South East London Integrated Care System

Royal Borough of Greenwich

NHS South East London

Our population

- 289,100 residents live within the Royal Borough of Greenwich, an increase of 13.6% from 2011
- The number of residents in the borough aged over 65 has risen by 15.6% since 2011
- The total number of economically active people in RBG make up 76.2% of the borough
- 5.9% of residents are unemployed
- 58.6% of residents have achieved NVQ4 and above
- 51.8% of households in Royal Greenwich are classified as being deprived in one or more of the following: employment, education, health and disability and housing

Health outcomes for our population

- Prevalence of hypertension in Royal Greenwich (all ages) is 12.4%, this is below the National average of 14.4% (2022/23)
- In Greenwich, over 60% of the adult population is obese or overweight
- Hospital admissions as a result of self-harm (10-24 years) are increasing and getting worse with 2050 counts in 2021/2022
- Mental Health is significant, with growing demand, with long waits particularly for CAMHS
- New referrals to secondary health services (all ages) increasing, above the National average
- Smoking prevalence in adults (18+) in Greenwich has been decreasing steadily. The most recent data for Greenwich is slightly above the national (13.5% vrs 12.7% nationally)
- Cancer is the leading cause of death for people in Greenwich (30.9%) with Heart disease following behind (28.6%)
- Musculo-skeletal conditions and poor mental health have the biggest impact on quality of life (morbidity) in our population

Inequalities within our borough

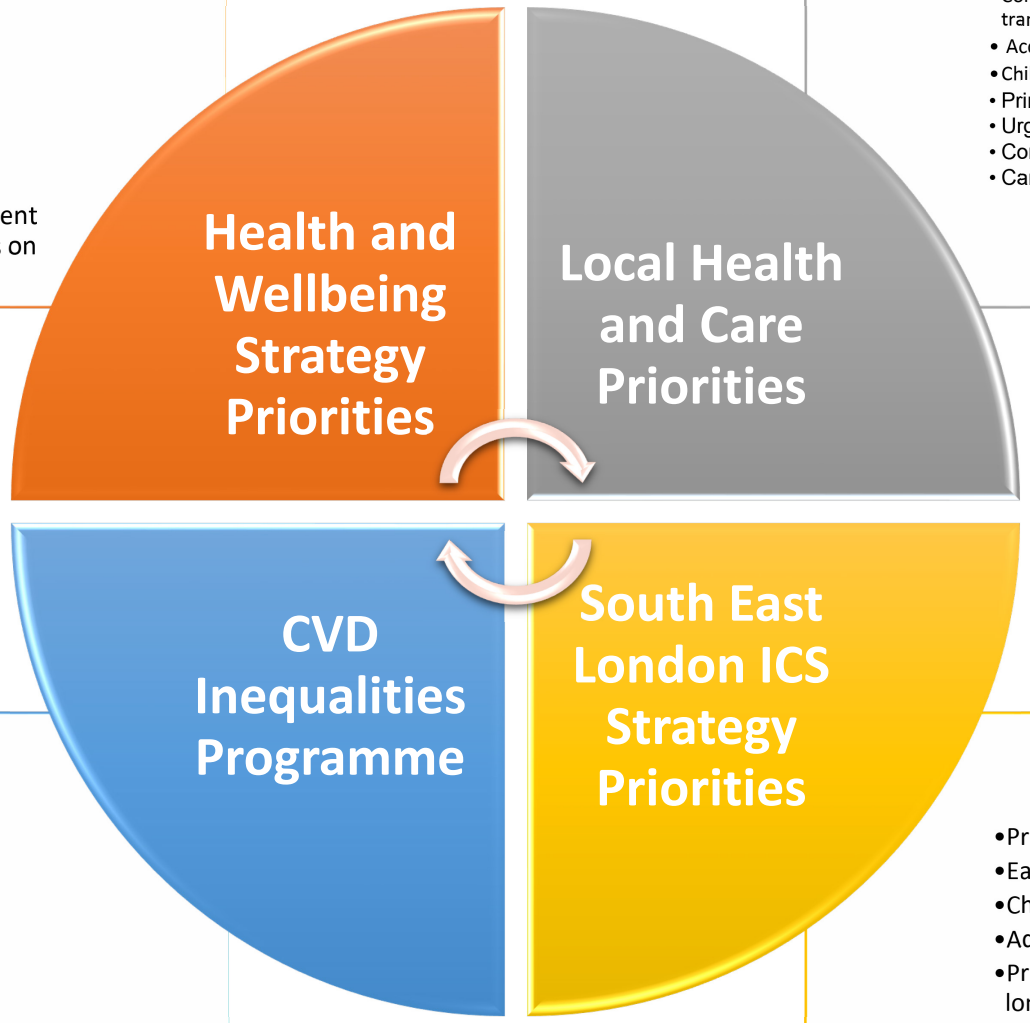
- In Greenwich, life expectancy is 5-6 years lower in the most deprived quintile when compared to the least deprived quintile
- The biggest contributory diseases to the gap in life expectancy between the most & least disadvantaged is circulatory disease, followed by cancers & respiratory disease
- In 2020-2021, deaths from COVID also contributed to the gap in life expectancy as poorer people were disproportionately affected
- Black, Asian and other minority ethnic communities are overrepresented in our more deprived areas and experience related health inequalities in addition to the direct impacts of structural inequalities and racism on mental and physical health outcomes
- The prevalence of obesity in children aged 10-11 increased sharply during the pandemic years, but has fallen over the last two years in Greenwich and nationally. Inequalities remain a significant factor, with children in the most deprived quintiles having much higher rates than those in the least deprived quintiles.

What we've heard from the public

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

The Greenwich Health and Care Plan Contents

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



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

Resources

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

Enablers

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

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

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

Further development of the Health and Care Partnership - HGP

Our priorities span a resident's life course

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

Support Greenwich residents to **start well:**

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

Support Greenwich residents to **be well:**

- Everyone is more active
- Everyone can access nutritious food

Support Greenwich residents to **feel well:**

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

Support Greenwich residents to **stay well:**

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

Support Greenwich residents to **age well:**

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

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

How we developed our priorities as a partnership

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

The Healthier Greenwich Partnership is on a journey to partner well. Between Sep-Dec 2022, the partnership co-developed:

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

There is a suite of plans that are linked, as follows:

- SEL ICB Joint Forward View (JFV)
- Greenwich Health & Well-being Strategy (HWBS)
- Greenwich Local Care Plan (LCP)

These plans have in common a set of priorities informed by engagement and key workstreams include:

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

The LCP is the key delivery plan for HGP – it contains 10 priorities with 32 High impact Activities (HIAs) that are organised across 5 areas – Start Well, Be Well, Feel Well, Stay Well and Age Well.

During the second half of 23/24 a progress update of the work to deliver against the 32 High impact Activities has been undertaken.

It was evident that good delivery progress was being made against the 32 HIAs, which was very encouraging given that this is a high-level plan to improve outcomes for people across Greenwich over the 5 years from 23/24 to 27/28.

Moving into 24/25, leads for each HIA have been looking at the activities and refreshing things so that they remain relevant for 24/25. They have equally considered the outcomes and metrics that we are collectively working towards achieving and make any amendments here too.

The HGP Board received a report on progress in Nov 23 and will receive another on the refreshed content in Apr 24.

Greenwich - Our objectives and priority actions

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

For our Citizens

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

For our frontline staff

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

For our Healthier Greenwich Partnership

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

Our priority actions

Support Greenwich residents to **start well:**

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

Support Greenwich residents to **be well:**

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

Support Greenwich residents to **feel well:**

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

Support Greenwich residents to **stay well:**

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

Support Greenwich residents to **age well:**

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

Greenwich – Our progress to date

Key Successes in Delivery in 2023/2024

All High Impact Activities have progressed - there is too much to celebrate to list everything in a comprehensive summary, so following is a flavour of what has been achieved during 23/24:

Start Well - 3 Family Hubs launched, specification for the Integrated Therapies Service is in place, additional capacity to increase ASD assessments, successful SEND inspection.

Be Well - 11 “School Streets” schemes, Park Runs increased from 2 to 5, 5 second-hand bike markets, Strong and Steady Falls Prevention classes, 17 Health Walks, HAF programme sessions 3482.

Feel Well - increase in babies born smokefree, improved quit rate, one of the first Lung Health Check Programme pilots, reduction in CYP waiting for initial CAMHS assessments, MH and WB Hub is live.

Stay Well - PCNs submitted Capacity, Access and Improvement Plans and signed up to NHSE Diabetes Outcomes & Improvement Programme, mobilised new UTC, work with the National Hub and Cancer Alliance to target non responders and DNAs to a breast screen.

Age Well - mobilisation of the new LNCS Homecare provider contracts, established a Carers’ Partnership, recruited two people with learning disabilities as Experts by Experience to support development of options around meaningful activities.

Key Challenges to Delivery in 2023/2024

- Unlocking the full potential of residents requires proper outreach, engagement and funding opportunities that meet people where they are.
- Good community engagement is ultimately built on trust (slow to build and easy to lose) and requires on-going investment of time, resource and budget.
- Agreeing a shared vision based about our approach and desired outcomes of neighbourhood development in Greenwich, e.g. community-led versus system-led, with agreed metrics to answer challenges from national, regional and SEL leadership

Learning and Implications for Future Delivery Plans

Good partnership working is built on strong communication and regular network meetings, where partners can stay abreast of progress, contribute at both a strategic and delivery level, and share learning (e.g. especially between commissioners and providers). This requires on-going investment of time.

Significant programmes of work are underway that build on years of community development. Valuing all people in the community as key partners brings new and creative approaches to work and is key to focusing on outcomes that matter.
It is important to have a shared change philosophy and an underlying approach that guides how we work in partnership (with our community and each other), which requires trust and transparency, clarity of purpose and objectives, and needs to include an agreed set of values and principles to work to.

South East London Integrated Care System

Greenwich priority action – Start Well

NHS South East London

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

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

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

How we will secure delivery

Actions for 24/25

Priority partnership actions:

- Review neurodevelopmental pathways (with a focus on ADHD) to identify improvements in diagnosis and support for children with autism and attention deficit hyperactivity disorder.
- Development of EMIS database to improve coordination of care between health visiting and primary care
- Launch of the new Greenwich Community Directory including improved Family Information Service and Local Offer
- Development of new Greenwich Special Educational Needs and Disabilities (SEND) Strategy and governance in partnership with children and families
- Development of a new Children and Young People's Plan in partnership with children and families

Actions for 25/26

- Implementation of the new Transitional Learning Centre (TLC) for young people up to 25 with SEND
- Identification of improvements in the sharing of health and care data for children and young people including the development of the CP-IS function to support the join up of information with unscheduled care.
- Review of Virtual Ward/Hospital at Home provision for children and young people and identification of opportunities for improvement.

Intended outcomes in 5 years' time

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

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

Greenwich priority action – Be Well (1)

Everyone is more active

Address people's health holistically through creating the conditions for people to be more active across Greenwich. This priority will focus on creating environments, activities and opportunities for people to be active in their everyday lives, maintain a healthy weight and enjoy access to affordable healthy food. Supporting active lives through travel, leisure, sport and daily living as part of a Whole-Systems Approach and improving the weight management services for children and adults. There will be greater focus on getting people who are least active into some activity. Primary and Secondary care services will routinely recommend and refer people to physical activity. Pathways to be accessible for people with all disabilities and for carers.

How we will secure delivery

Actions for 24/25

Priority partnership actions:

- Increase the number of Play Streets, Play Estates and School Streets as part of a wider programme to increase journeys foot and cycle and to reduce car journeys
- Design and implement adult physical activity pathway, which includes families - targeting behaviour change support and activity programmes at those who face the biggest barriers to getting more active
- Review, update and implement Royal Greenwich Get Active Physical Activity & Sports Strategy

Other actions:

- *Deliver cycle training and promote active travel plans.*
- *Develop streetscape design and initiate insight about car dependency.*
- *Further develop the use of Healthy Schools and Healthy Early Years frameworks to support children to have a healthy diet, be physically active and to thrive physically and mentally.*
- *Uplift to Active Lives data set*
- *Increased focus on physical activity in primary care*

Actions for 25/26

- Implement the Local Implementation Plan (LIP).
- Develop the Healthy Weight Care Pathway and take up of related training.
- Develop and implement the Good Work Standard.

Intended outcomes in 5 years' time

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

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

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

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

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

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

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

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

- Measures: comms activity and resident activation

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

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

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

Health outcomes and inequalities starting to be impacted include

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

Greenwich priority action – Be Well (2)

Everyone can access nutritious food

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

Actions for 24-26

How we will secure delivery

Priority partnership actions:

- Ensure that food and nutrition is included as part of all diet-related disease care pathways such as hypertension, CVD, diabetes, and excess weight
- Refresh the food poverty action plan to align with 'Our Greenwich' and emerging regional and national policy
- Improve the food environment at a neighbourhood, high street and organisational level , harnessing the contributions of all HGP partner organisations, working with planning levers, e.g. Thamesmead Superzone and through integrated commissioning for neighbourhoods
- Improved access to specialist services for those where food and nutrition is a challenge e.g. Dietetics and Speech and Language Therapy (Dysphagia)

Other actions:

•Review & update the Greenwich Healthy Weight action plan, identifying cross departmental and cross agency opportunities to improve the obesogenic environment, reduce weight stigma and support residents to access good food

• Develop a SEL infant nutrition strategy, mobilise a breastfeeding peer support and sustainable tongue tie service through the family hub. Children's centres, health visiting and maternity to achieve and maintain UNICEF Baby Friendly Initiative (BFI) accreditation

• Increase the use of the curriculum and extra-curricular activities to develop children's skills and knowledge around healthy eating, physical activity, and health and wellbeing

• Deliver the food skills programme, including cookery and food growing

• Deliver the Good Food in Greenwich (GFiG) action plan including work to mirror the TfL advertising ban of foods that are high in fat, sugar and salt. Develop Good Food in Greenwich healthy retail strategy

• Ensure all new food outlets engage with the Healthier Catering Commitment and increase engagement with existing outlets

• Develop a sustainable plan for Holiday Hunger/ enrichment programmes

• Deliver the National Child Measurement Programme (NCMP)

• Develop healthy weight care pathways which encourages stakeholders to raise the issue of weight and refer to specialist commissioned weight management programmes

• Further develop and expand of Neighbourhood Food Action Alliances (NFAA) where VCS food organisations are coming together to share food, intelligence and work together

• Link work into supported living services and support planning around independent living skills

Intended outcomes in 5 years' time

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

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

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

- Breastfeeding initiation and breastfeeding prevalence at 6-8 weeks
- BFI accreditation / BFI Gold status achieved by 2025
- Increase in percentage uptake of Healthy Start beneficiaries
- Number of residents attending cookery clubs
- Number of HCC accredited settings
- Number of settings achieving the Good Food in Greenwich Charter
- Number of schools engaged in the Healthy Schools programme
- Percentage participation in National Child Measurement Programme (NCMP)
- Number of residents engaged in weight management services
- Decreased numbers of foodbank users
- Number of VCS food aid organisations involved in surplus food distribution

Greenwich priority action – Feel Well (1)

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

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

How we will secure delivery

Actions for 24/25

Priority partnership actions (Tobacco):

- Embed evidence-based Tobacco Treatment through the consistent roll-out of Very Brief Advice (VBA), and at point of care within LGT, Oxleas (mental health and community services) and wider NHS pathways, to include offer of vapes and incentives for pregnant people as part of core treatment.
- Complete the Lung Health Check programme pilot, highlighting early-stage cancer for treatment and Very Brief Advice point of care referral to stimulate Tobacco Treatment

Priority partnership actions (Drugs and alcohol):

- Implement new funding for drug and alcohol treatment through our local partnership arrangements, ensuring increased access to high quality treatment.

Actions for 25/26

Tobacco, drugs and alcohol: Ongoing further implementation of our tobacco, drug and alcohol treatment and prevention programmes. This will include full implementation of the Targeted Lung Health Check programme, identifying lung cancers at an early stage & improve outcomes

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

Intended outcomes in 5 years' time

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

Key measures will include:

- Allocate additional DHSC funding regarding Tobacco Control & Treatment Service aligning with existing contract's demand of the borough, within awaited guidance
- Increased tobacco treatment services across community and NHS settings
- Increased smoking cessation numbers
- Increase uptake of Vapes as smoking cessation aid
- Reduction in substance misuse or crisis admissions
- Increased number of residents accessing drug and alcohol treatment
- Increased healthy life expectancy measures.
- Impact on priority health outcomes: cancers, cardiovascular diseases, respiratory diseases, inequalities, mental health and wellbeing
- Optimised personalised care for adults prescribed correct medicines to manage dependence and/or withdrawal
- More people will access effective, evidence-based drug and alcohol treatment services, reducing the harms to individuals, families and communities

South East London Integrated Care System

Greenwich priority action – Feel Well (2)

NHS South East London

Fewer adults are affected by poor mental health

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

How we will secure delivery

Actions for 24/25

Priority partnership actions:

- Develop diverse/personalised interventions for people experiencing mental health problems within community settings, considering psychological, physical, and social needs – including development of the MH Alliance and Community MH and Wellbeing Hub
- Work with people with lived experience to develop effective communications and engagement to help tackle stigma and provide a sense of belonging
- Continue to develop services in community/hospitals, including talking therapies and mental health liaison teams, to provide the right level of care for people with common or severe mental illnesses
- Ensure commissioned services meet responsibilities for the LDA programme – LeDeR, mental health hospital discharges and Annual Health Checks, through strong partnership working with specialist learning disability clinical services
- Increased engagement in community resources and activities including via self-directed support (PHB, ISF) options

Other actions:

• Develop a refreshed needs assessment for MH in Greenwich, followed by co-produced solutions to reduce inequalities

• Develop/promote a social model of disability and mental health services approach. This means that we have focused on the socially constructed barriers which impact the lives of people with mental health and or learning disability needs, and how those could be removed

•Support higher risk and vulnerable populations, with a focus on training, and

• Reduce the level and impact of social isolation and loneliness.

• Identify and implement effective approaches to engaging local employers around tackling mental health stigma and discrimination. Work with employers to provide workplaces that support good mental health, and with people who are self-employed

• Improve information and intelligence to tackle suicide, including communication, engagement and support

Actions for 25/26

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

Intended outcomes in 5 years’ time

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

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

Greenwich priority action – Feel Well (3)

Fewer children and young people are affected by poor mental health

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

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

How we will secure delivery

Actions for 24/25

Priority partnership actions:

- Development of a model for a Single Point of Access for children's emotional health and wellbeing needs
- Review the mental health in schools offer including Greenwich's Mental Health in Schools Teams and identify opportunities for improvement and the development of an equitable offer across the Place
- Establishment of a home treatment team for children's mental health
- Mobilisation and review of the new Integrated Clinical Team within RBG Children's Services
- Mobilisation and review of the new clinical support into the Adolescent Assessment Residential and Resource Centre
- Continue to work to embed a Thrive and system approach to Mental Health and Wellbeing in Greenwich

Actions for 25/26

- Implementation and Review of the Single Point of Access for children's emotional health and wellbeing needs
- Development and implementation of opportunities identified through the Mental Health and Schools work
- Development of a new model for providing mental health support to children aged 16-25 as part of the transition to adulthood; including care leavers (noting that care leavers are a protective characteristic in Greenwich)

Intended outcomes in 5 years' time

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

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

South East London Integrated Care System

Greenwich priority action - Stay Well (1)

NHS South East London

Everyone can access the services they need on an equitable footing

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

How we will secure delivery

Actions for 24/25

Priority partnership actions:

- Continue to improve Primary Care Access by implementing Access Recovery Plan – conversations with all practices continuing, including:
  - review of transition milestones to Modern General Practice to access national funding
  - Practice Improvement Programmes support offer
  - Offer of Greenwich development support programme
- Continue with actions to address acute care waiting times for elective care, both inpatient and outpatients, with a focus on inequalities
- Reduce waiting time for services in Mental Health and Community Care
- UTC – ensure benefits of integrated urgent care model are delivered with appropriate links to same day emergency care, urgent care and MH crisis response and pharmacy first.
- 111 – preparation for procurement process and its resulting impact
- Full roll-out of Population Health Management (HealtheIntent)
- Reducing waiting times for autism diagnosis

Actions for 25/26

- Realisation of integrated data sets that underpin our work – highlighting health inequalities, providing insight into the likely needs of residents as they age and ensuring that the Greenwich pound is invested in the right places to secure better outcomes
- Improve data flows including by (i) solving the problem of data sharing liability; (ii) working with system suppliers on extract functionality; (iii) improving data to support access (actions 1 and 2 above), and (iv) helping to identify population cohorts to be targeted by neighbourhood teams.

Intended outcomes in 5 years' time

Prevention and Health Inequalities:

- Continue to address health inequalities and deliver on the Core20PLUS5 approach.

Engage communities:

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

Community Health Services:

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

Primary Care:

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

Mental Health:

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

Acute Care:

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

Greenwich priority action – Stay Well (2)

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

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

How we will secure delivery

Actions for 24/25

Priority partnership actions:

- Build partnerships with local communities and improve the way local communities and organisations work together with the NHS and the Council to improve services closer to where people live that are joined up.
- Develop the way we commission collaborative public health prevention services at a more local level using transformative processes including outcome-based, co-design, collaborative development and integrated approaches based on what matters most to residents. These will link to all local services.
- Agree a shared vision for neighbourhood development in Greenwich, e.g. community-led versus system-led, with agreed metrics to report on impact and answer challenges from national, regional and SEL leadership
- Develop an understanding of what environment / culture is needed to enable and sustain effective system integration, and particularly agreeing the need to develop a learning culture & a systematic approach to learning that ensures we are properly able to connect what we learn from operational delivery with strategic decision-making and prioritisation.
- Agree and develop the necessary governance to enable sustainable system connectivity and delivery through shared learning focused on empowering communities of residents, patients, assets, providers, etc and removing barriers, connecting resources (human, financial and physical space).

Other actions:

• Support primary care and partners to evolve into neighbourhoods, identifying where primary care wants to work with other providers at scale, by establishing or joining provider collaboratives, GP federations, supra-PCNs or working with or as part of community mental health and acute providers.

• Develop our community approaches that connect individuals to sources of support that address the wider determinants of health. Build on our community development approaches and expand personalised care support including social prescribing.

Actions for 25/26

- Embed agreed metrics for a neighbourhood development dashboard to report on impact / outcomes and enable continuous learning
- Continue to support and connect GP through a tailored programme of development support, focused on bringing together existing good practice around neighbourhood development from across Greenwich
- Embed agreed governance structures supported by an extended social research function that enable visible connectivity between operational delivery and strategic prioritisation

Intended outcomes in 5 years' time

- Collaboration between residents, patients, carers, community assets and providers to work seamlessly to meet the needs of local populations / communities.
- Joined up, accessible support for those people who need it the most
- Use data and insight, (including from residents / patients) to understand local needs and wants and inform service improvements and new ways of working
- Strive for collaborative quality improvements focussed on prevention and shared outcomes
- Align clinical and operational teams of community health providers with established communities over time working alongside dedicated, named specialist teams from acute and mental health trusts, particularly community mental health teams wherever necessary and practicable.
- Increase collaboration between previously siloed teams and professionals, (including Secondary care, Primary care, Community, MH, VSCE and local providers) doing things differently and improving patient care, working with and for whole populations / communities.
- At place, identify opportunities to serve local needs more effectively / efficiently e.g. bringing together teams on complex / continuous care (e.g. LTC), admissions avoidance, discharge and flow – including urgent community response, virtual wards and community mental health crisis teams.
- Use population health management as a means of identifying, targeting and addressing the needs of particularly vulnerable patient groups, e.g. Core20PLUS5 populations
- Work with communities to further develop, or plug gaps with their own assets and resources, including supporting a "compassionate communities" approach.
- Embedded governance structures that use a systematic approach to learning to inform and drive strategic decision making and prioritisation for Greenwich, whilst remaining responsive to national, regional and SEL imperatives

Greenwich priority action – Stay Well (3)

Unfair and avoidable differences in health and wellbeing are reduced

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

How we will secure delivery

Actions for 24/25

Priority partnership actions:

- Embed new SEL-wide diabetes outcome scheme, aimed at PCN-level improvement and reduction in variation ('levelling up' the poorer performing practices) in core diabetes outcome/ care process measures.
- Develop targeted cancer screening improvements, focusing on Lung, Cervical, Prostate, Bowel and Breast in particular, key focus on influencing uptake, and then lifestyle changes to reduce risk (see other priorities)
- Build on the learning from the two 100-day challenges to reduce cardiovascular inequalities and the Connecting Thamesmead programme to reduce social isolation
- Coordinate an anti-racism community of practice (COP) to support stakeholders adopting processes within their work such as cultural humility principles to address structural racism and ethnic health inequalities.

Other actions:

- *Develop new, systematic and ongoing methods of gaining insights from our diverse communities into the factors that affect their mental and physical health; better understand what matters most to our residents and supporting the co-design of interventions.*
- *Ensure a particular focus on unwarranted variation in access, experience and outcomes; proactively challenging racism, discrimination and striving for equitable access to services in all we do*
- *Establishing a population health system to drive targeted improvement to tackle inequalities with a focus on Core20plus5*
- *Work with people with lived experience to develop universal and targeted communications to help tackle stigma and discrimination in the Royal Borough of Greenwich.*
- *Reduce the level and impact of social isolation and loneliness*

Actions for 25/26

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

Intended outcomes in 5 years' time

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

Engagement:

- the number and type communication and engagement activities with people from our diverse communities including those with lived experience of stigma and discrimination.
- The number and types of co-design; positive feedback from residents about their inclusion
- Number and type of grant programmes/grant funded community projects that improve outcomes and are sustainable

Spaces:

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

Isolation:

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

Cultural humility

Improved awareness of the impact of ethnic health inequalities and improved practice to address them.

Poverty:

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

Health outcomes:

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

Greenwich priority action – Age Well

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

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

How we will secure delivery

Actions for 24/25

Priority partnership actions:

- Delivering actions which improve market sustainability, quality and workforce recruitment and retention initiatives across community based, residential and nursing settings, including a refresh of Market Sustainability Plans and targeted use of government funding.
- Co-design, development and delivery of community-based support models for those with care and support needs and their carers. This will include delivery of the new Homecare model, development of community enterprises and new models of care.
- Optimise and develop our Home First approaches by expanding virtual wards to provide assessment, treatment and care to all patients in the place that they call home (including care homes), and to ensure that patients cared for at home have direct access to diagnostics.

Other actions include:

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

Actions for 25/26

- Focus on supporting providers around sustainability and quality via the delivery of the MSP
- Continue work to embed assistive digital technology into local offers that can improve the lives of residents with specific needs, both in prevention, short and longer-term support

Intended outcomes in 5 years' time

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

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

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

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

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

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

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

South East London Integrated Care System

NHS South East London

Royal Borough of Greenwich - local delivery

Greenwich borough delivery of SEL pathway and population group priorities

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

Urgent & Emergency Care

- Greenwich is continuing work to support the on-going success of Urgent Care and Same Day Emergency Care, particularly the UTC at QEH, with colleagues at SEL level. Focus on supporting QEH to achieve 76% ED target
- Greenwich's virtual wards will continue to expand, providing patients with acute care in their own home where possible. Key developments focus on linking these pathways to London Ambulance Service, preventing conveyance to hospital when this is not necessary and ensuring patients being cared for in the community have access to the diagnostics they need in a timely manner.
- System partners will continue to support the development of same day emergency care for patients requiring specialist support which can be accessed directly and managed in an ambulatory or ward environment without the need to attend ED.
- Continue to expand navigation roles, both into the community and voluntary sector, to ensure the holistic needs of residents can be met outside of the hospital environment. This includes active case-finding support within QEH, with social prescribers (Live Well) in ED and supporting discharge.
- With the 111 contract ending in 2025, there is the opportunity to design a model that integrates 111 with local services and new models of care, which we hope to pilot during 24/25.

Population Health & Prevention

Greenwich has undertaken a huge amount of work during 23/24 to ensure that relevant IG agreements are in place to support the roll-out of HealtheIntent. This system is hosted by LGT and has been rolled-out across Lewisham practices, secondary care and part of mental health. The ground-work undertaken in respect of Lewisham is helping with roll-out for Greenwich and we are benefiting from previous lessons learnt (this work includes our targeted CVD prevention programme). Once GP practices are signed-up, there are plans to extend the roll-out to community and mental health (Oxleas), Public Health colleagues and other data held by the local council (RBG). We are actively participating in wider networks and sharing progress and lessons learnt with colleagues across SEL ICB.

We are strengthening our community infrastructure, working with GHIVE, neighbourhood development, all building on the learning from Covid support, and deep engagement.

Learning Disability and Autism

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

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

We will be publishing our commissioning intentions in 24/25 and we have the Autism Strategy, both of which will influence the market.

Other examples of local delivery

- Greenwich is in the process of re-commissioning its MSK community service, with a lot of work undertaken since Sep 23 to collect feedback from people across the borough, as well as from referrers to the service. An event has been held in Feb 24 to look at how we can improve the pathway/model, based on the feedback and input from a wider range of people. This will eventually form the specification of the service that we will commission so that the new service is mobilised and can commence from Apr 25.
- Breast screening – successful application to SEL Cancer Alliance to run a campaign to increase uptake. "Breast screening – it's what we do" campaign (launching Mar 23) will use 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 accessing breast screening

Greenwich Enabler requirements

Workforce

What is needed to ensure success?

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

Estates

What is needed to ensure success?

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

Digital

What is needed to ensure success?

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

Finance

What is needed to ensure success?

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