# Healthier Greenwich Partnership (in public via MS Teams)

**Date:** Wednesday 24 April 2024
**Time:** 12.30 – 14.30
**Venue:** MS Teams Click here to join the meeting

**Chair:** Iain Dimond

## AGENDA

| | Item | Page no. | Presented by | Time |
|---|---|---|---|---|
| **Opening Business** | | | | |
| 1. | Welcome, introductions and apologies. | Oral | Chair | 12.30 |
| 2. | Declarations of interest | Oral | Chair | |
| 3. | Minutes of the meeting held 27 March 2024. | 3 | Chair | |
| 4. | Action Log and Matters Arising | 18 | Chair/ Neil Kennett-Brown | |
| 5. | Positive Partnership Story – CACT work on Discharge. | Oral | Deborah Browne | 12.35 |
| **Public Engagement** | | | | |
| 6. | Public Forum Feedback | 19 | Russell Cartwright | 12.40 |
| 7. | Questions and comments from members of the public<br>**Note**: only questions relating to agenda items would be taken. | | Chair | 13.00 |
| **Items for in-depth Discussion** | | | | |
| 8. | Greenwich Assistive Technology Enabled Care (ATEC programme) | 27 | Lisa Wilson/Kit Collingwood | 13.20 |
| **Item for Decision** | | | | |
| 9. | Reprocuring APMS Thamesmead Medical Practice | 63 | Maria Howdon /Ginny Morley | 13:45 |
| **Items for Noting** | | | | |
| 10. | HGP Partner's Report and Sub-committee assurance report | 66 | Neil Kennett-Brown | 14.00 |

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| 11. | MSK update | 72 | Lisa Wilson | 14.07 |
| 12. | Risk update | 98 | Ike Philip | 14.15 |
| 13. | HGP Development | Oral | Victoria Stanway / Neil Kennett-Brown | 14.20 |
| **Closing Administration** | | | | |
| 14. | HGP Forward Planner | 100 | Ike Philip | 14.25 |
| 15. | Any Other Business | | Chair | 14:28 |
| 16. | Next Meeting: 22 May 2024 | | Chair | |
| **Meeting closes at 14:30** | | | | |

**Healthier Greenwich Partnership**
**Private Seminar**
**Minutes of the meeting held on Wednesday 27 March 2024**
**MS Teams**

| **Members** | |
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| Iain Dimond | Chief Operations Officer, Oxleas NHS Foundation Trust (ID) (Chair) |
| Nayan Patel | PCN Clinical Director (NaP) |
| Neil Kennett-Brown | Borough Chief Operating Officer Greenwich (NKB) |
| Tuan Tran | Greenwich LMC (Local Medical Committees) Chair (TT) |
| Naomi Goldberg | Director of Strategy, METRO GAVS (NG) |
| Chris Dance | Associate Director of Finance, Greenwich, SEL ICB (CD) |
| Niraj Patel | Chair of Greenwich Health GP Federation (NiP) |
| Kate Heaps | Chief Executive, Greenwich, and Bexley Community Hospice (KH) |
| Kate Anderson | Director of Corporate Affairs, LGT (KA) |
| Jose Garcia-Lobera | Clinical and Care Professional Lead for Greenwich (JG) |
| David James | Chief Executive, Greenwich Health (DJ) |
| Steve Whiteman | Director of Public Health, RBG (SW) |

| **In Attendance** | |
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| Ike Philip | Corporate Governance Lead, Greenwich (Minutes) (IP) |
| Maria Howdon | AD Primary Care (MH) |
| Victoria Stanway | PPL (VS) |
| Mayara De Paula | PPL (MDP) |
| Tony Brown | Greenwich Leisure Limited (TB) |
| Steve Hicks | Charlton Athletic Community Trust (SH) |
| Luke Webster | Greenwich Leisure Limited (LW) |
| Matt Phillips | Charlton Athletic Community Trust (MP) |
| Kate Simpson | (KS) |
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**Apologies**

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| Sarah McClinton | Place Executive Lead Greenwich (SMc) |
| Lisa Thompson | Director of Children & Young People's Services, Oxleas (LT) |
| Ginny Morley | Interim Associate Director of Primary Care (GM) |
| Russell Cartwright | AD Comms and Engagement |
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| **1.** | **Introduction** |
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| **1.1** | **Introductions and Apologies for Absence** |

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| 1.1 | The Chair welcomed everyone to the meeting. Apologies for absence were noted. The Chair welcomed Kate Anderson from LGT as new representative and Maria Howdon for the primary care item. |
| **2.** | **Declarations of Interest** |
| 2.1 | The Chair asked if anyone had any interest to declare on any of the agenda items. None was declared. |
| **3.** | **Minutes of the Previous Meeting Held on 28 February 2024** |
| 3.1 | The minutes of the meeting held on 28 February 2024 were reviewed and approved as accurate. |
| **4.** | **Action Log & Matters Arising** |
| 4.1 | The action log was reviewed, and updates noted. It was noted the action for AN to have offline discussion with Kate Heaps relating to capturing the end-of-life investment and work in the local plan update for 2024-25, remains open. |
| 4.2 | <u>Matter arising.</u><br>NKB noted the Forward View plan refresh would be published by SEL ICB at the right time. NKB thanked everyone who contributed to the update. |
| **5.** | **MSK Procurement Update** |
| 5.1 | Neil Kennett-Brown gave an update, noting a market engagement event was held at Pegler Square in Kidbrooke, which was very well attended. The service design event was to review the current MSK model and the pathways, using feedback that was already received over the last few months. There has been feedback and involvement from a few providers including Circle (the current providers), LGT and Oxleas. Several patients were involved. |
| 5.2 | NKB noted some suggestions about improvements to the MSK service were received, although the event did not produce a definitive single model. NKB explained further work would be done to develop a future model ahead of a procurement. |
| 5.3 | NKB clarified the timeline for the procurement, noting finalising the specification would be done by end of May, together with the procurement strategy. Both would be coming back through the HGP for approval. The Invitation to Tender (ITT) would be prepared and published between June and July. Bids would be received, and the evaluation and moderation process will last for between August and October, for about three months. The contract awards recommendation report and sign off would happen between November and December and then mobilisation will take place between January and March of next year, with the new contract provider being in place by 1 April 2024. |
| 5.4 | NKB noted a full procurement would be undertaken using the new Provider Selection Regime (PSR) . This would ensure due process would be followed. Hence a lot of work would be done to get the right specification using the feedback received as inputs to that. |
| 5.5 | NKB pointed out several things have changed since the original MSK service went live, noting there are additional services running in GP practices, through the ARRS roles |

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| | with first contact physios. There is also a combination of Oxleas and LGT working as part of the MSK function, which is led by Circle. Things have also changed in terms of technology and virtual support etcetera. So, there are a variety of changes that would be factored into getting the model right going forward. There are opportunities to get the new model right. |
| 5.6 | NKB spoke about the MSK Community Day held on 20 March 2024 at Sutcliffe Park, noting that was a fabulous event. The community events are based on a model started in Sussex some time ago (www.selondonics.org.uk/mskday). About 180 people on MSK waiting lists at Circle and LGT were invited to the community event. Participants would have conversation with the physio - they understand the kind of onward referral services and the kind of support that people can do. Participants get given advice on exercises they can do, as well as having some clinical assessment spaces at the event. A lot of that was about working with the community and voluntary sector as part of that and getting people active and supporting people in that. |
| 5.7 | NKB disclosed that based on the feedback he got from talking to some of the teams that were there based on the Lewisham event that happened in a previous week, was that 40% of patients who came decided to go for patient initiated follow up, so they were happy to come off that waiting list. NKB explained what this means is giving people a quite different approach and it is quite an interesting innovation about how to deal with potential people on waiting lists where it is quite large. NKB noted there is quite a lot of coordination to run these kinds of events, but they are beneficial in terms of the outcomes. |
| 5.8 | NKB noted it was a positive event and similar ones are being held in other boroughs in SEL. There will be some learning that will come out of that going forward. |
| 5.9 | The Chair thanks NKB for the update, noting it is positive. The Chair asked if other members had any comments or questions. There was none. |
| 5.10 | The Board noted the MSK update. |
| **6.** | **Thamesmead Health Centre – APMS procurement** |
| 6.1 | Maria Howdon introduced the item and explained the paper is for noting, as the Primary Care Working Group (PCWG) would discuss the options tomorrow and the options they decide would come back to the HGP for ratification. MH spoke about the different options in the paper and confirmed that Option 3, full competitive process, is the one being recommended to PCWG to consider for approval. |
| 6.2 | MH clarified why options 1 and 2 would not be ideal. Option 1 is where you can award a new contract as part of a direct award process to the current provider. This is only if there is no considerable change to the contract, but what this means is unclear and it is untested now because the Provider Selection Regime (PSR) is a new regime that came in in January 2024. For example, is not clear if including something around neighbourhood development within the new contract would be classed as a |

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| 6.3 | considerable. It is also uncertain if the fact that the contract value and registered list has increased over its lifetime would be classed as considerable. |
| 6.4 | Option 2 is to award a new contract via the Most Suitable Provider (MSP) Process. This option is particularly good for areas where there is likely to be limited interest and only one provider, but this is unlikely to be the case for a practice of this size in Southeast London. It is unclear how to decide an MSP and there would be a risk of challenge around that, as lawyers have advised the same. |
| 6.5 | The Chair thanked MH for giving HGP early sight of the options being proposed for the PCWG's decision, noting the outcome from that group would come back to the HGP for ratification. The Chair asked if members had any comments? |
| 6.6 | NKB explained the reason the options paper came to HGP first, noting it was because next meetings in April would be in public and it would be helpful for HGP to have been sighted on this ahead of it coming back to the April meeting for ratification of PCWG's decision. It was useful to give the HGP a heads up about it before next meeting. |
| 6.7 | The Chair thanked NKB for the clarification and asked if it would make sense, given the nature of the item, for it to come back in May rather than April? NKB responded that national advice is that such decisions relating to primary care should be taken in public unless there are any reasons why it warrants a part2 confidential discussion. This would be tested based on discussions to be had at the PCWG. |
| 6.8 | Niraj Patel declared interest as a GP Partner in Gallions Reach Health Centre in Thamesmead, which is a neighbouring practice in the same locality as Thamesmead Health Centre. NP noted he was making a general point about a planned Riverside housing development that would provide about 10,000 new homes and the DLR extension to that area in about 10 to 15 years' time. NiP asked if this would be considered in terms of determining the contract duration and asked if the new APMS would by 5 years plus 5yrs or so? NiP was conscious that if there is going to be a massive population expansion and the APMS contract is just a 5yrs + 5yrs, which would be about the time this development is happening. |
| 6.9 | NiP asked if we get a new provider now and if it goes out to procurement again later at a time of massive population expansion, is that the most sensible thing or is that a good thing? Has this been part of the calculation or is it just so far out that we are just sticking with the five years and then review in five years? |
| 6.10 | MH thanked NiP for raising this as a critical issue, noting those things would be factored in as part of the conversation. MH explained that in this instance, the previous contract was 5yrs + 5yrs , so it has had some quite long substantial length of time to it. A decision would be made on whatever the next one looks like, including the type of longevity of that, would meet our needs as well as give some stability at the same time for whatever period it is. |
| | NG commented that the system is going to continue to be risk averse and constantly continue to go through these overly complex bureaucratic competitive processes. NG |

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| | understands now it would be a serious risk to go with option1 or option 2 in this case, but is it likely that there may be some case law or more detailed guidance, so that we do not in future have to go through such kind of bureaucratic processes around commissioning? NG responded that PSR is a new procurement regime and as it gets implemented, certain things would be tested through case law. For now, there are no detailed guidance or case law that would make it easier to undertake a direct award in this case. |
| 6.11 | NKB added that if the current provider were deemed as brilliant, high quality, best provider and was part of our local system already, it would be more tempting to go down option one. This is not a not a local provider and not in a in the top quartile performance in how it performs. NKB noted that integrated neighbourhood working etc and what we want to achieve there, would form part of the specification and that might help secure a provider who is committed to that kind of integrated working agenda. |
| 6.12 | Nayan Patel expressed the view that he was mindful of the risk around option 1 but had concerns because the partnership is trying to build primary care networks and neighbourhoods, and this provider has already worked in the past five years building those relationships. Now if the partnership gets another provider in who does not play ball or has a different take on it and may still be a national player who's not actually part of the local system, it will mean always starting from square one again. If that does give us grounds to be able to just roll over a contract but it depends on how good this provider is or compared to others. It would be worthwhile looking at it because you do not want to disrupt existing relationships. |
| 6.12 | The Chair thanked everyone for their comments, noting they are useful views from this group that MH can take into the PCWG discussion tomorrow. There were further discussions about bringing the outcome to the next HGP, noting that it would be purely for ratification and not to open the whole discussion again. |
| 6.13 | The Board noted the Thamesmead Health Centre APMS procurement update. |
| **7** | **HGP Partner's Report** |
| 7.1 | Neil Kennett-Brown introduced the item and noted a Healthier Greenwich Partnership (HGP) staff engagement event was held on Wednesday 20 March 2024 and was attended by about 50 to 60 people. There was good representation across the system, except for LGT which was not represented due to a clash with their management event that happened at the same time. The purpose of the event was to help in sharing the wider message around the Healthier Greenwich Partnership. |
| 7.2 | NKB explained there were a few people who knew of bits of work the partnership are doing, but very few people were aware of the connection of the whole. For example, some people might be aware of the partnership's role relating to children's work, but they were not aware of anything else that was going on. So, it was helpful for those people to understand much more about the coherent whole. The event provided opportunity to give an explanation about the services, the model and the partnership strategy going forward |

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| | and really an opportunity to listen to that wider group of staff. |
| 7.3 | NKB noted people's feedback was it was a positive event, and their commitment was too collaborative and partnership working. People want to do more of that going forward, which was really encouraging. Hopefully, a similar event would be held again in future. NKB felt it is the start of a good conversation. |
| 7.4 | NKB gave update about a HGP Public Forum on Cancer Prevention that was held on 25 March 2024 at the Greenwich Community Centre. Caroline Hollington and Sheila Taylor from the public health team did a joint presentation about cancer. It was a hybrid event, with people both online and physically there. It was a useful event, and more updates would be provided at the next HGP in public. |
| 7.5 | NKB provided a brief update about SEL ICB management cost reduction (MCR), noting the process of implementation is rife now. Several people have had ring-fenced interviews, some people are at risk and do not have roles. Other people have found out that they do have roles. The ICB is in a transition period, and it is quite a challenging time for staff overall. NKB is looking forward to Jessica Arnold starting on the 1st of May as the director of primary care and neighbourhoods, and Ginny Morley is continuing to hold the fort until the end of April. |
| 7.6 | The Chair thanked NKB for the update and for the helpful reminder in that MCR item, that we need to be mindful of colleagues' particular situation now, noting it is a tough time for some staff. The Chair noted from the staff engagement event, there's appetite to do more to engage wider group of colleagues in the work of the HGP and to think around comms and how to bring the work of the partnership to life. They felt it was an opportunity to reflect on the magnificent work that is happening out there, which is aligned with the work of the partnership, because some of the conversation was the fact that people are doing the work already. It is not that the HGP is something different, it is about how to bring existing good works together and kind of steer it in a particular direction. |
| 7.7 | David James spoke about the neighbourhood engagement events, noting he is keen to understand if Greenwich Health can get involved in attending one of those going forwards. He is quite keen to come out and talk to public about some of the changes that have been made to the Urgent Treatment Centre (UTC), the sort of patient flow model there and to get feedback from residents. DJ disclosed that Greenwich Health recently appointed a new engagement lead, and it would be helpful to connect with those neighbourhood engagement events. |
| 7.8 | NKB acknowledged it is a good suggestion and UTC could be a topic for one of the future sessions, noting he would pass the suggestion to Russell Cartwright. |
| 7.9 | **Action:**<br>**Neil Kennett-Brown to ask Russell Cartwright to link up with David James regarding future neighbourhood engagement events and to consider UTC as a** |

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| | **topic in one of the sessions.** |
| 7.10 | The Board noted the partnership report. |
| 8 | **100 Day Challenge Project Follow Up – Cardiovascular (CVD (Cardiovascular Disease))** |
| 8.1 | The Chair welcomed Victoria Stanway and colleagues in attendance for this item. VS introduced colleagues who were involved in the 100-day challenge – Mayara De Paula, Luke Webster, Tony Brown, Matt Phillips, Steve Hicks. |
| 8.2 | VS explained the 100-day challenge process, structure, and teams. VS noted the 100-day challenge is a successful methodology adopted more widely as a way of creating pace and bringing teams together to work on new and interesting things. VS gave an overview of the methodology, noting the teams came together during a period of four times in structured workshops. A workshop in October 2022 was used to build consensus and selected CVD inequalities as a shared priority for the partnership and the focus for the challenge. |
| 8.3 | The 100-day challenge adopt PDSA (Plan-Do-Study-Act) cycles type of quality improvement approaches, where they develop and iterate ideas over a period of 25 days and before coming back together in some structured learning and sharing sessions with the wider teams. That cycle is repeated four times over 100 days before it ends. This is completed by a final session focusing on sustainability and learning and how to embed some of the experiences within the system. |
| 8.4 | VS noted the 100-day challenge is very much designed to support people to work differently by breaking people out of their familiar business as Usual (BAU) working patterns. The idea is that by following some methodology, you can produce quite rapid and impactful change over a pretty quick period. One of the reasons for choosing this methodology to approach some of the challenges that Greenwich were facing was that it bears some striking similarities to the COVID landscape and the COVID world, where there is a really clear sense of shared priority and a lot of permission to do things differently, and for frontline staff to make decisions without usual bureaucratic and risk processes. And while it is recognised that long term strategies cannot be actioned too quickly or long-term impacts necessarily measured within 100 days, there is quite lot of emphasis on identifying proxy measures and thinking through. |
| 8.5 | There were two teams that worked on two areas. Wave 1 worked on hypertension – identifying high blood pressure, working with employers, families, and the Glyndon community. Wave 2 worked on increasing physical activity among children and young people. Mayara De Paula elaborated on the wave 1 project and outcomes. Three very different approaches were used and at the end of the 100 days, 803 blood pressure readings were collected through a variety of different methods and 10% of those were high or very high and 1% were very high. So, quite a significant amount. |
| 8.6 | About 60% of the readings were made-up of women and this might be reflective of the different methodologies that were used to take those blood pressure readings. So, with the employers, it was mixed. There are several events attended, sixteen events in eight workplaces and there were three hundred and thirty-three readings gathered just in those spaces. |

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| 8.7 | Matt Phillips commented one of the big sites visited for the employers' work was Plumstead bus garage, where the uptake was more of women than men. Steve Hicks explained they had done something with the bus garage previously which helped in getting the team access to work with them. He explained that it takes a couple of repeated visits to build rapport, especially with the men. |
| 8.8 | NaP noted the good engagement work with employers and families seems interesting in terms of getting people to engage and trying to find the hidden people. NaP asked if the team delved into the statistics to differentiate people who have a known diagnosis of high blood pressure? Are these brand-new cases or brand-new elevated readings and people who have not had a previous diagnosis of high blood pressure? NaP felt the engagement work of employers and families is pivotal, in terms of getting those people to feel comfortable going to see a doctor or engaging with health professionals when you have identified a problem. NaP suggested it would be helpful to get those stats right, as it would be interesting to know whether or how many of these people were already diagnosed with high blood pressure and then actually, was it that these readings were high because they were not complying with treatment or other things like that. |
| 8.9 | VS responded the data is a bit limited in terms of how currently it is collected, noting that would be an important iteration and improvement if we were to continue to do this and to collect that information. Potentially other data around ethnicity, et cetera, could be added, which could be interesting to be able to more effectively see where we have inequalities, would be good improvement. VS asserted that 30% of the readings taken overall were people who had not had their blood pressure taken in more than a year. It is not possible to link that to the blood pressure result, unfortunately because the way they are collected, it is not linked. |
| 8.10 | JC commented the findings are interesting, noting one of the things that comes to mind is just thinking about sustainability and how this can be reproduced is, thinking about where you would have the most impact in terms of identifying. This is because in the workplace, 0.9% of people were picked up as very high reading. Where do you want to invest resources and for how many events? How many people do you have to commit to such events? Where do you put your resources in terms of the number of people and where do we want to target people who potentially may be more at risk for the type of demographics or potentially also the other factors, people who potentially tend not to attend GP practices? So, this is a lot of information and always the question is now what? Now that they know that they have a rise in blood pressure, what is the next thing and who is going to help them to pick up? Are we leaving everything to the responsibility of the patient or how would we support that, in terms of giving empowerment, at the same time knowing that they do not fall through the net. |
| 8.11 | VS noted for sustainability moving forwards, one thing the team would look at is how to engage employers more effectively and sell them on the benefits or incentivise reasons why it might be helpful to allow some of the teams to come in and take blood pressure checks. Other things they started to think about is, depending on kind of where we expect to find previously undiagnosed high blood pressure, whether there is thinking about the return on investment, a slightly stratified model where the team can undertake repeated visits to really reach those people with undiagnosed hypertension. We can think about other things that we can do, even if it is just communications and posters, etcetera, that tells people they can go to the community pharmacy to get their |

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| | blood pressure checked. It was noted that some of those identified with high pressure readings were directed to Live Well Care Coordinators to help refer them to their GPs. |
| 8.12 | Regarding sustainability, NP suggested the work in linking community services with general practice would help. Through the new resources that we have together, that will reduce some of the barriers that have been highlighted and allow us to practise prevention in a unique way. Going forward, where general practise is an intrinsic part of the community and that is where you would see some of this magic start happening with employers and families because there is no point picking up a high blood pressure reading if you cannot get an appointment or if you cannot get the person into a GP surgery. VS noted that general practise alignment and involvement would have been really, helpful. This should be considered for any future projects. |
| 8.13 | KH made a couple of observations, noting that she does not remember her organisation being contacted to be visited by the project team. She suggested it would be good if her organisation is involved in a future project as they are one of the employers in Greenwich. For sustainability, KS suggested using tech to deliver this going forwards. Particularly once the relationship has been built or the kind of issue about blood pressure, just having a bit of equipment that staff can use to take their own blood pressure would be helpful. KS also suggested whether going forwards, we should be thinking about what are the other things we would want to do as part of this, such as broadening the projects or topic of conversation with people to include blood sugar levels or preventable diseases? |
| 8.14 | VS noted there is new technology coming on the market now, which allows diabetes testing to be done completely in the Community. SH noted the Morrison site was done as a pop up by the project team. It may not be possible to get different equipment, such as diabetes monitoring ones, into a limited space but as modern technology becomes possible, it may be possible to add other things. |
| 8.15 | NG asked if the data has been broken down to granular level to look at things like ethnicity and inequalities among the respondents? VS responded that unfortunately for this challenge those type of questions were not added into the forms. The teams felt that it was going to be too invasive a question, particularly in the Glyndon team etcetera, based on the level of trust and familiarity individuals had. NG asked if any communities were targeted by any of the project groups? It was noted apart from the project team focused on Glyndon community, no specific community was targeted, although one of the project teams did happen to visit a Nepalese event. |
| 8.16 | SW remembered a few years ago, a bigger road show called the now Know Your Numbers campaign, was done, which took about 10,000 blood pressures over a period. SW suggested the team could have a look at some comparative data around who were seen and what sort of numbers in terms of the proportion of people from that campaign that that had elevated blood pressure, etcetera. Also just sort of comparing both models, noting this 100-day challenge was in very particular sort of settings targeting places and that one was a bigger project over a longer period. It would be worth just having a look at that, to see if there are some lessons that we can learn from the comparison between the two. VS committed to take this as an action. |
| 8.17 | **Action:** |

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| | **Victoria Stanway to compare the outcomes from the 100-day challenge and the Know Your Numbers Road show held a few years ago, to see if there are some lessons that could be learnt by comparing both models.** |
| 8.18 | MP commented there are some good action points learnt from 100-day challenge and that just growing the partnerships between all the organisations involved is a winner. MP noted the team would always continue to build new relationships and new partnerships with organisations as this would be a basis for success of future collaborative working. |
| 8.19 | There followed discussion about the second challenge which was around increasing physical activity among children and young people. MDP noted she was the team coach for the group. The team recognised that children under five are diverse in terms of their needs of physical activity and how that changes throughout that specific period from being a one-year-old baby and learning how to walk and to being five years old. In recognising that parents and staff are very much the lynchpin and can be huge motivators for children in that age to have physical activity as part of their lifestyle, so the team really wanted to target the motivation, the confidence, and the knowledge of those groups. They developed a physical activity programme that was centred around providing practical guidance and tools in a safe space with take home resources. |
| 8.20 | MDP noted Lisa Walsh, who heads up Waterways children's centre was helpful, and she really did move mountains to make space for that training session to happen. It really brought to light the fact that we need to be quite flexible and think quite long term in the planning and working with these types of partners in the future. It is difficult to turn around very quickly, so a bit of patience and persistence is needed. MDP noted the outcome from this cohort was that knowledge, confidence, and motivation all improved after a 2-hour session. That is valuable. So, it is just thinking about taking that forward and making it sustainable long term. |
| 8.21 | MDP gave update about the next cohort which involved teenage girls. The group did a face-to-face approach starting with a discovery phase. Two co-production sessions were held with year 8 girls who identified as not being active to understand what the barriers is. Some of the top line things that came out of this is around the need to feel safe. With that fear comes the importance of doing activity with somebody who is quite familiar such as a friend. The group identified some of the barriers as well, such as their school uniform being too thin, for example, the girls T-shirts were thin. That was something that became known and that the team are taking back to the school to address. |
| 8.22 | LW was a member the teenage girls' group and gave update about the team make up, work and outcome. LW noted other team members were from the Explorer team at RBG. In terms of sustainability, LW noted working with Explorer, trying to get into schools and have those conversations can be a challenge. Once the barriers are overcome, the project worked very well. LW suggested having good contacts in schools or at least improving the relationships between schools and providers within in the borough would be helpful. |
| 8.23 | DB disclosed a meeting will be held with school heads partnership to discuss some of the messages which came out of the project, especially those relating to boys. There were some discussions about the need to tackle some negative attitudes that create barriers to physical activity. |

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| 8.24 | MDP spoke about the work of the team involved in the SEND schools and organisations. The team developed a pilot in partnership with the Willowdine School and GLL where a cohort of students would participate in weekly physical activity sessions to help really build their confidence and eventually be able to access mainstream settings like the gym. There have been four sessions scheduled and those would be rolled out throughout the academic year. In addition to this, there is a recognition that there are things that already exist and making sure that that those are communicated in the way that is accessible. The team collated that and designed and published a page on a local offer website. There is a screenshot of that on the screen that displays all the different opportunities for the children and young people with SEND to participate in physical activity. |
| 8.25 | MDP explained this was tested to get some feedback from the children and young people from Charlton Park Academy. Everybody thought it was easy to understand. They liked the way it looked, and it really encouraged them to start getting excited and participating in physical activity. TB shared his reflections of being involved in the team, noting what was excellent was that the school had already pictured a group within that setting that would benefit from an intervention. The team has designed a programme to be used to work with those young people and this would start after Easter. TB noted the project has been useful to generate ideas and to generate a comms approach with the local offer page. Additionally, there is an actual tangible programme that is going to make a difference. |
| 8.26 | The Chair thanked colleagues involved in the various projects for their work and for the insights generated, noting these were well received by the HGP. |
| 8.27 | The Board noted the 100 Day Challenge Project Follow Up Cardiovascular (CVD) update. |
| 9 | **100 Day Methodology - How to use this or similar methodology to shape HGP change approach for some of HGP's priorities.** |
| 9.1 | VS introduced the item, noting some of the priorities agreed by HGP for 2024 including the following:<br>• Nurturing workforce innovation;<br>• Delivering the LCP (Local Care Partnership) plan;<br>• Delivering a neighbourhood model;<br>• Tackling wicked issues. |
| 9.2 | VS made observations about some key themes in moving forward to developing an approach to solving future challenges and suggested putting some proactive time to think about and develop some of the leadership and comms around the challenge, is important as it underpins other things. VS emphasised that leadership and communication is important. The second one was around training and development. There needs to be consistent training and development across the teams around key health messages. The projects also identified some gaps in teams which need to be addressed to do this work more effectively, regarding things around evaluative practise and true co-production and co-design with communities. Teams would really benefit |

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| | from some additional training support in these areas to be able to do this work more effectively. |
| 9.3 | VS noted the third point was really to emphasise the importance and power of having diverse cross functional teams. VS noted the value added by involvement of voluntary sector, community, and social enterprise (VSCE) and public health teams in this kind of work. |
| 9.4 | VS explained some of the draw back identified from the projects that reflected traditional provider and commissioner splits - how they worked together, how they took instructions and risk taking. Teams were reluctant to build on ideas and take risks, So where for example, you had someone who was traditionally a commissioner and someone who's traditionally a provider, sometimes it was found that the providers would be unwilling to put forward their ideas or to lead on things without the explicit direction of commissioners, even though they had really good expertise and the relationships in that area. There is need for thinking about how we are role modelling that at a leadership level and how we communicate that down to teams when they are doing this innovation. We need them to be working in a unique way outside that relationship. |
| 9.5 | VS invited Kate Simpson, a director from PPL, to speak about the Conditions for People Powered Innovation. |
| 9.6 | KS noted prior to joining PPL she was from Nestor, which is an innovation hub and part of the UK Innovation Foundation, where the 100-day challenge methodology was developed. This was along with other people powered innovation tools, methods, approaches to help improve things in public sector systems and embed innovation capacity and capabilities within those complex systems. KS outlined four people powered innovations. |
| 9.7 | The first is around new modes of leadership. That is all about having a collaborative cross system leadership approach and the innovation tools and methods, including the Hundred Day Challenge. The way to develop that is by identifying a shared challenge or shared priority to focus the work on and sponsorship across the system for people to actively participate in addressing that challenge. |
| 9.8 | The second is around bringing people together in new ways. Again, this was illustrated really, well in the first couple of waves that were run in Greenwich across the HGP. That is about mobilising and supporting diverse groups to start developing and testing innovative ideas. It is about having that breadth of perspective and depth of experience from across a place or system to really produce the ideas that are going to address those kinds of wicked, persistent stuck challenges in place. |
| 9.9 | The third area is around real-world testing. This is around creating that space and providing support for people to learn and experiment. Often that will also mean supporting people when things do not go well. The fourth one is creating an environment for action and learning. When ideas fail or succeed, learning what that |

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| | means in terms of future directions of travel and strategy, plus embedding that rhythm and pace within any change effort or innovation, to help maintain energy, enthusiasm, and momentum and focus on that challenge. Tracking whether you are making progress and impact towards that challenge focus area. A big part of that is data. |
| 9.10 | KS explained data is useful for tracking and measuring progress and impact across the any sort of change effort and what you really need to be thinking about to do that. So how can you make the data more accessible, understandable, timely, actionable, and how can you support teams to start to build their evidence base for stuff that isn't there yet? So, where there is no metrics associated with these innovative ideas, what are the proxy measures that you could use to track progress and impacts to measure against? |
| 9.11 | KS noted that 100-day challenge works because it is relational, and it is about networks and a powerful way to involve staff. It is goal oriented, action focused, and data driven. KS commented that at Nestor they applied 100-day challenge methodology across loads and loads of different systems, from health and housing in the UK and beyond. A core part of that has included capacity building efforts. That entailed a knowledge transfer approach where you are building capacity and local coaches and leaders to be able to deliver the method and other innovation skills and methods beyond. |
| 9.12 | KS expressed the view that as the partnership looks forward about how to build on the foundations and learning from the first two challenges, it is important to strengthen capacity for innovation and change across the system. How can you make best use of available resources, build energy and capacity respond to emerging levels of need? KS suggested nourishing that sort of workforce, innovation and crucially, bridge that implementation gap. So, between the kind of strategy or the priorities that you have and what is happening on the ground and really making progress within the Greenwich local context. |
| 9.13 | The Chair thanked KS and VS for the presentations and asked if there were any comments from members? NKB noted it is a useful methodology and there are other areas that we could use this methodology to try and get a shift and a change in thinking. NKB stressed he is keen that we try and see if we can adopt this in some of our other areas. |
| 9.14 | SW noted one of the key points that have emerged from the discussions about this is that without such a framework, without this kind of intervention, several of the relationships that people now had would not have existed. People in different organisations wanted to do some things but were hindered by organisational boundaries. When they were in the same room together talking to each other, they were able to do that together through the 100-day challenge projects. |
| 9.15 | NaP asked if there are criteria for the scale of the project or the scale of the challenges that could be dealt with in a 100-day challenge? KS replied, noting there is a criterion in that it needs to be a cross system priority and that there is a personal stake from leadership from across the place or the system to support the effort in terms of scale. This is the main criterion. Additionally, typically you would have three teams of between |

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| | 8 to 12 people looking at cohorts of around up to sort of ten to fifteen thousand people maximum within the challenge period to be able to make progress, often that is reduced. You would have people working within a specific neighbourhood team or hospital focusing down on a much narrower cohort of people to make sure that they are able to make progress, design and test ideas within the brief time limits of the challenge. |
| 9.16 | NaP specifically asked about general practice transformation, noting it is a system priority, but it does not fit conveniently into the category of ten to fifteen thousand patient cohorts. It is a different setting that you have got to look at it through a unique way. So, is there a methodology that you could apply to get that sort of moving along? |
| 9.17 | The Chair noted it is a very useful question and suggested, because of limited time, KS, or VS to pick that up with NiP outside the meeting. |
| 9.18 | TT commented it is interesting hearing about 100-day challenges and understanding it. TT observed from own clinical experience when looking at behaviour change, people's behaviour is determined by their beliefs. So, the key thing is changing people's belief. The focus, if you want to see behaviour change and improve health outcomes, may be concentrated on understanding and changing that that belief in terms of sustainability. |
| 9.19 | TT asserted that it is important to empower organisations. So, for example, if you can get employers to be concerned about the health of the staff, then get them to take the initiative and do the blood pressure and take that forward. Similarly with schools, if you really want that change to happen with these teenage girls, you need to get the PE teacher or whoever in the school to drive it forward. You cannot be relying on external sources to make the work sustainable. If you want to look at cost effective sustainability, show someone how to fish and then you give them net and they can fish for life. That kind of analogy. |
| 9.20 | The Chair remarked he was really struck by the insight that was derived around the role of what was framed as kind of vertical integration, noting it often gets talked about in terms of a kind of middle management, which is a horrible kind of kind of way of terming it. The Chair explained there are a group of leaders that are trying to run services day-to-day, and they have really, difficult jobs. The Chair felt there is a question for the partnership about how to bring the kind of a unique way of working to life by supporting those leaders to meet and kind of balancing the needs of a 100-day challenge to prioritise that and keep the day job going as well. The Chair was of the view that is the kind of fundamental area of focus that we need to have as a partnership, to help them because they are key to moving us on. |
| 9.21 | The Chair thanked KS and VS for the work. The Chair asked NKB if the plan would be to return to this conversation at the next HGP development session? The Chair noted there is clearly a lot more to do with thinking about what the conditions of success are, if HGP are going to adopt this methodology. It is important to think about the selection of areas that the partnership might want to bring this to bear on. |

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| 9.22 | NKB remarked in terms of next steps, the proposal is to have further discussion at the HGP Executive Group, noting obviously PPL have done some support work and have really done a lot of the work on this so far. if HGP are going to take this forward, there could be a method of people being trained up to be able to do this ourselves, but that will require going on a journey over a period, one where people are working alongside, and people have been trained up. A second option could be one where we are doing the challenge projects, but with some background support to try and shift our own skills. |
| 9.23 | NKB noticed that workforce point and noted there is need to agree those areas to focus. NKB suggested the neighbourhood piece of work could be used as a starter, to try and in 100 days shift a neighbourhood, to use a new way of working and test it. |
| 9.24 | The Chair thanked NKB for clarification, noting there would be further discussion about the 100-day challenge methodology at the next HGP Exec Group. The Chair thanked all for their contributions.<br><br>**RESOLVED** |
| 9.25 | The Board agreed the Exec Group would have further discussions about the 100-day challenge methodology and recommend to the board how to take this forward. |
| 10 | **HGP Forward Planner** |
| 10.1 | This item is for information. The next HGP is in public on MS Teams. |
| 11 | **Any Other Business** |
| 11.1 | Farewell to Naomi Goldberg - The Chair noted this is NG's last partnership board before retirement. The Chair and other members bade her farewell, noting she is irreplaceable. |

## Action Log for the Healthier Greenwich Partnership – March 2024

## Updated 03.04.24.

| OPEN ITEMS | | | | | | |
|---|---|---|---|---|---|---|
| **Meeting date** | **Minute Ref** | **Action no** | **Action** | **Action Owner** | **To be Completed** | **Comments** |
| 28.02.24 | 7.5 | 001 | Annie Norton to have offline discussion with Kate Heaps on how to capture the end-of-life investment and work in the local plan update for 24-25. | Annie Norton | 26.03.24 | 27/03/24 It was noted the discussion had not happened as AN was unwell. Lisa Wilson to pick up with Kate. |
| 27.03.24 | 7.9 | 002 | Neil Kennett-Brown to ask Russell Cartwright to link up with David James regarding future neighbourhood engagement events and to consider UTC as a topic in one of the sessions. | Neil Kennett-Brown | 23.04.24 | 09/04/24 Completed, UTC on forward planner for public forum, likely to take place in September 24. **CLOSED.** |
| 27.03.24 | 8.17 | 003 | Victoria Stanway to compare the outcomes from the 100-day challenge and the Know Your Numbers road show held a few years ago, to see if there are some lessons that could be learnt by comparing both models. | Victoria Stanway | 23.04.24 | |

AGENDA ITEM: 6

# Healthier Greenwich Partnership

**Date: 24/04/24**

| | | |
|---|---|---|
| **Title** | Update on HGP Public Forum 25/03/24 – Tackling Cancer Together | |
| Healthier Greenwich Partnership are asked to discuss the update and note the feedback from residents. | | |
| Executive Summary | • This paper summarises the discussions at the Healthier Greenwich Partnership Public Forum on 25/03/24 | |
| Recommended action for the Committee | Members are asked to note the report and identify any particular issues raised that require further actions. | |
| Potential Conflicts of Interest | • None arise directly from the report. | |
| | | |
| Impacts of this proposal | Key risks & mitigations | • None arise directly from the report. |
| | Equality impact | • Demographic info from attendees has been collected and analysed in the report |
| | Financial impact | • None arise directly from the report. |
| | | |
| Wider support for this proposal | Public Engagement | • The paper outlines the report from one of the HGP's key engagement activities. |
| | Other Committee Discussion/ Internal Engagement | |
| Author: | Russell Cartwright | |
| Clinical lead: | Dr Caroline Hollington | |
| Executive sponsor: | Neil Kennett-Brown | |

**Healthier Greenwich Partnership Public Forum report**

**Forum date: 25/03/2024**

**Venue:** West Greenwich Community Centre

**Main Topic –** Tackling Cancer Together

This event was the seventh Healthier Greenwich Partnership (HGP) Public Forum. The Public Forums were established to try and find more meaningful ways for members of the public to engage with HGP work and to try to reach beyond the people who often attend our meetings. The event was held as a hybrid with members of the public joining in person at the West Greenwich Community Centre and online via Zoom between 5.30 and 7.30pm

We were joined by four members of the public in person and seven online (11 in total). This compares to the previous meeting held at Glyndon Community Centre where there were 20 members of the public in person and nine online (29 in total). The smaller attendance was disappointing however there were still valuable discussions.

There were lots of questions around screening and the availability of information for screening uptake in ethnic minorities. There was also interest around health inequalities and its effect on preventing, finding and treating cancer. There was also an appetite to be part of the solution and work together to improve prevention.

**Format**

Neil Kennett-Brown chaired the session. He was joined by Dr Caroline Hollington, Macmillan GP and Greenwich Clinical Lead for Cancer and Sheila Taylor, Senior Public Health Strategist - Population Health. Neil introduced the session followed by a presentation by Dr Hollington on Cancer prevalence and screening.

Participants asked questions after the presentation around the following topics:

- Age and screening and why screening invites stop after a certain age. *The response included that people over 70 can request a breast screening and that when it comes to cervical screening there is no evidence that a screening programme for people over 64 is effective. However anyone with symptoms should see a doctor.*
- Availability of data around screening uptake and cancer in ethnic minorities – would like it broken down further. *The response included that this is a frustration for us too - we would like to see more detailed ethnic profile data but unfortunately we don't control this data locally. However we have invested in a Population Health system that will enable us to see and use much more detailed information locally.*
- Health inequalities and access to a GP not being listed in the presentation as a barrier. Often people from ethnic minorities don't feel welcome, not that they don't have the time to attend. *The response acknowledged that we do still have much to learn and that this is the purpose of the event and the discussions.*

- Need to provide more opportunities for people to stay healthy in their communities. *The response covered that this is also one of the aims of the forum to discuss what can be done in partnership with communities. Also the Greenwich Healthier Communities Fund which was about to launch and will provide £1m of funding to small community groups every year for the next five (NHS Greenwich Charitable Funds) with the aim of reducing inequalities.*
- People shared how cancer has touched them and some felt that the effects of the treatment outweighed the benefits, especially as often cancer came back. *The response included that it is always best to identify and treat a cancer as early as possible and that there are constantly new treatments being developed. There are things that people can do to help reduce the risk of cancers reoccurring and this is less likely if the first diagnosis is very early.*
- One participant highlighted the National BRCA gene testing programme to identify cancer risk early amongst people of Jewish ancestry.

The presentation was followed by two breakout focus groups: One face-to-face and one online. The main points for discussion were:

1. What do you think stops people attending their screening appointments for cancer?
2. What do you think might help people like you attend for screening? What do you know has worked for others?
3. How can we work with you to tackle cancer? An example could be community cancer champions.

**Summary Themes**

- More awareness and culturally appropriate information around what getting screened involves in terms of the process.
- Accessibility of screening venues for those who are not mobile.
- Need better data when it comes to inequalities
- Need a better understanding of the barriers – what stops people accessing screening and other services (eg GP Practices)?
- Suggestion of screening buses or mobile units so people can get screened in various parts of the borough.
- Knowledge of up to date, relevant and trusted information to disseminate to groups and local communities around cancer in the form of training and or resources.
- Local cancer community champions programme is a good idea.
- The best people to spread the word about screening and cancer awareness are those from local communities and those who have contact with people through local groups.
- Engage with people through existing local groups.

- More support for people to eat healthy and stay healthy in the form of group activities within communities - the link to the Healthier Greenwich Communities fund was discussed.

**Detailed discussion points**

**Why are people not attending screening?**

- There is a fear amongst people around getting screened, there needs to be more information about the process to dispel fears.
- There is also a fear about receiving a diagnosis and what people need to do next, how will it affect their lives, jobs etc.
- Thinking about accessibility what about people with limited mobility? Can some screening be done at home?
- Is there such a thing such as a screening bus that can travel around the brough offering screening tests?
- It was discussed that there was a lung cancer screening bus but that was by invite only
- A Plumstead and Glyndon delivery team member spoke about her work within the community and felt there needed to be more awareness in the Black, African, and Caribbean and Nepalese and Chinese communities around screening for cancer. She felt that having the right information and messages to disseminate to these groups was important for her when having these conversations. It could be as simple as a basic cancer awareness training for those working in the community.
- It would be good to have a promotional campaign that we could help boost and spread the word about cancer. Staff mentioned the Breast Screening campaign and engagement work that will take place in groups around the borough.
- A lack of access to GP appointments was also identified as a barrier for people in making that first step to get screened if they thought there was a problem.
- People felt that lots of appointments are only made available on an app. Some people prefer the telephone or making an appointment at the desk in person.
- Inequalities when accessing GP services and other services. This can be due to language barriers, cultural understanding and people not being made to feel welcome.

**What might help people attend screening? What has worked for others?**

- Encouraging a friend or family member to go along with them.
- Could there be a ‘buddy’ scheme for people who do not have friends or family to accompany them?

- Cancer champions in local communities who can reassure, support, signpost and provide information
- Vouchers or an incentive for completing a screening test
- Clearer information on the screening process and what it involves, in culturally appropriate formats
- Explain what the procedure involves and that you are a person not an object.
- Making screening venues welcoming, and accessible. People with disabilities can avoid screening as they anticipate that the venues won't be accessible.
- Make screening procedures more comfortable (eg with breast screening women who have larger cup sizes can find screening uncomfortable) also for some procedures poorly fitting gowns are supplied.

**How can we work with you tackle cancer?**

- Link into existing community groups so they may spread the word with the right information.
- The best person to deliver this to the groups would be local people who are trained such as cancer champions. They could also help to reassure people as it can be very scary to get a diagnosis. There are financial and relational costs, plus there is still a stigma attached.
- A presentation by a clinician on cancer at community venues
- Giving the local community real stats on cancer prevalence and screening uptake in their area to raise awareness in general.
- Attending the council organised Greenwich Borough wide meetings to talk about cancer.
- Greenwich cycling co-ordinator mentioned that it would be good to have tackling cancer stay healthy messages as part of his cycling group.
- Its often harder to make links with men around their health. Cycling groups and other activities are a fantastic opportunity to talk to men about their health.
- More awareness around the HPV vaccines, how they can be accessed and more awareness amongst men who have sex with men around the importance of getting vaccinated.
- There were myths around the COVID vaccine and cancer. More work needs to be done to dispel myths.
- More support for people to eat healthy and stay healthy in the form of group activities within communities - the link to the Healthier Greenwich Communities Fund was discussed.
- Include spirituality when sharing coping mechanisms.
- More cancer prevention information such as understanding what carcinogens are.
- More information in local papers around cancer prevention and screening.
- More events like the recent successful cancer awareness event for carers

## Feedback from participants

Out of 11 people who attended the Public Forum 8 completed our feedback form. 3 people who attended in person completed a form and 5 people completed a form online. Of the 5 people who completed it online they were able to hear and see the speakers and participate fully.

Feedback indicated that taking part in the Public Forum was a positive experience and that participants' knowledge around understanding of cancer and how to tackle it was better after the event.

The results reflected that more female participants that took part with 1 male in attendance. The results reflected some diversity of the audience with Black African and Black Caribbean attendees taking part (however there was nobody in attendance from other ethnic groups e.g. South Asian) For this forum there were a mix of age ranges taking part and we heard from people with physical disabilities and long-term health conditions and carers.

Some of the key results are included below:

**To what extent do you agree with the following?**

| | Agree | Somewhat agree | Neither agree nor disagree | Somewhat disagree | Definitely disagree |
|---|---|---|---|---|---|
| I could hear the speakers (both online and in the room) | **5** | **3** | | | |
| I could see the slides and the people speaking | **5** | **3** | | | |
| West Greenwich Community Centre is a convenient and accessible location for me | **3** | | | | |

**How would you rate your knowledge of Cancer in Greenwich before and after the event?**

| | 1. Very poor | 2. Poor | 3. Neutral | 4. Good | 5. Excellent |
|---|---|---|---|---|---|
| Before | | | **3** | **5** | |
| After | | | | **2** | **6** |

Average score before = 3.63 Average score after = 4.75

**How would you rate your knowledge of Healthier Greenwich Partnership before and after the event?**

| | 1. Very poor | 2. Poor | 3. Neutral | 4. Good | 5. Excellent |
|---|---|---|---|---|---|
| **Before** | | **1** | **2** | **4** | **1** |
| **After** | | | **2** | **3** | **3** |

Average score before = 3.63 Average score after = 4.13

**Overall, how would you rate your experience of the Healthier Greenwich Partnership Public Forum?**

| 1. Very poor | 2. Poor | 3. Neutral | 4. Good | 5. Excellent |
|---|---|---|---|---|
| | | | **2** | **6** |

**What topics would you like to see included in future Healthier Greenwich Partnership Public Forum sessions?**

- GP services and appointments
- There is now a growing population of children and young people with autism, ADHD and other learning need but there lack of awareness, assessment, early diagnosis and support for family with autistic children and also lack of reference for adult that have has sign of autism, ADHD, Dyslexic, and Dyspraxia
- Simpler and data rich information on the health inequality as per ethnicity concerning cancer in Greenwich.
- Autism and ADHD

**Other feedback provided**

- It is important to pay people for their time in attending meeting and workshop like this as their contribution and community knowledge and lived experience is valuable to this research and outcomes.
- The venue was very nice.

**Learning Points**

**Venue** – The venue had good meeting facilities and was in the heart of West Greenwich next to the main line Greenwich station and residential areas around opposite the centre. The Greenwich West Community Centre have many groups/classes that take place there with local residents and the team based there also work around engaging the local community.

**Attendance** - 11 people had signed up to attend online and 15 people had signed up to attend in person, however there we are a large number of no shows with 2 people emailing in to say they can no longer attend. There is more work to be done to make and keep connections in the West Greenwich area. The previous HGP forum was

held in an area where a community delivery team has established for almost a year, and this helped to spread the word amongst local residents and groups.

**Promotion** - In the lead up to the event the forum was promoted widely on the Let's Talk website and on the ICS website. The Greenwich Info resident's newsletter, the community champions bulletin and WhatsApp group, on X (formerly Twitter). The forum was promoted in the weeks leading up to the event via talking to people in the area and handing out flyers to people.

Flyers were distributed and displayed at West Greenwich Community centre, and we spoke to the team there about spreading the word to groups that take place there. Flyers were left in local cafes and hairdressers in West Greenwich. We spoke to faith groups about the forum including Woolwich Gurdwara and Plumstead mosque. Flyers were left at Greenwich Centre Library and leisure centre and Woolwich Library.

Electronic flyers were sent via our extensive resident, practice manager and local community groups, council staff contact lists. We also used neighbourhood links to promote the forum such as Horn Park resident newsletter and WhatsApp group, Plumstead and Glyndon email and WhatsApp group, Blackheath and Charlton delivery team and Calestock estate WhatsApp group.

**Theme** – we have seen lower attendance at events that focus on specific diseases (cancer, cardiovascular disease) than those which focus on more general areas eg neighbourhood working.

**Timing** – The timing of this meeting was 5.30pm to 7.30pm. The previous meeting was also held at this time due to the winter months. However a later start time has previously seen higher attendance.

**Next Public Forum** – We are looking at venues and dates for the next Public Forum which will be held in early July with a theme to be agreed.

AGENDA ITEM: 8

# Healthier Greenwich Partnership

**Date: 24th April 2024**

| | | |
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| **Title** | *Greenwich ATEC Programme* | |
| This paper is for **noting and approval** | | |
| Executive Summary | • Royal Borough of Greenwich adult social care and ICS are investing in an extended Assistive Technology Enabled Care offer in 2024/25 and beyond to enable people to live more independently at home.<br>• This joint approach to technology will deliver demand and financial benefits to the NHS and social care system through enhanced independence, self-care, and early intervention. Priority cohorts for the first phase roll out include people who are moderately / severely frail, people eligible for CHC and specific Adult Social care cohorts. | |
| Recommended action for the Committee | • To approve the assistive technology enabled care service model and integrated commissioning approach. | |
| Potential Conflicts of Interest | • There are no specific conflicts of interest identified. | |
| | | |
| Impacts of this proposal | Key risks & mitigations | • There are no specific risks in relation to this board. Risks for the programme are managed by the ATEC Programme Board and SROs and there are none which are relevant to this forum at this time. |
| | Equality impact | • An equality impact assessment is being carried out as required by the key decision to be made by the Royal Borough of Greenwich Cabinet. This will be presented when the final service proposal is taken for approval to Cabinet in June.<br>• We believe that this programme will have a positive impact on equalities in the borough, as it opens access to high quality, modernised health and social care to those who may face barriers to access. The data available from the devices will also enable us to better target |

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| | | interventions for those who face inequalities or inequities in relation to access to services.<br>• The programme has undertaken significant engagement work with local communities throughout the borough, to ensure there is a diverse input into the design of the new service. Through this work we hope to actively break through barriers to accessing health and reduce barriers to accessing health and social care and consequently reduce health inequalities. |
| | Financial impact | • Extensive cost and benefit modelling has been carried out to ensure robust decision making with regards to introducing this new service.<br>• This work has identified opportunities for cost avoidances in health and social care budgets should this new service be implemented.<br>• Further details are shared in the main slide deck, key elements of which are to be presented in the meeting. |
| | | |
| Wider support for this proposal | Public Engagement | • To date we have engaged with over 200 residents and local people on this new service. This engagement has taken different forms, from interviews, to more engaged workshops, as well as regular meetings with a dedicated resident design group.<br>• We have also carried out a formal public consultation as part of the legal requirements of Royal Borough of Greenwich's constitution. The results of which will be taken to Cabinet in June. |
| | Other Committee Discussion/ Internal Engagement | • Regular updates and discussions have taken place across a range of Forums including the HGP Exec group.<br>• This item has previously been presented to the Joint Commissioning Board on 7th March. JCB have already had a presentation of the proposed approach and signalled their approval to proceed ahead of HGP |
| Author: | *Caleb Assirati (RBG, HAS), Rethink Partners (External), Lisa Wilson* | |

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| Clinical lead: | *Rachel Matheson – CCPL* |
| Executive sponsor: | *Lisa Wilson- Integrated Director of Commissioning – Adults & Kit Collingwood – Assistant Director Digital and Customer Services RBG* |

# ATEC DECISION - HGP

April 2024

# CONTENTS

# 1. VISION – CO-DESIGNED WITH RESIDENTS & STAFF

**A joint NHS and Royal Borough of Greenwich ATEC service that transforms how health and social care is delivered.**

This is a culture change programme that is using digital to enable new models of care. A successful ATEC service will support:

| Residents | Practitioners | Families | Partners |
|---|---|---|---|
| ✓ Live their best life independently.<br>✓ Use technology daily to stay well at home.<br>✓ Enjoy technology in their lives.<br>✓ Recommend it to others. | ✓ Focus on people first and their strengths.<br>✓ Are confident in recommending technology as part of care and support.<br>✓ Are enthusiastic about technology to improve lives.<br>✓ Offer technology routinely. | ✓ Have peace of mind that their loved one is safe and well.<br>✓ Use technologies to keep in touch and check-in.<br>✓ Help support the person to use the technology.<br>✓ Recommend it to others. | ✓ Use ATEC to support their services and teams, to join up care.<br>✓ Engage with the technology.<br>✓ Experience benefits of technology enabled care. |

# 2. DRIVERS AND THE CASE FOR CHANGE

**Nationally, Assistive Technology Enabled Care (ATEC) is supporting:**

- ✓ Councils to achieve their wider social care aims of improved quality, experience and efficiency.
- ✓ Improved joint health and social care working to improve holistic health and care experience for people, carers and staff.
- ✓ Wider ICS/system aims of improving outcomes in population health and health care, tackling inequalities, enhancing productivity and value for money and support broader social and economic development.
- ✓ Technology and digitisation aims as set out in the The Adult Social Care (ASC) White Paper "People at the heart of Care", NHS priorities and other national policy.
- ✓ CQC assurance – CQC looking for strong ATEC offer in councils as part of good practice.

Forward thinking councils are now investing in transformational ATEC programmes to improve outcomes and generate financial and demand benefits. Evidence from elsewhere shows an ROI of £3 of benefit for £1 invested (see appendix for exemplars from elsewhere).

# 3. BACKGROUND & HOW WE GOT HERE

RBG ATEC JOURNEY SO FAR: SEPTEMBER '22 – APRIL '23

## Discovery: understanding people's views & experience

Worked with sponsors and project leads to map stakeholder organisations and people across the health and care ecosystem and iterated this as we went along – building out contacts and networks as we went.

- Speaking to the less obvious people who may see things from a unique perspective and gather soft intelligence – spotting people and organisations who could collaborate over the longer term.
- Baselined starting point, engaging with over 200 local people both face to face and online. Roughly 50/50 residents and staff and we began to understand their attitudes, beliefs, assets, capabilities, gaps, fears and biases about using technology for independence.
- 1:1 conversations with stakeholders to understand appetite, confidence, strategic fit and readiness for a next generation ATEC offer (including the current local offer) and focus groups with key practitioner groups to baseline and understand the current approach to ATEC.

## Co-production: developing, testing & refining ideas

Building on strengths and needs identified in the discovery phase, we used the next stage to socialise and test ideas – setting out the ambition – through a range of co-production activities including workshops and smaller group work with key colleagues.

We held 3 in-person workshops with staff to co-produce and final vision, roadmap, target operating model, report and other supporting materials.

1. **Workshop 1:** People, outcomes and technology
2. **Workshop 2:** Practice and workforce culture
3. **Workshop 3:** Vision into action

We drew in expertise and connections to other councils and national intelligence on the art of the possible, market intelligence, next-gen technology – allowing colleagues at RBG to explore conversations with peers delivering best-in-class ATEC services.

**Residents & communities**
92 convos,
1 focus group,
4 pen portraits

**Staff**
94 convos across 12 teams,
9 focus groups

**Leadership**
20 leader conversations (internal & external)

**Current tech/Telecare offer**
10 convos
1 day spent with service

**Care provision**
inhouse and external

**Design workshops with staff**
c. 75 people

# 3. BACKGROUND & HOW WE GOT HERE

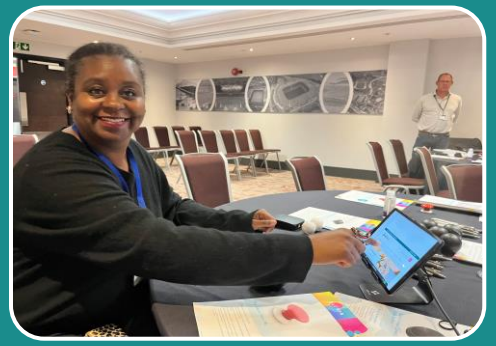
## RBG ATEC JOURNEY SO FAR: JUNE '23 – JANUARY '24

Developing the council's plans with staff and residents in greater detail.

Co-designing with staff and residents to build a sustainable model that can flex to need.

Working in an integrated way with health colleagues to progress co-commissioning and funding: integrated governance, programme office and workstreams established.

Detailed discovery with NHS to understand opportunities and challenges for health and integration with social care.



### CO-CREATION

Co-production with staff to designing the service

Co-production with residents to design the service

Culture change planning to support staff and residents

### SERVICE MODEL

Operating model

Benefits and outcomes model

Technology offer – matched to outcomes

Data and interoperability

Impact modelling

### PRIORITIES

Commitment and funding

Scope, phasing and eligibility

Creating a sustainable co-production model

Understanding how to deliver this programme

rethink partners

NHS South East London

ROYAL borough of GREENWICH

# 4. RESIDENT PERSPECTIVES

## Resident perspectives

- Don't underestimate our appetite and capability.
- Start with what is meaningful and purposeful for us.
- Wider inclusion impacts digital inclusion.
- Technology must be personal, adaptive and accessible – for everyone.
- Language is important; tell us your plans simply and clearly.

1 "Yes, we have varied needs and varied levels of confidence but we are up for new things."

2 "Find what we are interested in and start there."

3 "It isn't digital inclusion it is just inclusion."

4 "Say what you mean. We don't need fancy terminology."

rethink partners

NHS South East London

ROYAL borough of GREENWICH

# 5. STAFF PERSPECTIVES

## Staff perspectives

- Staff see the opportunity that an enhanced ATEC offer would present and have an appetite to use ATEC as part of their work. Confidence varies within and across teams.
- The ATEC operating model needs to provide support to staff, training, support to change practice and clear roles and responsibilities.
- It needs to be simple and easy for staff to recommend ATEC to people; they want to have confidence that the service and technology is good quality and personalised to meet people's needs.

1. "If you have a robust technology offer some people may not need care."
2. "You can't be expert at everything ...so bring in people who are."
3. "...in nearly 2023 there is all this technology that people use every day like Alexas etc but we just have the telecare offer in RBG. There is so much more."

# 6. JOINT NHS AND RBG VOICE & DECISION MAKING

**Purpose: Partnership decision making**

- Healthier Greenwich Partnership (HGP)
- Joint Commissioning Board (JCB)
- Integrated Leadership Meeting HAS (ILM)

## ATEC PROGRAMME BOARD
– monthly –

**PURPOSE**

- Overall programme responsibility & ownership
- Formal delivery sign off
- Escalation point for programme risks and issues

## ATEC TEAM HUDDLE
– weekly –

**PURPOSE**

- Project momentum
- Programme office activities
- Programme delivery tracking

### Wider resident engagement

**PURPOSE**

Broader, iterative, inclusive engagement with local residents.

Building in diverse voices from local community.

Working with established groups and also seeking new connections.

### ATEC Resident Design Group

**PURPOSE**

Local people as design/decision-makers for emerging service to ensure it meets needs of local residents and carers.

Key responsibility to ensure model is grounded in lived experience and need.

### ATEC Operations Design Group

**PURPOSE**

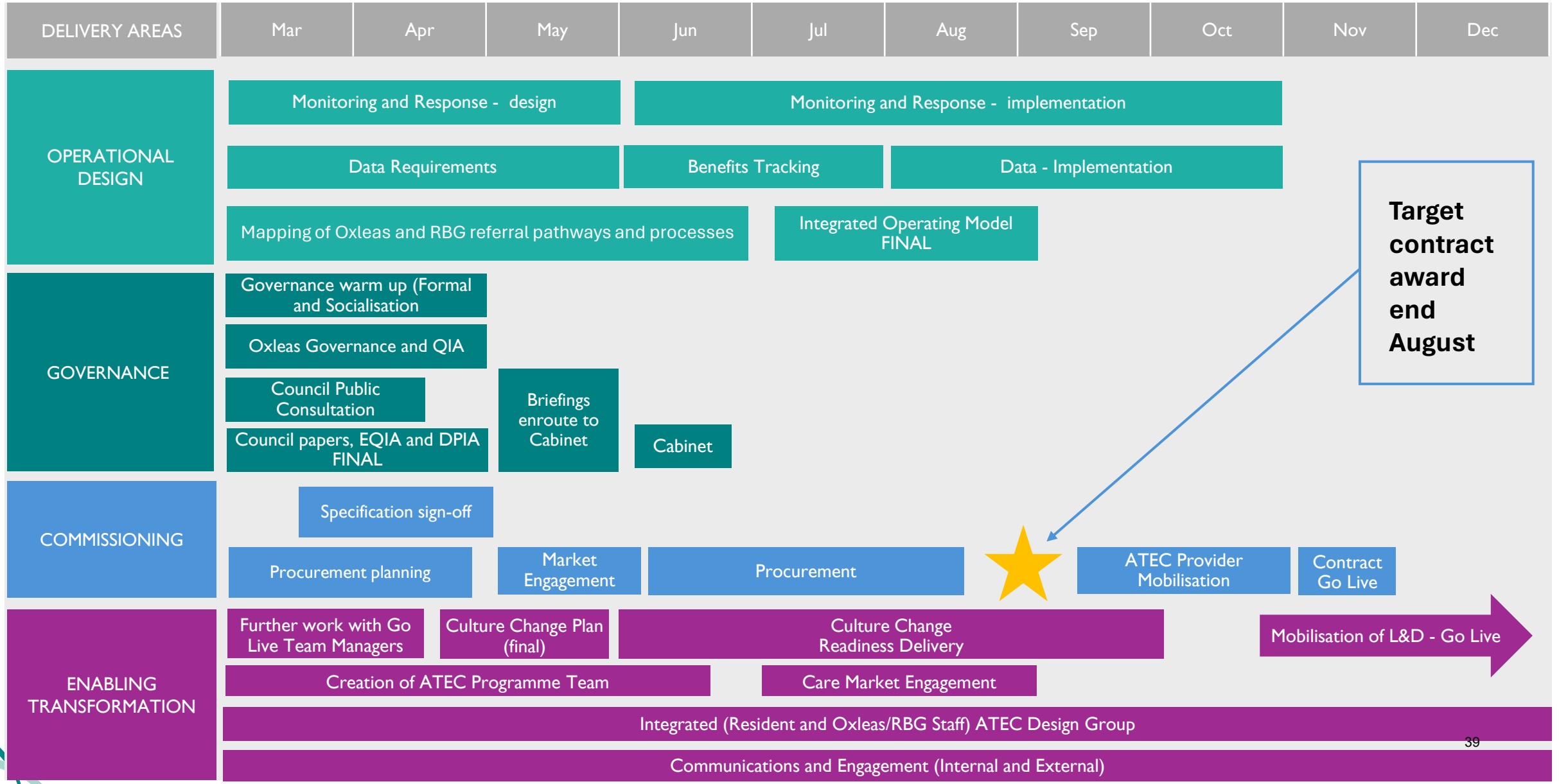
Staff as design/decision-makers for emerging service to ensure it meets needs of staff and operations.

Key responsibility to ensure model is grounded in practice and delivery.

**Workstreams**

1. Programme Delivery
2. Co-Production
3. Comms & Engagement
4. Culture & L&D
5. Operational Design
6. Service Delivery

# 7. GREENWICH ATEC PROGRAMME PLAN 2024



# 8. THE ATEC SERVICE MODEL

# RESIDENT OUTCOMES FRAMEWORK

**Care act outcomes**

- Managing and maintaining nutrition
- Maintaining personal hygiene
- Managing toileting needs
- Being appropriately clothed
- Being able to make use of the adults home safely
- Maintaining a habitable home environment
- Developing and maintaining family or other personal relationship
- Accessing and engaging in work, training, education or volunteering
- Making use of necessary facilities or services in the local community, including public transport, and recreational facilities or services
- Carrying out any caring responsibilities the adult has for a child

All areas of the outcomes framework map to the Care Act Outcomes.

Personalised outcomes relating to people's health will also be tracked for CHC and Frailty.

## Emotional wellbeing

- Social connection.
- Increased self-esteem.
- Provide mental stimulation.
- Peace of mind.
- Increased confidence.
- Build relationships.
- Reduce stress and anxiety. Promote good mental wellbeing.
- Fun and entertainment.
- Enhanced communication.
- Enhanced quality of life.
- Prevent carer breakdown.

## Safety

- Feel safe and supported.
- Track changes indicating a crisis.
- Reduce risk or impact of falls.
- Maintain a good home environment.
- Provide a secure home environment.
- Reduce hate crime.
- Protection from avoidable harm.
- Reduce safeguarding alerts.
- Reduce wandering risk.

## Physical wellbeing

- Prevent premature deaths.
- Improve health and wellbeing.
- Identify early deterioration.
- Stay healthy.
- Encourage healthy living.
- Aid recovery from illness.
- Support to manage long term health conditions.
- Keep active.

## Activities of daily living

- Manage nutrition and food preparation.
- Manage medication.
- Provide help with the caring role.
- Access information about available solutions.
- Make activities of daily living simpler.

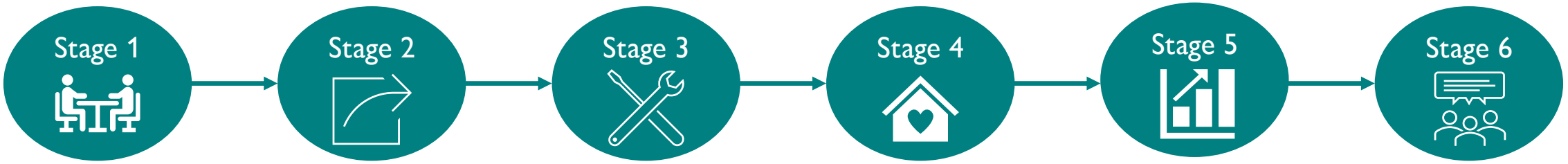
## Living independently at home

- Enable earlier intervention.
- Maintain independence.
- Avoid hospital admission.
- Facilitate early intervention to prevent a move to care home.
- Reduce length of hospital stay.
- Reduced need for care and support at home.
- Improved contingency planning.
- Enable carer respite.

## Choice and control

- Positive experience of care.
- Power sharing with HAS practitioners.
- Control over daily life and care.
- Receive a proactive and predictive service using data.
- Choice and control over when and how care is delivered.

# ATEC CUSTOMER JOURNEY




**1. Opportunity for ATEC identified**

Early strengths – based conversations with residents.

Sign posted or referred for assessment for ATEC.

**2. Personalised Assessment**

Holistic assessment placed on core system by practitioner.

Selection of technology to achieve health & care outcomes.

Tech referral sent to ATEC service through core system Rio/Mosaic.

**3. ATEC is provided**

Technology is sourced and installed by provider.

Reviewed by provider after 7 days.

Monitoring and response service set up (where required).

**4. People using ATEC everyday to live independently**

Residents are able to receive a monitoring service 24/7 365 days a year with an emergency response option by Telecare/JET.

Routine health device monitoring is performed by the monitoring provider and escalated when required.

**5. Data from devices is monitored routinely to enhance outcomes; immediate and long term**

Data is monitored routinely and reviewed by the monitoring team, practitioner, care provider or other at agreed frequency/as specified. Appropriate action follows.

Immediate alerts are forwarded to emergency response team and friends and family as a first option.

**6. Review and refresh of ATEC**

Technology is reviewed as part of any standard review or assessment; data reviews are undertaken periodically.

ATEC is refreshed or removed and reissued to other people.

Technology offer is updated regularly.

# DELIVERY MODEL: ROLES AND RESPONSIBILITIES

**ATEC Programme Team: Key responsibilities**
- Programme oversight and delivery including coproduction with residents and liaising with Care Market
- Procurement, contract monitoring and service performance including benefits tracking
- 3 x specialist practitioners supporting tech adoption

**Points of entry for People – ASC:**
- Front Door
- Discharge pathways
- Community teams

**Points of entry for People – NHS:**
- NHS SPA and JET
- Frailty cohort
- CHC team
- Partner services: Primary care, Virtual wards

**Key responsibilities**
- Early conversation
- Signposting/referral

**Adult Social Care/ Children's (Transitions)/ NHS Teams – all:**
**Key responsibilities**
- Consider appropriate use of technology as part of day-to-day work
- Identify priority outcomes for people
- Care technology embedded in practice models
- Match technology to needs where possible – seek advice/help when needed

Partnership approach to tech assessment and installation between practitioners and ATEC provider

**ATEC Service Provider:**
**Key responsibilities**
- Sourcing and supply of technology
- Arrange home visits for installation
- Co-produced technology innovation/service improvement
- Maintenance, decommissioning of tech
- Technical support for people/reviews
- Performance reporting

**Culture Change Team/Service:**
**Key responsibilities**
- Training and education of social care workforce recommending technology
- Training and education of people and partners signposting for technology
- Development of champions
- Other culture change activities to support take-up/embed in practice
- Communications

In house monitoring and response model

**Monitoring Team/Service:**
**Key responsibilities**
- Monitor requests for help/support
- Monitor urgent data alerts

**Data Team:**
**Key responsibilities**
- Interpret data

**Joint Responder Team/ Service:**
**Key responsibilities**
- Attend calls in people's homes as required
- Preventing ambulance attendance

Greenwich In-house | Joint Social Care/NHS | Service Provider | Rethink Partners

# TECHNOLOGY OFFER

| AREA | Tech devices |
|---|---|
| **Health and Social Care** | • Falls wearables<br>• Falls identification devices (i.e. radar)<br>• Video calling technology<br>• Remote monitoring (sensors)<br>• GPS trackers<br>• Smart speakers and home automation<br>• Bed and chair sensors<br>• Incontinence (enuresis) sensors<br>• Connection/social tools<br>• Tiered medication reminders<br>• Epilepsy sensors<br>• Oxygen sats level monitoring<br>• Blood pressure monitoring<br>• Medication dispensers<br>• Virtual medication reminder calls<br>• Hydration Monitoring |
| **CHC specialist categories** | • Tech which can be tailored to individual needs, incl. MND and spinal injuries<br>• Future integration of ATEC with AAC and eye gaze technology |

# SCOPE & PHASING – GO LIVE > 12 MONTHS

| PRIORITY RESIDENTS | TEAMS, SERVICES AND PATHWAYS | RATIONALE FOR PHASING |
|---|---|---|
| • Adults with learning disabilities living in the community or in supported living accommodation<br>• Older people who are eligible for social care living in the community.<br>• People receiving services under continuing healthcare funding.<br>• People leaving hospital (pathways 0 and 1 priority).<br>• People known to services who are at risk of needing more care and support such as:<br>  • People at risk of being admitted to hospital<br>  • People who are being considered for residential care<br>  • Other people in crisis<br>  • Adults who have fallen or who are at risk of falling<br>• People who are moderately or severely frail and are in contact with Oxleas services to meet their needs; this will include:<br>  • People identified as being moderately or severely frail (principally by PCNs)<br>  • People with neurological conditions, e.g. Multiple Sclerosis, Stroke, rare, progressive and complex neurological conditions<br>• People living with dementia and other related conditions. | • CLDT (LD)<br>• Reablement<br>• CRSTAT<br>• OT and Sensory<br>• CAIT<br>• HIDT<br>• Reviewing<br><br>• CHC<br>• Frailty team<br>• JET<br>• Neuro<br>• Falls team<br>• Older adult community mental health (memory service)<br>• Care Navigators (Oxleas) | • Priority services and residents have good use cases for improving outcomes and generating benefits for the council.<br>• Teams are in good states of readiness.<br>• Joint health and social care teams and links to NHS priority areas and outcomes. |

# SCOPE & PHASING – FAST FOLLOWERS

| PRIORITY RESIDENTS | TEAMS, SERVICES AND PATHWAYS | RATIONALE FOR PHASING |
|---|---|---|
| • Young people with a disability or long-term health need preparing to transition to adulthood.<br>• Residents who access day care facilities for respite<br>• People who require specialised housing to support the needs of older people and people with disabilities.<br>• Residents at risk of having to go into residential or nursing home care.<br>• People who access direct payments for services, self-funders and those who access personal health budgets.<br>• Adults with hearing/sight loss or other sensory impairment.<br>• Adults and older people with complex social care needs.<br>• Adults with a limitation on their physical functioning, mobility, dexterity or stamina.<br>• People with a chronic obstructive pulmonary disease.<br>• Residents requiring a cardiac rehabilitation service.<br>• Older people living with mental health conditions | • Complex CT<br>• Transitions<br>• DP/Brokerage/NRPF<br>• Physical disability<br>• CAT<br><br>• District nursing<br>• Single Point of Access (NHS)<br>• COPD<br>• Cardiac<br>• D2A therapy<br>• Older adult community mental health | • Greater complexity within these areas linked to data, funding streams, operating model or benefits realisation.<br>• Continue to expand across ASC as the next fast followers so that there is equitable access for everyone. |

# SCOPE & PHASING – FUTURE (AS FUNDING AGREED)

| PRIORITY RESIDENTS | TEAMS, SERVICES AND PATHWAYS | RATIONALE FOR PHASING |
|---|---|---|
| • Residents with requirements to prevent, delay or reduce the need for care and support in the local area.<br>• Adult prison inmates with social care needs.<br>• Adults who require care and accommodation for support needs in a shared housing arrangement.<br>• Unpaid carers who require help to continue in their role.<br>• Young people with care and support needs.<br>• Adults who live in Greenwich council owned properties plus residents who are accessing grant funding for home adaptations.<br>• Adults accessing residential and nursing care facilities.<br>• Working age adults who require support for mental health issues.<br>• People who are in the last months or years of their life.<br>• Residents accessing primary care services. | • Wider prevention activities<br>• Prison Social Care Assessment Team<br>• Shared Lives<br>• Carers<br>• Children's Social Care<br>• Housing<br>• Public Health<br><br>• Residential and Nursing – Residents<br>• Care Providers<br>• Acute Hospital Trust<br>• Broader health teams (+ health devices)<br>• Working age MH (social care)<br>• End of life care (hospice)<br>• Primary care | • Funding and use cases not currently defined or agreed for these areas. Additional work needed. |

# 9. IMPACT MODEL - BACKGROUND

- Over the past 6 months, we developed a model that enables us to explore the potential **impact of the new ATEC service** and the **costs required to deliver this**.
- The model explores how ATEC could reduce: (i) **care package costs for ASC and NHS clients**; (ii) **demand for residential and nursing care**; and (iii) **inpatient admissions**. It then estimates the potential **net benefit** of the combined impacts and costs over a 10-year period.
- The purpose of the modelling was to **help the ATEC Programme Board assess** whether the expected benefits of the new service justified the associated investment and on-going delivery costs. To achieve this, we have used **cautious assumptions** in calculating both benefits and costs. As a result, the benefits are likely to be **underestimated**, while the costs may be **overestimated**.

**ASC client groups** in-scope of the modelling include:

- Home Care
- Learning & Physical disabilities
- Mental Health
- Reablement
- Direct payments
- Residential & Nursing Care

And the **NHS client groups** include:

- Frailty inpatient admissions
- CHC

# 9. IMPACT MODEL | ASC BENEFITS

- Total gross ASC benefits are estimated to be **£51 million** over 10 years.
- Gross benefits in Year 1 (Oct 24 – Mar 25) are estimated to be **£390,000**. This increases to **£5.7 million** in Year 5 following the continued roll-out and increased uptake of ATEC across different client groups.

**ASC benefits modelled include:**

- reduced spending on **Home Care**
- reduced spending on **Reablement / Hospital**
- reduced spending on **Direct Payments**
- reduced spending on **Supported Living**
- reduced demand for **Residential & Nursing Care**

| Year | Home Care | Hosptial Discharge | Direct Payments | Supported Living | Res/Nur Care |
|---|---|---|---|---|---|
| Year 1* | £370,000 | £22,000 | £- | £- | £- |
| Year 2 | £585,000 | £68,000 | £115,000 | £20,000 | £2,000,000 |
| Year 3 | £1,110,000 | £114,000 | £375,000 | £60,000 | £2,300,000 |
| Year 4 | £1,460,000 | £162,000 | £670,000 | £100,000 | £2,500,000 |
| Year 5 | £1,750,000 | £164,000 | £974,000 | £120,000 | £2,650,000 |
| ... | ... | ... | ... | ... | ... |
| Year 10 | £2,200,000 | £170,000 | £1,480,000 | £120,000 | £3,120,000 |
| **Total** | **£15,800,000** | **£1,350,000** | **£9,260,000** | **£900,000** | **£24,300,000** |

***NB:** Only 6 months

*Figures rounded to nearest 000*

# 9. IMPACT MODEL | FRAILTY AND CHC BENEFITS

## Frailty Benefits

ATEC could reduce the percentage of frailty* in-patient admissions by **8.1%**. This reduction has been modelled for both **moderate** and **severe** frailty admissions.

- We have assumed a **10% reduction in admissions due to ATEC** derived from the number of ATEC users, which increases from 120 to 360 over 3 years.
- The average cost of an admission is **£3,567** for moderate frailty and **£4,016** for severe. Over 10 years, the value of all avoided admissions could be **£1.2 million**.

## CHC Benefits

Total gross cost avoidance benefits estimated to be **£9.1 million** over 10-years

- Gross benefits calculated based on an assumed uptake of ATEC, starting with **15 clients in Year 1**, and increasing to **60 clients by Year 4**. These are split between Learning Disability and Physical Disability care groups
- ATEC assumed to **reduce care costs by 10%** for users. Average care costs are estimated to be **£3,926** for LD clients and **£2,657** for PD clients.

# 9. IMPACT MODEL | PROGRAMME COSTS

- Total ATEC Programme costs are estimated to be around **£24.3 million** over a 10-year period. This is split between £17.3 million on **supplier costs** and £7 million on **internal RBG costs**.
- The **total Year 1 costs** are estimated to be around **£1 million**. These increase to **£2.7 million in Year 5** as the service is rolled-out and the uptake of ATEC increases. From Year 6, cost increases are modest and are primarily driven by population growth pressures and demand for ATEC stabilises.

**Modelled programme spending include:**

**Supplier costs**

- A: Programme delivery
- B: Direct costs
- C: Innovation & service development

**RBG costs**

- D: Monitoring & response costs
- E: Internal costs

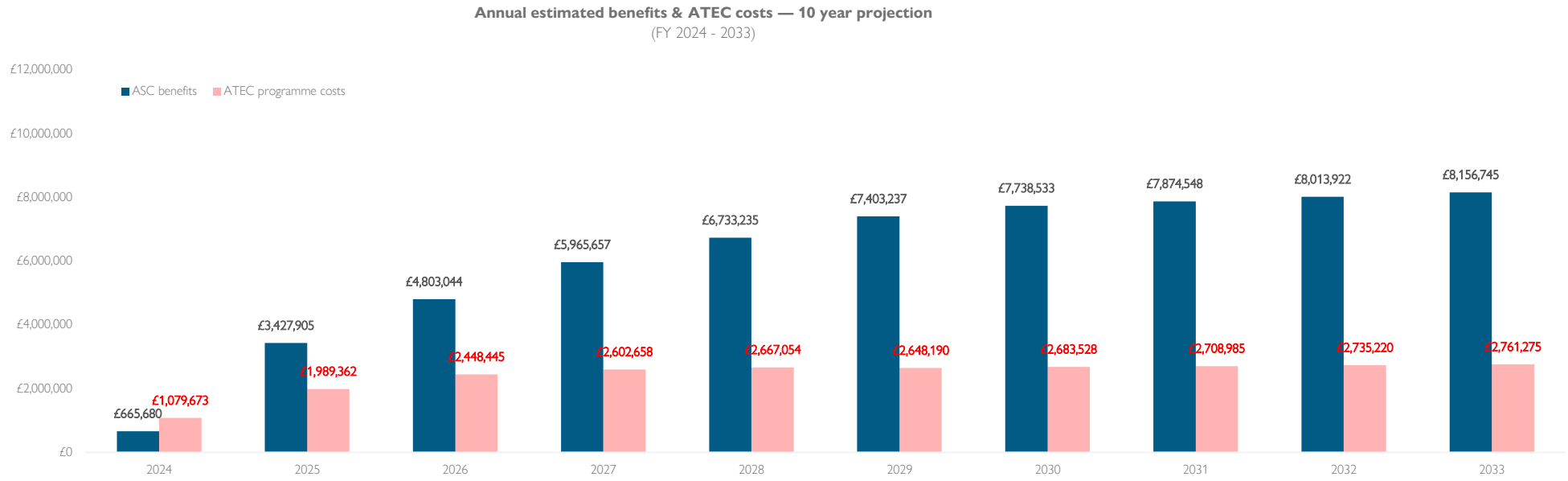
| Year | A: Programme delivery | B: Direct costs | C: Innovation | D: Monitoring** | E: Internal costs | Total |
|---|---|---|---|---|---|---|
| Year 1* | £348,000 | £436,000 | £- | £95,000 | £200,000 | **£1,079,000** |
| Year 2 | £186,000 | £973,000 | £200,000 | £230,000 | £400,000 | **£1,989,000** |
| Year 3 | £186,000 | £1,376,000 | £200,000 | £287,000 | £400,000 | **£2,449,000** |
| Year 4 | £186,000 | £1,600,000 | £100,000 | £318,000 | £400,000 | **£2,604,000** |
| Year 5 | £93,000 | £1,753,000 | £75,000 | £346,000 | £400,000 | **£2,667,000** |
| … | … | … | … | … | … | **…** |
| Year 10 | £- | £1,970,000 | £- | £392,000 | £400,000 | **£276,2000** |
| **Total** | **£1,000,000** | **£15,800,000** | **£575,000** | **£3,191,000** | **£3,800,000** | **£24,366,000** |

***NB:** Only 6 months

****NB:** This only includes new response costs. The programme will benefit from existing telecare staff being redirected to the ATEC service.

# 9. IMPACT MODEL | NET BENEFITS

- Total **net benefit** of the ATEC Programme is estimated to be **approx. £36 million** over a 10-year period
- The programme is expected to deliver a **net benefit in Year 2** of delivery**.** By Year 5, the total benefits are expected to **double** the total costs.
- If the **NHS benefits are excluded** from the modelling, the total net benefit decreases to £27 million (over 10 years). The ATEC programme should still break-even in Year 2, and from Year 3, it is expected to deliver annual net benefits.



# 9. IMPACT MODEL | SUMMARY TABLE

| Year | ASC Benefits | NHS Benefits | Total Costs | Net Benefit | Net Benefit<br>ASC benefits only |
|---|---|---|---|---|---|
| Year 1* | £392,000 | £274,000 | (£1,079,000) | (£413,000) | (£687,000) |
| Year 2 | £2,788,000 | £582,000 | (£1,989,000) | £1,381,000 | £799,000 |
| Year 3 | £3,959,000 | £823,000 | (£2,449,000) | £2,333,000 | £1,510,000 |
| Year 4 | £4,892,000 | £1,065,000 | (£2,604,000) | £3,353,000 | £2,288,000 |
| Year 5 | £5,658,000 | £1,065,000 | (£2,667,000) | £4,056,000 | £2,991,000 |
| … | … | … | … | … | … |
| Year 10 | £7,090,000 | £1,065,000 | (£2,370,000) | £5,785,000 | £4,720,000 |
| **Total** | **£51,610,000** | **£9,140,000** | **(£24,366,000)** | **£36,384,000** | **£27,244,000** |

# **10.** APPROACH TO PROCUREMENT

- We are proposing to use a framework to procure our ATEC service provider to streamline the process.
- Market intelligence suggests that there are a small number of service providers who can meet our requirements for technology, service and data, all of whom appear on appropriate frameworks.
- Soft market engagement planned for April/May to share specification and requirements with the market for feedback in advance of a formal process.
- Contract period is proposed as 5 + 2 + 2 + 1 years
- Bid evaluation framework will focus on quality and benefits/value creation along with the ability to integrate with other systems, continuously iterate our technology and take a data-driven approach.
- Procurement will include a full demonstration of technology and data platform capability, alongside written bid responses.
- We will involve residents in the procurement process.

# ATEC Governance: Oxleas

Quality Impact Assessment: This has been completed with input from Physical and Mental health community services within Oxleas. The AD for Physical health has reviewed with the Quality Director and this will go to the **Oxleas Clinical Senate meeting** to be reviewed on **16th May at 1pm.**

- Proposal for a 12 month Project manager to action mitigations for identified impact areas. Examples include training, business continuity plans, confirm clinical governance.

Pre-Approval Process: All new service proposals where there is a financial impact complete a pre-approval process to identify which service leads will require sign off. This will be presented at the **Oxleas Finance and Planning meeting** on **23rd April at 1.30pm**

- Checks alignment to the Trust strategic priorities
- Identifies implications for the organization (IT, Informatics, RiO, IG, Estates, HR, Communications, Finance, Project support)
- Proposal to fund a Project Manager across community physical and mental health directorates

# DECISION MAKING TIMESCALE

| Name | Description | Formal/Socialisation | Greenwich Lead Attending | Rethink Lead Attending | Date | Start | End | Confirmed & Agenda | Papers Required | Deadline for Papers | Meeting Co-ordinator |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Home First Strategic | Fortnightly Thursday 3.30–5pm<br>Clare met them in November to discuss frailty | Formal | Kit Collingwood, Lisa Wilson | n/a | 11/01/2024 | 3:30 pm | 05:00 PM | Confirmed & On Agenda | ATEC Briefing Deck | n/a | erica.bond@selondonics.nhs.uk |
| Councillor briefing Denise Scott McDonald, Member for Health & Adult Social Care | Denise Scott McDonald Cabinet Member for Health and Adults' Social Care | Socialisation | Lisa Wilson | n/a | 17/01/2024 | 2:00 pm | 03:00 PM | Confirmed & On Agenda | Greenwich Template Document | n/a | emma.dennien@royalgreenwich.gov.uk |
| HAS Joint Portfolio Board | Looks at joint projects adults and children | Formal | Kit Collingwood, Lisa Wilson | n/a | 19/01/2024 | | | Confirmed & On Agenda | ATEC Briefing Deck | n/a | ian.tasker@royalgreenwich.gov.uk |
| ICB Digital Board | Ask Kit what planning and when | Socialisation | Kit Collingwood, Lisa Wilson | Clare Morris | 23/01/2024 | | | Confirmed & On Agenda | ATEC Briefing Deck | n/a | christine.feeney@royalgreenwich.gov.uk |
| Oxleas Greenwich Leads Meeting | (Meeting Chair: Carol Haynes<br>Co-Chair: Michelle Adams) | Socialisation | Caleb Assirati | Jemma Mindham,<br>Simon Evans | 25/01/2024 | 2:00 pm | 02:30 PM | Confirmed & On Agenda | ATEC Briefing Deck | n/a | oxl-tr.acsadminteam@nhs.net |
| Integrated Commissioning Unit (ICU) | Lisa's integrated commissioning management.<br>Service managers and next level managers.<br>Full deck (time allowing) | Socialisation | Caleb Assirati, Lisa Wilson | Jemma Mindham | 13/02/2024 | | | Confirmed & On Agenda | ATEC Briefing Deck | n/a | jo.hawkes@royalgreenwich.gov.uk |
| Home First Operational | Go early, with Rachel, testing model – test with Rachel how and what we seek input on | Socialisation | Rachel Matheson, Caleb Assirati | Amie Witherspoon | 15/02/2024 | 11:30 pm | 12:00 PM | Confirmed & On Agenda | ATEC Briefing Deck | n/a | oxl-tr.acsadminteam@nhs.net |
| HAS Change Board | Update on Capital bid, consultation. Nick/Lisa chair | Socialisation | Caleb Assirati, Lisa Wilson | n/a | 19/02/2024 | | | | ATEC Briefing Deck | n/a | Caleb |
| Integrated Leadership Meeting (ILM) (was DMT) | Neil, Sarah | Formal | Lisa Wilson, Kit Collingwood | n/a | 20/02/2024 | 10:00 am | 12:00 PM | Confirmed & On Agenda | ATEC Briefing Deck | | emma.dennien@royalgreenwich.gov.uk |
| Adults' Management Team (AMT) | Nick's Social Care management team. Real life impact on people's roles; embedding in practice model, designing culture change. | Socialisation | Caleb Assirati | Amie Witherspoon | 07/03/2024 | 09:00 | | Confirmed & On Agenda | ATEC Briefing Deck | n/a | Caleb awaiting slot |
| Greenwich Wide Forum | Quarterly GP practices. 15 mins | Socialisation | Neil Kennett-Brown | n/a | 07/03/2024 | | | | | | |
| Joint Commissioning Board | This is the exec group of the HGP – (go here first) Detailed finance and funding content required | Formal | Kit Collingwood, Lisa Wilson | n/a | 07/03/2024 | 3:00 pm | 04:00 PM | Confirmed & On Agenda | Greenwich Cover Report | | ike.philip@selondonics.nhs.uk |
| **Healthier Greenwich Partnership – Exec Group** | End of timeline, two bites at exec group and actual meeting) (local care partnership) | Formal | Lisa Wilson | n/a | 20/03/2024 | | | Confirmed & On Agenda | ATEC Briefing Deck | | annie.norton@selondonics.nhs.uk |
| **Home First Strategic (Full Presentation)** | Fortnightly Thursday 3.30–5pm<br>Clare met them in November to discuss frailty. Rachel or Nick chairing in Lisa's absence | Formal | Kit Collingwood, Lisa Wilson | n/a | 21/03/2024 | | | Confirmed & On Agenda | ATEC Briefing Deck | | Request early slot<br>erica.bond@selondonics.nhs.uk |
| **Home First Operational** | Second presentation to group | Socialisation | Rachel Matheson, Caleb Assirati | n/a | 21/03/24 | 11a.m. | 12p.m. | Confirmed and On Agenda | ATEC Briefing Deck | | oxl-tr.acsadminteam@nhs.net |
| **Integrated Commissioning Unit (ICU)** | Lisa's integrated commissioning management.<br>Service managers and next level managers – 2nd session | Socialisation | Caleb Assirati, Lisa Wilson | Jemma Mindham | 04/24 TBC | | | TBC | ATEC Briefing Deck | n/a | jo.hawkes@royalgreenwich.gov.uk |
| **Healthier Greenwich Partnership Actual** | Local care partnership | Formal | Kit Collingwood, Lisa Wilson,<br>Neil Kennett-Brown | n/a | 24/04/2024 | | | Confirmed & On Agenda | Greenwich Cover Report | 14/04/24 | ike.philip@selondonics.nhs.uk |
| **Greenwich Local Medical Committee** | | Socialisation | Neil Kennett-Brown + clinician | Clare/Simon if required | 26/04/2024 | | | | | | |
| **Informal Political Cabinet (IPC)** | Lead members may suggest it goes here | Socialisation | Kit Collingwood, Lisa Wilson | n/a | 05/24 TBC | | | | ATEC Briefing Deck | | trevor.langworth@royalgreenwich.gov.uk |
| **Labour Group** | Likely any key decision paper will<br>go to labour group before full council<br>(Labour Group already seen as part of MTFS proposals) | Socialisation | Kit Collingwood, Lisa Wilson | n/a | 05/24 TBC | | | | ATEC Briefing Deck | | trevor.langworth@royalgreenwich.gov.uk |
| **Corporate Senior Leaders** | Directors & ADs (integrated but mostly RBG) | Socialisation | Kit Collingwood, Lisa Wilson | n/a | 22/05/2024 | | | | ATEC Briefing Deck | | chief.executives@royalgreenwich.gov.uk |
| **Cabinet Members Informal Briefing TBC** | As directed by Lead Member | Socialisation | Kit Collingwood, Lisa Wilson | n/a | TBC | | | | TBC | | |
| **Cabinet** | Requested June from Trevor | Formal | Lisa Wilson, Kit Collingwood | n/a | 06/2024 TBC | TBC | TBC | On agenda list (meeting not yet arranged) | Greenwich Template Document | | trevor.langworth@royalgreenwich.gov.uk |

# APPENDICES

# MOVING TO DATA LED PRACTICE

Individual and big data integrated with other datasets to realise additional value

Connected digital daily living devices (home and out and about) that proactively support real-time data


Monitoring Centre

Family

Care Workers/ Community

Remote monitoring through apps and dashboards involves families and communities alongside formal care & support; reduces demand and better outcomes

Individual data informs data-driven practice (assessment, review, planning) and care market commissioning

# ATEC VALUE CREATION MODEL


Better for the person

Better for the council & NHS

Increased independence better outcomes and experience

- Reduced demand for care = savings
- Preventing escalating needs = avoided costs
- Delaying increasing needs = avoided costs
- Individual data targets care & support = avoided costs

Data flows back to generate personalised and responsive care

# DRIVERS AND THE CASE FOR CHANGE – NATIONAL EXAMPLES


Hampshire County Council's TEC service has achieved £14m in savings over 6.5 years.

https://www.hants.gov.uk/socialcareandhealth/adultsocialcare/caretechnology


Kent County Council are predicting cost avoidance of £36m over the course of their 7 year TEC contract.

https://democracy.kent.gov.uk/documents/s118332/Decision%20Report.pdf


Essex County Council are predicting savings of £17.8m over 3 years through greater utilisation of TEC.

https://www.digitalhealth.net/2021/04/essex-council-signs-9m-deal-for-health-and-care-technology

rethink partners

NHS South East London

ROYAL borough of GREENWICH

# DRIVERS AND THE CASE FOR CHANGE – CASSIUS


## Also...

### Hospital Discharge Pathways: A Pilot

**In just nine months, we've seen:**

| | | |
|---|---|---|
| **46%** of referrals supporting hospital discharge | **54%** of referrals were to prevent hospital/ward admission | **12,900** hours of care saved |
| **333** high quality referrals for technology during this targeted piece of work | **£1.31m** preventative savings to social care through avoidance in care costs and residential placements | **£49,000** savings from reduction of ambulance call outs and hospital bed days saved |

**More people returned home faster after hospital stays,** giving them greater choice and control, and improving their long-term outcomes. The approach is now being replicated at the other two hospitals in Suffolk, moving from prototyping to scale.

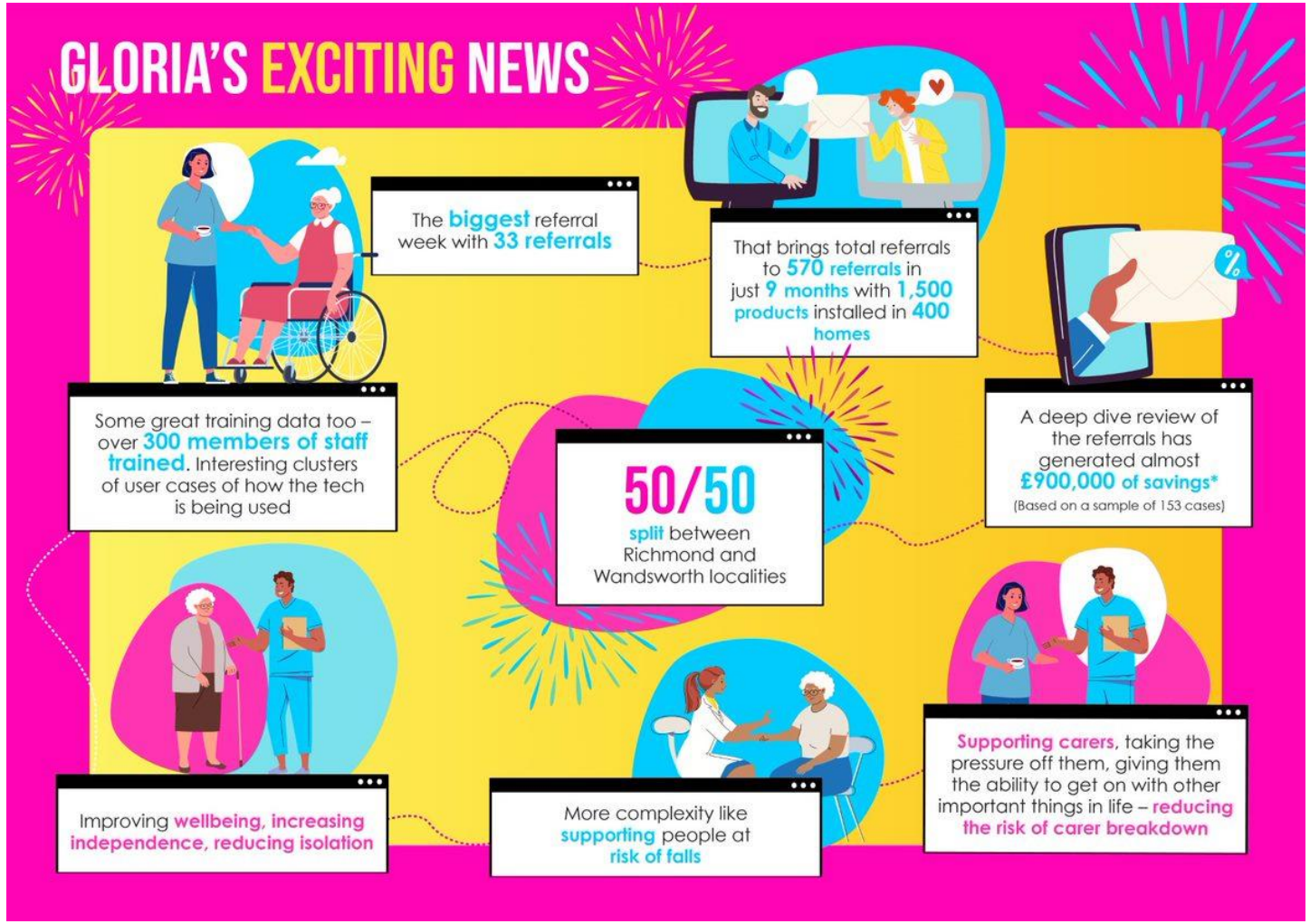
rethink partners

NHS South East London

ROYAL borough of GREENWICH

# DRIVERS AND THE CASE FOR CHANGE – 9-MONTH POSITION

- Gloria is the digital care technology demonstrator for Richmond and Wandsworth Borough Councils
- £900k savings (gross) generated at 9 months, success has continued at this rate
- Cost of 12 month demonstrator was £600k – payback achieved within demonstrator period
- Councils now planning to fully commission and expand



AGENDA ITEM: 9

# Healthier Greenwich Partnership

## Date: 24th April 2024

| | |
|---|---|
| **Title** | **Thamesmead Health Centre Contract Procurement Decision** |
| This paper is for **Decision** | |
| Executive Summary | This paper outlines the review by the Primary Care Working Group (PCWG) on the 28th March on the options for the Thamesmead Primary Care Contract which are now presented to the Healthier Greenwich Partnership (HGP) for approval.<br><br>The contract is currently an APMS contract which expires on 31st March 2025. The contract has previously been extended so that there is now no option to extend the contract and a decision for the future management is required.<br><br>Legal advice had been sought after the publication of the New Provider Selection Regime (NPSR) and the following options were presented to the PCWG for a decision.<br><br>*Option 1 Award a new contract to the current provider via Direct Award Process C*<br>This option applies if the contract value or terms of the contract have not been "considerably changed" but there is not definition yet under the new regime about what considerably changed means.<br><br>*Option 2: Award a new contract via the Most Suitable Provider (MSP) Process*<br>This option is particularly good for areas where there is likely to be limited interest and only one provider, but the PCWG were aware that this would be unlikely to be the case for a practice of the size of Thamesmead in South East London<br>*Option 3: Award a new contract via the Competitive Process*<br>This option means a full contract procurement which is time consuming and costly in terms of managing the procurement but if chosen this option cannot be challenged as being unfair. This option would allow for all potential bidders to submit tenders for the contract and through a review of the bids the best service can then be chosen for the population of Thamesmead. |

| | | |
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| | The PCWG reviewed a full report on the context of the decision and a detailed review of the options available as well as consideration of the comments made by the HGP in March when they were appraised that a decision would be needed. The HGP asked that the list growth be taken into consideration, and the PCWG were advised that the projected list growth is for 5-10,000 patients in the next 10-15 years which will be supported by a procurement for a practice on this site.<br><br>The membership of the PCWG all agreed that the best option for the practice would be Option 3 a full procurement.<br>Some members of the PCWG were conflicted by the decision such as local GPs from other practices, but these were excluded from the final decision. However, it should be noted that all members including the conflicted members agreed with the decision for Option 3 for a full procurement.<br><br>The recommendation is that this decision be seen as a long-term decision with the tender documents being written with a view to finding a contractor that will offer a long-term commitment for the Thamesmead practice and the local neighbourhood. It is hoped that caselaw will be enacted that would support an ongoing Direct Award of the contract to the successful bidder meaning that future procurement may not be needed. | |
| Recommended action for the Committee | Members of the Healthier Greenwich Partnership Board are asked:<br><br>• To approve the decision to undertake a full contract Procurement for the Thamesmead Health Centre contract which expires in March 2025. | |
| Potential Conflicts of Interest | There is a potential conflict of interest for any person working with the practice or where the decision may be affect their practice or PCN | |
| | | |
| Impacts of this proposal | Key risks & mitigations | • Patient Engagement and ensuring vulnerable people are not adversely affected by the decision.<br>• Risk for the PCN in developing a new relationship if the contract provider changes.<br>• Challenge to the decision by other providers.<br><br>**Mitigations**<br><br>• A working group will be established to manage the outcome including the mitigation of risks to ensure a smooth transition. Members of the group would be drawn from the wider SEL ICB |

| | | |
|---|---|---|
| | | Team including clinical and non-clinical members of staff and stakeholder organisations e.g. Healthwatch.<br>○ A communication strategy would be developed with partners and stakeholders i.e., Patient Participation Group advising patients on the future of the practice.<br>• Meetings with the PCN will be established to minimise any concerns.<br>• Legal advice has been sought and the recommended option will mitigate this risk |
| | Equality impact | • A Equality Impact Assessment will be completed following the decision and the ICB EIA policy fully Implemented to mitigate any impact. |
| | Financial impact | • The funding of the APMS contract is within the Primary Care budget, and this will continue.<br>• There may be costs associated with transfer of lease for the building but since the lease ends in March 2025 the work and much of the costs will be needed without procurement.<br>• There are costs with a new procurement in terms of time, but these cannot be avoided |
| | | |
| Wider support for this proposal | Public Engagement | Initial patient involvement has commenced but will be increased to gain a greater perspective and to ensure that residents in the vicinity understand that there will be no loss of service.<br>Public engagement will be part of the planned implementation of the decision and public representation will be sought on the tender decision group. |
| | Other Committee Discussion/ Internal Engagement | • The PCWG reviewed the options and have made their decision on the preferred option, this group includes members of the Local Medical Committee. |
| Author: | Maria Howden/Nicky Skeats | |
| Clinical lead: | Jose Garcia, Clinical and Care Professional Lead | |
| Executive sponsor: | Neil Kennett- Brown, Chief Operating Officer, Greenwich | |

AGENDA ITEM: 10

# Healthier Greenwich Partnership

## Date: 24 April 2024

| | | |
|---|---|---|
| **Title** | Partnership Report | |
| This paper is for **noting** | | |
| Executive Summary | The partnership report provides update on key developments, as follows:<br>1) Healthier Greenwich Partnership – staff engagement event on Wednesday 20 March 2024<br>2) Health Ambassador Programme<br>3) Breast screening – It's what we do campaign<br>4) Clinical summit on 6th June 2024<br>5) SEL ICB Management Cost Reduction (MCR)<br>6) NHS Greenwich Charitable Funds<br>7) Greenwich & Bexley Community Hospice | |
| Recommended action for the Committee | To note the report | |
| Potential Conflicts of Interest | None | |
| | | |
| Impacts of this proposal | Key risks & mitigations | None |
| | Equality impact | Not required for the direct purposes of the report |
| | Financial impact | Not required for the direct purposes of the report |
| | | |
| Wider support for this proposal | Public Engagement | Not required for the direct purposes of the report |
| | Other Committee Discussion/ Internal Engagement | Not applicable |
| Authors: | Neil Kennett-Brown, Chief Operating Officer | |
| Clinical lead: | Not applicable | |
| Executive sponsor: | All partners | |

# HGP Partnership Report – 24th April 2024

## 1) Healthier Greenwich Partnership – staff engagement event

We held a positive system wide staff engagement event on Wednesday 20 March, which brought together staff from across the health and care system to share and learn from our existing prevention work and discuss how, by working together across organisations, we can have more impact and help people to live longer, healthier, and happier lives.

It was great to bring our progress to life, bringing together staff who were involved in part of our collaborative work, but had low understanding of other aspects. We know that as a health and care system in Greenwich we need to focus on keeping people healthy, not just treating them when they become unwell. This can be difficult, especially when we all face short term pressures

## 2) Health Ambassador Programme

Great progress is being made, with 21 clinicians are now linked to 8 secondary schools in Greenwich, even more than last year. A recent Healthcare career fair was held at Shooters Hill College with 180 yr 10 and yr 11 students from multiple schools, and we had 10 different clinical and care backgrounds presenting the opportunities of working in our Greenwich health & care system, and we have great support from Oxleas, LGT, Hospice and our GPs in this. This is really helpful as we look to promote future careers locally. Next career fair is planned in Thomas Tallis in late April 24.

In addition, there is going to be an event aspirational student for Oxbridge/Russell Group University applicants for year 12, considering applying for Medicine or Dentistry in June.

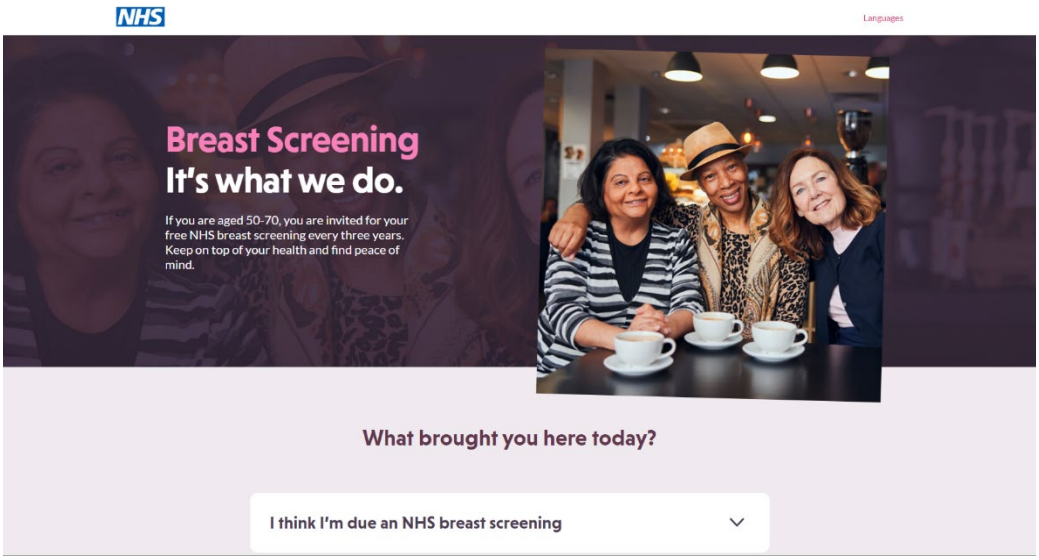
We are also able to link clinicians with food bank, homeless shelters to provide signposting services for our community.

## 3) Breast screening – It's what we do campaign

Uptake of breast screening in Greenwich has dropped significantly in recent years and there are health inequalities with lower uptake amongst some ethnic groups and in areas of higher deprivation. A successful application was submitted to South East London Cancer Alliance and £50k has been allocated to run a behavioural science informed campaign to increase uptake. The 'Breast screening – it's what we do' campaign has been developed as a partnership between the Greenwich ICB team, public health and primary care. It features Greenwich residents from a range of backgrounds. The project team have used behavioural science to better understand the diverse audiences, analyse behavioural barriers, refine decision-making

journeys, and create persuasive, creative communications so residents can easily move from intent to action and access their breast screening.

NHS Breast Screening in Greenwich - It's what we do (wedobreastscreening.org.uk)




The campaign has now launched and will run until the end of May 2024. We have already reached over 150,000 people through the test digital adverts. Activity will be mainly in the form of digital adverts, although these will be supplemented by outreach in communities where uptake is lowest and testing of interventions including using personalised letters from a patient's named GP and text messages. Learnings and resources will be shared with the Cancer Alliance and other boroughs.

### 4) Clinical summit

Dr Eugenia Lee, our Workforce Clinical & Care Professional lead has secured commitment for a shared clinical event in the evening 6th June, to build relationships between community/primary care/ hospital clinicians. This will involve circa 120 clinicians from Oxleas, LGT and Primary Care, Dr Nav Chana will be the keynote speaker (he is a national primary care leader, as well as Non-Executive Director at Lewisham and Greenwich NHS Trust.

### 5) Management Cost Reduction

The implementation of the new structures across the SEL ICB is nearing completion underway, and all ring-fenced interviews are complete. Staff at risk are continuing to apply for vacant roles within the new structures, and we expect interviews and appointments/redundancies to continue until the summer of 24.

This is a challenging time for many staff, and we will update the HGP on changes as and when we can announce them. I am pleased to report that our Medicines Management Team have completed their interviews, and Jin On is taking on Associate Chief Pharmacist across Greenwich and Lewisham, and Alex Pini is Greenwich Assistant Director of Medicines Optimisation, with team under him (majority of whom were existing team members). Jessica Arnold starts on 1st May 2024, and we want to thank Ginny Morley for her support over the past 3 months.

**6) NHS Greenwich Charitable Funds**

The Greenwich Healthier Communities Fund is now live and accepting applications. This grant programme has been established to support organisations and communities that seek to tackle health inequalities in Greenwich.

The grant welcomes applications from groups or individuals who can demonstrate that their work prevents or responds to health inequalities in Greenwich, and aligns with our Greenwich Health and Wellbeing Strategy which sets out the mental and physical health and wellbeing priorities for the next five years in the borough.

Two strands of funding have been announced so far – The Enabling Strand and the Delivery Strand. The Enabling Strand is live and accepting applications for a year, with assessments every three months. This strand aims to increase the ability and resilience of smaller groups and individuals to deliver and improve services that address health inequalities. The Delivery Strand goes live in May 2024, and will have two application deadlines a year. This strand will provide funding to small and medium-constituted community and voluntary sector organisations, for projects that tackle health issues across the borough.

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

7) **Greenwich & Bexley Community Hospice**

Following our recent recruitment round, we are pleased to announce that Dr Lesley Bull will be joining the hospice as Medical Director in August. Lesley is currently a GP Partner in Bexley and will bring her experience of hospice care, primary care and frailty to our services. We are still recruiting to our Palliative Medicine vacancy and in the short term, this leaves our medical team quite thin on the ground.

Natalie Moseley has now been appointed substantively as our Head of Community Services, and is now in a position to drive some of the transformation we need to see to support our team to reach a growing number of people in as timely a fashion as possible. Our Rehabilitation and Wellbeing services continue to grow, you can find out more here.

# HGP Committees Update April 2024

| No. | Date | Committee name | Agenda items of note |
|---|---|---|---|
| **1.** | 01/02/2024 | Joint Commissioning Board (JCB) | 1. The Board noted the Provider Selection Regime (PSR) implementation update.<br>2. The Board approved the Better Care Fund (BCF) Q3 23/24 Template submission.<br>3. The Board noted the Greenwich Quality update.<br>4. The Board noted the 2024/25 Planning Guidance Update.<br>5. The Board noted the Greenwich LCP assurance report. |
| **2.** | 07/03/2024 | Joint Commissioning Board (JCB) | 1. Tier 3 Weight Management Options Appraisals - The Board agreed Option 3 to Continue with existing additional investment (£83k) and undertake a pilot to look at stratifying patients, providing different levels of service to different cohorts.<br>2. The Board noted the Provider Selection Regime (PSR) implementation update.<br>3. The Board noted the NHS 2024/25 Planning & Budget update and RBG 2024/25 Planning & Budget update.<br>4. The Board noted the update about the new governance model for Enhanced Health and Care Homes Board (EHCHB).<br>5. Greenwich ATEC Programme - The JCB approved the ATEC Service Model, the integrated commissioning approach, and the investment from the Local Authority and the ICB. |
| **3** | 04/04/2024 | Joint Commissioning Board (JCB) | 1. The Board approved the Long-Term Condition(s) Annual Review Service for Housebound Patients Contract Variation.<br>2. The Board noted the Provider Selection Regime (PSR) implementation update. |

| | | | |
|---|---|---|---|
| | | | 3. The Board noted the 24/25 financial prioritisation updates for NHS SEL ICB and RBG.<br>4. The Board noted Better Care Fund (BCF) update.<br>5. The Board noted the Greenwich quality update. |
| **4** | 19/02/2024 | Charitable Funds Committee | 1. Groundwork London update - The Committee received update about Strand Development, noting there are two - Enabling Strand Outline and Delivery Strand Outline.<br>2. Charity Finance - The Committee noted Charity Finance Update. |

AGENDA ITEM: 11

# Healthier Greenwich Partnership

**Date: 24 April 2024**

| | |
|---|---|
| **Title** | MSK Recommissioning update |
| This paper is for **noting/approval** | |
| Executive Summary | This paper provides an update on the progress to recommission MSK services in Greenwich. We have been committed to working with residents and local partners to review the current offer, understand what is working well, what could be improved and to co design the model for the future ahead of any procurement planned.<br><br>We held a service design event on the 22nd February 2024 to review the current MSK model and pathways including feedback already received over the last few months. This was well attended by a range of partners and also patients. Whilst there were some ideas about improvements there was not a definitive outcome. This is ok at this stage as further work will take place with partners to do more detailed discussions on the future model ahead of the procurement<br><br>The key questions asked at the event were the following:<br><br>1. How can this pathway be improved to meet the needs of our local population? (what we do)<br>2. What else do we need to consider to enable great patient experience? (how we do it)<br>3. What have people experienced that works well elsewhere that we can learn from?<br><br>The process used was a world café style session. Each table were asked to respond to the questions and then to build on feedback from the previous group answering the questions as they moved around the tables. This facilitated a sharing of ideas for the future service and built on feedback already gathered ahead of the event.<br><br>Feedback is now being fully considered ahead of planning some further sessions to develop the future model and service specification alongside partners in line with the timeline we are working to.<br><br>Feedback summary : |

| | |
|---|---|
| | **Question 1**<br><br>- Focus on data to understand population and for future modelling across 5-10 years<br><br>- Holistic care – physical and mental health<br><br>- MSK service being able to directly refer into other services<br><br>- Leverage Community Champions re sign-posting / self-referral route / helping us to understand more about barriers to access and how to overcome them<br><br>- Inter-operability between services<br><br>- Training physios to be advanced practitioners in pain<br><br>- Investing in education so AHPs can do more (multi-skilled) – one team ethos with best use of resources<br><br>- Clinicians learning from each other<br><br>- Self-referral process and rates of uptake improved<br><br>- simplify the pathway to help patients understand where they are on it, what to expect, etc, along the journey – being clear and accessible in communications<br><br>- sign-post to other assets and services locally whilst people are waiting or to support them in a more holistic way.<br><br>- Increase use of community assets inc community and leisure centres<br><br>- If future approach means providers working together they need to ensure more aligned working and a one team approach<br><br>One stop shop:<br>- Multiple joints<br>- community drop-in hubs (consider hours incl evenings)<br>- Social prescribing<br>- Up-skilling Health Care Professionals<br>- Offering patient choice “within the lanes” – being clear / to target different groups<br>- Work to understand best way to engage patient directed follow-ups<br>- Make patient forums/groups accessible |

| | |
|---|---|
| | - Transparency re what the service is/does (expectations). Lots of information at different points of the pathway / where am I in the process / making every opportunity count / personal care planning / training of admin teams so that they also understand the service<br><br>- Standards to support consistency of experience across people/sites/organisations<br><br>Reducing barriers:<br>- Seamless referrals<br>- System working together<br>- Be clear about the role of primary care<br>- Pain management<br>- Ensure increased buy in and partnerships between primary and secondary care<br>- Using technology in the right way for the right people – easy to navigate but remembering that not everyone will be able to use technology<br>- Better support for patients whist they are waiting/ on wating lists<br>- Develop workforce, wider than MSK – enabling a more holistic approach<br><br>**<u>Question 2</u>**<br><br>*Co-production*<br>- (patient engagement / volunteers / patient representatives (employed) / marketing (local papers/radio/other)<br>- Creating an engaging experience – promote adherence / goals / supported self-management / remote monitoring / 2-way communication / ongoing management after discharge<br><br>*Communication*<br>- pre-appointment (patient expectation management)<br>- access – via primary care / self-referral<br>- throughout pathway – helpline / use apps<br>- digital /traditional / languages/ easy read<br>- on-going access via PIFU<br>- education (GPs, patients, FCPs)<br>- apps – when suitable / when not<br>- regular MDTs and operational meetings across the pathway<br>- Avoid patient repeating themselves<br><br>*Location*<br>- Spread across borough<br>- Related to where referrals are coming from (data) co-location of |

| | | |
|---|---|---|
| | teams (FCP / GP / Physios / APPs / Consultants)<br>- Better links with social prescribers / services in the community / health advisors<br><br>*Other key points:*<br><br>- Education and prevention – need a more preventative focus<br>- Holistic pain management needed<br>- Integrated IT<br>- Greater diversity of workforce (training / skill sets / including other professional backgrounds / mental health in the education and exercise programmes)<br>- Ensure clear transition between children's and adults services<br><br>There was a range of other points made and learning shared from other models. This is now being collated and will inform the next steps<br><br>• There was a also an MSK community event held on the 20th March at Sutcliffe Park in Greenwich. This was also well attended and provided lots of learning which will now feed in to the work over the coming weeks and months<br><br>• We aim to still achieve the timelines set out previously – if there are any risks to this there will be updates provided via the HGP exec group as required.<br><br>The timeline is outlined in the attached PowerPoint presentation which relates to the event held in February. | |
| Recommended action for the Committee | To note the enclosed update following recent engagement events and ensure continued partner engagement as the work to recommission the service continues. | |
| Potential Conflicts of Interest | NA | |
| | | |
| Impacts of this proposal | Key risks & mitigations | Workforce capacity to progress the work. We are currently looking to recruit some additional capacity in light of MCR changes to ensure we can continue to progress this key work |
| | Equality impact | Equality impacts of the future model and procurement planning will |
| | Financial impact | The available financial envelope is known for the service and we will be aiming to ensure best value |

| | | |
|---|---|---|
| | | whilst we continue to design and then commission the new service |
| | | |
| Wider support for this proposal | Public Engagement | *Patients and the public and partners continue to be engaged throughout the process* |
| | Other Committee Discussion/ Internal Engagement | JCB, HGP Exec and other forums will continue to be engaged and informed of progress |
| Author: | *Lisa Wilson – Integrated Director of Commissioning – Adults* | |
| Clinical lead: | | |
| Executive sponsor: | *Neil Kennet – Brown* | |

# MSK Service Design Event Greenwich

Lisa Hancock & Annie Norton, 22nd Feb 2024

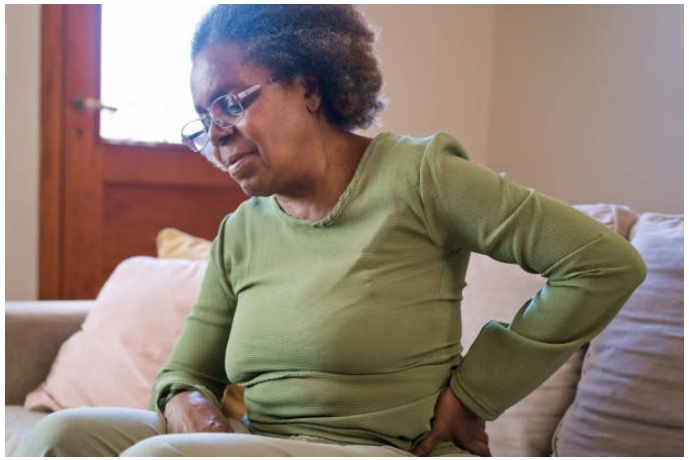
# Welcome & Purpose

**Purpose:** An informal opportunity to develop the vision for Greenwich's future MSK service, based on feedback from service users and other stakeholders and input from current and potential providers

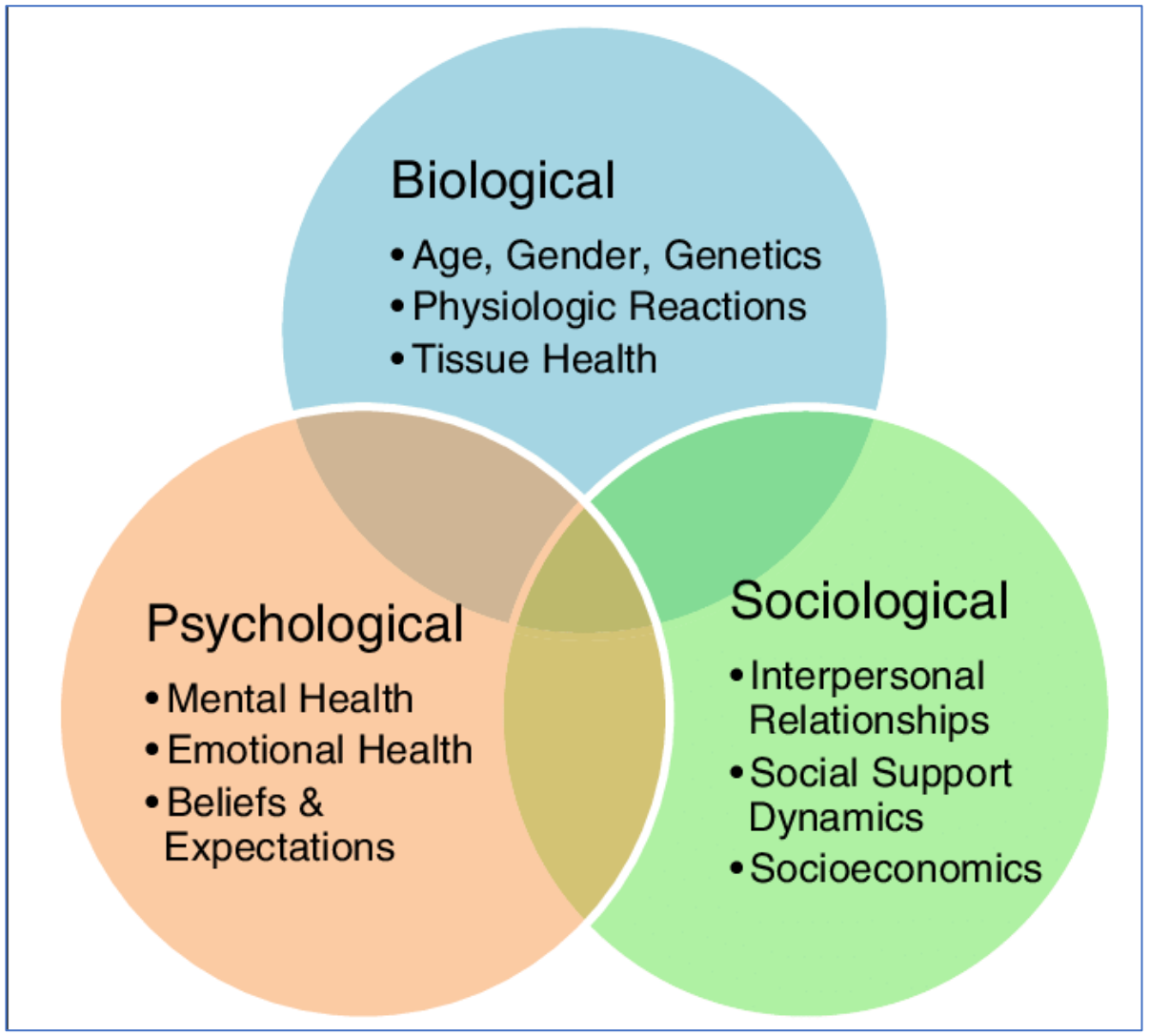
| Timing | Item |
|---|---|
| 9:30 | Welcome and purpose |
| 9:40 | Context and vision |
| 9:45 | Existing model and feedback regarding current service |
| 10.00 | Proposed model - based on feedback |
| 10.15 | Break |
| 10.30 | Collectively Building an Improved Service Model |
| 12:35 | Sharing Highlights |
| 12.50 | Next steps and check-out |
| 1:00 | Close |

# Context and Vision

# Context



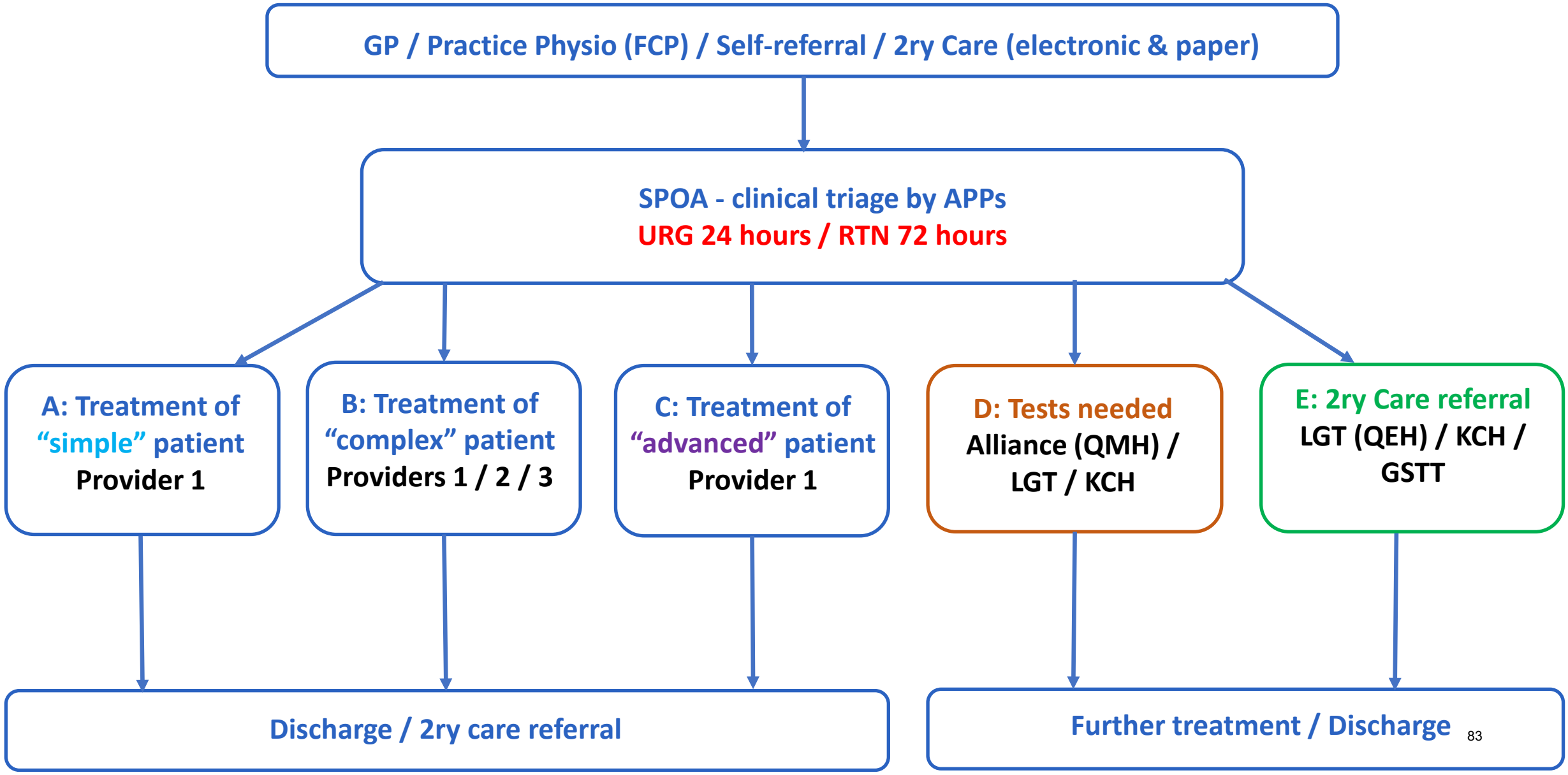
# Vision

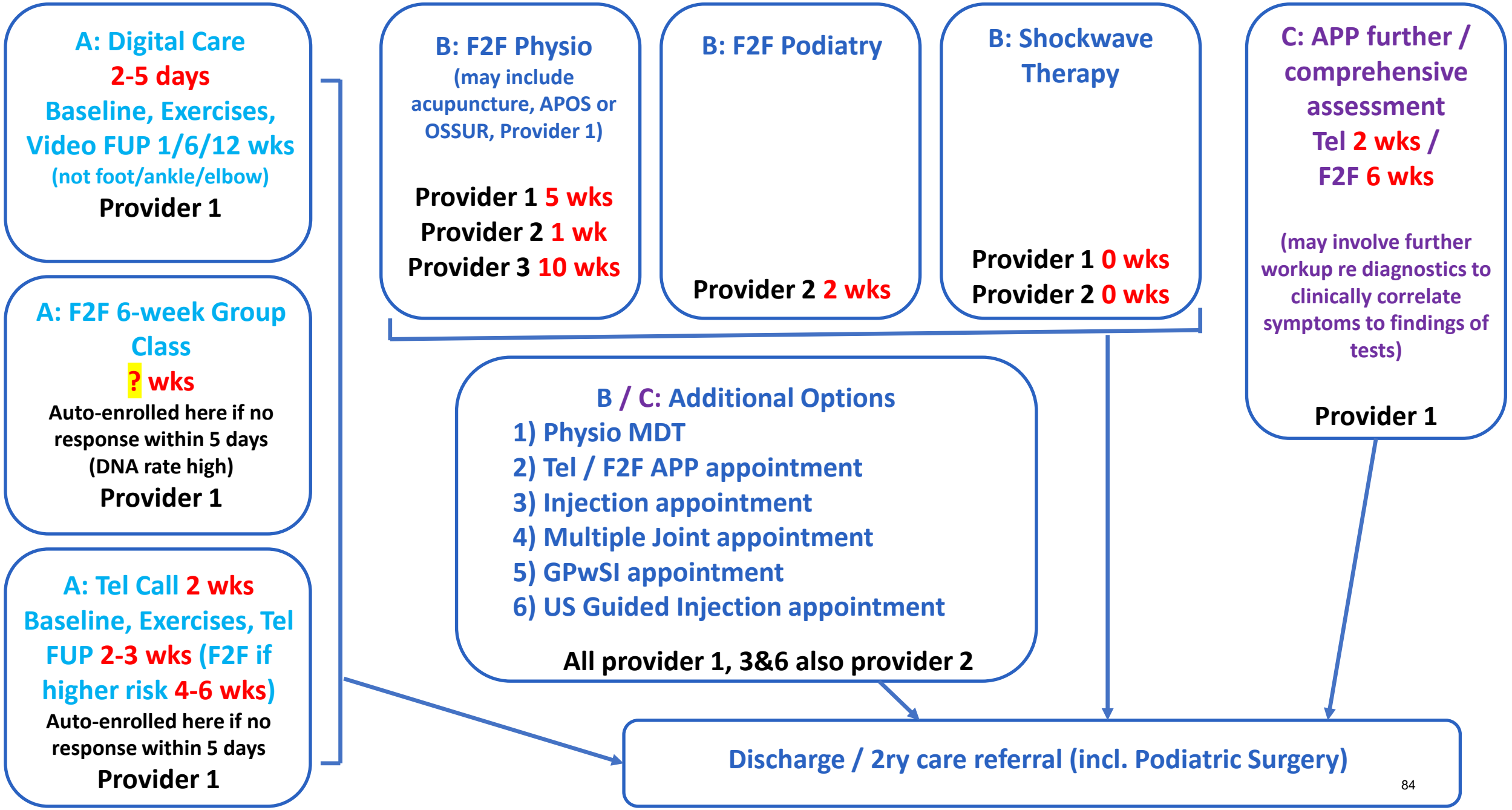

Biological
• Age, Gender, Genetics
• Physiologic Reactions
• Tissue Health
Psychological
• Mental Health
• Emotional Health
• Beliefs & Expectations
Sociological
• Interpersonal Relationships
• Social Support Dynamics
• Socioeconomics

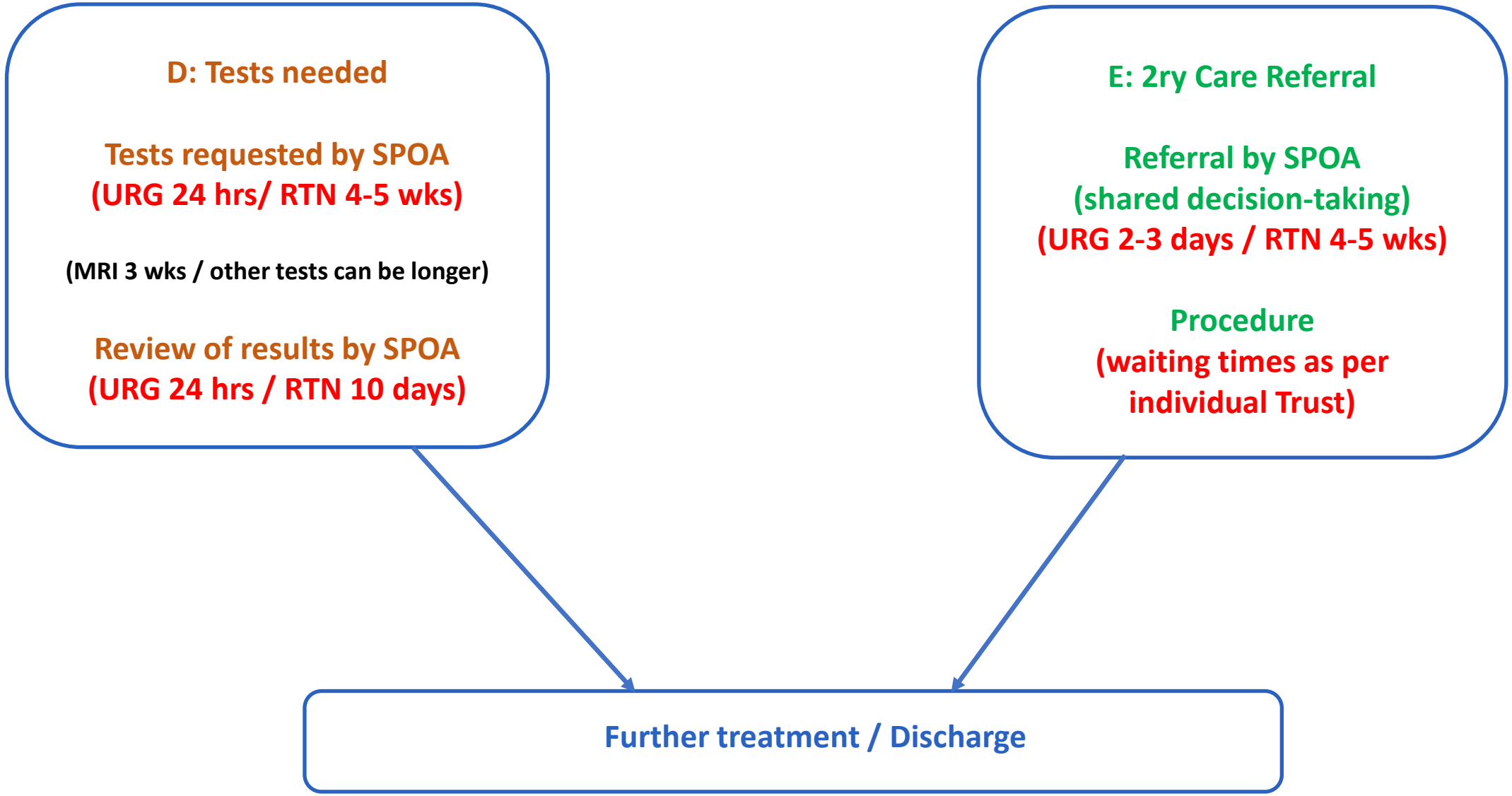

GREENWICHWEST
COMMUNITY & ARTS CENTRE

# Existing model and feedback regarding current service

# Currently


GP / Practice Physio (FCP) / Self-referral / 2ry Care (electronic & paper)
SPOA - clinical triage by APPs
URG 24 hours / RTN 72 hours
A: Treatment of "simple" patient
Provider 1
B: Treatment of "complex" patient
Providers 1 / 2 / 3
C: Treatment of "advanced" patient
Provider 1
D: Tests needed
Alliance (QMH) / LGT / KCH
E: 2ry Care referral
LGT (QEH) / KCH / GSTT
Discharge / 2ry care referral
Further treatment / Discharge


A: Digital Care
2-5 days
Baseline, Exercises, Video FUP 1/6/12 wks
(not foot/ankle/elbow)
Provider 1
A: F2F 6-week Group Class
? wks
Auto-enrolled here if no response within 5 days (DNA rate high)
Provider 1
A: Tel Call 2 wks
Baseline, Exercises, Tel FUP 2-3 wks (F2F if higher risk 4-6 wks)
Auto-enrolled here if no response within 5 days
Provider 1
B: F2F Physio
(may include acupuncture, APOS or OSSUR, Provider 1)
Provider 1 5 wks
Provider 2 1 wk
Provider 3 10 wks
B: F2F Podiatry
Provider 2 2 wks
B: Shockwave Therapy
Provider 1 0 wks
Provider 2 0 wks
C: APP further / comprehensive assessment
Tel 2 wks / F2F 6 wks
(may involve further workup re diagnostics to clinically correlate symptoms to findings of tests)
Provider 1
B / C: Additional Options
1) Physio MDT
2) Tel / F2F APP appointment
3) Injection appointment
4) Multiple Joint appointment
5) GPwSI appointment
6) US Guided Injection appointment
All provider 1, 3&6 also provider 2
Discharge / 2ry care referral (incl. Podiatric Surgery)


D: Tests needed
Tests requested by SPOA
(URG 24 hrs/ RTN 4-5 wks)
(MRI 3 wks / other tests can be longer)
Review of results by SPOA
(URG 24 hrs / RTN 10 days)
E: 2ry Care Referral
Referral by SPOA
(shared decision-taking)
(URG 2-3 days / RTN 4-5 wks)
Procedure
(waiting times as per
individual Trust)
Further treatment / Discharge

# Key Feedback from Service Users and Stakeholders

## What people valued about the current offer:

- The choice of F2F, telephone or video appointments
- The option of individual treatment as well as group classes
- Single point of access (SPOA)
- First contact practitioners (FCPs)
- Clinics are easy to get to
- Exercises to do at home (app/email/paper)
- Information about how to look after your body
- Professional knowledge and expertise

# Key Feedback from Service Users and Stakeholders

## What people felt could be improved:

### Access

- Language barrier e.g. Bengali and Nepalese communities
- People are not aware of option for self-referral
- Inability to book appointments on NHS app
- More weekend/evening appointments
- No clinics in NE of borough (Woolwich/Plumstead/Thamesmead/Abbey Wood)

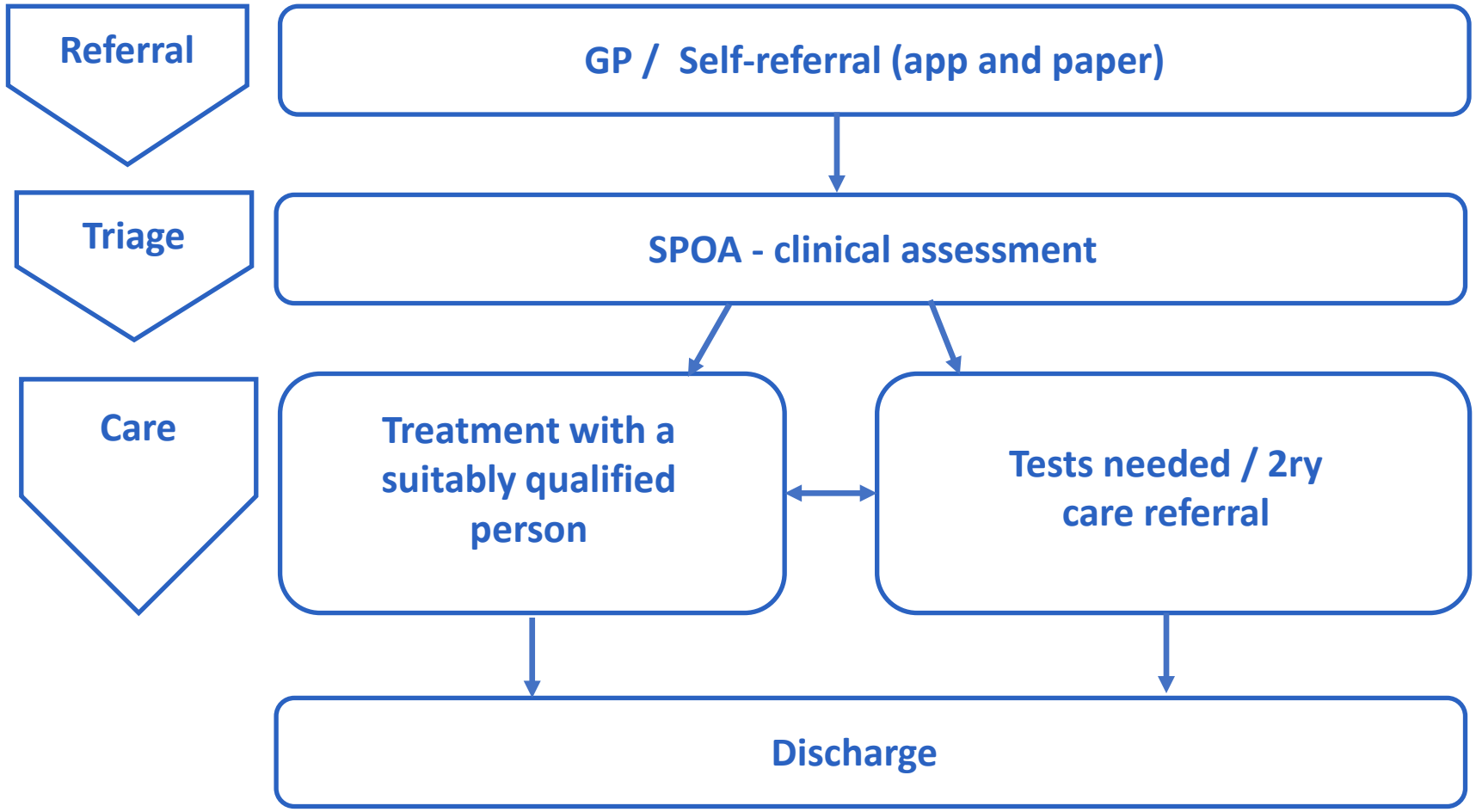
# What people felt could be improved (cont):

## Service

- Flexibility - treating people, not conditions
- Variability in service quality / attitude of staff
- Waiting times
- Diagnostic tests take a long time
- Lack of information about the service and what to expect
- Inequity around pain management
- Better links to social prescribing
- Consider extending group classes beyond 6 weeks
- Not always easy to contact to change an appointment or follow-something up
- Easy and efficient way to check if I need reassurance that doing exercises correctly
- Easier way back in if not long discharged and need to be seen / contact someone for advice
- Better way to deal with multiple joint issues
- Lack of understanding re Long-term Conditions (LTCs) and better links to Wheelchair and Equipment services
- Clear spinal pathway (MDT not seen as satisfactory)
- Better information at discharge

# Proposed model - based on feedback

# Very Much a “Starter for 10”



## Principles:

- Really robust SPOA with very clear criteria to allocate people to the correct pathway and minimize 2ry care referrals – dependent upon comprehensive referral information as a key input
- Effective use of the total capacity available, acting as one team
- All MSK-related referrals should only be made in a “forward” direction, to avoid unnecessary delays
- Equitable access to the service (geographically and given language barriers)
- Equitable access to pain management service

## Starter for 10 proposal, considering 2 possibilities:

- **Neighbourhood model** - staff working in GP practices, based on patient numbers / data about where referrals are coming from
- **Community-based model** - staff working in clinics, based on patient numbers / data about where referrals are coming from

# Break – 15 mins

# Collectively Building an Improved Service Model

## What we are asking you to help us with:

- At your tables, please discuss:
  1) How can this pathway be improved to meet the needs of our local population? (what we do)
  2) What else do we need to consider to enable great patient experience? (how we do it)
  3) What have people experienced that works well elsewhere that we can learn from?

## Process:

- World-café: each table to spend 20 mins exploring each question
- After 20 mins, you will rotate to another table to hear what others thought and to build on their thinking - we will repeat this process a few times

# Sharing Highlights

## Here's a reminder of what you've been thinking about:

1) How can this pathway be improved to meet the needs of our local population? (what we do)
2) What else do we need to consider to enable great patient experience? (how we do it)
3) What have people experienced that works well elsewhere that we can learn from?

## What highlights would you like to share with the room?

# Next Steps & Check-out

# Close

# Timeline

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

AGENDA ITEM: 12

# Healthier Greenwich Partnership

**Date: 24 April 2024**

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

**HGP Risk register update April 2024**

Since the last update to HGP in January, two new risks were added to the register and three risks were closed following review. There are currently 12 open risks on HGP Risk register, with seven of them relating to the delivery of the HGP 2023/24 plan.

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

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

| Risk No. | Risk Title |
|---|---|
| 508 | Risk to mobilising the new Integrated Community Equipment Services (ICES) contract |
| 521 | There is a clinical risk to a CHC funded individual in Greenwich and financial/legal/reputational risk to ICB |

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

| Risk No. | Risk Title | Latest update |
|---|---|---|
| 495 | Risk relating to co-ordination of timely discharge support for residents. | 01/03/2024 - There is continued pressure in hospital discharge pathways. There are programmes like QE Cares, the Home First operational group and the TOCC that have focus on ensuring flow. There is a focused set of actions to ensure discharge is optimised called Super March running through March 2024 with all partners contributing. |
| 493 | Risk to overspend in borough's delegated budget | 09/04/2024 – Reviewed and closed. 2023/24 year end position finalised within the control total. |
| 481 | Risk to Greenwich prescribing budget. | 11/04/2024 – Reviewed and closed. 2023/24 Year-end agreement for Greenwich has been reached. |
| 462 | Risk to primary care (PCN) access | 17/04/2024 – Reviewed and closed. All Practices now transitioned to digital telephony. Data on digital access will be monitored and reviewed as part of the 2024/25 Capacity and Access plan. Transition to Modern General Practice has been reviewed with 27 out of 29 Practices. |

# Healthier Greenwich Partnership Forward Planner 2024/2025

| Date | Standing Items | Main Business/Themed Item | Items for Information |
|---|---|---|---|
| April | • Welcome<br>• Introductions and apologies<br>• Declarations of interest<br>• Minutes of previous meetings<br>• Action Log<br>• HGP Partner's Report.<br>• HGP sub-committee report. | • Public Engagement Forum feedback – Russell Cartwright<br>• Greenwich ATEC programme - Lisa Wilson/Kit Collingwood<br>• MSK Procurement Update – Annie Norton<br>• APMS procurement options update – Maria Howdon | Board Meeting in public (on MS Teams) |
| May | • Welcome<br>• Introductions and apologies<br>• Declarations of interest<br>• Minutes of previous meetings<br>• Action Log<br>• HGP Partner's Report.<br>• HGP Development | • Acute Provider Collaborative - updates for HGP – Kate Anderson (LGT)<br>• 24/25 Plan update<br>• Neighbourhood development and approach<br>• Neighbourhood and Health Inclusion Steering group update – Jessica Arnold | Private Seminar (via Ms Teams) |
| June | • Welcome<br>• Introductions and apologies<br>• Declarations of interest<br>• Minutes of previous meetings<br>• Action Log | • Quarterly HGP Development session | Quarterly HGP Development Seminar |

| Date | Standing Items | Main Business/Themed Item | Items for Information |
|---|---|---|---|
| | • HGP Partner's Report. | | Tentatively booked Rooms 4 and 5 RBG Town Hall, opposite Woolwich centre |
| July | • Welcome<br>• Introductions and apologies<br>• Declarations of interest<br>• Minutes of previous meetings<br>• Action Log<br>• HGP Partner's Report.<br>• HGP sub-committee report. | • Public Engagement Forum feedback – Russell Cartwright<br>• Healthwatch thematic reviews – Joy Beishon | Board Meeting in public.<br><br>Tentatively booked Rooms 4 and 5 RBG Town Hall, opposite Woolwich centre |
| August | No meeting | No meeting | No meeting |
| September | • Welcome<br>• Introductions and apologies<br>• Declarations of interest<br>• Minutes of previous meetings<br>• Action Log<br>• HGP Partner's Report.<br>• HGP Development | • Quarterly HGP Development session | Quarterly HGP Development Seminar.<br><br>Tentatively booked Rooms 4 and 5 RBG Town Hall, opposite Woolwich centre |
| October | • Welcome<br>• Introductions and apologies<br>• Declarations of interest<br>• Minutes of previous meetings<br>• Action Log | • Public Engagement Forum feedback – Russell Cartwright<br>• | Board Meeting in public (on MS Teams) |

| Date | Standing Items | Main Business/Themed Item | Items for Information |
|---|---|---|---|
| | • HGP Partner's Report.<br>• HGP sub-committee report. | | |
| November | • Welcome<br>• Introductions and apologies<br>• Declarations of interest<br>• Minutes of previous meetings<br>• Action Log<br>• HGP Partner's Report.<br>• HGP sub-committee report. | • <br>• | Private Seminar (via Ms Teams) |
| December | • Welcome<br>• Introductions and apologies<br>• Declarations of interest<br>• Minutes of previous meetings<br>• Action Log<br>• HGP Partner's Report. | • Quarterly HGP Development session | Quarterly HGP Development Seminar. Tentatively booked Rooms 4 and 5 RBG Town Hall, opposite Woolwich centre |