Healthier Greenwich Partnership

Date: Wednesday 26 April 2023
Time: 13.00 – 14.40
Virtual link: Click here to join the meeting
Chair: Dr Nayan Patel

AGENDA

	Item	Page no.	Presented by	Time
Opening Business				
1.	Welcome, introductions and apologies.	Oral	Chair	13.00
2.	Declarations of interest	Oral	Chair	
3.	Minutes of the meeting held March.	3	Chair	
4.	Action Log and Matters Arising • Metro update	12-15	Chair/ Neil Kennett-Brown	
Public Engagement				
5.	Public Forum feedback		Russell Cartwright	13.06
6.	Questions and comments from members of the public		Chair	13.15
Items for Discussion				
7.	Chief Operating Officer's Report	16-23	Neil Kennett-Brown	13:40
8.	HGP Development update	Oral	Claire Kennedy / Neil Kennett-Brown	13.50
9.	2023/24 HGP Delivery Plan final - Next Steps including system risk review	24-65	Neil Kennett-Brown / Ike Philip	14.00
10.	Primary Care/Long Term Conditions strategic priority development	66-68	Sam Hepplewhite	14:20
Closing Administration				
11.	HGP Forward Planner	69	Ike Philip	14.30
12.	Any Other Business		Chair	14.35
13.	Next Meeting: 24 May 2023		Chair	
Meeting closes at 14:40				

PART 2 MEETING IN CONFIDENCE 14:40 – 15:00

Healthier Greenwich Partnership
Minutes of the meeting held on Wednesday 22 March 2023
13.00-15.00 hrs via Teams

Members	
Nayan Patel	Healthier Greenwich Partnership Chair & PCN Clinical Lead (Chair)
Neil Kennett-Brown	Borough Chief Operating Officer Greenwich (NKB)
Tuan Tran	Greenwich LMC (Local Medical Committees) Chair (TT)
Chris Dance	Associate Director of Finance Greenwich (CD)
Iain Dimond	Chief Operating Officer, Oxleas NHS Foundation Trust (ID)
Sandra Iskander	Acting Chief Strategy, Partnerships and Transformation Officer, Lewisham & Greenwich NHS Trust (SI)
Niraj Patel	Chair of Greenwich Health GP Federation (NP)
Lisa Wilson	Integrated Commissioning Director, RBG & SEL ICS (LW)
Steve Whiteman	Director of Public Health, RBG (SW)
Lisa Thompson	Director of Children and Young Peoples' Services, Oxleas NHS Foundation Trust (LT)
Florence Kroll	Director of Children's Services, RBG (FK)
David Borland	Integrated Commissioning Director, Children's Services (DB)
Jackie Davidson	Integrated Commissioning Director (Prevention, Primary Care, Population Health) (JD)
Sarah McClinton	Place Executive Lead Greenwich (SMc)
Joy Beishon	Chief Executive, Healthwatch Greenwich (JB)
David James	Chief Executive, Greenwich Health (DJ)
Nick Davies	Royal Borough of Greenwich (ND)

In Attendance	
Russell Cartwright	Assistant Director of Comms & Engagement Greenwich (RC)
Ike Philip	Corporate Governance Lead Greenwich (Minutes) (IP)
Jose Garcia	Overall CCPL (Clinical and Care Professional Lead) Greenwich (JG)
Rebecca Manzi	Consultant PPL (RM)
Victoria Stanway	Consultant, PPL (VS)
Mayar De Paula	Consultant, PPL (MDP)
David Segal	Consultant, PPL (DS)
Claire Kennedy	Consultant, PPL (CK)
Penny Hammond	Health Inequalities Programme Manager, SELICB (PH)

Apologies

Atul Sharma	PCN Clinical Lead
Naomi Goldberg	Director of Strategy, METRO GAVS (NG)

1.	**Introduction**
1.1	**Introductions and Apologies for Absence**

1.1	The Chair welcomed the attendees. Apologies were noted as above. It was noted that Claire Kennedy is in attendance as an observer.
1.2	The Chair reminded members about the values HGP committed to abide by and restated them - respect, honesty, compassion, commitment, sharing, outcome-focused, teamwork, and equality. Being mindful of them would hopefully help us working in genuine partnership way.
2.	**Declarations of Interest**
2.1	No new interests were declared.
3.	**Minutes of the Previous Meeting Held on 22 February 2023**
3.1	The Minutes of the previous meeting held on 22 February 2023 were reviewed and agreed by the Board as correct record.
4.	**Action Log & Matters Arising**
4.1	The action log was reviewed, and updates noted. • Noted the open action for Jackie Davidson & Nayan Patel to discuss primary care infrastructure development is in hand and ongoing. • The action on public engagement and involvement group update is due for April meeting, <u>Matters Arising</u>:
4.2	**A) Feedback on Terms of Reference for the Health Inequalities Group.** IP updated that David James (CEO of Greenwich Health) suggested Greenwich Health be included in the membership of the Health Inequalities Group. The Chair asked if there was any objection to this? There was none.
4.3	**B) PCN Fuller report** The latest report circulated ahead of the meeting is a comprehensive report with outputs from the workshop. The Chair is currently looking into how this work develops further with the ICB team. Further update will be provided in May.
5.	**Chief Operating Officer's Report**
5.1	Neil Kennett-Brown presented the agenda item, noting the first update was about an informal Health & Wellbeing Board which took place on 16th March, and focused on Cancer Screening uptake. It brought up significant issues on uptake in some communities, which creates health inequalities.
5.2	SMc noted the discussion focused on overall cancer screening uptake and it was pertinent that that the challenges highlighted really some of the health inequalities particularly around the uptake of screening, noting there is a lot of work going on jointly. It is about how do we change challenge our population to think differently about their uptake of screening opportunities?
5.3	NKB explained that we need the broad health and social care support, and support for holistic needs assessment work, working with LGBT, recognising that our numbers of those needs assessments are lower. NKB explained there has been some discussion with McMillan, with our Cancer Clinical Lead, and have come back to us and identified they may be able to provide some funding which would be helpful to support that.
5.4	SW commented that the presentation at the informal Health and Wellbeing Board really highlighted the degree to which lung cancer is diagnosed far too late for far too many people. The lung health check programme is about trying to find people much earlier on in the in the disease process, so their outcomes are far better. The pilot aims to switching around to diagnosing more people at stage one instead of later at stage three or four. Greenwich is one out of two London sites, and it is like likely to be another National Cancer screening programme once they have

	learned the lessons from the from the pilot phase.
5.5	LT noted that she lives in the borough and observed the invites for the screening programme has come through. NP believes it is important to link the cancer screening work with the inequalities work. NP disclosed that although 50% of his practice list are from BME backgrounds, when the practice received the output from the screening invitation, majority declined. NP stressed the need to use different approaches to engage with those declining these investigations, noting that various approaches were used to engage with people for covid vaccinations such as community leaders, faith leaders, comms and messaging including GP YouTube video about the importance of vaccination. It is vital to make deprivation linkage and BME communities linkage when addressing screening and immunizations issues in Greenwich, as both are impacted by health inequalities.
5.6	JD acknowledged there is a lot we can learn in terms of what we did for vaccinations and apply it for screening. A public health analysis work has begun to map pockets of areas where people are not attending screening. This will then lead to some interesting insights and intelligence that will be used to plan what we need to do going forward.
5.7	The Chair noted the need to look at the inequalities perspective in trying to improve uptake of screening. It is also important to understand why some of the population shy away from accessing screening, which could be due to some poor experiences they may have had when seeing health care professionals – if they felt they were rushed during consultations, not properly listened to or their conditions ignored. The Chair remarked that it is important to ensure the experience of patients are good in the first instance, and clinicians have the time to pick up the vague presentations and the early presentations in a consultation, and patients do not feel rushed due to pressures in the system.
5.8	It was noted that we should try and arrange screening at times that would be convenient to people.
5.9	NKB continued with the COO update, noting that the Charitable fund committee agreed for us to go out on procurement for a grant giving partner. The procurement process has begun.
	<u>Urgent Treatment Centre (UTC) Procurement award</u>
5.10	NKB updated about the UTC procurement, noting it was completed with the end of the standstill period on 17 March 2023. NKB disclosed that one of the local partners, Greenwich Health, won the procurement. NKB and other members congratulated Greenwich Health.
5.11	NKB clarified the next process is to finalise contract and begin mobilisation. There would be a mobilisation Board to oversee the mobilisation stage. A joint accountability framework would be developed for delivery, e.g., an alliance agreement, to ensure urgent and emergency care system working together. NKB confirmed the current provider, Greenbrook, will finish end of June.
	SMc assured that it was a robust competitive process. She recalled our values, noting they would be important as partners work with Greenwich Health as the new UTC provider.
5.12	NP expressed the view that Greenwich Health is happy to have won the bid. They do not underestimate the challenges but noted they have been preparing for this for the past four years and are ready. They have been planning for this, mobilising, and getting workforce in place to

5.13	make it work. NP confirmed that Greenwich Health has good relationship with LGT and other partners in the system and will work with them to deliver better outcomes for the system.
5.14	SI noted that LGT is confident this will work and is committed to working with Greenwich Health as the new UTC provider. ID noted that this presents opportunity for the system to look again at how the urgent and emergency care pathway will work better, noting that Oxleas is happy to be involved in the conversation. DJ declared Greenwich Health will be sending out comms about the proposed UTC model and will work with partners to ensure it works for all.
5.15 5.16	TT noted that based on his experience of working in UTC, interaction between UTC, A&E and other hospital service is crucial. Collaboration between LGT and Greenwich Health would be important. JB would welcome an opportunity to have conversation with Greenwich Health about how to gather and use information from patient experience to improve UTC service. The Chair congratulated Greenwich Health team for winning the bid, noting that successful delivery lies in partnership working with LGT. He noted this is good combination of providers who can deliver better outcomes for Greenwich residents.
5.17	➢ **The Board noted the update.**
6.	**Healthier Greenwich Partnership Development**
6.1	Victoria Stanway presented the agenda item, noting the development work is continuing, being split across four different work streams - the scaling, the shared identity work stream, the delivering our purpose, which broadly translates to the development of the local care plan, and 100-day challenge focusing on Cardiovascular (CVD) workstream.
6.2	RC updated about scaling the shared identity work and a recent workshop on 21 March 2023. RC noted there was representation from the communication teams of partner organisations except Oxleas. The initial focus is on staff but would be articulating the benefit for patients while framing the comms. There was particularly useful discussion about some of the barriers and the need to be creative to have impact, to reach and inform particularly frontline staff. Looked at different comms and marketing approaches to reach various staff across different partner organisation, including desk-based tools and face to face staff events if possible. A task and finish group would be formed to take forward the output from the workshop. RC would like partners to stress to their comms leads to engage with this and make it a priority.
6.3	DS gave an update about CVD planning and 100 Day Challenge, noting that CVD a priority for Greenwich and there is a clear link between inequalities and the impact of CVD, injury, and illness. DS described the process for the challenge, noting the key is to appropriately define a challenge that can be tackled. There was a workshop on 21/03/23 to do this, which decided on two 100-day challenge. So, two periods of 100 days looking at two different challenges, they will slightly overlap.
6.4	LT asked if the workshop had representation from children and young people's services? DB noted that he attended the workshop and expressed the view to look at early age, particularly for primary prevention. If we can do more work there, then we can both improve outcomes and reduce costs later in life. JD added that the rationalising of what area to focus on was more about building

	on work that has already been done and will take it to the to the next step. The workshop noted there is so much work that is already going on and there is so much intelligence.
6.5	DJ remarked that one of the largest programmes that exists for primary prevention of CVD currently is the NHS health checks programme, which screens 40 -74year olds. Greenwich health has strong data to show that around 1/3 of the consultations for health checks result in a referral into another service GPS but frequently into lifestyle programmes, smoking cessation services, weight loss. Greenwich health was not invited to the workshop on 21 March but have asked to be invited to subsequent ones.
6.6	JD noted the workshop attendees were not keen to focus on secondary prevention end and tertiary prevention, but rather on the primary end, particularly about getting people active. DS acknowledged there was keen interest about activating people, wanting to look at the challenge of increasing the level of physical activity of all people that live in Greenwich, including children. So that talks back to the children point.
6.7	DS confirmed the workshop recommended on two challenges – physical activity for the primary prevention bit, and early detection of high blood pressure.
6.8	The Chair asked what metrics would be used to measure improvement in childhood activity level? DS responded that one is not going to be able to demonstrate in 100 days measurable impacts or actual outcome as you would expect from people increasing the level of physical activity. So, key to this area, as with most primary interventions, is having a clear theory of change, being clear about what the outcomes are that we think will be achieved from an increase in activity.
6.9	The Chair asked what would be the interventions used as drivers to improve physical activity? DS noted we would organise a bigger workshop to include all levels of staff across different organisations and to include people from communities themselves to define that intervention. Those people would produce the ideas around those interventions and alongside that, the measures that will be looked at over the 100 days to demonstrate progress. This is the next step and would happen towards the end of April.
6.10	The Chair stressed the 100-day challenge should demonstrate partners working together to deliver something tangible, not just conversations. DS committed to provide the challenge back to the system during the next workshop to ensure we do not come out with something that is nebulous and unmeasurable. It is a crucial point to highlight throughout that this must be tangible change that even if it is focused and small, it would be scalable, but also making sure that it is very measurable and deliverable during the 100 days. DS will reach out to all partners to ask for relevant people to include in the next workshop.
6.11	➢ **The Board agreed on the output from the workshop to have two 100-day challenges focused on physical activity for the primary prevention bit, and early detection of high blood pressure. There would be further workshop to define the interventions for each area.**
7.	**2023/24 Planning**
7.1	NKB introduced the item, noting that the 5yr Forward View now includes a Greenwich borough section. The local delivery plan is a single document that pulls together the health and wellbeing delivery plan, SEL strategic priorities and 2023/24 Operational plan. The ten priorities are shown

	spanning or capturing a resident's life course. This is the first draft, noting that final draft is expected end of April.
7.2	NKB noted there is now a lymphoedema service for Greenwich and additional investment into diabetes care, additional investment into our community, mental health services and part of the transformation work for both children and adults. All those things are landed in the 23/24 contract with Oxleas, and aligned in the local delivery plan.
7.3	NKB elaborated on the ten priorities, noting the plan captures our ten priority areas across the life course - starting well, being well, feeling well, staying well, and ageing well. Included in there are the children, young people getting the best starts in life all the way through. Six of the priorities are lifted directly from the health and wellbeing priorities which links to the corporate plan as well. There is a connectivity of the priorities which means we end up with one plan that we must deliver rather than having six or seven different plans, which makes it easier.
7.4	NKB explained the expectation is that against each of our priorities, we identify the three high impact activities that we are planning to do. What that means for our resident health and wellbeing outcomes, what do we measure as a partnership which might be more things like in the example just given about taking part in physical activity, daily mile walk, as an example. But then what are the delivery mechanisms? It is expected the partnership will co-own and co-deliver the plan, that is every member of the partnership owns this, but understands what their response is.
7.5	NKB concluded by noting that it would be helpful to have partnership agreement on the 10 priorities, commitment for each partner to identify their role in delivery of the priorities by 12th April and comment on the approach to Delivery Plan development.
7.6	The Chair thanked NKB and asked for any comments or questions.
7.7	SI commented although it is useful to bring all the different priorities together in one place, this is still a very long list of things and if we end up with three actions per area, the actions could be quite broad. SI expressed the view we failed to grasp the opportunity to narrow down to a couple of things that we are going to do well together, happy to leave it if that is the collective decision.
7.8	ID remarked it is a useful planning piece, noting there is quite a lot in it. However, the partnership must collectively find ways of doing things differently to operationalise the plan, noting there is limited capacity, and everyone is busy.
7.9	NKB noted first recognising there is a lot in there, thirty actions are a substantial number, it is quite an ambitious approach that is different as well. However, there is the recognition that most of those high impact actions that are being identified are not entirely new and are more likely the opportunity to support them to sustained. NKB added the next HGP will be in public but if anyone would like a pre-meet before the meeting, they should let NKB know.
7.10	VS observed that for most of the prioritie there is scope to define level of ambition within each priority and determine actions that are specific and measurable. Mechanisms about how these are delivered would be jointly worked on.
	The Chair commented that he took on board all the comments made by others but thought the priorities are not onerous. They seem sensible for the partnership to strive for. They would require

7.11	doing some things differently to operationalise them.
7.12	➢ **The Board agreed to the 10 priorities.** ➢ **Each partner to identify areas they can focus on and commit to what they can deliver and inform NKB by 12 April.**
8.	**Health Inequalities update**
8.1	NKB presented the agenda item, noting that Penny Hammond is leading this piece of work as the Programme Manager and attends this meeting.
8.2	NKB noted we bid for some funding from South East London and got a part year effect of that in 22/23; with full year effect of £697K funding has been confirmed for 2023/24. The programme has three elements - the population health programme, workforce development and community infrastructure. NKB updated that substantive amount of work has been done on the population health system bit and thanked SI and the team at LGT who have been helping on this. This would be useful for the conversations around cancer and inequalities piece in relation to CVD.
8.3	NKB added that LGT has done a lot of work in linking relevant data together, and the system is already working for Lewisham residents. There is some work now on modifying the Information Governance documentation, which will enable data sharing agreements to be put in place., noting that LGT and other partners are working on this.
8.4	SI elaborated on the work LGT is doing around data, noting the trust have completed a few audits which can be easily transposed onto the Greenwich data. The first is around vital 5 indicators, which are things like hypertension, obesity, and mental illness. This provides data on things like severity and those without relevant tests. This would aid targeted interventions, for example, to those who have remarkably high severe unmanaged hypertension.
8.5	SI stated another project have identified the Core 20 Plus 5 population for Lewisham for the five disease areas. For example, trust can say of the Lewisham population who are pregnant, how many of them are vulnerable due to a few factors and therefore might need continuity of care or referral to a specialist team and so on. This can be done for the five clinical areas in the core 20 + 5 framework and the other piece of work trust waiting list. SI stressed these can be transposed for Greenwich as the trust holds the waiting list for Greenwich and Lewisham.
8.6	SI added the trust is reviewing people on the waiting list based on a few factors, in particular deprivation, serious mental illness or learning difficulties. This helps the trust produce a couple of pilot interventions to make sure those people either have sort of care coordination support or optimised for surgery where applicable.
8.7	JD gave update about a workshop that happened on 21 March 2023 to discuss inequalities, noting that it was helpful to explore the full range of things happening. This would help to identify the various work streams, map them, and join them up. This enable health inequalities to be reflected in the context of neighbourhoods.
8.8	The Chair asked what is the difference between LGT's data platform, Health-eIntent, and the Discovery data platform? SI responded that Discovery only has primary care data but is not live. The Health-eIntent system enables the join up of hospital and primary care data and is real time. The Chair asked what data governance is in place to enable the system to use the data for non-

8.9	direct care purposes? NKB responded that Data Protection Impact Assessment (DPIA) and other data governance requirements are in hand at the trust end. After it has been signed off at trust side, it would then come to Greenwich primary care, noting the London Wide LMC is involved already, and Greenwich LMC would be involved. NKB assured that practices would not be expected to sign up to anything until all the data governance requirements are in place. ➢ **The Board noted the report.**
8.10	
9.	**METRO - Race report update and response**
9.1	NKB introduce the item, noting that Metro Charity, of which Metro Gavs is part of, carried out an internal race equality audit. They published that on the 8th of March and there are some significant issues raised in the audit. NKB confirmed the audit report is on Metro's website. It is a significant issue, and it is a challenge given that a GAV is one of our key partners of the partnership and the situation has reflection on the partnership. NKB stated that he, the Chair and SMc have discussed and agreed a draft response, which he shared on the screen. The response would be published following approval.
9.2	JB sent a message via chat informing that she lost the audio on teams but sent some comments through chat. She raised that there is real risk to trust with local communities and Metro's own report demonstrates long term and systemic racism. She queried why HGP should remain committed to working with Metro as a partner?
9.3	SMc explained the Council is the main commissioning body for some of the services provided by Metro and includes some public health contracts for sexual health services. She noted there is a balance that we must maintain really in terms of stabilising services, but also making sure that that because of the work, there should be a robust action plan developed following the audit outcome. It is important that we are assured that the plans will lead to significant impact and improvement. So, now, the Council is in the process of working through some of those actions with Metro.
9.4	ID noted Metro wants to do something about it, but what happens in the meantime? He stated he was speaking in terms of children and young people services, because Metro is a is a partner with Oxleas, in Young Greenwich and delivering services to children and young people. He noted the situation is disappointing and overly concerning. Particularly he would like Oxleas staff working with Metro to be able to feel confident and have trust in working with the organisation. He recognised that struggling organisations need time to improve.
9.5	SMc responded that the Council has not seen the action plan from Metro yet, but would want to be assured about what is going to happen, what was going to change, and how we would know what has changed. This is contained within the statement that was shared. SMc stressed we need to understand what Metro is going to do about it before we take a view in terms of how we work with Metro going forward.
9.6	The Chair commented that he has read the report and shares the concerns expressed by members today, including the comments from JB. The Chair noted he appreciates the gravity of the situation and is why Metro Gavs representative on HGP was excluded from today's meeting. The Chair asked the board to consider our values as we respond to this situation, noting they would help the board deal with it in a balanced way.
9.7	The Chair explained Metro identified the problem, went ahead with an internal audit, and did a report which they shared in a very transparent way. Yes, it is a difficult read, and it has implications for Commissioners who commissioned services with them, but we need to work as partnership to resolve those issues.

9.8	TT noted that indeed it is a new scenario which is exceedingly difficult and challenging for the partnership. He expressed the view that, as the Chair said, we should try and handle it based on the values we committed to as a partnership. TT suggested looking at other organisations where there were similar scenarios and see what we can learn about how it was handled, for example the recent review of the Met Police.
9.9	SMC stated when Metro's action plan becomes available HGP will collectively consider it and decide what the next steps should be from partnership perspective.
9,10	➢ **The Board noted the update.**
10.	**HGP Forward Planner**
10.1	Noted for information.
11.	**Review of ways of working**
11.1	Claire Kennedy introduced the item, noting that it would be helpful for the Board to build a habit of reflection at the end of each meeting. CK asked members to take a moment, reflect on the values, and see how they were used in today's discussions. When the time was up, CK asked for feedback.
11.2	ID noted it was a good meeting, though the item about Metro was difficult. However, the conversations were right.
11.3	NP observed that partnership working is somehow hampered by national frameworks relating to procurement and contracting rules. For example, procurement rules and process are complicated and take too long, citing the case of MSK service which is due for procurement in April 2024. He also alluded to a financially challenged environment for the NHS.
11.4	The Chair commented that partnership can be stressed if there are inconvenient situations, such as the last agenda item about Metro. Hence it is important for us to remember our values, even in demanding situations.
11.5	CK thanked everyone for the feedback and asked anyone with any further feedback to email them to her.
12.	**Any Other Business**
	No items raised. The chair thanked everyone for their attendance and closed the meeting at 15.07 hrs.

Action Log for the Healthier Greenwich Partnership – April 2023

Updated 19 April 2023

OPEN ITEMS						
Meeting date	**Minute Ref**	**Action no**	**Action**	**Action Owner**	**To be Completed**	**Comments**
22 March	7.12	001	Delivery priorities - each partner to identify areas they can focus on and commit to what they can deliver and inform NKB by 12 April.	All	April 2023	Completed 18/4/23 through informal meeting with HGP members
25 January	10.14	002	Public engagement & involvement - All agreed to establish the HGP engagement group.	Russell Cartwright	April 2023	This will take place in April. Open
23 November	8.2	002	Jackie Davidson & Nayan Patel to discuss primary care infrastructure development.	Jackie Davidson/Nayan Patel	April 2023	This is in hand and ongoing. Open

AGENDA ITEM: 4

Healthier Greenwich Partnership

Date: 26th April 2023

Title	METRO Charity – Race Audit Report Update
This paper is for **noting**	
Executive Summary	METRO has carried out an internal race equality audit which focuses on the experiences of staff, trustees and volunteers across the charity's services. This audit has revealed serious issues relating to race, negative behaviour towards staff, and limited knowledge of multi-cultural norms amongst staff within the organisation. This report was published on their website on 8th March 23, and includes a summary of actions being taken. The Healthier Greenwich Partnership discussed the report at the meeting of the 22nd March 2023 , and has developed a statement in response, which is on the ICS website, and in this paper. METRO GAVS, is an important member of our partnership, as they represent the Voluntary and Community Sector, which is made up of many diverse organisations in geography, faith, cultural background, scale, community, and many are diverse-led. Healthier Greenwich Partnership (HGP) is committed to anti-racism. We are disappointed and concerned with the findings of the report. We are looking to ensure that sufficient actions are undertaken, and there will be an ongoing process to monitor these, with Royal Borough of Greenwich as the commissioner. We also recognise that issues of race, for all our partner organisations, in terms of staff and residents served are critical. This report, and those affecting other organisations (many recent examples in the media, such as Metropolitan Police, and NHS in terms of maternity care), show the reality of the challenges and discrimination faced by many, and we all as partners have to take active steps to address this.
Recommended action for the Committee	To note the report
Potential Conflicts of Interest	This report directly impacts on METRO GAVS. There is no decision that the HGP is to make on this update.

Impacts of this proposal	Key risks & mitigations	• None arise directly from the report
	Equality impact	• This is the focus of the update, and the HGP recognises the seriousness of the recent race equality audit at METRO charity. • We will consider how we are as a partnership are assured of our organisations work on this.
	Financial impact	• None arise directly from the report
Wider support for this proposal	Public Engagement	• This was not required for the direct purposes of the report
	Other Committee Discussion/ Internal Engagement	• METRO charity has been meeting with commissioners, representatives from the HGP, the GAVS Steering Group, Councillors about the report, and the actions being taken to address this.
Author:	Neil Kennett-Brown, Chief Operating Officer	
Clinical lead:	Nayan Patel, Chair of HGP	
Executive sponsor:	Sarah McClinton, Place Executive Lead, and Director of Health and Adult Services, RBG	

METRO RACE AUDIT FINDINGS
HEALTHIER GREENWICH PARTNERSHIP POSITION STATEMENT

METRO has carried out an internal race equality audit which focuses on the experiences of staff, trustees and volunteers at the charity. This audit has revealed serious issues relating to race, negative behaviour towards staff, and limited knowledge of multi-cultural norms amongst staff within the organisation.

Healthier Greenwich Partnership (HGP) is committed to anti-racism. We are disappointed and concerned with the findings of the report. The experiences described in it don't meet our values and agreed ways of working. We have asked METRO GAVS to temporarily stand down from their role representing the voluntary sector within HGP and we have asked for assurance that METRO takes action to change its culture and implement all of the report's recommendations as a matter of urgency. We will monitor this closely through existing contractual arrangements and partners will consider further steps, including the potential withholding of funds, if METRO fail to deliver the actions against the agreed milestones.
We remain committed to working closely with METRO who deliver services to some of our most vulnerable and at-risk residents. We will look for reassurance that these services can continue to be delivered robustly. The last annual survey, for example, showed that service users report receiving friendly, understanding, and reliable support services from METRO.

We acknowledge the reflective approach taken by METRO and will work with them as they progress the work required to create a fully inclusive environment for all of their staff and volunteers. We expect to see tangible progress and will keep under review their ability to lead with trust and confidence.

Sarah McClinton
Place Executive Lead, Greenwich

Dr Nayan Patel
Chair, Healthier Greenwich Partnership

Neil Kennett-Brown
Chief Operating Officer, Greenwich

22/3/23
ENDS

This statement has been put on the ICS website [HGP-Statement-re-METRO-Audit-final-.pdf (selondonics.org)]

AGENDA ITEM: 7

Healthier Greenwich Partnership

Date: 26 April 2023

Title	Chief Operating Officer's report	
This paper is for **noting**		
Executive Summary	The COO report provides update on: • mobilisation for the new Urgent Treatment Centre at QEH, and the Out of Hours GP service. • NHS Greenwich Charitable Funds – procurement for grant giving partner is underway. • COO visits to key services in the past month. • Visit by NHS Chief Executive Amanda Pritchard to South East London • Additional papers are updates from HGP committees – Primary Care Working Group and Health Inclusion Group.	
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
Author:	Ike Philip, Corporate Governance Lead, Greenwich	

Clinical lead:	Not applicable
Executive sponsor:	Neil Kennett-Brown, Chief Operating Officer, Greenwich

Greenwich Chief Operating Officer's Report
26 April 2023

Urgent Treatment Centre, Queen Elizabeth Hospital

1. The mobilisation is well underway for the new Urgent Treatment Centre at QEH, and the Out of Hours GP service. The new service is due to start on 1st July 2023. There is a weekly mobilisation board, with clear plans and management of risks and issues. Greenwich Health are driving the mobilisation, and have brought in significant additional capacity, and there is active involvement and support from ICB staff, and Lewisham and Greenwich NHS Staff. Plans are progressing well overall.

NHS Greenwich Charitable Funds

2. The charity committee has agreed to go out to procure an external partner to help support the grant giving process over the next 5-6 years. We expect to have selected the partner by July 2023, and the focus of the grants will be on supporting the health & wellbeing of Greenwich residents, working closely with the Royal Borough of Greenwich's Public Health Department, which is in line with the charitable aims. The ITT has been published, with bids evaluated during May/June 2023.

COO visits

3. The past month has provided the opportunity to visit a number of key services, which have been really useful.
    a. Practice visit – I spent a busy Monday morning, working alongside the duty GP in the Vanbrugh practice. It was helpful to see the significant demands on primary care, the challenge of clinical prioritisation, as well as how the systems working to join up information between the hospital and GP practices. Our GP practices are working extraordinarily hard.
    b. Short Breaks Service – this service supports teenagers with additional needs, during school holidays and weekends. I went to the Brighter Futures service, which was running during the Easter holidays. It was inspiring to see the work, as they help prepare for adulthood.
    c. HER Centre – which runs a range of services, and particularly focuses on women who have been victims of Domestic Abuse. It was useful to hear about the range of services, which include a Health Independent Domestic Violence Advisor (IDVA) - and how they are working with GP practices. The challenges on housing and poverty, are increasing the challenges of the work.
    d. Borough Deans – met with the various church leaders to talk about Safeguarding matters, hearing their concerns, and sharing opportunities to share the knowledge and skills of the Greenwich Childrens Safeguarding Partnership. This is part of developing an improved link to faith communities, where we are setting up a task and finish group.
    e. Learning Disability & Autism – I hosted with Oxleas at Queen Mary's Hospital, Sidcup, NHS England's Chief Executive, Amanda Pritchard and Tom Cahill, National Director for Learning Disability and Autism. See article below.

NHS boss devotes afternoon to south east London autism services.

NHS Chief Executive Amanda Pritchard visited south east London last week to learn more about developments in services for autistic people. Together with Tom Cahill, National Director for Learning Disability and Autism, she met with colleagues at Queen Mary's Hospital, Sidcup. Amanda and Tom found out more about the Oxleas Adult Autism Partnership Programme and South London and Maudsley's Transforming Care in Autism team.

Led by the South London Integrated Care System following a pilot with the two Trusts in 2019/2020, these services have been co-designed by parents and carers working with the Trusts' health professionals. The services aim to ensure that autistic people are only admitted to hospital when absolutely necessary and that they are discharged more quickly when they are.

Our analysis suggests there are about 9,000 people with a learning disability and 21,000 autistic people living in south east London – although as many of you will know there is overlap in these figures as 20-30% of autistic people have a learning disability. We also know autistic people are more likely to have a mental health condition. Around 70% of autistic people have at least one mental health condition and 40% have two or more.

Official data also shows that people with a learning disability and or autistic people living in south east London have more intensive mental health support needs. There is wide acknowledgement that regionally and nationally that in the past South East London had high rates of inpatient admissions of autistic people with mental health conditions.

However, the new services are already having an impact. The average number of monthly admissions by this client group across south east London fell from 7.8 in 2019 to 5.1 last year. Typically, there are now around 55 autistic people with mental health condition in hospital on any given day: down from 77 in 2019.

Ify Okocha, Chief Executive of Oxleas, said: "The visit from Amanda and Tom was a great opportunity to showcase the progress already made and to talk through plans to develop services further."

SEL ICB's Associate Director for Learning Disability and Autism, Carol-Ann Murray, said: "We were pleased that NHS leaders were able to see how our clinicians and managers have worked alongside autistic people and their parents and carers to change services over the last three years. They met with the parent of a young adult who was involved in co-producing the service and heard how being listened to and her involvement had benefitted her son and other autistic people.

"Coproduced services have already had a real impact on reducing the numbers of local autistic people in long stay hospitals – a key challenge set for us by NHS England and the Department of Health and Social Care."

The visit provided a great opportunity to highlight many other improvements, and we know that all our SEL health and social care staff (hospitals, community, primary care) need to develop the right skills and knowledge to provide safe, compassionate and informed care to autistic people and people with a learning disability, and we are currently rolling out the Oliver McGowan programme.

Neil Kennett-Brown, Chief Operating Officer, Greenwich and Joint SRO for the programme said "We were delighted to be able to highlight the positive improvements and initiatives to tackle waiting times, and explain our commitment to further improve holistic outcomes for all, so all can thrive through their lives."

The South East London Integrated Care System has signed up to Mencap's 'Treat Me Well' pledge. This aims to ensure NHS staff make reasonable adjustments for people with a learning disability so that the right care and treatment is given, and avoidable deaths are reduced. Learn more about the campaign here.

Information from meeting of the committee (Primary Care Working Group) to HGP.

1. Decisions made by HGP Committee (*Primary Care Working Group*)

1.1 Below is a summary of decisions taken by the committee.

No.	Meeting date	Agenda item	Items for Board to note
1.	23rd March 2023	Premises Business Cases	• ***Manor Brook Surgery:*** Approval of additional rent reimbursement for one clinical room to enable more patients to be registered with the practice and accommodate additional staff. • ***Eltham Palace Practice:*** Approval of additional rent reimbursement for temporary storage space to house medical records whilst awaiting digitalisation.
2.	23rd March 2023	Contractual Issues	• ***Manor Brook Surgery:*** Approval of boundary change (increase in area covered by current boundary and improved patient choice).
3.	23rd March 2023	Practice Transformation Fund (previously GPFV)	• Approval of simplified practice plan template used in previous years to enable release of funding.
4.	23rd March 2023	Greenwich Wide Forum: Presentation / Speaker Requests	• Approval of the following presentation / speaker requests for inclusion on future agendas: - ○ Greenwich Wide Forum Requests ○ Update from SEL Community Pharmacy Clinical Lead ○ Stronger Together Forum Theatre work on Access to health services for migrant communities, Importance of Safe Surgeries

			○ Improving EOL Care in the Community ○ Training Hub Nurse update & students in practice ○ Introductions and Cancer pathway updates for LGT / new projects ○ Waiting times website announcement and opportunity for GPs to ask questions. ○ Neighbourhood development in the context of Greenwich Primary Care ○ Long-Acting Contraception use and awareness of young women aged 18 and under ○ Presentation regarding access to secondary care MH services

2. Other Agenda Items of Note

2.1 Below is a summary of other significant actions and items of note for HGP information.

No.	Meeting date	Agenda item	Items discussed
1.	23rd March 2023	Primary Care Quality Dashboard	• Development of and timescales associated with the SEL wide Primary Care Dashboard

Healthier Greenwich Partnership – Update from Health Inclusion Group – April 2023

The Healthier Greenwich Partnership has agreed a programme of work to help reduce health inequalities in Greenwich in July 2022.

This work is being overseen by the Health Inclusion Steering group; our first meeting is scheduled for 10 May 2023 (TOR agreed 23 Feb 2023).

Three main work areas:

- **Population Health Management**
  - To achieve greater health inclusion through population health management we are implementing an informatics solution 'Healtheintent'. The analytics joins primary and secondary care data together in a dashboard.
  - An 'Equality Impact Assessment' is being completed for implementation of Healtheintent as part of the communications strategy.
  - We will be explaining this data sharing via leaflets and posters within GP surgeries, highlighting any opt out options. It is important that patient level information is only available for those responsible for direct patient care.
  - We are using Lewisham & Greenwich Trust as our anchor organisation (who have successfully used Healtheintent for the last 3 years in Lewisham) with roll out within the GP community expected in Q2 2023 / 2024.

- **Workforce Development**
  - We have made good progress since our last HGP meeting with most workforce in place to deliver our main areas of work, Healtheintent and community infrastructure.
  - We now have two experienced GP leads, Nupur Yogarajah and Eugenia Lee.

- **Community Infrastructure**
  - Our Health Inclusion workshop on 21 March was well attended with nineteen participants across 7 organisations.
  - We met to discuss current inclusion work within the borough with our next steps to join existing inequality work together and build on our successes.

AGENDA ITEM: 9

Healthier Greenwich Partnership:

Date: 26 April 2023

Title	Planning Update - LCP Delivery Plan & Health & Wellbeing Strategy
This paper is for **agreement**	
Executive Summary	The Healthier Greenwich Partnership is on a journey to partner well. In our first phase, between Sep-Dec 2022, the partnership co-developed together: • A clear narrative for the partnership and a shared purpose • A practical and flexible way of delivering together • A shared set of values and behaviours for enabling effective working together • A set of strategic objectives and priorities for the programme to develop into a delivery plan • A developing programme of work to create the infrastructure for shared outcomes • Greater clarity on the role of neighbourhoods as a delivery vehicle • Stronger relationships and a greater willingness to openly discuss "thorny" issues The Healthier Greenwich Partnership have been developing an overarching five-year Health and Wellbeing Strategy, that also links to the South East London Integrated Care System (SELICS) five Strategic Priorities and Joint Forward View, and aligns to Royal Borough of Greenwich's 'Our Greenwich' plan. This will mean we have a single core plan, enabling us to simplify for staff and residents on our priorities and approach. In March we agreed the 10 priority areas and five-year outcomes wanted. These are captured in the framework of start well, be well, feel well, stay well, and age well. We have now been working through the delivery plan elements for 2023/24, gaining commitment for each partner to identify their role in delivery of the key actions (3 per priority). The Greenwich Health and Wellbeing Strategy has now been drafted, which will be the key narrative document, which contains the five year outcomes, and the delivery plan for 2023/24. Each year going forwards we will update the delivery plan. The narrative draft is included in this paper, and feedback is welcomed. The next steps will be finalisation of the narrative, and designing the paper, so that it is ready for approval by

	the Health & Wellbeing Board in June 2023. If members have feedback on the draft narrative, please do this via Steve Whiteman by end of April. The five-year outcome section will feature both in our Greenwich Health and Wellbeing Strategy, as well as the overall SEL ICB Joint Forward View. This overall document has been compiled and brings together the inputs from the six SEL boroughs, as well as the shared programmes of work across the ICS. This large document is now ready for wider feedback (link here), and is due to be finalised and approved by the end of June 2023. To give your input, and for more information about engagement events that are planned at both south east London and borough level, go on Let's Talk Health and Care in South East London. **Next steps:** Following agreement of the Delivery Plan, we propose to hold a workshop in May, which will be focused on what this will require of us as partners to deliver. The development of Local Delivery Plan for Greenwich provides an opportunity to review approach to managing HGP risks in 2023/24. The aim would be to identify risks against the delivery plan. This will include how we work together on the risks and mitigations. T 1. Close all the 2022/23 risks. 2. Reset the 2023/24 risks against HGP Delivery Plan, completing this through May, and use part of a HGP seminar/workshop to identify risks that could impact on delivery of the plan and ensure ownership of risks across our partnership. 3. Categorise the 2023/24 risks under 2 headings. a. ICB related risks as part of our delegation (which would then be reflected in ICB Board Assurance Framework) b. LCP risks (not part of our 'delegation') but relate to our Delivery Plan which covers the overall partnership, or one or more key partners. <u>Contracts/funding:</u> As part of finalising plans for 2023/24, we now have agreed financial and activity schedules for incorporating with our main providers. Within this we have agreed funding to enable: - Further investment in: o Diabetes, Home First, Virtual Wards, Neuro rehabilitation - Commitment to recurrent inequalities funding - New investment in establishing Lymphoedema service (Greenwich was an outlier in not having a service).
Recommended action for the Committee	• **Agreement of the Delivery Plan – 9A** • **Feedback to on draft narrative for the Health & Wellbeing Strategy - 9B by end of April**

	• **Agreement to workshop in May, focusing on working differently to deliver our shared plan, and risks.**	
Potential Conflicts of Interest	• There are no conflicts of interest directly rising from this report.	
Impacts of this proposal	Key risks & mitigations	• Risks on delivery will need to be identified through the plan development, and will be the focus for May
	Equality impact	• Not required for the direct purposes of the report. The equality agenda is one of the key priorities
	Financial impact	• Financial planning is a critical part of our overall planning, so we ensure the appropriate resources are in place to enable delivery
Wider support for this proposal	Public Engagement	• This was not required for the direct purposes of the report. The priorities come from previous engagement on the 'Our Greenwich' Plan and ICS Strategy. • Focus of engagement will be on co-producing the local initiatives behind the priorities, often at a neighbourhood level. • Note – Some engagement planned on the final 5 year forward view plan in May/June.
	Other Committee Discussion/ Internal Engagement	• HWBB agreement in December 2022 to incorporate Mission 1 from 'Our Greenwich' as the Health & Wellbeing priorities • HWBB agreement on alignment with the ICS strategic priorities as agreed at the ICP.
Author:	Neil Kennett-Brown, COO	
Clinical lead:	Nayan Patel, HGP Chair	
Executive sponsor:	Sarah McClinton, Place Executive Lead	

Royal Borough of Greenwich

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*"

The Greenwich Health and Care Plan Contents

- Health inequalities
- Nutritious Food for all
- Everybody active
- Mental health & wellbeing
- Addiction health harms: tobacco, drugs, gambling
- Health & care services support fulfilling, independent lives with a particular focus on carers

- Adults Home First programme
- Community mental health transformation & ASC MH offer
- Accommodation Pathways
- Children's prevention strategy
- Primary care & LTCs
- Urgent & emergency care
- Community Care
- Carers strategy implementation

Resources

- NHS Health Inequalities funding
- RBG funding to strengthen resilience
- Public Health funds
- NHS Greenwich Charitable Funds
- Mainstream monies

Enablers

- PMO establishment to support co-ordination & delivery
- HGP Exec group to drive planning
- Establish refreshed delivery architecture
- Staff and community engagement

- Primary prevention
- Secondary prevention
- Tertiary prevention
  - Cardiovascular fitness
  - Diabetes
  - Hypertension
  - Circulatory disease

- Prevention & wellbeing
- Early years
- Children's mental health
- Adult mental health
- Primary care and people with long term conditions

Further development of the Health and Care Partnership - HGP

Our priorities span a resident's life course

Working together on our ten shared priority areas will produce better outcomes for Greenwich residents throughout their life and will inform our delivery structure for the Healthier Greenwich Partnership.

Support Greenwich residents to **start well:**

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

Support Greenwich residents to **be well:**

- Everyone is more active
- Everyone can access nutritious food

Support Greenwich residents to **feel well:**

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

Support Greenwich residents to **stay well:**

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

Support Greenwich residents to **age well:**

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

live well greenwich **Live Well Greenwich** live well greenwich

How we developed our priorities as a partnership

The Healthier Greenwich Partnership is made up of organisations and individuals who live, work and learn in Greenwich. We work together to enable high quality health and care outcomes in our local area.

The Healthier Greenwich Partnership is on a journey to partner well. In our first phase, between Sep-Dec 2022, the partnership co-developed together:

- A clear narrative for the partnership and a shared purpose
- A practical and flexible way of delivering together
- A shared set of values and behaviours for enabling effective working together
- A set of strategic objectives and priorities for the programme to develop into a delivery plan
- A developing programme of work to create the infrastructure for shared outcomes
- Greater clarity on the role of neighbourhoods as a delivery vehicle
- Stronger relationships and a greater willingness to openly discuss “thorny” issues

The Healthier Greenwich Partnership shares a desire to address health inequalities, and have chosen Cardiovascular Health as a focus area to test and develop their new ways of working. The partnership are taking a prevention approach, and using a 100-day challenge model to design and rapidly test interventions for addressing inequalities. Interventions will span primary, secondary and tertiary prevention, and the life course of Greenwich residents.

Furthermore, the priorities identified by the partnership in phase one, including Home First and mental health, together with mission one outcomes published in The Royal Borough of Greenwich's corporate plan ‘Our Greenwich’, are informing key plans for the organisation and delivery of Greenwich’s health and care services, including:

- SEL ICB Joint Forward View (JFV)
- SEL ICB 2023/24 Operational Plan
- Greenwich Health and Wellbeing Strategy
- Greenwich LCP delivery plan

These plans have in common a set of priorities informed by engagement in phase one.

In its second phase of development, the Healthier Greenwich Partnership has moved from discovery and development to focus on delivery. Key workstreams include:

- Scaling the shared identity - bringing staff on the journey
- Delivering the shared purpose – developing a clear plan for delivering shared priorities, and engaging with wider system partners
- Working differently - implementing the new delivery structure and agreeing how to manage conflict and apply collective resources in the best way.

Greenwich - Our objectives and priority actions

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

Greenwich priority action – Start Well

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

We want all children and young people in Greenwich to experience a safe, healthy and happy childhood where they enjoy family life and school and feel a part of the community. Our aim is to ensure every child growing up in Greenwich will begin, continue to develop and move into adulthood well. We will strive for all children to have a happy and healthy start to life - founded on support and love from parents and carers – by providing easy access to key services from the outset. We will work hard to ensure every child has a successful start to school and is ready to engage and learn from day one.

We will ensure young people develop and maintain a healthy lifestyle by providing access to regular extracurricular activities. We want all children do their best in school will make sure they are supported to meet any additional social, emotional and mental health need. We will work towards every child feeling safe at home and in the community, without fear of violent crime. We will build good foundations in their early and formative years to promote a healthy and successful adulthood.

How we will secure delivery

Actions for 23/24

- Mobilisation of the Integrated Therapies Service including the development of a new preventative navigator function.
- Launch of the new Greenwich Community Directory including improved Family Information Service and Local Offer
- Rollout of the Family Hubs programme including the Start for Life Offer on parenting, parent-infant relationships and perinatal mental health support, home learning environment and infant feeding support.
- Agreement of tripartite arrangements for children and young people requiring health, social care and educational support.
- Development of EMIS database to improve coordination of care between health visiting and primary care
- Review neurodevelopmental pathways to identify improvements in diagnosis and support for children with autism and attention deficit hyperactivity disorder

Actions for 24/25

- Review of Virtual Ward/Hospital at Home provision for children and young people and identification of opportunities for improvement.
- Development of an improved market offer and transition support for those progressing to adulthood as part of the implementation of the new transitions model
- Identification of improvements in the sharing of health and care data for children and young people including the development of the CP-IS function to support the join up of information with unscheduled care.

Intended outcomes in 5 years time

The key outcome is for **children and young people to reach their full potential**, which will be measured by the following:

- Increase in children and young people growing up in a safe and healthy environment with strong supportive networks around them.
- Increased confidence and skills in parenting and infant feeding through enhanced peer support
- Increased engagement with children and young people in positive activities supporting improvements in social skills and healthy lifestyles.
- Young people are better prepared to move into adulthood with increased independence.
- Improved Greenwich Community Directory (including Family Information Service and Local Offer) enabling easier to access advice and information on what support is available for children and families.
- Improved co-ordinated care for people with learning disabilities and autism with a reduction in the escalation of need.
- Reduction in the waiting times for a diagnosis of autism and attention deficit hyperactivity disorder
- Increase in breastfeeding initiation rates.
- Increased engagement and improved outcomes from seldom heard groups as part of the Start for Life offer.

Greenwich priority action – Be Well

Everyone is more active

Address people's health holistically through creating the conditions for people to be more active across Greenwich. This priority will focus on creating environments, activities and opportunities for people to be active in their everyday lives, maintain a healthy weight and enjoy access to affordable healthy food. Supporting active lives through travel, leisure, sport and daily living as part of a Whole Systems Approach, and improving the weight management services for children and adults.

How we will secure delivery

Actions for 23/24

- Deliver cycle training and promote active travel plans.
- Develop streetscape design ands initiate insight about car dependency.
- Enhance existing off-street leisure/transport assets such as the Thames Path, the green chain walk and continue roll out of Play Streets, Play Estates and School Streets initiatives.
- Further develop the use of Healthy Schools and Healthy Early Years frameworks to support children to have a healthy diet, be physically active and to thrive physically and mentally.
- Pilot the co-create youth engagement programme (working with the London School of Hygiene and Tropical medicine).
- 100 day Cardiovascular programme, focusing on primary, secondary and tertiary prevention will have significant 'active life' recommendations. These will build on existing plans, and central to this will be coproduction with our neighbourhoods

Actions for 24/25

- Implement the Local Implementation Plan (LIP).
- Design and implement adult physical activity pathway, which includes families - targeting behaviour change support and activity programmes at those who face the biggest barriers to getting more active.
- Review, update and implement Royal Greenwich Get Active Physical Activity and Sports Strategy.
- Develop the Healthy Weight Care Pathway and take up of related training.
- Develop and implement the Good Work Standard.

Intended outcomes in 5 years time

All people across Greenwich are more active as measured by level of physical activity data. Key outcomes include:

Increased proportion of journeys that are made on foot or by bicycle.

- Measures: Number of bikeability sessions delivered. Number of schools with TfL stars accreditation. Development of robust local data on people's attitudes toward car usage.

Improved physical environment to enable people to achieve and maintain a healthy weight.

- Measures: air quality and modal shift indicators. Parks Usage. Numbers of Play Streets, School Streets, Healthy Catering Commitment outlets.

Support in schools, public and community settings to promote healthy choices and support people to achieve and maintain a healthy weight.

- Measures: Schools with TfL Stars, Schools taking part in The Daily Mile.

Increased engagement and commitment to tackle child obesity among partners and residents

- Measures: comms activity and resident activation

Support and enable people to be more active and less sedentary in their everyday lives

- Measures: Reducing inactivity levels. Activity levels measured as part of the Active Lives, School Sports and Royal Greenwich School Health Education Unit (SHEU) surveys, Healthy Workplace Charter sign ups

Increased engagement and commitment to tackle child obesity among partners and residents.

Health outcomes and inequalities starting to be impacted include

- physical (CVD, respiratory, diabetes, healthy weight), and
- mental health (concentration & achievement, self-esteem, reduced common mental health disorders such as anxiety and depression)

Greenwich priority action – Be Well

Everyone can access nutritious food

Address people's health holistically through creating the conditions for people to enjoy a healthy and balanced diet across the lifecourse and maintain a healthy weight in Greenwich. This priority area will focus on tackling food poverty, developing cooking skills and confidence. We will work with workplaces, shops, the hospitality industry, schools, health services and others.

Actions for 23-25

How we will secure delivery

- Review & update the Greenwich Healthy Weight action plan, identifying cross departmental and cross agency opportunities to improve the obesogenic environment and support residents to access good food.
- Develop an infant nutrition strategy, procure a breastfeeding peer support service through the family hub. Children's centres, health visiting and maternity to achieve and maintain UNICEF Baby Friendly Initiative (BFI) accreditation.
- Increase the use of the curriculum and extra-curricular activities to develop children's skills and knowledge around healthy eating, physical activity, and health and wellbeing.
- Deliver the food skills programme, including cookery and food growing.
- Deliver the Good Food in Greenwich (GFiG) action plan including work to mirror the TfL advertising ban of foods that are high in fat, sugar and salt.
- Enhance the delivery of the elements of the Food Poverty action plan as a component of the implementation of the 'Our Greenwich' Plan.
- Ensure all new food outlets engage with the Healthier Catering Commitment and increase engagement in the programme with existing outlets
- Develop a Good Food in Greenwich healthy retail strategy
- Develop a sustainable plan for Holiday Hunger/ enrichment programmes
- Embed nutrition and healthy weight into neighbourhood development approaches (e.g within the Thamesmead Superzone and the integrated commissioning neighbourhood approach).
- Deliver the National Child Measurement Programme (NCMP).
- Develop healthy weight care pathways which encourages stakeholders to raise the issue of weight and refer to specialist commissioned weight management programmes.
- Ensure that food and nutrition is included as part of all diet related disease care pathways such as hypertension, CVD, diabetes

Intended outcomes in 5 years time

The key outcome for Greenwich is access to nutritious food, enabling residents to access a healthy diet and to maintain a healthy weight. Other key outcomes include:

- Increased breastfeeding rates and supporting parents and carers to establish a healthy diet for their children from a very early age.
- Increased range and accessibility of healthier meals, snacks and drinks that are available to buy locally.
- Increased engagement of schools, public and community settings to promote healthy choices and support people to access good food.
- Increased awareness of all services on the healthy weight care pathways
- Increased awareness of nutritious food on diet related care pathways eg CVD and hypertension

The outcomes will be measured by a range of measures which include:

- Breastfeeding initiation and breastfeeding prevalence at 6-8 weeks
- BFI accreditation / BFI Gold status achieved by 2025
- Increase in percentage of healthy start beneficiaries
- Number of residents attending cookery clubs
- Number of HCC accredited settings
- Number of settings achieving the Good Food in Greenwich Charter
- Number of schools engaged in the Healthy Schools programme
- Percentage participation in National Child Measurement Programme (NCMP)
- Number of residents engaged in weight management services

Greenwich priority action – Feel Well

There are fewer people who experience poor health as a result of addiction or dependency

To address issues of addiction and dependency, people need to be supported as a whole person, not as isolated conditions or symptoms to be treated. This requires an understanding of the challenges, desires, strengths, resources and support networks of each individual. Providing flexible services that meet an individual's circumstances is key to giving people greater control over managing their health and wellbeing.

How we will secure delivery

Actions for 23/24

Tobacco: work as part of the London and SEL tobacco networks to improve access to evidence-based, effective tobacco treatment for smokers wanting to quit.

- Improving nicotine vaping as a treatment option for smokers wanting to quit; embedding tobacco treatment in all NHS care pathways and trusts; developing an updated tobacco control plan with a focus on prevention
- Lung Health Check programme pilot, highlighting early stage cancer for treatment, and to stimulate cessation

Drugs and alcohol: fully implement the new funding through our Combatting Drugs Partnership arrangements, ensuring high quality increased access to treatment

Actions for 24/25

Ongoing further implementation of our tobacco, drug and alcohol treatment and prevention programmes

- This will include full implementation of the Targeted Lung Health Check programme, identifying lung cancers at a early stage & improve outcomes

Gambling: development of improved support for gamblers experiencing financial, social and health difficulties resulting from gambling addiction; through NHS, local authority and wider partnership activities

Intended outcomes in 5 years time

The key outcome is fewer people in the area experience poor health as a result of addiction or dependency. To do this we need to create the conditions for people to be more active, eat well and manage their mental wellbeing. As a result, we predict that numbers of those suffering with addiction/ dependency will decrease.

Key measures will include:

- Increased tobacco treatment services across community and NHS settings
- Increased smoking cessation numbers
- Reduction in substance misuse or crisis admissions
- Increased number of residents accessing drug and alcohol treatment
- Increased healthy life expectancy measures.
- Impact on priority health outcomes: cancers, cardiovascular diseases, respiratory diseases, inequalities, mental health and wellbeing
- Optimised personalised care for adults prescribed correct medicines to manage dependence and/or withdrawal

Greenwich priority action – Feel Well

Fewer adults are affected by poor mental health

The Royal Borough of Greenwich is adopting the Thrive LDN approach to improving mental health and wellbeing, working across these key areas: individuals and communities taking the lead; tackling mental health stigma and discrimination; a happy, healthy and productive workforce; mental health services available when and where needed; and working towards zero suicide. Performance measures are being developed for specific recommendations within the Social Mobility Delivery Plan.

How we will secure delivery

Actions for 23/24

- Work with people with lived experience to develop universal and targeted communications and engagement to help tackle stigma and provide a sense of belonging to a community of people with similar experiences.
- Develop a refreshed needs assessment for MH in Greenwich, followed by co-produced solutions to reduce inequalities
- Support higher risk and vulnerable populations, with a focus on training.
- Reduce the level and impact of social isolation and loneliness.
- Develop a diverse and personalised range of interventions to people experiencing mental health problems within the community setting considering psychological, physical, and social needs – including development of the MH Alliance
- Enable earlier access to support; enable people to recover and stay well; prevent progression of mental health issues and need for crisis intervention – including the delivery of the MH Hub
- To reduce inequality in access and experience of mental health and physical health care for people with severe, moderate, and mild mental health conditions across the borough
- Identify and implement effective approaches to engaging local employers around tackling mental health stigma and discrimination. Work with employers to provide workplaces that support good mental health, and with people who are self-employed, drawing on the expertise and skills of people with lived experience.
- Improve information and intelligence to tackle suicide, including communication, engagement and support.

Actions for 24/25

- Develop an understanding of local opportunities for more informal peer support so that people can engage in their communities and increase their connections, leading to supporting others
- Further develop the Greenwich Mental Health Hub, to bridge the gap between Primary and Secondary Care, including a "no wrong door" policy and information sharing, providing a holistic approach to assessing and meeting needs
- Build on the Greenwich Mental Health Hub to bring together service users, voluntary and community sector, Primary Care and mental health providers to provide prevention and early intervention support to avoid the need for Crisis services.
- Develop the support and accommodation pathway further to support people to recognise and develop independent living skills to integrate back into society after a hospital admission and to prevent crisis
- Address the wider socio-economic factors that affect mental health and wellbeing in our communities, including better support for people to access financial advice services.
- Work with planners, developers and residents to create mentally healthy public and domestic spaces.
- Work to ensure people are in the least restrictive settings, are supported in Greenwich where possible and pathways work as well as they can. This includes working with Housing colleagues

Intended outcomes in 5 years time

The key outcome is **fewer adults are affected by poor mental health**, which will be measured by the following:

- Reduced mental health service referral rates
- Reduced waiting times to access support
- Reduced average length of engagement as people are supported to quickly move through the service having received the input they need
- Sufficient, joined up, skilled and knowledgeable workforce to meet local needs
- Increased engagement in community resources and activities including via self directed support (PHB) options
- Reduced escalation of mental health problems as a result of unaddressed issues such as debt, housing, unemployment and social isolation
- Increased self-management skills for people with mental health problems.
- Reduced health inequalities, in particular for people from our black and minority ethnic communities
- Reduction in number of mental health crisis cases
- Lower rate of local deaths by suicide
- Increased numbers of frontline staff undergo suicide prevention training
- Successful establishment of the Alliance.
- More informed and responsive Primary Care.
- Improvements to new and established Accommodation Pathway.
- Increase in number of Time to Change Champions engaged and working around mental health and wellbeing.
- Residents have good access to green space. Improvement in quality of Health Impact Assessments are included as part of planning applications. Better, more effective and inclusive consultation and engagement happens between developers and local communities.

Greenwich priority action – Feel Well

Fewer children and young people are affected by poor mental health

Our aim is for all children, young people and families in Greenwich to have the support needed to be mentally healthy. This includes being empowered to know how we can help ourselves. Where more help is needed, children, young people and families will have a choice of support, provided by someone families can trust, which is welcoming, safe, without discrimination and easy to access.

We will develop and nurture mentally healthy environments that tackle discrimination and health inequalities. We will empower our children, young people, parents and carers to look after their own mental health and wellbeing. We will give them confidence to access help when they need it, ensuring the best experience and outcomes for a positive difference now and in their future. Our services will be easy to access, with support and treatment as close to home as possible. In line with iThrive, this priority is focused on the holistic needs of children and young people and their mental health and wellbeing. In order to meet our vision set out above, children's mental health must be viewed as a system priority that can only be addressed by all partners working together.

How we will secure delivery

Actions for 23/24

- Implementation and review of the impact of the Mental Health grants to Schools across the borough.
- Implement the new Integrated Clinical Health Team within the Local Authorities Children's Services
- Development of a new Single Point of Access for Mental Health and Wellbeing Needs including specialist child and adolescent mental health support.
- Development of a new model for providing mental health support to children aged 16-25 as part of the transition to adulthood.
- Roll out the new Empowering Parents, Empowering Communities (EPEC) programme
- Reestablishment of the mental health and wellbeing partnership group to shape provision

Actions for 24/25

- Mainstream the roll out of the parent-infant relationship and perinatal mental health support as part of the Family Hubs programme.
- Review the mental health in schools offer including Greenwich's three Mental Health in Schools Teams and identify opportunities for improvement and the development of a consistent offer across the Place
- Mobilisation of new 16-25 offer for children and young people's mental health and wellbeing.
- Implementation of the iThrive framework in Greenwich
- Review options for the development of a Mental Health Crisis Home Treatment Team for children and young people.

Intended outcomes in 5 years time

The key outcome is **fewer children and young people are affected by poor mental health**, which will be measured by the following:

- Reduction in waiting times from referral to treatment to receive specialist CAMHS support.
- Improved knowledge and skills on mental health and wellbeing for those working with children and young people in Greenwich
- More timely identification, interventions and support for mental health and wellbeing needs in children and young people to reduce and prevent need escalating.
- Improvements in representation of those accessing and engaging with specialist mental health provision
- Improved knowledge and skills on perinatal mental health needs for those providing support to parents in the early years.
- More timely identification, interventions and support for perinatal mental health to reduce and prevent need escalating.
- Improvements in children and young people's wellbeing as evidenced through the School Health Education Unit survey and Young Greenwich feedback.
- Improved awareness of the range of provision on offer to support children and young people with their mental health and wellbeing.
- Decrease in preventable hospital admissions of children and young people in crisis
- Improved response to children and young people experiencing a mental health crisis

Greenwich priority action - Stay Well

Everyone can access the services they need on an equitable footing

The Healthier Greenwich Partnership agreed that to enable high quality health and care outcomes in the local area, citizens' experience of health and care services should include timely care with fewer hand-offs and referrals, improved access to clinical and social support including peer support, integrated care, only having to tell their story once and without stigma, and with better and more equitable access to services.

How we will secure delivery

Actions for 23/24

- Work alongside local people and communities in the planning and implementation of health and care plans, ensuring that these plans are appropriately tailored to local needs and preferences, taking into account demographic and cultural factors.
- Develop a single system-wide approach to managing integrated urgent care to guarantee same-day care for patients and a more sustainable model for practices, including: enhanced access support by PCNs, Jet 2-hour rapid urgent response, and same day response COPD service
- Further work on home-based step-up (admission avoidance models of care) through delivery of virtual wards, community access to diagnostics, frailty services and Anticipatory Care models.
- Ensure the ARRS roles in primary care are maximised
- Mobilise Community Specialist Lymphoedema service bringing Greenwich in line with the other boroughs in SEL

Actions for 24/25

- To build an informal agreement between the Healthier Greenwich Partnership and residents on health and care services, named the "Greenwich Deal" with clear mutual expectations, transparency and resources.
- Develop integrated data sets that highlight health inequalities, provide insight into the likely needs of residents as they age to ensure that the Greenwich pound is invested in the right places to secure better outcomes.
- Improve data flows including by (i) solving the problem of data sharing liability; (ii) working with system suppliers on extract functionality; (iii) improving data to support access (actions 1 and 2 above), and (iv) helping to identify population cohorts to be targeted by neighbourhood teams.

Intended outcomes in 5 years time

Prevention and Health Inequalities:
- Continue to address health inequalities and deliver on the Core20PLUS5 approach.

Greenwich Deal:
- Empowered and enabled communities for their health and care outcomes. Co-produced and evaluated, will include using surveys to obtain feedback and compare them to baseline results.

Community Health Services:
- Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard
- Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals.
- Ensure access to urgent care treatment at home, including the ability to receive IV therapy at home following assessment by JET, provide multi-disciplinary community frailty assessments

Primary Care:
- Ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need.
- Increased referral to community pharmacy consultation service for same or next day appointment for self-limiting conditions or minor ailments, e.g. blood pressure, contraceptives

Mental Health:
- Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional people (from 2019) aged 0-25 accessing NHS funded services
- Increase the number of adults and older adults accessing IAPT treatment.
- Recover the dementia diagnosis rate to 66.7%
- Improve access to perinatal mental health services.

Acute Care:
- Reduction in waiting times for elective care, both inpatient and outpatients

Greenwich priority action – Stay Well

Effective Integrated community teams based in neighbourhoods, provide the right support when and where it is needed

This priority brings together prevention, primary care, community support, acute, mental health, social care, care providers and VCSE and wider partners. We will build on the Live Well community hub to establish effective and sustainable neighbourhood models of working. A neighbourhood is where communities that live together interact and support one another to live the best lives they can, with community services that meet the needs of local residents.

How we will secure delivery

Actions for 23/24

- Build partnerships with local communities by improving the way the Live Well Community hub, local communities and organisations work together with the NHS and the Council to improve services closer to where people live.
- Develop a shared narrative for neighbourhood working that speaks to staff, residents and organisations that helps us work together to improve outcomes and address health inequalities
- Support primary care and partners to evolve into neighbourhoods, identifying where primary care wants to work with other providers at scale, by establishing or joining provider collaboratives, GP federations, supra-PCNs or working with or as part of community mental health and acute providers.
- Develop our community approaches that connect individuals to sources of support that address the wider determinants of health. Build on our community development approaches and expand personalised care support including social prescribing. This will improve links between GP practices and local communities.
- Develop the way we commission collaborative public health prevention services at a neighbourhood level using transformation approaches that include working with residents, communities, front line staff, providers and stakeholders to co-produce priorities and interventions, outcome-based approaches based on what matters most to residents. These will link to all local services.

Actions for 24/25

- Continued implementation of the Public Health service transformation programme.
- Improve how we engage with residents and local communities to better understand what is needed now and how this is changing.
- Explore how home care support led by service users and local communities can be further developed within local neighbourhoods.
- Continue to develop training to support and improve the skills of health and social care workers.
- Facilitate opportunities for teams to collaborate, to identify how services should join up, for example through population health management approaches

Intended outcomes in 5 years time

Collaboration between providers within a neighbourhood area to work seamlessly to meet the needs of local populations.

- Provide joined up support for those people who need it the most
- Use data and insight to understand local needs and inform practices
- Strive for collaborative quality improvements focussed on shared outcomes
- Align clinical and operational workforces of community health providers with neighbourhood areas or 'footprints' working alongside dedicated, named specialist teams from acute and mental health trusts, particularly community mental health teams.
- Increase collaboration between previously siloed teams and professionals doing things differently and improving patient care for whole populations.
- Join teams from across PCNs, wider primary care providers, community care, mental health, secondary care, social care teams, and VCSE staff working together to share resources and information.
- Provide secondary care consultants aligned to neighbourhood teams with commitments reflected in job plans, along with members of community and mental health teams.
- At place, bring together teams on admissions avoidance, discharge and flow – including urgent community response, virtual wards and community mental health crisis teams.
- Proactively identify and target individuals who can benefit from interventions, committing to delivering neighbourhood teams first for Core20PLUS5 populations
- Provide a comprehensive service to those with long term conditions, by encouraging cultural changes to reduce a reliance on medicines and support shared decision-making between clinicians and patients, including increasing the use of social prescribing,
- Work with communities to develop their own assets and resources, including supporting a compassionate communities approach

Greenwich priority action – Stay Well

Unfair and avoidable differences in health and wellbeing are reduced

The factors that determine health outcomes for individuals and communities are complex, and include social, economic, cultural, environmental and commercial drivers. To address these issues people need to be supported as a whole person, not as isolated conditions or symptoms to be treated. This requires a strong understanding of and response to the complex determinants of inequalities, including both direct and indirect racism and other forms of discrimination including those related to age, gender, sexuality, disability and gender identity. This will require a proactive and systematic approach including working in new, genuine and sustainable partnerships with communities and places, tackling isolation and loneliness, and tackling poverty.

How we will secure delivery

Actions for 23/24

- Develop new, systematic and ongoing methods of gaining insights from our diverse communities into the factors that affect their mental and physical health; better understand what matters most to our residents, and supporting the co-design of interventions.
- Ensure a particular focus on unwarranted variation in access, experience and outcomes; proactively challenging racism, discrimination and striving for equitable access to services in all we do
- Establishing a population health system to drive targeted improvement to tackle inequalities with a focus on Core20plus5
- 100 day Cardiovascular inequalities programme, supporting primary, secondary and tertiary prevention
- Targeted cancer screening improvement, focus on Lung, Cervical, Prostate, Bowel and Breast in particular, key focus on influencing uptake, and then lifestyle changes to reduce risk (see other priorities)
- Work with people with lived experience to develop universal and targeted communications to help tackle stigma and discrimination in the Royal Borough of Greenwich.
- Reduce the level and impact of social isolation and loneliness
- Embed new SEL-wide diabetes outcome scheme, aimed at PCN-level improvement and reduction in variation ('levelling up' the poorer performing practices) in core diabetes outcome/ care process measures.

Actions for 24/25

- Change the way we engage with grassroots community organisations, including those working with our diverse populations, so they are effectively supported in their work with local communities. This will include funding community-led action to harness the energy, creativity and deep understanding of our residents held within these grassroots groups and organisations
- Work with planners, developers and residents to create mentally healthy public and domestic spaces.
- Support the implementation of the 'Our Greenwich' Plan to address the wider socio-economic factors that affect mental health and wellbeing in our communities, including by better supporting people to access financial advice services

Intended outcomes in 5 years time

The outcome is for Greenwich's residents to feel it is a welcoming and inclusive place, and to reduce inequalities in life chances for people with protected characteristics. Achieving this outcome will include the following measures in:

Engagement:

- the number and type communication and engagement activities with people from our diverse communities including those with lived experience of stigma and discrimination.
- The number and types of co-design; positive feedback from our residents about their inclusion

Spaces:

- Number of play streets, school streets and superzones delivered
- Effective activation of green and blue spaces in the Borough, with more residents accessing
- Improvement in quality of Health Impact Assessments included as part of planning apps
- Better, more effective and inclusive consultation and engagement between developers and local communities.

Isolation:

- Number of residents are supported to be less socially isolated by engaging in their communities, volunteering or through support from VCSE

Poverty:

- No resident in financial crisis is left unsupported, with those experiencing acute financial pressure provided with financial support & advice to prevent their situation becoming worse

Health outcomes:

- Better: Cardiovascular health, Cancer, diabetes, mental health, Vital 5, and vaccination uptake
- Reduced mortality through proactive health checks for those with Learning Disability, autism, or Serious Mental Illness
- Reduction in overprescribing in frail people improves patient experience and reduces waste

Greenwich priority action – Age Well

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

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

How we will secure delivery

Actions for 23/24

- Accelerate development of our Home First service offer which delivers step-up services to avoid admission and step-down services to expedite discharge for a range of chronic conditions and vulnerable patient groups.
- Work with partners to further develop Falls and Frailty offers across the Borough
- Mobilise home care and extra care services including starting to develop a range of local solutions to complement the neighbourhood model which offers choice and local good quality personalised support , including use of UC Plans
- Work with residents to co-produce areas of priority including with Healthwatch, VCS partners, people, families, Pensioners Forum, carers and the local practitioners
- Continue work to ensure provision is of good quality, sufficient and sustainable. This includes further engagement and partnership work with providers on Market Sustainability plans (MSP)
- Deliver workforce recruitment and retention initiatives to ensure availability to meet local needs and future demand
- Improve the join up of data and insight regarding demand and supply of community based services
- Define our strategy and delivery plan for accommodation with support services across needs and ages
- Further develop and promote the Framework for Enhanced Health in Care Homes
- Work in partnership to design and test an approach to embedding digital and care technology in to local offers
- Delivery of joint Carers strategy
- Work with all our partners to ensure that the learning from Safeguarding Adults Reviews informs our practice
- Develop community based offers to support those living with Dementia
- Procure a Community MSK service in line with best practice and aligned to the outputs of the SEL MSK programme
- Increase use of Urgent Care Plans (advanced care plans) across Greenwich Practices

Actions for 24/25

- Progress delivery of accommodation with support strategy and plan across needs and ages
- Focus on supporting providers around sustainability and quality via the delivery of the MSP
- Deliver new data and insight products regarding demand and supply of community based services
- Ensure Homefirst programme delivery including virtual wards
- Continue to offer choice and personalised local support options
- Focus on workforce initiatives which have most impact
- Continue to implement the Joint Adults Carers Strategy 2022-2027
- Continue work to embed assistive digital technology in to local offers that can improve the lives of residents with specific needs, both in prevention, short and longer term support

Intended outcomes in 5 years time

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

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

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

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

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

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

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

Royal Borough of Greenwich - local delivery

Greenwich borough delivery of SEL pathway and population group priorities

The Healthier Greenwich Partnership is committed to partnering well within our local population, our neighbouring boroughs and the South East London ICS. As such we are committed to working with our neighbouring boroughs, and recognise that a number of our partners are providers to more than one borough, and that our population's health & care needs are served by providers in wider SEL. The development of common pathways, support for core offers, and proactive engagement, support and championing of key SEL programmes will help deliver at scale benefits, whilst recognising that local engagement will also be critical to deliver the impact.

Urgent & Emergency Care

- An integrated urgent care pathway will be launched in summer 2023 focused on patients with a same-day need. The pathway will integrated with local GP practices and services which as Live Well Greenwich to provide patients with onwards care and support which meets their needs.
- Greenwich's virtual wards will continue to expand, providing patients with acute care in their own home where possible. Key developments focus on linking these pathways to London Ambulance Service, preventing conveyance to hospital when this is not necessary and ensuring patients being cared for in the community have access to the diagnostics they need in a timely manner.
- System partners will continue to support the development of same day emergency care for patients requiring specialist support which can be accessed directly and managed in an ambulatory or ward environment without the need to attend ED.
- Continue to expand navigation roles, both into the community and voluntary sector, to ensure the holistic needs of residents can be met outside of the hospital environment. This includes active case-finding support within QEH.

Population Health & Prevention

Greenwich is very committed to these programmes, with a dedicated Integrated Commissioning Director, overseeing Population Health, Prevention and Primary Care. We are implementing the HealtheIntent system in Q1 23/24, hosted by LGT, which will enable us to rapidly adopt the learning and benefits from Lewisham, such as the Core20PLUS5 dashboard and work with PCNs and KCL. We are establishing a robust clinical and care professional workforce, making every opportunity count to support the improvement work, with a range of key initiatives to deliver impact on inequalities. This includes our 100 day CVD focus which we are testing approaches this year. We are strengthening our community infrastructure, working with GHIVE, neighbourhood development, all building on the learning from Covid support, and deep engagement.

Learning Disability and Autism

Greenwich is committed to the aims of the SEL LDA programme, and our autism strategy will be aligned to the helpful comprehensive SEL framework and priorities across CYP and adults. We are supportive of the programmes focus on helping people to thrive, with a focus on care and support offers working across SEL, to developing the market, working with providers of inpatient secure, non-secure and community options, accommodation and housing. We also see the significant benefits of workforce development, improving the knowledge of skills of health & care staff, enabling reasonable adjustments, for better personalised outcomes.

Greenwich has a significant 'forward thinking' transformation programme for our LD services, which transforms the way we work with and support our residents to help them live the life they want to lead, and which aligns well with the SEL aims.

Other examples of local delivery

- Community MSK - Greenwich will be re-procuring its MSK service, ready to go live from April 24. The SEL MSK programme lead is part of project team developing the service spec and evaluation of bids to ensure outputs from the programme feed into the procurement. This joint approach should lead to shared learning.
- Community Specialist Lymphoedema service – Greenwich will have an Lymphoedema service in 23/24, and has been an outlier due to historical funding shortages. The service will be provided by Oxleas. The SEL cancer programme team have been involved in developing the service to ensure the service aligns with the wider SEL programme.

Enabler requirements

Workforce

What is needed to ensure success?

- Public Health service transformation
- Improved skills in securing outcomes through service design, procurement, transformation, system leadership and change capability
- A different, sustainable workforce model rooted in our communities with opportunities for volunteering and flexible career opportunities
- New ways of working in effective partnerships with our diverse communities & organisations
- Values-based recruitment and more integrated posts, collaborative workforce planning
- Working environments that support best practice and innovation, e.g. removal of bureaucratic boundaries to enable shared resources, less risk averse.
- Staff retention schemes, so they feel valued and supported by a health and wellbeing package
- Different ways of working and greater clarity for staff about how they fit into the big picture
- Expanded training places, fellowship opportunities, peer support groups and structured learning and development environments for staff to thrive
- ARRS roles fully recruited, retained with clear career pathways, supported by wider system
- A clinical model of care which transcends the traditional boundaries of primary and secondary care to allow more patients to be cared for at home by appropriately skilled clinicians.

Digital

What is needed to ensure success?

- Continued development of our online offer
- Investment in understanding and tackling ongoing digital divides in our communities and between different organisations
- Ability to securely share information and data and match services to needs
- Good data underpinning Population Health Management approaches across the system using tools such as Cerner – HealtheIntent, EMIS and other national and local datasets
- Use technology to further increase access to health and care support (e.g. remote monitoring and virtual wards). We will work with NHSE colleagues and suppliers to shape and enable systems that 'speak to each other' in different organisations.
- Build on the work already underway to tackle digital exclusion e.g., Digital Inclusion Officer
- Develop a single record for all citizens, to enable integrated multi-disciplinary and multi-organisational care, across health & care system, including non NHS
- Improved use of technology to support innovation or new ways of doing things, including consultations, social media, websites, telephony, record access, and bookings
- Use of social media for optimising the way we engage.

Estates

What is needed to ensure success?

- Utilisation of the 'One Public Estate' and other opportunities, especially within areas of growth, to ensure residents have access to appropriate facilities across the Borough identifying "anchor estates" in neighbourhood.
- Strategic priority planning and decision making to improve the utilisation of primary care estate space.
- Contribute to the development of the refreshed infrastructure delivery plan and local plan
- Maximise the potential of key sites, working closely with PCNs, including Kidbrooke Health & Wellbeing Hub, Eltham Community Hospital (including Community Diagnostic Centre and wards), existing practices, Gallions Reach, Woolwich, Plumstead Health Centre, Charlton Riverside

Finance

What is needed to ensure success?

- Funding for initiatives
    - VCS Grants programme
    - RBG public health funds and funding to develop community resilience
    - Inequalities funding
    - NHS Greenwich Charitable Funds
- Shared system view on shifting resources to prevention and community
- Collective approach to risk/gain share
- Continue to work together with partners to pool or align budgets where possible in order to jointly plan and deliver local offers
- Securing best value and working within available resources – leveraging investment where possible

Strategic priority:	Start well
Ambition:	Children and young people get the best start in life and can reach their full potential

Healthier Greenwich Partnership

Five-year vision statement

We want all children and young people in Greenwich to experience a safe, healthy and happy childhood where they enjoy family life and school and feel a part of the community. Our aim is to ensure every child growing up in Greenwich will begin, continue to develop and move into adulthood well.

High impact activity	Resident health & wellbeing outcomes	Partnership activity metrics	Core delivery partners
Rollout of the Family Hubs programme including the Start for Life Offer on parenting, parent-infant relationships and perinatal mental health support, home learning environment and infant feeding support.	• Increased confidence in early years workforce in supporting early language development. • Improved wellbeing for parents experiencing mild-moderate perinatal mental health needs • Improved confidence for mothers breastfeeding with increased sustainability	• Shared system delivery plan for an improved Perinatal Mental Health Offer • Delivery of professional training for the early years workforce to support improved early language development. • Delivery of infant feeding peer supporters	• Royal Borough of Greenwich • SEL Integrated Care Board • Oxleas • LGT • Bromley Healthcare • Children's Centre Providers • Young Greenwich Providers • Voluntary and community sector partners • schools
Review neurodevelopmental pathways to identify improvements in diagnosis and support for children with autism and attention deficit hyperactivity disorder	• Improved experience for children progressing through the neurodevelopmental pathway • Improved early intervention and support for children pre-diagnosis • More efficient neurodevelopmental pathway reducing, where possible, the time between referral and diagnosis.	• Agreed new neurodevelopment pathways for children • Improved communication and clearer support offer for those children moving through the neurodevelopmental pathway. • Utilisation of core offer services to support and signpost CYP. • Tracking of demand and capacity	• Oxleas NHS Foundation • Royal Borough of Greenwich • Voluntary and community partners
Mobilisation of the Integrated Therapies Service including the development of a new preventative navigator function.	• Improved Integrated Therapies online offer of support for families. • Provide integrated support for children and young people accessing therapy services	• Mobilisation of the new core Integrated Therapies Service. • Utilisation of core offer services to support and signpost CYP	• Oxleas NHS Foundation Trust • SEL Integrated Care Board • Royal Borough of Greenwich

Strategic priority:	Be well
Ambition:	Everyone is more active

Five-year vision statement
All people in Greenwich are more active, through reducing the environmental, social and cultural barriers to activity. There will be greater focus on getting people who are least active into some activity. Primary and Secondary care services will routinely recommend and refer people to physical activity.

High impact activity	Resident health & wellbeing outcomes	Partnership activity metrics	Core delivery partners
• Increase the number of Play Streets, Play Estates and School Streets as part of a wider programme to increase journeys foot and cycle and to reduce car journeys	• Increased physical activity for children and adults, with co-benefits for air quality, community safety, and social isolation, leading to better health and wellbeing	• Increase the proportion of people who choose to walk and cycle for their everyday journeys • Number of Play Streets, Play Estates and School Streets	• RBG Transportation • RBG Public Health • RBG Children and Young People Services • Schools • RB Greenwich Housing and Safer Communities • Live Well
• Design and implement adult physical activity pathway, which includes families - targeting behaviour change support and activity programmes at those who face the biggest barriers to getting more active	• Reduced inactivity levels – more inactive people active, leading to reduced prevalence of long term conditions, and more effective treatment of the symptoms and impacts of long term conditions amongst people at higher risk	• Activity levels measured as part of the Active Lives *and Active Lives Children and Young People* • Number of practices signed up to the Physical Activity Charter	• RB Greenwich Public Health • RB Greenwich CYP • RB Greenwich Sports and Leisure • ICB Integrated Commissioning • PCNs • Voluntary, community and faith organisations
• Review, update and implement Royal Greenwich Get Active Physical Activity and Sports Strategy	• Reduced inactivity levels – more people, more active, more often, leading to reduced prevalence of long term conditions, and more effective treatment of the symptoms and impacts of long term conditions	• Activity levels measured as part of the Active *Lives and Active Lives Children and Young People*	• RBG Public Health and Sports and Leisure • RBG Directorates • ICB Integrated Commissioning • Primary Care Networks • Oxleas • LGT

Strategic priority:	Be well
Ambition:	Everyone can access nutritious food

Healthier Greenwich Partnership

Five-year vision statement
Address people's health holistically through creating the conditions for people to enjoy a healthy and balanced diet across the life-course and maintain a healthy weight in Greenwich, tackling food poverty, developing food skills, and working with workplaces, shops, the hospitality industry, schools, and health services.

High impact activity	Resident health & wellbeing outcomes	Partnership activity metrics	Core delivery partners
• Ensure that food and nutrition is included as part of all diet-related disease care pathways such as hypertension, CVD, diabetes, and excess weight	• Residents receive consistent, evidence-based and relevant food advice and information, and are referred and signposted to services that support healthy eating	• Nutrition and diet included in pathways relating to the prevention and treatment of CVD, hypertension, diabetes and excess weight. • Provision of consistent, evidence-based and relevant advice and information in primary, secondary and specialist services and social care • Number of residents engaged in weight management services • Number of residents engaged in cookery clubs	• PCNs supported by CESEL and RBG Public Health • Diabetes Board • Oxleas, LGT, Bromley HC • The Training Hub • Live Well • RBG Public Health • Children's Centres • Family Hubs
• Refresh the food poverty action plan to align with 'Our Greenwich' and emerging regional and national policy.	• Improved access to nutritious food by lower income households, enabling residents to access a healthy diet and to maintain a healthy weight	• Increase in percentage of Healthy Start beneficiaries • Number of users of Greenwich Foodbank • Number of users of food clubs • Number of VCS food aid organisations involved in surplus food distribution	• RB Greenwich - Public H, Welfare Rights • Live Well • Greenwich Co-operative Development Agency • Registered Landlords • Voluntary, community and faith organisations
• Improve the food environment at a neighbourhood, high street and organisational level , harnessing the contributions of all HGP partner organisations, working with planning levers, e.g. Thamesmead Superzone and through integrated commissioning for neighbourhoods	• Residents have better access to safe, affordable, sustainable, culturally appropriate healthier food at a local level	• Increased engagement of schools, workplaces, NHS and social care services, public and community settings to promote healthy choices and support people to access good food and support with healthy weights • No. of Healthier Catering Commitment orgns • No. of breastfeeding welcome organisations • No. of Good Food in Greenwich organisations	• SEL ICB Integrated Commissioning for adults and children, PCNs, RBG Public Health, Oxleas, LGT and voluntary, community and faith organisations • Live Well Greenwich

Strategic priority:	Feel well
Ambition:	There are fewer people who experience poor health as a result of addiction or dependency

Five-year vision statement
Addressing issues of addiction and dependency not as isolated conditions or symptoms to be treated, but supporting the whole person and addressing environmental and social drivers of addiction.

High impact activity	Resident health & wellbeing outcomes	Partnership activity metrics	Core delivery partners
• Embedding evidence-based Tobacco Treatment through the consistent roll-out of Very Brief Advice (VBA), and at point of care within LGT, Oxleas (mental health and community services) and wider NHS pathways, to include offer of vapes and incentives for pregnant people as part of core treatment.	• More smokers will be identified and successfully treated especially from IMD 1-4 , and those target groups and offered effective, evidence-based support/referral at point of care to Tobacco Treatment support, reducing the short and long term health risks and increasing healthy life expectancy	• Increase in percentage of residents accessing Tobacco Treatment from target groups which then go on to quit • Feedback loop, of outcomes, back to referrer and primary care	SEL Tobacco Dependence Oversight Group (TDOG) and Greenwich Tobacco Control Alliance (to be set up),RB Greenwich Public Health, Trading Standards, Greenwich Health, Livewell, Oxleas, LGT and Drug and alcohol services (WDP), Community pharmacy
• Fully implement new funding for drug and alcohol treatment through our local partnership arrangements, ensuring increased access to high quality treatment	• More people will access effective, evidence-based drug and alcohol treatment services, reducing the harms to individuals, families and communities	• Increased number of residents accessing drug and alcohol treatment • Optimised personalised care for adults who are prescribed medicines associated with dependence or withdrawal symptoms NHS England » Optimising personalised	RB Greenwich Public Health, Adults and Children's' Services, Housing and Safer Communities, WDP, Thames Reach, Greenwich Winter Night Shelter, PCNs, Oxleas, LGT and Prison drug and alcohol services
• Implement the Lung Health Check programme pilot, highlighting early stage cancer for treatment and Very Brief Advice point of care referral to stimulate Tobacco Treatment	• More people at risk of lung cancer will be identified and offered risk reduction support, and more people with lung cancer and COPD will be identified earlier, leading to better outcomes and increased healthy life expectancy	• Increase in referrals and quits to Tobacco Treatment	• SEL ICB Integrated Commissioning, TLHC Clinical Reference Group, PCNs, Guy's & St Thomas', Kings Partnership, Ashfield and RB Greenwich Public Health

Strategic priority:	Feel well
Ambition:	Fewer adults are affected by poor mental health

Healthier Greenwich Partnership

Five-year vision statement
The Royal Borough of Greenwich is adopting the Thrive LDN approach to improving mental health and wellbeing, working across these key areas: individuals and communities taking the lead; tackling mental health stigma and discrimination; a happy, healthy and productive workforce; effective mental health services available when and where needed; and working towards zero suicide. Performance measures are being developed for specific recommendations within the Social Mobility Delivery Plan.

High impact activity	Resident health & wellbeing outcomes	Partnership activity metrics	Core delivery partners
Develop a diverse and personalised range of interventions to people experiencing mental health problems within the community setting considering psychological, physical, and social needs – including development of the MH Alliance and Community Mental Health and Wellbeing Hub	• Reduced average length of engagement as people are supported to quickly move through the service having received the input they need • Reduced escalation of mental health problems as a result of unaddressed issues such as debt, housing, unemployment and social isolation • Increased self-management skills for people with mental health problems.	• Reduction in hospital admissions • Delivery of the four-week waiting time for adult community mental health services as per the national ambitions • Reduction in the presentation to A&E of service users known to mental health services	• Oxleas NHS Foundation Trust • Royal Borough of Greenwich • Greenwich ICB • BLG Mind • Bridge Support • LGT
Work with people with lived experience to develop effective communications and engagement to help tackle stigma and provide a sense of belonging to a community of people with similar experiences.	• Increased self-management skills for people with mental health problems. • Reduced health inequalities, in particular for people from our black and minority ethnic communities	• Personal health budgets will be offered within mental health services. • Increased engagement in community resources and activities including via self directed support (PHB) options	• Oxleas NHS Foundation Trust • Royal Borough of Greenwich • Greenwich ICB • BLG Mind • Bridge Support • Healthwatch
Build relationships between Primary and Secondary Care to continue to develop services in the community and hospitals, including talking therapies and mental health liaison teams, to provide the right level of care for people with common or severe mental illnesses	• Residents are supported to quickly move through the service having received the input they need thus improving patient experience • Better mental health outcomes	• Reduction in the number of patients clinically ready for discharge • Delivery of the access target, waiting times (6 weeks and 18 weeks) and recovery rate for IAPT services as per the South East London trajectory. • A reduction in referral rates into mental health services • Reduction in waits to access support	• Oxleas NHS Foundation Trust • Royal Borough of Greenwich • Greenwich ICB • BLG Mind • Bridge Support • LGT

Strategic priority:	Feel well
Ambition:	Fewer children and young people are affected by poor mental health

Healthier Greenwich Partnership

Five-year vision statement

Our aim is for all children, young people and families in Greenwich to have the support needed to be mentally healthy. This includes being empowered to know how we can help ourselves. Where more help is needed, children, young people and families have a choice of support, provided by someone families can trust, which is welcoming, safe, without discrimination and easy to access.

High impact activity	Resident health & wellbeing outcomes	Partnership activity metrics	Core delivery partners
Development of an iThrive and preventative system approach to children's mental health and wellbeing including a new Single Point of Access and Schools offer.	Improved knowledge and understanding from practitioners and schools on supporting children's mental health and wellbeing. As part of a single point of access • Improved referral triage decision making • Improved and more timely access to CYPMH services	• New Single Point of Access pathways co-developed with children and young people and professionals. • New online digital single point of access for access to mental health and wellbeing resources and support. • Co-ordinated mental health offer for Greenwich schools	• Oxleas NHS Foundation Trust • Royal Borough of Greenwich • SEL Integrated Care Board • Voluntary and community sector partners • Schools
Implement the new Integrated Clinical Health Team within Royal Borough of Greenwich's Children's Services	• Improved support for mental health and wellbeing needs for children being supported by Children's Services. • Improved early intervention support for children and young people preventing potential escalation to specialist mental health provision. • Improved MH/ADHD service transition to adult	• Development of new Integrated Clinical Health Team structure • New Integrated Clinical Health Team posts fully recruited	• Oxleas NHS Foundation Trust • Royal Borough of Greenwich • SEL Integrated Care Board
Reduction in the waiting times for specialist child and adolescent mental health services	• More timely specialist child and adolescent mental health assessment and support • Reduce assessment waits to eliminate over 52 week by October '23 and 44 week wait by April '24.	• Recruitment of additional staffing capacity to reduce assessment times	• Oxleas NHS Foundation Trust • SEL Integrated Care Board

Strategic priority:	Stay well
Ambition:	For everyone to access the services they need on an equitable footing

Healthier Greenwich Partnership

Five-year vision statement

We want to enable high quality health and care outcomes in the local area, that citizens experience should include timely care with fewer hand-offs and referrals, access to health and social support including peer support, integrated care, having to tell their story once and without stigma, with better and more equitable access

Primary Care Access Improvement • Implement actions contained within the Access Recovery Plan (publication awaited) • Establish baseline position for patient experience of contact; ease of access and demand management;	• Residents able to access care and advice from the right healthcare professionals closer to home, including pharmacy in a timely manner, safely prioritised on clinical need • Improved patient experience of access	• Access offers are joined up across the system • Digital technology is fully harnessed as part of the access offer • Primary Care access, measured at practice, PCN and borough-wide	• Primary Care • GP Federation • Community pharmacy and ARRS • SEL ICB • Royal Borough of Greenwich
Acute Care • Actions to address waiting times for elective care, both inpatient and outpatients, with focus on inequalities	• Patients can access care more quickly, equitably and safely prioritised on clinical need • Patients are better informed and supported	• Outpatient and Inpatient elective waits • Patient information and support whilst waiting, with clarity on self-care	• Lewisham and Greenwich NHS Trust • Primary Care
Mental Health & Community Care • Actions to address Reduction in waiting times for range of services		• Mental Health & Community waits • Patient information and support whilst waiting, with clarity on self-care	• Oxleas • Primary Care
Single Integrated Urgent Care - Mobilise new UTC model - Partnership agreement across elements - UTC, ED initially, then to incorporate UCR, Same Day Emergency Care, Same Day Urgent Care, Mental Health Crisis response	• Residents are able to access same-day urgent care in a timely way • Residents experience a seamless pathway through urgent care and beyond to meet their ongoing care needs	• Consistent delivery of UTC activity within the 4-hour emergency care standard (76% across ED & UTC) • Increase in LAS handovers and referrals from other services which bypass ED • Reduction in MH delays • Urgent Crisis 2 hour response from JET	• Greenwich Health • LGT • London Ambulance Service • Oxleas NHS Foundation Trust • Royal Borough of Greenwich – Social Care
Development of a Greenwich Deal - Set out approach for building an agreement between our residents and our partnership, on roles and responsibilities in their own health & care	• Residents are clear on what are the expectations from statutory services • Residents are more engaged & enabled on their individual and collective roles and actions to help improve their own health & care outcome	• Development of a project plan and scope, incorporating best practice from other parts of country • Coproduction events/activities to test and refine approach ready for implementation in 2024	• Royal Borough of Greenwich • LGT, Oxleas • Healthwatch • VSCE sector • GP practices

Strategic priority:	Stay Well
Ambition:	Effective Integrated community teams based in neighbourhoods, provide the right support when and where it is needed

Five-year vision statement
Bringing together providers and partners to develop effective and sustainable neighbourhood models of working. A neighbourhood is where communities that live together interact and support one another to live the best lives they can, with community services that meet the needs of local residents

High impact activity	Resident health & wellbeing outcomes	Partnership activity metrics	Core delivery partners
Build partnerships with local communities and improve the way local communities and organisations work together with the NHS and the Council to improve services closer to where people live that are joined up.	• Residents feel connected • Residents feel listened to • Support is joined up • Cultural changes to reduce a reliance on medicines and support shared decision-making between clinicians and patients, including increasing the use of social prescribing	• Identified initiatives that support neighbourhood working. • Evidence of test and learn processes in place to support integration.	• PCNs, CACT, RBG Public Health, RBG, Children and Young People's Services, HAS, VCS, Healthwatch, Oxleas, LGT
Develop the way we commission collaborative public health prevention services at a more local level using transformative processes including outcome-based, co-design, collaborative development and integrated approaches based on what matters most to residents. These will link to all local services.	• Residents feel care is more holistic • Residents feel empowered to self-manage, • Residents are able to access care and services closer to home	• Evidence of providers working together e.g. no of provider engagement and co-design workshops, listening exercises and engagement activities, summaries of findings and outputs • Number of L&D events to support working in new way, evidence of learning outcomes and evaluations • Evidence of service user engagement including co-development activities.	• CACT, GCDA, LGT, Greenwich Health, RBG Public Health, Metrogavs, Oxleas, RBG, PCNs, Community Pharmacy, Healthwatch
Develop a "how to" narrative & approach for neighbourhood development that • empowers people (staff, patients, residents, etc) to work together to solve problems for themselves. • To shift our role from 'director' to 'connector' (facilitator and coach).	• Residents feel connected • Residents feel listened to • Support is joined up	• Agreed way of working with communities e.g. Community Development approach • Evidence of examples across range of areas of neighbourhood working in action • Growth of personalised care infrastructure.	• CACT, GCDA, LGT, Greenwich Health, RBG Public Health, Metrogavs, Oxleas, RBG, PCNs, Healthwatch

Strategic priority:	Stay Well
Ambition:	Unfair and avoidable differences in health and wellbeing are reduced

Healthier Greenwich Partnership

Five-year vision statement
We have a strong understanding of and response to the complex determinants of inequalities, including both direct and indirect racism and other forms of discrimination such as that related to age, gender, sexuality, disability and gender identity. This will require a proactive and systematic approach including working in new, genuine and sustainable partnerships with communities and places, tackling isolation and loneliness, and tackling poverty.

High impact activity	Resident health & wellbeing outcomes	Partnership activity metrics	Core delivery partners
• Embed new SEL-wide diabetes outcome scheme, aimed at PCN-level improvement and reduction in variation ('levelling up' the poorer performing practices) in core diabetes outcome/ care process measures.	• Residents feel supported to manage their own LT condition • They feel supported by joined up services • Diabetes is well controlled.	• Outcome scheme embedded • Understanding of the variation across practices • Evidence that partners are working together to support improvement • 8 care processes and 3 treatment targets and referral rate to NHS DPP	• PCNs, GPS, Oxleas, VCS, Live Well, RBG, LGT
• Targeted cancer screening improvement, focus on Lung, Cervical, Prostate, Bowel and Breast in particular, key focus on influencing uptake, and then lifestyle changes to reduce risk (see other priorities)	• Residents feel healthy and well • Residents feel they have culturally appropriate information and advice to make informed decisions of engaging in screening activities. • Residents take up offer of screening uptake rates especially in under represented groups, as evidenced by improved uptake rates	• Uptake rates improved • Partners feel engaged to help improve uptake • Evidence of sharing of good practice • Understanding of the variation	• NHSE, PCNs, GPS, Oxleas, VCS, Live Well, RBG, LGT, Public Health

• Two 100 day challenges to reduce cardiovascular inequalities. Suggested areas to develop.
  • high blood pressure detection
  • Improving people to get physically activity
	• People with early risk factors feel supported to address the risk holistically
	• People have the right information and feel supported to improve their cardiovascular health.
		• Two 100-day improvement cycle done Clear logic models for co-designed interventions aligning outputs to longer-term outcomes
		• Partners across the system are engaged in the challenge
		• There is a plan and progress of evaluation and shared learning
			• NHSE, PCNs, GPS, Oxleas, VCS, Live Well, RBG, LGT, Public Health

Strategic priority:	Age well
Ambition:	Health and care services support people to live fulfilling and independent lives and carers are supported

Healthier Greenwich Partnership

Five-year vision statement
Work with individuals and carers to develop an offer that supports people to live long, healthy, active and independent lives; this includes developing services in line with our Home First approach wherever possible to ensure care through an integrated urgent care system and stronger community based care. This includes helping people to die well, in line with their wishes.

High impact activity	Resident health & wellbeing outcomes	Partnership activity metrics	Core delivery partners
Market sustainability and quality improvement of commissioned community based, residential and nursing setting care	• People (including carers) have timely access to care and support from a range of providers and service types and to meet a range of needs across ages and disabilities • People receive personalised good quality care to help them achieve their personal outcomes	• Quality of services (CQC / LA/ICB quality measures) • Sufficient supply to ensure continuity of care • Diversity in the market across needs (service types) • Range of high quality services for people to choose from • Sufficient investment in workforce to attract and retain staff • Rates paid to providers and terms and conditions metrics • EHCH framework measures • Engagement rates with providers on MSP • Tangible feedback from residents regarding their experiences	• Oxleas • Providers, incl hospice, care home, home care • Primary care • VCS partners • RBG
Co-design, development and delivery of community based support models for those with care and support needs and their carers.	• Improved offer including choice and control over the care they receive • A meaningful impact on independence, enabling people to live and die well as part of a community • Increased specialist advice & support available to enable people to make choices about their care • People have access to meaningful activity and are able to feel well and active for as long as possible	• Homecare and Extra care mobilisation progress metrics • Development of alternative models of care such as Neighbourhood model, ISF, Community Micro Enterprises- number of new/diversified offers • Capacity in homecare market – measured using capacity and demand insight and workforce data • Satisfaction levels – residents including carers and partners • Successful delivery of joint carers strategy and action plan	• Residents • Providers, VCSE • RBG, incl Public Health • GCDA • Specialist advice partners • Primary care • Live Well Greenwich • Healthwatch
Optimise and develop 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	• A reduction in hospital attendances and admissions (particularly for >1 day), reducing the risks of protracted periods of recovery • A meaningful increase in the wellbeing of patients receiving multi-factorial frailty support • Enabling patients to die in their usual place of residence, where this is their preferred place of death.	• Delivering capacity for 179 patients simultaneously by the virtual wards in Greenwich, with 80% virtual ward occupancy • Reducing ED attendances and admissions by 50% (compared to the 6 months pre-intervention) for frailty MDT • Reduction in the median length of stay at QEH. • Number of primary care / LAS referrals to the virtual ward hub / Joint Emergency Team / maximising discharge pathways 0 and 1 • Admissions avoided due to referrals to community response	• Oxleas, LGT, Hospice • Primary care • London Ambulance Service • RBG Social Care • Urgent Treatment Centre provider

Greenwich Health & Wellbeing Strategy 2023-28

NOTE – this is draft narrative, final version to be approved by Health & Wellbeing Board in June 23

1. FOREWORD

This is Greenwich's new Health and Wellbeing Strategy, a 5-year strategy taking us from 2023 to 2028. It describes how we as the strategic leaders for the health and care system will work together with the people who live, work or study in the Royal Borough of Greenwich to create a happier, healthier place to be.

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

Health and Wellbeing Strategies are a statutory responsibility of Health and Wellbeing Boards, requiring local authorities to work with their NHS, third sector and wider partners to take collective action to improve health and wellbeing for their residents. The priorities in this strategy are based on a sound understanding of the greatest causes of poor mental and physical health for our populations. They are also built on our understandings of the things that matter most to our residents. Through our various engagement processes, we have heard from residents about those things that support and enable them to live their best lives.

This new strategy is being published at an historic point in time.

- The world continues to emerge from a global pandemic which presented unprecedented challenges to us all, as leaders, as service providers and as members of families and communities.
- Our understanding as a society has taken a big step forward regarding the roles that racism, discrimination, social and economic inequalities play in shaping poorer health for some in our communities, generating and sustaining unjust health inequalities.
- The cost-of-living crisis is placing huge stress and practical challenges in the way of our residents, especially those in our more disadvantaged communities. We know there is a direct association between health and wealth, and that this crisis is likely to worsen health inequalities in our society.
- The government has changed the way in which the health and care system is organised across the country, presenting new opportunities for health and care providers to work

differently together and with their populations to help them to stay healthy, happy and living independent lives for as long as possible.

- The Royal Borough of Greenwich has published a new corporate plan, *'Our Greenwich'* which sets out a vision for the borough for the next 5 years and places a strong emphasis on health, wellbeing and equality. Based on substantial engagement with local people, staff and stakeholders, the health and wellbeing priorities identified in *'Our Greenwich'* form the basis of this strategy.

This Health and Wellbeing Strategy sets-out the mental and physical health and wellbeing priorities for our partnership for the next 5 years. It is based on a shared understanding of the social, economic, environmental, commercial and cultural determinants of health.

High quality health and social care services are critical for us all when we and our loved ones need them. But the conditions that shape our health and wellbeing, and systematically cause some groups in our society to have poorer health than others, are complex. Addressing these conditions effectively requires complex solutions and mature partnerships between citizens and organisations.

Our strategy reaffirms our shared commitment to approaches which challenge and tackle racism and discrimination and support social justice and equality for our residents, our services users, our diverse communities and our staff. Racism, discrimination and inequalities damage health, both mental and physical health. We not be successful in achieving the aims set-out in this strategy unless we understand and address these inequalities as a core part of our work to protect and improve health and wellbeing.

Our new strategy takes a life course approach and aims to enable our residents to live well and to experience their best lives from childhood to older age. We have set-out our priorities under the following headings:

- Supporting Greenwich residents to *start well*
- Supporting Greenwich residents to *be well*
- Supporting Greenwich residents to *feel well*
- Supporting Greenwich residents to *stay well*
- Supporting Greenwich residents to *age well*

We are committed to making Greenwich a healthier, fairer place for all residents across our rich and diverse communities through all stages of life. We invite you to join us in creating a healthier future.

Councillor Anthony Okereke	Dr Nayan Patel
Leader, Royal Borough of Greenwich	GP in Royal Greenwich
Chair of the Health & Wellbeing Board	**Chair of the Healthy Greenwich Partnership**

2. INTRODUCTION

REFLECTIONS ON OUR LAST HEALTH AND WELLBEING STRATEGY:

The Greenwich Health and Wellbeing Board agreed its last Strategy at a meeting on the 11th March 2020, less than two weeks before the government introduced the COVID-19 related lockdown and the world become gripped by the pandemic. That strategy identified four priorities the importance of which became even more apparent as the pandemic unfolded. They were:

- *Improving mental health and wellbeing:* COVID-19 and the measures introduced to control it placed huge pressure on the mental wellbeing of people of all ages. Many people experienced the fear of getting seriously ill or dying from the disease, or worried for the safety of others. Others experienced the grief of losing a loved one. People were isolated, some asked to shield, and were not able to meet friends or relatives in person for months at a time. Children missed schooling, affecting their education and their social and emotional development. Key workers, especially those working in health and care services, worked in difficult and sometimes harrowing circumstances. The pandemic took a huge emotional toll on us all in many different ways, and we know that the impact on mental health for people of all ages was profound.

  We continue the critical focus on mental health and wellbeing in this new strategy.

- *Healthy weight:* the proportion of people of all ages who are overweight or obese has steadily increased in recent decades, increasing the risk of diabetes, cardiovascular diseases, stroke, cancers, musculoskeletal and mental health conditions. During the pandemic, one of the most significant risk factors for poorer outcomes from COVID-19 was weight, with obese people significantly more likely to need hospital care, intensive care and sadly more likely to die from the disease. There is evidence that the impact of the pandemic, lockdowns, diet and physical activity levels, contributed to an increase in levels of overweight amongst people of all ages, with those from more deprived backgrounds most affected.

  The factors which contribute to healthy weight, including access to affordable nutritious food and a physically active population, also continue to be priorities within the 2023-28 Strategy.

- *Live well Greenwich: embedding a preventative approach:* our commitment to a more systematic prevention offer in the borough and to tackling health inequalities was also a major feature of the pandemic period. We have always known that poorer health was concentrated in more deprived communities where our residents from Black, Asian and other ethnic minority communities are also over-represented. The pandemic affected these communities more profoundly, with both higher rates of acute illness and higher deaths rates. We also saw lower levels of trust and confidence in government and the

NHS responses amongst some of these communities, resulting in lower levels of vaccination uptake, for example.

Tackling unjust and preventable variations in health outcomes is a major priority within our new Strategy, cutting across all aspects of the strategy and embedded in how we work with our residents, neighbourhoods and stakeholders in more collaborative and equal partnerships going forwards.

- *Health and social care system development:* the pandemic required our services to change how they operated overnight; to be responsive, agile and flexible throughout the turbulent years at the height of COVID-19. The government has introduced structural reform to health and care organisations, creating Integrated Care Systems (ICSs) covering large geographical footprints. For Greenwich, we are part of the South East London ICS, with our nearby boroughs of Lambeth, Southwark, Lewisham, Bexley and Bromley.

  Whilst this provides opportunities for some action to be taken across a bigger geography, the importance of the borough, or 'place', remains paramount. Indeed, the emphasis is on work that understands, responds to and operates in partnership with neighbourhoods and communities at hyperlocal levels, to address the inequalities that drive poor health and to continue to provide more targeted and flexible services.

ABOUT THE HEALTH AND WELLBEING STRATEGY 2023-28

This new Health and Wellbeing Strategy builds on the lessons learnt from the pandemic. It represents a key delivery vehicle for those aspects of the *'Our Greenwich'* plan which relate to health and wellbeing, and also forms the Local Care Plan (LCP) for Greenwich. The LCP is the place-based plan for the borough; one of a series of plans for all 6 boroughs in South East London which collectively form the ICS in South East London.

To be successful in its aims, our strategy has to be delivered as a collaboration between the NHS, Greenwich Council, the Voluntary, Community and Faith Sectors and local people.

This new strategy builds on that work and the relationships which have been built in recent years. In the wake of Covid-19 and the impact that has had on our Borough, this new strategy redoubles our focus on tackling racism, discrimination, social, economic and health inequalities which continue to blight our communities.

It recognises the value of neighbourhoods, assets and community in supporting better health, the importance of mental and physical good health and the need to work together to support children and families to give children and young people the best start in life.

It draws on our analysis about health needs in the borough, what residents have told us, and starts to build our understanding of what really works to tackle health inequalities. This

includes addressing the wider determinants of health – such as housing, the economy, employment and the environment – and remaining focused on prevention.

This strategy particularly acknowledges that we cannot achieve our vision of a fairer, healthier Greenwich without collaborating and that communities should be at the heart of that collaboration. It is ambitious and sets out a challenging agenda for us over the next five years, within the context of a cost-of-living crisis and ongoing, systemic inequity. But this is an ambition we must meet to deliver for the people of Greenwich and to see health and wellbeing improve for all our residents.

RECENT CHANGES TO THE HEALTH AND CARE SYSTEM

Our current health and care services aren't always designed in a way to meet these needs. Most services focus on treating people when they get sick, rather than helping people to stay healthy in the first place. Services that help people with their physical health are often separate to other services that provide care and support, including mental health and social care services. This means it's a struggle to coordinate well across these services and make the best use of staff and resources. If residents have several problems, you can go from one service to the next, retelling your story, getting different advice, rather than getting support from a single joined up team.

We have been working, in partnership, to improve health and care services for a number of years. Recently there have been changes to the health and care system to create new formal partnerships called Integrated Care Systems (ICS). These will help us to deliver this improvement in care for people, whether that's in their neighbourhood, borough or across south east London.

What does the Integrated Care System do and how does it work?

South East London's Integrated Care System brings together all the organisations responsible for delivering health and care for our communities. We are a partnership that brings together the organisations responsible for publicly funded health and care services in south east London, to make the greatest possible contribution to the health and wellbeing of people living in our six boroughs.

This includes our Integrated Care Board, our NHS health services, our six Local Authorities and organisations from the voluntary, community and social enterprise sector. Together, we are responsible for allocating public money as well as planning and delivering a wide range of health and care services. We use our combined resources to tackle of some of the biggest health issues affecting local people in Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark. We aim to keep people well, prevent ill-health and support people to thrive and live healthier lives.

If we work together, we can intervene faster and earlier to keep people well, making better use of specialist skills and equipment. We can offer more joined up support for people facing significant challenges. This way, we can address problems faster and develop more effective solutions for local people.

The Healthier Greenwich Partnership formally reports into the Greenwich Health and Wellbeing Board and brings together partners from the NHS, local council, social care, and the community and voluntary sector. By planning and co-ordinating services more effectively, every Local Care Partnership delivers a more integrated health, care and wellbeing system for local people.

3. ABOUT GREENWICH

THE PLACE

There's so much to be proud of in our borough: from our hundreds of beautiful green spaces to our waterfront, which is the longest of any London borough. From the world-famous sights of Greenwich Town Centre in the west, to Thamesmead in the east; from Greenwich Peninsula in the north to Eltham in the south. Our borough is a mix of communities, cultures, backgrounds, ages, genders and experiences – and they're all vital to making Greenwich the place it is.

Reflecting the diversity and richness of the population, we have vibrant and dynamic community, voluntary and faith organisations in our borough, which provide critical support and cultural opportunities for our residents; connecting people, reducing social isolation and shaping the values and richness of the borough. Our public services provide, including health and social care services, work together in strong partnerships with the third sector, the private sector and with local communities to meet the diverse needs of our populations.

As well as the geography and the organisations of Greenwich, the borough has many other great assets. We have about 100 schools in Greenwich, 24 children's centres, further and higher educational institutions. We have the major town centres of Greenwich, Woolwich and Eltham, and many smaller places with strong identities, such as Charlton, Thamesmead, Abbey Wood, Plumstead, Blackheath and Kidbrooke. There are community centres across our borough offering a wide range of activities and learning opportunities.

Our transport links are good, with strong public transport provision across the borough, especially in the north where we are well served by rail, DLR and now the Elizabeth Line with stations in Woolwich and Abbey Wood; bus routes cross our borough.

THE PEOPLE – A DIVERSE POPULATION WITH DIVERSE NEEDS

Greenwich has a very diverse population, with significant demographic variation between areas within the borough across a number of characteristics, including age profile, ethnicity, country of origin and identity (Office for National Statistics, Census 2021; sub-areas listed are Middle Super Output Areas - MSOAs).

AGE

- 20.5% of the population is aged 15 and under in Greenwich, ranging from 15% in Greenwich & Deptford Creekside to the west of the borough through to 26.1% in Abbey Wood North to the east of the borough.
- 10.5% of residents are aged 65 and above, ranging from 3.4% in Greenwich Peninsular East through to 19.5% in Eltham South.

HOUSEHOLD COMPOSITION

- 29.9% of households in Greenwich are single person households, ranging from 23.5% in Eltham North through to 37.2% in Thamesmead Birchmere Park.
- 8.4% of Greenwich residents aged 66 years and above live alone, ranging from 2.5% in Greenwich peninsular East to 15.8% in Eltham Park.

ETHNICITY AND COUNTRY OF ORIGIN

- 62.5% of Greenwich residents were born in the UK; 37.5% were born overseas.
- Of those born overseas, 12.6% were born in other European countries, 10.4% were born in Africa, 9.6% were born in Asia and the Middle East, 3.3% were born in the Americas and the Caribbean.
- 55.7% of the population identify as being from a white ethnic group, ranging from 34.4% in Thamesmead West to 82% in Eltham Park.
- 21% of the population identify as Black, Black British, Black Welsh, Caribbean or African, ranging from 4.8% in Eltham Park through to 43.9% in West Thamesmead.
- 13.2% of the population identify as being Asian, Asian British or Asian Welsh, ranging from 5.4% in Thamesmead Birchmere Park through to 34% in Plumstead High Street.

IDENTITY – RELIGIOUS BELIEF

- 32.6% of the population state they have no religious belief, ranging from 16.6% in Plumstead High Street through to 44.6% in Blackheath Standard.
- 44.7% of residents identify as Christian, ranging from 33.5% in Greenwich Peninsular East through to 57.5% in Thamesmead Birchmere Park.
- 8.5% of residents identify as Muslim, ranging from 2.1% in Eltham Park through to 16.3% in Woolwich South.

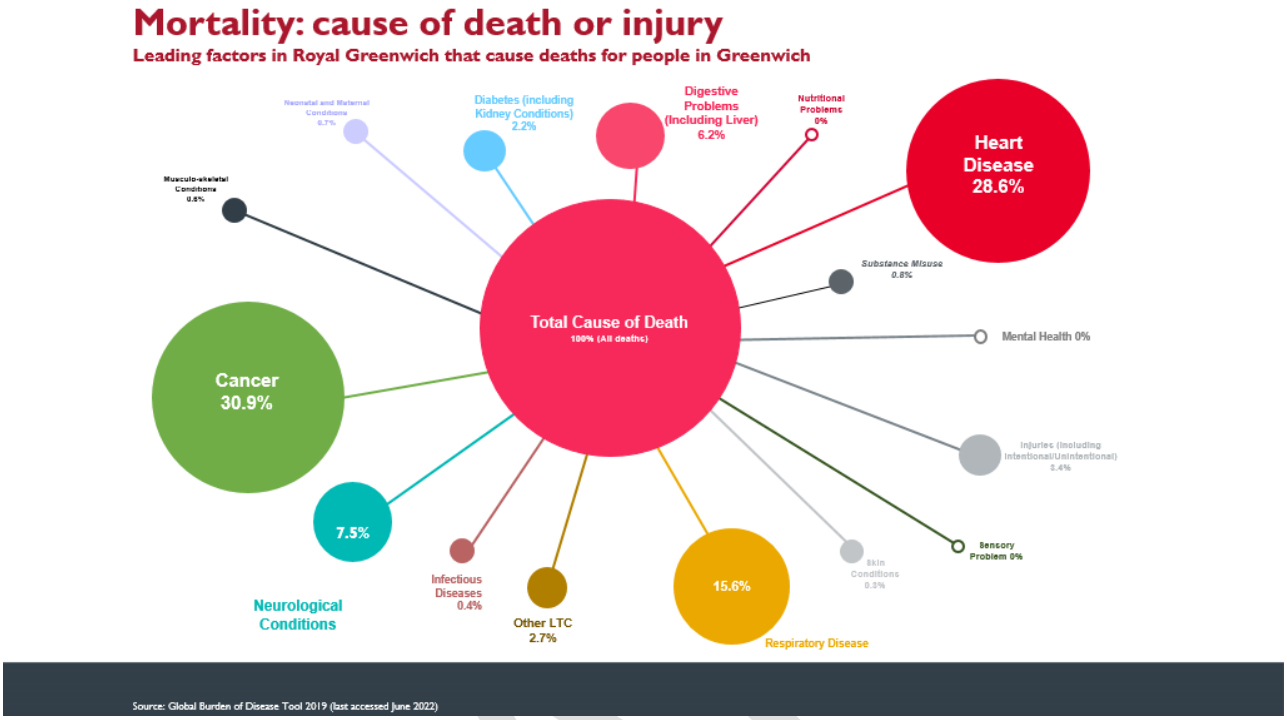
IDENTITY – SEXUAL ORIENTATION & GENDER IDENTITY

- 4.5% of the population of Greenwich aged 16 years and above identify as lesbian, gay, bisexual or other, ranging from 1.9% in New Eltham through to 9.1% in Woolwich Arsenal.
- 0.88% of the population aged 16 and older have a gender identity that is different from their sex registered at birth, ranging from 0.19% in New Eltham through to 2.23% in Plumstead High Street.

HEALTH AND WELLBEING IN GREENWICH

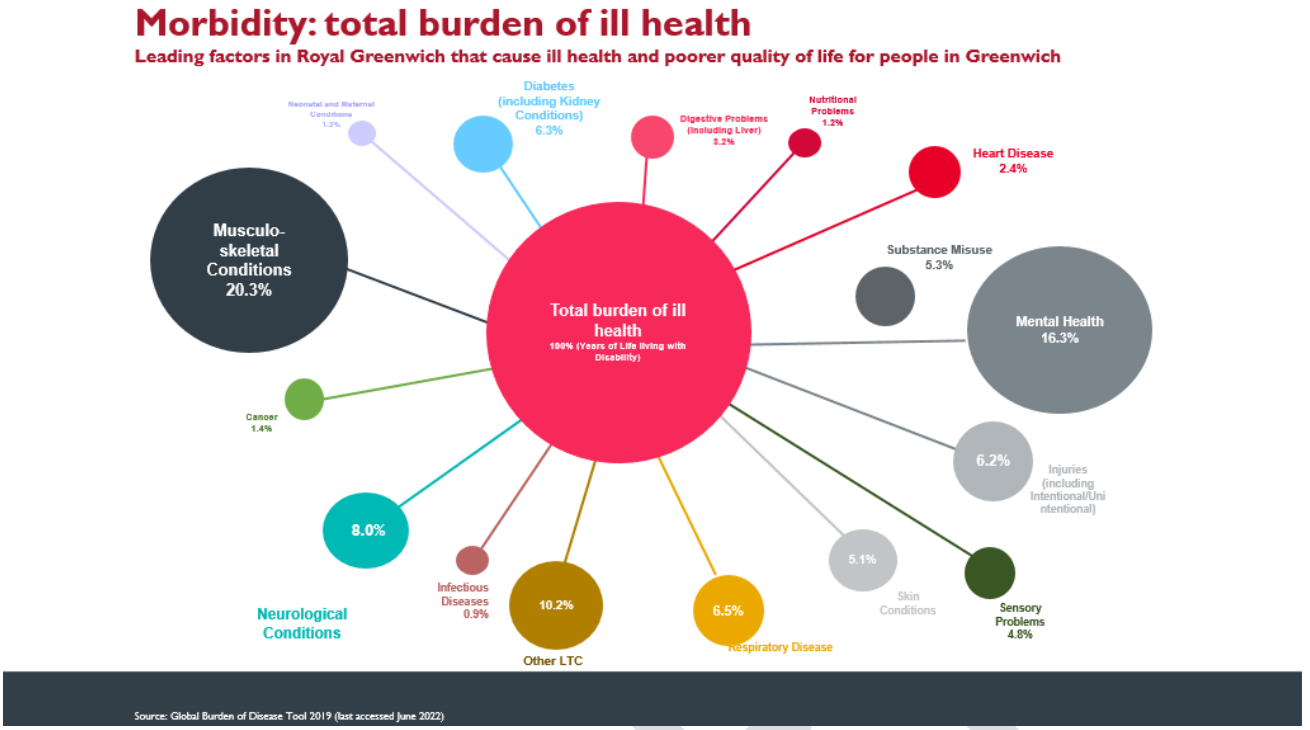
Our analysis of the health and wellbeing of the population in Greenwich tells us about the most significant causes of mortality (causes of death) and morbidity (causes of poor health).

The following infographic shows that cancers, heart diseases and respiratory diseases account for the majority of deaths for the Greenwich population.

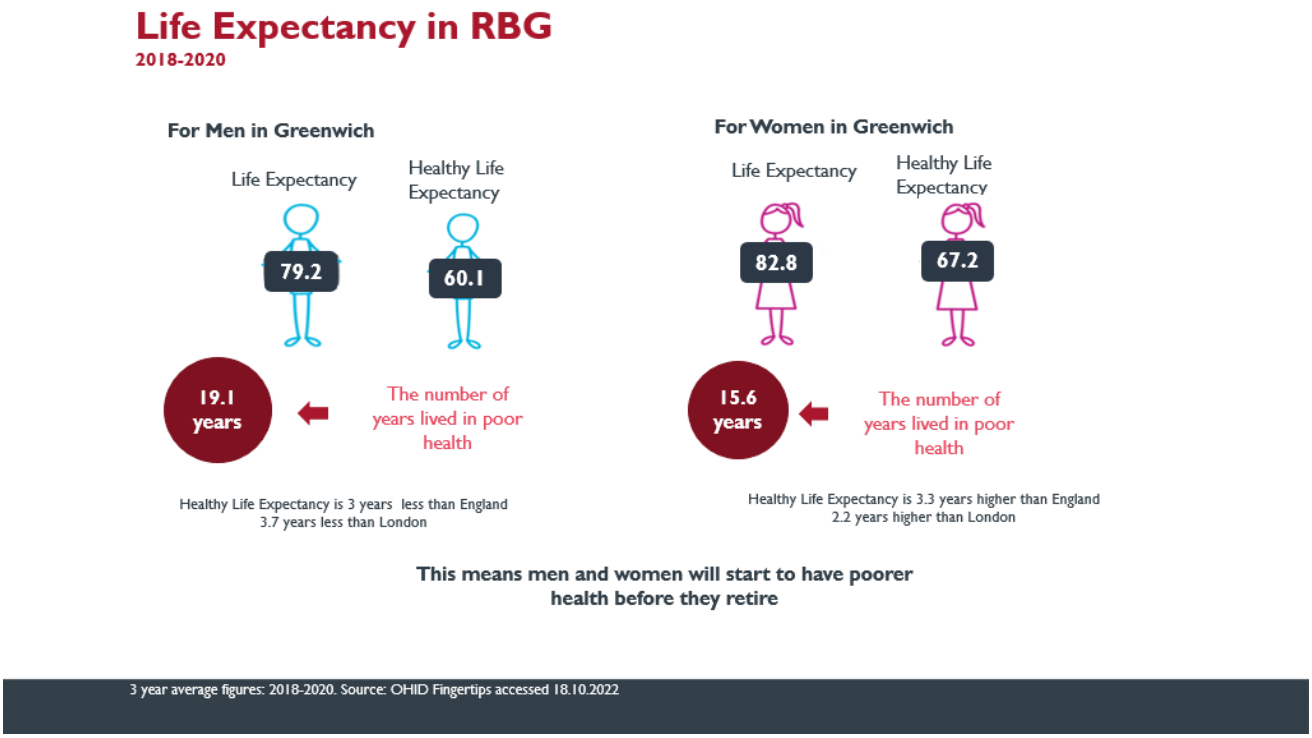


Many of the risk factors for these diseases are preventable, such as smoking, poor diet, obesity, physical inactivity and excessive alcohol consumption. Early diagnosis of many of these diseases is also critically important as the survival rate from many cancers, for example, is far higher the earlier a cancer is identified. Finding high blood pressure early, and providing advice and treatment, significantly reduces the chances of heart diseases and stroke. And providing treatment for smokers to help them to quit dramatically reduces the likelihood of respiratory diseases.

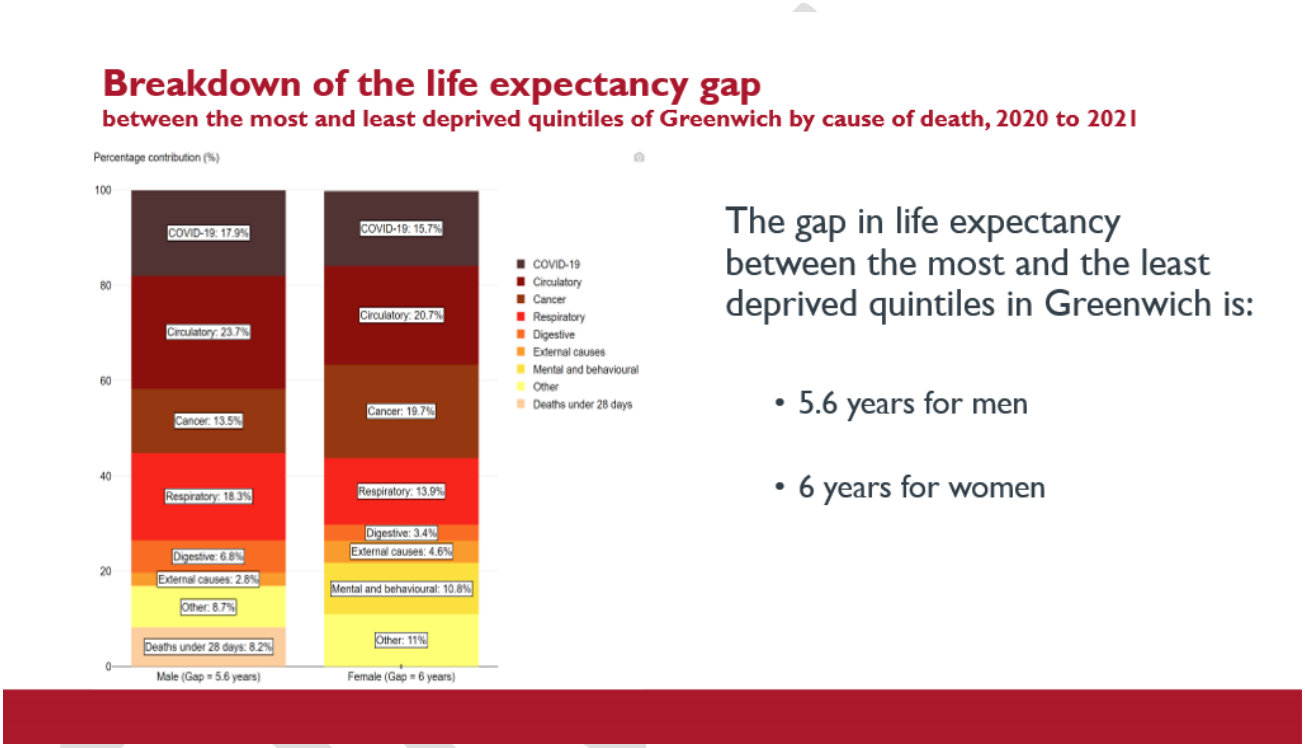
The following infographic shows that muscular-skeletal conditions (such as problems with joints and back ache) and mental health conditions are the most significant causes of poor health affecting our residents. These conditions are generally not those that end life, but they cause some of the biggest impacts on quality of life.



We also know that there are differences in health outcomes for men and women, and that deprivation and inequalities have a significant impact on health, with some groups having shorter lives and poorer health for a greater proportion of their lives. The following infographic shows that women live longer than men in Greenwich with an average life expectancy of 82.8 versus 79.2 years for men. They also have a lower proportion of their lives affected by poor health, with an average of 15.6 years lived with poor health compared to 19.1 years for men.



Deprivation, social and economic inequalities also cause significant differences in health outcomes between different groups within our borough. The following infographic shows that there is a 5.6-year difference in life expectancy between men living in the most deprived 20% of areas of the borough compared to the least deprived 20%; and a 6-year gap for women between the most and least deprived areas. It also shows that for the year 2020-21, COVID-19, circulatory diseases, cancers and respiratory diseases accounted for the majority of that difference in life expectancy; meaning that people living in the most deprived areas of the borough were significantly more likely to die from these diseases than those living in the least deprived areas.



Our health and wellbeing strategy is based on this understanding of the health and wellbeing needs of our population and seeks to address the underlying causes of avoidable poor health and early death. In doing so, it also aims to promote and enhance the positive influences on health and wellbeing for our populations; the assets, opportunities and support available in our borough which promote and protect good mental and physical health.

4. HOW THE STRATEGY HAS BEEN DEVELOPED

This Health and Wellbeing Strategy has been developed through a number of related routes:

1. The Healthy Greenwich Partnership has reviewed the needs assessment summarised above to ensure a good understanding across the partnership of the major drivers of poor health and avoidable early death for our residents. The priorities in this strategy relate to the things we will do together and working with our residents to address the risk and protective factors for these health outcomes.

2. The Health and Wellbeing Board decided, at its December 2022 meeting, to adopt Mission 1 from the *'Our Greenwich'* plan as the starting point for the strategy. Mission 1 states that *"People's health supports them in living their best life"* and is has the following objectives:

    a. *Unfair and avoidable differences in health and wellbeing are reduced*
    b. Fewer people are affected by poor mental health
    c. Everyone is more active
    d. Everyone can access nutritious food
    e. There are fewer people who experience poor health as a result of addiction or dependency
    f. Health and care services support people to live fulfilling and independent lives and carers are supported

    The *'Our Greenwich'* plan was developed through an extensive programme of engagement and consultation with residents, stakeholders and staff led by the Leader of the Council and Cabinet Members. It therefore reflects the things that local people and key stakeholders have identified as important to their lives, health and wellbeing being central to what they told us through this engagement.

3. The South East London ICS has developed strategic priorities covering all 6 boroughs across the sub-region, including Greenwich. These priorities were also developed through a programme of engagement and consultation with residents and stakeholders across all 6 boroughs. The priorities identified through this engagement have much in common with Mission 1 of the 'Our Greenwich' plan and are:

    a. Prevention and wellbeing
        - Become better at preventing ill health and helping people in south east London to live healthier lives.
    b. Ensuring a good start in life
        - Ensuring parents, children and families receive the most effective support before and during childbirth and in early years
    c. Children and young people's mental health

- Ensuring that children and young people receive early and effective support for common mental health challenges.

d. Adults' mental health
   - Ensuring that adults in south east London receive early and effective support for common mental health challenges.

e. Primary care and people with long term conditions
   - Ensuring that people, including those with continuing health needs, can conveniently access high quality primary care services.

We have synthesised the needs assessment, the priorities from Mission 1 of 'Our Greenwich' and the priorities in the ICS Strategy into the 10 priority areas within this Health and Wellbeing Strategy 2023-28.

5. OUR PRIORITIES:

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.

6. OUR DELIVERY PLAN **(detailed actions and outcomes)**

High level summary of each priority, the five year outcomes to be inserted here.

Delivery plan (item 9A) will be an appendix, and will be updated annually.

7. ACKNOWLEDGEMENTS

AGENDA ITEM: 10

Healthier Greenwich Partnership

Date: 26 April 2023

Title	**South East London ICS Strategic Priorities**	
This paper is for **noting**		
Executive Summary	• In February 2023, the ICS published the integrated care strategic priorities for South East London for the next five years. The strategy was the result of extensive discussions involving leaders, staff and partners from across our system, community organisations and our residents. The strategy focuses on a small number of areas where collective action across South East London will help improve outcomes and reduce inequalities. • The strategy sets out five immediate priorities for joint working across our system covering core medical prevention activities, support for children and families in very early years, early intervention for children and adults facing mental health challenges, addressing access to our primary care system and improving care for people with long term health conditions	
Recommended action for the Committee	• The committee is asked to consider the strategic priorities alongside the Healthier Greenwich Joint Forward View and Delivery Plan and the Greenwich Health and Wellbeing Strategy. • Share any reflections and thoughts on how collectively these priorities could be delivered across SEL and how they could support local delivery of key actions and priorities for Greenwich.	
Potential Conflicts of Interest	• No conflicts of interest have been identified at this stage	
Impacts of this proposal	Key risks & mitigations	• There is a risk of duplication of effort and resource which will be mitigated through effective planning and communication across SEL ICS.
	Equality impact	• At this stage an equality impact is not required but will be once the detailed work has been completed to define the priorities.
	Financial impact	• The financial impact has been taken into consideration and planned for at SEL ICB level through the inequalities funding

Wider support for this proposal	Public Engagement	• A significant amount of public and stakeholder engagement was carried out as part of the process to develop the strategic priorities as detailed in the attached report.
	Other Committee Discussion/ Internal Engagement	• There has been a range of discussions at various groups and committees on the strategic priorities.
Author:	Sam Hepplewhite, Director of Prevention and Partnerships	

South East London Integrated Care Strategic Priorities 2023-28

South East London Integrated Care System

Our mission and vision

Our mission is to help people in South East London to live the healthiest possible lives.

We will do this through helping people to stay healthy and well, providing effective treatment when people become ill, caring for people throughout their lives, taking targeted action to reduce health inequalities, and supporting resilient, happy communities as well as the workforce that serves them.

The principles set out in our vision:

Our priorities

Prevention and wellbeing

Improving prevention of ill health and helping people in South East London to stay healthy and well.

Early years

Making sure that children get a good start in life and there is effective support for mothers, babies and families before birth and in the early years of life.

Children's and young people's mental health

Improving children's and young people's mental health, making sure they have quick access to effective support for common mental health challenges.

Adults' mental health

Making sure adults have quick access to early support, to prevent mental health challenges from worsening.

Primary care and people with long-term conditions

Making sure people have convenient access to high-quality primary care, and improving support and care for people with long-term conditions.

Key enablers for reducing health inequalities and improving health equity

Ring fenced health inequalities funding with a specific focus on prevention

Embedding the Vital 5 (blood pressure, mental health, obesity, smoking and alcohol)

Using population health management to target interventions, including our ICS Core20Plus5 dashboard

Healthier Greenwich Partnership Forward Planner 2023/2024

Date	Standing Items	Main Business/Themed Item	Items for Information
April 2023	• Welcome • Introductions and apologies • Declarations of interest • Minutes of previous meetings • Action Log • Chief Operating Officer's Report, including sub-committee report. • HGP Development	• HGP Delivery Plan final 2023/24 • System Risk Review (to introduce a need for an LCP risk register focused on LCP plan and projects) – Neil Kennett-Brown/ Ike Phillip • PC/LTC strategic priority development – Sam Hepplewhite	
May 2023	• Welcome • Introductions and apologies	WORKSHOP/SEMINAR - Winter review – Gemma O'Neil - System Risk review – Ike/Neil - Annual Public Health Report – Steve Whiteman	
June 2023	• Welcome • Introductions and apologies • Declarations of interest • Minutes of previous meetings • Action Log • Chief Operating Officer's Report, including sub-committee report. • HGP Development	• SLP / Complex Care Phase 2 evaluation of options and next steps – Lisa Wilson • Healthwatch thematic reviews – Joy Beishon • Five Year View Plan Final • PCN Fuller final report and next steps – Nayan Patel • The London 'Every Child a Healthy Weight' Delivery Plan - Steve Whiteman	NOTE: Andrew Bland, ICB CO, will be in attendance.
July 2023	• Welcome • Introductions and apologies	• Draft System Intentions 2024/25 – Deane Kennett	

Date	Standing Items	Main Business/Themed Item	Items for Information
	• Declarations of interest • Minutes of previous meetings • Action Log • Chief Operating Officer's Report, including sub-committee report. • HGP Development	• LCP System Risk Review – Neil Kennett-Brown/ Ike Philip • Review of HGP Terms of Reference	
August 2023	•	•	
September	•	•	
October	•	•	
November	•	• Healthwatch thematic reviews – Joy Beishon	
December	•	•	