women & girls, disabilities and school providers
- Cohesion - different backgrounds, ages, and communities and shared experiences
- Information and communication -discounts and incentives and about physical activity and sport

HEALTHIER GREENWICH PARTNERSHIP

Health and care professionals engagement 2025

- Training mapping completed.
- Survey June 2025 to find out:
  How many professionals are aware and have completed physical activity training.
  What are the opportunities and barriers to completing training.
  What conversations and referrals are being made locally for physical activity.
  How can we raise awareness and communicate with health and care professionals.
  What support do they need and want.
- Engaged with 38 professionals and so far…
  A significant portion (57.9%) has not completed any formal physical activity training in the last 5 years.
  Only 28% are confident in knowing the CMO guidelines and benefits with only 8% knowing all of them.
  Only 34% are confident in referring or signposting with only 3% aware of low cost or beginner sessions.
- Further analysis and recommendations currently being analysed
- 7 clinical contacts to take this work forward with focus groups/ network meetings

HEALTHIER GREENWICH PARTNERSHIP

Physical activity and sport strategy – achievements and next steps

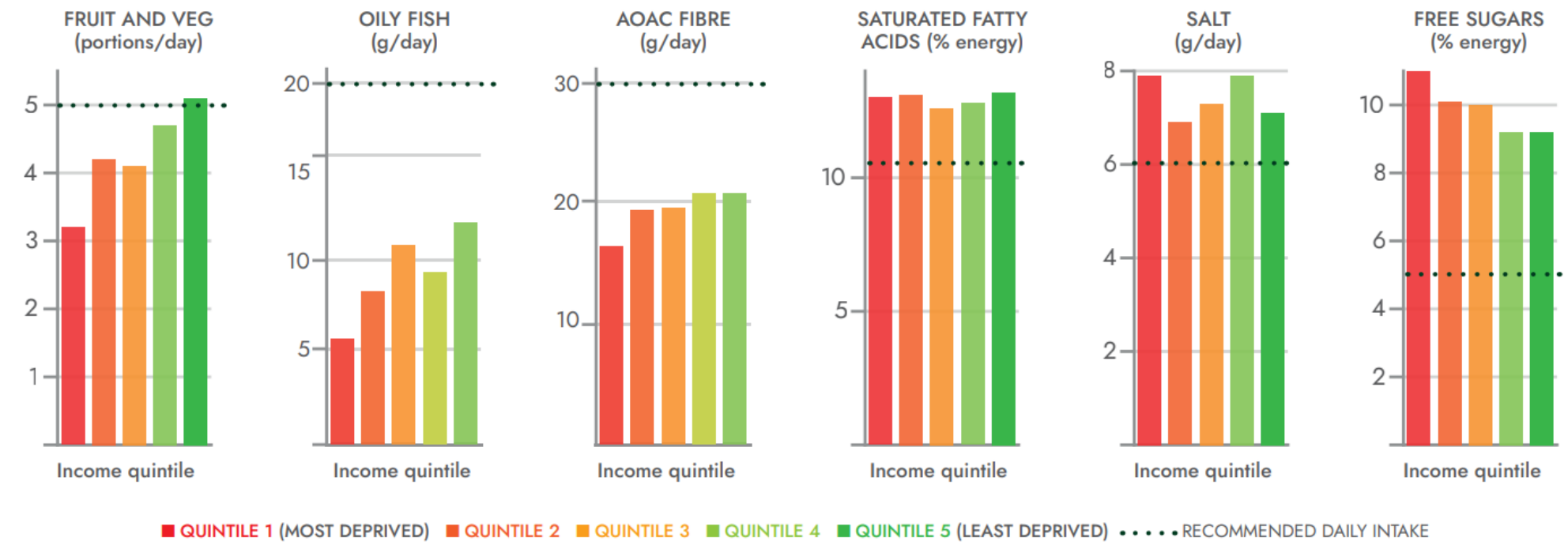
- January 2025 post filled in the team.
- April 2025 Greenwich had an increased number of schools completing active lives survey.
- June 2025 started work on a physical activity JSNA to inform the new strategy to be completed in the Autumn.
- August 2025 Resident engagement survey to inform the strategy.
- Physical activity and sport strategy – aim final draft end of 2025.
- Playing pitch strategy started 2024 due to finish by the end of 2025.

HEALTHIER GREENWICH PARTNERSHIP

Be Well – Everyone can access nutritious food

The **most deprived fifth** of adults consume **less fruit** and **veg** (37% less), **oily fish** (54% less) and **dietary fibre** (17% less) than the least deprived fifth.

Nutritional intake by quintile of deprivation



Source: Analysis of the National Diet and Nutrition Survey.

Develop an approach to ensure that food and nutrition is included in all diet related disease care pathways

- Food-related ill health is responsible for about 10% of morbidity and mortality in the UK and costs the NHS about £6 billion annually
- The total costs of obesity and overweight in the UK 2025 are £126billion this includes NHS and social care costs
- Inequalities in diets contribute to overall inequalities in health. The most deprived 20% of adults consume a more than a third less fruit and veg, over 50% less oily fish and 20% less dietary fibre than the least deprived 20%.

Outputs: 2024/25

- Weight management services:
  - Commissioned a new weight management service for adults with learning disabilities
  - Adult T2 (Better weight Management) - 1151, starters, 74% completion rate, 72% lose weight
  - Adult T3(TBC Limited) - 94.4% lost weight, 1,400 on waiting list,
- Cookery clubs:
  - 616 participants attended a 5 week cookery club. 92% from bottom two deciles, 42% from global majority population groups, 70% female
- Number of GP practices receiving HE training for long term conditions:

HEALTHIER GREENWICH PARTNERSHIP

Develop an approach to ensure that food and nutrition is included in all diet related disease care pathways

- Challenges:
  - Healthy eating is seen as a nice to have.
  - Capacity.
  - Other solutions available.

- Next steps:
  - Work with long term conditions and primary care team to identify opportunities for pathway updates and inclusion including in neighourhood models.
  - New public health commissioning.
  - New training for healthy eating / nutrition .

HEALTHIER GREENWICH PARTNERSHIP

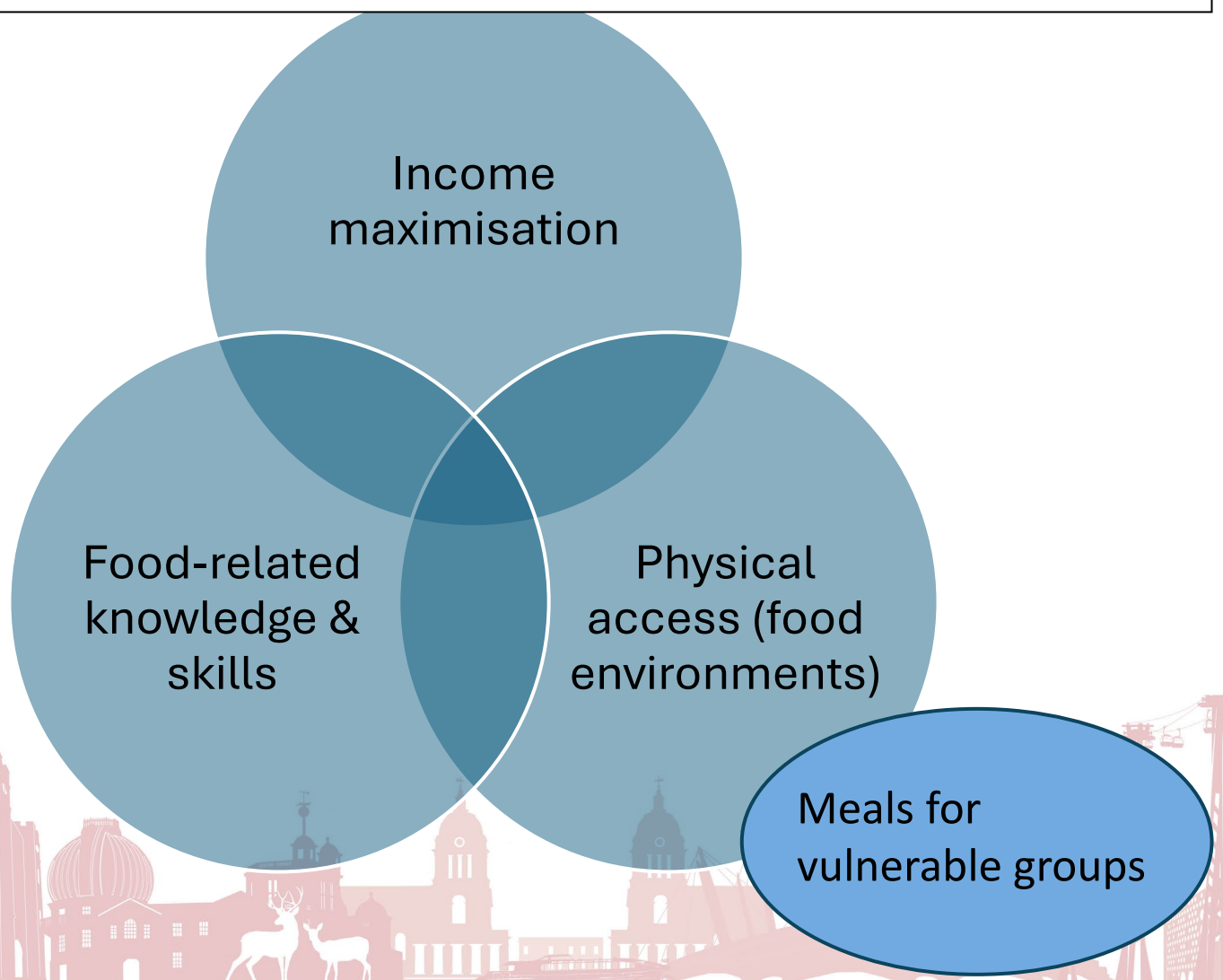
Improve the food environment at a neighbourhood level

- Aim: Residents have better access to safe, affordable, sustainable, culturally appropriate healthier food at a local level.

HEALTHIER GREENWICH PARTNERSHIP

Linking advice & support services with people experiencing food need

Food response action plan



Food insecurity response

Healthy Start

FOOD Clubs / pantries

Mayor's Free School Meals

Holiday meals

HAF

Strategic food response

Neighbourhood Food Action Alliances

Ambient Food project

Hunger and safeguarding guidelines

Community meals

HEALTHIER GREENWICH PARTNERSHIP

On the ground

- Achievements:
  - 12 community meals delivered
  - 20 food businesses adopted GFIG hospitality charter
  - 2 Good food business training sessions delivered
  - 15 GFIG community charters
  - Growing spaces protected and supported

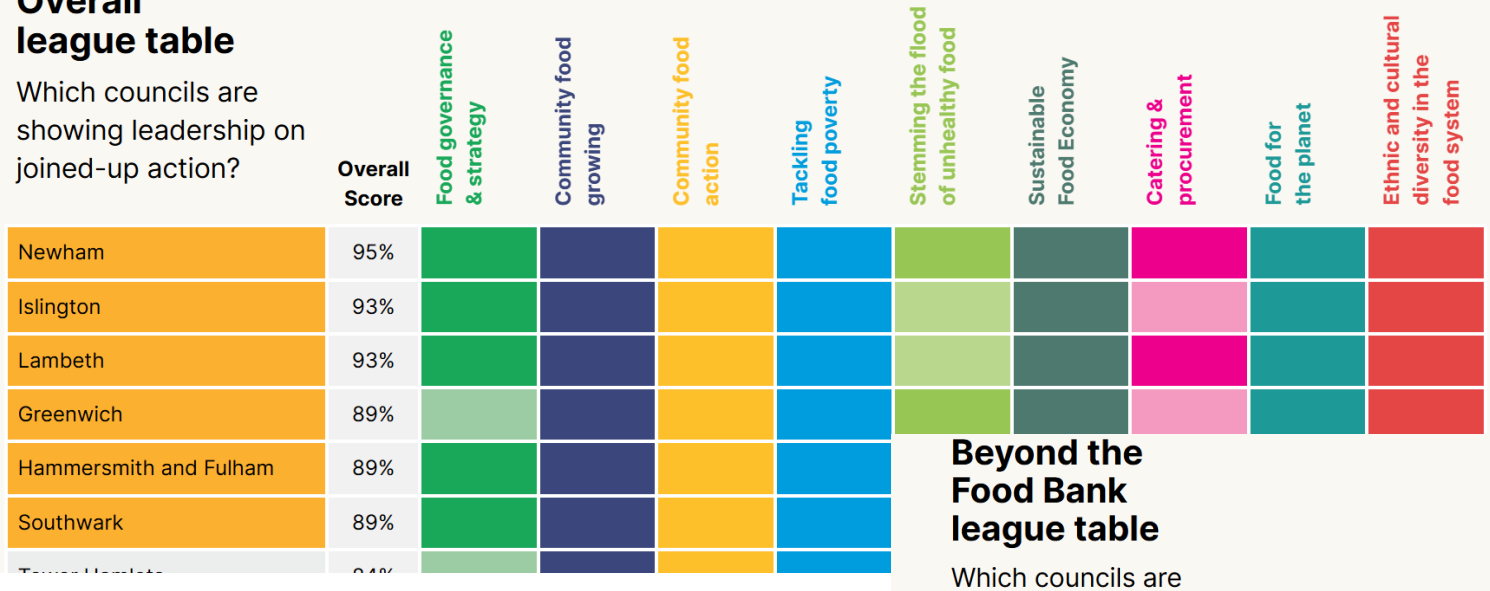
- 6 different pantries across Greenwich
  - 3 x FOOD Clubs delivered by Family Action (funded by PH)
  - 1 x Pantry at New Leaf Cabin (prev. Charlton Triangle Homes)
  - 1 x pantry at Quaggy Children's Centre
  - 1 x pantry at Roots4life

HEALTHIER GREENWICH PARTNERSHIP

Good Food Local

Overall league table

Which councils are showing leadership on joined-up action?



	Overall Score	Food governance & strategy	Community food growing	Community food action	Tackling food poverty	Stemming the flood of unhealthy food	Sustainable Food Economy	Catering & procurement	Food for the planet	Ethnic and cultural diversity in the food system
Newham	95%									
Islington	93%									
Lambeth	93%									
Greenwich	89%									
Hammersmith and Fulham	89%									
Southwark	89%									

Beyond the Food Bank league table

Which councils are leading the way in tackling food poverty?

	Overall Score	Food poverty alliances	Food poverty action plans	Cash-first responses to food insecurity	London Living Wage	Food access for older and disabled people	No recourse to public funds (NRPF)	Infant feeding	Healthy Start	School meals	Nurseries and early years settings	Holiday activities and food
Islington	94%											
Hammersmith and Fulham	91%											
Lambeth	91%											
Newham	91%											
Southwark	91%											
Greenwich	88%											

Next steps

- Undertaking a whole food system JSNA
  - First borough to do a systems based JSNA
  - Focused on Food and Health, Food and the Environment, Food and Culture, Food and the Economy
- Developing a whole systems food strategy.
- Influence cross council action to improve access eg through the Local Plan, Healthy High Streets, environmental health.

HEALTHIER GREENWICH PARTNERSHIP

AGENDA ITEM: 7

Healthier Greenwich Partnership

Date: 23 July 2025

Title	Identification of the Integrator for Greenwich	
This paper is for **noting/approval**		
Executive Summary	• This paper summarises work to date to identify an integrator arrangement for Greenwich • The paper sets out a proposal for a 12 month piece of Partnership Development work • This paper sets out a proposal to refer the decision of Health Host organisation for Greenwich to 4 SROs to make a recommendation back to the HGP	
Recommended action for the Committee	• There are 2 decisions for HGP: 1) Whether to support a 12 month piece of development work for the wider Partnership Collaborative 2) Whether to agree to refer the decision of Health Host in Greenwich to the 4 names SROs to make a recommendation	
Potential Conflicts of Interest	• Partners may be conflicted on the identification of a Health Host in Greenwich – in particular members of LGT and Oxleas may be conflicted. However, the recommendation is to refer this decision to SROs and a final decision will be made by the ICB Board.	
Impacts of this proposal	Key risks & mitigations	• There is a risk of investing in a partnership development programme if not all partners are bought in, that this would realise the intended benefits
	Equality impact	• Resident and community engagement will be key to the development of the neighbourhood health and care approach in Greenwich • This programme is intended to better enable us to address inequalities in the borough through better use of data and collaboration with community partners
	Financial impact	The costs of the Stone King demonstrator site proposal are set out within the paper at £120k (£10k per month fixed cost)

Wider support for this proposal	Public Engagement	• Not required for the direct purposes of this report, but planned as part of the programme
	Other Committee Discussion/ Internal Engagement	• HGP has previously held a workshop on this topic.
Author:	Gabi Darby and Lisa Wilson	
Clinical lead:	NA	
Executive sponsor:	Gabi Darby	

HGP Paper on Integrator Identification

Context:

On 3rd June 2025, Andrew Bland wrote to Local Care Partnerships and systems to set out the next steps for delivering a Neighborhood Health Service in South East London. This included the function of a system 'Integrator' to support and drive forward neighborhood working. Place Executive Leads, on behalf of their borough partnership, were asked to confirm by the end of June 2025:

• Their Integrator arrangements and their adherence to those elements outlined

• Their plan and timetable to achieve these same milestones in quarter three in the case of Greenwich and Bromley (who may wish to act faster if locally agreed).

At the HGP in June, we agreed the following approach and timeline for Greenwich:

- Integrator workshop 7th July – Partners meet to discuss success factors and models elsewhere

- HGP 23rd July (in public) – HGP reviews the options appraisal for integrator arrangements and confirms preferred approach to the Partnership development and Health Host role
- 8th August: If there are multiple NHS organisation who wish, and are considered credible, to deliver the Health Host function then this decision will be referred to the programme SROs for a decision
    - Greenwich SROs: Gabi Darby and Nick Davies
    - SEL ICB SROs: Ceri Jacob and George Verghese
- The assessment will incorporate an assessment of support from the Local Authority, Primary Care and all partners. The SROs will make a recommendation back to the HGP for endorsement, before this progresses to the ICB Board for a final decision

- By end of August: Submission from the integrator to PEL and ICB CEO
- By end of September: Agreement of integrator arrangements by the HGP and the ICB Board
- By end of October: Completion of the maturity matrix by the integrator
- By end of November: Review maturity assessment and agree developmental priorities and deployment of £250kfunding
- December 2025: Greenwich submission to ICB Board on maturity position

Note: it is anticipated that work to develop the provider partnership/ collaborative is anticipated to be ~12 month facilitated process including VCSE and community partners from Sept 2025 – Sept 2026.

Partner submissions on key success factors and risks:

Following the April HGP all partners were invited to feedback to the ICB on 3 things:

- Success factors for the integrator arrangement
- Risk factors for the integrator arrangement
- Models that partners would like to explore

This feedback will provide us with a framework against which we can base our decisions on the right arrangements for Greenwich.

Success factor
Builds on what we have - does not start from scratch
Collaborative and clear decision making
Reduce barriers to share resource across partners
Prepared to ignore short-term self-interest for the interests of the partnership and population as a whole
Leadership that can navigate and synthesise complexity so that people and communities, staff and partners can understand the full picture, and be able to draw people together around the shared goal of improving population health and wellbeing
Will get the basics right (such as ensuring all services are accessible to people with disabilities and implementing reasonable adjustments as needed)
Takes a systematic approach to engaging with local communities and working with them as equals to design and deliver services
Encorporates effective clinical and professional leadership, governance and oversight to ensure that decision-making is based on a solid understanding of population risks and best practice care pathways
Minimises duplication of effort across Partners
Builds on existing abilities to deliver the integrator function
Track record of partnership participation and relationships
Able to operate borough-wide, and flex to 4 neighbourhood footprints
Able to deliver key infrastrucure: estates, digital, shared clinical record, data use
Credible and trusted - and explcitly has the confidence of other partners to undertake the role
Credible ablity to resource the leadership of the integrator function without sacrificing core operational performance
Proven ability to develop a workforce that cane operate across organisational boundaries
Already has foundations of ability to deliver 'integrator' functions - recogninsing need to build on this

Blue = a feature of the wider arrangement

Green = Features of the Health Host

The risks highlighted were generally the opposite of these success factors:

- That the arrangement should not be about take-overs or vertical integration or compromising organisational integrity
- That we should avoid barriers to decision making resulting from differing contractual arrangements that prevent making better use of system resources
- That we must avoid duplication of governance
- That the arrangement fails to utilise exiting organisational capabilities
- That the arrangement centralises too much influence with a single organisation
- That decision making is not driven by purpose and outcomes for residents, and is too influenced by organisational interests

The models which partners would like to explore included:

- Special purpose vehicle or similar subsidiary whose primary function is to deliver the integrator function
- As partnership / working matures, interested in the potential to move towards accountable care provider in the borough to promote fuller integration
- Lead provider arrangements
- Different partnership arrangements
- Multi-stakeholder co-operative (an inclusive, social values based partnership regardless of legal form) with differing delivery roles for partner organisation based on capability
- A combination of legal provider partnership with a hosts of particular delivery components

Feedback from the workshop on 7th July:

On the afternoon of 7th July we held a well-attended workshop to discuss:

- The purpose of the integrator arrangements in Greenwich

- How this will build upon the successes of the HGP so far and reflect the agreed values of the HGP
- Reflections on examples from elsewhere of collaborative approaches that have achieved social value
- Hearing experiences from Surrey Downs of an 8 year Partnership journey
- Discussed the timelines and key development phases for this work going forwards

- **Key takeaways included:**
    - The need to continue the proactive engagement across all parties – including our practices, VCSE organisations and residents
    - The need to maintain the triple focus on delivery, governance and relationships as we progress our work
    - The need to ensure that we make top-down (whether they be national, London or SEL) directives work for us (and seek not to get diverted by speculating on new contractual forms, but by focussing on doing the right thing for our population in order to be ready for them)
    - The need to ensure the integrator works for, and serves the partnership, and that we develop a clear a view of what we need from it

It was also clear that the legal form should follow on from our purpose and objectives, and we have secured legal advice that will aid us in making these decisions in due course.

Decision 1: The approach to the wider Partnership Collaborative

Recommendation: That the HGP supports, and sign -up to participate in, a 12 month development programme for a Partnership Collaborative. This facilitated approach would be funded be commissioners. It would be a purpose-led approach building on the existing HGP values. It will involve working towards an MOU between partners by April 2026 and a legally binding agreement from the end of September 2027.

Scope

At the local level, across Greenwich good relationships exist between the key stakeholders. However, the there is an opportunity to improve the approach to collective governance, collaborative strategic commissioning and development organisational structures or partnership arrangements needed to implement more formal collaborative delivery models. HGP brings together partners from the NHS, local council, social care, and the community and voluntary sector. Together HGP seeks to improve health and care services in Greenwich, helping local people live longer, healthier and happier lives.

The development project aims to partner with **Stone King Public Services Transformation Consultancy (PSTC)** to provide the specialist, public purpose legal and consultancy services required to support the Healthier Greenwich Partnership (HGP) explore and develop the options available to deliver joined up neighbourhood health services in Greenwich via a more formalised collaborative governance model. This project involves supporting HGP in the co-design of an effective collective governance model and identifying the integrative organisational structure(s) needed to:-

1) Building on the HGP values, mission and purpose, establish partner goals and success criteria for future arrangements (Shared Outcomes Framework)

2) Develop options to achieve these

3) Assess option amongst the partnership and then move in to formal steps to deliver the preferred approach

Integrated Neighbourhood Teams (INTs) improve health outcomes and reduce inequalities. In the wider context, the Greenwich Integrator project aligns with the public policy objectives of the SE London ICS, NHS South East London ICB and the Government's health mission to shift care from hospital to community; treatment to prevention and analogue to digital.

Their legal expertise captures mutual agreement, from an early stage, to reflect and assure mutual understanding and to provide the legal framework for progressive development and flexible adaption to circumstances which HGP are in at this time of change. Such an agreement is a platform for strategic alignment and common purpose delivery. There may then be follow on work to develop provider collaboration models under the partnership collaborative.

Detailed Proposal: Specialist Legal and Consultancy Support - One-Year Project Support

Stone King LLP is 240 year old leading public benefit firm offering specialist integrated legal and consultancy services. Building upon a foundation of trusted provider relationships, our Public Services Transformation Consultancy, supports sophisticated, advanced levels of partnership working by creating safe spaces, addressing power imbalances, and re-imagining the art of the possible in the codesign and delivery of effective community services.

Their specialist Public Services Transformation Consultancy (PSTC) team is led by public benefit partner Julian Blake and international social value consultant and academic Sandra Hamilton.

The focus of our PSTC is reaching beyond the theory and language of progressiveness to support the real complexity and hard, detailed work required to realise genuine transformation. Integration in public services entails multiple elements, including: between health and care; between commissioners, providers, investors and community organisations, as multi-sector stakeholders; between different traditional service categories; and between different contributory functions, within and across different organisations. Negotiating such complexity requires legal precision and dynamic advice and support in a seamless package. In their detailed proposal which has been reviewed by the Integrated Commissioning Partnership leaders for Adults and Children's they describe their capability, pioneering work in public service transformation and Demonstration Project immersive methodology, which they have embraced and adapted for the UK context based on Sandra Hamilton's proven model in Canada.

Their Demonstration Project model typically takes place over a one-year period, with capacity from specialists dedicated to supporting the project virtually and in person, with one day each month dedicated to being onsite to deliver in-person Design Labs and Learning and Development Workshops as needed. Commencing September 2025, the first phase of the project will focus on the co-design of collaborative delivery models, with the latter project phases focused on the development and drafting of legal agreements such as MOU's, Partnerships, Multi-Sector, Multi-Party Collaboration agreements, Alliance Contracts or the creation of Special Purpose Vehicles (SPVs). These are to be decided as part of the work and the onward steps to engage various partners specialist advisors or legal teams as part of the project work to arrive any agreed form of partnership model.

Core principles of the approach to this work:

(a) **System Stewardship Mindset:** public authorities and partners adopt a system stewardship mindset.

(b) **Person-Centred and Proportionate**: the system identifies and values what matters most

(c) **Integration and partnership:** required across sectors and between stakeholders, through purposeful strategic alignment.

(d) **Culture** – purpose drives process: non-integrative models are deeply entrenched and all the commitment of all participants to meaningful change is a pre-requisite.

(e) **Core VCFSE system intelligence**: the purpose-driven, purpose-aligned, local public benefit sector's dedication, knowledge, and expertise needs to be embraced.

(f) **Trust:** Public services under New Public Management ideology became commercial, marketized, transactional environments, making purpose a possible effect not a mission and forcing public benefit providers, against their nature and distinctive value, into commercial market competitors. Collaboration, based on trust and relational agreements based on common community purpose provides for alternative, integrating methodologies.

(g) **Mutual understanding:** working with public authorities, providers, social investors and community groups reveals, even among the most enlightened members of each group, that constant work is required to educate all participants about the perspectives and concerns of other groups

(h) **Challenge:** any improvement and especially critical transformation requires an open acceptance of positive challenge to status quo arrangements and concepts.

(i) **Continuous Learning:** the public sector partners, in consultation, asking other stakeholders what the public authorities might do differently to get the best out of providers;

(j) **Backbone Infrastructure:** identifying, enhancing and further developing the capability and capacity requirements of providers is a continuous priority.

(k) **Public Value Imperatives:** identifying absolute prerequisites for best public value service delivery is critical – purpose, participation, dedication, commitment to collaboration, including open book principles, among them.

(l) **Best Value Outcomes:** the purpose and mission provide the only proper project targets. This means embracing and working with complexity and uncertainty to improve what can be improved and to remove obstacles to success.

(m) **Leveraging and maximising resources and attracting investment:** Funding for public services is limited and without effective integration the expenditure of limited funding is wasteful. Pooling public authority and wider community resources and leveraging further resources through the strategic social value corporate citizenship may optimise project resources and appeal to social and even commercial investment.

(n) **Accountability to purpose, mission and outcomes:** regulatory and funding requirements are designed to assure proper focus, but slippage into narrower accountability to compliance and proxy targets, such as rigid KPIs is a continuing problem.

(o) **Amplification and adoption**: successfully integrated and well-focused public service arrangements present pathways and models appropriate for further development, dissemination and systemisation.

Terms and Costs:

The total cost of the support and advice for **12 months is fixed at £120k.**

A budget has been identified to cover this cost including funds which were set aside to develop our strategic commissioning approaches. This means that HGP will derive further benefit from this than would otherwise have been possible. As part of the project there will be learning and development opportunities opened up to partners on HGP and professional services supporting organisations so we do the learning together and apply it to our work as a partnership.

NB: Event expenses, travel, meals and accommodation are not included in professional fees.

They have agreed to a fixed fee project rate which is based on statutory factors together representing the value of our advice and assistance, including time reasonably spent undertaking instructions, complexity, urgency and importance.

How we will engage them:

As the Integrated Commissioning teams in Greenwich have established routes to secure this type of expertise, the team will support HGP to ensure a contract is in place with Stoneking on behalf of HGP for 12 months subject to this decision being taken. RBG procurement team will support to ensure the necessary arrangements and Joint Commissioning Board under HGP will oversee this governance. The commissioners will then be able to support any onward work as required.

More information about Stone King LLP can be found here: https://www.stoneking.co.uk and annex 1 includes detail of their experience.

Decision 2: The approach to the Health Host identification

There are two NHS Trusts in Greenwich which have expressed their interest in being the Health Host organisation for the Greenwich partnership, these are Lewisham and Greenwich NHS Trust and Oxleas NHS Foundation Trust. These organisations both have significant NHS infrastructure within in Greenwich and would incorporate primary care in the governance arrangements of the Health Host.

Recommendation: As these organisations are both interested, and both core to our place partnership, the recommendation is to refer this decision to the 4 SROS agreed at the June HGP meeting: Gabi Darby (Greenwich Acting PEL), Nick Davies (Greenwich Director of Health and Adult Services), Ceri Jacob (Neighbourhood Programme SRO for SEL), Dr George Verghese (GP member of the ICB and Neighbourhood Programme SRO for SEL ICB).

This assessment will consist of two components:

- Evaluating the support for the Health Host organisation from the Local Authority, Primary Care and all Partners of the HGP
- A written submission against a short set of questions assessing how the Health Host would deliver the Integrator functions in line with the success criteria set out by the Partnership

Annex 1: Prior experience of Stone King in partnership development

Their experience:

Case Study Examples Vitalising Purpose: The Power of the Social Enterprise Difference in the delivery of public services. Eighteen chapters of practical examples, with chapter 14 by Julian Blake and chapter 15 by Sandra Hamilton. https://e3m.org.uk/vitalising-purpose-book/

In Demonstration Project engagements, they typically reference the E3M Procurement to Partnership Toolkit case studies https://e3m.org.uk/case-studies-of-public-service-community-partnerships/

These have developed as part of a long-standing campaign for purpose-driven collaborative commissioning, to which Julian Blake has been central.

These case studies include:

• Leicestershire County Council's Children's Innovation Partnership which developed from Julian Blake's promotion of the Innovation Partnership model in the E3M Bold Commissioners' Group – See Phase One Evaluation Report by Bedford University

• Oldham Council's Social Prescribing Innovation Partnership, on which Julian Blake advised, and which included a focus on pre-requisite "Public Value Imperatives"

• The Plymouth Alliance Contract supporting people with complex needs, in which the Public Health Specialist Commissioner, Gary Wallace deconstructed processes he described as "routine and not thoughtful" to create a city-wide partnership of public sector and provider stakeholders under a partnership governance model

• Norfolk Council appointing HCT Group, following a market-testing Transparency Notice, to provide a then unique independent travel training service, proposed by HCT Group, as an additional element to community transport services. Julian Blake persuaded the Council that the Transparency Notice approach was appropriate in the circumstances

• West Linday District Council being supported by a joint venture between P3 and Social & Sustainable Capital in a social investment programme for social housing, following an E3M Alchemy event which highlighted the lack of community housing as a root cause of wider social problems In addition to these case studies, we also draw upon:

• Camden Council's Mission-Driven Procurement, which includes a focus on pre-requisites for providers similar to "Public Value Imperatives"

• Gateshead Council's promotion of "the Liberated Method" which starts with the person and their needs, not with the pre-existing multiple and separate, duplicating services such a person typically engages with, at great expense. Also see Netherlands Breakthrough Method

• Greater Manchester VCSE Accord, Alternative Provider Network and Stockport Prevention Alliance – Established 2015. The Wigan Deal, a new social contract between the council and the community

• Preston Council worker co-operatives as stewardship of the local social economy.

• The extension of the London Single Homelessness Prevention Scheme from the Brent Council pilot, in relation to which Julian Blake the lead Islington Council on the appropriateness of a market-testing Transparency Notice.

• Proposals by Catalyst Choices in Warrington and Halton for the joint-venture development of social care infrastructure, in relation to which Julian Blake advised

• The international example of Groupe SOS in France which in 45 years established a £1 billion social enterprise working with local authorities on projects which improved services and peoples' lives and saved money at the same time

• The international example of the Mondragon Corporation in the Basque Country in Spain, which, in 70 years, has established a £7 billion network of worker co-operatives and subsidiaries, integrated with regional government and the regional education system

AGENDA ITEM: 8

Healthier Greenwich Partnership

Date: 23 July 2025

Title	**Contract Extension UTC & GP Out of Hours (GPOOH)**	
This paper is for **ratification**		
Executive Summary	Greenwich Health were awarded the contract to provide the UTC and GPOOH Home Visiting Service in July 2023 following a competitive tender process. A contract was awarded for three years with the option to extend for a further two years. The paper assesses delivery against four key areas, to determine whether the option to extend should be exercised: • Performance • Quality • Value for Money • System Working The Joint Commissioning Board has already reviewed this paper and have recommended and approved the extension to be enacted. Therefore, this paper is coming to HGP to ratify that decision.	
Recommended action for the Committee	To ratify the decision made by JCB on the 3rd July to extend the contract based on the JCB review of performance, quality, value for money & system working	
Potential Conflicts of Interest	• Members of Greenwich Health • Greenwich GP's who are affiliated with Greenwich Health • Other UTC providers in South East London • All providers of services	
Impacts of this proposal	Key risks & mitigations	Greenwich Health may not wish to extend the contract and therefore, there would be a need to start

		a full procurement process; however by initiating the contract discussions now, we would have a full year to go through a procurement process.
	Equality impact	None arise directly from the report
	Financial impact	Greenwich Health are seeking a financial uplift to the GPOOH HV element of the contract. We have submitted a proposal, which is detailed in the paper.
Wider support for this proposal	Public Engagement	Not required for the purpose of this report
	Other Committee Discussion/ Internal Engagement	This paper was discussed and the extension approved at JCB on 3rd July 2025
Author:	Erica Bond Programme Lead Bexley and Greenwich	
Executive sponsor:	Gabi Darby Place Executive Lead	

Contract Extension - Request Form

This form should be completed where an extension to an existing contract (both NHS and non-NHS) is required and **is allowable in the contract and is within budget**.

In order to align with requirements in the ICB Schedule of Matters Delegated to Officers the following information is required to demonstrate positive assurance in respect of value for money, performance and quality.

NB: Contract Extensions below £5m p.a. can be reviewed and signed by the Place Based Executive Director, whereas **contracts over £5m p.a. need to be reviewed and signed by the Chief Executive and Chief Financial Officer**. The Governance process for review and sign off can be found in Appendix 1.

Contract Details:

Name of Requestor	Erica Bond
Name of Contract/Service/Project	UTC Service and GPOOH
Annual Contract Value	£5,426,703 (£5,108,609 UTC plus £318,094 GP OOH)
Associate Commissioners/Interdependencies	No associate commissioners. Patients attend the UTC from other boroughs/ICB's with the highest percentage of these attending from Bexley.
Current Provider	Greenwich Health
Start Date	July 2023
End Date	30th June 2026
Extension Terms	2x12 months
Extension Period Being Sought	2 years

Rationale:

Greenwich Health were awarded the contract to provide the UTC and GPOOH Home Visiting Service in 2023 following a competitive tender process.

Quality
Meetings between commissioners and Greenwich Health are held every six weeks and alternate between contract meetings and Quality meetings. Greenwich contract leads and quality leads are present at these meetings to oversee reporting and provide support and challenge (if necessary). Greenwich Health participate in the friends and family test and have their own internal patient satisfaction survey. They work closely with Healthwatch. They are currently working with the SEL ICB to develop their PSIRF plan and policy.

Performance
Greenwich Health generally perform well against the national and local KPI's. Four-hour breaches have reduced significantly over the last 6 months, and this performance helps support the ED target.

The 15-minute streaming target has been an area of focus, with the national target being 95%. Greenwich Health do not currently meet this KPI. There has been a steady increase in performance against this metric since March and during May and June it has ranged between 70-80%. Additional streamers are in place at the front door with Greenwich Health adjusting their workforce to provide this. The current front door environment also makes effective streaming challenging as there are not enough designated rooms. Building work will commence ahead of this winter to make the front door area bigger with more rooms/space in which to provide efficient streaming and we anticipate that this will lead to Greenwich Health achieving the 95% target.

System Working

Greenwich Health are an active participant at many forums within SEL. There is a partnership meeting in place with LGT which has senior membership, and this forum gives both organisations the opportunity to share information and update each other on future plans. Greenwich Health have participated in MADE events and Super March – these are events held within the hospital with all system partners to collectively improve performance.

Value for Money

Open book monitoring is in place quarterly. Recently Greenwich Health have advised commissioners that the budget for the GP Out of Hours Home Visiting (GP OOH HV) element is not sufficient to continue (10K loss each month) We have worked with Greenwich Health to explore other options these include:

- Collaborating with another SEL borough to provide the service
- Reviewing their workforce in the main UTC contract
- Financial uplift to the current contract
- Giving notice on this element of the contract (notice period 1year)

Conversations with Bromley have taken place and are ongoing and it is possible that once a new UTC contract is in place in Bexley (Oct 25) that Bexley may join discussions.
Greenwich Health are advising that there are no further efficiencies to be made with their existing workforce.
Below is the financial budget as detailed in the contract (minus yearly national tariff uplifts). Mobilisation costs were added to year 1.

UTC Service

	Year 1 (July '23 to June '24)	Year 2 (July '24 to June '25)	Year 3 (July '25 to June '26)
Annual Contract Value (£)	5,729,092	5,052,062	4,818,002
Monthly Payment (£)	477,424	421,005	401,500

The Provider will be responsible for billing Out Of Area (outside of SEL ICB) activity.

OoH Home Visiting Service

	Year 1 (July '23 to June '24)	Year 2 (July '24 to June '25)	Year 3 (July '25 to June '26)
Annual Contract Value (£)	299,999	299,999	299,999
Monthly Payment (£)	24,999.92	24,999.92	24,999.92

By utilising the extension option, we would avoid several disadvantages these include:

- High mobilisation costs
- Disruption to current arrangements
- Out of step with our work on neighbourhood health which is detailed in the 10-year plan
- A draw on staff and resources at a time when the ICB is changing with a reduction in resources

It would be advantageous to continue with the current provider in terms of continuity and partnership stability.

Internal conversations have taken place to discuss an increase to the GP OOH HV budget. We have advised Greenwich Health that we will make a payment of 50% (£52,000) to stabilise GP OOH HV for the remainder of the contract term. A further potential payment of 50% will be staged and subject to an incentivised payment. These KPI's which will attract an additional payment will include:

- Streaming performance achieving the national KPI of over 95% of patients streamed within 15 min
- Patient experience
- Redirection – the number of patients redirected to an appropriate healthcare environment
- System working in line with plans to develop a wider collaborative approach

Although this is a further investment it is better value than starting a new procurement that may destabilise partnership working.

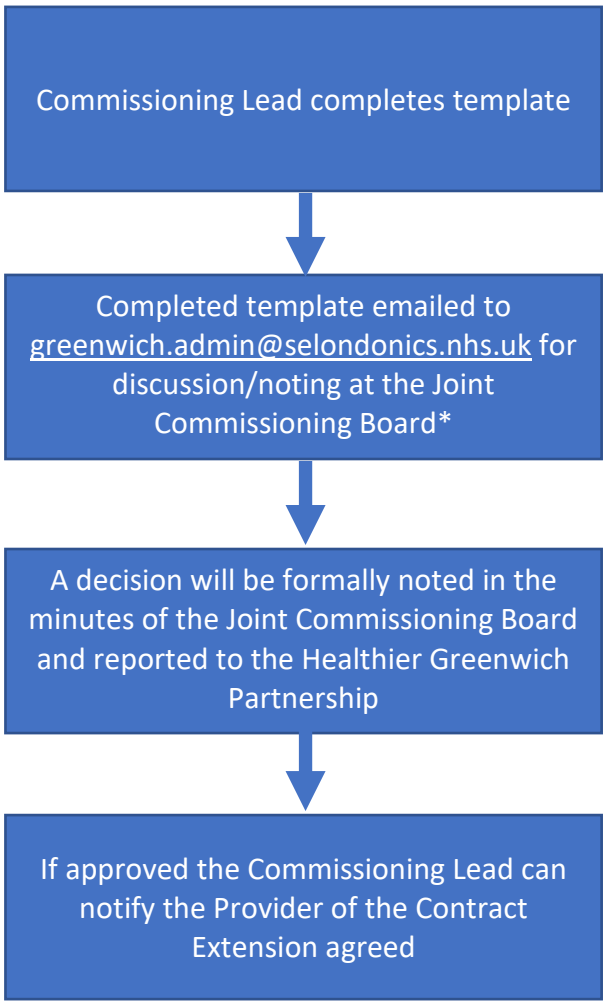
The recommendation to extend the contract was discussed at JCB on the 3rd July 2025 and was approved, with the decision to be ratified at HGP.

Recommendation
HGP to ratify the decision to extend based on the JCB review of performance, value for money & quality

The optional 2-year extension will then be enacted, and the contract extended to the 30th June 2028 subject to agreement from Greenwich Health.

:

Appendix 1 – Governance Process (Greenwich)



** It is recognised that in some instances a decision will need to be taken ahead of the next scheduled Joint Commissioning Board meeting. In these instances, the completed form should be emailed to greenwich.admin@selondonics.nhs.uk with an explanation of why approval can't wait until the next meeting. It will then be considered outside of the meeting to prevent delays. However please note that this route should be by exception rather than the norm.*

AGENDA ITEM: 9

Healthier Greenwich Partnership

Date: 23 July 2025

Title	SEL Aging Well Framework
This paper is for **noting**	
Executive Summary	The SEL Ageing Well framework was developed between January and March 2025 driven by multiple stakeholders at Place and involving colleagues from across the whole SEL system. The framework builds on the good work already underway at Place, enabling Places to incorporate it as part of their local development. The framework will help us to share success between Places, develop parity and a consistent offer for SEL, recognising the need for local variation The Ageing Well framework is aligned with and enabled by other emerging SEL strategies for example, Integrated neighbourhood Teams, Long Term Conditions and Urgent Community Response; recognising the interplay between these. The framework also aligns with key national directives such as the 2025/26 NHS Operating Guidance, 2025/26 Neighbourhood Health Guidelines and Lord Darzi's investigation in 2024. The Framework comprises three interconnected zones: Zone 1 Promoting independence and wellbeing Zone 2 Proactive Community Care via Integrated Neighbourhood Teams Zone 3 Holistic and person-centred Urgent Response, Intermediate Care and Frailty Attuned Hospital Care Key principles and requirements for people living with Mental Health Problems, Dementia and/or delirium are captured within each zone. Palliative care and end of life support is also included. Key enablers identified as critical to the development of the framework include – One agreed frailty score, consistent approach to use of CGA, UCP, Workforce Development and Culture and Population Health Management. Draft Outcomes to monitor and evaluate the success of the framework have been defined and will be further refined. Key performance indicators for each outcome are being considered. Next Steps at Place Level are

	• Broaden the engagement and socialisation of the model with stakeholders. • Individual place led self-assessment against the framework, assess gap/opportunity for development. • Creation of place roadmaps for implementation	
Recommended action for the Committee	HGP members are asked to accept the SEL Aging Well Framework and work together on engagement, implementation, oversight and assurance	
Potential Conflicts of Interest	None arise directly from this report	
Impacts of this proposal	Key risks & mitigations	None arise directly from the report
	Equality impact	This proposal will improve health inequalities
	Financial impact	TBA
Wider support for this proposal	Public Engagement	Not required for the direct purposes of the report
	Other Committee Discussion/ Internal Engagement	This is an SEL wide proposal to be adopted by all boroughs in SE London
Author:		
Clinical lead:		
Executive sponsor:	Gabi Darby, Acting Place Executive Lead, Greenwich	

South East London Integrated Care System

NHS South East London

SEL Ageing Well Framework

'Age without limits: you say, your way'

Final Draft Report
April 2025

Programme supported by:

HEALTH INTEGRATION PARTNERS

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South East London Integrated Care System

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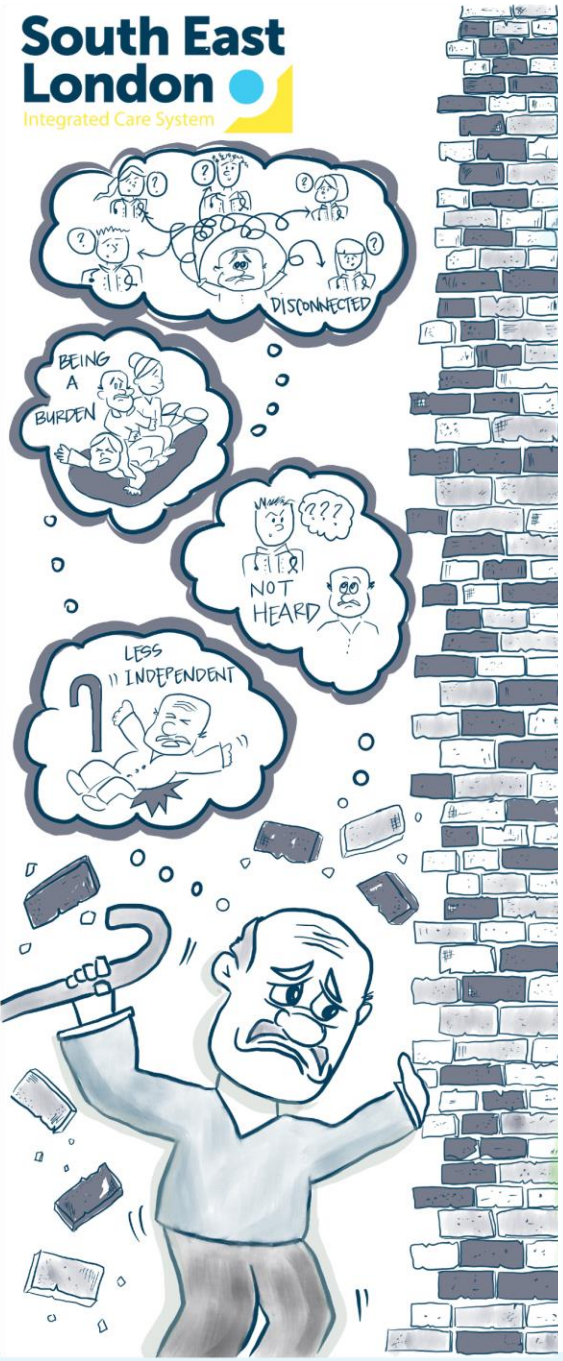
1. Executive Summary

HEALTH INTEGRATION PARTNERS



Executive summary

Introduction

- The SEL Ageing Well framework was developed between January and March 2025 driven by multiple stakeholders at Place and involving colleagues from across the whole SEL system. The framework builds on the good work already underway at Place, enabling Places to incorporate it as part of their local development. The framework will help us to share success between Places, develop parity and a consistent offer for SEL, recognising the need for local variation.
- Over 170 SEL colleagues and stakeholders have been involved in multiple working sessions to develop a shared vision and ambition for the framework with over 70 colleagues taking part in 3 face to face workshops to define the detail.
- The focus of the framework is initially on those aged 65+ including those at all stages of the frailty continuum (mild, moderate and severe). However, it is recognised that many of the elements included apply to younger cohorts showing earlier signs of ageing or frailty. The framework is not just health focused. It encompasses the wider factors and determinants pertinent to ageing well such as destigmatising ageing, building age friendly communities, the role of the carer and tackling social isolation. Definitions of ageing well and frailty were shaped as part of the work to achieve a focus on what would be important.
- The Ageing Well framework is aligned with and enabled by other emerging SEL strategies for example, Integrated neighbourhood Teams, Long Term Conditions and Urgent Community Response; recognising the interplay between these. The framework also aligns with key national directives such as the 2025/26 NHS Operating Guidance, 2025/26 Neighbourhood Health Guidelines and Lord Darzi's investigation in 2024.

Executive summary .. *continued*

Why we want to promote ageing well

- There are compelling reasons for promoting ageing well in SEL. More than 61% of non-elective beds are utilised by those age 65+ (equivalent to 1594 beds at a cost of over £250m in 2023/4).
- At least 12% of these admissions (154 per day) are due to ambulatory care sensitive conditions and therefore could be avoided with more effective management in the community.
- 50% of frail patients also stay in hospital for over 21 days, adding to the severity (and consequences) of hospital acquired disability.
- For those aged 65 and above admission costs and associated A&E attendance rates are higher in SEL compared to national benchmarks
- By 2028 the SEL over 65 population is expected to grow by 18%, adding to the above pressures. There is therefore a need to shift the focus to earlier identification and prevention – whilst equally supporting those at the other end of the frailty scale.
- The voices of residents also strongly point to the need for change. Over 100 residents were spoken to as part of the work. Their views, along with those captured from existing engagement work have helped inform priorities within the framework. For example, residents highlighted the need to feel more respected, trusted, listened to and believed.
- Residents need more help with the practicalities of life but want to remain independent and resilient despite vulnerabilities. They want purpose and connection and to be seen as 'whole' beings, equal to younger people. They also want to see more joined-up services that intervene with each other on their behalf.
- Unpaid carers want more flexible support and respite opportunities to help them to continue in their roles.
- A graphic has been produced that distills the views and aspirations of residents and is included in this report.

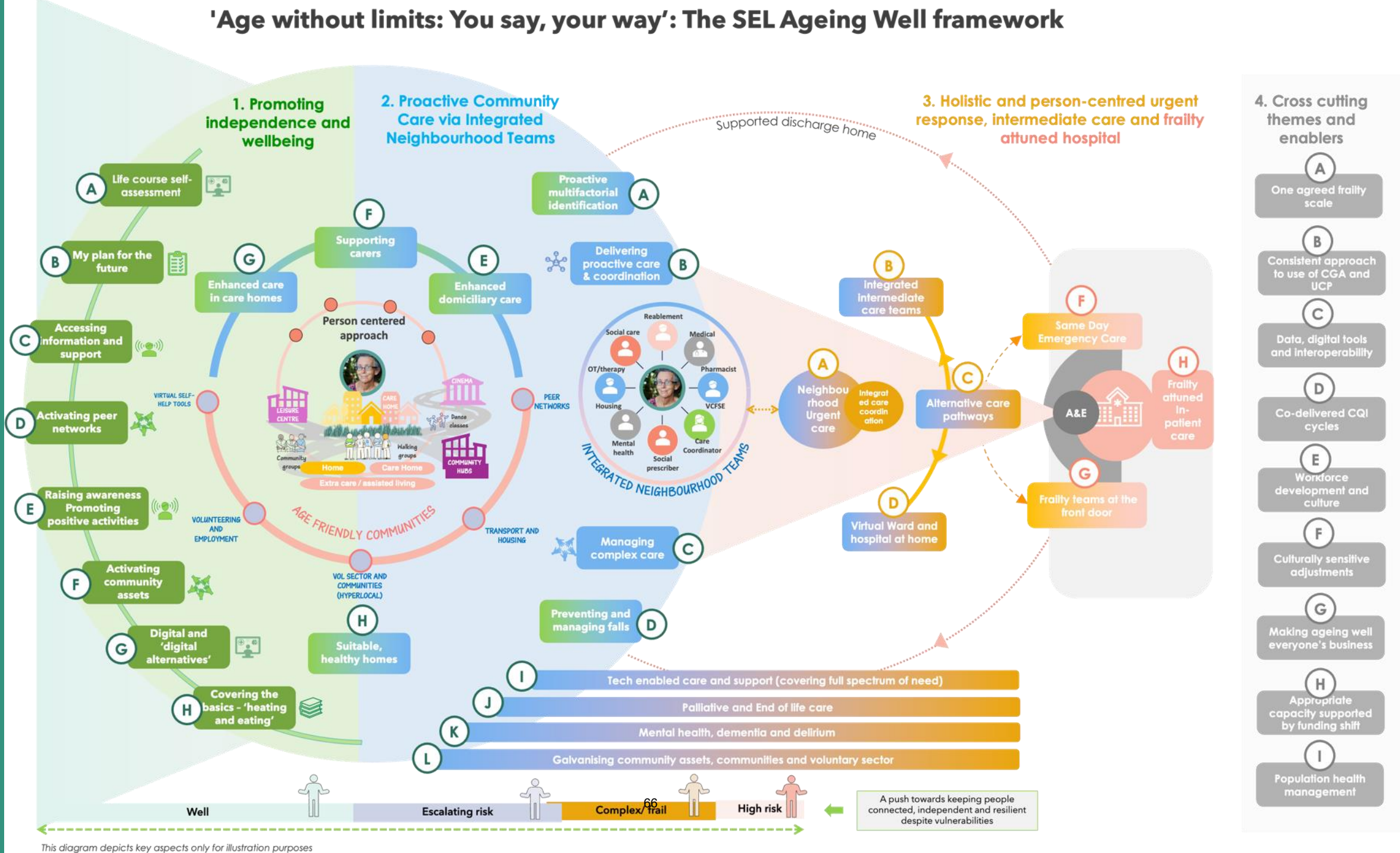
Executive summary .. *continued*

'Age without limits: You say, your way': The Ageing Well framework

- The framework comprises three interconnected zones, enabling people to move easily between zones based on where they are in their journey. The underlying principles and values relevant to all zones are also captured, such as the need for seamless navigation, a focus on active and engaged living and effective self-help.
- Zones are:
  - **Zone 1: Promoting independence and Wellbeing** – Supporting people to age well, maintain independence and social participation
  - **Zone 2: Proactive Community Care via Integrated Neighbourhood Teams** – Early identification of frailty and well-coordinated community-based care/response to exacerbation
  - **Zone 3: Holistic and person-centred Urgent Response, Intermediate Care and Frailty Attuned Hospital** – Neighbourhood based urgent response, step up/step down intermediate care, hospital front door and inpatient care
- Key principles and requirements for the care and support of people living with mental health problems, dementia and/or delirium are also captured for each zone. Palliative and end of life care and support needs are also summarised.
- A single overarching diagram that captures all the key elements of the framework per zone is provided. Each of these elements is then described in a zone summary, followed by more detailed description of each of the elements. These descriptions of each element include the factors and principles considered most important to SEL colleagues and reference some example initiatives already underway in SEL where good outcomes are being achieved.
- A range of enablers have been identified as critical to the development of the framework and a brief description of each is included. Key enablers include moving towards one agreed frailty score, a consistent approach to the use of tools such as Comprehensive Geriatric Assessment (CGA) and the Universal Care Plan (UCP), Workforce Development and Culture and Population Health Management (PHM).

The SEL Ageing Well Framework

'Age without limits: You say, your way': The SEL Ageing Well framework



This diagram depicts key aspects only for illustration purposes

Executive summary .. *continued*

How will we know we are making a difference?

- Outcomes that can be used to monitor and evaluate the success of the framework have been defined in areas such as quality of life, the effectiveness of support provided and whether we are reducing health inequalities for this population. Following review these outcomes have been further refined and prioritised. Potential key performance indicators for each outcome are suggested and an example system-level dashboard is outlined.

How will we implement the framework?

- Key success principles for implementing the framework are described, based on learning from elsewhere. The key to success during delivery is to emphasise a focus on people – for example, creating meaning, engaging and taking people on the journey, developing the right skills and motivations and providing strong leadership that inspires and establishes clear accountability.
- An overview implementation road map is provided summarising the key next steps at Place and SEL levels to deliver and embed the framework. As part of this it is proposed that Places assess themselves against the framework to help identify opportunities and priorities for delivery. These can then feed into (existing) local roadmaps for delivery.
- It is recommended that these roadmaps include definition of the ideal local care model and plans for local leadership, resources and project and change management methods. In parallel, demand and capacity modelling can take place to understand the impacts and shape the ‘left shift’ in resources required to invest in delivery. Implementation is likely to be phased and will need to be supported by a robust project delivery team and clarity on what support will be provided to Places.
- A QI methodology will be required that enables real-time learning and improvement and sharing of success between Places.

Executive summary .. *continued*

Next steps

Continued work is now required to support Places to adopt it as part of local design, planning and delivery. This includes:

- Broadening the engagement and socialisation of the model with stakeholders
- Individual Place led self-assessment against the framework, assess gap / opportunity for development
- Creation of Place roadmaps for implementation.

Appendices

- A set of appendices are provided which include a record of key outputs from workshops that have helped in shaping the framework and a summary of external cases studies and recognised best practices from elsewhere.

The picture on the right depicts the vision as defined during the resident and carer engagement sessions. Illustration done by an artist.

South East London Integrated Care System

NHS South East London

2. Introduction

HEALTH INTEGRATION PARTNERS

The work to deliver the SEL Ageing Well framework will require continued stakeholder engagement and understanding, enabling Places to utilise it as part of local design, planning and delivery

This report reflects the work that took place between January and March 2025, involving a wide range of stakeholders across SEL in developing the SEL Ageing Well framework. Continued work is required to refine the framework and support Places to adopt it as part of local design, planning and delivery. A great deal of work is already underway at Place to support residents with ageing well. This framework builds upon that work. It is not a mandated framework, but rather a capture of the most important elements and principles expressed by SEL colleagues alongside recognised best practices. It will hopefully enable achievement of local aims at an accelerated pace, sharing of 'what good looks like' between Places and greater parity of provision as part of a unified approach – recognising the need for local variation.

The framework will:

- Help **ensure parity** in the offer we provide to people
- Enable us to **maximise** our collective resources
- Enable us to **share best practice** and the good work already underway at a local level
- Provide a more s**treamlined experience** for people and staff.

Benefits of a shared SEL frailty framework:

- **Consistent approach**: e.g., assessment and care planning tools acknowledged by all partners
- **Collaboration and workforce:** real integration in place-based systems, with an upskilled, flexible workforce
- **People and processes:** Improved consistency of care, and increased focus on prevention and early identification of frailty
- **Measuring impact:** measuring consistent outcomes across the board and knowing what good looks like.

The development of the Ageing Well framework has been led and overseen by colleagues from across SEL

Colleagues from across the SEL system have participated in the development of the framework, including from the ICB, Local Authorities, Public Health, Primary Care, community-based care, VCFSE, acute care and mental health. Colleagues have taken part in **121's, extensive discussions, ongoing working sessions/forums and 3 key workshops each with around 50-70+ attendees** to help shape the recommendations. Four resident workshops were also held and several residents also joined in other forums and workshops:

121 sessions	**Place based meetings**	**3 Workshops**	**Meetings to align with INT/LTC developments**	**Resident and carer voice sessions**
Reference group meetings	**VCSE meetings**	**Housing and Social care meeting**	**4 deep dive meetings for core elements***	**Regular core Group meetings**

* care homes, domiciliary care, palliative and end of life care and mental health, dementia and delirium.

Engagement with multiple stakeholder groups from across the system to build the picture

A list of the names of key stakeholders who participated in this work can be found in the appendices.

The 3 face to face workshops were very well attended and represented all Places

The overall objective of the framework is to pull together our collective ambition for ageing well, building on the work already underway

A great deal of positive work on ageing well and frailty is under way at Place. The development of the framework is an opportunity to pull this together and build on it to define shared principles, key elements and best practices - towards providing consistent care that is equitable, safe and efficient. Objectives include:

- **Forming a co-developed vision with Place to generate local ownership**
- **Understanding current services, success stories and linking into other work at Place e.g. INTs, LTC, enhanced care in care homes**
- **Maximising the value of our collective learning and resources**
- **Encompassing wider factors and determinants e.g. housing, social isolation and building ageing attuned communities**
- **Inclusion of patient stories and involving residents in helping to shaping the framework**
- **Defining ageing well and frailty and addressing the needs of people across the frailty continuum**
- **Inclusion of the role of unpaid carers and family, acknowledging their important role**
- **Bringing together all partners across the system to improve service quality, optimise skills and manage pathways**

The work has taken place over three months, following a structured methodology

December	January	February	March	April
Mobilisation	**Establishing the baseline position and ambition**	**Developing the SEL Ageing Well framework**	**Testing and refinement of the framework**	**Finalising the framework**
• Confirm objectives, scope and outputs • Stakeholder mapping • Request for data and documents • Establishment of core design group • Initial comms, diarising and set up • Workshop dates to be confirmed • Project governance	Defining the 'as is' position and ambition at Place level via questionnaire template Data story board & patient stories Connecting with key stakeholders e.g., executives to create buy-in **Workshop 1** • Definitions of ageing well and frailty • Agree cohesive vision and ambition • Place level 'as is' positions	Place based focus group meetings –10 things Place's want from the framework Connect with resident groups to capture voice National & international best practice learnings **Workshop 2** • Defining the framework and key components • Presentation of the residents' voice	Sub-group meetings to define opportunities to generate ageing well services & communities 1:1's with wider system to fill in the gaps, refine & ratify outputs Governance forums e.g., Ageing Well groups/ UEC to broaden buy-in **Workshop 3** • Finalising the framework • Outcome measures • Developing a mantra • Defining next steps for implementation	• Development Roadmap including overall phasing and timeframes and at Place • Final 1:1 meetings as required • presentation at board meeting(s) • Final sign-off • Final
OUTPUTS 1. Stakeholder map 2. Comms and diarised meetings 3. Agreed governance	1. Key opportunities around ageing well and frailty 2. Cohesive vision and ambition 3. Current work at Place 4. Definitions	1. Framework with unified language 2. Clear way forward for social construct elements 3. Residents' voice reflected in the framework	1. Final report including vision, SEL framework, outcomes, etc. 2. Roadmap leading into delivery	1. Finalised roadmap 2. Finalised report document complete and endorsed

Definitions of ageing well and frailty were shaped early on to achieve consensus on the core drivers for the work and population in scope

- Around 70 colleagues and 100 residents were asked what 'ageing well' means to them and their views are reflected throughout
- It was agreed that mild, moderate and severe frailty are in scope and the priority focus in on people aged 65+
- However, it's recognised that frailty can occur much earlier (particularly in those prone to health inequalities e.g. lower socio-economic groups, significant mental health disorders) and therefore elements of the framework (such as early identification, prevention and positive ageing) increasingly apply to younger cohorts.

The appendices include a capture of what ageing well means to SEL colleagues and overall definitions for ageing well and frailty - drawn from these views and from recognised national bodies. Excerpts are as follows:

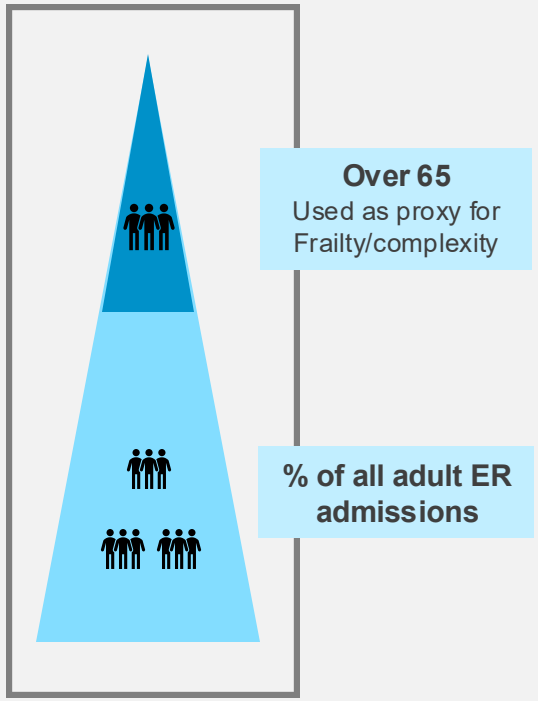
Ageing well *- The ability to maintain low risk of disease-related disability, high mental and physical function, and active engagement with life - including a positive attitude, sense of engagement, purpose and a desire to stay active and healthy in later life, including seeking help when needed and practicing self-care.*

Frailty *- a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves... a state of increased vulnerability resulting from aging-associated decline in reserve and function.*

Ageing well and frailty definitions

3.
Why we want to promote ageing well

Let us understand the scale posed by frailty across SEL: More than 61% of non elective beds are utilised by over 65 (over 65 used as a proxy in absence of frailty data)



Over 65
Used as proxy for Frailty/complexity

% of all adult ER admissions

	Number of admissions per day (2023/24) (Non elective only)	Number of beds utilised [1] (2023/24)	Total cost of admissions [2] (2023/24)
Over 65	154	1594	Over £250m
% of all adult ER admissions	39%	61%	54%

Length of stay of patients over 65 is longer largely due to higher complexity, social circumstances or process bottlenecks. Hence, the total bed days is disproportionately higher than total admissions

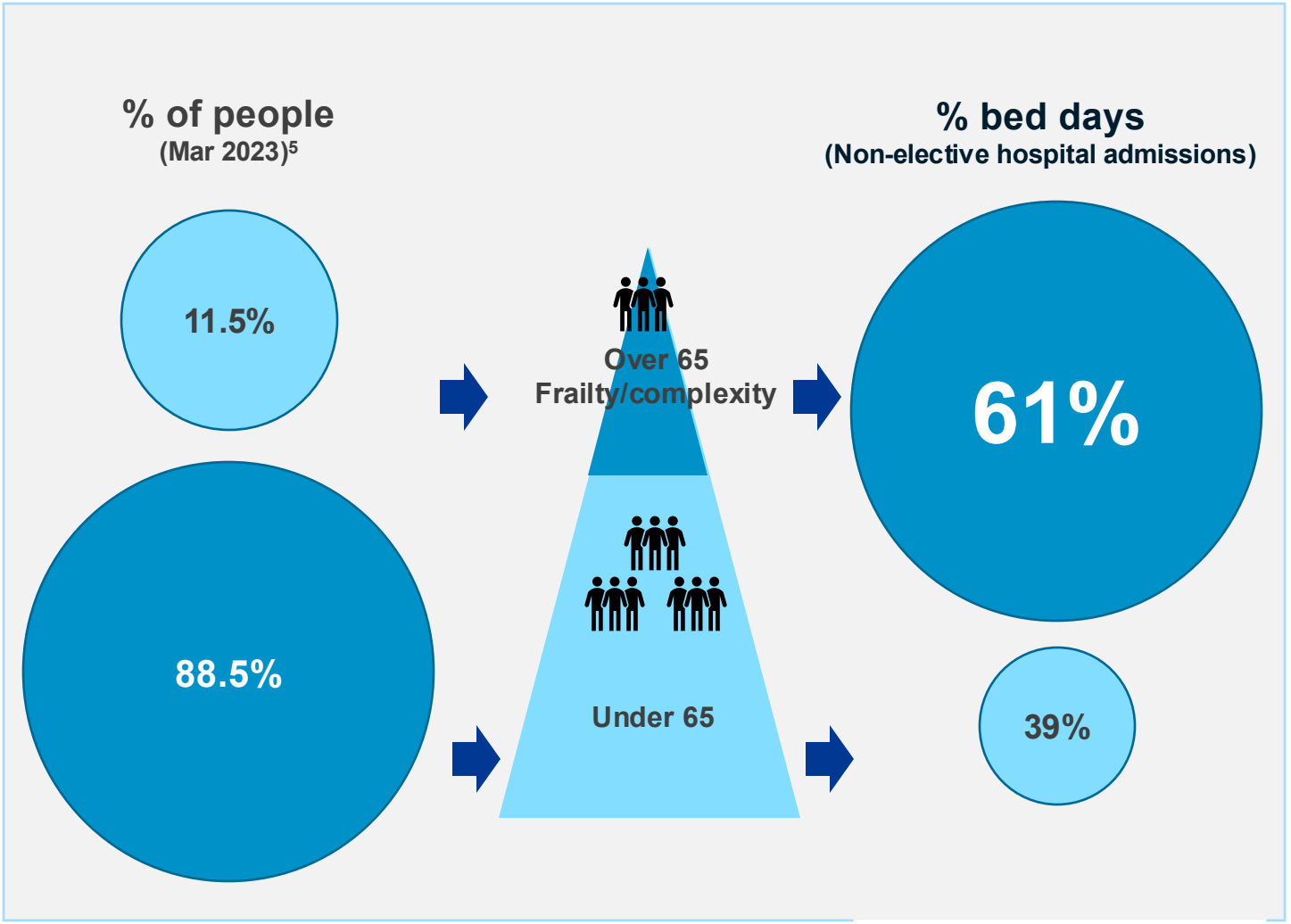
*Please note, data to be validated further
Data source: SUS aggregate download FY 2023/24
[1] Beds utilized calculation (bed-days / 365 and then adjusted for 95% occupancy – BOR)
[2] PBR cost used a proxy for total cost

With increased population growth and composition, the pressure and need for hospital beds will rise

Population growth

By 2028, the population aged 65 and over in SEL is projected to grow by 18%[3]

- **Bexley:** Population 244,247. Up to half of Bexley's population of over 65's are affected by frailty, rising to 65% in those over 90 years of age. There are estimated 23,500 people aged above 50 with frailty[4].
- **Bromley:** Population: second eldest population in London (17.7%), expected to grow to 67,000 over 65's by 2030[4].
- **Greenwich:** 289,100 residents within Greenwich. Number of residents aged over 65 has risen by 15.6% since 2011[4].
- **Lambeth:** 322,000 residents, 50% growth expected in the over 50s in the next 10 years[4].
- **Lewisham:** 200,600 population, 9.5% are aged 65 or over. Younger population, however, it is thought population growth won't be evenly spread across the ages, and there will be an increase in the older population[4].
- **Southwark:** 307,000 residents, comparatively younger population, population will continue to grow with over 17,000 additional people living in the borough by 2030[4].



*Please note, data to be validated further
[3] SEL ICS People strategy 2023/24- 2027/28
[4] South East London 2024/25 Joint Forward Plan
[5] Population and Person Insight data (PaPI)

There are a number of admissions that can be avoided through better proactive care in the community

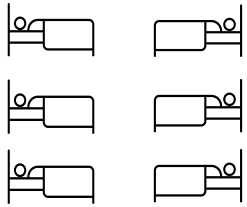
Number of admissions per day (Emergency only)

154

Ambulatory Care Sensitive Conditions (ACSC)

12%

1 ward in each Place



Falls	Sepsis	Pneumonia	UTI	COPD exacerbation
Congestive Heart Failure	Acute Renal failure	Cellulitis	Pneumonitis due to food and vomit	Fracture of neck of femur

Avoidable admissions

ACSC are conditions for which effective management and treatment within the community, should limit emergency admission to hospital.

A few examples include heart failure, COPD, influenza, pneumonia.

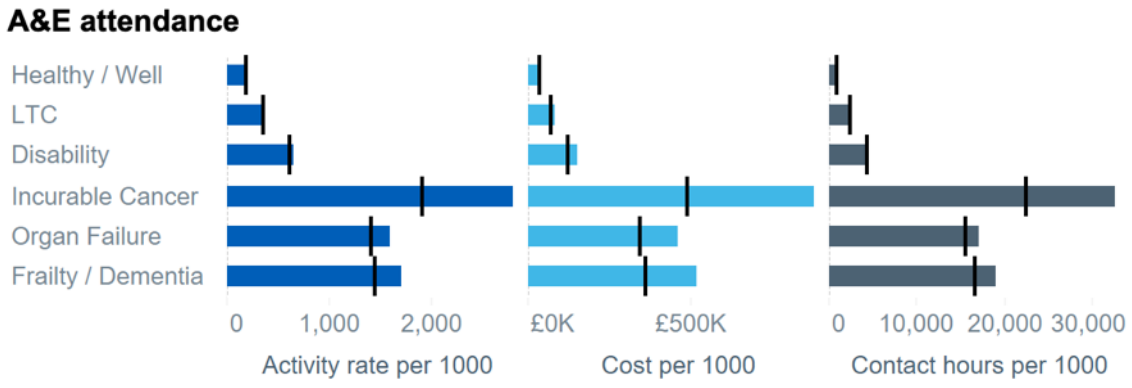
"In 2022/23, within 10 months, there were 1598 avoidable admissions to hospital relating to Ambulatory Care Sensitive Conditions, compared to 2205 in 2021/22. This suggested a 5% reduction target was on course to be met and exceeded.[5]"

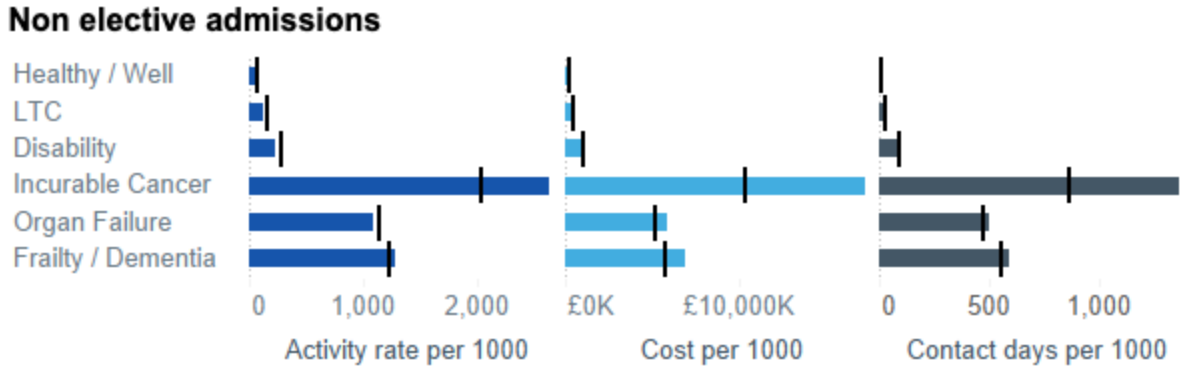
Utilisation of services for those that are frail/ dementia is substantial

For those aged 65 years and above, non-elective admission activity rates per 1000 are higher for SEL when benchmarked against national data[5]:

- SEL 245 per 1000
- England 238 per 1000

Non-elective admissions[5]: Cost per 1000 people in SEL is £1,223,000 which is £250,997 higher than the national benchmark





- For those with frailty/ dementia, in relation to A&E attendance, the activity rate, cost and contact hours are all above national benchmarks.
- The progression from LTC to frailty results in a substantial increase in activity and cost, hence prevention is critical.

We want to draw attention to hospital acquired disability (HAD)

50% of frailty patients stay in hospital for over 21 days[6]

The cumulative impact of extended or complicated hospitalisation among older patients typically results in patients experiencing a decrease in muscle mass and significant functional decline due to a complex process of physiological changes that can affect multiple systems

(Brown, Friedkin, & Inouye, 2004; Brown, Redden, Flood, & Allman, 2009; Chastin et al., 2019).

In a study of hospitalised community-dwelling older people at 6 months after discharge, 43% needed continuing help with medications, 24% were still unable to walk a quarter of a mile, and 45% were still unable to drive. The overall prevalence of HAD across studies has been estimated to be around 30%

National Institutes of Health (NIH)

Studies have observed that at least 30% of older patients hospitalised with an acute medical illness show a persistent decline in their ability to maintain Activities of Daily Living (ADLs)

(BMC Geriatrics)

So significant can the muscle loss be in bedridden seniors that while complete bed rest causes young adults to lose about 1% of muscle mass per day, the elderly may lose up to 5% per day

(Sarcopenia: Loss of Muscle Mass in Older Adults. Mary Ann E. Zagaria, 2010)

It has been estimated that 68 % of patients are discharged from post-acute medical settings below their pre-admission level of function.

(Gill, Gahbauer, Han, & Allore, 2009)

This means that post-hospitalisation, patients are not only recovering from their acute illness but also facing physiological stress and susceptibility to complications not directly related to the cause of their admission.

(English & Paddon-Jones, 2010; Hartley et al., 2019; Kortebein, 2009; Kosse, Dutmer, Dasenmbrock, Bauer, & Lamoth, 2013)

National Audit Office (NAO)

Today's analysis by the National Audit Office reveals that after spending ten days in hospital unnecessarily, a patient's health has deteriorated to such extent their life expectancy has been shortened by ten years - 18th March 2024

'It is often said that for every 10 days of bed rest in hospital, the equivalent of 10 years of muscle ageing occurs, in people over 80 years old- this may or may not be true to the word but certainly puts things in perspective'.
Dr Amit Arora, consultant geriatrician

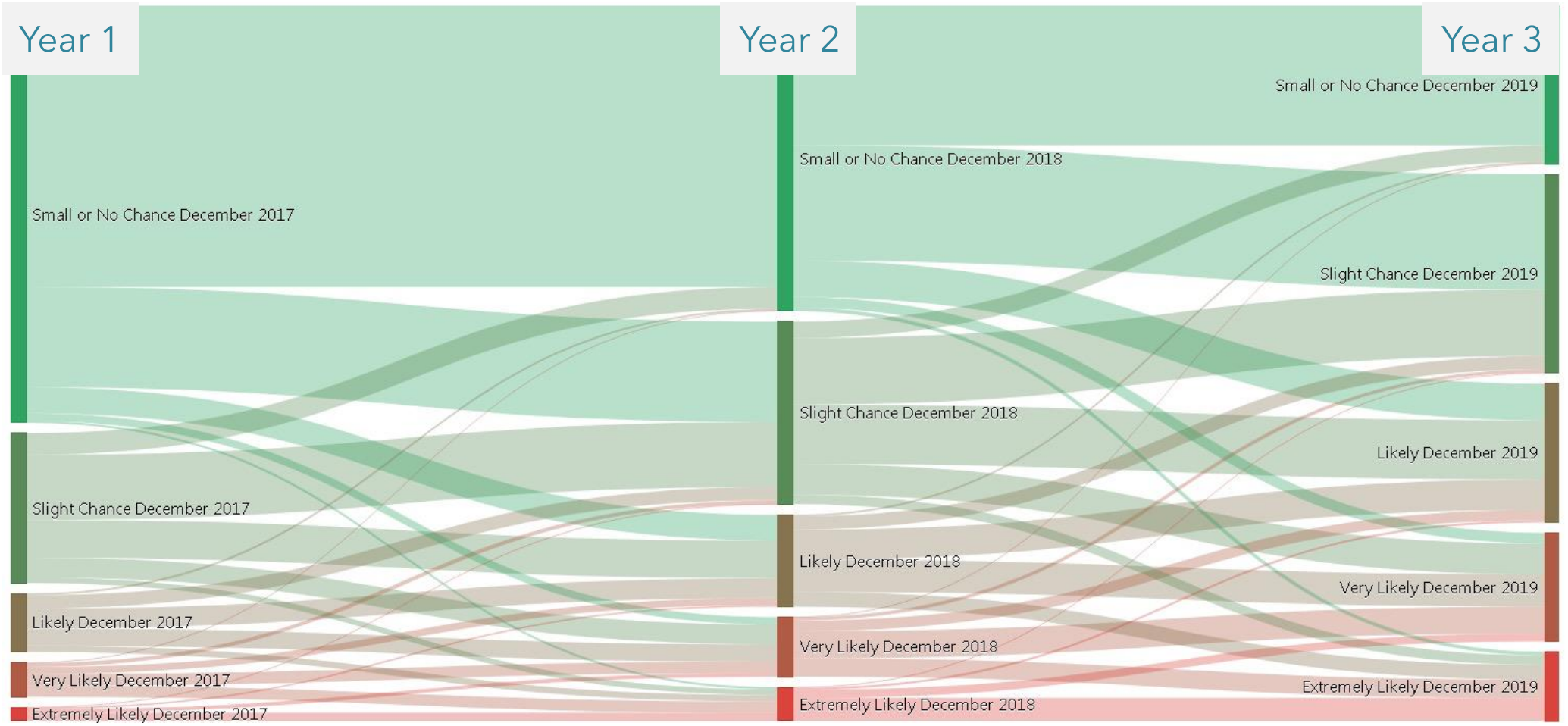
**Please note, data to be validated further. Data source: Frailty and multiple LTC SEL ICB presentation*

How risk/complexity changed over 3 years and why it is critical that we capture people at/before the point of rising risk (example taken from another ICS with pseudonymised data)

The chart shows how risks rose in people across a period of 3 years. Data is only for over 65 across one Place (2 boroughs).

It shows how those who had low risk (green) in Year 1, moved into higher risk segments (red) just within a period of 1 or 2 years.

Risk was measured using ACG algorithm from John Hopkins customised further to improve identification. Includes aspects such as frailty, LTC, H/O, Rx.



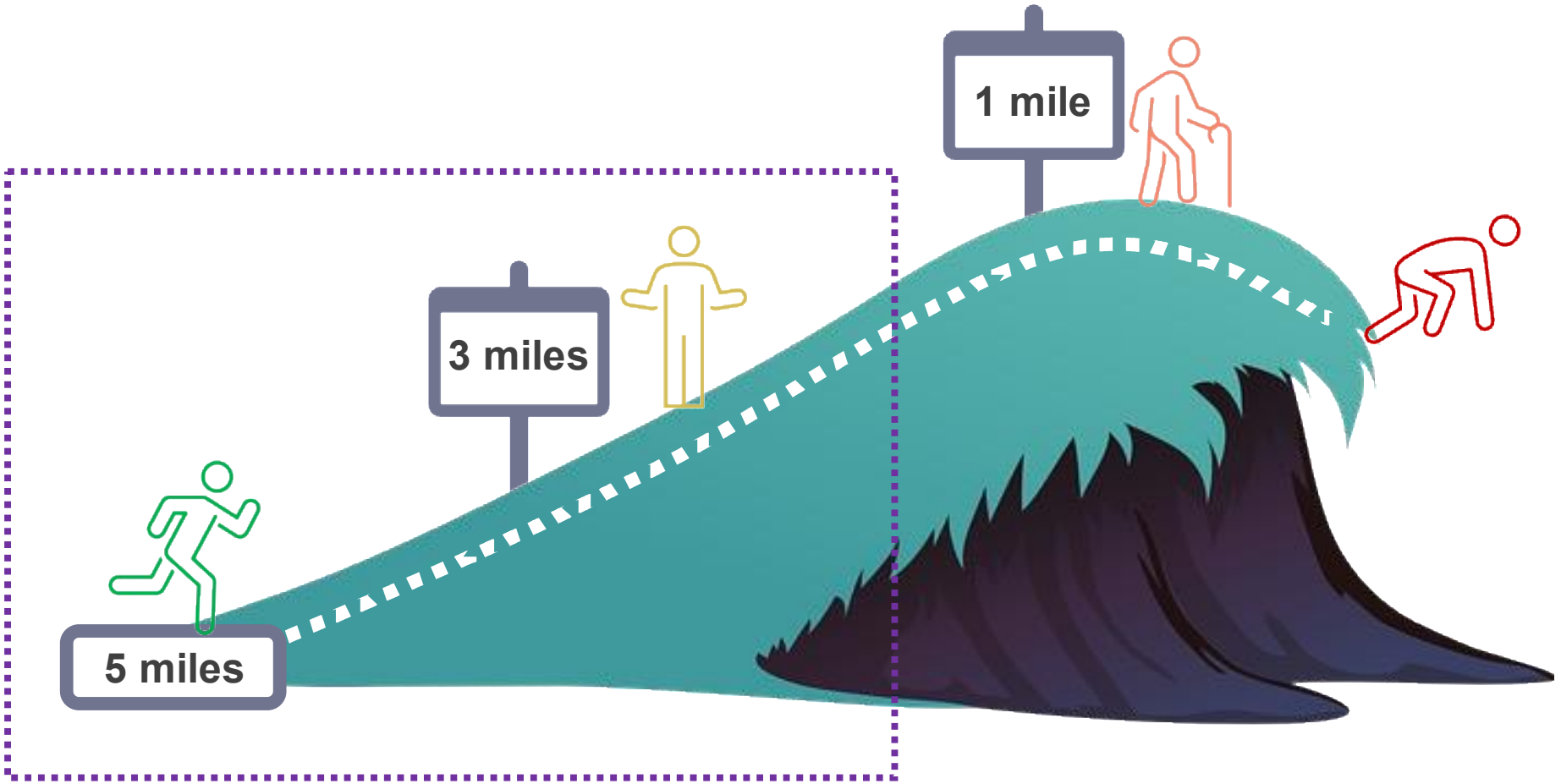
Year 1 profile of exactly the same population – two years ago

Year 2 profile of exactly the same population – one year ago

Year 3 profile of all over 65 who were admitted in hospital/attended A&E

There is a need to shift the focus towards early proactive prevention whilst equally supporting those at the other end of the scale

- Catching people at the '5-mile mark': there is a clear need to continue to shift focus towards early identification, proactive prevention and working with people holistically (health and social care).
- Equally, focusing on initiatives to support people when they are at the other end of the scale, looking at how we can proactively and reactively manage those living with frailty/ complexity.



The Ageing Well framework aligns with and helps meet the drivers and objectives of key national directives

Example national directives:	Examples of how the Ageing Well framework aligns
 British Geriatrics Society Blueprint for preventing managing frailty in older people (2023)	The framework delivers against the key BGS recommendations for the 'seven touchpoints' – from enabling independence and promoting wellbeing through to frailty-attuned hospital care
NHS 2025/26 NHS priorities and operational planning guidance	• Neighbourhood health services models to prevent admissions and improve access to care • Address inequalities and shift towards prevention
NHS England Neighbourhood Health Guidelines Neighbourhood Health guidelines 2025/26	• Integrated working, reducing fragmentation, poor communication and siloed working. Increasing ability to self-care • Shifting focus from hospital to community and from treatment to prevention
 Fuller Stocktake Report 2022	• Providing more proactive, personalised care with support from a multi-disciplinary team • Helping people to stay well for longer and a focus on early identification and prevention • Streamlining access to care and advice
 Lord Darzi's independent investigation of the NHS in England (2024)	• Shifting spend from hospital to community • Listening and responding to the patient voice • Empowering patients • Multi-disciplinary teamwork and working.
National Association of Primary Care: Creating Integrated Neighbourhood Teams. March 2025	• Engaging communities, citizens and patients • Start with staff and equip them to deal with the work • Simplify processes • Enlist hospital specialists

South East London Integrated Care System

NHS South East London

4.
What do our SEL residents and carers say?

Quotes captured from primary research and a range of SEL reports providing residents' feedback

HEALTH INTEGRATION PARTNERS

A range of parallel activities took place involving residents to ensure their voice is reflected in the framework

1. Distilling themes from SEL and Place - based engagement work done so far

SEL has done significant work around engagement across all age groups and communities in the past few years. It was important that we capture and distill key themes that needed to be incorporated in the framework.

2. Connecting with residents to understand what ageing well means for them

- Blackfriars Settlement
- Bexleyheath in Bexley
- Orpington in Bromley
- Southwark Carers

Connected with residents across SEL to understand what 'ageing well' means to them, their experience and expectations. The engagement is still ongoing and will convert into a graphic. The key themes will be woven into the framework and will influence our priorities for delivery

3. Attendance in co-design workshops

Representatives attended both workshops (1 and 2) to support the co-design of framework

4. Continued engagement at Place

While the framework is being established, there will be continued hyper local engagement at Place to ensure the model of care is defined locally in line with the needs of the local population

Residents highlight the need to destigmatise ageing. They want to feel like they count and are respected and trusted. They place importance on purpose, connection, resilience and independence

1. **Remaining resilient despite physical vulnerabilities. Preventing deconditioning: physical, functional and cognitive**
   Missing out on physical, social and cognitive activities decreases confidence, increases fear and intrinsic capacity to protect myself. Optimising social, physical, functional and cognitive avoids deconditioning.

2. **Hopes and dreams for ageing well**
   Wanting to do things for myself, getting support adds to ageing well, having a sense of purpose, being able to use my previous skills to help others and laughter ☺

3. **Help with how to set yourself up for success to age well**
   Trusted, professional information and advice. **Having peace of mind.**
   Not having to burden friends and family.

4. **Loneliness and participation**
   Need for true human connection and bond between friends and family and opportunities to be part of other groups

LAUGHTER is essential for ageing well, and to share in the laughter with others, and seeing others enables me to focus less on pain and ailments

"Dreams? I don't really have any because I'm just trying to stay alive. I want to be there for my grandkids, but some days I'm just counting the days, and I need to make the most of every day. If I could, I would love to travel and fly, but I can't because I'm immobile."

"For me, ageing well means being able to feel INDEPENDENT. And have the ability to take care of yourself."

"Pensioners aren't necessarily the frail and retiring types of popular imagination. I don't think many people my age (early 60s) will be interested in playing Bingo in our retirement."

"On the whole as people get older, they would prefer not to be seen as a 'category' but simply as themselves ... among all sorts of other humans ... being as active, intelligent, engaged, healthy, friendly and involved as possible. Many frailties and disadvantages and problems are shared across age groups"

Includes excerpts from SEL resident engagement papers e.g., Age Friendly engagement insights – SEL Ageing Well Strategy 2025

Resident voice … continued

5

Reduce fears and increase safety
Need for more police, level pavements fewer blocked pavements due to roadworks, fear of electric bikes as a hazard, easier access to public toilets, more disability toilets.

6

Joined up care, coordination and accurate navigation, seamless continuity and effective coordination
Accurate, consistent signposting and need for more connection / **communication between services** and settings. Ensuring seamless continuity of care and through co-ordination.

7

Primary Care
Need to see the same GP for continuity
Telephone and video calls not being as good as face to face.
Difficulties in getting an appointment, especially online triage.
Having to give their same medical history repeatedly, and not all doctors read it before their appointments

8

Housing
Ability to adapt or change housing to meet changing needs as you age

"There should be a database enabling older people to swap homes to get what they want"

"I was falling but told I couldn't join strength and balance classes because I needed to see a cardiologist. 6 months later I'm still waiting"

"I would like to get advice but it's too hard to navigate"

"Virtual GP appointments only work if I have a Carer with me, otherwise I don't feel seen or heard, I prefer face to face"

"I wanted to join the gym but couldn't get past the questions, form filling and documents required at reception"

"I would like to get advice but it's too hard to navigate"

"We're going to hand over our lives, probably to a white person or a South Asian person but there's no trust between us and those communities"

"When I phoned up on the day, the appointments have already gone. I can't tell you the last time I've actually seen my doctor face to face because I can't get an Appointment."

Resident voice … continued

9

Caring role

Access to more flexible, ad hoc support (including respite) instead of an 'all or nothing' arrangement.

Unpaid carers able to get a GP appointment quicker and at a time they need it. Pre-emptive planning for carer crisis – leading to peace of mind and the right action.

Advocacy and earlier respite for carers.

10

Respect and feeling heard

Considering the person's whole life not just seeing a health problem.

Feeling that you must lie and exaggerate to be seen.

Feeling judged and dismissed as a patient or carer.

"Someone to talk to mum about how to live better in her own home – keeping warm, paying bills, buying a hearing aid, checking for risk of financial abuse."

"Contacted NHS for an eye appointment, chased up for weeks without action....admin was not listening, when final action was taken, I was told that I should have come sooner, leaving me feeling that I can't win, when I tried everything in my power to be seen."

"I get exemplary support from my local GP and the Guys and St Thomas' NHS Trust…"

"I felt like I was dismissed and spoken down to as well. They were still offering me what I said I don't need so I thought it was more or less a box ticking exercise."

"There's also the systemic issue of structural racism. I'm very, very aware of it. I know that doctors are under pressure. I believe that the wider system does, either actively, sometimes disadvantage us or through negligence as Black people."

"Work needs to be done to close the wealth gap, as poorer residents have less positive experiences with ageing."

"You can tell the difference between a doctor who tells you what to do and the one that converses with you right? Someone who takes the time to explain things to you, who listens to you, you know, and takes into consideration your views."

"But being aware of the community that you serve. What does that community that you're serving look like? So then be more educated about them… about foods, about culture, about all those things, because you can then better support. Because when somebody is coming to you, you can show that understanding."

Feedback from unpaid carers highlights practical changes that would make a real difference to their quality of life

"Carers' organisations and carers carry no weight, they should be respected, they should mean something"

"No communication between organisations whatsoever – each has its own agenda and won't intervene with the other"

"I can't get my Mum to activities in the community if there is no reliable transport"

"What if the person I care for won't accept help from anyone else? I need an advocate to help free me up from the trap"

"I would have peace of mind as a carer if a plan was in place for what should happen if I am taken ill or go into hospital."

"When carers are coping they should still be allowed some respite; a chance to recharge the batteries. It will mean they can go on caring for longer – it's an investment"

"Staff need time to have proper conversations with carers who often know the answers more than anyone"

"Mum is not considered bad enough to get help, so I do everything! But something more flexible is needed; even if the voluntary sector helped me out half a day a week. But the current approach is more 'all or nothing"

"As a carer it should be easier for me to get a GP appointment. I should be a priority to enable me to keep on caring"

"My mother needs help with paying bills, making appointments, getting groceries online, sorting glasses and hearing aids, online banking, using parking apps, dealing with chatbots and having her questions answered."

An artist attended the sessions that we held with residents to understand what ageing well means to them – and their voices have been captured in a graphic

Four workshop sessions were held with residents and unpaid carers to understand what ageing well means to them and to capture their experience and expectations of services. The workshop sessions were as follows:

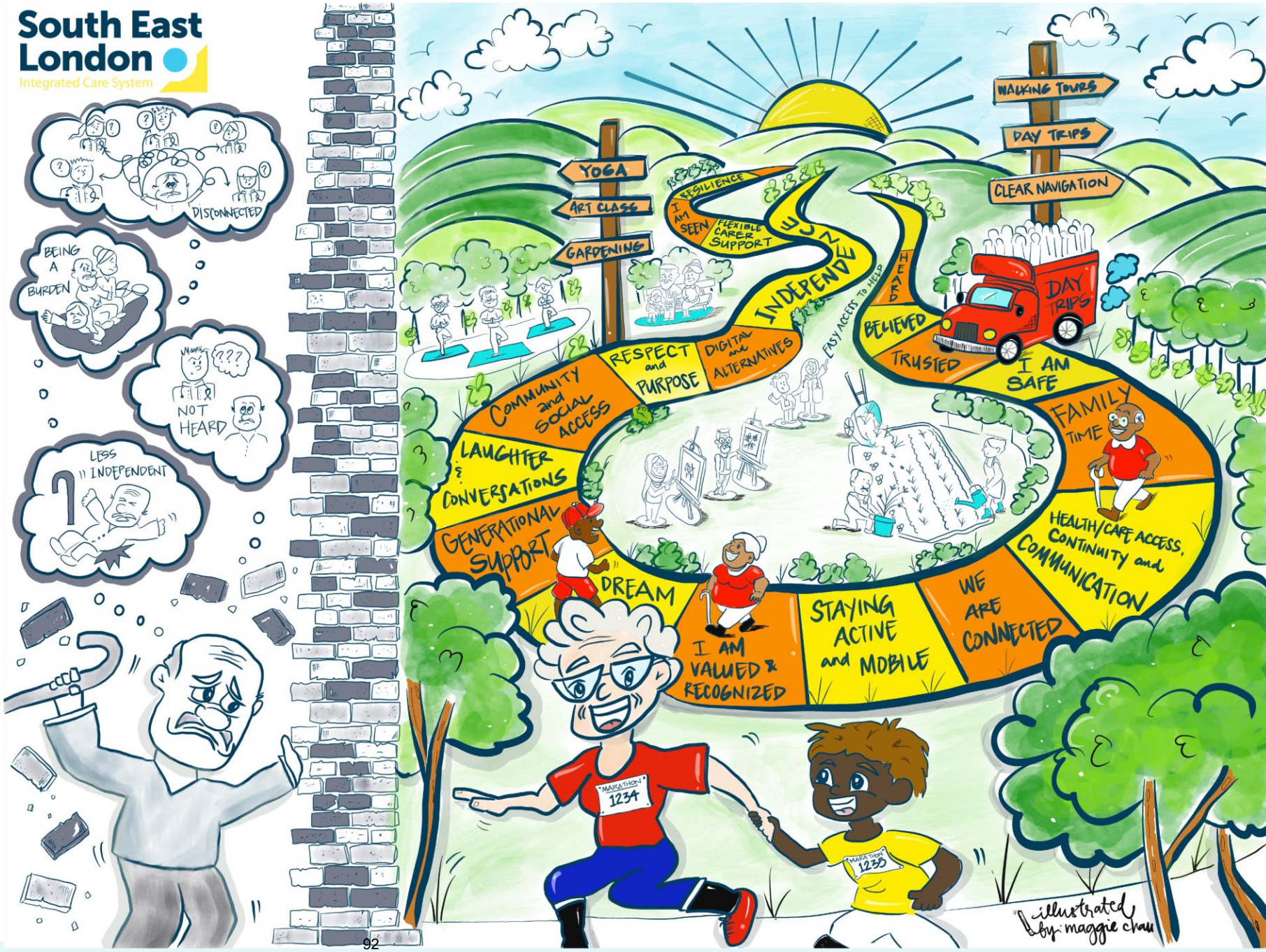
Borough	Resident/Carer organisation	Date of engagement
Southwark	Southwark Carers Cafe	21 February 2025
Southwark/Lambeth	Blackfriars Settlement	11 March 2025
Bromley	Orpington Methodist Church Art Class Group	13 March 2025
Bexley	Bexleyheath Geddes Place Church	10 March 2025

The key themes from the sessions have been woven into the framework to help inform the priorities for delivery. In addition, an artist has produced a graphic depicting the voice of residents and unpaid carers, which can be found on the following slide.

Resident voice

The left-hand side of the graphic captures some of the main challenges residents face when dealing with services.

The right-hand side of the diagram portrays the aspirations, hopes and dreams that residents have including what they like to do and how they would like to feel.



5.
‘Age without limits: You say, your way’
The SEL Ageing Well framework

150+ clinicians and professionals have been engaged and involved in developing the framework, at SEL and local levels - identifying key values and principles that underpin the framework, below

1. Early identification
Understanding who our older and frail population are and identifying them sooner

2. Seamless navigation
Visibility and clarity about what sits where across settings, enabling easier signposting, self-navigation (by problem) and movement between zones and real connection and dialogue between professionals

3. Hyperlocal VCFSE involvement
Stronger connection, Increased visibility, bigger role in healthcare, trust and financial security for VCFSE, especially grass roots offers

4. Improved Accessibility
Removing barriers to accessing amenities and services such as need for form filling, providing documents and overcoming travel, digital and language barriers. Providing alternatives to digital

5. Social Well-being
Fostering environments where people build and sustain lasting friendships and social connections to prevent the loneliness spiral

6. Personalised Care
What it means to the individual e.g., listening, understanding, believing, trusting and respecting. Seeing an active, whole life, not a health problem. Making nuanced decisions based on *'what matters to me'* and accepted shared risk with residents and families.

7. Active & Engaged Living
Focus on exercise, cognitive stimulation, nutrition, hydration, & self-care - enabling purposeful living that creates resilience, connection and independence

8. Positive Ageing
De-stigmatising ageing and promoting positive representations of older people as having a purposeful life to live and a strong contribution to make. Making amenities and services more age and culturally friendly.

9. 'Heating and eating'
Ensuring the basics are supported to set yourself up to age well such as heating, eating, paying bills, getting appointments, using on-line services

10. Equity
Independence and wellbeing of people is of equal importance regardless of setting. Care homes and home care are not separate ecosystems and require an integrated offer that enables equitable access.

11. Wider factors
Addressing the wider things that foster ageing well – e.g., feeling safe on the streets, level pavements, access to shops and public toilets, bus drivers being mindful of older people stepping onto buses

12. Activating self-help
Facilitating communities to help themselves e.g., via peer and expert support groups, volunteering, linking people up with people, allowing people to swap their homes

The Ageing Well framework comprises three inter-connected zones. People move easily in and between zones based on where they are on their journey

The emphasis of the framework is on early proactive prevention but also includes 'what good looks like' for those further along the frailty continuum.

1

Promoting independence and wellbeing- thriving at home

Working in partnership to create local age-friendly, compassionate and responsive communities that encourage and support people to age well, through supporting their health and wellbeing, independence and social participation. Improving the building blocks of ageing well such as safety, access and housing.

2

Proactive community care via integrated neighbourhood teams

Early identification of frailty and rising risk, working with people, their carers and networks to provide well-coordinated, community-based care that maintains resilience, delays and responds to exacerbation.

3

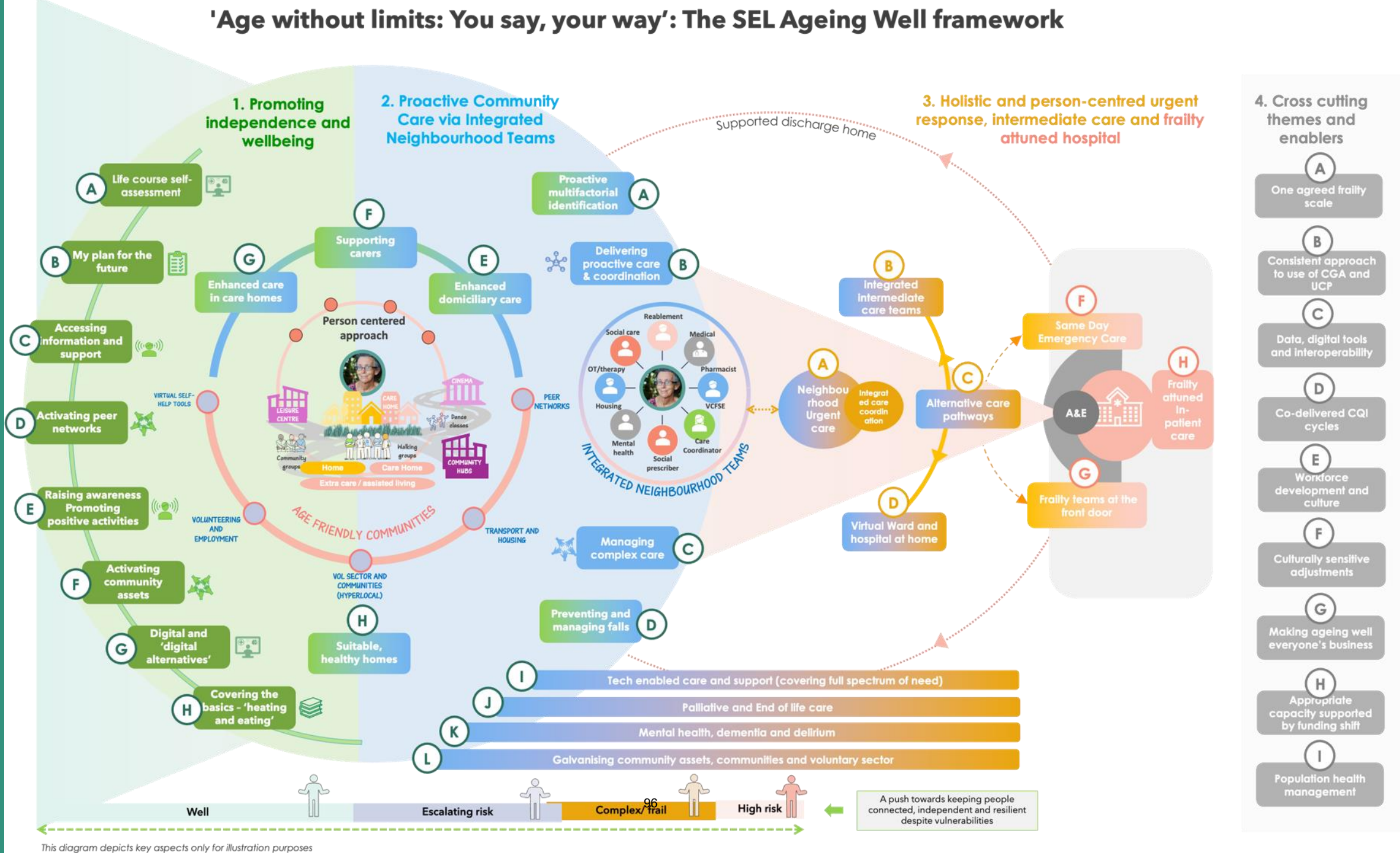
Holistic and person-centred urgent response, intermediate care and frailty attuned hospital

95

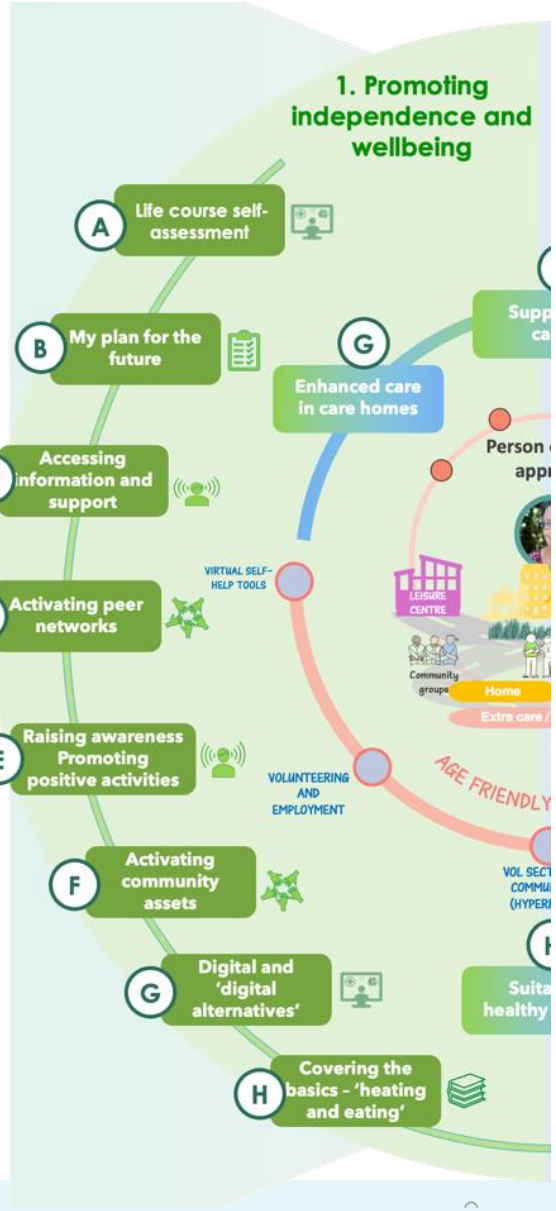
Working closely with zones 2 and 4 to provide holistic and person-centred urgent / timely step-up and step-down community care that helps to avoid unnecessary hospital attendance, admission or readmission and enables timely discharge.

Front door frailty team focused on identification of frailty and same day delivery of coordinated care so that people can be discharged back into the community or undertake a short stay in a frailty unit, avoiding admission where possible. Frailty-attuned hospital care and hospital discharge for those who are admitted.

The SEL Ageing Well Framework



Zone 1: Promoting independence and wellbeing - thriving at home

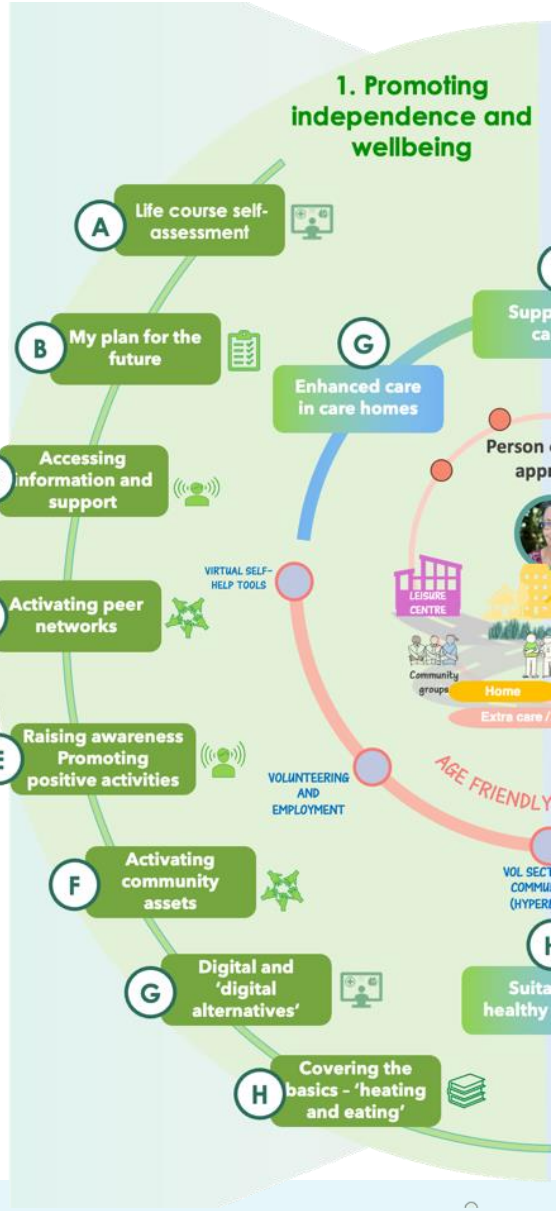


Zone 1: Working in partnership to create local age-friendly, compassionate and responsive communities that encourage and support people to age well, through supporting their health and wellbeing, independence and social participation. Improving the building blocks of ageing well such as safety, access and housing.

This zone comprises of the following elements:

- Life course self-assessment, empowering people to self-identify goals and take holistic actions based on 'ageing well milestones' This feeds into 'My Plan for the Future' OR "Planning ahead for what matters to me?"
- 'My Plan for the Future', a self-led holistic tool and plan reflecting personal goals and informed by the ageing well milestones including actions I will take to maintain my health and wellbeing, e.g. adopting a healthy lifestyle and preparing for the future. Includes support and resources I will access, e.g. a community exercise programme or other support through voluntary, community, faith and social enterprise (VCFSE) such as managing money. Plan includes end of life. Can be generated digitally and produced with support from a community champion.
- An easily accessible one stop shop ('access hub') that provides and signposts people to information and knowledge about ageing well and helps them to access local services, support and VCFSE sector offers. Could be virtual/digital or walk-in, providing an alternative for those unable to access digital offers.
- Building and delivering local community peer support groups and networks that for example, provide opportunities for older people to contribute, share and learn new skills leading to improved social connections and reduced isolation, and that contribute to building age friendly environments. Inter-generational working e.g. bringing students into care homes/older people into schools and utilising industry e.g. professionals being role models or peer mentors to others.

Zone 1: Promoting independence and wellbeing - thriving at home



Zone 1: Working in partnership to create local age-friendly, compassionate and responsive communities that encourage and support people to age well, through supporting their health and wellbeing, independence and social participation. Improving the building blocks of ageing well such as safety, access and housing.

- Raising awareness of the factors that prevent, slow, and reverse frailty and enable ageing well such as exercise, hydration and nutrition (insights from blue zones). Raising awareness of, normalising and breaking down taboos associated with ageing and dying. Promoting a positive approach and positive representations of older people. Delivery of the above via hyperlocal social media/marketing, NHS App, smartphones as well as other non-digital media
- Incentivising and activating community assets to provide easy, affordable or free (off-peak) access to local activities, events and facilities (including gyms, cinema, yoga classes, leisure centres, education courses). Asset based community development in which communities do it for themselves. Systems taking an active role in local leadership to influence community developments according to local need.
- Improving the accessibility, knowledge and use of digital tools by residents. Supporting access equity where digital access is not achievable for individuals.
- Ensuring that the basic, minimum things are more easily accessible and in place to support wellbeing, prevent illness and assist recovery from illness such as a secure home, heating, cleaning, having access to food and that food is being eaten
- Addressing other wider factors that support independence such as ensuring decent housing, well-lit streets, level pavements and easy to read signage.

Zone 1: Promoting independence and wellbeing - thriving at home

A. Life course self-assessment	• The aim is to focus on prevention by doing the right thing at the right time. This can be enabled through supporting people to self-identify suitable goals and actions based on 'ageing well milestones'. The milestones create a shift in perception, empower people and strengthen understanding of actions that should be taken to 'age well'. This may include information such as "at age 75 focus on this type of exercise, diet and lifestyle to keep your bones healthy and reduce risk of falls". • Milestones will also flag national screening programmes such as the bowel cancer screening kit offered every 2 years for 50–74-year-olds and highlight local resources, e.g. how to access community exercise programmes. It can include continence care information for those over 50. • Milestones can also help educate younger people (e.g., men in their 40s and 50s to take earlier action to prevent issues as they age. • The milestones provide a guide to the production of 'my plan for the future'. This should not be a one-off assessment and can form part of the person's universal care plan (UCP).
B. My plan for the future	• A personalised plan, which is self-generated or co-produced with a 'wellness coach' or similar, that captures the person's self-identified goals and actions **they** will take to maintain wellbeing and stay healthy. • The life course self-assessment (above) will help inform and feed into the plan. • The plan will also encourage people to think through what matters most to them, and plan what they want to happen in future, for example if they become unwell – and prompt earlier action, e.g. around producing a lasting power of attorney (LPA) or deciding arrangements for care they may need, including what to do should a crisis be looming or occur, and preferences or arrangements for end of life. • Approach to recognise that changes with ageing can be stressful (e.g. retirement) and therefore be done with empathy.

Zone 1: Promoting independence and wellbeing - thriving at home

C. Accessing local information and support	• An easily accessible (to residents, carers and staff) one stop shop ('access hub') that provides and proactively signposts people to information and knowledge about holistic ageing well and helps them to understand and access local services, support and VCFSE offers. • Could be virtual/digital or walk-in, providing an alternative for those unable to access digital offers. The hub can be co-located with existing community services at Place, with a focus on local health promotion. Hub may also be able to aid professionals with navigation of local resources to support residents. • Public health involvement to promote prevention, working in partnership with residents and resident-facing professionals. • Sharing of information on different partner initiatives, across partners e.g. visibility between health and social care about ambitions, innovations and developments (e.g. falls prevention). A resource that enables staff to understand what is provided in the community and how it helps to get home from hospital earlier with better support or avoid unnecessarily going into hospital. • Sharing self-help information about falls, continence care, mental health and education around diet, hydration and exercise will have a significant impact on quality of life for residents. Practical advice e.g. how to get a hearing check, manage gas and electric, pay bills, get an optician appointment. • Information is sensitive to cultural and generational challenges. • Information be provided to the 'access hub' through people e.g. champions and networks. • Include simplifying existing websites, making them more accessible.

Zone 1: Promoting independence and wellbeing - thriving at home

D. Activating peer networks and intergenerational relationships	• Building local community peer support groups, improving social connections and reducing isolation (therefore improving mental health and reducing depression and anxiety) within the local community. • Utilisation of community champions and creating community networks which are of high value, providing support and resilience. • Creating intergenerational connections to reduce societal ageism barriers e.g. older people mentoring in schools, students volunteering via local VCSFE organisations. • Interventions and activities should be personally relevant (e.g. acceptable in different cultures).
E. Raising awareness and promoting positive activities	• Raising awareness, changing perceptions and activating people to prevent frailty as well as identifying signs of frailty at the earliest opportunity, hence implementing actions to reduce progression. • Early discussions and awareness of palliative care/death literacy. Promoting episodic symptoms support e.g. palliative care. • Raising awareness of the factors that prevent, slow, and reverse frailty (insights from blue zones). • Putting out key messages such as ‘come to us early to prevent illness’ or ‘do this for yourself to take charge of your health’ – or messaging to activate neighbours to look out for older people in their neighbourhood. • Delivery of the above via hyperlocal social media/marketing, NHS App, smartphones and other non-digital alternative media. • Changing the images and photos we use to portray older people, to more positive, breaking down stereotypes.

Zone 1: Promoting independence and wellbeing - thriving at home

F. Activating community assets

- Setting up and running social and exercise classes, including strength and balance training, tai chi, yoga, pilates, walking, circuit training, dance, spin, cheerleading, choir and swimming.
- Easy, affordable/free access to local activities such as leisure centres/cinema/ gyms to improve connections.
- Musical and dance activities from their era, keeping sighted different older people will have grown up in different years and cultures.
- 'Expert patients' teaching e.g. exercise groups, how to use gym equipment or other new skills such as DIY, gardening co-ops (e.g. building gardens in care homes or GP surgeries), men in sheds to maximise peer-peer influence and mentorship.
- Expert patients may also encompass specific co-morbidity and mental health peer support and identifying champions in key areas e.g. falls, hydration, continence, loneliness, hearing loss, etc. As well as death and technology literacy.
- Activating people to contribute to their communities by recognising their contributions and maximising volunteering opportunities and skills.
- Providing recognition, accreditation and awards for both those who lead and those who participate in exercise groups. e.g. NHS 'couch to 5k'.
- Local and community gyms and swimming pools promoting classes
- Corporate social responsibility: connecting with local corporate companies who can support people to age well e.g. local theatre, professionals providing peer mentorship, tapping into philanthropic opportunities.
- Having accessible transport links (volunteering opportunities around this).
- Community assets need to be dementia-friendly and mental health trained
- Consider adopting interventions such the 'paperweight armband'- an easy tool to help identify older people who are at risk of malnutrition, developed by Age UK Salford. Since the introduction of the paperweight armband, Age UK Salford has reported a reduction in hospital admissions, a 50% increase in reporting of underweight BMI in primary care after 1 year and a more appropriate prescribing of oral nutritional supplements).

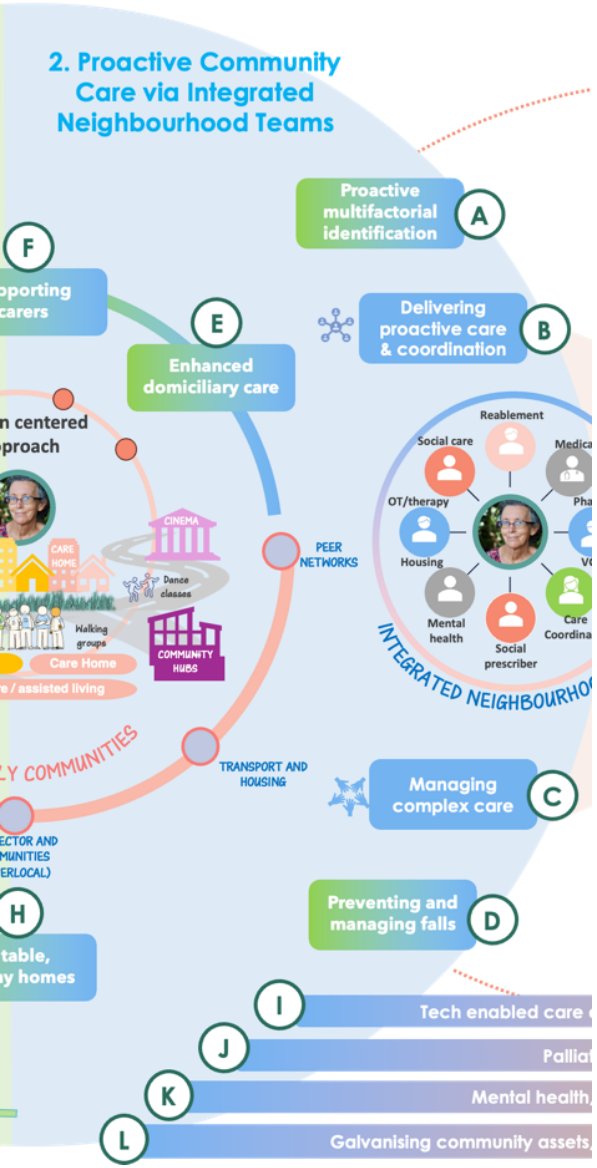
Zone 1: Promoting independence and wellbeing - thriving at home

G. Tapping into the digital world	• Improving accessibility, knowledge and use of digital tools by residents within the local community. This may be achieved through implementing digital 'drop-in' sessions within local libraries or community centres for instance, or that may be supported by local university student volunteers/peer mentors. • Supported by key FAQ leaflets. • Age friendly support available within libraries. • Providing alternatives to digital (e.g. appointment cards, paper diaries) for people with dementia/others who would benefit e.g. dementia, digital poverty, language barriers / others.
H. Covering the basics – 'heating and eating'	• Ensuring that the basic, minimum things are more easily accessible and in place to support wellbeing, prevent illness and assist recovery from illness • Examples include a secure home with working locks, minimising drafts, heating, cleaning, having access to suitable food and checking that suitable food is being eaten and managing money. • Whilst services exist that focus on these 'basics' for people with an identified need, the numbers of people living without them are significant and it is incumbent on all to be alert, identify gaps and problems and help address them, which may include being proactive and notifying VCFSE organisations that can support. • Consider an 'older person's' review in their home, "I want... I need.... I can... I can't..." • Consider what population health management (PHM) data we need and what we want to capture to address the 'basics.'

Zone 1: Promoting independence and wellbeing - thriving at home

Wider determinants	• Identifying changes that are required within the wider infrastructure to create an age friendly community (in reference to WHO age-friendly cities framework). • Addressing issues such as pavements, street lighting, access to clean and usable public toilets, access to outdoor seating, support with employment and better transport links. • Uptake of benefits, managing rising cost of living, financial advice and employment support. • Recognising and meeting people's spiritual beliefs, personal values and needs. • Ageing well cafes and death cafes. • Where people are in receipt of extra care, ensuring this is integrated with the wider social/community offer so it supports people to get out and join in rather than become isolated at home.

Zone 2: Proactive community care via integrated neighbourhood teams



Zone 2: Early identification of frailty and working with people, their carers and networks to provide well-coordinated, community-based care that maintains resilience, delays and responds to exacerbation.

Proactive community care focuses on delivering an integrated and coordinated primary and community care-based offer, which is holistic and personalised for people with frailty and/or at rising risk, enabling a good quality of life. Through understanding *who and what matters*, it prioritises what is important to the individual. Key components include:

- Proactive multifactorial identification of people living with frailty and/or at rising risk via consistent means
- A dedicated care team of multi-agency professionals formed within the neighbourhood, including specialists who provide a personalised and holistic approach, with multi-disciplinary team (MDT) interventions and support which includes facilitation of interventions beyond only health and social care.
- Robust, flexible support for unpaid carers, ensuring a carer's assessment is completed, regular reviews occur and signposting to appropriate resources takes place.
- Increased focus on hydration, nutrition, eyesight, hearing to tackle the modifiable risk factors for frailty and falls.
- Multifactorial assessment of frailty including falls and its prevention and continence promotion amongst others using a comprehensive geriatric assessment (CGA) framework for those with moderate/severe frailty.
- Managing people with frailty and escalating complexity via a named care coordinator i.e., someone to holds the case to enable pulling together and coordination of support.
- Enhanced and more integrated domiciliary care which is flexible, high quality and personalised, via well trained and supported staff.
- Defining elements that will improve the way ageing and frailty are managed in care homes, e.g. ensuring all residents have a CGA and proactive planning ahead including end of life.
- Easier access to responsive advice and guidance, with reduced bureaucracy.
- Developing and integrating the use of telecare and telehealth to enable people to stay at home where possible.
- Structured face to face medication reviews resulting in better patient understanding of medications and shared decision-making based on patient-oriented goals
- Increasing the role of VCFE organisations, including more formal, longer-term funding.

Zone 2: Proactive community care via integrated neighbourhood teams

A. Proactive multi-factorial identification	• Proactive multifactorial identification of frailty and its severity (mild, moderate, severe) with a uniform tool across health and social care, e.g. using the clinical frailty scale (CFS) to enable standardisation and one common language. • Using collective local intelligence (wider proactive community flag) to supplement the data e.g. from GP practices in which all system staff (regardless of host organisation) are trained to **help** identify frailty (with a united system language of what we mean by frailty) and connect with others to enable residents earlier access to CGA and help. Making all system interactions count to enabling holistic whole person approach, whether resident accesses help via their GP, secondary care, community pharmacists, social care, district nursing, carers, VCFSE, learning disabilities services, homeless and refugee services, housing, domiciliary care and pharmacy. All partners working together to deliver as an MDT. • No wrong door to an organisation approach. Move organisational navigation from the user to the access point. • Community information hub or 'access hub' to also report and raise concerns about vulnerable people. • Consider an in-reach team with an ageing well skill set (geriatrician, nurse, AHP), working with GPs, allocating whole day going into e.g., sheltered accommodation, Latino centre to test different 'out of the box' ways of finding and responding to people (see Lambeth approach) • Ensuring people with severe mental illness (SMI) and/or dual diagnosis, are not excluded. • Looking at the value of shared records, collected by all, to create a single, shared frailty register. • Use of data and/or artificial intelligence (AI) to identify people with frailty or at a rising risk.

Zone 2: Proactive community care via integrated neighbourhood teams

B. Delivering proactive care and coordination

- A dedicated care team of multi-agency professionals formed within the neighbourhood, including primary care, allied health professionals (AHPs), including speech and language therapists (SALT), physiotherapists, occupational therapists (OT), substance use, mental health, housing, community nursing and secondary care specialists. Consider establishing a specific frailty neighbourhood team as part of integrated neighbourhood teams (INT) that visits, conducts CGA/tests, plans, delivers and follows up care.
- Frailty neighbourhood team to include CGA & frailty skilled workers working within their scope of practice with support, admiral nurses, social prescriber, pharmacist, council access (social care and housing) as well as geriatrician input feasible to context.
- Focus on individual's holistic needs and preferences, established through 'talking to the person', carers and family on 'what matters to them', enabling nuanced decision-making, as well as and providing a personalised and holistic approach, with MDT interventions.
- Consistent minimum core actions to be carried out at mild/moderate/severe stages of frailty.
- Building a strong social prescribing resource/team who build relationships with individuals.
- Seeing people who are teetering before they reach crisis point and galvanising holistic (not just health) interventions straight away before exacerbation occurs.
- Above arrangements to include making reasonable adjustments for people with mental health needs and dementia or other characteristics that mean care or care pathways need nuance to facilitate equity.

Zone 2: Proactive community care via integrated neighbourhood teams

B. Delivering proactive care and coordination .. Cont'd	• Close liaison and optimal use of VCFSE organisations, including hyper local offers. • Definition of a strategy for medicines management and de-prescribing including proactive identification of most vulnerable patients with medication issues, structured face to face medication reviews based on shared decision-making and what matter to the person • Access to pharmacists for a second opinion (including via MDTs with social prescribers for non-drug options), • Clear links to community pharmacy to enable bi-directionally MDT working between primary care, frailty teams and community pharmacist to better identify non-concordance, better access to help, information and health education • Provision of help especially post-discharge (e.g., through the New Medicines Services and Discharge Medicines Service), information and education so that patients better understand their medications – and clear ownership of these elements so professionals know 'who does what'. • Existing examples that incorporate some of these aspects are the integrated clinical pharmacy services – GSTT Integrated Local Service Pharmacy team, Lewisham Integrated Medicines Optimisation Service (LIMOS), Bromley Integrated Medicines Optimisation Service (BIMOS).
C. Managing complex care	• Cohort may include homeless, asylum seekers and prisoners, as well as more obvious groups e.g. severe mental health disorders, care homes. • Manage people with frailty and escalating complexity via complex care coordination. • Bring specialist and acute input into the community MDT e.g. SALT, substance use, secondary care experts. • Strong role for social prescribing and use of VCSFE sector. • Explicit medicines management strategy for complex patients with MDTs including prescribers (e.g., GPs), pharmacists and specialists to make balanced decisions about polypharmacy and de-prescribing for complex patients. Guide by patient-oriented goals, so that complex decisions about stopping/starting medications are supported and made and in a timely way – and complex patients are supported with proactive help and advice to optimise concordance (e.g., via referral to community pharmacy to engage with and support complex patients).

Zone 2: Proactive community care via integrated neighbourhood teams

D. Preventing and managing falls	• Falls management model as part of proactive community care. Timely multifactorial assessment for falls addressing additional factors such as eyesight and hearing, for those that are complex and predisposed to falling. • Preventative measures such as activity, strength and balance exercises are highlighted in Zone 1 (Component F).
E. Supporting carers	• Unpaid carer's assessment completed and reviewed regularly. • Earlier, more flexible and episodic, ad hoc support (including respite) for carers (instead of an 'all or nothing' offer). • Unpaid carers able to get a GP appointment at a time they need it, recognising the importance of their role. • Signposting to appropriate services including financial advice and support groups within the community e.g. carers café. • Pre-emptive planning for carer crisis e.g. contingencies if the carer becomes unwell, leading to peace of mind and the right actions taken. • Carer identity card indicating where to find an 'emergency pack' so that urgent and emergency services know where to find everything in the event of a carer crisis. • Providing training for carers to increase their skill and resilience to managing older people with frailty.

Zone 2: Proactive community care via integrated neighbourhood teams

F. Enhanced domiciliary care

- For stable people at home, care which is flexible, high quality and focused on how to support people to achieve their full potential supported by a personalised care plan that is regularly reviewed.
- Redesign recognising the holistic opportunity to keep people at home for longer, prevent escalation and delay admission to a care home. Redesign aligned to the CQC framework.
- Moving from a 'task and time' approach to outcomes; optimising the person, increasing self-sufficiency and encouraging/supporting social engagement and participation.
- Establishing stronger partnership working between domiciliary care providers, informal carers and the health and care system so that issues are identified and acted upon earlier.
- Domiciliary care staff upskilled and supported in proactively identifying signs of deterioration early on and able to make direct referral to the resident's nominated coordinator and be involved in MDT meetings. Uniformity in training needs across the borough, to reduce the variation in care delivered by domiciliary care providers including in skills related to frailty to enable earlier escalation of concerns.
- Provision of coaches to support workers through oversight, giving advice, coaching and training e.g. in practical ways to optimise the person, identifying and managing concerns such as frailty, delirium and behavioural and psychological symptoms of dementia (BPSD).
- Training can be also attended by other formal/informal carers to create local support networks within communities to become the 'eyes and ears' of domiciliary care.
- Option for people to select their preferred wellbeing worker using summary info about their profile (experience, style of working).
- Health visitor role coordinated with domiciliary care to provide enhanced support.
- Ensuring clear expectations are set between wellbeing worker and client at outset e.g. 'I will use my mobile phone as part of my job whilst I am with you'.
- Paying workers the London living wage.

Zone 2: Proactive community care via integrated neighbourhood teams

G. Enhanced care in care homes (including sheltered supported housing and extra care housing)

- Care homes are not a separate ecosystem and residents are to receive equivalent care and support as those in other settings, recognising they are of equal importance and that the model may need nuance to enable equity of access. For example, ensure use of the life course self-assessment in care homes (see Zone 1), and use of CGA, UCP and ACP.
- Care home settings are often poorly understood by health teams. There is a need to shift to a positive approach, listening and championing care home staff and asking them what they most need. Consider a care home champion post per Place.
- Training and support to maintain competency are key, so that care home staff feel confident (recognising they sometimes do tasks infrequently so get out of practise e.g. using a syringe driver). Healthcare should play an active role in supporting health-related training, e.g. in falls prevention, wound care etc.
- Provision of training around early recognition of deterioration with supportive tools (e.g. RESTORE2) and 4AT (screening tool used to assess delirium and cognitive impairment).
- Consider establishing a care home support team (CHS) and/or primary care, to provide a transparent, uniform offer into care homes, supporting e.g. bedside training, clinical supervision (around topics such as falls prevention/management, tissue viability, polypharmacy reduction, nutrition and hydration) to build trust and dissipate fear (see Penninsula Practice, Greenwich as an example). This support to be provided to care home health care assistants (HCAs), not just registered staff.
- Consider a specific care home mental health/dementia team as part of the above provision, to provide training and support to e.g. mental health, dementia, delirium and BPSD.
- Consider a geriatrician in-reach model reaching into care homes to support MDTs, training and to visit specific residents to prevent admission (Whipps Cross Hospital model).

Zone 2: Proactive community care via integrated neighbourhood teams

G. Enhanced care in care homes (including sheltered supported housing and extra care housing) Cont'd	• Regular feedback to relatives regarding the resident's progress and proactively addressing any relative's concerns. • Care homes direct referral pathway to same day emergency care (SDEC). London Ambulance Service (LAS) transfer to SDEC, SDEC provide treatment and LAS return to care home). • Specifically ensure an Alzheimer's support worker supports transitions into care homes to settle the person and resolve issues. • Include care homes within a telecare and telehealth strategy, e.g. providing the opportunity for wearables to be utilised where this shows evidence-base to support its utility. • Involvement of activity coordinators within care homes to keep residents engaged with social activities and group activities and to promote self-help and independence and include accessing the community where possible. • Include a spell in care homes as part of student training, e.g. to enable deeper understanding of frailty. • Align with the national framework for enhanced health in care homes (EHCH).
H. Suitable homes	• Develop processes to swap social homes with others to get a home that meets changing needs and preferences as you grow older (e.g. moving from a high rise flat to a ground floor flat with a balcony if you develop knee problems and have a dream of having a place to sit outside). • Prioritising housing adaptations and changes for people with specific needs via making a link between health, social and housing services - working together to respond to people's changing needs in a coordinated way. • Influencing the design of new build housing and estate infrastructure so that it is suitable for older people's future needs.

Zone 2: Proactive community care via integrated neighbourhood teams

I. Technology enabled care and support (TECS)	• Consider development of an integrated telecare and telehealth strategy and approach that optimises the ability to keep people living with frailty safe and independent at home (aligned to virtual ward offer). • As part of strategy scan the market to identify new products to innovate the offer, move from analogue to digital and upgrade the user experience. • Examples of TECS include community alarms and detectors, door alarms, home activity detectors (e.g. falls), TECS supporting daily activities of living such as picture clocks with visual, audible clues, and wearables (e.g. blood pressure monitors), low tech items like walking sticks also included. • Consider same day TECS delivery to expedite timely discharge of people with frailty from hospital. • Consider VCSFE ability to directly source smaller items themselves to increase speed of response and source at cheaper prices. • Monitor clinical and cost effectiveness outcomes, satisfaction levels and benefits gained as part of rigorous evaluation process.

Zone 2: Proactive community care via integrated neighbourhood teams

J. Palliative and end of life care (PEoLC)

- The narrative should be focussed on what is right for the individual and include shared decision making, not on what is best for the system.
- Recognising 'ordinary dying' – palliative and end of life care should be everyone's business, not just that is the palliative care specialists.
- Build PEoLC skills within the neighbourhood teams to reduce over-dependence on specialists. Recognise the need for a personal navigator role at the end of life.
- Recognising that domiciliary care and district nursing play a vital role at the end of life, alongside GPs and community services.
- Social care plays a huge role in the holistic care for a person – palliative care is not just about medical care needs.
- Palliative care does not just happen at the end of life – it can be episodic and last a number of years.
- Creating a culture where people are more comfortable to talk about death and see it as part of the continuum of care, 'planning for the end'.
- Recognising that advanced care planning (ACP) is not a one-off conversation, rather should be ongoing and it is not the responsibility of a single role – it is everyone's responsibility.
- Embedding early advanced care planning as a standard, before a crisis happens, 'planning for the future is key', particularly for people living with dementia.
- Having difficult conversations regarding PEoLC earlier to enable care, and death, to happen in the person's place of preference, with family members/friends present.
- Outcome measures should be focussed on quality of advance care planning rather than preferred place of death, as well as learnings from national audit of care at the end of life (NACEL), and the emphasis on staff and bereaved carer feedback.
- Timely support to carers is key and gaps in bereavement services need to be filled and offers made more transparent (e.g., in a brochure). (Greenwich public health team undertaking pilot bereavement project).

Zone 2: Proactive community care via integrated neighbourhood teams

K. Mental health, dementia and delirium	• Please see the next slide that summarises some of the important elements across all zones regarding Mental Health/Dementia & delirium within the framework.
L. Galvanising community assets, communities and voluntary sector	• A key feature of the framework involves increasing partnership working between voluntary, community, faith and social enterprise (VCFSE) sector organisations and the wider system to improve health and care outcomes • Specifically, there is an opportunity to increase the role of voluntary sector organisations who often know residents better than other agencies, are more skilled in supporting their needs and can do so more effectively and efficiently than statutory services • To do this best, voluntary sector organisations need to be 'around the table' from the kick-off, involved in designing solutions and services and require more formalised roles supported by secure, longer-term funding. They also need to be part of the ongoing review and refinement of services • Places are at different points in this journey; effective starting points include helping to build a local collaborative of organisations supported by some practical governance (such as collaborative meeting points, clear leadership, etc.). Identifying a specific aim in terms of shifting budgets to the voluntary sector is also recommended • It is also important to ensure strong participation from hyper-local organisations, helping to build real local knowledge, goodwill and cooperation with residents and resident groups at neighbourhood level • The extent to which the above represents a change in culture and way of thinking is not to be underestimated, so continual challenge to change the status quo is to be encouraged.

Mental Health/Dementia & delirium within the framework

ZONE 1	ZONE 2	ZONE 3
• Knowing exactly who our population with mental health problems and dementia are • Equally promoting independence and wellbeing for people living with mental health problems and dementia ensuring parity of provision for these groups and reducing stigma. • Early identification: spotting and responding proactively to early signs of deterioration. • Supporting people to engage with their health, e.g. to address excessive drinking and resultant low mood. • Early support and advocacy to good decision-making about what to do e.g. post diagnosis • Supporting people to build resilience post-diagnosis • Understanding and acting upon carer risk	• Clear support post-diagnosis (instead of being sent all over the place) • Dementia care home team providing advice, training and coaching to staff e.g. managing BPSD, monitoring hydration, etc. • Upskill domiciliary care workers to reduce avoidable escalation and admission with earlier detection and action to deterioration and delirium. • Strong connections with social care link workers • Pre-planned crisis escalation support (including e.g. giving carers urine pots so testing can be expedited quicker). • Carers as full partners in decision making and effective carer support and respite • Managing behavioural issues associated with dementia (across zones). Understanding people's unmet needs and what they are trying to communicate via their behaviours to keep people in the least intensive setting. • Access to substance use specialists e.g. to take part in MDT discussions • Making reasonable adjustments e.g. providing paper appointment cards, using paper diaries (instead of automation).	• Timely step-up/step-down to intermediate care • Provision of specialist input e.g. speech, language, nutrition. • Integrated, wrap around offer (housing, homecare, domiciliary care). • Speedy return to normal place of residence • Skilled management of emergency presentations to avoid admission. • Timely identification and assessment of dementia/delirium in hospital (4AT). • Strong focus on nutrition, hydration and constipation checks at all stages of the journey. • Minimal ward moves and improving the patient experience • Nuanced decision-making based on what and who matters to the person. • Optimising the discharge process for people with mental health problems and dementia, so they experience parity. • Being more empathetic and proactive when appointments are missed, e.g. following up, taking time to explain and re-setting appointments. • Consider Admiral nurse as part of team to provide support to and help to navigate/coordinate and signpost care for people living with dementia (including support to carers).

Skills and knowledge to respond to mental health issues, dementia and delirium and the interplay between them.
Cohesion and effective communication between teams.
Data and digital interoperability.
Dementia-attuned environments.

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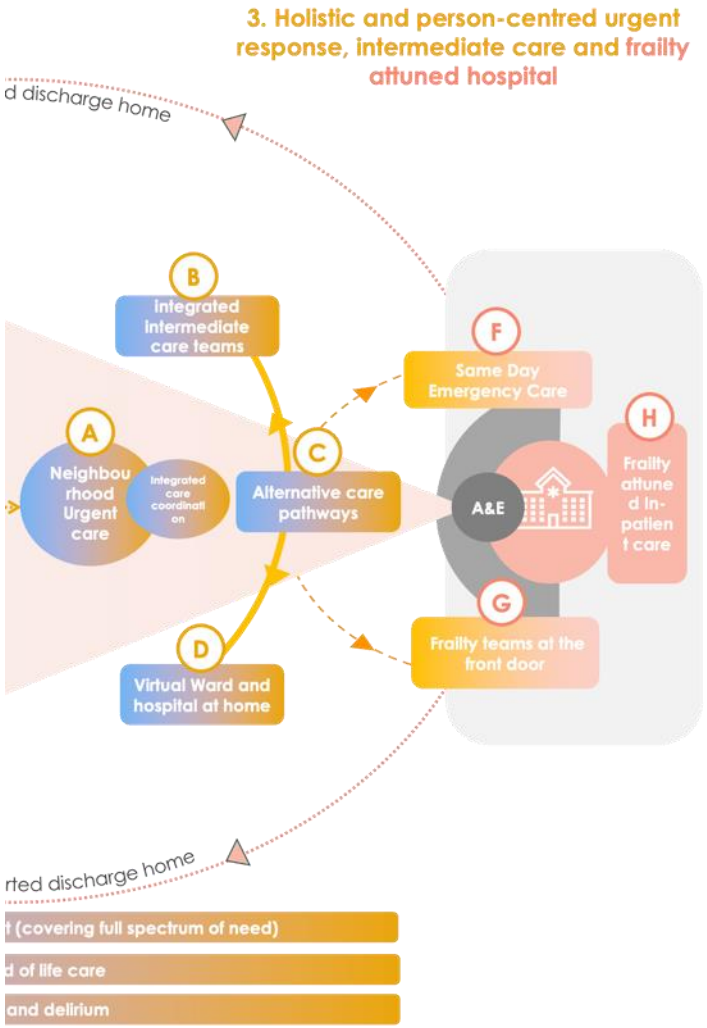
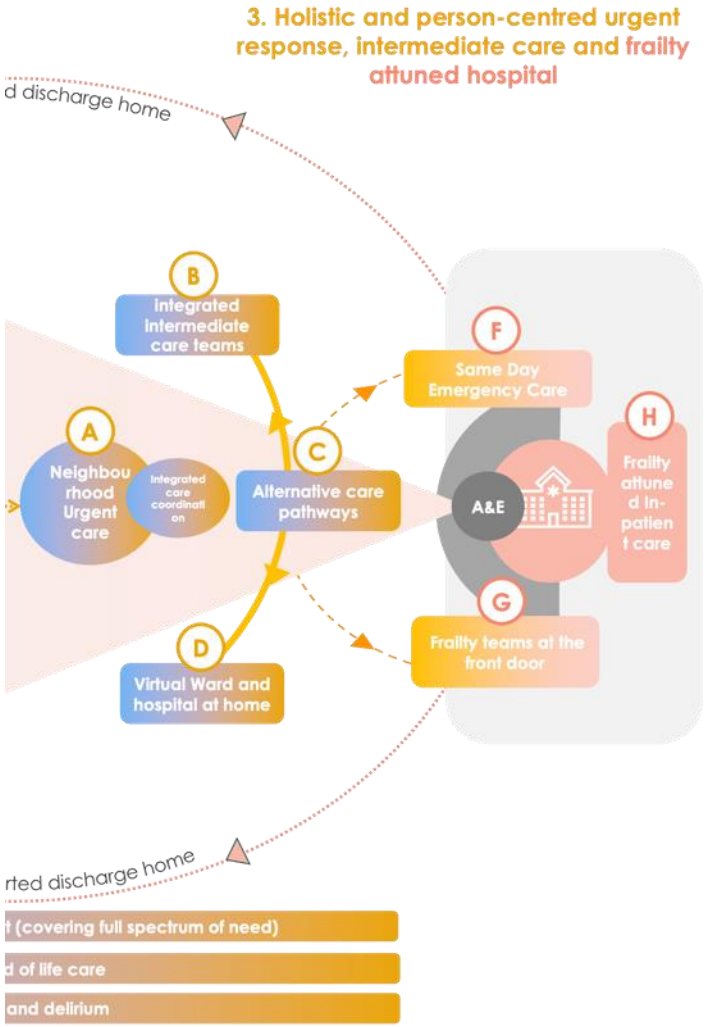
Zone 3: Holistic and person-centred urgent response, intermediate care and frailty attuned hospital



Zone 3 - working closely with zone 2 to provide:

- Neighbourhood-based urgent community care preventing escalation for those at home
- Integrated care coordination (hub) that provides a single point for remote assessment via MDT resulting in (1) advice, (2) direct booking or referral or (3) case holding – where appropriate.
- Step-up intermediate care and/or hospital@home helping to avoid unnecessary hospital attendance or admission.
- Step-down intermediate care and/or hospital@home for those at the hospital front door or who have been admitted, enabling timely discharge and avoidance of readmission.
- Strong focus on step-up provision to ensure fewer people are unnecessarily admitted to hospital in the first place.
- Simplified and coherent community escalation attuned to the holistic needs of older people and those living with frailty to keep people at home for as long as possible. Neighbourhood-based urgent care encapsulates a range of functionalities including urgent community response (UCR) and is directly connected with neighbourhoods (these are being developed and will be further refined).
- Provision of timely, strengths-based and coordinated intermediate care (recovery, reablement and rehabilitation) based on people's goals and focused on wellbeing and independence, for those who need a continued period of managed care in the community or following presentation at or admittance to hospital.

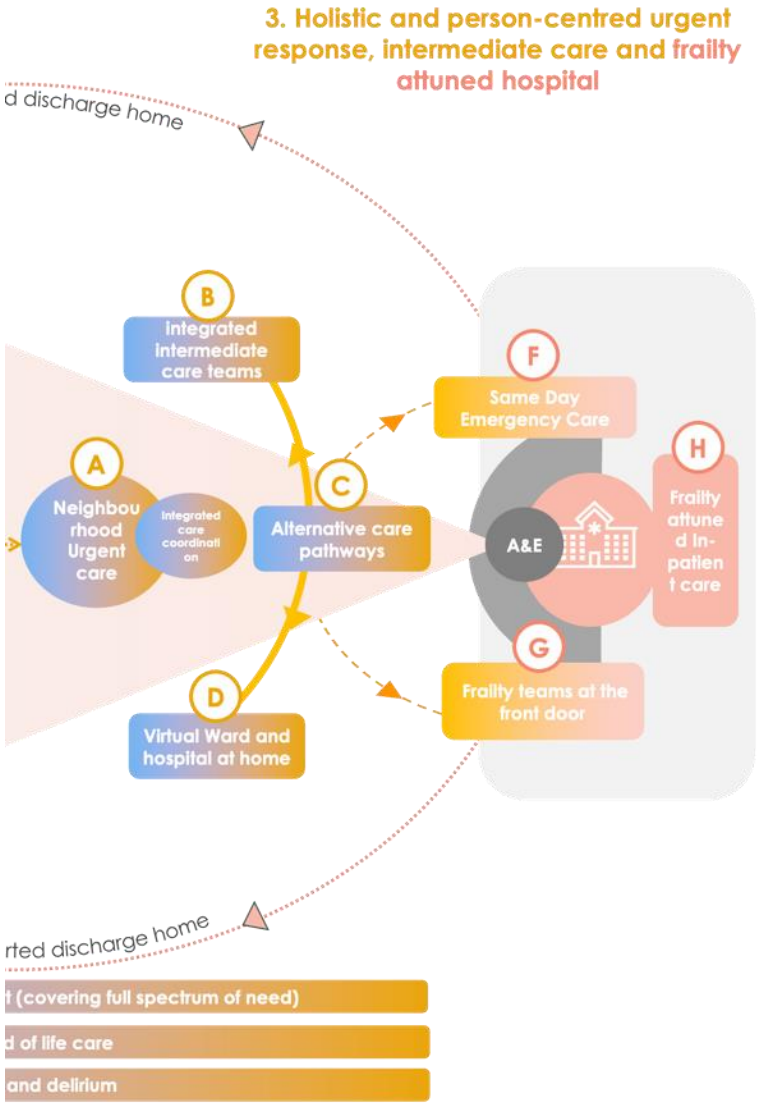
Zone 3: Holistic and person-centred urgent response, intermediate care and frailty attuned hospital



Zone 3 - working closely with zone 2 to provide:

- Intermediate care needs identified in the community or hospital front door escalated into a single point of access for advice or acceptance for rapid therapeutic transfer of care, including real time review of any existing package of care in place.
- Timely delivery of intermediate care and support without delay that would otherwise lead to deterioration at home or deconditioning in hospital, e.g. therapy starts immediately post discharge to avoid person becoming bed bound and to optimise independent living.
- Includes advice and support to help people manage life events such as bereavement, organising care requirements and planning lasting power of attorney.
- Ability to make direct referral to a virtual ward to prevent admission or expedite earlier discharge from hospital.
- Inclusive of direct access to medical support (including via advice and guidance) and a solid out of hours provision.
- The ability to align mental health resources to the more urgent mental health and dementia cases to ensure parity of care for people with mental health problems and dementia. For example, admiral nurse involvement to expedite swifter hospital discharge and provision of a short period of specialised support at home to enable earlier discharge for people with delirium.

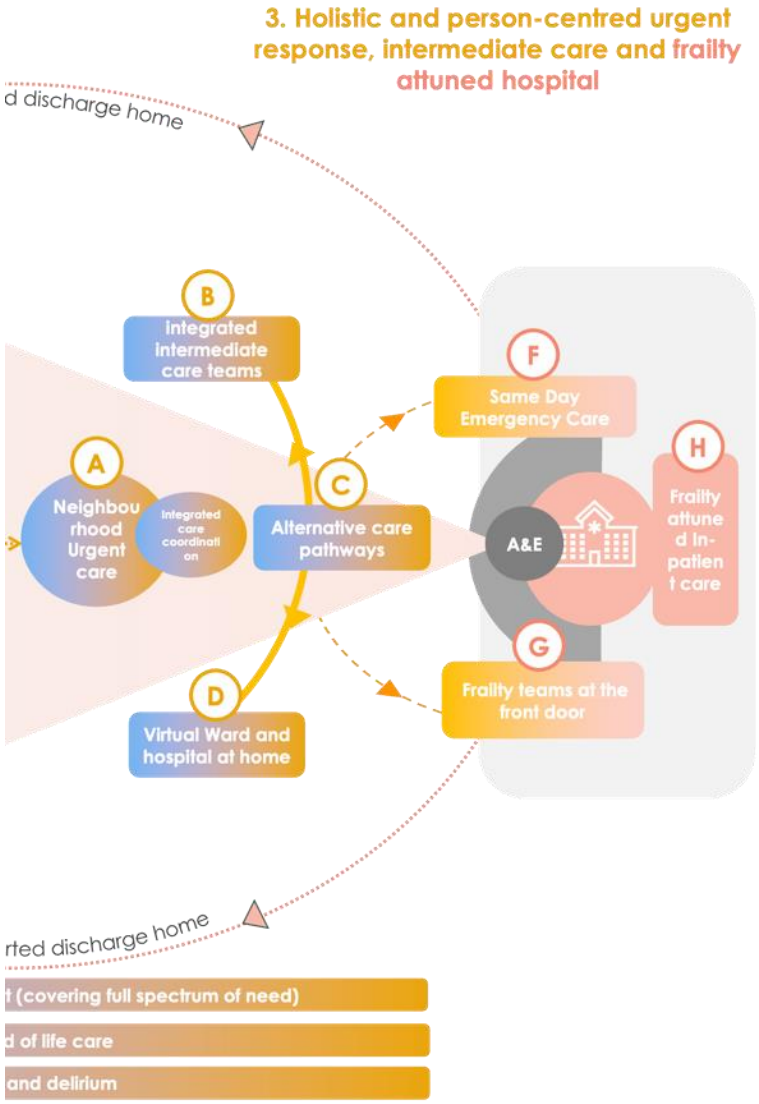
Zone 3: Holistic and person-centred urgent community response, reablement and rehabilitation and frailty attuned hospital



Front door frailty team focused on identification of frailty and same day delivery of coordinated care so that people can be discharged back into the community or undertake a short stay in a frailty unit, avoiding admission where possible. Frailty-attuned hospital care and timely hospital discharge for those who are admitted. Flexible boundaries and closer working between acute teams and integrated neighbourhood teams.

- Frailty team at the front door to proactively identify frail people, carry out holistic assessment and care planning and where possible transfer directly back to community-based care before the person becomes ‘medicalised’.
- Establishing realistic independence and activities of daily living (ADL) baseline and making nuanced decisions based on this and 'what and who matters to the person'.
- SDEC - assessment and care by specialist clinicians on the day of arrival to hospital as an alternative to admission, ensuring those that would not benefit from hospital admission are discharged back into the community.
- Acute frailty unit - a multidisciplinary assessment unit, to address the urgent medical needs for those that are frail and require a short stay (less than 3 days) in hospital.
- Fracture liaison service - identification of people who have suffered a fragility fracture, providing a bone health assessment to identify future falls risks and to reduce the risk of future fractures.
- An inpatient older people’s ward for those who require a longer inpatient stay due to medical reasons – including a focus on reablement, mobility, exercise and cognitive stimulation to reduce deconditioning during their stay.

Zone 3: Holistic and person-centred urgent community response, reablement and rehabilitation and **frailty attuned hospital**



Front door frailty team focused on identification of frailty and same day delivery of coordinated care so that people can be discharged back into the community or undertake a short stay in a frailty unit, avoiding admission where possible. Frailty-attuned hospital care and timely hospital discharge for those who are admitted. Flexible boundaries and closer working between acute teams and integrated neighbourhood teams (cont'd)

- Transfer of care hub providing coordinated discharge back to the community, including taking actions from day of admission (as part of discharge planning) to expedite timely discharge without delay.
- Frailty and dementia/delirium skilled and attuned staff in all key hospital roles, so that for example, decision-making about care is more nuanced and driven by *what and who matters* to the person.
- Defined standards for frailty-attuned care for people in other settings such as surgery, oncology and other non-geriatrician led inpatient services.
- Consider use of summary acute medicine indicator table (SAMIT 75+) offering national comparative data for frailty at site level. Metrics cover demand, flow and outcome for both the admission and recovery phases of frailty care.

Zone 3: Holistic and person-centred urgent community response, reablement and rehabilitation and **frailty attuned hospital**

A. Neighbourhood urgent care with integrated care coordination

- Neighbourhood-based urgent care encapsulates a range of functionalities including urgent community response (UCR) and is directly connected with neighbourhoods (these are being developed and will be further refined).
- Integrated care coordination (hub) that provides a single point for remote assessment via MDT resulting in (1) advice, (2) direct booking or referral or (3) case holding – where appropriate.
- Seamless flow and pathways between services and in-reach into neighbourhoods as a shared resource.
- Core MDT: An MDT approach consisting of paramedics, nurses, OT, dietician, social care professionals, advanced care practitioners and managers.
- Connected teams: Direct interface with health and social care provision such as GP, 111, pharmacy, INT, Virtual ward, LA front door, Housing,
- System collaboration: Access to other professionals including UEC, GP, hospital, mental health, housing, urgent response mental health placement etc
- System integration/technology: ensuring visibility of patients, access to shared records, data transfer between MDT and use of tele-monitoring/tele-care
- Care navigator/ co-ordinator with clear ownership of cases. Strong key relationships and conversations-with clear communication lines
- Holistic approach with focus on prevention, e.g. ensuring that lower-level or emerging social needs are not missed

Zone 3: Holistic and person-centred urgent community response, reablement and rehabilitation and **frailty attuned hospital**

B. Integrated intermediate care teams	• MDT working to deliver a timely step-up and step-down service focused on recovery, wellbeing and independence • MDT comprising of medical, therapy, mental health, nursing, VCSFE, pharmacy, reablement, night carers, handyman service. • Access to extended MDT and/or advice including housing, geriatricians, cardiologists, etc. • Coordinated, proactive support, putting everything in place, working closely with a carer or family where present • Real time review and adjustment of support and ability to increase or decrease care to optimise outcomes • Access to existing CGA or ability to carry out a CGA, aligned to an urgent care plan • Specific liaison role with care homes to ensure proportional access and utilisation of service by care homes • Utilisation of service by specialist palliative care, hospice and end of life care teams • Timely access to equipment to ensure care and support commence rapidly.
C. Urgent community response and alternative care pathways	• Consistent UCR offer across SEL aligned to national standards and population health. Seamless flow/pathways into/in-between ACP :virtual wards, frailty units, SDEC • Intermediate care needs identified in the community, at the hospital front door or at discharge from hospital are escalated into the single point of access for advice, guidance or referral for a rapid, therapeutic transfer of care, including real time review of existing packages of care • Specifically for frailty, which is delivered at a place level, and may differ operationally between places based on local requirements. • Anyone can access and be signposted, including professionals working in zones 1 and 2, care homes, palliative care, etc. • Timely, direct access to reablement and rehabilitation via one and done process (no hand-offs). • A senior experienced clinician and social care led service, with authority and decision-making capabilities. • Rotation of staff within the system for care alignment and development. • Standardisation and simplification of proforma.

Zone 3: Holistic and person-centred urgent community response, reablement and rehabilitation and frailty attuned hospital

D. Virtual ward and hospital at home	• Direct referral pathway from intermediate care teams, urgent community response teams, front door frailty teams, SDEC, discharge teams and transfer of care hub (TOCH) to virtual ward. • Virtual ward teams specifically skilled in frailty care and falls management.
F. Same day emergency care (SDEC)	• An MDT led frailty SDEC approach (geriatrician, advanced frailty practitioner, case manager, pharmacist). • Conduct investigations and delivery of short-term treatment e.g. iron infusion. • Assessment of acute issues referred from LAS, community teams, outpatients, care and nursing homes and front door frailty team • Direct link to virtual ward.
G. Frailty Teams at the Front Door	• Proactive screening and identification of frailty in ED through seeing all people age 65+ • Automatic CGA for CFS frailty score 6 and above and for those living in care homes. • An MDT approach: geriatrician, advanced frailty practitioner, physician associate, frailty pharmacist, frailty dedicated physiotherapist, social worker, community advanced nurse practitioner (ANP) and mental health representation. • Assessment and planning, including redirecting people back home, referral to community-based care, falls clinic, intermediate care, fast-tracking to the acute frailty unit or admission. • Providing advice to the ED team. • Geriatrician-led frailty advice line for GPs, community health services and ambulance service. • Good links to community teams, virtual ward, equipment services and voluntary sector (e.g. for meals, shopping, etc.).

Zone 3: Holistic and person-centred urgent community response, reablement and rehabilitation and **frailty attuned hospital**

H. Frailty Attuned In-patient Care	• An acute MDT bed base utilised to address urgent medical needs for those that require assessment and/or a short stay (less than 3 days) in hospital. • Utilised by the frailty at front door team. • Direct and easy referral to intermediate (step down) care. • A dedicated environment providing patient-centred care (and continuity) via a frailty and dementia/delirium trained MDT (including a frailty consultant and access to mental health specialist) that focuses on the patient, carer(s) and families. • Routine screening for delirium (4AT). • Timely access to CGA e.g. to identify/avoid people being constipated, dehydrated, becoming delirious, resulting in falls. • Increased VCSFE involvement, expediting early action to support timely discharge such as making home ready for person to go home. • Focus on food and feeding and hydration. • A focus on reablement, mobility, exercise, continence care and cognitive stimulation on the ward to reduce deconditioning and hospital acquired disability (HAD), helping to minimise the need for packages of care once discharged. • Dementia support worker present with time to have the conversations and help plan and put support in place. • Focus on early discharge recognising every day in hospital has detrimental outcomes and leads to loss of independence.

Zone 3: Holistic and person-centred urgent community response, reablement and rehabilitation and **frailty attuned hospital**

Supported Discharge Home

- Frailty attuned, therapeutic transfer of care processes, interfaces, proforma, assessment, out of area arrangements, etc.
- Link to discharge coordination.
- Direct interface with specialist older people's ward, care and nursing homes and intermediate care
- Live view of capacity for frailty-related services.
- Personal health budget in hub to enable discharging the person sooner/on time e.g. via provision of food, towels, and other items required, that were unforeseen or not addressed as part of a discharge plan
- Ability to refer directly e.g. to handyman services e.g. to fit key safe, repair locks or windows, fix the heating
- VCSFE support to unpaid carers/families at point of discharge to navigate the system and achieve a coordinated, timely and worry-free discharge.
- Full sharing and use of CGA and other information with care or nursing homes at point of transfer, recognising that going into a home is a major life event and that a 'discharge letter' is not sufficient to expedite this or achieve a person-centred, therapeutic transfer of care.

(this element does not appear as a numbered item in the overarching framework)

A range of enablers have been identified as critical to the delivery of the framework

The cross-cutting themes and enablers that will support the ageing well/frailty framework include the following:

- One agreed **frailty scale** to be used across the ICS.
- Consistent approach to use of **Clinical Geriatric Assessment** (CGA) and Universal Care Plan (UCP) - develop a technological solution to pull information from clinical systems such as EMIS in primary care into the UCP.
- **Digital tools** and data sharing - enabling digital solutions for patients and obtaining digital equality. Having required data sharing agreements in place to support collaboration
- **Continuous quality improvement cycles** – Formal QI methodology in place co-developed, owned and actioned across partners.
- **Workforce development and culture** – Achieving a universal minimum skill and competency level for ageing well and frailty (ideally including dementia and delirium) across all roles. Supporting the wellbeing of staff to prevent burnout and increase job satisfaction and staff retention. Developing 'employer of choice' status and attracting the best people with a passion for supporting older people to SEL. Achieving a shift in culture so that e.g., older people are respected, trusted and believed as equal citizens living full and well-rounded lives and with hopes and dreams. Supporting a cultural shift to increase pre-emptive thinking and genuine shared responsibility for prevention e.g., through talking to one another and triggering timely action in response to concerns or yellow/red flags, regardless of role. Co-location of teams to support building of strong, authentic teams and relationships
- **Culturally sensitive adjustments** – understanding the barriers to accessing services and wider amenities in the community, which could be real or perceived. Adjusting practices, processes, pathways, measures etc. in response to older peoples' experiences to create inclusion, encourage self-care and meet their needs. Health inequalities – look at how to tackle inequalities not only in access to services but also regarding preferences and limitations due to race, gender, etc.
- **Making ageing well everyone's business.** Ensuring that ageing well/frailty is "everyone's business" including raising awareness and upskilling the workforce to understand ageing well and recognise frailty and early signs of deterioration. Making it "every professional's responsibility" to input into the UCP. Supporting the upskilling and raised awareness of staff in care homes and domiciliary care
- Having a clear and overt strategy in place for **delivering the funding shift** needed to fulfil the ambitions of the framework, supported by a demand and capacity model that sits alongside the framework, pinpointing the capacity needed in each area to successfully deliver the required care and support
- **Population health management** (PHM) - using PHM capabilities such as predictive risk analytics to identify cohorts and further predict the risk of deterioration. Using alerts e.g., to indicate where patient reviews have been missed or need to be undertaken. Access to granular detail, e.g., to enable identification of people with frailty and at risk of deterioration.

South East London Integrated Care System

NHS South East London

6.
How will we know if we are making a difference

Outcomes and measures

HEALTH INTEGRATION PARTNERS

Introduction

- The following slides outline a list of outcomes developed through engagement with stakeholders across all Places in SEL, encompassing a wide range of professions (e.g., clinical, social, managerial) and care settings (voluntary sector, local authorities) as well as residents.
- Please note that this list of outcomes is still "in development." Other outcome frameworks, such as those for LTC and neighbourhoods, have already been or are currently being developed. It is essential that we align these outcomes, and as such, the list will evolve alongside the development of other programs.
- The goal is to establish a unified set of outcomes across SEL that reflects progress and achievements at three levels: neighbourhood, Place, and South-East London. To ensure practicality and relevance, it is crucial to limit the number of indicators that effectively demonstrate overall impact in line with the aspirations of the ageing well framework.
- To keep it practical and meaningful, it is important that there is a finite number of indicators that can show the overall impact in line with the aspirations of the ageing well framework.
- The indicators should be SMART and, ideally, based on established data points that can be centrally extracted to support an automated dashboard across the system. This dashboard will be designed to filter by location, population segment, and severity of frailty (mild, moderate, severe). Developing this automated (or semi-automated) dashboard is a key part of the roadmap ahead and will require a task and finish group, including data experts, clinical/professional leads, and executive oversight.
- Considerations for dashboard development includes: (1) availability of and access to viable data points (such as in GP records, HES and LA datasets), (2) creation of repository of joined-up datasets, (3) assessment of data quality, (4) defining key algorithms and definitions, and (5) the development of the dashboard, which will involve testing, refining, and implementing through a quality improvement (QI) process.

How we will know if we are making a difference
Outcomes that will be used to monitor and evaluate

The following table outlines the key outcomes that were jointly developed with input from stakeholders. The outcomes aligns with the aim to improve outcomes and experience for people with a more sustainable health and care economy. The indicators will be refined further as part of implementation.

	Outcomes	What do we aim to understand from the indicators	Potential Indicators Long list at this stage - to be refined further
1	**Improvement in quality of life**	• Are we genuinely supporting in people to age well and thrive? • Are we making a difference to the quality-of-life outcomes of people (residents, patients and carers)?	**At system level:** • Priority: Healthy life span as a marker of ageing well * • Priority: Quality of life of people who use services (ASCOF) • Carer reported quality of life (ASCOF) • Mortality rate of >65 population * **At an individual / cohort level:** • EQ-5D patient reported outcomes-based quality of life score • Set of outcomes defined in INT at the time of care planning and then assessed at defined intervals 1. Achievement of goals defined at the time of care planning 2. Improvement in ADL from baseline (if relevant) 3. Reduction in reported loneliness (if relevant) 4. Improvement on overall mental wellbeing 5. Improvement in clinical outcomes (exact indicator will depend upon the clinical condition of the patient) • Self reported outcomes: Use of simple wellness star. Use of digital / telehealth to monitor wellness scores where possible

* Indicators that will show impact in the longer term

How we will know if we are making a difference
Outcomes that will be used to monitor and evaluate

The following table outlines the key outcomes that were jointly developed with input from stakeholders. The outcomes aligns with the aim to improve outcomes and experience for people with a more sustainable health and care economy. The indicators will be refined further as part of implementation.

	Outcomes	What do we aim to understand from the indicators	Potential Indicators Long list at this stage - to be refined further
2	**Supporting people to age well**	• Are we able to reduce risk for individuals and stop or slow their progression into higher frailty zones for e.g. mild to moderate and moderate to severe / reduce manifestations of growing frailty	• Priority: Reduction in number of admissions due to ACSC / avoidable admissions *(avoidable admissions codes to be confirmed locally and monitored against baseline or as a rate of population)* • Priority: Reduction in people with 10+ medications (poly-pharmacy) *(https://www.who.int/docs/default-source/patient-safety/who-uhc-sds-2019-11-eng.pdf)* • Priority: Reduction in people with self reported isolation (ASCOF) • Reduction in number of admissions due to falls *(measure against baseline or as a rate of population)* • Reduction in number of people requiring domiciliary care (new) • Reduction in people who are house-bound *
3	**System sustainability (value-based care)**	• Are we reducing demand from resource intensive areas such as hospital and long-term residential care and shifting focus of care into community	• Priority: Reduction in ED presentations for over 65 or those who are mild/mod/severe frail • Priority: Reduction in % of patients over 65 with a Length Of Stay of 21+ Days • Priority: Reduction in admissions into residential care (nursing and residential care homes) • Priority: Reduction in number emergency admissions to hospital and beddays (measure against baseline and as a rate of population) • Increased SDEC utilisation and reduction in ED utilisation for people with moderate to severe frailty with UCP in place • Reduction in care home conveyances to ED • Reduction in LAS conveyances to hospital

* Indicators that will show impact in the longer term

How we will know if we are making a difference
Outcomes that will be used to monitor and evaluate

The following table outlines the key outcomes that were jointly developed with input from stakeholders. The outcomes aligns with the aim to improve outcomes and experience for people with a more sustainable health and care economy. The indicators will be refined further as part of implementation.

	Outcomes	What do we aim to understand from the indicators	Potential Indicators Long list at this stage - to be refined further
4	**Improved resident / carer experience**	• Are the experience of our residents, patients and carers positive. Do they feel supported, seen, heard and respected in their interactions with health and care services. Do they have a positive experience of ageing.	**At system level:** • Priority: Proportion of people who use services who report having control over their daily life (ASCOF measure) • Priority: Social Isolation: Percentage of adult carers who have as much social contact as they would like (ASCOF) • Social Isolation: Percentage of adults who feel lonely often or always **At an individual / cohort level:** • To be delivered at service level such as people supported by Integrated neighbourhood teams • Qualitative survey (person feedback): List of 5 questions - could include aspects like 'ability to self manage', 'improved connectivity' and 'feeling trusted, heard and respected' • Real life stories through deep dive semi-structured interviews (for learning and CQI)

5	**Improved access to community assets**	• Are residents provided with opportunities to access support in the community to support them in ageing well.	• Priority: Proportion of people accessing the green and blue zone such as:
			  • Access into neighbourhood services (e.g. INT), community activities
			  • Access to community-based support and amenities (e.g. exercise classes)

6	**Reduced health inequalities**	• Are the outcomes the same in all resident/population groups ie gender, ethnicity, sexual orientation, deprivation level (IMD), mental health, LD and other exclusion groups such as homeless • Is access to community-based support and neighbourhood equitable	In addition to dissecting the data, survey and interviews above to identify any signs of inequality, the following additional objective measures to be considered: • Priority: Rate of NEL admissions in respective population cohorts • Priority: Access into neighbourhood services (e.g. INT), community activities and amenities (e.g. exercise classes) • Access to suitable housing • Rate of multi-morbidity (4 and more LTC) in respective population cohorts

* Indicators that will show impact in the longer term

How we will know if we are making a difference
Outcomes that will be used to monitor and evaluate

The following table outlines the key outcomes that were jointly developed with input from stakeholders. The outcomes aligns with the aim to improve outcomes and experience for people with a more sustainable health and care economy. The indicators will be refined further as part of implementation.

	Outcomes	What do we aim to understand from the indicators	Potential Indicators Long list at this stage - to be refined further
7	**Identification of people with escalating frailty**	Are we identifying people with escalating frailty or complexities before it is late	• Priority: Proportion of people with Moderate frailty who are identified and supported by INT • Dementia diagnosis rate for 65+ years old * • Proportion of people that have been enrolled in neighbourhood care that have been flagged by population health algorithms (future) • Consider: Increased coding of frailty status of population
8	**Positive dying**	Are the patient's wishes being included in their ACP, including their preferred place of death. Are we recognising 'ordinary dying'	• Priority: PPoC and PPOD from UCP correlated against actual place of care and death • Number of 'Plan for the future' achieved (tbc - % of total population over 65)
9	**Other**		• Priority: Proportion of UCP and CGA completed for people with frailty (mild, moderate and severe) • Number of SMR / polypharmacy reviews

* Indicators that will show impact in the longer term

7.
How we implement the framework

A recommended first principle is that the biggest proportion of effort in implementing the Ageing Well framework should be on people

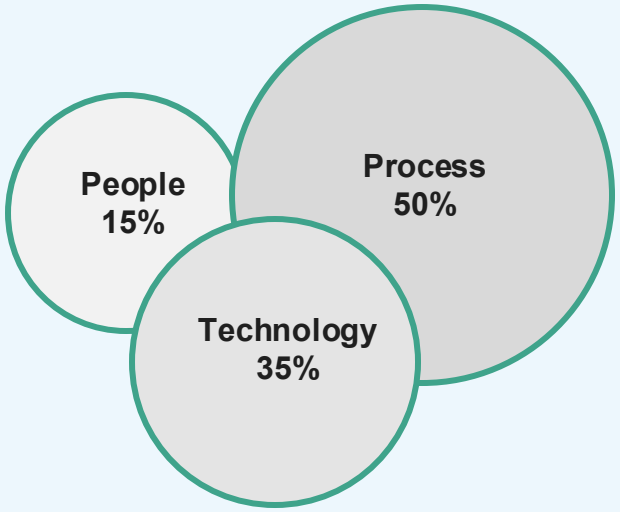
Nearly two thirds of healthcare change projects fail and less than 5% deliver what they are supposed to[1]

Common pitfalls include insufficient focus on:

- → Creating meaning and purpose
- → Engaging and taking people/partners on the journey
- → Having the right team, skills and knowledge for the job
- → Visible leadership championing the work
- → Tapping into values, feelings and attitudes
- → Creating trust, ownership and accountability
- → Tracking, reporting and promoting success
- → Project methods that drive delivery at scale and pace

Most healthcare transformations **under invest in the human dimension**

Proportion of effort showing less focus on people led change



Change dominated by process and technology only achieves around a 10% level of adoption [2]

1. *NCBI 2022*
2. *Ian Gotts. Common Approach, Uncommon Results 2007*

This recommended first principle then translates into some further recommendations for how SEL should approach implementation of the framework

Engagement	• Developing a strong 'brand' identity for the framework that conveys not just the 'tasks' bit also the 'spirit and emotion' behind the ambition and embedding this in each Place • Developing a robust approach to engagement at SEL and Place level including executive and front-line buy-in across all partners e.g., health providers, social care, Local Authority, Public Health, VCFSE, private providers e.g., domiciliary care and care homes • Patient, carer and family education, engagement and co-production.
Leadership, resources and skills	• Clarifying programme leadership and project management resources at SEL and Place levels (identifying inspirational leaders) • Putting the resources in place required to deliver the framework • Establishing a multi-professional training and job shadowing/rotational roles skills transfer framework for ageing well and frailty.
Delivery and change management	• Having clarity on what the ICB is doing and what Place is doing and ensuring the ICB provides the required practical support needed to Place (e.g., identifying and agreeing the deliverables that can be done 'once for SEL' that support standardisation, efficiency and avoidance of duplication such as the Life course self-assessment, My Plan for the Future, CGA, UCP, frailty identification/scoring tool and the enablers) • Developing a new, proactive and dynamic approach to change e.g., via establishment of a community of practice and champions to inspire and drive developments, capture and assimilate feedback etc. • Sharing good practice examples across SEL enabled by a single, easy to use communication channel.
Measurement and funding	• Developing clear success measures and minimum standards to be achieved by services and the implementation programme/project itself (and securing a signed agreement to these across providers) • Establishing a holistic, longer-term plan for funding versus a short-term or piecemeal approach • Planning the investment into ageing well and frailty jointly and openly with wider partners, around an approach emphasising people.

Implementation planning – key elements

Change initiation planning at Place

- Review of framework against current Place plans and initiatives underway
- Understanding of gaps and opportunities and what to prioritise from the framework
- Identifying the key interventions to be developed building from what is already underway
- Defining the *how* – including resources, change management approach, requirements for support from SEL
- Production of practical delivery plan of action including stages, phasing, QI cycles, etc.

SEL parallel review

- Parallel review of Place plans and understanding of what can be done at SEL level/practical support Places need from SEL
- SEL level planning (aligned to Place plans) and mobilisation of SEL-level resources to deliver
- Alignment and coordination of plans with wider SEL strategies and initiatives (INTs, LTCs etc.)
- Plans to include SEL level comms and engagement e.g., resident education, launch of brand, etc.
- Plans include laying foundations for investment shift e.g., to upstream prevention, longer term VCSFE funding, etc.

Engagement and mobilisation at Place (building on existing work underway)

- Identifying Place lead(s) who will drive delivery (overall leads and lead clinicians, professionals, etc.)
- Engaging and onboarding of partners/individual stakeholders at Place who will participate in and help lead design and delivery
- Set up of collaboration and sharing across Places e.g., community of practice, shared communication channel, best practice library, change management approaches, etc.
- Establishing/activating resident engagement and co-production approach
- Mobilising the Place-level resources and project to deliver, including comms, engagement, launch of the brand etc.

Implementation planning – key elements

Demand and capacity modelling

- Scoping and mobilising the D&C modelling – SEL and Place levels
- Marrying the modelling to Place plans e.g. Place assumptions, timings, phasing, etc.
- Gaining collaboration with wider partners e.g., agreeing principles/actions for resourcing, investment, investment shift, etc
- Building the SEL and Place level D7C model
- Gaining buy-in to the model across all stakeholders

Creating a dashboard

- Creating a SEL dashboard of outcome measures and KPIs
- Populating the dashboard with baseline assumptions (SEL and Place level)
- Quarterly reporting of progress and achievement of outcomes as change is delivered.

Enablers

- Scoping and detailed specification of enablers required to enable the framework
- Developing a specific plan for delivery of enablers to meet the requirements of the framework
- Aligning the specification and plan with existing work already underway on enablers and adjusting any existing specification and plans as required to ensure delivery meets Place requirements
- Mobilising delivery of enablers, prioritised against plans.

Roadmap for implementation

Stage 1: Establishing the vision and the framework to deliver it

Stage 2: Embedding the framework (SEL–Place-Neighbourhoods) Change initiation planning

Stage 3: Phased QI led implementation

SEL Ageing well framework

- Bringing system stakeholders together
- Resident voice
- Framework for ageing well

Demand and capacity modelling

- System baseline for frailty demand and capacity
- Utilisation hot spots and projections
- Overall shift in demand and capacity with new framework

Defining outcomes

- Key outcomes and indicators to know what we are making a difference
- Define system dashboard for frailty
- Establish data points and beta test live dashboard

1. Self assessment @ Place

- Map services against framework
- Map performance: What is working well & not
- Define - stay as is, scale, enhance

2. Analysis of opportunities

- Identify areas of improvement against framework
- Scope of development – SEL vs Place
- Impact (£, outcomes)

3. Priorities for delivery

- Prioritise based on potential impact, deliverability and strategic alignment
- Roadmap for implementation

6. Change management, OD and enablers

- Identify change leaders
- Engage, inspire, empower frontline
- Requirements; Digital/OD/training
- Change management

5. Demand and capacity

- Impact on baseline demand and capacity
- Identify shift in resources (Left shift)
- Upfront investment or business case (if req'd)

4. Operating model

- Engage – frontline / clinical / professional
- Define operational model
- Define who/what/how
- Trajectory of implementation

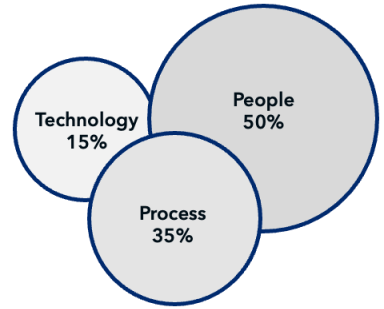
Key tenets of delivery

Regular touchpoints

System-wide cross learning workshops

System governance, oversight and review

Achieving the right focus for change



Phased implementation

- Robust program delivery team (representing system partners)
- Oversight and governance
- Clarity on SEL-level support to Places
- QI methodology and system-wide learn and share events
- Communication plan

- Continued QI cycle
- Test and titrate
- At scale delivery

8.
Appendices
(circulated as a separate document)

Appendices - contents

1. Project Plan
2. Summary of baseline positions at Place
3. Outputs from workshops
    a) Ambition and vision
    b) What must change?
    c) What else must change?
    d) Ageing well and frailty definitions
4. Governance
5. What ageing well and frailty mean in SEL
6. Mantra
7. Case Studies
8. List of stakeholders who participated in developing the framework

South East London Integrated Care System

NHS South East London

Programme supported by:

HEALTH INTEGRATION PARTNERS

AGENDA ITEM: 10

Healthier Greenwich Partnership

Date: 23 July 2025

Title	Partnership Report	
This paper is for **noting**		
Executive Summary	The partnership report provides updates on key developments from the partnership, as follows: 1) Healthier Greenwich Partnership 2) Neighbourhoods update 3) Royal Borough of Greenwich 4) Update from Oxleas NHS Foundation 5) Greenwich Healthier Communities Fund 6) Lewisham and Greenwich NHS Trust 7) Community Hospice 8) Healthwatch Greenwich	
Recommended action for the Committee	To note the report	
Potential Conflicts of Interest	None	
Impacts of this proposal	Key risks & mitigations	None
	Equality impact	Not required for the direct purposes of the report
	Financial impact	Not required for the direct purposes of the report
Wider support for this proposal	Public Engagement	Not required for the direct purposes of the report
	Other Committee Discussion/ Internal Engagement	Not applicable
Authors:	Greenwich Business Support Lead	
Clinical lead:	Not applicable	
Executive sponsor:	All partners	

Partnership Report – July 2025

Table of Contents

1. Healthier Greenwich Partnership (HGP)

The report that follows provides an overview of the activities of our partners across the Healthier Greenwich Partnership noting some challenges but also highlighting some excellent developments and contributions we have achieved.

Since our last meeting in public, we have all managed high demands and pressures whilst continuing to develop our plans for 2025/26 amid significant policy and economic challenges.

In early July the government launched its 10-year Health Plan for England, which is its health mission to build a heath service that is fit for the future, setting out how the government plans to reinvent the NHS through three radical shifts:

- Hospital to community
- Analogue to digital
- Sickness to prevention

In depth information about the plan can be read here.

As a partnership our challenges are shared and affect us all, but through collective, coordinated efforts we will continue to work hard for all our residents and communities.

2. Neighbourhoods Update

Greenwich's programme to deliver Neighbourhood Health Services is now fully underway, with three core strands established and developing plans through workshops, steering groups and feeding into Place governance. These are care models, workforce

and population health and each has a senior sponsor leading the work. Enabler workstreams have also been established – digital, estates and communications – also with leads and gathering momentum.

Highlights include:

- a well-attended and productive workshop with the LCP and a wider group of local experts and stakeholders to take forward all core strands of the Greenwich approach.
- Greenwich Wide Forum and Greenwich Community of Clinical Influence sessions with local GP and practice staff to discuss the role of general practice in Neighbourhoods.
- active participation at recent SEL workshops to define and refine a consistent approach to Population Health Management in Neighbourhoods, and to develop the SEL Aging Well Framework.
- following the Greenwich Estates Strategy adoption locally, a workshop with all system Estates leads and wider stakeholders to identify and refine potential Neighbourhood Hub opportunities, with follow up workshops looking at Children's opportunities and the West Greenwich area

Find out more about Neighbourhoods here.

3. Royal Borough of Greenwich

The Healthier Greenwich Partnership reports directly into The Royal Greenwich Health and Wellbeing Board which is a statutory committee of the Council bringing together senior leaders from the NHS, Royal Borough of Greenwich, Healthwatch Greenwich, the Metropolitan Police, and the voluntary and community sector to work in partnership.

The Board aims to enhance health and wellbeing in Greenwich and address health inequalities borough-wide

You can find our more here.

4. Update from Oxleas NHS Foundation Trust

Oxleas NHS Foundation Trust works with partners in Greenwich to provide a wide range of physical and mental health services mostly in community settings. These include district nursing, frailty and rehabilitation teams, children's mental and specialist physical health services and adult mental health care including Greenwich mental health hub Home - Bexley, Bromley and Greenwich Mental Health Hubs.

10 Year Health Plan

Oxleas welcomed the publication of the 10 Year Health which aims to achieve more personalised, accessible care and give more power to patients: It builds on existing partnership working and co-production with people using services and community organisations.
NHS ten year plan to deliver care closer to home | Oxleas NHS | Oxleas NHS Foundation Trust

Working with local communities

Oxleas, including Greenwich Time to Talk Talking Therapies service, has linked in with Headlinerz barbers in Greenwich to increase access to mental and physical health services
Jesse's Mission: Championing men's health, one haircut at a time | Oxleas NHS | Oxleas NHS Foundation Trust

Improving access to health services for women and girls
Launched in March 2025, our virtual health hub continues to grow. It allows local people to self-refer for expert advice and care, reducing the need for hospital visits and improving access to timely support.
Women's and Girls Hub | Oxleas NHS Foundation Trust

NHS Employers good practice
Oxleas work to support staff and local communities has been highlighted by NHS Employers as examples of good practice. NHS Employers is showcasing how the trust boosts colleagues' wellbeing and supports reservists and armed forces veterans. Visit NHS Employers or Good practice recognised by NHS Employers | Oxleas NHS | Oxleas NHS Foundation Trust

5. Greenwich Healthier Communities Fund

The Greenwich Healthier Communities Fund over the next 4 years aims to prevent and respond to key health issues across Greenwich to ensure everyone has equal access to the health services and support they need. The Fund awards grants across different funding strands, which support different kinds of work within Greenwich, all aligned to the agreed Health & Wellbeing Strategy.

Phase 1: Two strands of funding for VSCE organisations were launched in April 2024.The Enabling strand aims to increase organisation's capacity building to better tackle health inequalities, whilst the Delivery strand aims to fund projects that prevent and respond to key health inequalities.

The Enabling Strand has supported 31 organisations across three rounds, with a total of £245,726 awarded. The Delivery Stand has supported 48 organisations across two rounds, totalling £1,122,701

Phase 2: After a period of development, with stakeholder input and grantee feedback, the Fund relaunched in April 2025 with an additional strand; Micro Grants. This funds the continuation or pilot of small projects, to encourage the trial of innovative projects on a smaller scale, before they are developed. The Delivery Strand was also split into Small Awards and Medium Awards. Small awards fund projects up to £20,000 and Medium awards up to £50,000.

In round 1, we have had 18 applications to Delivery Small Awards and 21 applications to Delivery Medium Awards, with funding decisions to be made over the next month. On the Delivery Strand Medium Awards, final funding recommendations will be made by a Community Panel of key individuals who live or work in Greenwich, to ensure the Fund addresses key issues identified by the community.

On The Delivery Strand Medium awards, organisation have had to submit against a set of priority themes. Themes were chosen based on the aforementioned stakeholder and grantee input. The themes are:

- Improving Health Outcomes for People with Learning Disabilities and/or Autism
- Tackling Isolation
- Long-Term Health Conditions
- Active Healthy Living for Children and Young People

The Delivery Strand Large Awards will launch in September 2025, awarding up to £200,000. Applicants must demonstrate how their project will align with a priority theme, as well as demonstrate collaborative working within the neighbourhoods in Greenwich.

6. Lewisham and Greenwich NHS Trust (QEH)

At Lewisham and Greenwich NHS Trust, we are:

- Continuing to see **high demand for our services** across both our hospital sites, despite the recent hot weather. Queen Elizabeth Hospital continues to face high emergency care demand, compounded by spatial and flow constraints. We're responding through a comprehensive redevelopment programme and targeted operational improvements. These include the conversion of the hydrotherapy pool to expand Same Day Emergency Care (SDEC) capacity, a new Acute Medical Unit (AMU) model to reduce length of stay, and, in the longer term, the opening of new bed capacity in ward 26. We are also mobilising our plans to taken on the management of the urgent treatment centre in Bexley later from October 2025.
- Focusing efforts to reduce long waits for patients. Construction of our new **elective surgical space in Lewisham** remains on track and is currently scheduled to begin a phased operational launch in late November 2025, with full-year operations commencing from April 2026.
- Digesting the content of the **Government's ten-year health plan** which aims to create a new care model by bringing the NHS closer to patients' homes. This plan will inform our Trust strategy under development, but we already have a number of projects underway that will support the delivery of the plan including new Community Diagnostic Centre's at Eltham and Sidcup, our new patient portal and trials of AI in areas like radiology. We are also focusing on the development of new and innovative services such as our Proactive Aging Well Team.
- Focusing efforts to prepare for a **new wave of industrial action** following recent confirmation of new Resident Doctor Strike action. The first strike dates have been announced to run from 7am Friday 25 July through to Wednesday 30 July. Planning is underway and we will be doing all we can to mitigate against patient impact.
- We are excited to announce that **the LGT Clinical Academy** was recently relaunched on Monday 30 June, with a brand-new, dedicated space at our Catford office. The refreshed Clinical Academy is designed to empower clinical colleagues with the skills and knowledge needed to deliver exceptional patient care and provides bespoke, high-quality, peer-reviewed teaching, delivered by clinical experts, to support their continuous professional development.

For full details of the latest Trust news, please see News | Lewisham and Greenwich

7. Community Hospice

Updated referral guidelines and improvement to triage

We've been working hard to support earlier access to our services for anyone with a life limiting illness and have launched updated referral guidelines I'm also delighted to say that with the recent changes we have made in our triage processes we've been able to significantly reduce our waiting time for community referrals. We will be discharging more patients to patient initiated follow up to accommodate higher volumes of referrals, but if you have a patient who has been under our care that you are worried about, or if you are a person with a terminal illness or their carer and need support, please do get in touch via communityhospice@nhs.net or for urgent referrals call 0208 312 2244

Compassionate Neighbours 7th birthday

We're excited to celebrate the 7th anniversary of our compassionate neighbours programme https://communityhospice.org.uk/compassionate-neighbours/ In the last seven years, we've run 52 training groups, trained 320 Compassionate Neighbours and made nearly 300 matches. As a consortium of 16 hospices, we've trained over 3000 volunteers! If you are interested in making a referral or getting involved as a Compassionate Neighbour, please get in touch

Assisted Dying Bill progresses through parliament

The Terminally Ill Adults (End of Life Bill) passed its second reading in the House of Commons and has now gone to the House of Lords for debate. We continue to engage with politicians to ensure that if the Bill is passed it pays attention to the needs of the people we care for and the wider community and is as safe as it can be. Our position on Assisted Dying remains neutral https://communityhospice.org.uk/news/the-assisted-dying-bill-our-statement/ If you would like to have a conversation to share your views, please get in touch with info@gbch.org.uk

8. Healthwatch Greenwich

Reducing Health Inequalities Through Community Voice: Our Work, April–June 2025

At Healthwatch Greenwich, we work alongside residents to tackle health inequalities and improve access to care. Between April and June 2025, we directly supported over 875 people and published 19 reports, briefings, and newsletters capturing lived experiences. Our focus has remained firmly on amplifying voices from communities too often excluded from decision-making — including people from global majority backgrounds, disabled residents, unpaid carers, migrants, refugees, and those with additional communication needs.

This quarter, our work has led to tangible impact. Following our Enter and View visits to nine hospital wards, LGT has improved communication with patients and families. Our feedback also contributed to changes in how escalation procedures — including Martha's Rule — are explained on wards. Our evaluation of the Anti-Racism Community of Practice helped shape plans for a second phase with stronger links between learning and service improvement. At the same time, young peer researchers co-designed and launched a social media campaign on HPV vaccination, increasing awareness among hard-to-reach groups in Thamesmead and beyond.

Through the Be Well Support Programme, we've worked with grassroots organisations and delivered tailored support and training to help them extend their reach and impact. Our safeguarding workshops, co-designed with marginalised and faith-based groups, supported residents to identify and respond to concerns — many of whom had never previously engaged with statutory safeguarding systems.

We also influenced system-level priorities. Our insights were used by the RBG to support their review of support for unpaid carers. In addition, we highlighted the exclusion experienced by residents with limited English, resulting in renewed conversations about how translation and interpreting services are accessed and delivered.

Though our abolition has been announced by the Department of Health and Social Care, no timeline for the new legislation required has been confirmed. Until then, our focus remains clear: to listen, support, and advocate — making sure that every voice counts in shaping a fairer health and care system.

You can read our recently published annual report here:
https://healthwatchgreenwich.co.uk/report/2025-06-27/healthwatch-greenwich-annual-report-2024-25

South East London Integrated Care System

NHS South East London

Greenwich Local Care Partnership
LCP performance data report

June 2025

South East London Integrated Care System

NHS South East London

Introduction and summary

Reported metrics

Overview of report

- Areas of performance delegated by the ICB board to LCPs.
- Metrics aligned to the six ICB corporate objectives that fall within delegated responsibilities LCPs.
- Metrics requested for inclusion by LCP teams.

here.

South East London Integrated Care System

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Standard	Trend since last period	Period covered in report	Comparator	Benchmark	Current performance
Dementia diagnosis rate	↑	May-25	National standard	67%	64%
IAPT discharge	↓	Apr-25	Operating plan		215
IAPT reliable improvement	↓	Apr-25	Operating plan	67%	63%
IAPT reliable recovery	↑	Apr-25	National standard	48%	47%
SMI Healthchecks	↑	Q4	Local trajectory	70%	57%
PHBs	↑	Q4 - 24/25	Local trajectory	837	616
NHS CHC assessments in acute	↔	Q4 - 24/25	National standard	0%	0
CHC - Percentage assessments completed in 28 days	↓	Q4	Local trajectory	80%	72%
CHC - Incomplete referrals over 12 weeks	↔	Q4 - 24/25	Local trajectory	0	0
Children receiving MMR1 at 24 months	↓	Q2 - 24/25	PH efficiency standard	90%	85%
Children receiving MMR1 at 5 years	↓	Q2 - 24/25	PH efficiency standard	90%	83%
Children receiving MMR2 at 5 years	↓	Q2 - 24/25	PH efficiency standard	90%	72%
Children receiving DTaP/IPV/Hib % at 12 months	↓	Q2 - 24/25	PH efficiency standard	90%	87%
Children receiving DTaP/IPV/Hib % at 24 months	↓	Q2 - 24/25	PH efficiency standard	90%	87%
Children receiving pre-school booster (DTaPIPV%) % at 5 years	↓	Q2 - 24/25	PH efficiency standard	90%	69%
Children receiving DTaP/IPV/Hib % at 5 years	↓	Q2 - 24/25	PH efficiency standard	90%	87%
LD and Autism - Annual health checks	↓	Apr-25	Local trajectory	67	58
Bowel Cancer Coverage (60-74)	↓	Sep-24	Corporate Objective	66%	65%
Cervical Cancer Coverage (25-64 combined)	↓	Jun-24	Corporate Objective	66%	66%
Breast Cancer Coverage (50-70)	↑	Sep-24	Corporate Objective	60%	58%
Percentage of patients with hypertension treated to NICE guidance	-	Q3 - 24/25	Corporate Objective	70%	67%
Flu vaccination rate over 65s	↑	Feb-25	Corporate Objective	66.4%	62.0%
Flu vaccination rate under 65s at risk	↑	Feb-25	Corporate Objective	36.9%	35.4%
Flu vaccination rate – children aged 2 and 3	↑	Feb-25	-	-	38.2%
Appointments seen within two weeks	↓	Apr-25	-	-	91%
Appointments in general practice and primary care networks	↓	Apr-25	Operating plan	-	114994
Appointments per 1,000 population	↓	Apr-25	-	-	349

SEL context and description of performance

- The national dementia diagnosis rate target is 66.7%. Dementia diagnosis rate is defined as the diagnosis rate for people with dementia, expressed as a percentage of the estimated prevalence.
- South east London is achieving this target. May 2025 performance was 71.0%.
- There is, though, variation between boroughs. Greenwich has not achieved the target during the previous 24 months.

		May-25						
Metric	**Target**	**Bexley**	**Bromley**	**Greenwich**	**Lambeth**	**Lewisham**	**Southwark**	**SEL**
Dementia diagnosis rate*	**66.7%**	71.5%	74.0%	64.4%	75.3%	64.7%	72.2%	71.0%
Trend since last report	-	↓	↑	↑	↓	↑	↑	↑

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

Talking Therapies

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SEL context and description of performance

- The NHS Talking Therapies metrics introduced in 2024/25 have continued into 2025/26. The targets are as follows:
  - Number of patients discharged having received at least 2 treatment appointments in the reporting period.
  - Reliable improvement rate for those completing a course of treatment.
  - Reliable recovery rate for those completing a course of treatment and meeting caseness.
- The target for the number of patients discharged following at least two treatments has not been met since April 2024. The reliable improvement and recovery targets have been met in April 2025. Performance is variable across individual services.
- Note: Service level targets for the number of patients discharged having received at least 2 treatment appointments are currently being finalised.

	Apr-25						
Metric	Bexley - MIND	BHC	Greenwich (Oxleas)	Lambeth (SLaM)	Lewisham (SLaM)	Southwark (SLaM)	SEL
Talking Therapies discharge metric	185	175	215	500	285	355	1690
Trajectory							2034
Trend since last reporting period	↔	↑	↓	↓	↓	↑	↓

		Apr-25						
Metric	Target	Bexley - MIND	BHC	Greenwich (Oxleas)	Lambeth (SLaM)	Lewisham (SLaM)	Southwark (SLaM)	SEL
TT reliable recovery	48%	48.0%	45.0%	47.0%	55.0%	47.0%	42.0%	48.0%
Trend since last report	-	↓	↓	↑	↑	↓	↓	↓

		Apr-25						
Metric	Target	Bexley - MIND	BHC	Greenwich (Oxleas)	Lambeth (SLaM)	Lewisham (SLaM)	Southwark (SLaM)	SEL
TT reliable improvement	67%	69.0%	64.0%	63.0%	75.0%	71.0%	66.0%	69.0%
Trend since last report	-	↑	↓	155 ↓	↑	↔	↔	↑

SEL context and description of performance

- The south east London ICB board has set Improving the uptake of physical health checks for people with SMI as a corporate objective.
- There was a significant increase in the number of AHCs undertaken for people with an SMI during 2023/24 and the SEL operating planning trajectory was achieved at the end of 2023/24. All LCPs significantly improved their position and delivered health checks to over 60% of their registers. Indicative trajectories, aligning with the SEL operational plan, were met by 3 out of 6 LCPs.
- As part of the operational planning process, a trajectory to achieve 70% uptake by the end of 2024/25 was agreed for south east London. This target was not achieved in 2024/25.
- Where annual health checks are being completed, quality can vary as can onward referral to other physical health services.

	Q4 - 24/25						
Metric	**Bexley**	**Bromley**	**Greenwich**	**Lambeth**	**Lewisham**	**Southwark**	**SEL**
SMI Healthchecks	63.4%	56.5%	57.4%	63.6%	53.9%	64.6%	59.9%
Trajectory	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%
Trend since last report	↑	↑	↑	↑	↑	↑	↑

***NOTE:** The above figures have been calculated based on published LCP performance for Q4: Physical Health Checks for People with Severe Mental Illness - NHS England Digital.

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SEL context and description of performance

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

	Q4 - 2024/25						
Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
PHBs	1076	1442	616	442	303	385	4283
Trajectory	676	966	837	934	773	741	4926
Trend since last report	↑	↑	↑	↑	↑	↑	↑

SEL context and description of performance

- There are a number of national standards which systems are required to achieve consistently. Where deviating from the standard, there is an expectation that performance will be addressed as a priority. Performance standards are as follows:
    - A national target was previously set to reduce the number of CHC assessments in an acute hospital setting to less than 15%. The aim, however, is that zero assessments should be completed in an acute setting and this is the benchmark that LCP and ICB teams are measured against.
    - Complete assessments of eligibility within 28 days from the date of referral in >80% cases.
    - Reduce the number of outstanding referrals exceeding 12 weeks to Zero
- All targets were achieved at the end of 2024/25.

		Q4 - 24/25						
Metric	Target	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
NHS CHC assessments in acute	0	0	0	0	0	0	0	0
Trend since last reporting period	-	↔	↔	↔	↔	↓	↔	↓

	Q4 - 24/25						
Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
CHC - Percentage assessments completed in 28 days	74%	97%	72%	83%	92%	64%	86%
Trajectory	80%	80%	80%	80%	80%	80%	80%
Trend since last reporting period	↔	↑	↓	↑	↑	↑	↑

	Q4 - 24/25						
Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
CHC - Incomplete referrals over 12 weeks	0	0	0	0	0	0	0
Trajectory	0	0	0	0	0	0	0
Trend since last reporting period	↔	↔	↔	↔	↓	↔	↓

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Description of metric and SEL context

- Vaccination saves lives and protects people's health. It ranks second only to clean water as the most effective public health intervention to prevent disease. Through vaccination, diseases that were previously common are now rare, and millions of people each year are protected from severe illness and death. South East London and our 6 local care partnerships recognise this in the ICS Strategic Priorities and our Joint Forward Plan.
- South East London ICB has recently refreshed its Vaccination and Immunisation Strategy and has embedded within the six boroughs an approach to increase uptake by developing trust and confidence in the childhood immunisation programme with local communities.
- Since December 2023 there have been a number of reported cases of measles across the country resulting in a national and regional response. SEL boroughs and programme team are co-ordinating and aligning plans across the system in response to the concerns. A full report detailing the position and proposed actions was agreed at the ICB Executive Committee in February 2024. Actions include: SRO/director level attendance at London IMT meetings; production of regular sitrep feeding up to London IMT; A sub-group of the SEL board meets on a regular basis with borough leads, public health, communications and primary care leads to co-ordinate the local response and to support local plans. Each borough has produced a local action plan and are using their local place level vaccination groups to support delivery.
- Borough plans are also in place in response to the rise in numbers of whooping cough numbers and the imperative to focus on the full range of childhood immunisations including pertussis and flu.
- The 24/25 operational planning guidance identifies the following as a key action for systems: maximise uptake of childhood vaccinations and flu vaccinations for CYP, achieving the national KPIs in the Section 7a public health functions agreement, including reducing inequalities. The 25/26 operational guidance states that it remains critical that ICSs explicitly agree local ambitions and delivery plans for vaccination and services aimed at addressing the leading causes of morbidity in all age groups, including CYP.
- The performance indicators have an efficiency standard of 90% and an optimal performance standard of 95% for childhood immunisations. Based on current performance for south east London (and London more widely), the 90% efficiency standard is used as the comparator for RAG ratings in the 2024/25 LCP performance below. This is a change in approach compared to previous year (which used the national average as comparator)

		Q2* - 24/25								
Metric	Efficiency standard	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL	London	England
Children receiving MMR1 at 24 months	90%	84.8%	86.9%	84.9%	79.5%	84.8%	78.3%	83.2%	80.0%	88.8%
Trend since last reporting period	-	↓	↓	↓	↓	↓	↓	↓	↓	↓

		Q2* - 24/25								
Metric	Efficiency standard	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL	London	England
Children receiving MMR1 at 5 years	90%	86.1%	87.1%	82.7%	79.8%	83.3%	82.6%	83.6%	81.8%	91.2%
Trend since last reporting period	-	↓	↓	↓	↓	↓	↓	↓	↓	↓

		Q2* - 24/25								
Metric	Efficiency standard	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL	London	England
Children receiving MMR2 at 5 years	90%	74.5%	81.1%	72.4%	70.0%	76.8%	72.5%	74.7%	69.5%	83.4%
Trend since last reporting period	-	↓	↓	↓	↓	↓	↓	↓	↓	↓

***Important note: Data now includes unregistered children; previous submissions only included children registered with a GP.**

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Metric	Efficiency standard	Q2* - 24/25 Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL	London	England
Children receiving DTaP/IPV/Hib % at 12 months	90%	88.8%	89.7%	87.4%	84.7%	86.7%	87.2%	87.3%	84.5%	90.7%
Trend since last report	-	↓	↓	↓	↓	↓	↑	↓	↓	↓

Metric	Efficiency standard	Q2* - 24/25 Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL	London	England
Children receiving DTaP/IPV/Hib % at 24 months	90%	89.4%	91.5%	87.4%	85.8%	88.0%	84.8%	87.7%	85.9%	92.1%
Trend since last report	-	↓	↓	↓	↓	↑	↓	↓	↓	↓

Metric	Efficiency standard	Q2* - 24/25 Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL	London	England
Children receiving pre-school booster (DTaPIPV%) % at 5 years	90%	73.0%	75.1%	68.6%	63.4%	69.2%	60.9%	68.5%	62.9%	80.8%
Trend since last report	-	↓	↓	↓	↓	↓	↓	↓	↓	↓

Metric	Efficiency standard	Q2* - 24/25 Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL	London	England
Children receiving DTaP/IPV/Hib % at 5 years	90%	85.7%	90.0%	86.7%	83.6%	86.2%	85.6%	86.4%	84.8%	92.6%
Trend since last report	-	↓	↓	↓	↓	↑	↑	↓	↓	↓

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*Important Note: Data now includes unregistered children; previous submissions only included children registered with a GP.

SEL context and description of performance

- The south east London ICB board has set improving the uptake of physical healthchecks for people with LDA as a corporate objective and a south east London trajectory for 2025/26 was submitted as part of the operational planning process.
- SEL achieved the 2024/25 plan with 7,471 health checks delivered against a plan of 6,600. All LCPs achieved their individual targets.
- SEL is currently below trajectory for April 2025 (month 1).
- Where annual health checks are being completed, quality can vary as can onward referral to other physical health services.

	Apr-25						
Metric	**Bexley**	**Bromley**	**Greenwich**	**Lambeth**	**Lewisham**	**Southwark**	**SEL**
LD and Autism - Annual health checks	43	34	58	62	32	68	297
Trajectory	48	50	67	68	79	52	364

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SEL context and description of performance

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

	Sep-24						
Metric	**Bexley**	**Bromley**	**Greenwich**	**Lambeth**	**Lewisham**	**Southwark**	**SEL**
Bowel Cancer Coverage (60-74)	73.9%	76.0%	65.4%	61.8%	64.0%	62.7%	67.7%
Trajectory	73.0%	75.5%	65.6%	62.6%	63.5%	62.6%	67.6%
Trend since last reporting period	↔	↑	↓	↔	↓	↑	↔

	Jun-24						
Metric	**Bexley**	**Bromley**	**Greenwich**	**Lambeth**	**Lewisham**	**Southwark**	**SEL**
Cervical Cancer Coverage (25-64 combined)	71.5%	73.7%	66.0%	62.7%	67.4%	63.6%	66.9%
Trajectory	72.1%	74.4%	66.2%	63.3%	68.0%	64.4%	67.4%
Trend since last reporting period	↓	↓	↓	↓	↓	↓	↓

	Sep-24						
Metric	**Bexley**	**Bromley**	**Greenwich**	**Lambeth**	**Lewisham**	**Southwark**	**SEL**
Breast Cancer Coverage (50-70)	70.2%	71.2%	58.4%	56.4%	58.2%	59.3%	62.3%
Trajectory	70.8%	73.8%	59.9%	58.1%	59.6%	57.9%	63.5%
Trend since last reporting period	↑	↓	↑	↑	↑	↑	↑

NOTE: Due to lag in national reporting, local data is shown. This uses the same Open Exeter data source

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SEL context and description of performance

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

	May-25 (Local data reporting)*						
Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Percentage of patients with hypertension treated to NICE guidance	67.0%	69.0%	68.0%	67.0%	63.0%	68.0%	67.0%
Trajectory	72.3%	73.6%	73.4%	73.3%	70.9%	73.1%	72.8%
Trend since last report	↓	↓	↓	↓	↓	↓	↓

Note: Recent data migration has resulted in correction to historic data.

	Q3-24/25 (published CVD prevent reporting)						
Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Percentage of patients with hypertension treated to NICE guidance	63.0%	65.6%	66.5%	65.3%	62.1%	66.7%	64.9%
Trajectory	68.4%	70.4%	70.0%	69.9%	66.4%	69.6%	69.2%

*Local data has been updated to include coding for self reporting of home monitoring. This affects current and historic data and has led to an increase in reported performance. Further work is planned to check that local reporting is inline with the national data definitions.

SEL context and description of performance

- The south east London ICB board set improving adult flu vaccination rates as a corporate objective. The ambitions for 2023/24 was as follows: improve the vaccination rate of people aged over 65 to 73.7%, improve the vaccination rate for people under 65 at risk to 46.0%.
- Performance in 2023/24 (year 1) was significantly below ambition for both metrics and represented a decrease in performance from the previous year.
- In order to ensure that 24/25 ambitions were informed by place, their knowledge of and insights into their local population, their role in commissioning services and their strategic plans for delivery, each borough team set their own ambitions to improve uptake for the two main adult flu cohorts for the upcoming flu season. This approach to setting ambitions is also being taken ahead of the 2025/26 flu season.
- The below table provides targets set at borough level
- The following slide provides the published February borough level performance vs trajectory

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

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

Published February Performance

Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Over 65s vaccinated	70.0%	73.2%	62.0%	54.6%	54.2%	55.8%	63.1%
Local February trajectory	75.0%	76.2%	66.4%	60.0%	61.0%	61.5	68.1%

Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Under 65s at risk vaccinated	35.8%	39.4%	35.4%	29.9%	29.3%	32.3%	33.3%
Local February trajectory	42.0%	46.5%	36.9%	32.9%	34.3%	34.2%	37.3%

Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Children aged 2 and 3 vaccinated	35.7%	49.2%	38.2%	37.2%	39.2%	37.5%	39.8%

SEL context and description of performance

- The 2025/26 Priorities and Operational Planning guidance states that ICBs are expected to continue to support general practice to enable patients to access appointments in a more timely way and improve patient experience.
- The following trajectories have been agreed at an SEL level as part of the annual planning process:
    - Planned number of general practice appointments.
- Appointments totalled 741,850 in April against the operating plan of 636,239.

		Apr-25						
Metric	Planning trajectory	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Appointments seen within 2 weeks	-	88.3%	83.5%	91.4%	90.6%	80.4%	85.8%	86.9%

		Apr-25						
Metric	Planning trajectory	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Appointments in general practice and primary care networks	636239	105150	128577	114994	168137	110034	114958	741,850
Appointments per 1,000 population	-	409	357	349	372	307	318	350

AGENDA ITEM: 11

Healthier Greenwich Partnership

Date: 23 July 2025

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

HGP Risk register update July 2025

Since the last update to HGP, a number of new risks have been added following a review of the register. There are currently 17 open risks on risk register. 13 of the risks have been added to the register this financial year.

The updates are noted below. Full details about each risk is available on the risk register.

1. **Risks recently added to the Risk register.**

Risk No.	Risk Title
574	Primary care premises lost / insecure lease agreements / other estates issues
596	Achievement of Financial Balance 2025/26
599	Greenwich Dementia Diagnosis Rate
614	Risk of not achieving the National/Local trajectory for SMI Primary Health Checks
615	Risk of not achieving the National/Local trajectory for LD Annual Health Checks
616	Increased waiting times for CYP Autism and ADHD Diagnosis
618	Risk of an overspend of the Greenwich Prescribing Budget for 2025/26
619	HealtheIntent (HI) Platform and Funding Position
621	Risk of insufficient appointments in primary care creating delays in accessing clinical care or advice and which might result in possible harm or increase dissatisfaction with care delivery by patients and practice staff.
622	Risk of MMR Outbreaks in Greenwich
623	Risk of apathy in the community towards flu vaccinations
624	Risk to achieving the cancer screening target
625	Risk to achieving the ICB target (73.4%) and the national NHSE target (85%) for the management of hypertension to NICE guidance

2. **Risks reviewed during the period.**

Risk No.	Risk Title	Latest update
465	Risk to development of an iThrive and preventative system approach to children's mental health and wellbeing including a new Single Point of Access and Schools offer	31/03/2025 - As a result of a job advert withdrawal of a Strategic Commissioning and System Development Lead for Mental Health and Emotional Wellbeing this risk has increased slightly from the last review. The role was withdrawn due to the recent recruitment freeze. \n\nThe appointment of a design partner in PPL for the development of the Single Point of Access has helped to mitigate against a higher increase in likelihood. Work is now underway with stakeholders to establish the governance required to take the work forward.
495	Risk relating to co-ordination of timely discharge support for residents.	Nick noted the risk remains on the register and that the BCF support work recommendations are being implemented to support the mitigation of the risk through 4 workstreams.
596	Achievement of Financial Balance 2025/26	Increased scoring from 9 to 12 to reflect recent emerging pressures identified within mental health around the 'Right to choose' pathway ongoing discussions to ensure mitigations are in place and progress will be assessed within 6 weeks. \nAt this time insufficient data available on prescribing to make an informed assessment will review again within 6 weeks. CHC good traction on saving plans established now reporting within budget will closely monitor and review again within 6 weeks.
614	Risk of not achieving the National/Local trajectory for SMI Primary Health Checks	Awaiting information on the SMI validation and PHC work completed in collaboration with South London Health Innovation Network and assess the learning and recommendations within that report to improve this target. June/July 2025: Would be appropriate to liaise with Clinical Directors and MHPs to gauge their support for completion of PHC.

Greenwich Risk Report with Review Comments
Enterprise Risk Manager View (with Risk Owner), 15/6/2023 10:27 am

Risk ID	Owner Date	Risk Owner	Risk Source	Risk Title	Risk Description	Initial Likelihood	Initial Consequence	Initial Rating	Controls	Gaps in Control	Current Likelihood	Current Consequence	Current Rating	Assurances	Gaps in Assurance	Target Likelihood	Target Consequence	Target Rating	Review Date and Comment	Next Review Due
465	13/7/23	Roneeta Campbell-Butler	Dave Borland	Risk to development of an iThrive and preventative system approach to children's mental health and wellbeing including a new Single Point of Access and Schools offer	There is a risk that we don't deliver on all areas of the high impact activity covered within this strand. This is as a result of current commissioning capacity. This has presented significant challenges to drive forward more complex large scale pieces of work. To mitigate against this risk re-prioritisation of other work is being undertaken to support delivery. The impact on HGP would be a higher risk that we don't deliver on all areas within this high impact activity. PLEASE NOTE: This is related to very major strategic projects and risk reviews should happen on six monthly basis.	4	3	12	Temporary utilisation of RBG funded commissioning capacity; alongside use of external capacity to support delivery of Single Point of Access., The establishment of multi-agency task and finish group to take forward the mental health in schools work., Establishment and maintenance of the Children's Mental Health and Wellbeing Partnership Board., Recruitment of partner to develop and implement the Single Point of Access for children's mental health and emotional wellbeing., CAMHS and Commissioner representation on the Entry to Care Panel to inform future support for children in our care at an individual level. ICB representation on the Corporate Parent Partnership Board and leading the Sub-Group on Health and Wellbeing in place.	Resource to support high level mental health and wellbeing needs for children in our care, primarily within residential children's homes.	4	3	12	The Healthier Greenwich Partnership Board has oversight of the delivery plan.	No gaps in assurance have been identified at this time.	3	2	6	29/01/2025 - The development of an iThrive System continues to be a high priority for the ICS in Greenwich across partners. The CYP Mental Health and Emotional Wellbeing Partnership continues to oversee the delivery of the Mental Health and Emotional Wellbeing Delivery Plan with updates being provided at meetings on progress. The tender for identifying a partner to support the delivery of the Single Point of Access is being finalised with a provider expected to be appointed by 17 March 2025. The new Integrated Clinical Team is now in place within the Local Authority's Children's Services and providing support to families and advice and guidance to practitioners on mental health and wellbeing. In addition, new Wellbeing in Schools Hubs are beginning work with families within 8 Greenwich Schools. \n\nThis still represents a key priority for the partnership and continues to be a High Impact Areas for the Local Care Plan Refresh under Feel Well. The risk score remains at 9 due to balancing the further work progressed with the significant mental health and wellbeing need for children and young people. In addition, there are significant resource pressures particularly in respect of the mental health and wellbeing need of children in our care., 31/03/2025 - As a result of a job advert withdrawal of a Strategic Commissioning and System Development Lead for Mental Health and Emotional Wellbeing this risk has increased slightly from the last review. The role was withdrawn due to the recent recruitment freeze.\n\nThe appointment of a design partner in PPL for the development of the Single Point of Access has helped to mitigate against a higher increase in likelihood. Work is now underway with stakeholders to establish the governance required to take the work forward.	30/6/25
474	16/8/23	Rachel Matheson	Lisa Wilson	Risk to optimising and developing our Home First approaches by expanding virtual wards (including a virtual ward hub) to provide assessment, treatment and care to all patients in the place that they call home.	There is a risk that the Home First (HF), and associated social care allocations, will be insufficient to meet the needs of the programme moving forward. There is also a risk to the awareness of partners and colleagues across the system of the virtual ward provision. These risks are caused by; * The anticipated financial allocations being lower than anticipated for Virtual Wards (VW). * The shift of acute care into the community increasing costs in social care and other areas of primary and community care that do not have additional funding * The lack of a fully established dashboard tracking delivery of HF and VW and understanding impacts, the cause relates to a lack of join up and capacity related to data and performance. * The availability of skilled workforce to deliver the specialist and generalist roles needed in the community. * The lack of a communications strategy to widen awareness of the VW programme across partners and the wider workforce. The impact on the Healthier Greenwich Partnership would be challenges in understanding and demonstrating the impact and benefits of the Home First approach. This could lead to a loss of confidence amongst partners and a negative financial impact in other areas of the system.	3	3	9	Operational board overseeing delivery and meets regularly., The Strategic Board receives escalations from the Operations Board and have decision making functions about workforce and financial resources. Oversee the Home first dashboard.	There are no gaps in controls	3	3	9	The Operations Board oversees delivery of Home First, receives progress reports and escalates any concerns to the Strategic Board.	No gaps in assurance identified.	2	3	6	16/01/2024 - The Home first operational and strategic Boards are embedded. \nThere is a Home First dashboard developed and circulated over the last 8 months for sharing data at both boards.\nThere is also a Greenwich and Bexley (QEH System) Urgent and Emergency Care Board dashboard. This includes data relating Virtual Wards and the Urgent Community Response (UCR).\n\nFor 2023-24 there was a reduction in Virtual Wards funding against the plan from the original bid. The recurrent funding for 24/25 remains at reduced level, requiring review of virtual wards pathways against funding allocation. The risk of this is that the full number of beds that were originally planned would not be available.\n\nThere has been challenges for the workforce, especially in recruiting specialist roles. For example, recruiting advanced clinical practitioners to deliver the virtual wards within JET and recruitment of a palliative care consultant within the hospice. \n\nThe Communications Lead does attend the Home First Strategic Group and a number of resources are in development.\n\nThe Risk score should remain at 9 due to ongoing challenges regarding funding level below original modeling for virtual wards., 02/05/2024 - The Home First communications strategy is in development. The risk remains the same and all the risk issues are still relevant. The risk rating remains the same too., 07/11/2024 - The Home First Operational board and Strategic board continue to deliver the programmes and the Home First dashboard is circulated on a monthly basis. Virtual ward and UCR data is produced for the UEC board. From December 16th 2024 community providers will also be producing opel scores. A Home First communication strategy has been devised and is now being implemented by a multi provider communications group. Savings schemes have been implemented by all system stakeholders and whilst a small amount of investment was contributed to Virtual	28/7/25
495	29/12/23	Nick Davies	Lisa Wilson	Risk relating to co-ordination of timely discharge support for residents.	There is a risk that patients who are medically fit for discharge are unable to leave hospital. This can be caused by a combination of: internal hospital processes holding discharge up as well as pressure on community and social care services and a changing demographics of the borough. This could impact negatively on Trust A&E and elective performance as well as the best outcomes for residents.	4	4	16	^1UEC Board has oversight of winter planning. BCF Planning Group has oversight of BCF which has main targets for discharge and admissions avoidance, including 22/23 Discharge Fund and 23/24 planning. Home First Board has oversight of TOCC review and initiatives that support discharge processes and outcomes., ^1SEL Discharge Solutions and Improvement Group looking for sub regional solutions to common challenges such as data analysis and insight.	^1Impact of Discharge Activity on social care staffing and budget resources being financially unsustainable and needing a system solution. ^1Short term and short notice nature of winter and discharge funding flows. ^1Specific pressures on system such as industrial action, Covid-19 outbreaks, staff shortages etc.	4	3	12	^1Joint commissioning Board, UEC Board, SEL Discharge Solutions and Improvement Group rolling out improvement plans for acute and mental health settings. ^1Discharge framework issued across SEL for implementation in borough	Lack of accurate and reliable data insight on delayed transfers of care and demand and capacity planning - this is however under development	3	3	9	12/06/2025 - Nick noted the risk remains on the register and that the BCF support work recommendations are being implemented to support the mitigation of the risk through 4 workstreams, 23/01/2025 - Since the last update, we have seen improved discharge performance over a difficult winter in terms of hospital discharge demands. Home First Strategic Board has supported with resources and clear steer. The Better Care Fund support team are working on site for a 3 month project to identify and implement improvements based on a better understanding of data and a focus on outcomes that residents are achieving post discharge. There are other actions being undertaken as part of the UEC recovery plan that are being actively worked on.	25/9/25
574	11/2/25	Jessica Arnold	Gabi Darby	Primary care premises lost / insecure lease agreements / other estates issues	Across the borough, there are a number of general practice estates that have leases coming for renewal or that may not be renewed, practices at risk of closure due to persistently poor CQC ratings, and practices that are in an excessively poor state of repair and no longer fit for purpose. Resolving these challenges is a costly and long-term endeavour, such that unexpected problems at short notice are difficult to manage.	4	3	12			4	3	12							11/8/25
596	5/5/25	Chris Dance	Gabi Darby	Achievement of Financial Balance 2025/26	During 2024/25 Greenwich delivered in line with the delegated borough budget. However given material and escalating prescribing, and activity driven pressures within Mental Health (Adults) and Continuing Care Placements (Children), substantial non recurrent mitigations were required to achieve financial balance. The cost pressures trajectory is expected to continue into 2025/26, hence a material risk the borough will not be able to achieve recurrent financial balance if the full scale of the savings/efficiency plan is not delivered in full	4	4	16	Monthly budget meetings with budget holders to review expenditure, progress of saving schemes and to ensure mitigation plans are in place where appropriate., Commissioning leads have been fully engaged with the 25/26 planning process, and through coordination with service leads, have prepared & assumed full ownership of the efficiency saving plans.		3	3	9	Additional mitigations developed to address emerging pressures via the SEL Finance Sub-Group		3	3	9	08/07/2025 - Increased scoring from 9 to 12 to reflect recent emerging pressures identified within mental health around the 'Right to choose' pathway ongoing discussions to ensure mitigations are in place and progress will be assessed within 6 weeks. \nAt this time insufficient data available on prescribing to make an informed assessment will review again within 6 weeks. \nCHC good traction on saving plans established now reporting within budget will closely monitor and review again within 6 weeks.	28/8/25
599	16/5/25	Phil Darby	Lisa Wilson	Greenwich Dementia Diagnosis Rate	The current dementia diagnosis rate in Greenwich is 64%. The target rate is 67% so there is a risk that we are not supporting people living with dementia to get a timely diagnosis	2	4	8	Working with primary care to ensure residents diagnosed with dementia are coded correctly on GP IT systems., Working with Oxleas Memory Service to identify any issues, Continue to work with Dementia Action Group to raise the awareness of dementia in local communities, continue with numerous activities to raise awareness of dementia		2	4	8	Oversight will fall under the home first board						10/7/25
614	9/6/25	Jenny Lamprell and Rena Amin	Lisa Wilson	Risk of not achieving the National/Local trajectory for SMI Primary Health Checks	Based on local position against key ares of local performance, (Q3/Mar 2025 data) from SEL ICB, Greenwich has not achieved the target physical health checks. There seems to be a slight disconnect with different providers and/or disconnect with SMI patients and/or their carers. There is a lack of co-ordination in call and recall across various providers/primary care. The impact of not providing a comprehensive PHC is potentially significant in terms of health outcomes leading to co-morbidites, hospital admissions and premature death. The role of Mental Health Practitioners is key to this task but again there was significant variance in their clinical portfolio across various practices. The lack of digital interoperability is another gap leading to data lost due to IT systems not able to communicate across Oxleas, Primary Care and occasionally VCS. The last reported performance for SMI PHC for year ending 2024/2025 was 49% across a SEL trajectory of 68% across the 6 core health check components.	3	3	9	Developing a robust awareness programme across Primary Care and Voluntary Care Sector., Develop a Task & Finish group with stakeholders to support this programme and achieve the performance target., A regular agenda item on the Mental Health Oversight Committee to review performance, manage challenges and barriers and provide timely strategic support where required., Roll out a patient engagement event in collaboration with expert patient group/MIND etc to raise the importance of having annual, physical health checks for patients with SMI., Work with SEL and explore any avenues that can improve the workforce (e.g. ARRS staff) capabilities within primary care to undertake robust SMI PHC to ensure sustainability of improving health outcomes, Empower care providers to promote PHC for clients they manage through their care settings	There are no major gaps in controls however it is important to note that the SMI physical health checks is NO longer part of the 2025/26 Quality and Outcomes Framework (QOF), the aim of which was to reduce health inequalities.The risk therefore is SMI PHC may be impacted and will invariably have huge variance across Primary Care.	3	3	9	Mental Health Oversight & Co-ordination Board	There are no major gaps in controls however it is important to note that the SMI physical health checks is NO longer part of the 2025/26 Quality and Outcomes Framework (QOF), the aim of which was to reduce health inequalities. The risk therefore is SMI PHC may be impacted and will invariably have huge variance across Primary Care.	2	3	6	09/06/2025 - Awaiting information on the SMI validation and PHC work completed in collaboration with South London Health Innovation Network and assess the learning and recommendations within that report to improve this target. \n\nJune/July 2025: Would be appropriate to liaise with Clinical Directors and MHPs to gauge their support for completion of PHC.	18/9/25
615	9/6/25	Jenny Lamprell & Rena Amin	Lisa Wilson	Risk of not achieving the National/Local trajectory for LD Annual Health Checks	Based on local position against key ares of local performance, (Q3/Mar 2025 data) from SEL ICB, Greenwich has not achieved the target annual health checks. There seems to be a slight disconnect with different providers and/or disconnect with LDA patients and/or their carers. There is a lack of co-ordination in call and recall across various providers/primary care. The impact of not providing a comprehensive AHC is potentially significant in terms of health outcomes leading to co-morbidities, hospital admissions and premature death. The lack of digital interoperability is another gap leading to data lost due to IT systems not able to communicate across Oxleas, Primary Care and occasionally VCS. The last reported perfomance for LD AHC for year ending 2024/2025 was 69.5%, it was an increase from previous dataset. Actual performance of 1128 Vs Trajectory = 908, for Greenwich. However the GP DES contract expects a 75% target for patients over 14 years of age. LD population =1998.	3	3	9	Developing a robust awareness programme across primary and VCS. Develop a Task & Finish group with stakeholders to support this programme and achieve the performance target., Roll out a patient engagement event in collaboration with LD Partnership Board etc to raise the importance of having annual health checks for patients with LD., Work with SEL and explore any avenues that can improve the workforce (e.g. ARRS staff) capabilities within primary care to undertake robust LD AHC to ensure sustainability of improving health outcomes * Empower care providers to promote AHC for clients they manage through their care settings.	Based on local position against key ares of local performance, (Q3/Mar 2025 data) from SEL ICB, Greenwich has not achieved the target for annual health checks. Due to an error in the national Primary Care Data (PCD) ref set, the current reported LD figures are potentially overstating the numbers in this inclusion group. The data will be refreshed once the PCD red set has been updated. It is equally vital to note that the date provided from primary care is reliant on the completeness and consistency from practice coding across different GP systems.Therefore there are cases where figures may not match up to other sources.	3	3	9	Learning Disability & Autism Oversight Board.	There are no major gaps in controls	2	3	6	09/06/2025 - Awaiting information on the LD AHC dataset to assess how near or far Greenwich performance was to the trajectory. June 2025: Optimise the LD Awareness Week to promote LD AHCs. \n\nPlans: July2025/Sept 2025: Would be appropriate to liaise with Clinical Directors and LD MPs to gauge their support for completion of AHC.	18/9/25
616	22/5/25	Ronetta Campbell-Butler	David Borland	Increased waiting times for CYP Autism and ADHD Diagnosis	There is a risk of increased waiting times for a diagnostic assessment for Autism and Attention-Deficit/Hyperactivity Disorder (ADHD) for children and resulting non-contracted activity costs due to patient choice referrals to private providers. This is caused by increased demand for assessments combined with historical waiting lists. The impact on the ICB will be on its ability to meet statutory oblications. Achieving timely access to assessment will reduce diagnosis waiting times and in some areas of the subsequent support e.g. medication pathway.	4	4	16	New pathway launched from 1 April 2025 that enables children to move inbetween Autism and ADHD pathways and as they progress without needing to 'start again' reudcing the waiting time for them., SEND Improvement Board co-chaired by Place Exec Lead and Director of Children's Services overseeing improvement plan that includes Autism and ADHD waiting times., Additional non-recurrent investment in Healios and Oxleas staffing capacity to manage with the increased referrals., Core offer for CYP Autism assessment developed and agreed. Set up of Community of practice to share best practice and find solutions to ongoing issues. SEL Wide programme established to review the core offer for ADHD., Reviewing waiting wel offer including publicising of support available without a diagnosis through the Local Offer.	no gaps in controls	4	3	12	SEND Improvement Board provides high level oversight, SEND partnership senior leadership team meeting provides operational leadership oversight, Children's Community Service Meetings between Commissioners and Oxleas inclue review of Autism and ADHD waiting times	No Gaps in Assurance identified	3	4	12		7/8/25

618	2/6/25	Alex Pini	Jin On	Risk of an overspend of the Greenwich Prescribing Budget for 2025/26	There is a risk that there may be an overspend of the Greenwich Prescribing Budget for 2025/26, this is caused by a number of contributing factors SEL launching MOP September 2025. Long Term Condition Management, new drugs coming to market especially for obesity management. Increased prescribing and meds optimisation needed to improve outcomes for patients with Diabetes, Respiratory, Hypertension (to NICE Guidance) and Lipid Management. Drug shortages – hard to mitigate against these, impacting many clinical areas still impacting ADHD medication and HRT. Drug price rises: NCSO/price concessions and Category M Increased patient demand for self care items to be prescribed rather than purchased as cost of living increases OptimiseRx: Depends on practice engagement and individual clinician action at point of prescribing. The impact on the ICB would be that Greenwich practices are overspent compared to prescribing budget.	4	3	12	PCN Engagement, review 24/25 and prep PCN's for MOP 25/26		4	3	12	BI Weekly Team meetings discussing prescribing, MPIG Meetings every 6 weeks - Governance Group,		3	2	6		18/9/25
619	25/6/25	Rachel Smith	Gabi Darby	HealtheIntent (HI) Platform and Funding Position	The current Memorandum of Understanding (MOU) for funding the HealtheIntent (HI) platform, provided by Lewisham and Greenwich Place ICSs, is set to expire at the end of March 2026. It is unlikely that LGT would be able to continue funding the platform independently beyond that point. The HI contract itself runs until March 2027, in parallel with the Oracle Millennium contract. As such, a decision needs to be made regarding the future of the HI platform, with the following options available. HealtheIntent is a digital platform which allows healthcare professionals to provide more proactive care to residents and communities. Options for HI Platform Contract: 1.Terminate at March 2026. Give six months' notice to Oracle by the end of September 2025. Platform would cease in March 2026. 2.Extend Beyond March 2026 (Temporarily). Continue for a TBC defined period beyond March 2026. Six months' notice can technically be served at any point during the contract period. 3.Maintain HI Until Contract End (March 2027). No early termination; platform remains active through the full contract term. If Termination Notice is served a plan will be needed to: •Pause, archive, or store the existing work at the end of the notice period •Or transfer some or all of the work and data to another environment where delivery can continue.	4	4	16	We are setting out the data and platform requirements for PHM, the timelines and the decommissioning plans. We will set out the initial view of our requirements, indicative timelines, and a draft decommissioning plan during June 2025,. We are engaging with the SEL PHM team to explore and gather options for meeting our requirements through alternative solutions and to understand the gaps. E.g LDS, SEL BI Team,. During July to September 2025 - this period will be used to assess the available options, consider the implications, and ultimately decide whether to give notice on the HealtheIntent contract by the end of September 2025.	There is a lack of information available across London and SEL on what the options are for meeting our requirements,	4	4	16	Timelines and initial meetings in place	Case finding to support MDMs, INTs, PAW, and other delivery arms will be significantly compromised if we are unable to continue or replicate the work currently being undertaken to generate and maintain cohort lists	3	3	9		4/8/25
621	23/6/25	Nicky Skeats	Jessica Arnold	Risk of insufficient appointments in primary care creating delays in accessing clinical care or advice and which might result in possible harm or increase dissatisfaction with care delivery by patients and practice staff.	The possible risks of delay in access to appointments are (1) Increased use of other services such as A&E and UTC (2)increase in stress and reduced staff well being resulting in increases staff attrition (3) patients not accessing appointments leading to delays in diagnosis and avoidable harm.	3	3	9	6 practices due to participate in national Practice Level Support (PLS) programme which includes implementation of Modern General Practice Model,. PCNs working with Digital and Transformation leads to implement CAIP plans which includes equity of access for patients no matter how they contact the practice and improved access to e consults,. Monitoring and identification of practices needing additional support through use of Ardens Manager and through the national Practice Dashboard,. Using patient feedback and to address patient concerns about access through FFT data, complaints and social media feedback. Option to take Contractual action if practice do not deliver GP contractual requirements on access such as online consultations throughout core hours.	Practice not engaging fully with Modern General Practice Model,. Unexpected increase in patient demand outside of GP control,. Gaps arising from implementation requirements of Fit For The Future 10 Year Health Plan for England	3	3	9	Primary Care Commissioning Board reviews reports access as reviewed through the Quality and Improvement Group,. Concerns and Resilience Group reviews individual practice performance,. PCNs are encouraged to deliver their CAI plans via regular review meetings with Primary care Commissioning team,. Greenwich practices offering appointments in a timely way with patients booking more than two weeks ahead as an exception rather than a norm	No Gaps	2	2	4		18/9/25
622	15/7/25	Farrell Green	Jessica Arnold	Risk of MMR Outbreaks in Greenwich	Insufficient MMR vaccination coverage in under 5s to maintin herd immunity. London has a multicultural population with communities where scepticism around vaccination is historically more prevelant. It is highly unlikley in London broughs to reach the national 95% target coverage. Furthermore GP practices experience a range of workforce issues which undermine capacity to proactively or personally engage with communities.	3	3	9	MMR campaigns advertising clinic locations targeting parents in low uptake wards,. Community catch-up clinics offering MMR vaccinations,. MMR vaccinations offered in 3 community pharmacies,. Offer of £250 to outreach clinics held by GP Practices,. MMR booster vaccinations bought forward to 18 months of age	Engagement with the community	3	3	9	Health Protection Board	ICB restructuring poses a risk to accountability,. without clear ownership of immunisation performance in future organisation.	1	2	2		25/9/25
623	15/7/25	Farrell Green	Jessica Arnold	Risk of apathy in the community towards flu vaccinations	Low public confidence in vaccination programmes and vaccine fatigue has increasingly impacted the success of vaccination campaigns since the COVID pandemic.	4	2	8	Developing a winter comms plan prior to September, including targeted advertising campaigns to reach at-risk cohorts,. Utilise positive,. clear messaging using the \Why we get vaccinated campaign\ toolkit,. Work with voluntary groups to increase reach of positive messaging,. Tailor Communication styles to local communities,. Offer more convenient access with pop-up clinics in low-uptake areas,. Leverage reminder systems in primary care,. such as text messages and phone call reminders for flu appointments,. Performance will be reported in the bulletin and Ardens Manager reviewed to direct supportive discussions with practices.	Engagement with the Community,. The reach of comms social channels,. relationships with community leaders are not longstanding	4	2	8	SEL Operational Group	ICB Restructuring	2	2	4		25/9/25
624	15/7/25	Michelle Barber	Jessica Arnold	Risk to achieving the cancer screening target	There is a small risk that Greenwich may not achieve the cancer screening trajectory (bowel, cervical and breast) as set out in the LCP performance data report. The cancer screening is commissioned by NHS England and there is always a significant lag in the reporting - current data is from September 2024 for bowel and breast, and June 24 for cervical.	2	3	6	Based on the data in the LCP performance report,. Greenwich is only 1% below the trajectory for each of the cancer screening programmes. In order to increase public awareness and uptake of cancer screening,. the following actions have been taken,. and continue to be: "Bowel Screening we are meeting the national target 62% - Greenwich currently at 65.4% The national Cervical Screening or Breast Screening target is not currently being met across SE		2	3	6	Integrated working between ICB staff (Greenwich Place),. Greenwich Public Health team and the CCPL for cancer on a targeted work plan to increase awareness of the importance of cancer screening and increase uptake,. Greenwich won a bid to purchase breast models to take out in the community to show women how to look for lumps in their breasts. These will be used in outreach work and other opportunities to make improvements to breast screening,. RBG colleagues have identified other workplaces to offer cancer screening information and training where interest found,. Head and Neck Cancer - Training has been provided to interested barber shops in Greenwich with merchandise currently being distributed. PH are currently looking to undertake an evaluation,. Cancer Alliance have provided some funding to do training around community champions and connectors to talk to people about the first signs of breast cancer. ICB working with RBG leads and have organised dates for 2 sessions of Talk Cancer training. 1 F2F and 1 online. 1st session held in January 25. SEL Cancer Alliance to provide £5k per borough to support VCSE LED projects to raise awareness of cancer screening programmes. - breast,. bowel,. cervical in all boroughs (Lung in Greenwich). Funding to be decided for events or other community driven initiatives and be allocated to single organisations. In Greenwich MetroGAV have shown an expression of interest and are awaiting an outcome to progress this. We are looking for VCSE organisations to host a gynae cancer awareness workshop from September 25 in partnership with the Eve Appeal. We are continuing to work closely with practices in Greenwich to provide support and resources to make involvements. CCPL has attended Nurse Fourm on 19th June to Talk about Cancer Screening in the borough and to raise awareness,. Vacancy for PH Cancer Screening Lead - Post is currently out to advert and is required urgently to ensure this work is progressed.	No gaps identified	2	2	4		24/9/25
625	15/7/25			Risk to achieving the ICB target (73.4%) and the national NHSE target (85%) for the management of hypertension to NICE guidance	There is a risk that lower than target hypertension management within primary care may increase cardiovascular risk and contribute to poorer health outcomes for residents and future avoidable demand on secondary and acute health care services.	4	3	12	'Clinical Excellence South East London' (CESEL) and the Greenwich LTC team work with practices and PCNs to ensure that they have the latest data regarding their hypertension management,. together with a resource pack and best practice guidance on how to improve hypertension management. SEL also support with \Call to Action\ webinars to increase awareness with clinicians,. showcase best practice and provide expert clinical advice,. Increasing awareness with the general public through community outreach events (working with public health and the comms & engagement team) concerning the importance of having blood pressure checked and controlled,. . The 2025/26 priorities and operational planning guidance identifies increasing the percentage of patients with hypertension treated to NICE guidance to 85% by March 2026 as a national objective. For 2025/26,. this will remain the primary aspirational goal for SEL. SEL will also pursue a 'minimum achievement' target (which will serve as the revised SEL ICB corporate objective) to achieve 73.4% for Greenwich. The current achievement is 68%.		4	3	12	The hypertension target is monitored by CESEL and is a regular agenda item on the LTCs Programme Group - to support improvements,. Further outreach and engagement via the Comms & Engagement team and Charlton Community Trust,. LTC CCPL and LTC Programme Lead have arranged a series of meetings with the PCN CDs over the next couple of months to discuss the hypertension management and opportunities to make improvements and understand any ongoing challenges.	No Gaps in Controls	3	3	9		24/9/25

Conditional Format List

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

Forward Planner Greenwich Meetings	Aug-25		Sep-25		Oct-25		Nov-25		Dec-25		Jan-26		Feb-26		Mar-26		
HGP - Healthier Greenwich Partnership		27-Aug		24-Sep		22-Oct		26-Nov		17-Dec		28-Jan		25-Feb		25-Mar	
		In Private		**Development Workshop/Seminar**		**In Public**		**In Private**		**Development Workshop/Seminar**		**In Public**		**In Private**		**Development Workshop/Seminar**	
	School holidays	School holidays	School holidays	In person Venue: TBC		MS Teams or in person - TBC	School holidays	MS Teams		In person Venue: TBC		MS Teams or in person - TBC		MS Teams	School holidays	In person Venue: TBC	
		Papers due 19/08				**Papers due 14/10**		**Papers due 18/11**				**Papers due 20/01**		**Papers due 17/02**			
Chair - Kate Heaps (wef May 2025) **Business Support** - Julie Mann **Standard Agenda Items** -Welcome -Introductions and apologies -Declarations of interest -Minutes of previous meetings -Action Log -Public engagement: delivering our Healthier Greenwich Plan (focus on 'well' areas) - **Quarterly at Public Meeting** -HGP Partner's Report.- **Quarterly at public meeting** -HGP sub-committee report - **Public Meeting** - HGP Development - **Private Meeting** **Developmental Workshops/Seminars**; Held every quarter, in person only. Focus on working together across the partnership strategically		Board meeting in private (on MS Teams) Introduction and apologies Declarations of interest Minutes of previous meeting in private Action Log Main Business/Themed Item The Wells: Feel Well - CYP- Dave Borland; Adults - Lisa Wilson; Addiction - Sam Bennett/Helen Buttivant Items for noting/limited discussion Forward planner		LCP plan refresh in light of 10 Year Plan (including role for PH and prevention)		Board meeting in public Introduction and apologies Declarations of interest Minutes of previous meeting in public Action Log Positive partnership story The Wells: Stay Well - Jessica Arnold Items for noting/limited discussion Public Forum Feedback Healthier Greenwich Charitable Funds update HGP partners report Performance report Sub-committee report Risk register Forward planner		Board meeting in private (on MS Teams) Introduction and apologies Declarations of interest Minutes of previous meeting in private Action Log Main Business/Themed Item The Wells: Age Well - Lisa Wilson Items for noting/limited discussion Forward planner		Greenwich Neighbourhood Workforce		Board meeting in public Introduction and apologies Declarations of interest Minutes of previous meeting in public Action Log Positive partnership story Items for noting/limited discussion Public Forum Feedback Healthier Greenwich Charitable Funds update HGP partners report Performance report Sub-committee report Risk register Forward planner		Board meeting in private (on MS Teams) Introduction and apologies Declarations of interest Minutes of previous meeting in private Action Log Main Business/Themed Item TBC Items for noting/limited discussion Forward planner		One of Neighbourhoods & Place alignment/ HIUs/ Mental health impact on physical health (to define later)	
Future Agenda items - not linked to specific meeting CYP focussed workshop MSK procurement Thamesmead APMS Procurement																	