Healthier Greenwich Partnership (in public)

Date: Wednesday 29 April 2026
Time: 12.30 – 14.30
Venue: MS Teams Click here to join meeting
Chair: Talia Barry

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 – relating to today's agenda	Verbal	Chair	12:45
4.	Minutes of the meeting held 25 February 2026	1	Chair	
5.	Action Log and Matters Arising	9	Chair	
6.	Shared successes	Verbal	ALL	12:50
Public Engagement: Delivering our Healthier Greenwich Plan				
7.	Positive Partnership Story: S106 Funding awarded to Hospice	Verbal	Jon Devlin	13:05
8.	Age Well update	10	Phil Darby	13:20
9.	Healthier Greenwich Charitable Funds update	39	Danielle Grant-Vesty	14:00
Items for Noting				
10.	Healthier Greenwich Partnership report	47	Gabi Darby	14:15
Closing Administration				
11.	HGP Forward Planner	51	Chair	14:20
12.	Any Other Business	Verbal	Chair	14:25
13.	Next Meeting in public: 29 July 2026		Chair	
Meeting closes at 14:30				

Healthier Greenwich Partnership
Held in Public at Community Hospice
Minutes of the meeting held on 25 February 2026

Members		**Voting member**	**Apologies**
Kate Heaps (Chair)	Chief Executive, Greenwich, and Bexley Community Hospice (KH)	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	Acting Place Executive Lead, SEL ICB Greenwich (GD)	No	
Lindsey MacLeod	Greenwich LMC (Local Medical Committees) Chair (LM)	No	
Florence Kroll	Director of Children's Services (FK)	Yes	
Talia Barry			Yes
Jo Sutcliffe	Deputy Chief Operating Officer, LGT (JS)	Yes	
Nupur Yogarajah	Clinical and Care Professional Lead for Greenwich (NY)	Yes	
David James	Chief Executive, Greenwich Health (DJ)	No	
Samantha Bennett	Director of Public Health, RBG (SB)	Yes	
Nick Davies	Director of Health and Social Care, RBG (ND)	Yes	
Jenny Ioseliani	Director of Children & Young People's Services, Oxleas NHS Foundation Trust (JI)	No	Yes
Andrew Kerr	Metro GAVS (AK)	Yes	
Joy Beishon	Chief Executive Officer, Healthwatch Greenwich (JB)	No	
Sarah Burchell	Service Director Adult Community Physical Health Services, Oxleas NHS Foundation Trust (SB)	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	
Patricia Ojo		No	
Johnson D'Souza	PCN Clinical Director (JdS)	No	

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In attendance	
Julie Mann	Business Support (Minutes) (JM)
Chris Dance	Assistant Director of Finance, Greenwich, SEL ICB (CD)
Shelley Whittaker	Engagement & Communications Manager, Greenwich, SEL ICB (SW)
Jon Devlin	Director of Partnerships, Greenwich & Bexley Community Hospice (JD)
Eugenia Lee	Clinical Lead, Population Health (EL)
Adebisi Olunloyo	Clinical Lead, CYP & Maternity (AO)
Members of the public	**0**

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1	**Welcome, introduction and apologies**
1.1	• Apologies as noted above • It was noted that Jon Devlin (Director of Partnerships, Greenwich & Bexley Community Hospice) was in attendance to shadow the Chair in relation to leadership transition at the Hospice
1.2	**Questions from the public related to today's agenda**
1.3	• None received
2	**Conflicts of Interest - relating to agenda items**
2.1	• No Conflicts of interest were noted
3	**Minutes of the meeting in public held on 22 October 2025**
3.1	• The minutes of the meeting held on 22 October 2025 were accepted and approved as a true record of the meeting
4	**Action Log and Matters Arising**
4.1	• It was noted that there four open actions on the Action Log which are to be closed • There were no matters arising
4.2	**Action:** • Action Log to be updated as noted above
5	**Developing the CYP Neighbourhood offer and aligned programmes** Papers were circulated in advance This item is for noting
5.1	**Introduction and overview** • There have been several workshops across SEL to identify core elements of the CYP Integrated Neighbourhood framework • 10 core framework functions were agreed • Population health management will be critical, with early identification and information sharing across the partnership • Sharing amongst partners will identify and alleviate escalations as early as possible • There is a flourishing VCSE sector supporting the work • Education will play a large role in the sector • Implementation roadmap was shared • A lot of data is held but there are gaps in how it is disseminated and used • Adult mental health also impacts children – parental and children's needs must be considered concurrently • There are five key areas that will be concentrated on: • Interdisciplinary Family Help • Strengthening Kinship • Multi-agency Child Protection Teams • Regulating Private Care Providers • Investment in Workforce and Systems • Must be conscious about not adding more layers of bureaucracy • Proposal to reform to allow for MDTs to support families through the entire system

	• Need to be aware of how government programmes interlink (DFE, DHSE) • NextGen Greenwich papers can be read here • Local child health teams – report in June 2025 • Education white paper published on 23 Feb • Education health and care plans must be considered in INTS – must align and complement existing programmes • Adult work will impact positively on children, especially in the mental health area

5.2	**Implementation roadmap**
	• Deadline is 2029
	• Launch of test INT by end of 26/27 and embedded in 2029
	• Multiple steps involved
	• Population Health Management
	• Design and development
	• Test INT model
	• Ongoing engagement with CYP and families
	
	Governance
	• There are several strategic oversight groups that interface with CYP health and wellbeing
	  ○ Youth Service Justice Management Board
	  ○ Safer Greenwich Partnership
	  ○ Greenwich Safeguarding Children's Partnership
	  ○ Children and Young Peoples Partnership Board - proving strategic oversight of development
	  ○ SEND Improvement Board
	  ○ Health and Wellbeing Board
	  ○ Healthier Greenwich Partnership – receiving updates and input on development
	  ○ Corporate Parenting Partnership Board
	• Wider groups will be involved in input into the shaping of INTs, with the extent of participation varying dependent on cohorts or focus
	• Holding demand with genuine intervention at the earliest opportunity
	• Everything is rooted in prevention

5.3	**Comments and observations**: • Population health management still needs work in this area, especially in rising risk • There may be some funds available to support the programme from strategic funds • Must work together to create a system that is not overly complex • Intersectionality with mental health – significant issue around children with parents with life shortening illness – there is an opportunity to improve on this • Sometimes children are the best influence to change adult behaviours • A welcome approach • Tackling needs of children differently • Must dovetail with general practice approach • Have we identified what is needed to implement this to achieve outcomes • Not only a programme but an active solution is needed • Startling to see statistic on children in care due to parental issues • Prevention over crisis • Culture change needed not only by practitioners but also by parents • How do we implement a culture change to encourage parents to speak out • Would like to see short-, medium- and long-term outcomes • Important to see real differences • Really need to consider what can be removed to free up people's time to effectively manage outcomes

	• Majority of children will live happy healthy lives • First 1000 days are the most important • Public health are building an adult prevention framework – as this develops need to include the children's framework to embed this • Embed early prevention • Community pharmacy does see entire families, providing an insight into how they operate – important to bear in mind whilst developing INTs • Need to include community pharmacy in children's health pathways – part of the MDT pathways • Must bear in mind those with learning disabilities • Children with significant needs also impact on their health • What changes will need to be in place to make this happen, it is a resource intensive [process • If funding model changes may need to revisit for further
5.4	**Response:** • Culture change is happening in children's services through changing the way we work • Need to build trust with GPs, faith groups etc • Incumbent on all to consider referrals very carefully – considering having more social workers working with neighbourhoods • We also need to work differently and get everyone involved into shifting into community • Under 5's - • Creative and impactful model • Need to consider funding • There may be opportunities for efficiencies • Need to get social workers to change the way they work • The vision is there; we all need to work together to make it happen
5.5	**Actions:** • Proposal to be shared with Neighbourhood Programme Board later in the year
6	**NEIGHBOURHOOD HUBS** Papers were circulated in advance Item is for approval
6.1	• NHSE Neighbourhood Health Guidelines 25/26 state the importance of exploring use of neighbourhood building across all system partners • Neighbourhood Hubs are: • co-located, community accessible spaces supporting integrated teams • service delivery sites for residents (provided by public health and care services, including VCSE organisations) • Must make optimal use of public estates • Estate challenges include: • GP premises not fit-for-purpose for modern healthcare • GP premises have insufficient space • Limited capacity • Uneven distribution of community spaces in some areas • Cost and available funding for refurbishment and development • VCSEs struggle to find suitable space • Must be smart about how space is used • There is a lot of pressure on existing space • Community spaces are not just for delivery of services but also for communities to meet • Greenwich General Practice Estates Strategy signed off in April 2025:

	○ Managing existing general practice sites, especially poor quality premises ○ Proactive planning ahead of large housing and regeneration developments in the high-growth borough ○ Agreeing the principles for future investment into estates • Some successful applications for investment made in 2025 from UMF (Utilisation and Modernisation Fund) and LIG (London Improvement Grant), as well as the Greenwich S106 programme • Greenwich Local Estates Forum brings together system partners across Greenwich • housing and regeneration teams in statutory services are working together to think about future opportunities • Greenwich is in a better place than many others in the country, and was the first borough in South East London to develop neighbourhood hubs • Funding sources and planning are still under consideration
6.2	Comments and observations • Could we be more creative about sharing spaces like community centres and Peabody estate buildings • Need to ensure that there is good use of a variety of spaces in communities as some are more easily accessible than others • Need to be cautious as previous attempts (Darby centres) were not as successful as anticipated • Bear in mind that people want services in their local areas • Pursue doing the right thing rather than what is proscribed by NHSE • What is the definition of neighbourhood hubs - what do they need to be • How to include community pharmacies into this as well • Good progress
6.3	Response: • Definitely need to do the 'right thing' • Very interested in exploring what community pharmacies can contribute
6.4	• All agreed to the proposal based on the listed caveats
7.	**FIVE YEAR STRATEGIC COMMISSIONING PLAN** Papers were circulated in advance This item is for noting
7.1	• 10-year plan published a year ago • Each ICB had to publish a 5year plan • Slide 64 summarised the delivery priorities • Appendices list contributions, and provides details on population health improvement and neighbourhood delivery plans • ICB board was approved in Feb and submitted to NHSE – still awaiting comments and feedback from NHSE
7.2	• Members were asked to note the report
8	**THAMESMEAD APMS CONTRACT AWARD** Papers were circulated in advance Item is for noting
8.1	• Following on from agreement at HGP in .. the contract has been awarded to Addison Rod Medical Practice • Transition and mobilisation is going well, both for the incoming provider and the outgoing provider • No changes to services offered at the practice including patient registration • Many of the existing staff will remain at the practice under TUPE

	• The telephone number and email addresses to contact the practice will remain the same • The only change is a change to the online consultation app
8.2	• Members were asked to note the report
9.	**NEIGHBOURHOOD INVESTMENT PLANS** Papers were circulated in advance This item is for noting
9.1	• This item was approved at HGP in private on 28 January 2026 • Non-recurrent funds were identified which could be used for the integrator role • Recurrent and non-recurrent funds originally allocated for long term conditions and frailty will be re-directed for the development of neighbourhood work
9.2	• Members were asked to note the report
10.	**HEALTHIER GREENWICH PARTNERSHIP REPORT** Papers were circulated in advance This item is for noting
10.1	• The document contains updates on activities form partners
10.2	• Members were asked to note the report
11.	**RISK UPDATE** Papers were circulated in advance This item is for noting
11.1	The Chair noted: • This report provides an update on the most recent review of risks on the Greenwich risk register • There are currently 18 active risks on the register, since the last update to HGP two new risks have been added • Since the last update to HGP, 17 risks have been reviewed and updated • Since the last update to HGP, one risk has been closed • The report includes a range of actions that are being undertaken to manage and mitigate risks • Risks are updated monthly • The risk around achieving financial balance has reduced • There is a high risk score on Autism and ADHD assessments, in line with all places across South East London
11.2	• Members were asked to note the report
12.	**FORWARD PLANNER** Papers were circulated in advance This item is for noting
12.1	• The Chair noted that if anyone wants items included at future meetings, these should be emailed to JM
12.1	**Actions:** • ALL to email JM with any future agenda items
13	**AOB**
13.1	• There is a clinical summit on 18 March 2026 to be held at Dial Arch in Woolwich, members are encouraged to attend if available • Healthier Greenwich Charitable funds are hosting a networking event for grantees on 24 March 2026 which members are welcome to attend

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	• It was proposed that due to the Design Lab workshops, HGP workshops are discontinued in the interim and replaced with meetings 'in private' and 'in public' as applicable and to continue with the 'Wells' theme at each meeting – **All agreed**
13.2	**Action** • Meeting series to be amended to remove currently planned workshops • Forward planner to be updated with 'Wells' theme for each meeting
	Next meeting in public: 29 April 2026

Action Log - Open

Date of meeting	Minute reference	Action and updates	Lead	Deadline	Update/Date closed
25/02/2026	5	CYP Neighbourhood offer to be shared with Greenwich Neighbourhood Programme Board later in year	Dave Borland	TBC	
25/02/2026	13	Forward planner to be updated: remove current planned workshops (due to clash with Design Labs) Wells theme for each meeting	Julie Mann	31-Mar	Completed

AGENDA ITEM:

Healthier Greenwich Partnership

Date: 29/04/2026

Title	*Ageing Well Update*	
This paper is for **noting**		
Executive Summary	*The report sets out progress made against the ambitions of the Ageing Well priority for the Healthier Greenwich Partnership. The report provides updates on the following areas of work:* • *Coproduction, Market Shaping and Workforce* • *Support for unpaid carers* • *Digital Health and Care Technology (DHACT)* • *Developing Home First and Virtual Wards* • *Falls Prevention and Management* • *Community Frailty Development into INTs* • *Increasing the use of Universal Care Plans (UCP)* • *Development of the Transfer of Care Hub* • *Community Hospice* • *Support for people living with Dementia* • *Integrated Community Equipment Service (ICES)*	
Recommended action for the Committee	• *To note the contents of the report and provide feedback on any areas of development highlighted*	
Potential Conflicts of Interest	• *No conflicts of interest have been identified*	
Impacts of this proposal	Key risks & mitigations	• *None arise from this report*
	Equality impact	• *For each project and Equality Impact Assessment is completed as required.*
	Financial impact	• *None arise from this report*
Wider support for this proposal	Public Engagement	• *Public Engagement was not required for the direct purposes of the report. For individual*

		projects coproduction and engagement with residents is integral to the development of proposals.
	Other Committee Discussion/ Internal Engagement	• Not Applicable
Author:	*Philip Darby*	

Ageing Well Update

Healthier Greenwich Partnership

April 29th 2026

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 and will inform our delivery structure for the Healthier Greenwich Partnership.

Support Greenwich residents to **start well:**

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

Support Greenwich residents to **be well:**

- Everyone is more active
- Everyone can access nutritious food

Support Greenwich residents to **feel well:**

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

Support Greenwich residents to **stay well:**

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

Support Greenwich residents to **age well:**

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

Live Well Greenwich

South East London Integrated Care System

Greenwich priority action – Age Well

NHS South East London

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

We will work with individuals and carers to develop an offer that supports people to live long, healthy, active and independent lives. This includes developing services in line with our Home First approach wherever possible to ensure care and effective treatment for both sudden and unexpected, and longer term health problems or disabilities, through an integrated urgent care system and stronger community based care. The Age Well priority also focuses on ensuring individual have access to safe and high-quality home, residential and nursing care when needed. Help people to die well, in their usual place of residency, in line with their wishes.

How we will secure delivery

Priority partnership actions:

- Delivering actions which improve market sustainability, quality and workforce recruitment and retention initiatives across community based, residential and nursing settings, including a refresh of Market Sustainability Plans and targeted use of government funding.
- Co-design, development and delivery of community-based support models for those with care and support needs and their carers. This will include delivery of the new Homecare model, development of community enterprises and new models of care.
- Optimise and develop our Home First approaches by expanding virtual wards to provide assessment, treatment and care to all patients in the place that they call home (including care homes), and to ensure that patients cared for at home have direct access to diagnostics.
- Focus on supporting providers around sustainability and quality via the delivery of the MSP
- Continue work to embed assistive digital technology into local offers that can improve the lives of residents with specific needs, both in prevention, short- and longer-term support

Other actions include:

- *Work with partners to further develop Falls and Frailty offers across the Borough and with residents to co-produce areas of priority*
- *Improve the join up of data and insight regarding demand and supply of community-based services*
- *Define our strategy and delivery plan for accommodation with support services across needs and ages*
- *Further develop and promote the Framework for Enhanced Health in Care Homes*
- *Work in partnership to design and test an approach to embedding digital and care technology into local offers*
- *Delivery of joint Carers strategy*
- *Work with all our partners to ensure that the learning from Safeguarding Adults Reviews informs our practice*
- *Develop community-based offers to support those living with Dementia*
- *Shape the approach for a Community MSK service in line with best practice and aligned to the outputs of the SEL MSK programme*
- *Increase use of Urgent Care Plans (advanced care plans) across Greenwich Practices*

Intended outcomes in 5 years time

For our local residents to receive consistent high quality care in the most independent environment across the continuum of care and wherever possible in their own home.

- To provide care and treatment at home for people experiencing a wide range of chronic conditions and acute episodes of ill health. This includes services which can assess, treat and provide ongoing management of COPD, dementia and delirium, frailty and falls, palliative and end of life care and dehydration and infection.
- An increase of deaths in Usual Place of residence by 2% by 2027. 0.5% of patients on primary care registers have an advance care plan

People with the potential to live more independently are moved to less intensive care and support services build on what is already in place promote prevention, self-care and social prescribing:

- Greenwich have a range of good quality community based options including access to local clubs and meaningful activities and employment, Home First Service, neighbourhood based home care and accommodation with support, with outcomes quantified by measuring satisfaction levels, healthy life expectancy measures, health and wellbeing indicators. People are able to self direct their care and support

A modernised offer with strength based and joined up practices are in place across our local offers which enable people to access local assets and support within neighbourhoods. Good access to safe and high-quality home, residential and nursing care when needed;

- Local people, practitioners and partners will have a good understanding of the local options, including self-funders, and will assume quality of care and a skilled and compassionate workforce.
- We continue to work alongside local people in co production
- Digital and technology solutions are embedded in local offers, people and staff are confident in its benefits
- Data and insight is joined up so we are aware of the quality of provision, people access good and outstanding settings, demand and supply is known and informs service developments and continuous improvement

Carers are: respected as expert care partners, have access to personalised services they need to support them with unmet needs, are more able to have a life of their own outside their caring role, are supported to mitigate (where possible) the financial impact of the caring role, are supported to stay mentally and physically well and will be treated with dignity

Co-production, Market Shaping and Workforce

Co-production

Within the Ageing Well portfolio there is a commitment to genuine and meaningful involvement with residents in our work, co-producing wherever possible. There are multiple examples of this within Ageing Well including in the Carers re-design and Homecare re-design work and is informed by a three-pronged approach:

- Developing a HAS approach to resident involvement
- Embedding the Making it Real approach to how we undertake co-production, including I and We statements
- Utilising the HGP Engagement Network to maximise the intelligence and insight gathered by our system.

Market Shaping

Significant work is being undertaken to shape and develop the markets within the Ageing Well portfolio, supporting the development of key relationships in the market, as opposed to purely transactional provider interactions.

Project specific work is being undertaken such as;

- Carers redesign, in collaboration with Stone King
- Homecare redesign, in collaboration with Stone King
- Extra Care future development, in collaboration with RBG Housing colleagues.

In addition to this significant work is taking place to shape and sustain the care homes market, specifically through financial sustainability programmes and uplifts.

Workforce

Workforce remains a key pressure with a high proportion of care workers over the age of 55 in Greenwich.

Managing capacity, skills and experience within the sector is a challenge that all organisations are facing, and so the approach agreed at HGP to develop a sector-based workforce approach will also be embedded within Ageing Well, with Care providers such as LNCS Homecare and Care Homes within Greenwich invited to form part of the programme.

Additionally discussions around how Homecare and Care Home providers can be integrated within INTs is ongoing and formed conversations in recent Homecare design workshops.

Carers

Delivery of joint Carers strategy

Area updates

Key achievements:

Carer Inclusive Workplace accreditation

Royal Borough of Greenwich achieved its Carer-Inclusive Workplace Accreditation, awarded by Greenwich Carers Centre and funded through the Carers Innovation Fund

Civic Awards

This year we celebrated our first ever winners in the new Unpaid Carer category of the Civic Awards

Carer's Centre Hardship Grants

Greenwich Carer's Centre secured funding from the Carer's Trust. They secured a total of £12,000 for carers in Greenwich and worked across community partners to identify carers who could benefit from the grant. These were issued at £100 per carer.

This demonstrates the added value and exceptional commitment to supporting carers from Greenwich Carer's Centre.

Best of Royal Greenwich Business Awards

Greenwich Carer's Centre were also named as the winner of the Inclusive Employer Champion Award at the Best of Royal Greenwich Business Awards.

Carers Survey Results

Analysis of the Survey of Adult Carers in England (SACE) results **indicates improvements** across many areas, including satisfaction with social services, access to information, and social contact. In addition, we have seen:

Improved satisfaction levels

Carers' **overall satisfaction with social services rose significantly**, surpassing London averages and nearing national benchmarks.

Improved carer quality of life

Carer-**reported quality of life has improved by 4.1%**, placing local performance above both the London and national averages

Increased social contact

More carers report adequate social contact, reflecting enhanced emotional and social support impacting wellbeing positively.

Enhanced access to information

Access to information improved notably, placing RBG well above London and national averages in service accessibility.

Sustained performance in carer consultation

Carer involvement in discussions has remained in line with the previous year, staying above the London average and closely aligned with the national benchmarks.

Contributing factors:

- Launch of the Our Greenwich, Our Carers guide
- Training for AOPS staff and development of practice
- The high performance of our commissioned carers service including Greenwich Carer's Centre, who exceed requirements in added value
- Non-RBG support including community carer support groups and champions within the community

HEALTHIER GREENWICH PARTNERSHIP

Carers Survey Results

Areas to Improve:

Carer's own health needs

Carers reported that there was an impact of their own health because of caring. Only **13% said their health had not been affected by their caring role.**

GP support

When asked if they feel GPs support them in their role as a carer, **33% said never, 33% said sometimes,** and **29% said the GP they see doesn't know they're a carer.**

Support reflecting cultural needs

When asked if the support you receive respects your background, language needs, cultural life, and religious beliefs, 53% said always and 32% said usually, but **7% said rarely** and **7% said never.**

Carers strategy targets

We are still **short on achieving the carers survey targets in 3 out of 5 ASCOF measures**. However, in all these areas we have improved or maintained performance, and all 3 are above the London average.

What have we learned from the survey?

- Carers health is a key area for improvement
- There is still a deficit in offering culturally appropriate support
- We need to better understanding of how actions link to the strategy and how we measure overall performance.

HEALTHIER GREENWICH PARTNERSHIP

Carers Engagement

We are carrying out engagement sessions with residents to support future commissioning and development of the carers strategy.

We have themed our questions around:

- Information, advice, guidance
- Support services including commissioned and wider VCS groups
- Time outside of caring

Engagement Sessions

- Mencap Carers Group – 6 carers
- Greenwich Carers Centre Café Drop-In – 15 carers
- Carers Social Group – mix of 14 carers and cared for
- Greenwich Carers Centre – 25 carers and advocates

- **We've spoken to around 50 residents so far.**

- We are also reaching out and setting up further engagement with:
  - Ana Huna
  - Irish Community Services
  - Caribbean Social Forum
  - Greenwich Carer's Centre Men's Group

HEALTHIER GREENWICH PARTNERSHIP

Carers

Delivery of joint Carers strategy

Next steps:

Over the next few months our plan is to:

• with the current carers centre contract expiring in March 2027, we are now designing what our future carers support should look like which includes engagement and co-production with carers. We are exploring a strategic partnership approach to this contract rather than a competitive tender, reflecting the strengths of local relationships and the market for carers support services

• Our Mobilise contract for digital resources expires in March 2027, we are looking to ensure online support is available to people which we know is typically accessed out of hours

• Using a small pot of funding from the Accelerating Reform Fund (ARF) to explore how we can better provide support for carers at the point of discharge from hospital, building on a pilot led by Bromley Council

• Increasing capacity of assessments by recruiting an additional post within Adult Social Care for 18 months. This will allow for further exploration of a trusted assessment model.

• Refreshing our carers partnership board to be more collaborative and deliver on the actions in our strategy

• Work with colleagues in our Children and Young People directorate explore ways we can align support for carers of all ages and develop a new All age Joint Carers strategy for 2027

Digital Health And Care Technology (DHACT)

Work in partnership to design and test an approach to embedding digital and care technology into local offers

Area updates

- Greenwich launched the Digital Health and Care Technology service on 31st March 2025, and are now just past a year into delivery
- In this first year, the service has had over 2,000 people referred in - more than double what was originally modelled
- That's over 2,000 people receiving support for their health and care needs in a different way, giving them more choice and control
- Residents love the service - with all of the 6 co-produced outcome measures trending positively including improving people's physical and mental wellbeing
- In addition we have seen great benefit from a social care funding perspective, by enabling people to stay more well connected, manage risks differently, and stay independent for longer - which is releasing care capacity for others in Greenwich that may need it more
- We're working with Oxleas and SEL ICB BI teams to understand the impact on caseloads, contacts and productivity - and should have the outputs for this in the next month
- For year 2, we are expanding DHACT into other teams and pathways as well as refining those already referring to make sure we are providing the best outcomes and impact for residents
- The big ticket items for this year are bringing in remote health monitoring (initially to cover the two virtual wards using this in Greenwich in JET and Frailty), proactive monitoring (where we are looking to identify through device data where people may need more help before an acute episode like a fall) and working with the care market to understand how new models of delivery could be built using DHACT

DHACT

Improve the join up of data and insight regarding demand and supply of community-based services

Area updates

- Using funding secured through the Accelerated Reform Fund (ARF), we are working to understand how we can join up different data indicators to identify people who may be near "stepping up" into needing help.
- We are delivering this on behalf of South-East London (SEL), and have been workshopping with SEL and Greenwich leads - this has led to us now understanding what our approach should be, in the context of wider system architecture and strategy, to deliver insights for operational change
- Over the next 18 months we will be identifying these indicators, joining them up where helpful, and sharing to support and enable us to better identify people at risk who could benefit from early "enablement" or a different outreach before they reach crisis or really need help
- To do this, we are recruiting a dedicated post to coordinate this work, as well as commissioning specialist data discovery expertise from the market - with a view to having these both in place by summer
- In addition, we have commissioned the Social Care Institute for Excellence to evaluate this work and the impact
- This will be a significant enabler for Integrated Neighbourhood Teams and our move to a community based proactive and preventative approach

Developing Home First and Virtual wards

Priority partnership action: Optimise and develop our Home First approaches by expanding virtual wards to provide assessment, treatment and care to all patients in the place that they call home (including care homes), and to ensure that patients cared for at home have direct access to diagnostics.

Virtual ward achievements identified through a recent borough wide deep dive:

- Supported hospital-level care at home, enabling admission avoidance and earlier discharge across adult pathways. Predominantly admission-avoidance model in adult services (Oxleas: 89% admission avoidance), supporting system flow and acute capacity.
- Oxleas adult virtual wards: since the beginning of 2024, 5,105 admissions, with 4,573 people supported to remain at home (90%).
- Implement recommendations from the Virtual Ward Deep Dive
- Remote health monitoring has been provided by DOCCLA, shortly to become part of the DHACT service with an integrated model.
- Established a multi-pathway adult offer (including Frailty, JET, COPD, IV therapy, Palliative and Community Care Plus/physio), providing a broader community alternative to admission.
- Community Hospice virtual ward: 221 of 268 admissions (83%) supported to remain at home, helping people achieve their preferred place of care and reducing avoidable hospital/hospice admissions.
- Strengthened integration across partners through a multi-provider model (Oxleas, Community Hospice, and Royal Borough of Greenwich social care), underpinned by Section 75/MOUs.
- Social care contribution has increased seven-day discharge capacity (reported as average of 9 discharges per weekend supported through the weekend offer).
- Pilot of Point of Care Testing in JET Virtual ward for CRP, NT-proBNP and D-dimer
- Enhanced joint working around end-of-life care, including embedding a palliative care ANP in the Emergency Department at QEH to identify and support suitable patients.

HEALTHIER GREENWICH PARTNERSHIP

Falls prevention and management

Priority partnership action: Work with partners to further develop Falls and Frailty offers across the Borough and with residents to co-produce areas of priority

Falls prevention services and management post fall continue to be a priority for the borough:

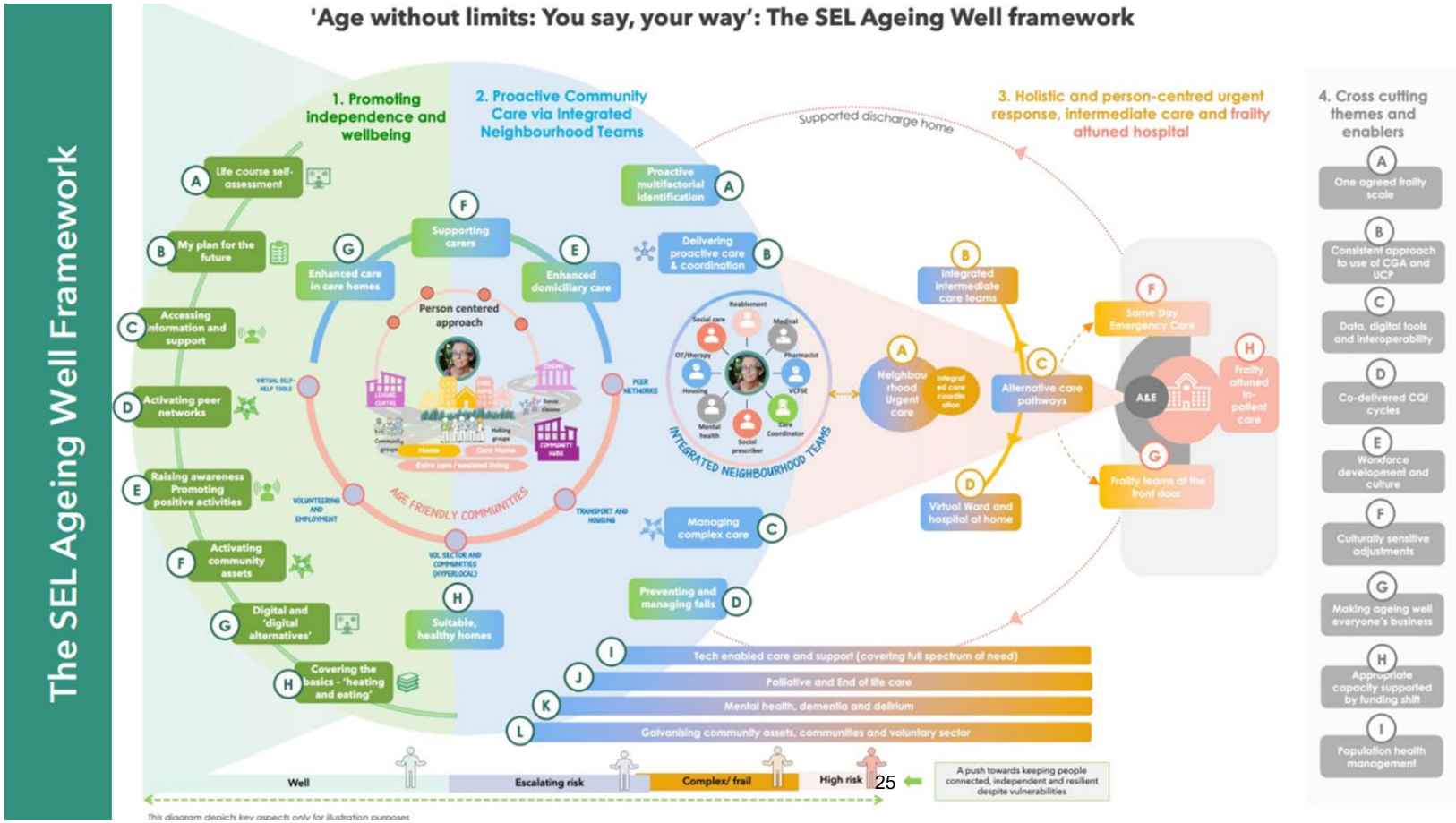
- Falls pick up service offered for patients through the JET UCR as an alternative to LAS/999
- Falls team recently reviewed and combined with CR-STAT team to streamline pathways and prepare for neighbourhood working
- Digital Health and Care Technology service (DHACT) co-designed with residents and offering improved digital technology for falls prevention
- JET/Frailty Pharmacist reduces polypharmacy to aid falls prevention
- 6 Greenwich Care homes have Raizer lifting equipment to improve patient experience and reduce the need for LAS to assist
- Live Well Greenwich provide Staying Strong and Steady group exercise sessions with education, falls prevention exercises and an opportunity to socialise with others who have fallen or have balance problems

HEALTHIER GREENWICH PARTNERSHIP

Community Frailty development into INTs

Priority partnership action: Work with partners to further develop Falls and Frailty offers across the Borough and with residents to co-produce areas of priority

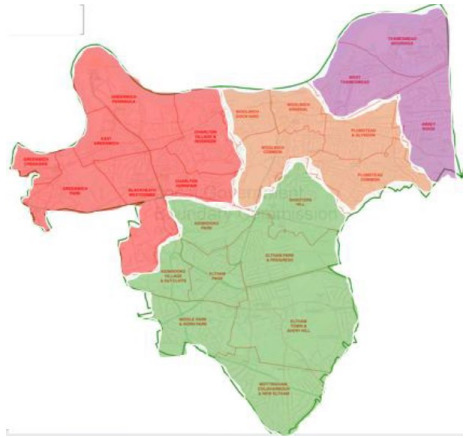
Mapping exercise completed against the SEL Frailty Framework



Community Frailty development into INTs

Evidence base clearly established for the Community Frailty team:

- 53% reduction in Emergency Department attendance
- 33% reduction in unplanned hospital admissions
- 21%% reduction in London Ambulance call outs
- An average of £143 saved per patient through medicines optimisation
- This equates to approximately £762,000 system savings over 12 months based on 622 patients referred
- Average of 5 hours of GP home visiting time saved per patient
- 96% positive response for the Friends and Family test
- 59% increase in mental wellbeing (Warwick Edinburgh Mental Wellbeing scale)



Moderately Frail population projection by neighbourhood:

West	905
South	1535
Central	780
East	363

Service Development:

- Neighbourhood investment to expand and increase from 80 to 120 referral capacity per month
- Case Manager, administrators and Care Navigators (AgeUK Social prescribers) funded through SIF
- Recruitment of an LGT Geriatrician across Frailty SDEC and Community Frailty team
- Align staff to the GPs in each of the 4 neighbourhoods
- Jointly complete the UCP
- Weekly Task and Finish group

HEALTHIER GREENWICH PARTNERSHIP

Increase use of the Universal Care Plan (UCP)

The Universal Care Plan (UCP) is a digital, personalized care planning system for London that allows individuals to share their health preferences, wishes, and care needs with healthcare professionals across the city, including NHS 111, ambulances, and hospital staff. It focuses on "what matters to you" and is used for end-of-life care, long-term conditions (dementia, frailty, etc.), and patient contingency planning.

Context

- UCP Task and Finish group in place for Greenwich since Feb 2024, and will run until September 2026 chaired by Age Well CCPLs (Rachel Matheson, Dr Heather MacFarlane)
- UCP Project manager recruited for 12 months (ICS PEoLC ageing well funding of £64k), started in June 2025 and recruited by Greenwich Health.

Achievements/ Updates

- UCP completion has risen to **0.6% for Greenwich** (was 0.3% in Feb 2024) approx. 1,900 residents
- Complex Case Managers and Care Home GP have completed over 500 UCPs of 670 residents. Guidance is in place for shared completion with GP reviewing and completing DNACPR.
- Various UCP Updates in GP Newsletter, workshop at PLT in Feb 2025
- Sickle Cell service using UCP following MDT
- QEH plan in place to read UCP for all patients on admission or presentation to ED
- UCP project Manager has visited 19 GP practices and worked with CNS in QEH. Now on maternity leave- secondment completes on return (Dec 2026)
- GP premium agreed by LMC for UCP completion with Frailty team referrals. CCPL to link with PCN CDs to review joint approach

HEALTHIER GREENWICH PARTNERSHIP

Development of the Transfer of Care Hub

The Transfer of care hub operationalises a Home First Approach to hospital discharges. This was also a recommendation of the Better Care Fund review that was completed in Spring 2025.

What is the Transfer of Care Hub (ToCH)?

- An integrated Bexley and Greenwich Hub, supporting the coordination of discharges across pathways 1-3, to ensure timely and safe discharge from acute hospital.
- The hub will have oversight of delays, identify and propose solutions to service gaps.

Transfer of Care Hub opening March 2026

Achievements

- Co-location in QEH from 09/03/2026, current hub staff include Bexley and Greenwich hospital social care teams, Oxleas Community Care Navigators and Borough Flow Leads improving collaborative working
- Implementation of OPTICA – action focused digital discharge platform, supporting real time task management
- Digitalisation of DPTL through OPTICA – system shared view
- Implementation of 14+ LOS meetings during Super March, successful in increasing oversight of complex patients, to be continued long term
- Starting to see the benefits during Super March, recent MADE event supporting QEH

HEALTHIER GREENWICH PARTNERSHIP

Community Hospice – Overview

Specialist palliative and end of life care across every setting | Greenwich & Bexley

Service Lines

Inpatient Unit
Specialist beds for complex symptom management and end of life care. 478 admissions; median stay 6 days. (Combined G&B)

Community Palliative Care
CNS-led caseload management at home and in care homes. 1,836 referral episodes — our largest service. (Combined G&B)

Hospital Team at QEH
Specialist advisory and direct care to inpatients. 1,553 episodes; 48% ending in death. (Predominantly Greenwich)

CHC Fast Track
Coordination of Continuing Healthcare fast-track packages — enabling rapid discharge from QEH into community or hospice care.

Outpatients, Rehab & Wellbeing
Specialist clinics, physiotherapy, OT, fatigue and breathlessness management — supporting independence.

Voluntary & Community Programmes
Compassionate Neighbours volunteer befriending (~14 hospices nationally). Family & Carer Support — fastest-growing line; 113 episodes. (Combined G&B)

Key Figures & Ageing Well Role

Key figures (Greenwich patients, 2025/26)

- **~1,300** unique Greenwich patients
- **~2,500** referral episodes (up 29% since 2023/24)
- **1,211** new Greenwich referrals in 2025/26

How we contribute to Ageing Well

- Supporting people to die well at home
- Activating rapid community pathways from QEH
- Reaching beyond registered caseload through volunteering & carer support
- Integrated model spanning acute, community & voluntary — seamless transitions without handoffs

COMMUNITY HOSPICE

ANP in the Emergency Department

Community Shift Programme Pilot · Queen Elizabeth Hospital, Woolwich · Dec 2025 – Mar 2026

The Programme

The gap

Patients arriving at QEH's ED with palliative care needs were frequently unrecognised — leading to avoidable admissions, extended stays, and care that didn't reflect their wishes.

The pilot

A Band 8a Specialist Palliative Care ANP, conceived and led by Sangeetha Francis from her seven years in the hospital palliative care team at QEH, was embedded in the ED for 14 weeks. Funded under LGT's Winter Community Shift Programme.

Why this model works

The ANP can refer into community palliative care, arrange a hospice admission, or initiate a CHC fast-track package — all within one organisation, often in one shift.

What happens next

The SELICS End of Life Care group has committed 12 months of funding to continue at QEH and build the evidence base for replication across South East London.

Pilot Evidence · 14 weeks, 47 clinical days

- **159** patients reviewed
- **551** palliative screens
- **13** admissions avoided*
- **20** bed days saved
- **2.1×–3.2×** return on investment
- **£61k–£92k** estimated gross savings

** Adjusted figure — reported data shows under-recording. ROI uses NHS Payment Scheme 2025/26 tariffs. Programme cost: £28,853.*

"Every metric improved month-on-month. The trajectory shows a longer programme would deliver substantially greater returns."
— Pilot Evaluation, April 2026

COMMUNITY HOSPICE

Investing in the Future: IPU Redevelopment

Modernising our Inpatient Unit for the next generation of palliative care

The Project & Why It Matters

The project

Redeveloping the Inpatient Unit at 185 Bostall Hill, Abbey Wood. Two four-bedded shared bays will be replaced with four new private en-suite single rooms — ending routine patient moves for infection control, end-of-life privacy, or same-sex accommodation.

The scheme also creates dedicated staff welfare facilities and improves the entrance and reception area. **Total project cost: £779,224.**

Why this matters

85% of IPU admissions are White British, compared with 73% for CHC fast-track — a gap linked to privacy concerns. Feedback from Nigerian, Vietnamese, Nepalese and South Asian communities identifies private rooms as a prerequisite for trust. Private rooms also improve clinical flow: eliminating same-sex bay conflicts, reducing daily bed moves, and strengthening infection prevention — supporting step-up from community and acute settings without delay.

Funding & Projected Return

The funding

- **£389,612** — Royal Borough of Greenwich (Section 106)
  Awarded. We are grateful to RBG and system partners who supported this bid.
- **~£690,000** — Government £100m hospice capital programme
  Phase 2 allocation, 2025/26 — ring-fenced for capital improvements.
- **£15,044** — Morrisons Foundation
  Designated specifically for bathroom conversions.

Projected system return

Estimated £137,000 annual saving through avoided ED transfers, prevented acute admissions, reduced delayed transfers and reduced care escalation.

Delivery partners: Innova Care Concepts (specialist hospice contractor) and plans developed pro bono by LandSec U+I.

COMMUNITY HOSPICE

Dementia – Overview

Develop community-based offers to support those living with Dementia

Area updates

Dementia Diagnosis rates

The national Dementia diagnosis target is 66.7%. This is defined as the diagnosis rate for people with dementia, expressed as a percentage of the estimated prevalence. In SEL this is currently 71% with Greenwich an outlier at 62.9%

Oxleas Memory service

Approx 3 month wait list following referral. Number of factors impacting waiting times including quality of referrals, volume and some non dementia causes of cognitive decline.

Admiral Nursing

Admiral nurse role sits with Oxleas with task and finish group set up to review scope and relationship to INT / GPs

Joint engagement project

Royal Borough of Greenwich (commissioning and public health teams), University of Greenwich, and Dementia Dialogue are working together to undertake an engagement project, funded with a grant from the Vivensa Foundation.

•We are running 5 workshops and engagement events with residents to hear their views on living with dementia. The conversations are themed around diagnosing well, supporting well, and living well, as defined in the NHS Well Pathway for Dementia.

•We will use the experiences gathered to explore short, medium and long term opportunities for developing dementia support.

GP Fellow

GP Fellow – Dr James Rogers

Dr Rogers has been working to review dementia pathways for people in Greenwich alongside Integrated Commissioning for Adults team, Oxleas, LGT, Mind care and GPs.

This work is identifying the existing support available and any gaps where there may be opportunities.

So far the findings have found good support for people during and immediately post diagnosis, at End of life and where there is Young onset dementia.

Future opportunity sits within the space post diagnosis when people are discharged back to GP's and would benefit from support when there are changes in presentation to avoid contacts with secondary care. This is currently fulfilled by an Admiral Nursing role in Oxleas with a new task and finish group established to review scope.

Dementia context

We believe there are over 2,000 people living with dementia in Greenwich

POPPI - People over the age of 65 predicted to have dementia in Greenwich

Dementia - all people Show by gender	2025	2030	2035	2040	2045
People aged 65-69 predicted to have dementia	177	209	222	217	224
People aged 70-74 predicted to have dementia	238	277	326	347	338
People aged 75-79 predicted to have dementia	397	391	456	535	576
People aged 80-84 predicted to have dementia	455	554	544	654	777
People aged 85-89 predicted to have dementia	419	469	580	580	706
People aged 90 and over predicted to have dementia	413	436	530	625	684
Total population aged 65 and over predicted to have dementia	**2,097**	**2,337**	**2,658**	**2,959**	**3,305**

Figures may not sum due to rounding
Source: Office for National Statistics licensed under the Open Government Licence v. 3.0

Dementia diagnosis rate is defined as the diagnosis rate for people with dementia, expressed as a percentage of the estimated prevalence

The national dementia diagnosis rate target is 66.7%.

		Jan-26						
Metric	Target	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Dementia diagnosis rate*	66.7%	71.4%	72.9%	62.9%	73.2%	71.6%	71.1%	71.0%
Trend since last report	-	↑	↔	↓	↓	↑	↑	↔

Dementia specific support

Two directly commissioned contracts:

Dementia Inclusive Greenwich – this includes working with local services to become more dementia inclusive. The work is supported by the Dementia reference group and Dementia Action group

Dementia information and advice - this service is currently provided by SEL Mind for people newly diagnosed with dementia or anyone requiring information and advice.

Additional focus on support for people living with dementia and their carers through:

Oxleas Dementia Care home support – this service works closely with our older people care homes, the residents, families and staff. Support is available to support staff with training and advice and for residents and families to understand changes, behaviours and support to live well

Oxleas Advanced Dementia Service – The service allows the patient's family to have a real alternative to placement for the patient when their dementia advances to the later stages

Care Homes – 11 older people care homes across Greenwich, with 10 of these providing specialist dementia care

Homecare – 6 framework homecare providers with expectations around good dementia care

Carers – support for unpaid carers inc cares of people living with dementia

Hospice - dementia and end of life care

LGT – Lead Dementia Nurse Specialist, offers support to patients and families to discuss what support they might need on discharge from hospital Advises hospital staff on how to offer the best support and advise our partners how to make our space and service as dementia supportive as possible

Voluntary Sector including:

- Volcare - Provides a free 'sitting' service for people living with dementia. This provides a respite break for the family carer.
- Carers Centre - practical and emotional support to people caring for family members plus a variety of activities
- Reflections - This is a free group for people living with dementia, and their family and friends meeting bi-weekly
- Age Exchange - programme to provide person-centred creative care for older people and young onset dementia

Dementia Inclusive Greenwich

We are working to make Greenwich a better and safer place to live, work, learn or visit for people with dementia and their carers.

Dementia Inclusive Greenwich' helps businesses adapt their services to be more inclusive. It offers local organisations free training and practical support to make big or small changes that can help people living with Dementia and their carers

The initiative gets people to think about building a dementia inclusive environment by having:

- more natural light
- colour contrast interior design
- clear signage
- accessible spaces and facilities
- social areas suitable for people with dementia and their friends or family to meet and chat
- quiet areas

Become a dementia inclusive organisation | Royal Borough of Greenwich

By joining the initiative, people receive:

- free dementia awareness training
- advice on how to make a business more dementia inclusive
- window stickers that can help people see that a business is dementia friendly and attract more customers
- free membership to the Dementia Inclusive Network Group

Greenwich currently has over **40** businesses and services accredited as Dementia inclusive

Dementia

Next steps:

Over the next few months our plan is to:

- Coproduction work through 2026 including joint research work with the university of Greenwich to understand the experience of people with dementia and their carers to understand people's experiences, what they want dementia to look like in the future
- This information will be used to shape recommissioning plans for dementia support when our current contracts end next year
- We have extended the funding to continue the dementia care home support team, supporting people to live well with dementia in care home settings
- A task and finish group has been established to identify gaps in support on people's journey along the dementia pathway. This will include a review of the admiral nursing service, linked to the review of virtual wards
- We've held an initial session with Greenwich GP's, the memory service, Oxleas and RBG where we started a conversation about improving dementia diagnosis rates. This will inform future conversations, and we will develop an action plan to identify opportunities to improve dementia diagnosis rate

Integrated Community Equipment Service (ICES)

- The Council had been part of the London Consortium for the delivery of community equipment since 2012. The latest iteration of the service commenced in April 2023 delivering equipment services for 21 London boroughs and has been delivered by NRS Healthcare. NRS entered administration in July 2025, and an interim solution needed to be sourced.
- Officers worked collaboratively with commissioners in SEL to source alternative provision and a short-term contract was awarded to Inspire commencing 1st August 2025.
- Provision began as emergency provision only, with 40 jobs available per week. System partners worked together to prioritise this limited capacity to reduce impact on residents from this reduced capacity, with a focus on supporting hospital discharge and people with complex needs. There were bi-weekly meetings led by the commissioning team to update on progress and manage any emerging issues.
- The original plan was to reach full capacity within the 6-month contract award period. Due to effective partnership working with the new provider, full capacity was achieved within 3 months instead. There was minimal impact on hospital discharge across this period, in part due to mutual support offered by Bexley and effective system working.
- A further contract has been awarded to Inspire for a maximum period of 24 months, up until January 2028. Work is commencing on a tri borough procurement between Bexley, Bromley and Greenwich. Design work on this new model will start from May 2026

HEALTHIER GREENWICH PARTNERSHIP

HEALTHIER GREENWICH

PARTNERSHIP

AGENDA ITEM: 9

Healthier Greenwich Partnership

Date: 29 April 2026

Title	Greenwich Healthier Communities Fund Update	
This paper is for **noting**		
Executive Summary	Greenwich Healthier Communities Fund is moving into the third year of funding. The report provides an overview of funding awarded, outcomes and future funding.	
Recommended action for the Committee	To note and raise awareness of the funding opportunity to all relevant organisations and encourage partnership working.	
Potential Conflicts of Interest	• None currently identified	
Impacts of this proposal	Key risks & mitigations	None
	Equality impact	Fund works to tackle health inequalities
	Financial impact	None
Wider support for this proposal	Public Engagement	• Consultation with key stakeholders in Greenwich • A Community Assessment Panel of 8 community members evaluated delivery medium and large applications, making recommendations for award. • Grantee Networking Events

	Other Committee Discussion/ Internal Engagement	Stakeholders included: • RBG Public Health, • RBG Children & Young People • Oxleas • GAVS
Author:	Danielle Grant-Vest, Groundwork London	
Clinical lead:	*NA*	
Executive sponsor:	*NA*	

Greenwich Healthier Communities Fund

Update April 2026

HEALTHIER GREENWICH PARTNERSHIP

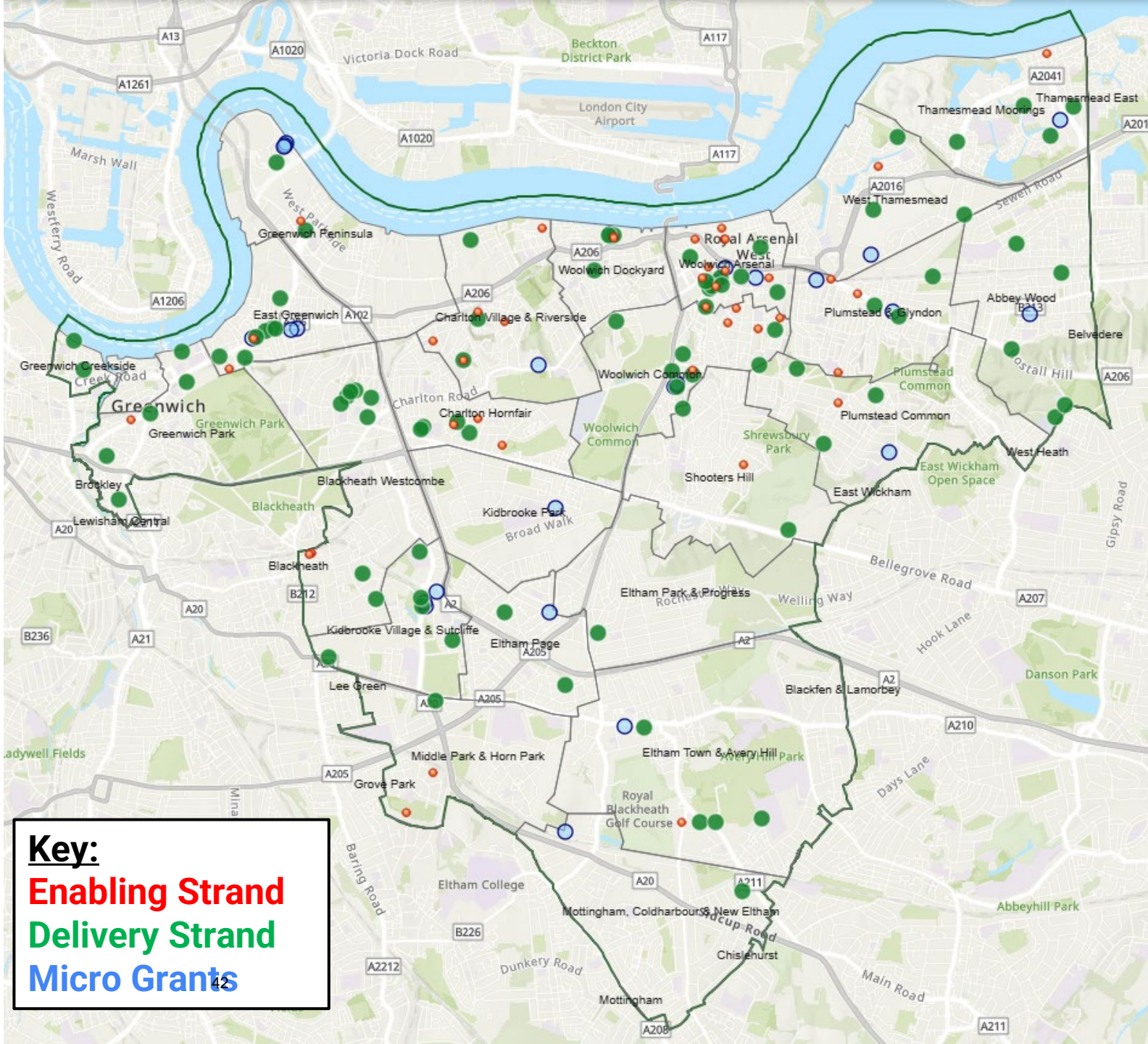
Funds Awarded to Date

- 161 Grants totalling **£2,780,527**
- 142 Individual organisations
- Across all Greenwich wards
- 88% Equity-led

Three funding strands:

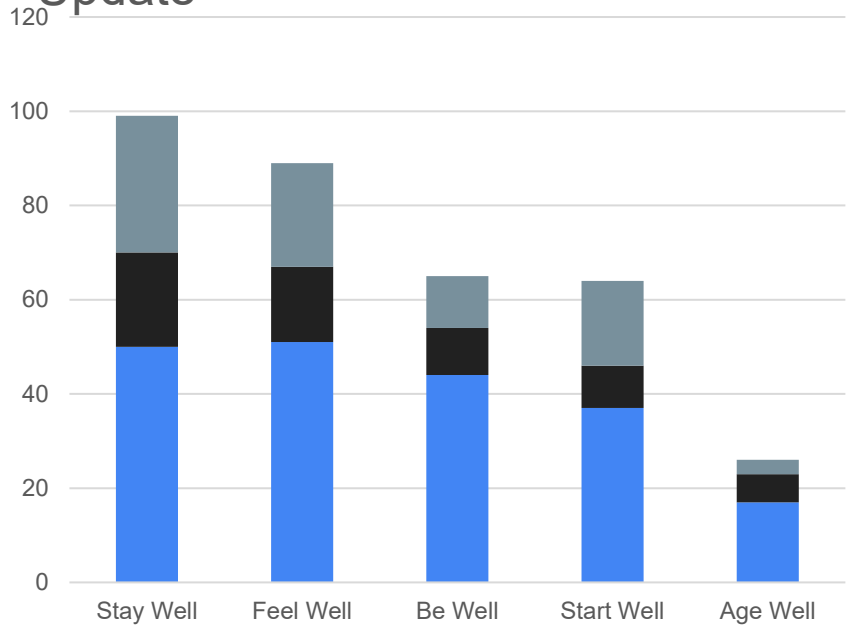
- 44 Enabling Strand - £300k
- 30 Micro Grants - £140k
- 87 Delivery Strand - £2.34
    - 41 Small – £587k
    - 43 Medium – £1.47m
    - 2 Large – £267k

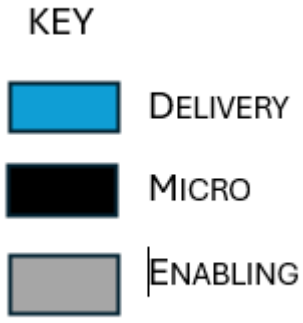
Greenwich Healthier Communities Fund



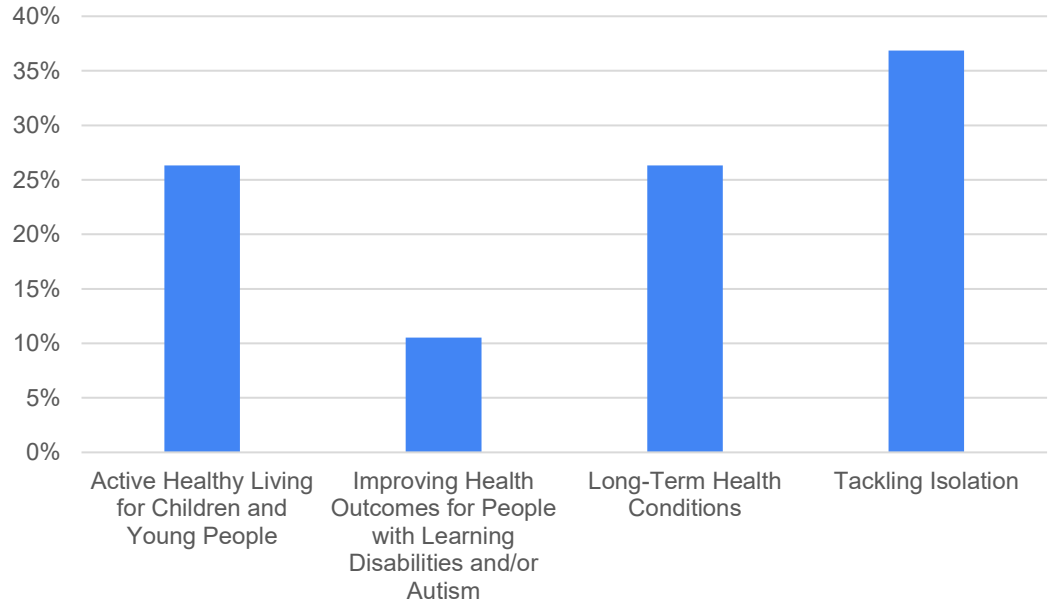
Funding by Project Priorities and Themes

Greenwich Healthier Communities Fund Update





Medium and Large Priority Themes



Greenwich Healthier Communities Fund

Independent Evaluation – DG Cities

Emerging Insights

- Strengthened VCSE capacity through staff and volunteer recruitment, training, and improved governance
- Enhanced collaboration between VCSE organisations and statutory health services
- Delivered measurable benefits, including:
  - increased reach
  - reduced social isolation
  - improved mental and physical wellbeing
  - greater sustainability through innovative service models and new partnerships

https://www.groundwork.org.uk/wp-content/uploads/2025/12/GHCF-Evaluation_w1_Emerging-Insights_To-share-v2-4.pdf

Greenwich Healthier Communities Fund

Grant Timeline 2026-2027

	Micro	Enabling	Delivery – Small	Delivery – Medium	Delivery – Large
Strand Allocation	£50,000	£150,000	£300,000	£575,000	£750,000
Grant Value	£500-£5,000	£500-£5000	£5,001 to £20,000	£20,001 to £50,000	£50,001 to £200,000
April 26	Micro and Enabling documents updated		Delivery Strand Review and Development Period		
May 26	Applications Open *NB assessment and award completed as applications received*				
Jun 26					
Jul 26			Applications Open		
Aug					
Sep 26					
Oct26					
Nov 27					
Dec 27					
Jan 27	Applications closed during assessment and award period for the Delivery Strands		Assessment and Award Period		
Feb 27					
March 27					

Greenwich Healthier Communities Fund

NB Please note that all dates and figures are indicative and will be confirmed over the coming weeks and months

Any Questions?

https://www.groundwork.org.uk/london/greenwich-healthier-communities-fund-grants/

GreenwichHealthierCommunities@groundwork.org.uk

Greenwich Healthier Communities Fund

AGENDA ITEM: 10

Healthier Greenwich Partnership

Date: 29 April 2026

Title	Partnership Report	
This paper is for **noting**		
Executive Summary	The paper provides update on news and activities by partners in the Healthier Greenwich Partnership	
Recommended action for the Committee	HGP to note the update.	
Potential Conflicts of Interest	None	
Impacts of this proposal	Key risks & mitigations	None arise directly from the report
	Equality impact	Not required for the direct purposes of the report
	Financial impact	Not Applicable
Wider support for this proposal	Public Engagement	Not required for the direct purposes of the report
	Other Committee Discussion/ Internal Engagement	Not Applicable
Author:	Julie Mann, Business Support Lead, Greenwich	
Clinical lead:		
Executive sponsor:	Gabi Darby, Acting Place Executive Lead, Greenwich	

Partnership Report – April 2026

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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 that have been achieved.

Since the previous update, Greenwich has accelerated the development of the Neighbourhood health and care service. A dedicated co-ordinator has been identified for each Neighbourhood to lead implementation of the frailty and long-term condition pathways, and preparatory work is under way to develop mental health and children and young people pathways. The Delivery SROs have convened the inaugural partner Delivery Committee, and the East Neighbourhood has made significant progress against key priorities, including carers, housing, and a new partnership with the local children's hub. In addition, the Transfer of Care Hub has been launched at Queen Elizabeth Hospital to support more timely and coordinated discharges across Greenwich and Bexley.

You can read more about our work here.

2. 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 out more here.

For more information on local activities in the Royal Borough of Greenwich follow this link.

3. 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.

London region visit

Members of the Greenwich Frailty Team enjoyed sharing the positive outcomes of partnership working with Dame Caroline Clarke, Regional Director for NHS England London, when she visited them in April.

Dame Caroline met many members of the team and heard how their proactive and connected care with partners has reduced the need for hospital treatment for their patients and costs have been reduced by reducing unnecessary medication. She was impressed by how the team works closely with partners in the borough through sharing care planning and also links patients into community groups to promote their health and wellbeing.

Greenwich mental health hub grants

Real, lasting change to reduce health inequalities is boosted by grassroots organisations working directly within our communities. To support this Greenwich and Bromley mental health hubs have undertaken an equality grants programme for 2026. Activities that will be supported through the grants include singing, advocacy, and greater support to people from a range of cultural backgrounds and to people from the deaf community.

Horn Park developments

The Horn Park Health Hub (formerly *The Source*) is being remodeled using Section 106 funding to enable a broader range of community services to be delivered from the site. Oxleas has signed the Heads of Terms and agreed a 5-year lease. Once refurbished, the Hub will operate five days a week and include two clinical rooms and one consulting room. Based on neighbourhood referral data, in addition to the drop in nurse led clinic, Oxleas also proposes running new clinics, including advanced wound care Therapy-based rehabilitation, and provide space for GP Federations to deliver services such as vaccination clinics. The Horn Park Health Hub is expected to open in Summer 2026.

For the latest updates from Oxleas, visit Oxleas NHS | Oxleas NHS Foundation Trust

4. Lewisham and Greenwich NHS Trust (LGT)

Lewisham and Greenwich NHS Trust, (LGT), is a community-focused provider of local and acute care, delivering high-quality services to over one million people living across the London boroughs of Lewisham, Greenwich and Bexley, providing whole-life care and supporting communities to live healthier lives as well and taking care of them when they need us the most.

Employing almost 7,500 colleagues, affectionately known as Team LGT, we provide services at Queen Elizabeth Hospital in Woolwich, University Hospital Lewisham, and at over a dozen community settings in Lewisham. We also provide some services at Queen Mary's Hospital in Sidcup.

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

5. Community Hospice

The community hospice is a charity providing free, specialist palliative and end-of-life care to patients with terminal illnesses, their families and carers in the London's Royal Borough of Greenwich and Borough of Bexley

For full details of the latest Hospice news, please visit News | Greenwich & Bexley Community Hospice

6. Healthwatch Greenwich

Healthwatch Greenwich is an independent champion for people who use publicly funded health and social care services in the Royal Borough of Greenwich.

For full details of the latest Healthwatch Greenwich news, please visit: https://healthwatchgreenwich.co.uk/

7. Greenwich Healthier Communities Fund

Groundwork London is responsible for awarding grants from the NHS Greenwich Charitable Funds to community organisations across the borough that prevent and respond to health inequalities.

For more information, please visit our website, Greenwich Healthier Communities Fund - Groundwork

	May-26	Jun-26	Jul-26	Aug-26
Healthier Greenwich Partnership	**20/05/2026 12h30-14h30**	**24/06/2026 12h30-14h30**	**29/07/2026 12h30-14h30**	**26/08/2026 12h30-14h30 - potential cancel**
	School Holidays 25/5/2026-29/05/2026	**Potential to make a shorter meeting**	**School Holidays 21/7/2026-1/9/2026**	**School Holidays 21/7/2026-1/9/2027**
	In Private - MS Teams	**In Private - MS Teams**	**In Public - In Person OR MS Teams - to be decided**	**In Private - MS Teams**
	Papers due 12/05	**Papers due 16/05**	**Papers due 21/07**	**Papers due 18/08**
Chair - Talia Barry (wef April 2026) **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** **Meetings in public** At least one meeting a year to be held in person - no hybrid opportunities **Developmental Workshops/Seminars - NOTE: No workshops will be held whilst the Design Labs are being held (labs due to end in Sept 2026)**; 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 Standing item - updates from all partners on success/good news **Main Business/Themed Item** Neighbourhood submission (Strategic Investment Funds & integrator) - for approval 50-60 minutes Mental Health in Neigbourhoods- Lorraine & Jenny Healthwatch Greenwich update _ Joy Beishon RBG update on the Change programme 26/27 - Nick Davies Items for noting/limited discussion Forward planner	Board meeting in private (on MS Teams) Introduction and apologies Declarations of interest Minutes of previous meeting in private Action Log Standing item - updates from all partners on success/good news **Main Business/Themed Item** Be Well Items for noting/limited discussion Forward planner	Board meeting in public Introduction and apologies Declarations of interest Minutes of previous meeting in public Action Log Standing item - updates from all partners on success/good news *Positive partnership story* **Main Business/Themed Item** Healthwatch Greenwich Annual Report Start Well Working with VCSFE and Greenwich Charitable Fund Sam B 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 Standing item - updates from all partners on success/good news **Main Business/Themed Item** Feel Well Items for noting/limited discussion Forward planner
Future Agenda items - not linked to specific meeting CYP focussed workshop Discussion on Autism & ADHD - link on transition from childhood to adulthood Proactive Care MSK Procurement Regular updates from partners at meetings in private Workshop/seminar discussion - One of Neighbourhoods & Place alignment/ HIUs/ Mental health impact on physical health (to define later) Sam B- Health equity programme and addressing health inequalities Generally to keep under review case for wider work on housing and wider determinants – but noted it also comes into HWBB and next HGP design lab so would need to be clear on ask		Agreement to have a series of updates on partner transformation plans – starting with RBG in May and with Oxleas and LGT to follow. Then to consider how to have similar discussion for hospice and primary acre.	partner transformation plans – Oxleas or LGT to follow. Then to consider how to have similar discussion for hospice and primary care.	

HGP Design Lab Workshops with Stone King (not minuted) Outputs documented from session notes	**21/05/2026 10h00-13h00**	**17/06/2026 10h00-13h00**	**22/07/2026 10h00-13h00**	**19/08/2026 10h00-13h00**
	Kidbrooke Community Centre	**Venue TBC**	**Venue TBC**	**Venue TBC**
Main Facilitator - Sandra Hamilton (Stone King) **HGP Leads -** Gabi Darby and Lisa Wilson **Business Support** - Julie Mann and Jo Hawkes In partnership with Stone King, monthly design sessions to work on collaboration across all partners in Greenwich All workshops are in person	Theme Working with VCSE Objectives Identify opportunities for working different with VCSE in Neighbourhoods and what would need to be true to enable that Understand different ways other areas have approached bringing together VCSFE and stat sector via alliance etc Explore role of Greenwich charitable funds and grants – and opportunities to align to neighbourhoods and building community capacity Explore social investment opportunity in Greenwich	Theme Working with wider system housing, employment, business, Greenwich local plan, early prevention Objectives Understand our role within wider system and economy in Greenwich Include partners from housing, employment, growth, AIG – opportunities for linkage between neighbourhoods and employment and housing, public health and wider council prevention role via ASC other services for residents Look at future change and growth in Greenwich and how this will change neighbourhood profiles	Dedicated session with Primary Care Objectives Common understanding from PC about what it means to be part of a neighbourhood PC leadership and workshop in INT context Move towards MOU content that includes practices	Theme Outcomes and MOU Objective What we would want to include in any agreement What it means to be outcomes focussed, and pros/ cons of metrics focus Review in more detail the state of the MOU and wicked issues Future ambitions?

	Sep-26	Oct-26	Nov-26	Dec-26
Healthier Greenwich Partnership	**30/09/2026 12h30-14h30**	**28/10/2026 12h30-14h30**	**25/11/2026 12h30-14h30**	**16/12/2026 12h30-14h30**
	Potential to make a shorter meeting	**School Holidays 26/10/2026-30/10/2026**		**School Holidays 21/12/2026-1/1/2027**
	In Private - MS Teams	**In Public OR MS Teams - to be decided**	**In Private - MS Teams**	**In Private - MS Teams**
	Papers due 22/09	**Papers due 20/10**	**Papers due 17/11**	**Papers due 8/12**
Chair - Talia Barry (wef April 2026) **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** **Meetings in public** At least one meeting a year to be held in person - no hybrid opportunities **Developmental Workshops/Seminars - NOTE: No workshops will be held whilst the Design Labs are being held (labs due to end in Sept 2026)**; 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** Stay Well Items for noting/limited discussion Forward planner	Board meeting in public Introduction and apologies Declarations of interest Minutes of previous meeting in public Action Log Standing item - updates from all partners on success/good news *Positive partnership story* **Main Business/Themed Item** Age Well 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** Items for noting/limited discussion Forward planner	
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HGP Design Lab Workshops with Stone King (not minuted) **Outputs documented from session notes**	**16/09/2026 10h00-13h00**
	Venue TBC
Main Facilitator - Sandra Hamilton (Stone King) **HGP Leads -** Gabi Darby and Lisa Wilson **Business Support** - Julie Mann and Jo Hawkes In partnership with Stone King, monthly design sessions to work on collaboration across all partners in Greenwich All workshops are in person	Theme Flexible session - to be used if needed, to consider and discuss later could be used to give sme topics more time or for a MH focus

	Jan-27	Feb-27	Mar-27
Healthier Greenwich Partnership	**27/01/2027 12h30-14h30**	**24/02/2027 12h30-14h30**	**31/03/2027 12h30-1h30**
		School holidays 15/2/2027-19/2/2027	**School Holidays 26/3/2027-9/4/2027**
	In Public - MS Teams	**In Private - MS Teams**	**Development Workshop/Seminar - In Person, Venue TBC**
	Papers due 19/01	**Papers due 16/02**	
Chair - Talia Barry (wef April 2026) **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** **Meetings in public** At least one meeting a year to be held in person - no hybrid opportunities **Developmental Workshops/Seminars - NOTE: No workshops will be held whilst the Design Labs are being held (labs due to end in Sept 2026)**; Held every quarter, in person only. Focus on working together across the partnership strategically	Board meeting in public Introduction and apologies Declarations of interest Minutes of previous meeting in public Action Log *Positive partnership story* **Main Business/Themed Item** 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	
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