Royal Greenwich Health and Wellbeing Strategy 2023-2028

Healthier Greenwich Partnership

ROYAL borough of GREENWICH

Contents

1 Foreword

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

Royal Greenwich is a diverse place to live, with a rich cultural and historical heritage. Internationally recognised sites like the Cutty Sark, Royal Observatory and Greenwich Park sit alongside iconic modern landmarks such as the O2 Arena and Woolwich Works; and the borough has seen a huge amount of regeneration over recent years. Royal Greenwich is now home to 290,000 people, speaking over 150 languages.

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

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

- The world continues to emerge from a global pandemic which presented significant challenges to us all, as leaders, as service providers and as members of families and communities.
- Our understanding of how racism, discrimination, social and economic inequalities lead to health inequalities has taken a big step forward.
- The cost-of-living crisis is placing huge stress and practical challenges in the way of our residents, especially those in our more disadvantaged communities. We know there is a direct association between health and wealth, and that this crisis is likely to worsen health inequalities in our society.

- The government has changed the way in which the health and care system is organised across the country, presenting new opportunities for health and care providers to work differently together and with their populations to help them to stay healthy, happy and living independent lives for as long as possible.
- The Royal Borough of Greenwich has published a new corporate plan, 'Our Greenwich' which sets out a vision for the borough for the next five years and places a strong emphasis on health, wellbeing and equality. Based on substantial engagement with local people, staff and stakeholders, the health and wellbeing priorities identified in 'Our Greenwich' form the basis of this strategy.

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

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

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

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

Supporting Greenwich residents to **START WELL**

Supporting Greenwich residents to **BE WELL**

Supporting Greenwich residents to **FEEL WELL**

Supporting Greenwich residents to **STAY WELL**

Supporting Greenwich residents to **AGE WELL**

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

Councillor Anthony Okereke
Leader, Royal Borough of Greenwich
Chair of the Health & Wellbeing Board

Sarah McClinton,
Greenwich Place Executive Lead,
NHS South East London ICB

2 Introduction

Reflections on our last Health and Wellbeing Strategy

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

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

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

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

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

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

Tackling unjust and preventable variations in health is a major priority within our new strategy, shown by how we work with our residents, neighbourhoods and stakeholders in more collaborative and equal partnerships going forwards.

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

> **“Tackling unjust and preventable variations in health is a major priority within our new strategy.”**

Whilst this provides opportunities for some action to be taken across a bigger geography, the importance of the borough, or ‘place’, remains the most important. Indeed, the emphasis is on work that understands,

responds to and operates in partnership with neighbourhoods and communities at local levels, to address the inequalities that drive poor health and to continue to provide more targeted and flexible services.

About the Health and Wellbeing Strategy

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

To be successful in its aims, our strategy has to be delivered as a collaboration between the NHS, The Royal Borough of Greenwich, the Voluntary, Community and Faith Sectors and residents.

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

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

It draws on our analysis about health needs in the borough, what residents have told us, and starts to build our understanding of what really works to tackle health inequalities. This includes addressing the wider determinants of health – such as housing, the economy, employment and the environment – and remaining focused on prevention.

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

Recent changes to the health care system

Our current health and care services aren't always designed in a way to meet these needs. Most services focus on treating people when they get sick, rather than helping people to stay healthy in the first place. Services that help people with their physical health are often separate to other services that provide care and support, including mental health and social care services. This means it's a struggle to coordinate across services and make the best use of staff and resources. If residents have

several problems, you can go from one service to the next, retelling your story, getting different advice, rather than getting support from a single joined up team.

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

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

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

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

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

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

> **"We use our combined resources to tackle some of the biggest health issues affecting local people. We aim to keep people well, prevent ill-health and support people to thrive and live healthier lives."**

3 About Royal Greenwich

The place

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

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

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

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

The people - a diverse population with diverse needs

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

Age

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

Household composition

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

Ethnicity and country of origin

- 62.5% of Greenwich residents were born in the UK; 37.5% were born overseas.
- Of those born overseas, 12.6% were born in other European countries, 10.4% were born in Africa, 9.6% were born in Asia and the Middle East, 3.3% were born in the Americas and the Caribbean.
- 55.7% of the population identify as being from a white ethnic group, ranging from 34.4% in Thamesmead West to 82% in Eltham Park.
- 21% of the population identify as Black, Black British, Black Welsh, Caribbean or African, ranging from 4.8% in Eltham Park through to 43.9% in West Thamesmead.
- 3.2% of the population identify as being Asian, Asian British or Asian Welsh, ranging from 5.4% in Thamesmead Birchmere Park through to 34% in Plumstead High Street.

Identity - religious belief

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

Identity - sexual orientation & gender identity

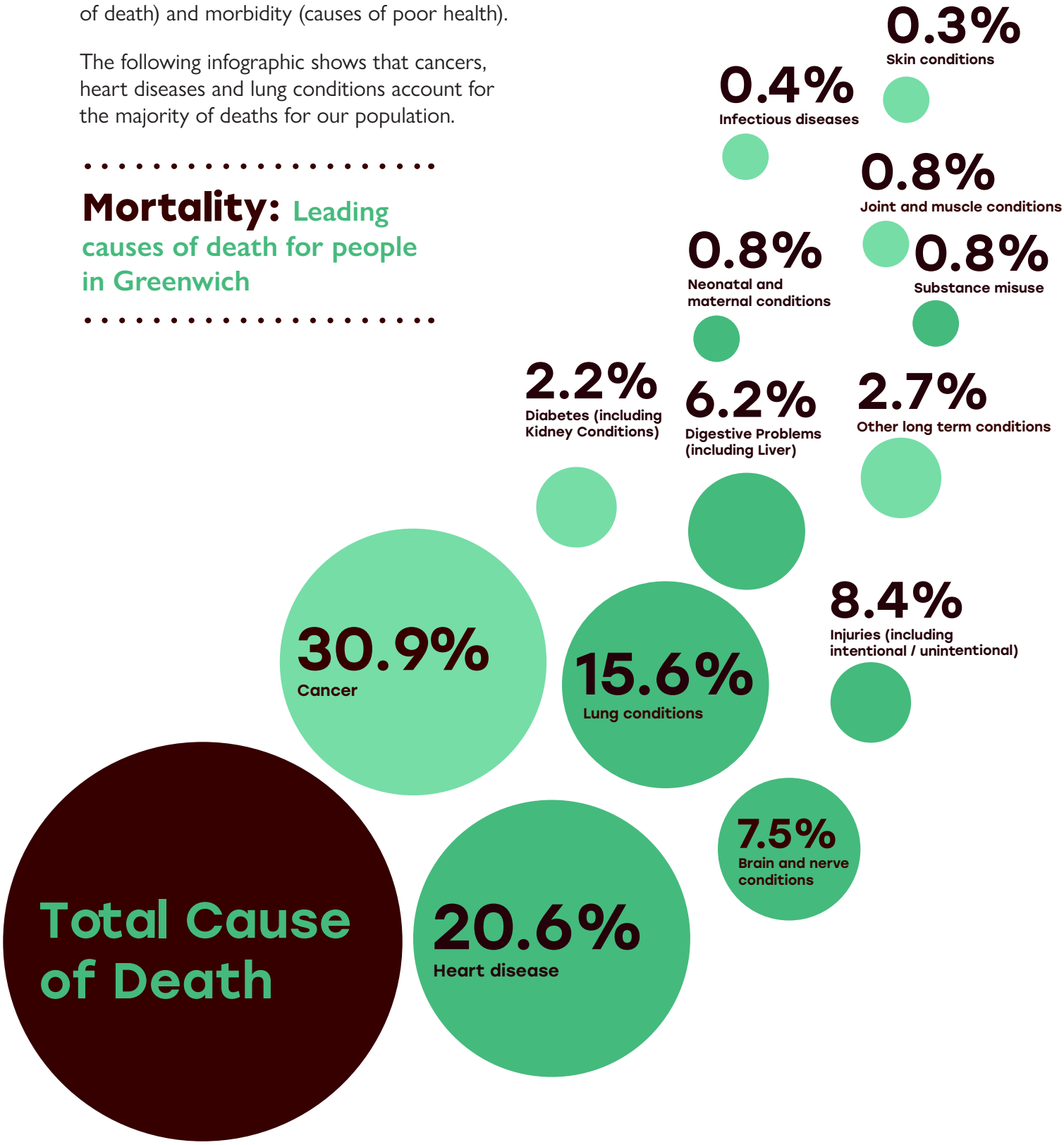
- 4.5% of the population of Greenwich aged 16 years and above identify as lesbian, gay, bisexual or other, ranging from 1.9% in New Eltham through to 9.1% in Woolwich Arsenal.
- 0.88% of the population aged 16 and older have a gender identity that is different from their sex registered at birth, ranging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

Health and wellbeing in Greenwich

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

The following infographic shows that cancers, heart diseases and lung conditions account for the majority of deaths for our population.

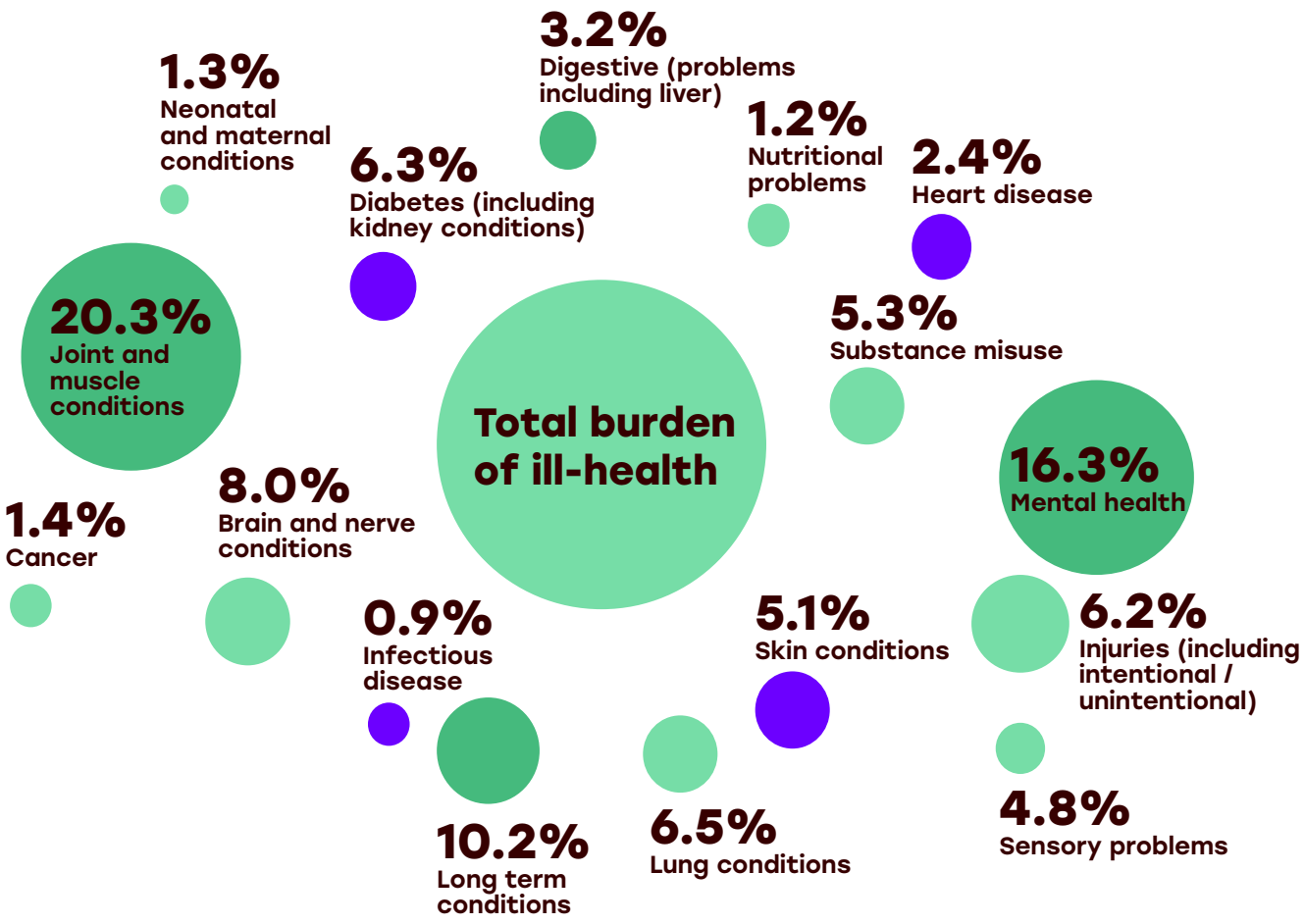
Mortality: Leading causes of death for people in Greenwich



Morbidity:
total burden of ill health

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

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



Life expectancy in Royal Greenwich

2018 - 2020

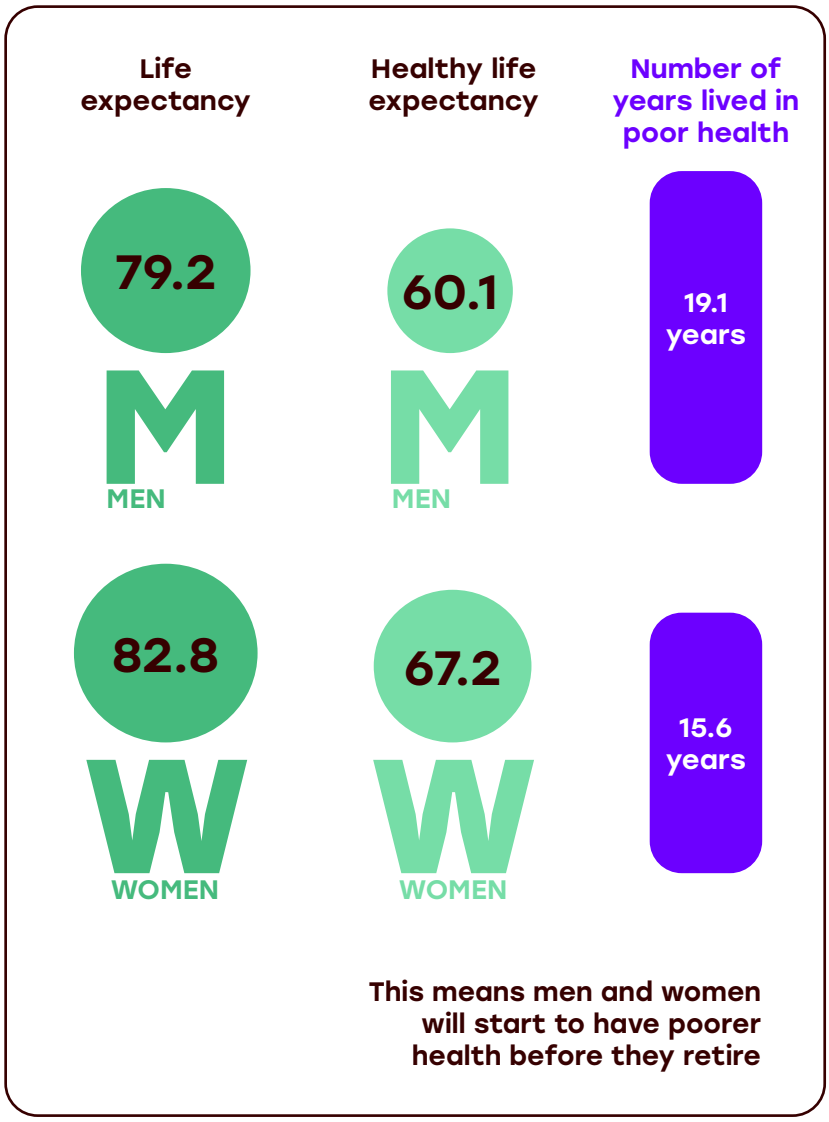
We also know that there are differences in health outcomes for men and women, and that deprivation and inequalities have a significant impact on health, with some groups having shorter lives and poorer health for a greater proportion of their lives. The following infographic shows that women live longer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

MEN

Healthy life expectancy is 3 years less than England and 3.7 years less than London

WOMEN

Healthy life expectancy is 3.3 years higher than England and 2.2 years higher than London



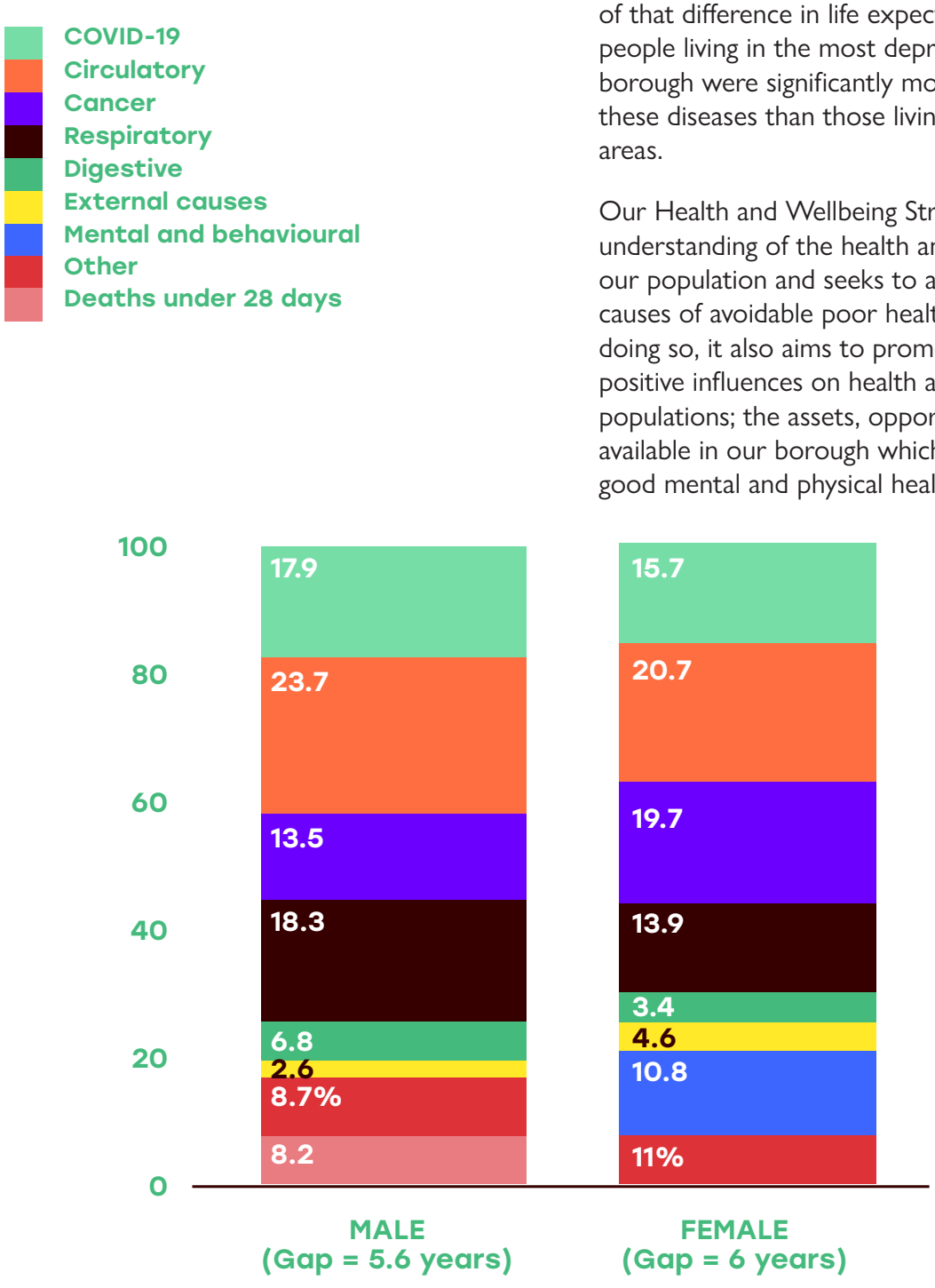
Breakdown of the life expectancy gap

Between the most and least deprived areas of Greenwich by cause of death, 2020 to 2021

Deprivation, social and economic inequalities also cause significant differences in health outcomes between different groups within our borough. There is a 5.6 year difference in life expectancy between men living in the most deprived 20% of areas of the borough compared to the least deprived 20%; and a six year gap for women between the most and least deprived areas.

The following infographic shows that for the year 2020-21, COVID-19, circulatory diseases, cancers and respiratory diseases accounted for the majority of that difference in life expectancy; meaning that people living in the most deprived areas of the borough were significantly more likely to die from these diseases than those living in the least deprived areas.

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



4 How the strategy has been developed

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

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

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

    a. Unfair and avoidable differences in health and wellbeing are reduced

    b. Fewer people are affected by poor mental health

    c. Everyone is more active

    d. Everyone can access nutritious food

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

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

Our Greenwich was developed through an extensive programme of engagement and consultation with residents, stakeholders and staff led by the Leader of the Council and cabinet members. It therefore reflects the things that local people and key stakeholders have identified as important to their lives, health and wellbeing.

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

a. **Prevention and wellbeing:** become better at preventing ill health and helping people in South East London to live healthier lives

b. **Ensuring a good start in life:** ensuring parents, children and families receive the most effective support before and during childbirth and in early years

c. **Children and young people's mental health:** ensuring that children and young people receive early and effective support for common mental health challenges

d. **Adults' mental health:** ensuring that adults in South East London receive early and effective support for common mental health challenges

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

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

5 Our priorities

We support Greenwich residents to:

Live Well Greenwich

Start well

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

Be well

- Everyone is more active
- Everyone can access nutritious food

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

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

Age well

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

Our priorities span a resident's life course

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

6 Overview of our plans for the next five years

Starting well – Children and young people 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 and will make sure they are supported to meet any additional social, emotional and mental health needs. 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.

Overview of our plans for the next five years:

- 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.
- Increased engagement with children and young people in positive activities around 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 the support available.
- More co-ordinated care for people with learning disabilities and autism.
- Reduced the waiting times for a diagnosis of autism and attention deficit hyperactivity disorder (ADHD).
- Increased engagement and improved outcomes from lesser heard groups as part of the Start for Life offer.

> **We want to improve people's health through creating the conditions for people to be more active across Greenwich. We 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.**

Being well – everyone is more active

We want to improve people's health through creating the conditions for people to be more active across Greenwich. We 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. We will support active lives through travel, leisure, sport and daily living and improving weight management services.

Where we plan to be by 2028:

All people across Greenwich are more active:

- Increased proportion of journeys made on foot or by bicycle.
- Improved physical environment and air quality to enable people to achieve and maintain a healthy weight.
- Support in schools, public and community settings to promote healthy choices and support people to achieve and maintain a healthy weight.
- Increased commitment to tackle child obesity among partners and residents.
- Support and enable people to be more active in their everyday lives.

This will start to reduce health inequalities and have a positive impact on people's physical health (including cardiovascular disease and diabetes) and their mental health. Active travel, increasing the proportion of journeys made by walking and cycling, also has a positive impact on the environment, supporting the commitment by the Council and the NHS to tackling the climate emergency and working towards a carbon neutral footprint.

Being well – everyone can access nutritious food

Improve people's health through creating the conditions for people of all ages to enjoy a healthy and balanced diet and maintain a healthy weight. We will focus on tackling food poverty, developing cooking skills and confidence. We will work with workplaces, shops, the hospitality industry, schools, health services and others.

Where we plan to be by 2028:

- Increased breastfeeding rates and support to 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.
- Increased engagement of schools, public and community settings to promote healthy choices and support people to access good food.
- Increased awareness of healthy weight services.
- Increased awareness of nutritious food on diet related care pathways for example for people with cardiovascular disease and hypertension.

Feeling well – fewer people experience poor health as a result of addiction or dependence

To improve issues such as 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. We will provide flexible services that meet an individual's circumstances to give people greater control over managing their health and wellbeing.

Where we plan to be by 2028:

For fewer people in the area to experience poor health as a result of addiction or dependency we need to create the conditions for people to be more active, eat well and manage their mental wellbeing. This will reduce the numbers of people suffering with addiction/dependency and also positively impact other priority areas (including cancer and cardiovascular disease).

- There will be more tobacco treatment services across community and NHS settings.
- More people will access help to give up smoking.
- Fewer people will be admitted to hospital for substance misuse or crisis.
- More people will access drug and alcohol treatment, personalised to their needs.
- Healthy life expectancy measures will improve.

Feeling well – fewer adults are affected by poor mental health

We are 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. We are developing a Social Mobility Delivery Plan.

Where we plan to be by 2028:

- There will be a reduction in health inequalities, in particular for people from our black and minority ethnic communities.
- Fewer people in total are referred to mental health services.
- Waiting times to access support are reduced and the average length of treatment will be lower with people able to access the right support, quickly. This will often be through primary care services where staff will be more equipped to support people's mental health needs.
- Fewer people's mental health problems escalate as a result of unaddressed issues such as debt, housing, unemployment and social isolation. Fewer people experience a mental health crisis.
- More people are supported to self-manage their mental ill-health and more people use community wellbeing resources and activities
- More frontline staff will have had suicide prevention training which will help lead to fewer local deaths by suicide.
- Mental Health Alliance established and joining up care across organisations.

Feeling well – fewer children and young people are affected by poor mental health

Our aim is for all children, young people and families in Greenwich to have the support needed to be mentally healthy. 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. 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. This work is in line with the I-Thrive Framework.

> **“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.”**

Where we plan to be by 2028:

- Improvements in children and young people’s wellbeing.
- Children and young people from across our diverse populations access and engage with specialist mental health services equitably.
- Reduced waiting times from referral to treatment for specialist child and adolescent mental health services (CAMHS).
- The mental health and wellbeing needs of children and young people are identified quicker and they are able to access support quicker meaning their needs are less likely to escalate.
- Improved knowledge and skills on mental health and wellbeing for everyone working with children and young people in Greenwich.
- More timely identification, intervention and support for perinatal mental health to prevent symptoms worsening.
- Increased awareness of the range of services on offer.
- Services will be better able to support children and young people experiencing a mental health crisis meaning there are fewer preventable hospital admissions.

Staying well – everyone can access the services they need on an equitable footing

The COVID-19 pandemic and other pressures on the health and care system have led to more people waiting longer than they should for treatment, and to difficulties accessing primary care services. To enable high quality health and care outcomes residents' experience of health and care services should include timely care with fewer referrals, access to medical and social support including peer support, integrated care, having to tell their story once and without stigma, with better and more equitable access to services.

Where we plan to be by 2028:

- Residents will help create a Greenwich Deal outlining what they can expect from services and what services expect from them. Data will be used to drive improvements in health such as improved life expectancy and reduction in inequalities.
- Improved community health services which are able to respond to urgent needs more quickly, provide urgent treatment at home, reduce the need for GP appointments and enable people to access the services they need directly.
- Reduction in waiting times for hospital care (inpatients and outpatients).
- Everyone who needs an appointment with their GP surgery gets one within two weeks and those who contact their surgery urgently are assessed the same or next day according to their needs.
- Better access to mental health services for people of all ages.

Staying well – effective integrated community teams based in neighbourhoods, provide the right support when and where it is needed

For this work we will bring together people working on prevention, primary care, community support, acute, mental health, social care, care providers, voluntary and community sector and other 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. In Greenwich, neighbourhoods will be developed in

“The COVID-19 pandemic and other pressures on the health and care system have led to more people waiting longer than they should for treatment, and to difficulties accessing primary care services.”

partnership with local teams and communities to make change to help people across the borough connect and work differently together.

Where we plan to be by 2028:

- More collaboration from teams across health and care including primary care networks, pharmacies, dentists, community care, mental health, secondary care, social care teams, and voluntary and community sector staff. They will work together with residents to share resources and information, doing things differently to improve patient care and better meet the needs of local people.
- Better use of data and insight to understand and respond to local needs earlier.
- Align clinical and operational workforces of community health providers with neighbourhood areas or 'footprints' working alongside dedicated, named specialist teams from acute and mental health trusts, particularly community mental health teams.
- Bring together teams to keep residents in the community and avoid hospitalisation when possible, smooth discharges - including

> **"In Greenwich, neighbourhoods will be developed in partnership with local teams and communities to make change to help people across the borough connect and work differently together."**

urgent community response, virtual wards and community mental health crisis teams.

- Proactively identify and target individuals who can benefit from support, using the Core20PLUS5 approach to address health inequalities.
- Provide a range of services to people with long term conditions, reducing reliance on medicines and supporting shared decision-making between clinicians and patients, including increasing the use of social prescribing. (when GPs, nurses and other health and care professionals refer people to a range of local, non-clinical services)
- Work with communities to develop their own assets and resources, including supporting the development of a compassionate communities approach.

Staying well – unfair and avoidable differences in health and wellbeing are reduced

The factors that determine health and wellbeing for individuals and communities are complex, and include social, economic, cultural, environmental and commercial drivers. With this in mind 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 factors 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.

Where we plan to be by 2028:

- Greenwich's residents feel the borough is a welcoming and inclusive place, and inequalities in life chances are reduced across our diverse populations. This will be achieved by engaging and involving people to help create local solutions.
- Partners (including planners and developers) working together with residents to make local areas a healthier environment to live in. This will include establishing play streets, school streets, and activities to encourage people to access green and blue spaces.
- More residents are supported to be less socially isolated by engaging in their communities, volunteering or through support from voluntary or community organisations.
- No resident in financial crisis is left unsupported, with those experiencing financial pressure provided with financial support and advice to prevent their situation becoming worse.
- Health will improve in key areas including cardiovascular, cancer and mental health, meaning that people across our diverse populations will live longer, healthier and happier lives.

Ageing well – health and care services support people and their carers to live fulfilling and independent lives

We will work with individuals and carers to develop an offer that supports people to live long, healthy, active and independent lives. Health and care services will work together to develop our Home First approach wherever

possible to ensure care and effective treatment for both sudden and unexpected, and longer-term health problems or disabilities. We will also ensure individuals have access to safe and high-quality home, residential and nursing care when needed. And, as people reach the end of their life, we will support more people to die in their usual place of residency, in line with their wishes.

Where we plan to be by 2028:

- Local residents receive consistent high quality health and social care services in the most independent environment. Care and treatment is provided 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 conditions including cardiopulmonary disease (COPD), dementia and delirium.
- People are less isolated and more people are able to access activities and support within local neighbourhoods. These will include access to local clubs and meaningful activities and employment, Home First Service, neighbourhood based home care and accommodation with support. People are able to self-direct their care and support.
- People will have good access to high-quality home, residential and nursing care when needed and health and social care staff will have a better knowledge of the local options.
- Carers are respected as expert care partners, they have access to personalised services they need to support them and are more able to have a life of their own outside their caring role. They are supported to improve (where possible) the financial impact of the caring role, are supported to stay mentally and physically well and are treated with dignity.
- More people will be supported to die in their usual place of residency.

> **We will continue to work together with partners to pool or align budgets where we can to jointly plan and deliver services, making the most of the money and resources available.**

Enablers - work that will help us with each of the above priorities

Strengthening our workforce

We will focus on making Greenwich a great place to work with excellent opportunities so that we are able to recruit and keep the best staff. We will develop a different, sustainable workforce model rooted in our communities with more opportunities for volunteering and flexible career opportunities. This will enable staff to work across partnerships and develop new ways of working with our diverse communities.

Making the most of digital technology

We will continue to develop our online offer for residents and invest in understanding and supporting people who are currently digitally excluded. We will share information better across organisations and use this to plan services to match local population needs. We will also use technology to further increase and promote access to health and care support including remote monitoring, virtual wards, consultations, access to records and booking appointments.

Making the most of our estates

We will work together to plan how we make best use our buildings across health and care services to ensure that residents have access to the services they need.

Making the most of the money available

We will continue to work together with partners to pool or align budgets where we can to jointly plan and deliver services, making the most of the money and resources available. Together we will shift resources to focus on prevention and keeping people well, alongside developing our communities. We will fund local initiatives in a number of ways including through voluntary and community sector grants, NHS Greenwich Charitable Funds, funds to reduce health inequalities and increase community resilience.

7 Further Information

Keep up to date with Health and Wellbeing in Royal Greenwich by heading to the following websites:

Live well Greenwich offers signposting and support
Call on 0800 470 4831 or visit livewellgreenwich.org.uk

Royal Greenwich Health and Wellbeing Strategy and Action Plans:
Visit royalgreenwich.gov.uk/health-wellbeing-strategy

South East London Integrated Care System
selondonics.org

Healthwatch Greenwich
healthwatchgreenwich.co.uk

Follow the Royal Borough of Greenwich on social media:
Twitter
Facebook
Instagram

We would like to invite you to sign up to join our team of Community Champions and help share key information and advice about health and wellbeing in Royal Greenwich. Find out more royalgreenwich.gov.uk/community_champions

Appendix 1: 2023-24 delivery plan

1.1

Strategic priority: **Start well**

Ambition: **Children and young people get the best start in life and can reach their full potential**

Five-year vision statement

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

High impact activity	The difference it will make	How we will measure success
Rollout of the Family Hubs programme including the Start for Life Offer on parenting, parent-infant relationships and perinatal mental health support, home learning environment and infant feeding support	• Increased confidence in early years workforce in supporting early language development • Improved wellbeing for parents experiencing mild-moderate perinatal mental health needs • Improved confidence for mothers breastfeeding with increased sustainability	• Shared system delivery plan for an improved Perinatal Mental Health Offer • Delivery of professional training for the early years workforce to support improved early language development • Delivery of infant feeding peer supporters
Review neurodevelopmental pathways to identify improvements in diagnosis and support for children with autism and attention deficit hyperactivity disorder	• Improved experience for children progressing through the neurodevelopmental pathway • Improved early intervention and support for children pre-diagnosis • More efficient neurodevelopmental pathway reducing, where possible, the time between referral and diagnosis	• Agreed new neurodevelopment pathways for children • Improved communication and clearer support offer for those children moving through the neurodevelopmental pathway • Utilisation of core offer services to support and signpost children and young people • Tracking of demand and capacity
Mobilisation of the Integrated Therapies Service including the development of a new preventative navigator function	• Improved Integrated Therapies online offer of support for families • Provide integrated support for children and young people accessing therapy services	• Mobilisation of the new core Integrated Therapies Service • Utilisation of core offer services to support and signpost children and young people

1.2

Strategic priority: **Be well**

Ambition: **Everyone is more active**

Five-year vision statement

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

High impact activity	The difference it will make	How we will measure success
• Increase the number of Play Streets, Play Estates and School Streets as part of a wider programme to increase journeys foot and cycle and to reduce car journeys	• Increased physical activity for children and adults, with co-benefits for air quality, community safety, and social isolation, leading to better health and wellbeing	• Increase the proportion of people who choose to walk and cycle for their everyday journeys • Number of Play Streets, Play Estates and School Streets
• Design and implement adult physical activity pathway, which includes families - targeting behaviour change support and activity programmes at those who face the biggest barriers to getting more active	• Reduced inactivity levels – more inactive people active, leading to reduced prevalence of long term conditions, and more effective treatment of the symptoms and impacts of long term conditions amongst people at higher risk	• Activity levels measured as part of the Active Lives and Active Lives Children and Young People • Number of surgeries signed up to the Physical Activity Charter
• Review, update and implement Royal Greenwich Get Active Physical Activity and Sports Strategy	• Reduced inactivity levels – more people, more active, more often, leading to reduced prevalence of long term conditions, and more effective treatment of the symptoms and impacts of long term conditions	• Activity levels measured as part of the Active Lives and Active Lives Children and Young People

1.3

Strategic priority: **Be well**

Ambition: **Everyone can access nutritious food**

Five-year vision statement

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

High impact activity	The difference it will make	How we will measure success
• Ensure that food and nutrition is included as part of all diet-related disease care pathways such as hypertension, CVD, diabetes, and excess weight	• Residents receive consistent, evidence-based and relevant food advice and information, and are referred and signposted to services that support healthy eating	• Nutrition and diet included in pathways relating to the prevention and treatment of CVD, hypertension, diabetes and excess weight • Provision of consistent, evidence-based and relevant advice and information in primary, secondary and specialist services and social care • Number of residents engaged in weight management services • Number of residents engaged in cookery clubs
• Refresh the food poverty action plan to align with 'Our Greenwich' and emerging regional and national policy	• Improved access to nutritious food by lower income households, enabling residents to access a healthy diet and to maintain a healthy weight	• Increase in percentage of Healthy Start beneficiaries • Number of users of Greenwich Foodbank • Number of users of food clubs • Number of VCS food aid organisations involved in surplus food distribution
• Improve the food environment at a neighbourhood, high street and organisational level, harnessing the contributions of all HGP partner organisations, working with planning levers, e.g. Thamesmead Superzone and through integrated commissioning for neighbourhoods	• Residents have better access to safe, affordable, sustainable, culturally appropriate healthier food at a local level	• Increased engagement of schools, workplaces, NHS and social care services, public and community settings to promote healthy choices and support people to access good food and support with healthy weights • Number of Healthier Catering Commitment organisations • Number of breastfeeding welcome organisations • Number of Good Food in Greenwich organisations

Strategic priority: **Feel well**

1.4

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

Five-year vision statement

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

High impact activity	The difference it will make	How we will measure success
• Embedding evidence-based Tobacco Treatment through the consistent roll-out of Very Brief Advice (VBA), and at point of care within LGT, Oxleas (mental health and community services) and wider NHS pathways, to include offer of vapes and incentives for pregnant people as part of core treatment.	• More smokers will be identified and successfully treated especially from IMD 1-4 , and those target groups and offered effective, evidence-based support/referral at point of care to Tobacco Treatment support, reducing the short and long term health risks and increasing healthy life expectancy	• Increase in percentage of residents accessing Tobacco Treatment from target groups which then go on to quit • Feedback loop, of outcomes, back to referrer and primary care
• Fully implement new funding for drug and alcohol treatment through our local partnership arrangements, ensuring increased access to high quality treatment	• More people will access effective, evidence-based drug and alcohol treatment services, reducing the harms to individuals, families and communities	• Increased number of residents accessing drug and alcohol treatment • Optimised personalised care for adults who are prescribed medicines associated with dependence or withdrawal symptoms • NHS England Optimising personalised care
• Implement the Lung Health Check programme pilot, highlighting early stage cancer for treatment and Very Brief Advice point of care referral to stimulate Tobacco Treatment	• More people at risk of lung cancer will be identified and offered risk reduction support, and more people with lung cancer and COPD will be identified earlier, leading to better outcomes and increased healthy life expectancy	• Increase in referrals and quits to Tobacco Treatment

1.5

Strategic priority: **Feel well**

Ambition: **Fewer adults are affected by poor mental health**

Five-year vision statement

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

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

1.6

Strategic priority: **Feel well**

Ambition: **Fewer children and young people are affected by poor mental health**

Five-year vision statement

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

High impact activity	The difference it will make	How we will measure success
• Development of an iThrive and preventative system approach to children's mental health and wellbeing including a new Single Point of Access and Schools offer	• Improved knowledge and understanding from practitioners and schools on supporting children's mental health and wellbeing as part of a single point of access; • Improved referral triage decision making • Improved and more timely access to CYPMH services	• New Single Point of Access pathways co-developed with children and young people and professionals • New online digital single point of access for access to mental health and wellbeing resources and support • Co-ordinated mental health offer for Greenwich schools
• Implement the new Integrated Clinical Health Team within Royal Borough of Greenwich's Children's Services	• Improved support for mental health and wellbeing needs for children being supported by Children's Services • Improved early intervention support for children and young people preventing potential escalation to specialist mental health provision • Improved MH/ADHD service transition to adult	• Development of new Integrated Clinical Health Team structure • New Integrated Clinical Health Team posts fully recruited
• Reduction in the waiting times for specialist child and adolescent mental health services	• More timely specialist child and adolescent mental health assessment and support • Reduce assessment waits to eliminate over 52 week by October 2023 and 44 week wait by April 2024	• Recruitment of additional staffing capacity to reduce assessment times

1.7

Strategic priority: **Stay well**

Ambition: **For everyone to access the services they need on an equitable footing**

Five-year vision statement

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

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

Strategic priority: **Stay well**

1.8

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

Five-year vision statement

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

High impact activity	The difference it will make	How we will measure success
• Build partnerships with local communities and improve the way local communities and organisations work together with the NHS and the Council to improve services closer to where people live that are joined up	• Residents feel connected • Residents feel listened to • Support is joined up • Cultural changes to reduce a reliance on medicines and support shared decision-making between clinicians and patients, including increasing the use of social prescribing	• Identified initiatives that support neighbourhood working • Evidence of test and learn processes in place to support integration
• Develop the way we commission collaborative public health prevention services at a more local level using transformative processes including outcome-based, co-design, collaborative development and integrated approaches based on what matters most to residents. These will link to all local services	• Residents feel care is more holistic • Residents feel empowered to self-manage • Residents are able to access care and services closer to home	• Evidence of providers working together e.g. the number of provider engagement and co-design workshops, listening exercises and engagement activities, summaries of findings and outputs • Number of Learning and Development events to support working in new way, evidence of learning outcomes and evaluations • Evidence of service user engagement including co-development activities
Develop a "how to" narrative and approach for neighbourhood development that: • empowers people (staff, patients, residents, etc) to work together to solve problems for themselves • To shift our role from 'director' to 'connector' (facilitator and coach)	• Residents feel connected • Residents feel listened to • Support is joined up	• Agreed way of working with communities e.g. Community Development approach • Evidence of examples across range of areas of neighbourhood working in action • Growth of personalised care infrastructure

1.9

Strategic priority: **Stay well**

Ambition: **Unfair and avoidable differences in health and wellbeing are reduced**

Five-year vision statement

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

High impact activity	The difference it will make	How we will measure success
• Embed new SEL-wide diabetes outcome scheme, aimed at Primary care network-level improvement and reduction in variation ('levelling up' the poorer performing surgeries) in core diabetes outcome/ care process measures	• Residents feel supported to manage their own long-term condition • They feel supported by joined up services • Diabetes is well controlled	• Outcome scheme embedded • Understanding of the variation across surgeries • Evidence that partners are working together to support improvement • Eight care processes and three treatment targets and referral rate to NHS Diabetes Prevention Programme'
• Targeted cancer screening improvement, focus on Lung, Cervical, Prostate, Bowel and Breast in particular, key focus on influencing uptake, and then lifestyle changes to reduce risk (see other priorities)	• Residents feel healthy and well • Residents feel they have culturally appropriate information and advice to make informed decisions of engaging in screening activities • Residents take up offer of screening, especially in under represented groups, as evidenced by improved uptake rates	• Uptake rates improved • Partners feel engaged to help improve uptake • Evidence of sharing of good practice • Understanding of the variation
• Two 100 day challenges to reduce cardiovascular inequalities. Suggested areas to develop • High blood pressure detection • Improving people to get physically activity	• People with early risk factors feel supported to address the risk holistically • People have the right information and feel supported to improve their cardiovascular health	• Two 100-day improvement cycle done Clear logic models for co-designed interventions aligning outputs to longer-term outcomes • Partners across the system are engaged in the challenge • There is a plan and progress of evaluation and shared learning

Strategic priority: **Age well**

1.10

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

Five-year vision statement

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

High impact activity	The difference it will make	How we will measure success
• Market sustainability and quality improvement of commissioned community based, residential and nursing setting care	• People (including carers) have timely access to care and support from a range of providers and service types and to meet a range of needs across ages and disabilities • People receive personalised good quality care to help them achieve their personal outcomes	• Quality of services (Care Quality Commission (CQC), LA, Integrated Care Board (ICB) quality measures) • Sufficient supply to ensure continuity of care • Diversity in the market across needs (service types) • Range of high quality services for people to choose from • Sufficient investment in workforce to attract and retain staff • Rates paid to providers and terms and conditions metrics • Enhanced Health in Care Homes (EHCH) framework measures • Engagement rates with providers on Managed Service Provision (MSP)' • Tangible feedback from residents regarding their experiences

Strategic priority: **Age well**

1.10

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

Continued

High impact activity	The difference it will make	How we will measure success
• Co-design, development and delivery of community based support models for those with care and support needs and their carers	• Improved offer including choice and control over the care they receive • A meaningful impact on independence, enabling people to live and die well as part of a community • Increased specialist advice and support available to enable people to make choices about their care • People have access to meaningful activity and are able to feel well and active for as long as possible	• Homecare and Extra care mobilisation progress metrics • Development of alternative models of care such as Neighbourhood model, Informatics Skills Framework (ISF), Community Micro Enterprises- number of new/diversified offers • Capacity in homecare market – measured using capacity and demand insight and workforce data • Satisfaction levels – residents including carers and partners • Successful delivery of joint carers strategy and action plan
• Optimise and develop our Home First approaches by expanding virtual wards (including a virtual ward hub) to provide assessment, treatment and care to all patients in the place that they call home	• A reduction in hospital attendances and admissions (particularly for >1 day), reducing the risks of protracted periods of recovery • A meaningful increase in the wellbeing of patients receiving multi-factorial frailty support • Enabling patients to die in their usual place of residence, where this is their preferred place of death	• Delivering capacity for 179 patients simultaneously by the virtual wards in Greenwich, with 80% virtual ward occupancy • Reducing Emergency Department attendances and admissions by 50% (compared to the 6 months pre-intervention) for frailty Multidisciplinary team (MDT) • Reduction in the median length of stay at Queen Elizabeth Hospital • Number of primary care / London Ambulance Service referrals to the virtual ward hub / Joint Emergency Team / maximising discharge pathways 0 and 1 • Admissions avoided due to referrals to community response