Healthier Greenwich Partnership (in public - Hybrid)

Date: Wednesday 24 January 2024
Time: 12.30 – 14.30
Venue: Rooms 4 & 5 Woolwich Town Hall, Wellington Street, Woolwich, SE18 6HQ
Hybrid - MS Teams Click here to join the meeting

Chair: Iain Dimond

AGENDA

	Item	Page no.	Presented by	Time
Opening Business				
1.	Welcome, introductions and apologies.	Oral	Chair	12.30
2.	Declarations of interest	Oral	Chair	
3.	Minutes of the meeting held 22 November 2023.	3	Chair	
4.	Action Log and Matters Arising - No open actions		Chair/ Neil Kennett-Brown	
5.	Positive Partnership Story – Groundwork London preparation for grant giving		Daniella Finch	12.35
Public Engagement				
6.	Public Forum Feedback on Neighbourhoods 15/1/24		Russell Cartwright	12.40
7.	Questions and comments from members of the public		Chair	12.50
Items for in-depth Discussion				
8.	Engagement in Greenwich - the SEL LTC Framework of Care	10	Robert McCarthy/ Michelle Barber/Joanne Hare	13.00
9.	Animation and Update on Population Health Management	37	Annie Norton / Nupur Yogarajah	13.20
10.	MSK Update	45	Annie Norton	13.40
Items for Decision				

11.	Reprocuring APMS Thamesmead Medical Practice contract approach for 2025	52	Maria Howdon /Jackie Davidson	13:50
Items for Noting				
12.	HGP Partner's Report and Sub-committee assurance report	57	Neil Kennett-Brown	14.10
13.	Risk update	72	Ike Philip	14.15
14.	HGP Development – Output from December Workshop	76	Victoria Stanway / Neil Kennett-Brown	14.20
Closing Administration				
15.	HGP Forward Planner	94	Ike Philip	14.25
16.	Any Other Business		Chair	14:28
17.	Next Meeting: 28 February 2024		Chair	
Meeting closes at 14:30				

Healthier Greenwich Partnership
Minutes of the meeting held in public on Wednesday 22 November 2023
MS Teams

Members	
Nayan Patel	Healthier Greenwich Partnership Chair & PCN Clinical Director (Chair)
Neil Kennett-Brown	Borough Chief Operating Officer Greenwich (NKB)
Tuan Tran	Greenwich LMC (Local Medical Committees) Chair (TT)
Naomi Goldberg	Director of Strategy, METRO GAVS (NG)
Chris Dance	Associate Director of Finance, Greenwich, SEL ICB (CD)
Jackie Davidson	Integrated Commissioning Director (Prevention, Primary Care, Population Health) (JD)
Joy Beishon	Chief Executive, Healthwatch Greenwich (JB)
David Borland	Integrated Commissioning Director for Children and Young People, RBG and SEL ICB (DB)
Steve Whiteman	Director of Public Health, RBG (SW)
Iain Dimond	Chief Operations Officer, Oxleas NHS Foundation Trust (ID)
Niraj Patel	Chair of Greenwich Health GP Federation (NP)
Lisa Thompson	Director of Children & Young People's Services, Oxleas (LT)
David James	Chief Executive, Greenwich Health (DJ)
Russell Cartwright	Assistant Director of Comms & Engagement, Greenwich (RC)
Lisa Wilson	Integrated Commissioning Director, RBG & SEL ICS (LW)

In Attendance	
Ike Philip	Corporate Governance Lead, Greenwich (Minutes) (IP)
Victoria Stanway	Consultant PPL (VS)
Gemma O'Neil	Deputy Director, System Development, Bexley, and Greenwich (ICB) (GO)
Annie Norton	Ass. Director, Partnerships & Programmes, Greenwich (AN)
Jose Garcia-Lobera	Clinical and Care Professional Lead for Greenwich (JG)

Apologies

Nick Davies	Director of Adult Social Services, RBG (ND)
Sarah McClinton	Place Executive Lead Greenwich (SMc)
Florence Kroll	Director of Children's Services (FK)

1.	**Introduction**
1.1	**Introductions and Apologies for Absence**
1.1	The Chair welcomed everyone to the meeting. Apologies for absence were noted.

2.	**Declarations of Interest**
2.1	The Chair asked if anyone had any interest to declare on any of the agenda items. None was declared.
3.	**Minutes of the Previous Meeting Held on 25 October 2023**
3.1	The Minutes of the previous meeting held on 25 October 2023 were reviewed and agreed by the Board as correct record.
4.	**Action Log & Matters Arising**
4.1	Action 001 27/09/23 is – it was noted the report of the review of place and ICS delegation by the London ICS network is not yet available but would be shared when received. Action to be closed. Action 001 25/10/23 – Discussion was held with Dr. D'Souza in Valentine Practice about the need to engage with their Patient Participation Group (PPG). Action to be closed.
5.	**Progress Update re High Impact Activities within LCP - for information, including feedback to those involved in the process**
5.1	Annie Norton introduced the item, noting there are lots of positive activities going on across all the 10 ambitions in the Local Care Plan (LCP). Timely progress has been reported for the first 6 months. There is nothing specific that any of those leading the various activities requested either from the Exec Group or from the partnership. AN noted the risk report in the pack would also be shared with the Health and Well-Being Board on 7 December 2023.
5.2	VS commented that colleagues from the various parts of the system who contributed to the feedback process were wonderfully receptive and enthusiastic. AN noted some lessons being learned across the 32 priority activities under the 10 ambitions in the plan, as captured in section 4 of the risk report.
5.3	NG noted the satisfactory progress which has been reported and asked what baseline indicators are being used to measure the effect of the impacts of those activities? VS responded that the LCP contains medium to long term outcomes that the partnership wanted to work to produce and then a selection of activities which were identified as being proxies on the way to that journey. VS noted that in the report there are some places where the relationship between that proxy activity and the outcome are clear, but there are some where they are less clear. VS and AN would have further conversations with the Senior Responsible Owners (SROs) from within this partnership to have some of those more granular conversations about impact and baselines.
5.4	The Chair observed that the table shows outputs against activity and suggested there is a need to look at outcomes and see if there are real improvements. For example, if activities relating to children have been done, how does that map to parents still reporting about lack of access to Health Visitors? The Chair suggested end to end mapping of activities and outcomes would be better than relying on proxies. VS acknowledged they are valid points and suggested being mindful of those when considering how to approach the delivery plan for next year.

5.5	NKB expressed delight that most of the activities in the plan are under way and progressing, noting a set of outcomes were agreed in Five year forward view document which was signed off earlier in the year. There would be need to decide which outcomes to focus on and level of details required. NKB suggested it would be helpful for HGP members to go and meet and work with some of these teams, not to have a reassurance meeting on the detail, but to see how the activities are going on the ground. Any member interested in such a visit should let NKB know.
5.6	ID agreed getting the right link between the outputs and the outcomes would be good. ID noted there is a lot of data that sits with individual organisation that could be used, for example, in terms of mental health through the mental health oversight boards. It would be useful to know what relevant data would be useful and get the information to review it collectively by the partnership. ID supports the idea of HGP members going to visit operational teams to see the work happening on ground. VS welcomed the suggestion about strengthening the logic model with relevant underpinning data.
5.7	The Chair explained linking activity outputs to outcomes from a formative perspective. JG suggested seeing the work from a partnership perspective and seeing how the partnership approach is making a difference. DB expressed that the discussions are around some of the high-level outcomes and what are the various influences of them. DB suggested the HGP ought to be thinking about the collective constructive collaboration of all the partnership's work together and hopefully having the biggest influence on them.
5.8	VS thanked everyone for the contributions noting they would be explored in subsequent conversations with the SROs.
5.9	The Board noted six month's progress Update about the High Impact Activities within the Local Care Plan (LCP).
6.	**Neighbourhood Development Approach**
6.1	Jackie Davidson introduced the item, noting the aim is to take a slightly more scientific and more evidence-based approach to neighbourhood development, using Social Research as the basis. This is set in the context of national drivers but focused on connecting local people better with local priorities and place. The paper looks at what have been done successfully in some other places. There would be different approach to different neighbourhoods, and it would be important to have a network of community connectors, including primary care. JD gave examples with Horn Park, Plumstead and Glyndon neighbourhoods, noting the contrasting approaches in connecting those neighbourhoods.
6.2	JD noted that Dr. Navchana, who is a GP and a Non-Executive on LGT board, has been involved nationally with a lot of primary care development and came to the HGP Exec Group recently. He gave interesting insight about neighbourhood development, noting the need to engage and involve primary care colleagues in the process of system transformation, partly because of the relationship in terms of registered lists and the

	accessibility. He also reflected about improving clinical integration and the use of social prescribers. The final reflection he had was about a focus on population health, process, and outcomes. JD acknowledged that some of these themes are reflected in some of the models in the pack. For example, the Camden model is interesting as it has overlaps between the integrated neighbourhood teams, children, family hubs and other focus such as civic infrastructure. And then equally, it is about the civic infrastructure.
6.3	JD articulated some of the outcome from the social research work so far, noting the following principles would need support from HGP. • Consensus around neighbourhood development is essential backed by and a strong mandate – a rationale for its existence, providing legitimacy and supporting its longevity and success. • Mandate and consensus must be supported by appropriate resources and flexible infrastructures. HGP would need to visibly enable and resource neighbourhood development work. • It is important to develop a shared vision around Neighbourhood Development based on joining people and places. HGP to agree collectively the purpose or common problem to be addressed and vision for each neighbourhood work. The local population and their needs would be key. • Consider some potential barriers and how HGP can enable the system remove barriers to neighbourhood working.
6.4	JD would like agreement of HGP to the principles outlined in the approach.
6.5	There was robust discussion by the board and the following key points were noted. i. Financial capacity is required to put things in place in local community neighbourhoods. Does NHS and RBG have the resources required? Sustainability is key – do not start something and pull it halfway for lack of resources. ii. PCN population-based data can be used to determine health priorities for that PCN neighbourhood. iii. HGP should ensure equity in allocation of any available funds to meet priorities of the various neighbourhoods – it does not mean each neighbourhood gets the same pot and it does not mean the community that shouts the loudest gets the most. iv. Involve the local population to understand and delineate the core health needs and the wider social determinants of health for each neighbourhood. v. Start small and spread and scale, but ensure people understand the context in which the partnership is operating. vi. Listen to communities and work with them, fall in love with the problems, learn from available evidence from places that have done this successfully. vii. Build community assets using the local people to think differently how to solve their health priorities, including GP transformation and re-stratification.

	viii. Use various data sources to understand the shared problems for each neighbourhood including wider determinants of health. Do not limit it to PCN data only as many residents do not visit GPs. ix. Language needs to be meaningful to the local community, as they may not know about PCNs (Primary Care Networks) or population health. x. Noted 80% of health is due to wider determinants of health, so need wider system involvement to join the dots together. There is opportunity to undertake neighbourhood development in a collaborative, joined up way. xi. Population segmentation and targeting of high impact issues, such high-density healthcare users or targeting neighbourhoods with low screening uptake. xii. Different neighbourhoods would have different issues and priorities which would require different solutions. xiii. GP practices should be considering the health of the wider population in addition to dealing with illness, so need to go beyond the 20% high density users and consider the other 80% of population.
6.6	The Chair thanked everyone for their contribution and asked if members were happy to agree or support the principles for the neighbourhood development approach? This was unanimously agreed. **RESOLVED**
6.7	The HGP expressed support for the neighbourhood development approach and agreed to the principles.
7	**Proposed new governance – merger of the Health Inclusion Group (HIG) and Integrated Neighbourhood Working Group (INWG)**
7.1	Neil Kennett-Brown introduced the item, noting the HSIG and INWG are working together to test and develop a new merged Neighbourhood / Population Health Steering Group and will report on proposed changes at the first HGP in 2024. Both groups see the proposed merger as a useful direction of travel. A draft term of reference for the merged group is expected to be available at HGP January meeting.
7.2	The Chair asked if members were happy with the proposed merger? There was unanimous support from members.
7.3	HGP noted the proposed merger of the Health Inclusion Group and Neighbourhood group and expressed support for it.
8	**HGP Partnership Report**
8.1	Annie Norton introduced the item, taking the paper as read. The report contains up-dates relating to the following. • Executive Group • Breast Screening • General Practice • Assistive Technology Enabled Core Offer

	• Same Day Urgent Care / 111 re-procurement • Clinical Cabinet – first meeting would be on 14 December.
8.2	NKB remarked that assistive technology provides real opportunity to use as a unique way to support the population and thanked TT and all those involved in making it happen.
8.3	JB noted some concerns were received by Healthwatch relating to the use of EPIC, noting SEL ICB have agreed for Healthwatch to have access to the quality alert system.
8.4	NP explained there have been current issues with test results and affected practices were submitting DATIX alerts. The LMC and ICB are working on this.
9	**HGP Rotational Chairing Arrangement and Vote of Thanks to Outgoing Chair**
9.1	Following the agreement of rotational chairing arrangement, members gave vote of thanks to NP for all his hard work in chairing HGP during the first year.
9.2	It was noted that Iain Dimond would take over as Chair from January 2024.
10	**HGP Forward Planner**
10.1	The forward plan was noted. There would be a face-to-face workshop on 12 December 2023.
11.	**Any Other Business**
11.1	NG reminded members of the invitation to attend the G-HIVE Voice and Influence Conference on 6 December 2023.
11.2	NKB and other members congratulated Oxleas for winning HSJ's Trust of the Year award. The Chair thanked everyone for their attendance and closed the meeting at 14.25hrs.

Action Log for the Healthier Greenwich Partnership – December 2023

Updated 23.11.23.

OPEN ITEMS						
Meeting date	**Minute Ref**	**Action no**	**Action**	**Action Owner**	**To be Completed**	**Comments**

AGENDA ITEM: 8

Healthier Greenwich Partnership

Date: 24th January 2024

Title	**Developing a SEL approach for Long Term Condition care**	
This paper is for **noting/approval**		
Executive Summary	This is a joint presentation, delivered by the SEL Long Term Conditions Team – giving an overview of the long term vision for Long Term Conditions' Care, together with the Greenwich System Development Team providing an overview of achievements to date. The presentation includes: • Diabetes • CVD • London Renal Programme • Respiratory Diagnostic Service The presenters will be seeking suggestions and recommendations from the Healthier Greenwich Partnership to support the development and improvements of long term conditions' care for Greenwich residents.	
Recommended action for the Committee	• The report is for information and input from the HGP.	
Potential Conflicts of Interest	• None	
Impacts of this proposal	Key risks & mitigations	• N/A
	Equality impact	• N/A
	Financial impact	N/A
Wider support for this proposal	Public Engagement	• Patient engagement is part of some of the projects included in the slide pack.
	Other Committee Discussion/ Internal	• Not Applicable

	Engagement	
Author:	Rob McCarthy, SEL Associate Director LTC Management & Improvement Michelle Barber, LTC Programme Lead, Greenwich & Bexley	
Clinical lead:	Dr Krishna Subbarayan	
Executive sponsor:	Dr Krishna Subbarayan	

South East London
Integrated Care System

Developing a SEL approach for Long Term Condition care

NHSE Diabetes Outcomes & Improvement Programme

South East London Integrated Care System

- This is a SE London scheme, launched in March 2023. The aim of this programme is to provide financial support to PCNs to make improvements in 8 Care Processes & 3 Treatment Targets and reduce variation within their PCN
- Funding covers the years from 2022/23 to 2024/25
- PCNs have been able to decide how to best utilise the funding to make improvements in patients' outcomes
- For 22/23, there were no targets associated with the payment
- For 23/24, PCNs will receive 75% of the payment on a block basis, the other 25% will be based upon PCNs achieving their 2019/20 level of 8 Care Processes (or more), together with **reducing the variation of achievement to less than 20% between the highest and lowest performing practices**
- 2023/24 will focus on 8 Care Processes Improvements only
- 2024/25 will focus on 3 Treatment Targets improvements (achieving same level as in 2019/20 or more), together with a stretch target to make further improvements in 8 Care Processes. **Again, reducing the variation of achievement to less than 20% between the highest and lowest performing practices.**

Diabetes – Greenwich, 8 Care Processes

This table shows performance as of December 23 for 8 Care Processes against 2019/20 Target per PCN

Borough / PCN	Registered patients	Population with Diabetes	All 8 Care Processes % as of December 2023	2019/20 8 Care Processes Target to achieve	Distance to target
GREENWICH (overall)	320,831	16,222	52.2%	-	-
Blackheath & Charlton	50,911	2,034	64.9%	52.2%	+12.7%
Eltham Health	67,924	3,581	57.7%	40.0%	+17.7%
Greenwich West	47,640	2,069	35.8%	40.0%	-4.2%
Heritage	30,515	2,336	46.5%	44.8%	+1.7%
Riverview Health	86,263	3,644	59.4%	58.6%	+0.8%
Unity	37,578	2,558	42.9%	40.0%	+2.9%

Diabetes – Greenwich, 3 Treatment Targets

This table shows performance as of December 23 for 3 Treatment Targets against 19/20 Target for PCNs

Borough / PCN	Registered patients	Population with Diabetes	All 3 Treatment Targets as of of December 2023	2019/20 3 Treatment Target to achieve	Distance to target
GREENWICH (overall)	320,831	16,222	27.6%	-	-
Blackheath & Charlton	50,911	2,034	29.4%	40.5%	-11.1%
Eltham Health	67,924	3,581	30.9%	38.8%	-7.9%
Greenwich West	47,640	2,069	23.7%	38.4%	-14.7%
Heritage	30,515	2,336	27.8%	38.8%	-11.0%
Riverview Health	86,263	3,644	28.1%	37.1%	-9.00%
Unity	37,578	2,558	23.7%	39.8%	-16.1%

South East London Integrated Care System

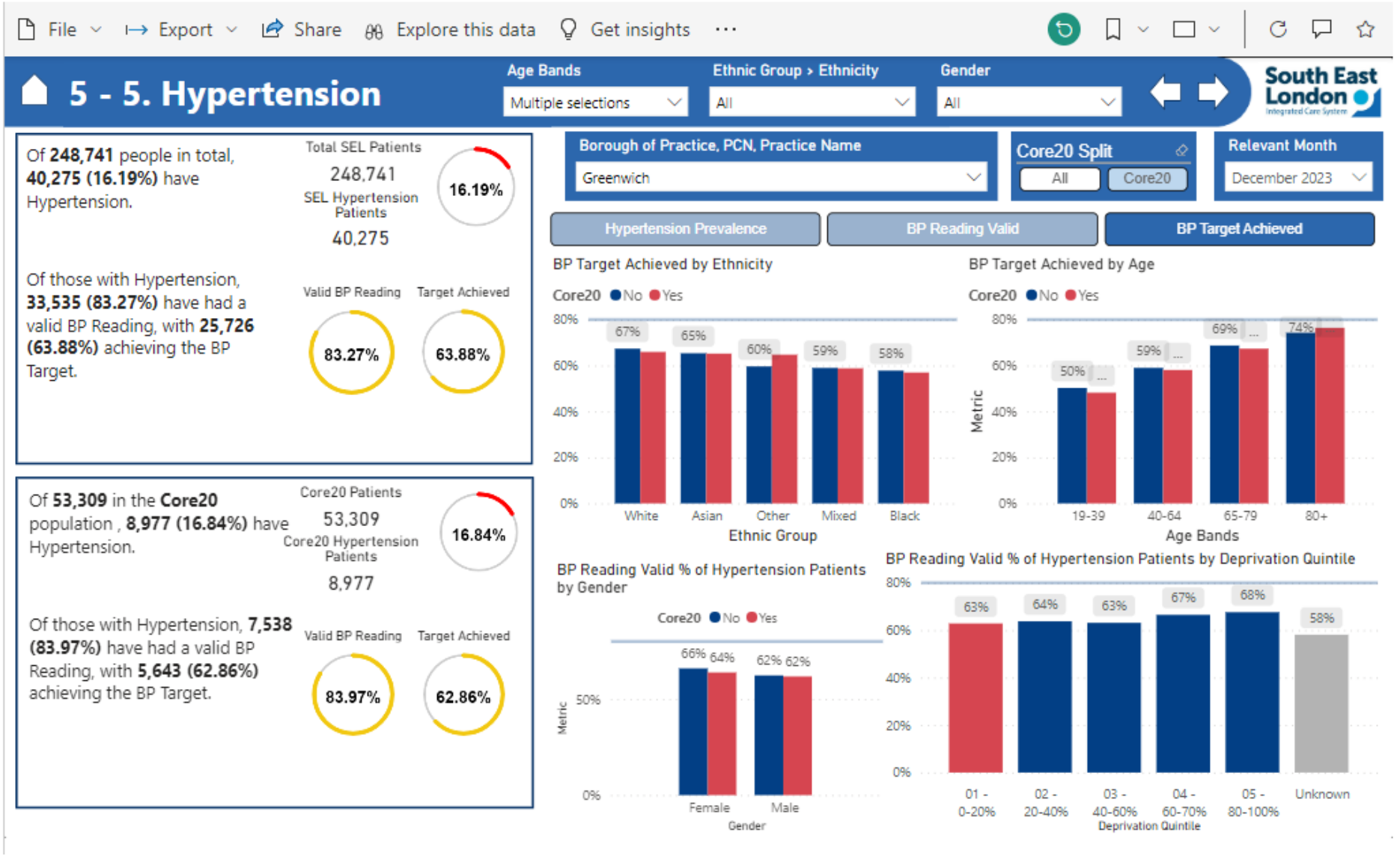
CVD:

National Operating Plan Targets 23/24:

Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024

Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%

Hypertension Results against target of 77%



Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%

- **Greenwich PCNs (data source CVDPrevent June 2023)**
- Greenwich West: 65.82%
- Unity: 62%
- Heritage: 68.64%
- Riverview: 68.84%
- Eltham: 60.6%
- Blackheath & Charlton: 60.06%

Respiratory Diagnostic Service

- Currently:
  - Adults - Oxleas provide the service for patients with suspected COPD
  - Adults - Respiricare provide the service for patients with other suspected respiratory conditions e.g. asthma

- Future:
  - Oxleas & LGT to provide an integrated Respiratory Diagnostic Service for adult patients with any suspected respiratory condition – these clinics will be held within the community, from Spring 2024

  - Children: Oxleas Community Children's team to be trained to provide spirometry and FeNO to diagnose / rule out, respiratory conditions in children over the age of 6 (from Spring 2024)

Prevention – Multi-Morbidity Model of Care

South East London Integrated Care System

The aim:

Our service aims to build a person-centred, holistic, and fully integrated model of care for people with multiple LTCs across the pathway. This includes healthy.io at home test kits to identify those with CKD, remote and personalised engagement for a long list of those with early signs of CKD, integrated and multidisciplinary neighbourhood teams providing personalised case management for a smaller cohort with complex multiple LTCs including CKD ~3, and integrated acute care for those with end-stage kidney disease.

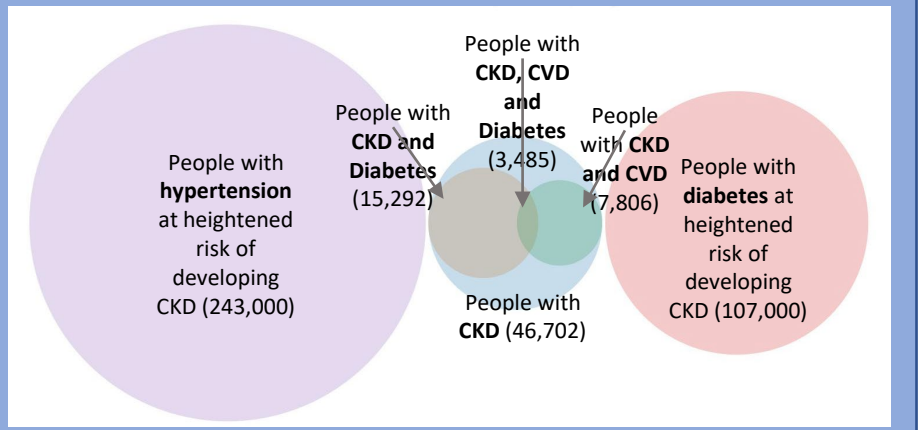
What has been done:

- **6 neighbourhood team sites** have been selected
- **3 in person codesign workshops** between October and December 2023 with cumulative **180+ in attendance**
- **1 online workshop** for acute colleagues with **3 monthly acute steering groups** taking place so far
- Begun to engage with general mangers, service managers and divisional directors at the **3 SEL trusts**
- Begun working with KCL to work out healthy.io delivery with **7,000 additional test kits secured**
- Developed a **comprehensive theory of change** to show the process of our project from inputs through to impact
- **Fortnightly** check-in meetings with each of our project teams with a clinical and non-clinical SEL LTC lead

Why our project is important:

Those with **multiple LTCs often experience a lack of coordination**, multiple appointments in multiple settings, a **lack of personalisation or holistic** approach. With **over 46,702 in SEL with identified CKD**, many with additional long term conditions, and **over 350,000 at heightened risk of developing CKD**, there is significant need for transformation of services for those living with multiple LTCs. Moreover, this population suffer from **significant inequalities**, with 40% of patients living with CKD, CVD and diabetes being from a BAME background (disproportionate to the SEL BAME profile). Therefore, responding to the Fuller Report, London Region, the LKN and the SEL LTC Framework of Care, our project will activate existing resources to build integrated neighbourhood teams that provide holistic, joined-up care in community to support the SEL community to have better health outcomes, be healthier for longer and avoid end stage kidney disease and dialysis, leading to a more **sustainable and effective model of care**.

SEL ICB LTC Comorbidities Dashboard (drawn from QOF registers, April 2023):



What it has achieved:

- **Relationship development and building** across clinical and non-clinical primary care staff, community care staff, ARRS funded roles, acute colleagues across 3 SEL trusts (renal, cardiology, diabetology, geriatrics; nurses, pharmacists and consultants), VCSE partners
- Development of **clinical case management model**, personalised across 6 neighbourhood sites
- **APL Risk Stratification tool installed** at all 6 neighbourhood sites by CESEL facilitators
- Working with the SEL Workforce Development Hub, CESEL and the HIN to develop a bespoke training offer.

Why are we here – and why did we start this process?

- Key context
  - Delegation to Place of primary/ community commissioning responsibility – LTC care is primarily delivered at Place, by Place
  - ICB in its system strategy, convenor and assurance role
  - Fuller Report – opportunities and challenges
- Don’t assume the answers are known and given – we need to co-design our collective approach
- People need to be at the centre of the care we provide
- Huge amount of great, innovative LTC care happening at place – but also big barriers to spreading and scaling
- The co-design work showed just how much alignment there is – we want to take that forward
- No single organisation, no single borough can deliver great LTC care on its own for SE London

What is the problem we are trying to solve?

"There are real signs of genuine and growing discontent with primary care, both from the public who use it and the professionals who work within it… [we need to] provide more proactive, personalised care with support from a multidisciplinary team of professionals to people with more complex needs, including those with multiple long-term conditions"

Fuller Stock take Report, May 2022

For many people going to hospital urgent care centres works better than going to their GP.

You need to prioritise the continuity of care for patients with complex needs and easy access to services for those who are in the greatest need of help. The system is difficult to navigate.

SE London resident feedback, SEL Integrated Care Strategic Priorities, 2023

People living with LTCs in SE London have told us that they want to:

- Feel confident about the self-management activities needed to manage their conditions
- Receive motivational support to help stick to changes in their lives
- Have the opportunity to discuss mental health and non-health issues affecting their conditions
- Discuss their conditions with people that they can relate to who have lived experience of their condition (peer support)
- Be treated with dignity and respect by their healthcare professionals

"Outcomes that Matter to People – I/ We statements" – SEL ICB-commissioned Mabadiliko CIC research, 2022

What the data is telling us

- Despite a younger-than-average population profile in SE London, we are still an aging population with an increasing number of LTCs - in England more than 15 million people (over a quarter of the population) have at least one LTC
  Nuffield Trust March 2023

- In SE London, 658,000 people have an LTC – one third of the total SEL population

- 300,000 SE Londoners have 2 or more LTCs – just under half of the total SEL LTC population
  SE London ICB analytics portal, Comorbidities Dashboard, June 2023

- People with LTCs account for 50% of all GP appointments, 64% of all Outpatient appointments and 70% of all inpatient bed days
  Kings fund 2024

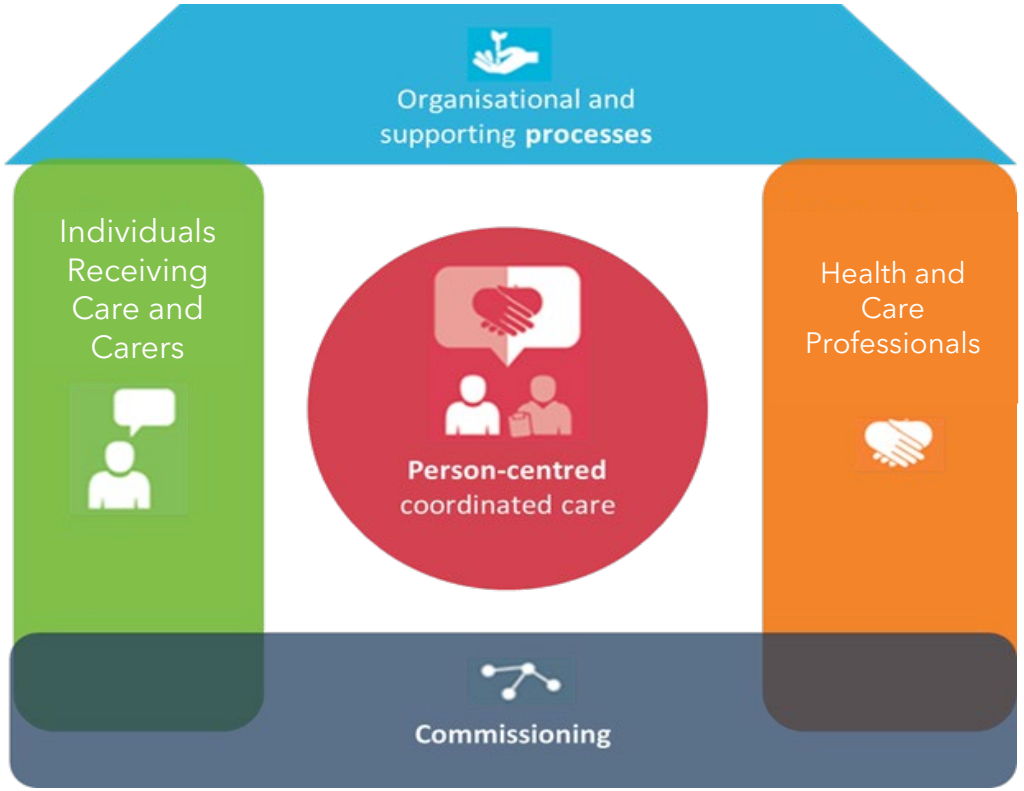
Developing a SEL Approach to LTCs: Workshops Summary

Over a series of 3 workshops, well over 100 people working and receiving care in South East London ICS came together to work through the challenges and opportunities around LTC care, using the NHSE House of Care as a methodological framework.

This group of people identified ***five core values*** that underpin a Framework of Long-term Condition (LTC) Care – in line with the best practice described by Fuller, the House of Care and the recent SEL ICS Strategy (Strategic Priorities, 2023-2028)

Building on these core values, the rich outputs of the workshops gave us ***seven essential components of LTC care*** which would enable the delivery of improved outcomes for people living with LTCs.

Most of the SEL LTC workshop insights have been understood for a long time, but not implementable/ sustainable at scale



The House of Care

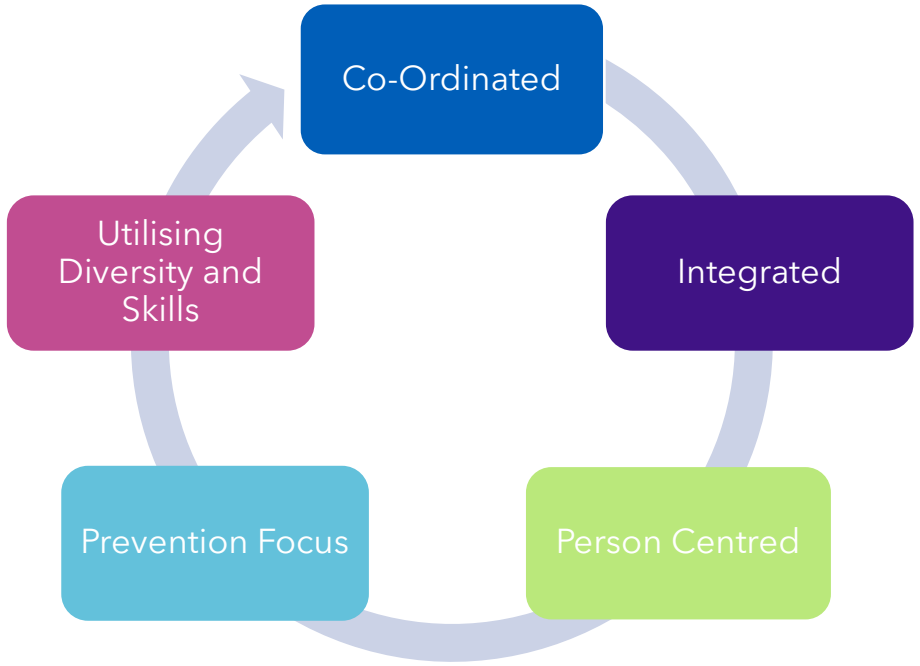
https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/delivering-better-services-for-people-with-long-term-conditions.pdf

Core Values – and their translation into Essential Components of LTC Care

South East London Integrated Care System

NHS South East London

Core Values



Essential Components

- Equitable and effective prevention
- Early diagnosis of people with LTCs
- Patient-centred care, personalised care planning and high quality self-management support
- Risk stratification and data-driven approach to prioritisation of care
- Closer working between health and care professionals (e.g. MDT based care), with clear coordination
- Holistic care, including mental health/wellbeing and social care
- Joined up IT / shared care records

Key Vision Statements

South East London Long Term Condition Care

Key underpinning themes for Long Term Condition Care in South East London

The key vision statements for what Long Term Condition Care will look like in South East London

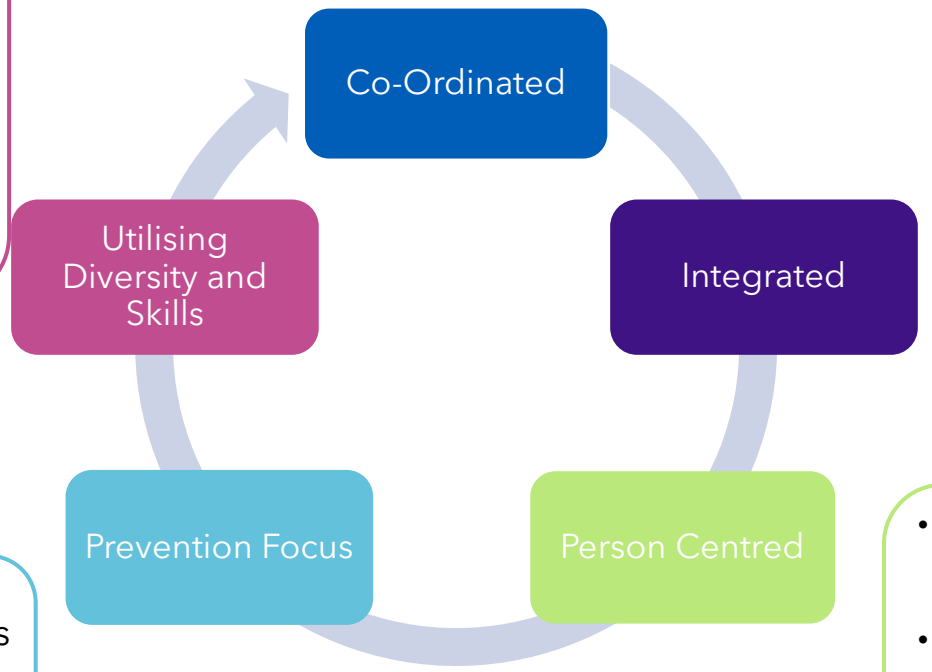
Greenwich

South East London Integrated Care System

NHS South East London

- Develop a single record for all citizens, to enable integrated multi-disciplinary and multi-organisational care, across health & care system, including non NHS.
- Support Primary care and partners to evolve into neighbourhoods.

- Work alongside local people in planning and implementation of care and ensure these plans are tailored to local needs
- Ensure the ARRS roles in primary care are maximised



- Effective integrated community teams based in neighbourhoods.
- Expand integrated urgent care pathway for patients with same-day need.
- Develop a single record for all citizens, to enable integrated multi-disciplinary and multi-organisational care.

For everyone to access the services they need on an equitable footing- thereby feeling empowered and responsible for self-care

- Develop our community approaches that connect individuals to sources of support that address the wider determinants of health.
- Focus on wider determinants of health and wellbeing behaviours such as smoking cessation, drug and alcohol treatment programmes and support for people with gambling addiction.

How can we work together to realise our shared ambitions?

- Sharing best practice
  - Identifying what is working well in each place and sharing across SEL
  - Developing shared approaches (for example multimorbidity pilots in each borough)

- Establishing new ways of working
  - SEL wide LTC steering group to coordinate long term conditions strategy, share plans, tackle system-wide problems
  - Developing a shared approach to measuring our progress – building on the core values identified in the framework of care

- SEL LTC team to co-ordinate and convene

Questions for Local Care Partnership teams

- Any questions about work to date?
- What existing pieces of work do you see as central to delivering your plans?
- Discussion of how we use the framework of care
  - Steering group – Who would be best to represent your borough at an SEL steering group?
  - How to use the framework of care within the context of that group – metrics, programme planning, strategy

South East London Integrated Care System

NHS South East London

Appendix

System Enablers in SE London

- We know the core values and essential components of LTC care are strongly supported – and have been for years – but how can we work together to ensure great LTC care across our boroughs is scalable and sustainable?
- The SEL LTC team will support the work of LCPs by seeking to loosen, over time, system blockers (cultural/ behavioural change) and support system enablers (practical tools)

Cultural/ Behavioural Change

- **Influence funding flows and funding requirements** (e.g., consolidate NHSE 'small pots' and give LCPs/ PCNs flexibility on spend)
- **Enable LCP/ PCN autonomy to act** (high level ICB frameworks/ guidance that allows lots of local flexibility)
- **Stand up ICB/ ICS governance that puts boroughs at the heart of decision making** (e.g. NBCB, the in-development LTC Steering Group)
- **Improve engagement and influence with acute and community trusts** (e.g., influencing trusts to outreach, as per the multimorbidity funding opportunity)
- **Influence ICB planning and finance (over time,** movement away from sector-specific planning,

Practical tools

- **SEL-wide accessible and intuitive Population Health Management tools** (e.g. Diabetes, Core20Plus, mLTC and Primary Care Access dashboards)
- **Aligned and significant funding opportunities** (e.g. the multimorbidity funding opportunity)
- **Harnessing collective skills and expertise across SE London** (e.g. communities of practice)
- **Support and training packages to enable sustainability** (e.g. multimorbidity support package, being co-designed with PCNs)
- **End-to-end pathway reviews – starting with obesity** (in development)
- **Turning 'outcomes that matter to people' into metrics**

An Example of what a multiple LTC model of care at PCN/ Neighbourhood level could look like

We know there are existing models in SEL that do much of this - we want to support a *step change* in how widespread it is applied

Prevention and Screening

- Proactive identification
- Increase and better target risk for LTC screening to effectively reach our underserved communities
- Joined-up prevention offer that sees the person holistically
- Use of Primary Care searches to identify high risk individuals based on NICE guidance
- Access to digital tools where needed / appropriate
- Accurate coding following diagnosis

Community led patient optimisation as part of a multi-morbidity model (core general practice offer)

- Patient held and co-produced care plan, with ongoing care planning and support
- Holistic care co-ordination, incorporating mental wellbeing / MH screening
- Access to clinical management guides and quality improvement resource (CESEL) & meds management and review
- Structured support for patient education, self-management and behaviour change

Community Case Management/ MDT approach (including consultant input)

- Risk stratification of people with multiple LTCs
- MDT-led reviews and clinics, led by trained multi-morbidity primary care specialist (GP), delivering personalised holistic care
- Specialist input from, e.g. secondary care consultants; Mental Health practitioners; relevant ARRS roles such as dieticians, podiatrists, clinical pharmacists, care coordinators and social prescribers
- Secondary Care-based MDT Case Management, including excellent/ seamless interface with community MDT model

SEL Multi-Morbidity Model of Care (MMMoC)

- In April 2023, London ICBs were offered a very rapid bidding opportunity from London Renal Specialised Commissioning **to improve outcomes for people with chronic kidney disease (CKD)** - **£1m per year, for two years.**

- The SEL ICB LTC team has worked hard with regional colleagues to realign this opportunity to enable pump-priming of cardiometabolic multi-morbidity (CKD, Diabetes, CVD, Obesity) integrated neighbourhood teams through the lens of renal disease. We have been successful in securing this funding – which will translate to roughly £150k for 6 SEL PCNs (1 per boro)
- Core of the proposal is for a holistic GP-led community-based integrated neighbourhood team – taking a GP-led, multi-morbidity management approach, integrated secondary care input and support from ARRS roles.
- Risk Stratification process (including both healthy.io identified patients and patients already known to primary care) would select the right patients for MDT management
- The focus cohort will be CKD patients with diabetes and/or CVD, for whom at least one of their conditions is poorly controlled
- Approach would be led by a GP with an interest in cardiometabolic health, supported by a range of existing ARRS roles to optimise physical health, mental health and social wellbeing and include secondary care consultant input (nephrologist, cardiologist, diabetologist, geriatrician) as well as End of Life Care support.
- Capability to support this case management/ MDT/ care coordination approach will be built through a bespoke training and support package
- Community-based multi-morbidity approach would interface with a secondary care based cardiometabolic clinic for those patients with the most complex need – supported by the same clinicians giving the secondary care input into the community-based team

MMMoC - What are we looking to achieve?

- The testing of INTs will support greater understanding at a national level of our ability to reduce the number of patients requiring RRT and haemo-dialysis over the longer term. Clearly, it won't be possible to test these outcomes robustly over a short-term pilot, so we have developed a set of **proposed proxy measures and associated indicators** which we will want to track across the course of our pilot

Proxy outcomes/ outputs (for our identified cohort)	Proposed Indicator measures (testing the impact)
Patients living with CKD are supported to stay healthier for longer: - newly-identified CKD patients' and the community MDT cohorts' progression through CKD stages will be slowed and - a reduction in cardiovascular events and diabetic complications	Improved BP control Increased ACR testing Increased % appropriately coded with CKD (to help reduce the diagnosis gap) Improvement in 3 treatment targets Outcomes for non-diabetic CKD/proteinuria Change in smoking status/referral to SCS/increase in smoking therapy Improved uptake of Lipid Lowering Therapies Measuring anxiety scores (e.g. HAD/ GAD score) Improved appropriate medicines optimisation (i.e. take up of SGLT2i or ACE or ARB)
Increased Quality of Life	Range of relevant PROMs (tbc – pilot sites to propose – potentially picking up improvement in, for example, chronic pain and depression)
Reduced duplication and increased efficiency across cardiometabolic care Increased integration across pathway and improved relationships between clinical and care professionals	Reduction in handovers of care Reduction in DNAs and improved patient adherence to testing regimes Reduced GP appointments Reduced 1st and FU OP appointments
Increased patient trust and confidence in their care and their care team Increased patient activation, goal-setting and education, leading to improved self-care and management	Range of relevant PROMs (tbc – pilot sites to propose)
Shift from reactive to proactive care management	Reduction in UEC usage Increase in personalised care plans Increase in ACP conversations

- Our six INTs will not have identical cohorts – however the above are broad *indicator* measures to test impact across all pilot sites and will be iterated/ honed over the co-design period.
- As an over-arching measure, we also expect reduced variation in identification and health outcome measures, particularly across ethnic groups and those in the lower deprivation deciles.

MMMoC - What would we like to test?

- We would like to test an integrated neighbourhood team model in 6 ‘proof of concept’ neighbourhoods (one per Local Care Partnership), working with LCPs/ Place to progress a light touch, transparent selection process, by the 18th August.
- Key elements we would like to test are:
  - an integrated team approach with horizontal integration at place and vertical integration with our specialist teams (nephrology, diabetology, cardiology, frailty and palliative care).
    - We have already fostered a high level of engagement and commitment from secondary care teams with a focus on ensuring equal engagement from all trusts so that the specialist input is available to local teams.
  - Case management of patients living with cardiometabolic disorders through the lens of renal disease and who are at high risk of needing more specialist care without intervention, so it is expected that the cohort would be patients with CKD and either diabetes or CVD (ideally both), at least one of which is not controlled, *and who have other aspects that make the management of their care complex (e.g. depression, chronic pain, social circumstances).*
  - Integration and use of existing or planned ARRS roles as part of the INT.
  - A model which is personalised and holistic with an emphasis on personalised goal setting and inclusion of person-centred outcome measures
  - A model which provides support to the wider practice membership of the neighbourhood team to support the care of the whole cardiometabolic cohort, in terms of prevention, detection and diagnosis and medical optimisation.
  - *Other than elements noted above, participating neighbourhoods have flexibility in design of the model*

MMMoC - What are we able to offer?

- Each neighbourhood will receive £221k to support the delivery of the model - £75k in 2023/24 (Sept-March, a part year effect) and a further £146k in 2024/25 (full year effect)
- Palliative Care/ CNS and senior clinical mental health clinical input are included in this INT funding, as is funding for a lead INT clinician and non-clinical support/ change management staff
- Specialist clinical input into the INT model (nephrology, cardiology, diabetes, geriatrics), which is separately funded to the integrated neighbourhood team funding
- Training and support package – there will be an important support package that is available which will be co-designed with participating INTs. We are working with the SEL Workforce Development Hub to draw together a straw man offer, to be iterated through the co-design process
- Central project management support will be available to work with neighbourhoods on any barriers and blocking issues
- Supporting data – we are currently scoping what additional data we might provide to neighbourhoods to support their models
- CESEL guides and support
- Healthy.io ACR testing – we have agreed a support package with Healthy.io for home ACR testing covering 80% of SE London
- A *different way of working at a neighbourhood level* – a genuine proof of concept for vertical and horizontal integration, taking a collaborative and co-designing approach with SEL ICB, particularly the SEL LTC Clinical Leads [37]

AGENDA ITEM: 9

Healthier Greenwich Partnership

Date: 24 Jan 2024

Title	Population Health Management (PHM) Overview	
This paper is for **noting**		
Executive Summary	The report provides an overview of PHM, as follows: 1) PHM – what is it? 2) PHM tools 3) HealtheIntent – what is it? 4) HealtheIntent – benefits? 5) HealtheIntent for Greenwich	
Recommended action for the Committee	To note the report	
Potential Conflicts of Interest	None	
Impacts of this proposal	Key risks & mitigations	HealtheIntent has been signed-off with respect to IG by all relevant Ig personnel and by LMC
	Equality impact	HealtheIntent is a tool that can be used to reduce inequalities
	Financial impact	Adequate financial provision has been made for the introduction of HealtheIntent in Greenwich
Wider support for this proposal	Public Engagement	Not required for the direct purposes of the report
	Other Committee Discussion/ Internal Engagement	HealtheIntent has been signed-off with respect to IG by all relevant Ig personnel and by LMC
Authors:	Annie Norton, Ass. Director Partnerships & Programmes & Nupur Yogarajah, Clinical Lead for Health Inequalities, Greenwich	
Clinical leads:	Nupur Yogarajah & Eugenia Lee	
Executive sponsor:	Neil Kennett-Brown, Chief Operating Officer	

Population Health Management (PHM) - Overview

24th Jan 2024

Nupur Yogarajah, Clinical Lead for Health Inequalities, Greenwich
Annie Norton, Ass. Director Partnerships & Programmes, Greenwich

PHM – what is it?

[Population Health Management - South East London ICS (selondonics.org)]

(video - 4 mins)

PHM Data Tools

SEL BI Dashboards

Useful overview/trend data at SEL, borough, PCN and practice level

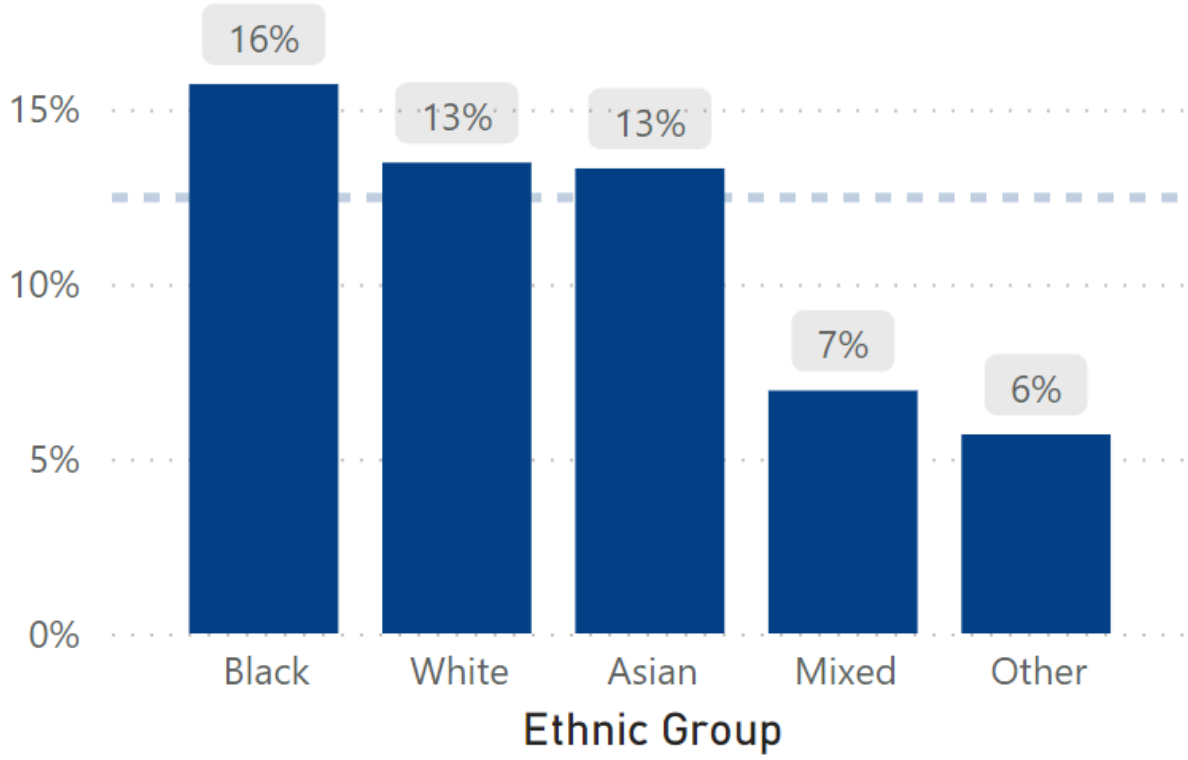
Refreshed monthly

Primary care data only (for now)

No PID

Useful for population health QI

Health Inequalities- Hypertension prevalence by ethnic group in Greenwich



SEL Analytics: Core20PLUS5 Dashboard- HYP, Accessed May 2023

PHM Data Tools (cont)

Ardens

Practice Level

Live refresh

Primary care data

PID

Useful for practice level QI

HealtheIntent

Greenwich & Lewisham

Live refresh

Primary care data + secondary + community **(linked data)**

PID

Useful for practice/PCN/borough/ population health QI

CESEL

SEL data driven programme

Monthly/dependent on source

Primary care data

Non-PID

Useful for targeted practice/PCN level QI provided by facilitator

HealtheIntent – what is it and what are the benefits?

HealtheIntent is a data platform provided by Oracle that aggregates and patient matches Lewisham and Greenwich population data from the following data sources:

- Acute Icare data for Lewisham and Greenwich Trust
- Primary Care EMIS data for Lewisham and Greenwich
- Community RiO data for Lewisham
- SLAM mental health EPJS data for Lewisham

The platform is used to give a whole population view of healthcare contacts, conditions and demographics to support service planning and direct care

The benefits are:

- It provides a place for data sets to be linked up, i.e. primary care, secondary care, community health care, mental health care, social care, etc
- An additional layer of information that can be interrogated and ultimately used to enhance the care provided to people in our community

HealtheIntent in Greenwich

9 practices have signed up in the 1st tranche

- 2 step process: agree on Data Controller Console and then accept in EMIS (7 of 9 completed)
- Validation and checking of the system, by Oracle, to verify that the aggregate data changes in line with what is expected (Dec – Feb/Mar)
- Practice data checks (Mar/Apr, depending on how busy with QOF)
- Ability to start using from Mar/Apr 2024

5 more practices have signed up in the 2nd tranche - hopeful that the remaining 15 practices will come on board for the 3rd tranche

During 24/25, we plan to include Oxleas' community and mental health data and also look at how RBG data could be linked

HealtheIntent in Greenwich (cont)

- **Linked data allows population of QOF and other clinical metrics from secondary/community care**
  - BPs, blood tests etc
- **Population health projects i.e. Multimorbidity pilot**
  - Slicing data with inequalities data – Core20PLUS5, ethnicity, etc with linked data – picks up patients with secondary care/community data
  - Layer above Ardens at practice/PCN level
- **Learning from Lewisham**
  - T&O waiting list - optimising care to avoid delays to surgery
    - 25% of patients are in the most deprived quintile
    - 65% of patients are from the lowest two quartiles for deprivation
  - Targeted health checks to those experiencing poorer outcomes – homeless, safeguarding, lowest socioeconomic groups (>1300 N Lewisham PCN)
- **Harnessing AI**
  - HTN risk predictor model – 39 factors from GP record to calculate risk of developing HTN (categorised from “very high risk” to “low risk”)
  - No other SEL data/dashboards using AI

AGENDA ITEM: 10

Healthier Greenwich Partnership

Date: 24 Jan 2024

Title	MSK Update	
This paper is for **noting**		
Executive Summary	This report updates on work in respect of the MSK community service following the last one in September 2023.	
Recommended action for the Committee	• To discuss and note the report.	
Potential Conflicts of Interest	• None at this point in the process – any potential provider(s) will be treated in accordance with relevant regulations to ensure fairness of the re-procurement part of the re-commissioning process	
Impacts of this proposal	Key risks & mitigations	Capacity has been increased to undertake this work and is being kept under review to ensure successful completion in line with the timetable
	Equality impact	Will form part of the procurement part of the process
	Financial impact	Will be included as one of the key parameters when undertaking the procurement part of the process
Wider support for this proposal	Public Engagement	Work has been undertaken to collect views from a wide range of service users (as well as referrers and those working within the service), about what's good/working well, what's tricky/not working so well and what needs to be different
	Other Committee Discussion / Internal Engagement	Not applicable at this point in time – JCB will be involved at the appropriate time in the process
Author:	Annie Norton, Ass. Director Partnerships & Programmes	
Clinical lead:	Rachel Matheson & John D'Souza, with support from Emma James	
Executive sponsor:	Lisa Wilson	

MSK Community Service Update

24th Jan 2024

Annie Norton
Ass. Director Partnerships & Programmes

Re-commissioning Timetable

Phase	Activity	Start	End	Months
Commissioning and preparation phase	**Stakeholder engagement / review and refine service model using co-design principles**	**Sep-23**	**Feb-24**	**6**
	Finalise service specification and procurement strategy	Mar-24	May-24	3
	Prepare and publish ITT	Jun-24	Jul-24	2
Procurement Phase	Evaluation / moderation	Aug-24	Oct-24	3
	Contract award recommendation report and sign-off	Nov-24	Dec-24	2
Mobilisation Phase	Mobilisation	Jan-25	Mar-25	3
	Contract commences	1st April 2025		

Progress to-date

a) **collecting views from a wide-range of stakeholders**, i.e. service users, referrers and those working within the service, about what's good/working well, what's tricky/not working so well and what needs to be different

- people across the borough of Greenwich have been encouraged to send in their views via the online survey to help us understand what's good, what's tricky and what needs to be different going forward
- we have also held a number of smaller "focus" groups particularly aimed at those that we hear from less often and/or those who may have not accessed the service so that we can incorporate their feedback as an important input to the ensuing service model (pathway) – people from different groupings such as Age UK, Bengali residents, Nepalese residents, etc
- we have also received feedback from referrers, those providing the service currently, social care and are awaiting feedback from the JET Team
- work is underway to collate this feedback into themes and to sense check this with a small group of people prior to mirroring this back to people

b) **obtaining agreement to a tender waiver** from CFO SEL ICB – agreement obtained Dec 2023, incumbent will continue to provide service until the new contract comes into effect from 1/4/25

- a tender waiver was agreed in Nov 23 and the incumbent will continue to act at the prime provider of the service until the new contract comes into effect from 1/4/25

WIP for Jan - Mar

1) **an informal market engagement event will be held on 22nd Feb**

- to think through what is needed to provide a sustainable MSK community service for Greenwich which meets the diverse needs of our population
- it's a great opportunity to co-design and commission a new model for the provision of MSK Community services for Greenwich
- we want to shape our thinking in collaboration with a diverse mix of people who will bring different perspectives, ideas and experience
- we are inviting interest from a wide-range of organisations, including those providing other services that link to MSK Community services in Greenwich

Plan for Jan - Mar

2) **a first community assessment day is being planned for March**

- based on an approach that originated in Sussex
- the aim is to provide a setting that gives people a different way of engaging with us to help them better manage their lives, including, but not limited to any musculo-skeletal issues that they are dealing with
- people on the MSK waiting list will be invited to come along to a community-based setting and have a conversation with a physiotherapist (not a consultation) to ascertain what matters most to them
- there will also be an area to chat with other people over a cuppa and a suite of supporting services (e.g. health checks, MH support, debt advice, Live Well, etc) that people can choose to visit there and then
- people are given a passport to record things in and the relevant sections of this are scanned into their medical notes before they leave
- they have various options in terms of follow-up/self-management/discharge, depending on what is most appropriate and what they agree whilst there

Plan for Mar - May

3) **Preparing for the future phases of the re-commissioning process:**

- refining and agreeing the service specification, based on feedback, informal market event and anything additional that we may learn from the community assessment day (Mar/Apr 2024)
- considering the procurement route that we will be using, under the new PSR procurement regulations (Mar/Apr 2024)
- agreeing this route at JCB (Apr 2024)
- undertaking any further work with procurement colleagues in readiness to commence the formal procurement part of the process in Jun/Jul (May 2024)

AGENDA ITEM: 11

Healthier Greenwich Partnership

Date: 24 January 2024

Title	Expiry of the Thamesmead Health Centre APMS contract held by AT Medics and the time frame for future procurement	
This paper is for **noting**		
Executive Summary	This paper outlines the end of the APMS contract for the Thamesmead Health centre and the time frame for re procurement of the contract. The changes in the new Provider Selection Regime (commenced 1st Jan 2024) have changed the process for procurement and the options for undertaking this. It is recognised that there is likely to be significant interest in what is a relatively large practice in a London Borough and with this landscape a full options appraisal is needed. The options will be reviewed by the Primary Care Working Group in March and a recommendation for approval of the chosen option made to the HGP at the next meeting afterwards.	
Recommended action for the Committee	The committee is asked to note the work being undertaken to produce an options appraisal for the future management of the GP contract for the practice known as Thamesmead Health Centre.	
Potential Conflicts of Interest	Other practices and providers working across Greenwich might wish to bid for the contract and will have a conflict of interest in making the decision about chosen options.	
Impacts of this proposal	Key risks & mitigations	• There are risks associated with a new process, but this is being mitigated by seeking with legal advice on the options. • Ensuring good patient engagement to inform the procurement. • High levels of interest in the procurement and risk of challenge to the decision which will be mitigated by an open and transparent process where any interested party would be able to be involved and be part of the bidding process for the service.
	Equality impact	This will be included in the options appraisal

	Financial impact	This will be included in the options appraisal

Expiry of the Thamesmead APMS Contract

Background

The contract was offered under an APMS contract on the 1st April 2015 with an expiry date of 31st March 2020. The contract was extended for a further 5 years in 2018 when a PMS contract premium was introduced which will end on 31st March 2025.

There is currently no option to extend this contract although under the new Provider Selection Regime (PSR) criteria there could be an option to continue with the current provider under an option to contract with the current provider under a Direct Award.

Contract Value and KPI's

	Indicative annual figures based on 23/24 prices and April 2023 list sizes
	£
Global Sum Equivalent/ Baseline	1,121,289
APMS Time Limited Premium	52,273
Premium Services Payment (100%)	84,577
Less OOH opt out deduction (if applicable)	
Core Contract Price	**1,258,139**
Indicative QOF earnings	96,103
Indicative Primary Care DES earnings	24,394
Indicative Premises Reimbursements	58,231

The contract reviews currently undertaken are part of the national monitoring of GP Contracts through QOF, enhanced access and the PCN DES.

The lease for the premises also ends on 31st March 2025. Estates colleagues have advised that if the current provider bids again for the contract and were successful, they could agree a new lease with the landlord. However, if the current provider were not successful or did not bid then early discussions with the landlord to ensure a lease is in place for 1st April 2025 would be needed and will be initiated should a decision to retender be made.

Available options summary

When considering the primary care landscape within the Borough it is expected that there will be considerable interest in this contract. With this interest in mind, it will be important to ensure that all options are given careful consideration and due regard to the commercial requirements around tendering this contract.

The changes in the new Provider Selection Regime, which went live on 1st January 2024 have affected the options to manage contracts and everyone is adjusting to the new guidance, the primary care team are working with lawyers to ensure that we understand the new options.

Initially the potential options are thought to be as follows.

1. Direct award of a contract to the current provider but this can only be used if:
    - the contract value has not increased more than £500k since it was originally awarded in 2015
    - there is no large variation in the service to be provided.
2. Most Suitable Provider (MSP). This option could be used following a review of the Provider Landscape and would be useful if there are likely to be limited providers interested in the contract.
3. Full procurement through a competitive processes of the APMS contract

A further option is technically possible, which is dispersal of the practice list, however this is highly unlikely, given the large list size of circa 12,500k patients meaning that this is an attractive practice contract. We expect therefore that this option will not be included in the final appraisal.

In addition, there is a need to ensure that the contract meets the needs of the community. Thamesmead has a deprived population with a hugely diverse ethnic population including 38% with black ethnicity.

National General Practice Profiles - Data - OHID (phe.org.uk)

Patient engagement

The ICB has a legal duty to involve the public in any procurement. A Section 14Z2 Duty Public Involvement Assessment form will need to be completed following the initial decision. Patient engagement is now being set up to review with existing registered patients on the options and will be involved in supporting the procurement process.

Patient engagement will start in early February on the procurement seeking input into the details and possible changes that they would like to have included in the new APMS contract particularly around meeting local need.

Proposed timeline for procurement

The time to write the tender documents, put this out for procurement, allow time for potential bidders to ask questions and then submit their bids takes at least 9 months to complete.

There also needs to be time to handover from one provider to the next should this be needed following the award of the contract. The procurement process would therefore need to commence in April 2024 to ensure continuation of services.

The Primary Care commissioning team have proposed to the Primary Care Working Group that they will bring a more detailed paper on options for procurement to their next meeting in March 2024 for a recommendation to be made later to the next Greenwich Partnership for approval of the chosen option.

AGENDA ITEM: 12

Healthier Greenwich Partnership

Date: 24 Jan 2024

Title	Partnership Report	
This paper is for **noting**		
Executive Summary	The partnership report provides update on key developments, as follows: 1) Winter Plans 23/24 2) Staffing changes – Jackie Davidson 3) HGP Board Development Session (Dec 23) 4) Inaugural Clinical Cabinet (Dec 23) 5) General Practice Development Support Visits 6) New Procurement Regulations (PSR) re Healthcare Services 7) LMC Update 8) Encouraging CYP to Start Well 9) Digital Front Door at Queen Elizabeth Hospital 10) AT Medics proposal for change of control 11) Developing and Scaling a Shared Identity for our Local Care Partnership	
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:	Annie Norton, Ass. Director Partnerships & Programmes	
Clinical lead:	Not applicable	

Executive sponsor:	All partners

Partnership Report - 24th Jan 2024

1) Winter Plans 23/24

Greenwich's winter planning approach in 23/24 is based on strengthening, connecting and investing in existing services across the borough to support the physical and mental health needs of residents, and reduce health inequalities. It was known since August 2023, that there would be no new money for ICBs in relation to winter 23/24 and relevant services were notified of the funding allocation in early November 2023. Key principles, include:

- Building on existing services in the system
- Build on local community assets (people, places, existing services)
- Delivering short-term actions that support long-term aims
- Not relying on NEW workforce or services or destabilise current infrastructure
- Things that were measurable in terms of their impact of key performance and patient-outcome metrics
- Things that were targeted known inequalities in Greenwich where possible
- Things that we had clinical / operational capacity to deliver

The plan also complements the national approach which is centred on the achievement of 2 key ambitions for urgent and emergency care recovery:

- 76% of patients being admitted, transferred, or discharged within four hours by March 2024
- Ambulance response times for Category 2 incidents to 30 minutes on average over 23/24

Local Care Partnerships were also asked to select 4 priority areas from a list of high-impact change areas focused around urgent and emergency care. Greenwich (as part of the wider QEH focused system with Bexley) selected:

- Same Day Emergency Care
- Inpatient flow and LOS
- Care Transfer Hubs
- Acute Respiratory Infection Hubs

We undertook engagement with colleagues across HGP and colleagues were asked to identify opportunities in a priority order taking the following principles into account:

- Opportunities that were in place or had been piloted but had to stop in-year due to a lack of available / recurrent funds
- Opportunities that could be scaled / strengthen existing provision
- Opportunities that could bridge a critical gap in commissioned capacity

- New opportunities to transform the experience and outcomes for residents

A shortlisting process was undertaken by a sub-group of the Joint Commissioning Board, and in partnership with the Home First Board, to identify opportunities which would best support system resilience during winter and also impact on the national ambitions and high impact areas of change.

Those involved also reflected on what they had learnt from the winter planning process re: what went well, what was challenging and what we might do differently next year.

Please see Appendix A for the list of winter schemes.

2) Staff Changes

Jackie Davidson, Integrated Commissioning Director (Prevention, Primary Care and Population Health) is leaving Greenwich after 15 years on 13th February 2024. We are immensely grateful for all she has done, developing innovative public health services, such as Live Well, and being such a core part of our health and care system. We wish her well as she starts a new role on the Wirral, and we have an opportunity to say goodbye and thanks properly at her leaving do on the 7th February.

We have been given the green light to recruit to a replacement post, which will become the Director of Primary Care and Neighbourhoods. This role will also support medicines management/wider primary care, but will not include Jackie's former public health role. However, the role will work closely with the public health team to ensure we continue to support integration/neighbourhood development. We hope to finalise this recruitment in the next month, starting dates will depend on notice periods.

As recruitment will take a little while, we are putting in some interim arrangements to support the primary care team. Many of you will know Virginia (Ginny) Morley, she worked in Greenwich as the Clinical Commissioning Director and has previously supported primary care. I am sure you will welcome her back and support her.

3) HGP Board Development Session

A development session for HGP Board was held on 12th December which looked at:

- Confidence about delivery of the current work-plan
- Identified the key things we want to work together on as a Board for the next 6-12 months– full details are covered in another item on the agenda.
- Further clarifying the function of our monthly meeting

- Improving accountability i.e. holding ourselves to account and each other to account for working in line with our agreed values and how to do this

A full report on this development session is included on the agenda for this meeting, hence it is not repeated here.

4) Inaugural Clinical Cabinet

The first Clinical Cabinet was held on 14th December with relevant people from across the system invited to:

- Agree the purpose / role of Clinical Cabinet
- Agree how the Clinical Cabinet would work (ways of working / principles)
- Starting to identify what the Clinical Cabinet would focus its time and energy on, in light of its purpose / role

The group agreed that:

- The purpose / role of Clinical Cabinet is to ensure that there is an effective network of clinical people supporting and enabling the work of HGP, such that we are collectively reducing inequalities and improving health and well-being for our community
- The Clinical Cabinet will work together in a supportive way in recognition that partnership working is fundamental to delivering successful outcomes
- It wanted to set up some practical ways to keep connected and to ask for help in respect of pieces of working going on across the local system, so that peers could link other in, if needed, and / or act to ensure that the clinical network was optimised in line with its purpose.
- there are already sufficient meetings / governance structures such that decisions about clinical pathways, etc, do not need to be considered by this group since this would be an unnecessary duplication / add no value

The group started to identify areas where collaboration is needed or where partnership working could be improved. All members of the group will be acting to support progress in these areas, as relevant, which will ultimately ensure alignment with the delivery of the Local Care Plan and the aims of the Healthier Greenwich Partnership.

The group will meet twice yearly and use this time to reflect on how well they are fulling the agreed purpose, the extent to which ways of working and values / behaviours are consistent across the local system and the impact of collaborative working, with any further lessons learnt. It is likely that there will be a need for one or two extra meetings in the near future in order to put the things that have been agreed fully into motion.

5) General Practice Development Support Visits

It has been agreed with Clinical Directors that we would work with individual practices to review their individual and collective development needs to inform a 2-year programme of development support.

The NHSE Primary Care Transformation Team is also offering support to general practice to enable the delivery of the Modernising GP and GP Recovery Plans, with criteria for accessing this.

General practice leaders across Greenwich agreed a shared vision for their work in January 2023, which will require them to be more outward facing and connected with the wider system. To help them on this journey, and in recognition of their critical role in delivering the wider Greenwich system transformation plans, we have identified local funding for a tailored development programme aligned with local strategic plans and programmes of work.

Recognising the high levels of demand and resourcing challenges across general practice, we have also identified resources and funds to help release the time needed to develop individuals / teams over the next 24-months.

Emerging themes are:

- increased connection
- increased influence
- population health improvement – opportunities to influence at civic, service and community levels
- creative and shared problem solving

To-date, 15 of the 29 practices have taken up the full offer of support (10 of these have been visited so far) and 3 practices have taken up the Modernising funding without the support offer. The remaining 11 practice are considering their options or looking at dates for a meeting.

From these visits there is a list of 11 emerging population health management / improvement projects.

It is very encouraging that, of those practices visited, 97.5% rated the usefulness of the meeting with the Greenwich (ICB) Primary Care Team as 10/10.

6) New Procurement Regulations - Provider Selection Regime (PSR) re Healthcare Services

On the 1st of January 2024, new regulations were passed into law governing the procurement of Healthcare Services. Integrated Care Boards, Local Authorities, NHS Trusts/Foundation Trusts and NHS England are required by

law to apply PSR when procuring Healthcare Services regardless of contract value.

The new Provider Selection Regime (PSR) is significantly different from previous regulations providing new routes to procurement as well as changing how procurements are undertaken.

To learn more about the new regime or to book onto a webinar, please visit the following link 1.

To view presentations on the new regime, please visit the following link 2.

7) LMC Update

GP practices acknowledge the tremendous pressure that LGT is under and are doing their very best to support our system partner.

General practice itself remains challenging during this winter period, with the rise in acute illnesses, compounded by staff absences.

A glimmer of hope was provided by the news that SEL ICB was one of only three ICBs to meet NHSE's GP Recovery Target to expand self-referral pathways by the end of Sep 23. These pathways included: falls response services, musculoskeletal services, audiology, weight management services, community podiatry, wheelchair services and the community equipment service. **It would be really useful if local teams could share these with GPs to alleviate pressures and optimise the benefits for patients.**

There is an urgent need to focus on fulfilling the remaining intentions in the Primary Care Recovery Plan that focus on addressing and reducing external failure demand to ensure sustainable general practice in Greenwich. Measures such as setting up internal referrals and organisations following through on their own requests and investigations would be a good starting point.

Finally, as a we start a new year, the London-wide LLMCs continue to work with the General Practitioners' Committee (of the BMA) to raise awareness of the precarious state of general practice and the need to truly invest in order to realise the vision of "high-quality, expert-generalist, GP-led family medicine from cradle to grave."

8) Encouraging CYP to Start Well

Greenwich continues to focus on reducing cardiovascular disease and is sponsoring work for frontline practitioners and residents to develop and test new solutions over 100 days. Teams are encouraged to develop and test small, measurable changes that could be scaled if they work well. The purpose is to work together differently with communities to rapidly create real tangible change.

Wave 1 was focused on high blood pressure identification and concluded in August 2023. Wave 2 started on 3 November and is focused on physical activity in children and young people with three main priorities:

- Early years: improving physical activity within early years / children's centres settings. This project is aiming to build confidence and improve attitudes of parents and staff of children under 5s to physical activity, which is maintained throughout the lifecycle. The team is working with parents to develop a programme which will be tested at Waterways Children's Centre, which is in an area of high childhood poverty.
- Teenage girls: increasing physical activity in young teenage girls and understanding what they feel their barriers are. This project aims to increase the amount of planned physical activity in teenage girls in Year 8, focusing on outside the school day. The team is working with teenage girls to develop alternative physical activity sessions that are more appealing than traditional sport activities. They are also exploring using local girls and women as role models to inspire others.
- Special Educational Needs & Disability (SEND): developing physical activity programmes within SEND schools and organisations. This project aims to increase the number of children and young people with SEND accessing 20 minutes of activity each day to improve their cardiovascular health, mental health and mood. The team is looking at developing resources to better signpost families and carers to opportunities for physical activity; creating opportunities for young people in special educational settings and creating opportunities for children with SEND in mainstream settings.

9) Digital Front Door at Queen Elizabeth Hospital

At the Urgent Treatment Centre at Queen Elizabeth Hospital, patients are now using an innovative self-service kiosk to record their symptoms before being directed to the most appropriate service. This means that they can be seen more quickly and in the correct setting, as the digital triage tool is used to assess symptoms before a patient is seen by a clinician. The kiosk is expected to improve both the patient experience and the care provided. This is one of a number of improvements put in place by Greenwich Health Ltd (GP Federation) since they took over as the provider of the service in June last year.

9) Potential change of control of AT Medics Ltd

NHS South East London has been notified of a potential change of control of AT Medics Ltd. AT Medics Ltd provides general practice care to patients across south east London.

Whilst no change has taken place yet we would like to explain the process and to reassure our patients and partners of the steps we will be taking to ensure that the proposed change, if approved, will not adversely affect the GP practices.

AT Medics Ltd holds seven Alternative Provider Medical Services (APMS) contracts in south east London. AT Medics Ltd is part of the Operose Health Group which holds a number of other contracts in London and elsewhere in England. Greenwich has one such practice:Thamesmead Health Centre

AT Medics Ltd was set up by GPs in 2004 and is a large provider of general practice services. It was acquired by Operose Health Ltd in 2021 who are ultimately owned by Centene Corporation.

AT Medics Ltd recently wrote to us to seek the ICB's consent to a change of control. They have informed us that:

- The change of control arises as a result of a proposed change in ownership of Operose Health Ltd, which owns AT Medics Ltd through a holding company.
- It is intended that the ownership of Operose Health Ltd will transfer from the current owner, MH Services International (UK) Ltd, to "T20 Osprey Midco Limited ("HCRG Care Group")".

Under the terms of the APMS contract, before undergoing a change of control the contract holder must first obtain our consent.

NHS South East London will carry out a due diligence process to check that the proposed new owner of Operose Health Ltd is of good standing. We will also seek assurance that the change of control would not affect service provision and that patients would not see any difference in their GP practice, so that patients will still access care in the same way and continue to see the same practice teams.

When considering whether to consent to the change of control, we will assess the proposal carefully and consider whether it is necessary to seek any additional assurances.

That decision will be made via the south east London Local Care Partnerships which will meet in public to take the decision. Members of the public will be able to attend and observe proceedings. We will publicise when the meeting occurs and interested members of the public will be able to submit comments and questions in advance of the meeting.

Following the formal request for a change of control we have taken steps to let AT Medics Ltd practice patients know about the change of control and answer the questions that they have. This will includes NHS South East London wide webinar on 23rd January at 6.30pm.

If you have any questions relating to this, please email greenwich.primarycare@selondonics.nhs.uk

Note - this change of control is an entirely separate matter, to the APMS contract ending in March 2025, which is covered in a separate HGP paper.

10) Developing and Scaling a Shared Identity for our Local Care Partnership

Healthier Greenwich Partnership members have been working together to develop and scale the identity of the partnership. This is necessary to improve awareness and bring the partnership to life amongst front-line staff, encouraging them to think and act differently for the benefit of patients and residents. A visual identity has been developed and agreed and an event has been organised for staff in March 2024 as part of this work.

Here is the refreshed logo, with some options of how we use this.

Appendix A: List of schemes re Winter Plan 23/24 (item 1 above)

Scheme title and summary	Expected impact	Non recurrent cost (£000)
▶ **Same day urgent care interventions December - March:** **Virtual Clinical Assessment Service** - to pro-actively contact patients referred by NHS111 as walk-ins/booked appointments before they arrive at UTC (illness only) - 7 days/week, 8hrs/day **Acute Respiratory Hub model via Greenwich health** - 7 days/week, 8hrs/day which could accept both NHS111 and practice bookings	▶ Supports patients to access same day urgent care where this is required. Reduces the burden on primary, urgent and emergency care. 90% of patients consulted via the VCAS can be supported without the need for an onward face to face consultation	200
▶ **Reablement capacity development** – increasing capacity to take additional referrals during the winter period to maintain flow out of the acute hospital	▶ Maximises the number of people in receipt of Reablement support and reduces any delays waiting for support to commence	100
▶ **Employ an end-of-life OT to** ensure patients who are receiving End of Life care to access the support, advice and equipment they need to die at home	▶ Supports patients to die at home where this is their plan by increasing confidence, safety and comfort for the patient and their family/carers. Reduces unnecessary conveyances and admissions for this vulnerable group	90

Scheme title and summary	Expected impact	Non recurrent cost (£000)
▶ **Community pharmacy consultation service incentivisation scheme to encourage practices to refer for minor ailments**	▶ Currently 5 Greenwich GP practices make referral to the community pharmacy consultation service for minor ailments. This scheme will support more patients to be directed to this service, reducing the burden on primary and urgent care	50
▶ **Increase capacity in the falls team** – demand is currently outstripping capacity hence the proposal to increase capacity and reduce the wait for this over the winter period	▶ Increase throughput of patients to reduce falls and resulting conveyances and admissions	50
▶ **CYP virtual ward capacity** – increase in capacity over winter to support more children to receive their treatment at home	▶ Will reduce admissions and LOS for the target group	50
▶ **Glyndon co-production** approach in a local neighbourhood which has high levels of inequality and where there are already trusted relationships and opportunities for co-design	▶ Will focus on what the community feel is needed to reduce attendances based on their specific local needs	50
Total investment		**590**

HGP Committees Update Jan 2024

No.	Date	Committee name	Agenda items of note
1.	02/11/23	Joint Commissioning Board (JCB)	1. Weight Management Contract Variation - The Board approved the Weight Management Contract Variation to provide a non-recurrent £83,001 to the Provider to increase the number of courses available in 23/24. 2. Provider Selection Regime (PSR) Briefing – The board noted the update about the PSR Statutory guidance. 3. Better Care Fund (BCF) - JCB approved BCF Q2 Report on behalf of the Health and Well-Being Board (HWBB) as part of JCB delegation and the Board supports the work that is going on. 4. Greenwich LCP Assurance report - The Board noted the Greenwich LCP Assurance report Sept. 2023. 5. Quality briefing - The Board noted the Quality Briefing November update. 6. Medicines Management Bi-Monthly Update - The Boad noted Medicines Pathway and Implementation Group (MPIG) Q2 update. 7. Housebound Annual Review Service - The Board approved in principle the recommendation that a centralised service is commissioned with Greenwich Health to provide annual reviews for housebound patients with long term conditions.
2.	07/12/23	Joint Commissioning Board (JCB)	1. 24/25 Planning – Commissioning intentions and Priorities update - JCB noted the 2024/25 planning update. 2. Wheelchair procurement - The JCB agreed a joint Bexley, Bromley, and Greenwich (BBG) procurement subject to Bexley and Bromley agreeing this in their governance. 3. Care Home Contract for Primary Care Services - The Board agreed a 6+3-month NHS standard contract extension of the Care Home contract, pending completion of the service review and presentation of an options appraisal to be presented to the committee in early 2024. 4. Communitas Dermatology Contract Extension Request - The Board agreed a 12-month extension to the Communitas, Dermatology contract. 5. Provider Selection Regime (PSR) update – the Board noted the update.

			6. Greenwich LCP Assurance Report - The JCB noted the Greenwich LCP Assurance October report. 7. Allied Health Professionals (AHP) - The Board noted the Allied Health Professionals (AHP) update. 8. Winter Investment Plan – The Board noted the Winter Investment Plan Update.
3	11/01/24	Joint Commissioning Board (JCB)	1. Procurement Decisions / Contract Awards, including PSR – The Board noted the update. 2. Better Care Fund (BCF) – The Board noted the update. 3. MTFS and Impact on Joint Funding Arrangements - The Board noted the update. 4. 2024/25 Planning Guidance Update – The Board noted the national planning guidance is still being awaited. 5. Greenwich Community Anticoagulation Service: Overview of Current Service Provision and Options Appraisal for Future Commissioning Arrangements - The Board agreed with the proposed options for Greenwich Community anti-coagulation service.
4	18/12/23	Charitable Funds Committee	1. Staff Support from charity funds proposal - all committee members agreed to the proposal. 2. Groundwork London update - The Committee received update about logo, website and programme officer, consultation period and plans. 3. Charity Finance - The Committee noted Charity Finance Update.

AGENDA ITEM: 13

Healthier Greenwich Partnership

Date: 24 January 2024

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

HGP Risk register update January 2024

There are 13 open risks on HGP Risk register, with eight of them relating to the delivery of the HGP 2023/24 plan. Five of the risks were recently added.

Four risks were recently reviewed. 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
481	Risk to Greenwich prescribing budget.
492	Risk of overspend against the borough's delegated Continuing Health Care (CHC) budget
493	Risk to overspend in borough's delegated budget
494	Risk to delivery of Greenwich delegated performance targets
495	Risk relating to co-ordination of timely discharge support for residents.

2. Risks recently reviewed.

Risk No.	Risk Title	Latest update
462	Risk to primary care (PCN) access	15/12/2023 1. Risk Owner has met with all 6 PCNs and confirmed they are all on target to deliver their plans. 2. The Digital team are working with practices to transition to cloud based telephony. This is expected to be completed for all practices not currently on cloud based telephony by April 2024. 3. Practice development visits are being undertaken to review with them areas identified for support, including managing patient demand and staffing levels. It was agreed the risk score should be reduced from 12 to 6.
464	Risk to engagement with Greenwich communities.	17/01/2024 • The Social researcher has provided an interim report which would form the basis for next stages of the programme. • The Healthier Greenwich Partnership (HGP) public forum was held on 15 January 2024 with focus on neighbourhood engagement. • Community corners in GP Practices in Blackheath and Charlton PCNs being launched early 2024. Recruitment of Community Connectors planned for early 2024. It was agreed to leave the risk score as 9.
474	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.	• 16/01/2024 – • The Home first operational and strategic Boards are embedded. • There is a Home First dashboard developed and circulated over the last 8 months for sharing data at both boards. There is also a Greenwich and Bexley (QEH System) Urgent and Emergency Care Board dashboard. This includes data relating Virtual Wards and the Urgent Community Response (UCR). For 2023-24 there was a reduction in Virtual Wards funding against the plan from the original bid. • The recurrent funding for 24/25 remains at reduced level, requiring review of virtual wards pathways against funding allocation. The risk of this is that the full number of beds that were originally planned would not be available.

		• There has been challenges for the workforce, especially in recruiting specialist roles. For example, recruiting advanced clinical practitioners to deliver the virtual wards within JET and recruitment of a palliative care consultant within the hospice. • The Communications Lead does attend the Home First Strategic Group and a number of resources are in development. The Risk score should remain at 9 due to ongoing challenges regarding funding level below original modelling for virtual wards.
481	Risk to Greenwich prescribing budget.	12/01/2024 - The cost pressure due to price concessions has started to settle from October 2023. However, the accrual effect on prescribing budget remains. Therefore, forecast outturn continues to show overspend. The trend is similar across 6 boroughs. The risk score of 12 should remain unchanged for now until next review.

Healthier Greenwich Partnership
Development workshop – 12th December 2023

Outputs

Aims and approach

About the workshop

On the 12th December 2023, members of the Healthier Greenwich Partnership came together for a developmental workshop to develop their approach and build on the annual stocktake.

Key aims for the workshop

1. Welcome new members to the Healthier Greenwich Partnership
2. Strengthen relationships and build on work to-date
3. Agree a plan to align our time with our strategic objectives
4. Co-develop a shared approach to accountability

Our agenda

Timing	Item	Lead
15:00 – 15:10	Welcome	Sarah
15:10 – 15:15	Reminder of the aim and ground rules	Claire / Victoria
15:15 – 15:30	Check-in icebreaker	Victoria
15:30 – 15:40	Our journey	Iain / Victoria
15:40 – 15:50	Break	
15:50 – 17:20	Strategic forward planning	Victoria
17:20 – 17:40	Holding ourselves accountable	Claire
17:40 – 17:55	Actions and next steps	Claire
17:55 – 18:00	Check-out	Victoria
18:00	Close	Sarah

Attendees

Attendee	Job Title	Organisation
Andrew Kerr	Programme Manager	Metro GAVS
Annie Norton	Ass. Director, Partnerships & Programmes, Greenwich	NHS South East London ICB
Chris Dance	Assistant Director of Finance Greenwich	South East London ICS
Daniel Rattigan	Associate Director - Strategy	Lewisham and Greenwich NHS Trust
David Borland	Integrated Commissioning Director -Children's Services	Royal Borough of Greenwich / South East London ICS
Deborah Brown	Head of Health Improvement	Charlton Athletic Community Trust (CACT)
Dr Nayan Patel	GP Partner and PCN Clinical Director	Blackheath standard PMS
Dr Tuan Tran	GP Partner and Local Medical Committee Chair	Valentine Health Partnership
Iain Dimond	Chief Operating Officer and Healthier Greenwich Partnership Chair	Oxleas NHS Foundation Trust
Ike Philip	Corporate Governance Lead- Greenwich	NHS South East London ICB
Jackie Davidson	Integrated Commissioning Director for Primary Care, Prevention and Population Health	Royal Borough of Greenwich / South East London ICS
Joy Beishon	Chief Executive Officer	Healthwatch Greenwich
Kate Heaps	Chief Executive Officer	Greenwich & Bexley Community Hospice (GBCH)
Lisa Thompson	Director of Children & Young People's Services	Oxleas NHS Foundation Trust
Neil Kennett-Brown	Chief Operating Officer (Greenwich)	NHS South East London ICB
Nick Davies	Deputy Director Health and Adult Services	Royal Borough of Greenwich / South East London ICS
Russell Cartwright	Assistant Director of Communications and Engagement (Bexley, Greenwich and Lewisham)	South East London ICS
Sarah McClinton	Greenwich Place Executive Director, Deputy Chief Executive of the Council & Director Health and Adult Services	Royal Borough of Greenwich
Steve Whiteman	Director of Public Health	Royal Borough of Greenwich

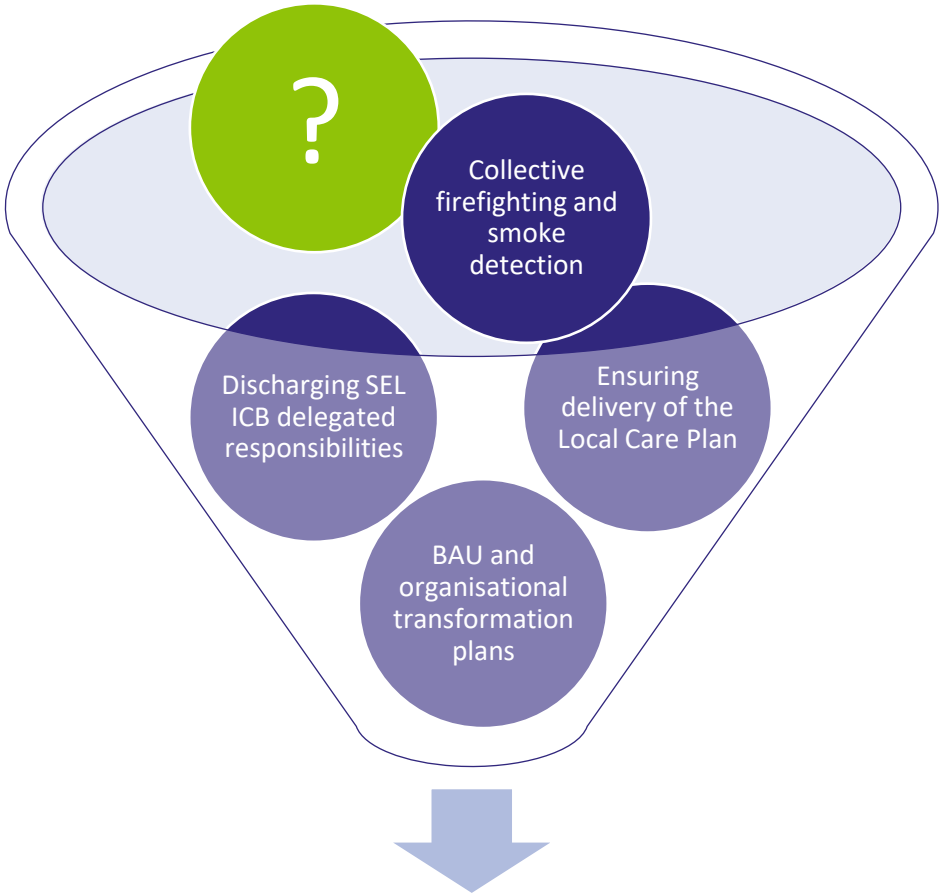
We challenged ourselves on our current workplan

Objective

- As a partnership, we have a clear understanding of what we want our respective organisations and delivery teams to work together on. We have agreed a set of strategic objectives, a five-year plan and one-year plan, the latter comprised of thirty-two high impact activities. In this session, we sought to challenge the assumption that this work alone would deliver the strategic objectives and produce a forward plan for the next 6-12 months of partnership working.

Approach

- In pairs, and then on our tables, we debated the likelihood we would achieve our strategic objectives if we continued to prioritise and work together as we are. We mapped out 'what is the work leftover' and explored two sub-questions:
  - Where are the opportunities for the Board to add value?
  - What activity by the Board is going to have the greatest impact and return on investment?
- Given this, we asked ourselves 'what do we want to spend our time on over the next twelve months of partnership working?' and explored five sub-questions:
  - What is needed from an ICB delegated responsibility perspective?
  - What is needed from a HWB strategy/LCP plan perspective?
  - What is needed to respond to less well predicted items?
  - What is the most important?
  - What else does the Board need to give time to, to ensure the objectives are achieved over the long term?

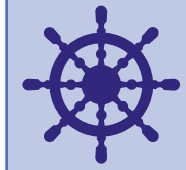


Strategic objectives

We identified areas we need to develop in our workplan

We asked ourselves 'what is the work leftover?' and identified additional activity for the Board to achieve its 5-10 year objectives:

Moving our shared purpose, objectives and priorities from a point in time, to an ever-present, widely understood and incentivised focus for all meetings in Greenwich



Leaders consistently putting values into action, building trust, and convening the right people at the right times

Developing the neighbourhood model of working as a key delivery vehicle for multiple priorities

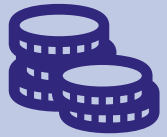
Engaging communities to magnify seldom heard voices, build relationships and promote patient activation

Developing and scaling the 'partnership' workforce culture of shared values, behaviours, agency, and permissive risk taking

Championing and supporting system-wide adoption of community asset and strength-based approaches

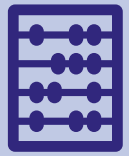
Shifting the system mindset from reaction to prevention, with clear expectations between Boards and less "left to chance"

Growing a sustainable workforce, with collective planning to meet growing demand in the next 5-10 years



Greater sharing and transparency, including budgets, data and information

Explicitly focusing on addressing the wider determinants of health and inequality, with the right voices to contribute solutions



Promoting health equity through the alignment and distribution of resources, such as through audits and long-term planning

Increasing the voice of the VCSE sector, asking them what needs to be done and increasing representation in our meetings

Healthier Greenwich Partnership

PPL

We agreed to dedicate our time to seven activities

Having identified our key areas, we identified the key things we want to work together on as a Board for the next 6-12 months:

- We agreed five key items to focus on over the next 6-12 months. The expectation is that agenda time will be given to shape and inform this work, but that a significant proportion of this will take place outside the meeting between partners.
- In addition to these activities, it was recognised that partners working together should continue to use time outside the Board meeting to work through wicked issues and respond together to unexpected situations, such as the COVID-19 pandemic.

WHAT

Resolving key challenges to delivery of LCP plan

A wider group of partners coming together every twelve weeks to focus on the 1-3 issues that require a senior leader partnership response.

WHAT & HOW

Developing our neighbourhood working model

Continued focus on developing a Greenwich model of neighbourhood working that marries the ideological with the real-world and provides a vehicle for driving forward work on addressing inequalities and supporting residents to stay well.

WHAT

Practicing greater financial transparency

Put into practice the long-held desire for greater transparency by selecting an area of intervention to share budget information around, to enable closer working relationships and better return on investment for Greenwich.

HOW

Negotiation on wicked issues

Board point of escalation for when things get stuck, and a full partnership intervention is required.

WHAT

Demand and capacity modelling for the future

Start the work required to model the resource requirements for a growing, aging population, and long-term planning to develop a sustainable workforce and estates strategy.

HOW

Collective responses to the unexpected

Riding the wave and giving time as required to think and respond to risks and issues that have significant impact for the strategic objectives of the partnership.

WHAT

Nurturing workforce innovation

Dedicated time to consider how leaders of organisation are fostering a culture of innovation and partnership. May include street walks, skills gap analysis, staff comms and engagement, and wider organisational development.

We clarified the function of our monthly meeting

We differentiated between the function of our monthly board meeting, other meetings and the role of individual leaders. We discussed what good would look like and agreed some changes to how meetings could be run to maximise their value.

- We recognised that a lot of the work we do takes place out of the formal Board meeting; however, this meeting remains a heavily invested in opportunity for partnership working.
- Used sub-optimally the time investment from partners can produce diminishing returns and undermine positive working relationships. This is more likely to happen when a meeting lacks a clear function, or the contents do not reflect the agreed priorities of the group.
- Part of the challenge is appreciating what the meeting is a good opportunity for and only giving time to those cross-cutting items which derive value from being discussed by the full complement of partners.
- A distinction was made between the function of the Board meeting, the HGP Exec and the expectations we place on individual members.

Ultimately, the meeting is not the partnership, the people are.

Expectations for the Board meeting

- The meeting agenda will be split into two parts:
  - Part one will focus on discharging SEL ICB delegated responsibilities and other administrative functions, including approving minutes, tracking actions and raising comments by exception to papers submitted to note.
  - Part two will provide an opportunity for partners to have rich conversation focusing on a small number of items.
- There will be strict time management in meetings enabling a wider range of voices (inc. content and context experts) to be invited in for specific discussions.
- Agenda items will be strictly regulated by the HGP Exec to avoid overlapping functions of the Health and Wellbeing Board, SEL ICB boards (e.g., UEC), HGP Exec and sovereign organisational executive boards.

Expectations for Board members

- Championing the partnership purpose, objectives and priorities in other meetings, and ensuring our own organisational strategies and priorities are aligned and not competing.
- Sharing ideas and innovations.
- Incentivising teams and staff to work in new ways consistent with the partnership values and behaviours.
- Reading advance materials for meetings and working to resolve issues/answer questions ahead of the meeting, where possible.

We set time aside to reflect on increasing accountability

Objective

- In July 2023 we undertook a rapid "stocktake" of our progress following the one-year anniversary of the refresh of the Healthier Greenwich Partnership. We used this as an opportunity for partners to reflect on the journey over the past 12 months, consider what is working well and what we would like to develop in this way of working into the future.
- One of the emerging findings was a desire to work on our values and holding ourselves to them. We sought to explore mechanisms for this in our session.

> *We can revisit our values and reflect, but can we really hold ourselves to them?*
>
> Quote from the HGP Annual Stocktake 2023

Approach

- We discussed briefly in pairs, and then held a plenary discussion, exploring why accountability is important to us and how we want to encourage greater accountability.
- As part of this discussion, we explored three sub-questions:
  - Why do we want to be held accountable?
  - What would a bad process look like?
  - What would a good process look like?

What do we think we can do differently?
We want to develop our leadership structure
We want to change our approach
We want to change our meeting structure
We want to manage how we deal with conflict and conflicts of interest
We want to work on our values and holding ourselves to them
We want to keep working together
We want to continue to engage more with the wider system
We want to refine how we deliver

We talked about how to make accountability easier

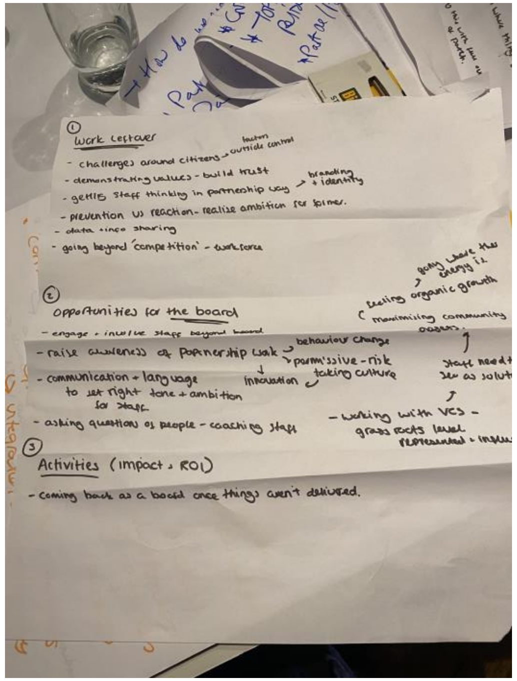
A common theme in our annual stocktake was a need for greater accountability, for our activities, actions and behaviours.

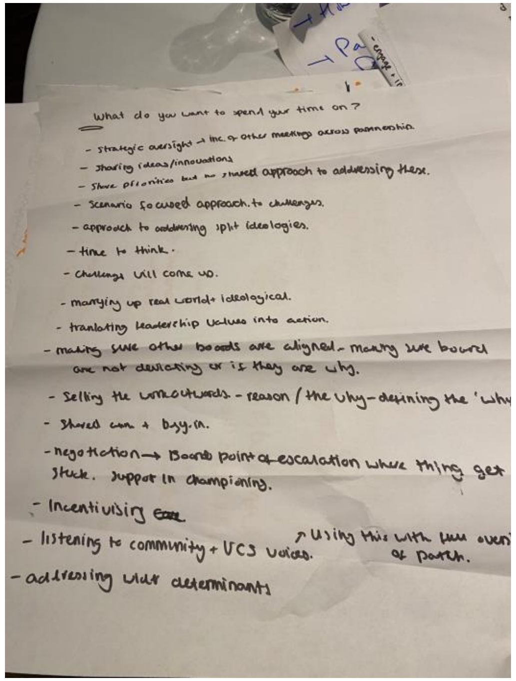
When we agree to a priority, an activity or to work in a certain way, we are setting an expectation that we will individually and collectively behave in a way that is consistent with this agreement. We know that this doesn't always happen, that we individually and collectively fall short of the expectations we set, particularly where we may have competing priorities or a negative frame of reference. We know that being held accountable by ourselves or our peers can feel uncomfortable and may sound or feel like blame.

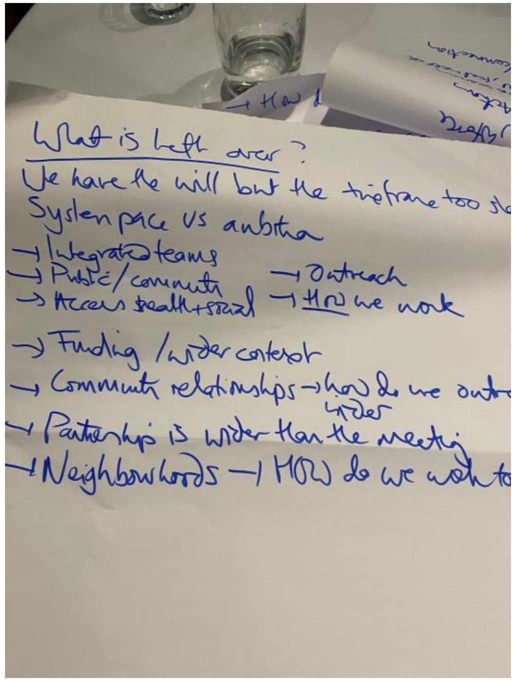
In our last session of the workshop, we discussed what a good process for accountability could like, and agreed on a few principles for encouraging greater accountability in our Board:

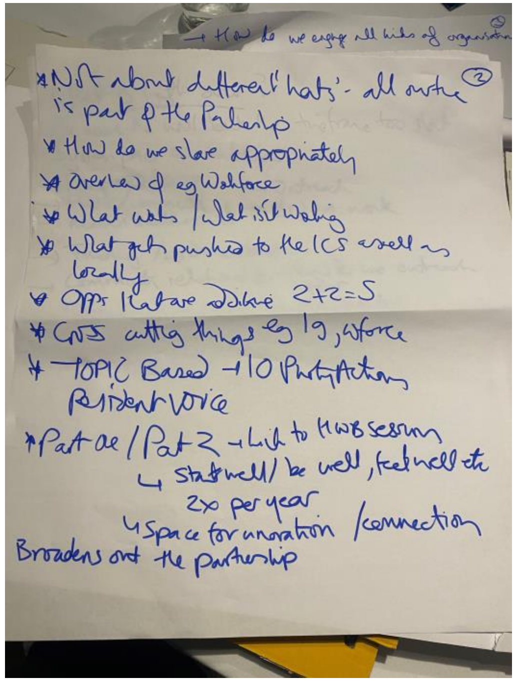
1. We need time and consistent investment from partners to build the relationships and reciprocity that promote greater accountability.
2. We need to assume good intent first, giving partners the benefit of the doubt and trusting that we share a common aim.
3. We need to be clear about roles and responsibilities for actions and devolved pieces of work.
4. We need to be clear about 'why' we are setting expectations and what the desired outcomes are.
5. We need to spend time with new members, so they have understanding about our journey so far etc.
6. We need to continually remind ourselves that we are on a journey and approach partnership from a place of compassion.
7. We need to praise and celebrate examples of good accountability where we individually or collectively meet expectations.
8. We need to continue our commitment to quarterly development sessions.
9. We need to be realistic about what partners can commit to and achieve on the journey.
10. We need to set action owners up to succeed with adequate support and resources.

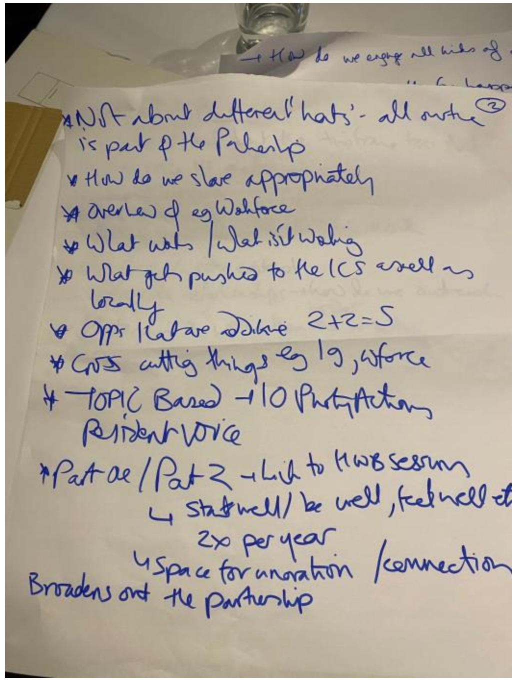
Appendix A – raw outputs


1 Work culture
- challenges around citizens → factors outside control
- demonstrating values - build trust → branding + identity
- getting staff thinking in partnership way
- prevention vs reaction - realise ambition for times.
- data + info sharing
- going beyond 'competition' - workforce
2 Opportunities for the board
- engage + involve staff beyond board
- raise awareness of partnership work
- communication + language to set right tone + ambition for staff
- asking questions of people - coaching staff
- working with VCS - grass roots level
3 Activities (impact + ROI)
- coming back as a board once things aren't delivered.


What do you want to spend your time on?
- strategic oversight → inc. other meetings across partnership.
- sharing ideas/innovations
- share priorities and ... shared approach to addressing these.
- scenario focused approach to challenges.
- approach to addressing split ideologies.
- time to think.
- challenge will come up.
- marrying up real world + ideological.
- translating leadership values into action.
- making sure other boards are aligned - making sure board are not duplicating or if they are why.
- selling the work outwards - reason / the why - defining the 'why'
- negotiation → Board point of escalation where things get stuck. support in championing.
- Incentivising
- listening to community + VCS voices. ↗ using this with the overall partn.
- addressing wider determinants


What is left over?
We have the will but the timeframe too
System pace vs ambition
→ Integrated teams
→ Public / community → Outreach
→ Access health + social → How we work
→ Funding / wider context
→ Community relationships → how do we outr wider
→ Partnership is wider than the meeting
→ Neighbourhoods → How do we work to


* Not about different hats' - all on the is part of the Partnership
* How do we share appropriately
* overview of eg Workforce
* What works / what isn't working
* What gets pushed to the ICS as well as locally
* Opps / Culture 2+2=5
* CVS cutting things eg 19, workforce
* TOPIC Based → 10 Participation Resident voice
* Part one / Part 2 → Link to HWB session
↳ Start well / be well, feel well etc
2x per year
↳ Space for innovation / connection
Broadens out the partnership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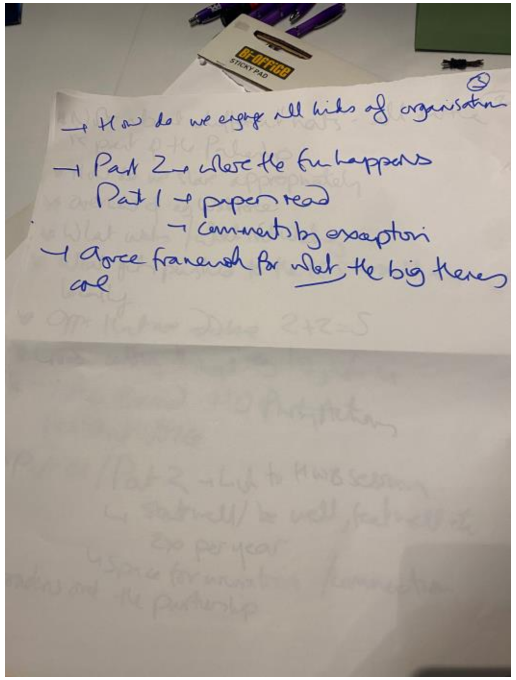
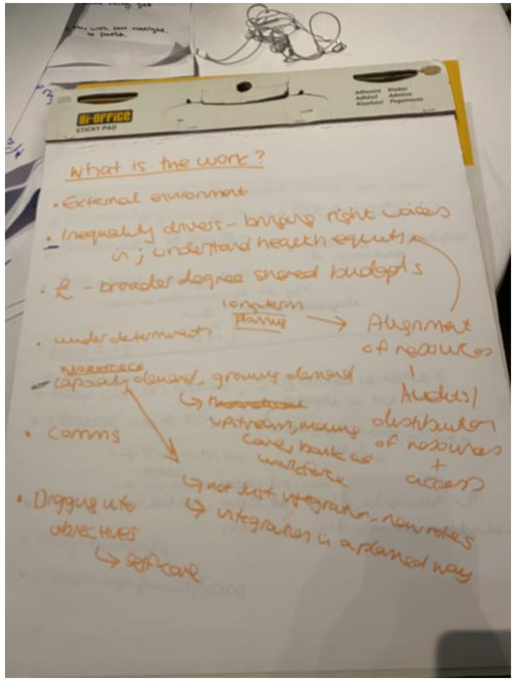
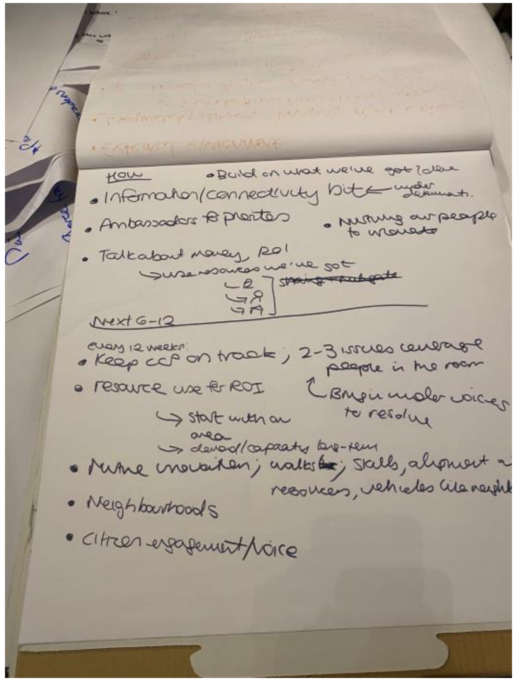

→ How do we engage all kinds of organisation
→ Part 2 → where the fun happens
Part 1 → papers read
→ Comments by exception
→ Agree framework for what the big themes are

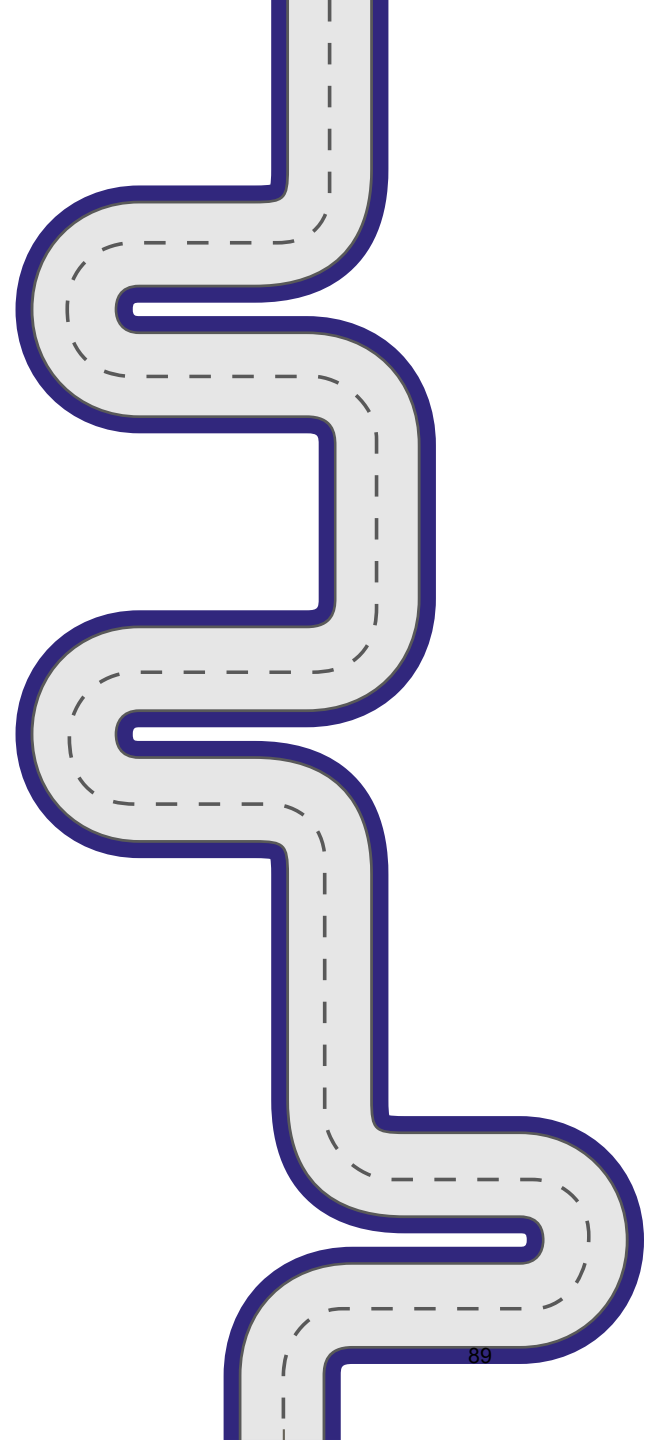

What is the work?
- External environment
- Inequality drivers - bringing right voices in, understand health equity
- £ - broader degree shared budgets
- wider determinants → longterm planning → Alignment of resources
- capacity demand, growing demand → Audits / distribution of resources + access
- Comms → partners, money, care, health care, workforce
- Dragging into objectives → self care
→ not just integration - new roles
→ integration in a planned way


How
• Information / connectivity bit ← wider determinants
• Build on what we've got / clear
• Ambassadors for priorities
• Nurturing our people to innovate
• Talk about money, ROI → use resources we've got
Next 6-12
every 12 weeks
• Keep CCP on track; 2-3 issues coverage, people in the room
• resource use for ROI; Bring wider voices to resolve
→ start with an area
→ demand/capacity long-term
• Nurture innovation; walks, skills, alignment of resources, vehicles
• Neighbourhoods
• Citizen engagement/voice

Appendix B – key presentation slides

The road travelled

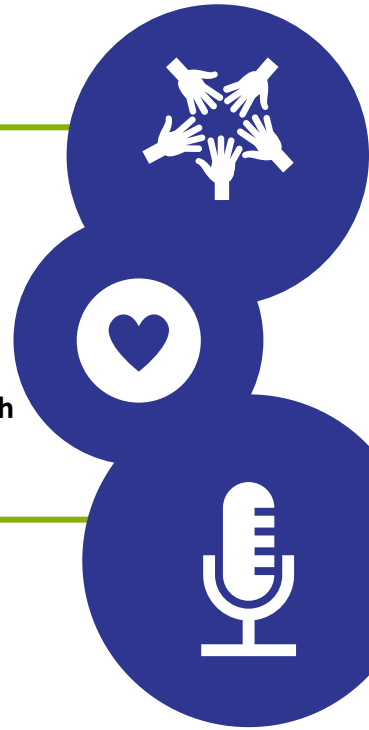
- **In December** we agreed priorities and developed a draft delivery infrastructure
- **In February** we agreed decision-making principles
- **In May** we reflected on how partners collaborate, and we undertook a risk assessment of our Local Care Plan high impact activities
- **In June** we participated in an annual stocktake, reflecting together on what had gone well, and what we were worried about for the future
- **In July** we explored our governance and decision-making arrangements, and produced our first functions and decisions map
- **In August** we stood up the HGP Executive which promptly undertook a review of Local Care Plan delivery teams and reporting structures
- **In September** we shared a plan for implementing the stocktake and agreed three key priorities for board development
- **In October** we implemented the first few actions of this plan, which included introducing a partnership report and a rotating chair schedule to foster a greater sense of shared ownership
- **In November** we completed a six-month check-in of our Local Care Plan high impact activities and flagged any risks to delivery
- **In December** we will launch the inaugural Clinical and Care Professionals Cabinet



Our mission for Healthier Greenwich Partnership

The Healthier Greenwich Partnership (HGP) is a collective of organisations and individuals in Greenwich working together to support the health, care and wellbeing needs of the local residents. It includes partners from the NHS, local council, social care, and the community and voluntary sector.

Using our combined strengths, skills and local knowledge, we work together for and with our communities, with a common goal to make Greenwich a place where people are supported to live healthy and fulfilling lives at every stage of life.



Our purpose is to work together to enable high quality health and care outcomes in our local area. To do so, we will as a Partnership:

1. **Foster collaboration, learning and innovation** between health, care and wellbeing organisations and local residents, all for the common goal of **making decisions and driving action how, when and where this will make the positive most difference** for the people who work, live and study in Greenwich.

2. **Never compromise on fairness, kindness and compassion**, and will create a space where **everyone has a chance, and is enabled to speak and be heard whatever their circumstances.**

3. **Communicate** with each other and with the people who work, live and study in Greenwich and externally **in a way that is clearly, consistent and inclusive, with great consideration and respect to the diversity of our borough.**

Key partners:

- Royal Borough of Greenwich – Public Health, Adults, Children & Young People
- Oxleas NHS Foundation Trust – Community Services and Mental Health provider
- Greenwich Health Primary Care Network Clinical Directors
- Healthwatch Greenwich
- Lewisham and Greenwich NHS Trust
- METRO GAVS
- Charlton Athletic Community Trust

Healthier Greenwich Partnership Values

Respect	Honesty	Compassion	Commitment	Sharing	Outcome-focused	Teamwork	Equality
We will have the same conversations in this room as we do outside of it	We will be genuine	We will look after ourselves and each other	We will prioritise the time and space needed to make this a success – in and out of the meeting – and be present when we are together	We will share our work and be ambassadors for the partnership	We will know what we're trying to achieve and how we measure it	We will think and make decisions for the benefit of the whole system	We will give everyone a chance to speak and be heard
We will appreciate the value of different skills, backgrounds, professional experiences and perspectives, and that we work towards a common outcome	We will be transparent in the work we will undertake	We will understand where each other is coming from	We will be committed to active communication and having difficult constructive conversations where we need to	We will share learning and perspectives in and beyond partnerships	We will use a range of data and intelligence to take a rounded view of the difference we're making	We are able to negotiate and find some sense of compromise	We will consider the needs of vulnerable people
We will consider the impact of our decisions on the wider system	We will be realistic about deadlines and what we are able to achieve	We will assume the best intentions of each other	We will work together to deliver what we have committed to achieve	We will share resources: people, time, money, buildings and equipment	We will focus on priorities we agree on	We will share challenges and take collective ownership	We will have the "right" people around the table, having representation from all walks of life
					We will remain focused on our residents and what matters to them		

South East London Integrated Care System

Royal Borough of Greenwich

Healthier Greenwich Partnership

Our population

- 289,100 residents live within the Royal Borough of Greenwich, an increase of 13.6% from 2011
- The number of residents in the borough aged over 65 has risen by 15.6% since 2011
- The total number of economically active people in RBG make up 77.9% of the borough
- 5.9% of residents are unemployed
- 58.6% of residents have achieved NVQ4 and above
- 51.8% of households in Royal Greenwich are classified as being deprived in one or more of the following: employment, education, health and disability and housing

Health outcomes for our population

- Prevalence of hypertension in Royal Greenwich (all ages) is 12%, this is below the National average of 13.9%
- In Greenwich, over 60% of the adult population is obese or overweight
- Hospital admissions as a result of self-harm (10-24 years) are increasing and getting worse with 150 counts in 2020/2021
- Mental Health is significant, with growing demand, with long waits particularly for CAMHS
- New referrals to secondary health services (all ages) increasing, above the National average
- Smoking prevalence in adults (15+) in Greenwich is decreasing (16.7% down from 17.4% in 2019/2020) although still higher than the National average of 15.9%
- Cancer is the leading cause of death for people in Greenwich (30.9%) with Heart disease following behind (28.6%)
- Musculo-skeletal conditions and poor mental health have the biggest impact on quality of life (morbidity) in our population
- 52% of people who die in Greenwich do so in hospital and only 14% of people identified as being in the last year of life have an advance care plan

Inequalities within our borough

- In Greenwich, life expectancy is 5-6 years lower in the most deprived quintile when compared to the least deprived quintile
- The biggest contributory diseases to the gap in life expectancy between the most & least disadvantaged is circulatory disease, followed by cancers & respiratory disease
- In 2020-2021, deaths from COVID also contributed to the gap in life expectancy as poorer people were disproportionately affected
- Black, Asian and other minority ethnic communities are over represented in our more deprived areas and experience related health inequalities in addition to the direct impacts of structural inequalities and racism on mental and physical health outcomes
- Prevalence of obesity in children aged 10-11 is increasing, however, for children in the most deprived quintile, from 2020 onwards, the rate of increase is double that of the least deprived

What we've heard from the public

- Adults and children and young people are struggling with mental health
- Managing money and cost-of-living is impacting mental and physical health
- Linked to the cost of living, housing availability and affordability are required to meet growing needs
- *"We need to make sure our streets are safe for all"*
- Environmental factors are affecting health, need improved use of space and air quality
- Adults are focused on balancing caring responsibilities and personal life
- *"Provide better and varying opportunities for children and young people"*

South East London Integrated Care System

Greenwich - Our objectives and priority actions

Healthier Greenwich Partnership

Our key objectives - what we want to achieve over the next five years

For our Citizens

- Peoples' health supports them to live their best lives
- Living longer, more equitable and rewarding lives
- Better and more equitable access to services
- Timely care with fewer hand-offs and referrals
- Integrated care – with a united care record
- Only having to tell their story once, and without experiencing structural inequalities and racism
- Feeling empowered and responsible for self-care
- Can access health and social support, including peer support, without stigma

For our frontline staff

- To have a workforce fit for the future
- Better retention and values-based recruitment
- To have a different, sustainable workforce model rooted in our communities
- To have genuinely integrated teams for Greenwich, with local staff, supporting our neighbourhoods
- To have strong communication with the public, sharing challenges and positive stories
- Greater job satisfaction and to understand where they fit and how they contribute

For our Healthier Greenwich Partnership

- All partners to feel valued and trusted in a community of equals; enabling, convening, devolving
- Meeting people where they are and being better at working with communities
- To share our resources better
- To have effective means of communicating
- To track what we want to do and manage it
- To celebrate our success and learning
- To be catalysts for change in new ways of working
- To have trust at the heart of our work

Our priority actions

Support Greenwich residents to **start well:**

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

Support Greenwich residents to **be well:**

2. Everyone is more active
3. Everyone can access nutritious food

Support Greenwich residents to **feel well:**

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

Support Greenwich residents to **stay well:**

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

Support Greenwich residents to **age well:**

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

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
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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 **Live Well Greenwich** live well greenwich

Healthier Greenwich Partnership Forward Planner 2023/2024

Date	Standing Items	Main Business/Themed Item	Items for Information
January	• Welcome • Introductions and apologies • Declarations of interest • Minutes of previous meetings • Action Log • HGP Partner's Report. • HGP Development	• Animation and update on Population Health Management • Reprocuring APMS Thamesmead Medical Practice contract approach for 2025 - Maria Howdon/Jackie Davidson • MSK update – Annie Norton • Winter Planning – Gemma O'Neil/Neil Kennett-Brown • Engagement in Greenwich - the SEL LTC Framework of Care – Robert McCarthy/ Michelle Barber/Joanne Hare	Meeting in Public (via Ms Teams and face to face)
February	• Welcome • Introductions and apologies • Declarations of interest • Minutes of previous meetings • Action Log • HGP Partner's Report. • HGP sub-committee report. • HGP Development	• HGP Identity progress update – Russell Cartwright • Healthwatch thematic reviews – Joy Beishon • PCN Fuller final report and next steps – Primary Care	Meeting in Private (via Ms Teams)
March	• Welcome • Introductions and apologies • Declarations of interest • Minutes of previous meetings • Action Log • HGP Partner's Report.	• Acute Provider Collaborative - updates for HGP – Neil Goulbourne • Greenwich ATEC programme - Lisa Wilson/Kit Collingwood • MSK update – Annie Norton	

Date	Standing Items	Main Business/Themed Item	Items for Information
	• HGP Development	• March HGP mtg on the LCP (input from Exec Grp in Feb re does anything significant need to change re this plan, going into 24/25). – Annie Norton Quarterly HGP Development session	