Greenwich Commissioning Strategy

Transforming our health and social care system 2018 to 2022
About Greenwich CCG

NHS Greenwich Clinical Commissioning Group (CCG) is responsible for planning and buying (commissioning) most of the health care services for people in the borough of Greenwich. This includes hospital services, GP practices, mental health services and community care. We are also responsible for monitoring how well these services are provided.

Our mission is to secure the best possible health and care services for the population that we serve, specifically in primary care settings and in hospitals as necessary. In doing this, we will work with patients and the wider public to develop the services that we offer, reduce health inequalities and improve health outcomes.

We are a clinically-led organisation. Our Governing Body is led by a Clinical Chair and comprised of GP lay members (representing the public interest), a secondary care doctor, a registered nurse, three clinical commissioners elected by the CCG membership, and buying (commissioning) most of the health care services for people in the borough of Greenwich. This includes hospital services, GP practices, mental health and major health services and community care. We are also responsible for monitoring how well these services are provided.

We also have a new executive leadership team. A new Managing Director joined the CCG in September 2017, with responsibility for day-to-day leadership of the organisation and to ensure that people in Greenwich continue to receive high quality local health care. We appointed a new Chief Officer of the South East London Commissioning Alliance, covering all six south east London CCGs, who is also the STP Lead for Our Healthier South East London.

More details about the organisation, our Governing Body, and the way we work are available at www.greenwichccg.nhs.uk
Foreword

I am delighted to endorse the new Greenwich Commissioning Strategy Transforming our Health and Care System 2018 to 2022.

The launch of this strategy, along with our recent ‘Good’ rating from NHS England is a hugely positive milestone in our journey from not too distant challenges including financial turnaround and special measures.

Creating this strategy has been a process of collaboration and engaging with local people and partner organisations who have participated in developing a comprehensive, integrated commissioning strategy for Greenwich.

This is part of a longer journey for health and social care locally, and across south east London. The test will be putting this strategy into action, and the CCG has already made sound plans to do that in our commissioning intentions for 2019/20.

It is evident that everyone wants the best for local people and local services. We are working towards a shared purpose of health and wellbeing for Greenwich people, with high quality, effective and sustainable health services. This strategy provides the vision to achieving our shared purpose.

Dr Krishna Subbarayan
Chair

Summary

This commissioning strategy sets out bold ambitions for transforming health and care services in Greenwich. Continuing without significant change is not an option. If we do nothing, we will need far more hospital beds to meet current demand, and this is neither feasible nor sustainable. Instead, we want to focus on providing more services closer to home and ease pressures on other parts of the system. Achieving this relies on effective collaboration between primary, community-based and secondary care, as well as with the Royal Borough of Greenwich and the voluntary sector. It means crossing provider and sector boundary lines, to build effective local health and social care systems. Only by working as a system, across Greenwich and with our neighbouring boroughs, can we achieve real health, quality and efficiency gains for our population.

This strategy makes frequent mention of integrated care pathways and systems. According to NHS England, ‘for health, care and support to be ‘integrated’, it must be person-centred, coordinated, and tailored to the needs and preferences of the individual, their carers and family. It means moving away from episodic care to a more holistic approach to health, care and support needs, that puts the needs and experience of people at the centre of how services are organised and delivered’. It is this objective that underpins our strategy. Achieving it means investing in primary and community care, including in the primary care workforce and infrastructure. We have already begun this journey and we have the building blocks needed to continue it over the next three years, and beyond.

Strategy at a glance – health and care services in Greenwich

Greenwich population
Patients, carers and service users

Primary care
GPs, pharmacies, dentists, optometrists, Live Well Greenwich

Community-based care
(Oxleas), children and adult social care (disabilities, mental health, older people, residential, rehab)

Acute care
(Lewisham and Greenwich Hospital Trust), adult mental health and child and adolescent mental health (Oxleas), specialised care

Maximise prevention and self-care
• Live Well Greenwich
• Community cohesion

Strengthen community-based care
• Resilience
• Support for marginalised / vulnerable people
• Integration of services (e.g. children’s centres)

High quality acute services when really required
• Working across south east London on care models and productivity

1 www.england.nhs.uk/ourwork/part-rel/transformation-fund/
### Our plan on a page

<table>
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<th>Our challenges</th>
<th>High levels of deprivation, inequality and unemployment</th>
<th>High prevalence of mental health issues and learning disability – mental health the biggest cause of poor health in Greenwich and gaps in service provision</th>
<th>Fragmentation of planned care, GP workforce shortages and estate not fit for purpose. Financial challenge across the system – savings of more than £14m needed</th>
<th>Cancer is one of the main causes of premature death and living with ill-health</th>
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<tbody>
<tr>
<td>Our plans for transformation</td>
<td>• To prevent ill-health and increase health and wellbeing, intervene early to avoid hospital admissions, and to streamline service provision</td>
<td>• To develop an integrated care system for Greenwich, in collaboration with social care, public health, providers and community and voluntary sector organisations</td>
<td>• To provide the wrap-around health and social care needed by people living with a physical and mental health condition</td>
<td>• To invest in a wide range of primary care services, working at scale, across four Local Care Networks, which are responsive to local people</td>
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<td>• To engineer shifts away from expensive hospital services to primary and community-based care closer to home. A frailty care pathway, better end of life care, integrated care hubs, and the highest quality urgent care should all help in reducing unnecessary hospital attendances</td>
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<td>Our four priorities for the next three years</td>
<td>To prevent illness and help our population to live well</td>
<td>To strengthen local support for people with mental illness, including children and young people</td>
<td>To better meet the needs of frail older people with care closer to home, an integrated urgent care system, and stronger community-based care</td>
<td>To improve the prevention, detection and treatment of cancers for our local population</td>
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<td>The impact of our plans by 2022</td>
<td>• Children get the best possible start in life</td>
<td>• We see better mental health and wellbeing for both children and adults</td>
<td>• Frail people receive safe, high quality interventions in the community</td>
<td>• Uptake of screening for cancers</td>
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<td>• Improvement in life expectancy, particularly for women</td>
<td>• Decrease in A&amp;E attendances for mental health issues</td>
<td>• Fewer hospital attendances and admissions for frail people</td>
<td>• Improvements in the factors associated with an increased cancer risk (e.g. smoking, alcohol, diet)</td>
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<td>• Reduction in alcohol consumption and smoking</td>
<td>• Reduction in out of area treatments</td>
<td>• Hospital interventions only when necessary and for the shortest periods</td>
<td>• Increased public awareness of cancer symptoms and the need for early diagnosis</td>
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<td>• Increase in children and adults who are a healthy weight</td>
<td>• Services are joined up and well-coordinated</td>
<td>• Greenwich population benefits from enhanced community provision and improved access</td>
<td>• Consistent access to high quality care, timely diagnosis and treatments</td>
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<td>• Better mental health and wellbeing, and early identification of children’s educational and communication needs</td>
<td>• Unnecessary hospital admissions and inappropriate discharges fall</td>
<td>• More people nearing the end of life can die at home or in the community with multidisciplinary support</td>
<td>• Increase in cancer survival rates from one to five years</td>
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<td></td>
<td>• Reduction in diabetes and other long-term conditions</td>
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<td>• Improved patient experience scores</td>
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1. About this strategy

Our role is to use NHS funds to meet the needs of the people living in Greenwich in the best possible way. This strategy sets out our plans for commissioning, in partnership with others, health and social care services for the next three years.

Our objectives, agreed by the CCG Governing Body in January 2018, are:

1. To commission safe, sustainable, efficient and affordable services to meet the health and wellbeing needs of the population of Greenwich and reduce health inequalities with an additional focus on the urgent and emergency care system improvement along the pathway

2. To ensure the CCG’s position recovers to meet its financial and governance duties and performance standards

3. To nurture and support primary care to be resilient and thrive

4. To strengthen productive relationships with partners and the public to work as a health and care system

5. To actively engage with our communities to improve their experience of healthcare

6. To play an active and influential role in shaping South East London (SEL) and London-wide commissioning.

These objectives are reflected in this commissioning strategy and the four priority areas that we will focus upon over the next three years. We began consultation about these priorities in March 2018 with local GPs, our partners, patients and the public. Their feedback is reflected in this strategy.

In creating this strategy, we have been mindful of national policy, and we recognise that we may have to adapt the strategy in light of long-term commitments set out in the NHS 10 Year Plan. This strategy has been informed by the following policy documents in particular:

- NHS Five Year Forward View (NHS England, 2014)
- Next Steps on the NHS Five Year Forward View (2017a)
- 2018/19 planning guidance
- General Practice Forward View (NHS England, 2016a)
- Mental Health Five Year Forward View (NHS England, 2016b)
- Integrated Urgent Care Service Specification (NHS England, 2017b)
- Achieving World-Class Cancer Outcomes: Taking the strategy forward (NHS England, 2016c)

Our strategy is also set in context of other strategic plans for Greenwich and south east London, including:

- Transforming Primary Care in London: A Strategic Commissioning Framework (2018)
- South East London: Sustainability and Transformation Plan (2016)
- and, as part of this, Our Healthier South East London

Working in partnership

The development of this strategy has been led by NHS Greenwich CCG, working in partnership with the Royal Borough of Greenwich. Our commitment to improving health and wellbeing, reducing health inequalities, and ensuring everyone has equal access to the health services they need, can only be achieved through close working with the council and its social care and public health functions.

This is a clinically-led, multi-partner strategy.

Transformation across the system requires everyone to work together. We work closely with our main NHS providers: Lewisham and Greenwich NHS Trust and Oxleas NHS Foundation Trust (our main community and mental health provider). We also commission primary care from a range of providers, including our 35 GP practices, and work effectively with Greenwich Health GP federation.

We are working closely with Lewisham CCG to provide an integrated approach across our respective areas as part of the South East London Commissioning Alliance.

We will work to ensure that this strategy aligns with Lewisham’s approach, with a view to building resilience and driving transformation across the wider system.

We regularly engage with Healthwatch Greenwich and other community groups, residents, patients and carers, to make sure that patients are at the centre of our commissioning decisions. Our partners in the voluntary sector (represented by METRO GAVS) will continue to play a vital role in supporting delivery of our strategic aims.
2. What are the challenges?

To improve the health and social care outcomes for our local population we must respond to changes in the population, our population’s health and the health system. Several of the challenges we face are common across England, however we have challenges that are particular to Greenwich, such as high levels of deprivation, inequalities and unemployment.

2.1 The health needs of Greenwich

Greenwich has a young and very diverse population. It is estimated that there are just under 283,500 people living in Greenwich, and almost 1 in 4 of our population are under 19 years (compared to 1 in 5 in England). With new building in the borough and changes in the housing stock, we expect there to be further growth in the numbers of families and young people living in Greenwich. Our population is likely to grow by nearly 15,000 people in the next three years.

Just over 1 in 10 of our population is over 65 years (compared to just under 1 in 6 for England), however this proportion is set to increase over the next 10-15 years (Greenwich Public Health, 2018). The population of over 65s is set to increase by 7% over the next three years. The growth in the number of older people will mean an increase in the proportion of the population living with more complex conditions and health and social care needs. The major causes of death in Greenwich are cancer and cardiovascular diseases, especially heart attacks and strokes, although overall death rates from these conditions are improving. Respiratory diseases, including chronic obstructive pulmonary disease (COPD), are the next biggest cause of preventable deaths in the borough. The biggest burden on morbidity (poor health) is mental ill health, followed by musculoskeletal health conditions such as back pain, arthritis and other joint conditions.

Our population is more diverse than England’s overall population, with around 2 in 5 people from a Black and minority ethnic background (compared to 1 in 7 in England). The two biggest ethnic groups are black, Asian Caribbean/African and South Asian/Chinese. More diversity is seen in our children, young people and young adults, and over the next decade our older population will also become more ethnically diverse.

Nearly a quarter (23%) of our population live within the most deprived areas nationally. Overall, Greenwich ranks 78th out of 326 local authorities of the most deprived in England, our rank has improved since 2010. Greenwich ranks 78th out of 326 of the most deprived local authorities of the most deprived in England, our rank has improved since 2010.

Over the next 10 years population increases will be greater in our BAME groups

Diversity varies between age groups with increasing diversity in older age groups over the next decade.
Our population’s health

Life expectancy
On average, women in Greenwich live 3.1 years more than men. The overall difference in life expectancy between the most affluent and most deprived areas is 4.6 years for females and 6.9 years for males.

Healthy life expectancy
Healthy life expectancy is the average number of years we can expect to live in good health. Whilst men and women are living longer, there is a gap between how long we live and how long we live in good health.

The life expectancy gap between most deprived and most affluent:

<table>
<thead>
<tr>
<th></th>
<th>Female</th>
<th>Male</th>
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<tbody>
<tr>
<td>79.3</td>
<td>82.4</td>
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Years lived in poor health:

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<tr>
<th></th>
<th>Female</th>
<th>Male</th>
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<td>4.6 years</td>
<td>6.9 years</td>
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Potential years of life lost (PYLL) is a measure of the number of years of life lost by every 100,000 adults aged 20 and over dying from conditions which are usually treatable by healthcare. PYLL has decreased for women and men with rates now lower than London.

Mortality
Cancer, cardiovascular disease and respiratory disease are the leading causes of premature and avoidable mortality.

Prevalence of disease
GP reported numbers of people with long term conditions

<table>
<thead>
<tr>
<th>Disease</th>
<th>Prevalence</th>
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<tbody>
<tr>
<td>Hypertension</td>
<td>40,000</td>
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<tr>
<td>Depression (18+)</td>
<td>35,000</td>
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<tr>
<td>Diabetes (17+)</td>
<td>25,000</td>
</tr>
<tr>
<td>Asthma (all ages)</td>
<td>20,000</td>
</tr>
<tr>
<td>Chronic kidney disease (18+)</td>
<td>15,000</td>
</tr>
<tr>
<td>Coronary heart disease (all ages)</td>
<td>10,000</td>
</tr>
<tr>
<td>Atrial fibrillation</td>
<td>5,000</td>
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<tr>
<td>Mental health (all ages)</td>
<td></td>
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<tr>
<td>Heart failure (all ages)</td>
<td></td>
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<tr>
<td>Dementia (all ages)</td>
<td></td>
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</tbody>
</table>

There is a gap between the reported disease and estimated levels of disease, in some cases this is considerable.

Lifestyle indicators
Greenwich has the 6th highest rate of alcohol related hospital admissions in London (613 in every 100,000 people)

Fewer than 1 in 5 (16.9%) of our adults smoke, 8.9% of mothers smoke at time of delivery

More than 3 in 5 (63.8%) of Greenwich adults are overweight or obese.

26.8%
Of our 10-11 year old children are obese

Transforming our health and social care system 2018 to 2022
Greenwich Commissioning Strategy
Figure 2, below, provides a summary of some of the main areas in which health is poorest in the borough and some of the associated factors (such as poverty and obesity) when compared with England. It shows where improvements are being seen (for example, in early deaths from cardiovascular diseases), as well as where outcomes are getting worse (such as life expectancy). It also shows improvements in outcomes where the impact affects small numbers of the population (such as late HIV diagnosis) versus impact on large numbers (for example, under 75s deaths from cancer).

Summary of status of key health outcomes and their determinants in Greenwich

Summary of status of key health indicators in Greenwich

- Diabetes prevalence
- Late diagnosis HIV
- Population vaccination coverage – HPV*
- Tuberculosis (TB) incidence
- Adult obesity
- Childhood obesity
- Under 75s death from cardiovascular disease (persons)
- Under 75s mortality rate from liver disease (persons)
- Infant mortality
- Suicide rates
- Population vaccination coverage – shingles
- Gap in life expectancy between Greenwich and England (females)
- Adult smoking rate
- Male healthy life expectancy
- Female life expectancy
- Male life expectancy
- Under 75s death from cancer (all persons)
- % people aged 16-64 in employment
- Under 18 conception rate

Worse than England
Similar to England
Better than England

The Greenwich health system is under pressure.

**GP workforce shortage**

Like many parts of the country, we have a shortage of qualified GPs. The impact of this is felt acutely in Greenwich, as our GP population is dispersed (see Box A, right), which leads to a lack of resilience and limits the primary care services we can offer.

Greenwich Health GP federation is an integrated network of all 35 Greenwich GP practices and has been working ‘to realise efficiencies and create synergies and economies of scale’. Levels of collaborative working will need to increase significantly, however, to support delivery of primary care services over the coming years and manage the workforce shortage.

We intend to give greater attention to providing primary care at scale, whilst making sure services are responsive to local people. We also need to expand the primary care workforce to provide a wider range of care options for patients, and enable GPs to focus attention on those with complex needs. Such expansion also reflects changes in the way newer generations of GPs prefer to work, including a rise in part-time working and more salaried doctors and long-term locums. Section 3 sets out our aspirations for the primary care workforce and for primary care at scale (page 28).

**Workforce**

Workforce is a top concern for the NHS, with staffing challenges now as pressing as the financial challenge. Recruitment and retention of enough staff with the right skills and experience is increasingly difficult across the country and this position is mirrored in NHS organisations across Greenwich. There are significant shortages of clinical staff, most notably nurses, paramedics and some medical specialists. Demand for services, and in turn, demand for staff to deliver services, has grown more quickly than the pipeline of new staff. These pressures are having a
direct impact on the ability of trusts and primary care to deliver safe and sustainable high-quality care.

The NHS is not training enough healthcare professionals to be self-sufficient, meaning that it relies on EU and other international staff to ensure safe staffing levels and will need to continue to do so for the foreseeable future. Tougher language tests introduced in 2016 for European Economic Area nurses registering to work in the UK have made recruitment and retention of overseas staff more difficult. Similarly pay restraint up until 2018 and increasingly pressurised working conditions further adversely impact on recruitment and retention.

Providers locally have made sustained improvement in tackling workforce challenges by reducing agency spend, developing new and more staff (for example, development of the nursing associate role and furthering apprenticeship opportunities) and strengthening links with local universities. The NHS in Greenwich in 2022 will be looking after more patients and we are therefore going to need to continue to improve productivity and grow our frontline workforce, especially in priority areas of nursing, mental health, urgent and primary care. Achieving this will require more training, with fast track options, more recruitment, better retention and greater return to practice after time out from the workforce. Similarly, we will also need to ensure better job planning, e-rostering and a focus on staff health and wellbeing. It will also require greater flexibility as roles and places of work evolve in line with changes to medicine and the shape of health care.

Taking primary care as an example, we need to nurture other health care professionals to help meet demand and deliver primary care services. General practice nurses are an essential component of the general practice workforce. However, the recruitment and retention of general practice nurses is an issue. The workforce is ageing – with predictions that a third of the workforce may retire by 2020 (The Queen’s Nursing Institute, 2016) – and placement and training in general practice have been found to be in short supply (Ipsos Mori, 2017). Greenwich has just 97 practice nurses (three of whom are advanced nurse practitioners) and 28 healthcare support workers.

NHS England’s Ten Point Plan for General Practice Nursing seeks to help nurses and health care support workers to demonstrates their contribution to reducing the gaps identified in the Five Year Forward View (the health and wellbeing gap, the care and quality gap, the funding and efficiency gap). It includes raising the profile of general practice nursing, increasing the number of pre-registration placements in general practice, establishing inductions and preceptorships, and improving access to ‘return to practice’ programmes (NHS England, 2017). Working at scale could support Greenwich practices to offer initiatives, such as preceptorships, and offer opportunities to strengthen the nursing workforce.

Access to primary care
Access to primary care is the most common cause of complaint, according to Healthwatch Greenwich, including problems getting appointments, information and communication issues. Its GP Access Report identified big differences in patient registration practice across the borough, with many people experiencing problems in registering with a local practice (Healthwatch Greenwich, 2017a). This became more problematic when the two walk-in centres in Greenwich were replaced by GP access hubs in late 2016, which required patients to be registered with a Greenwich GP to be able to get an appointment. This is thought to have resulted in increased pressure on the local A&E. Greenwich is ethnically diverse and issues around access are particularly pronounced for residents for whom English is not their first language.

Estate
We are part of The London Health and Care Estates Strategy developed by the London Estates Board (2018); it is the first London-wide estates strategy for health and care.

Much of the estate in Greenwich requires improvement to support our growing population. Taking primary care as an example, many practices are small and branch surgeries are not always held in suitable premises. Two Community Health Partnership buildings in the borough, Eltham Community Hospital and Garland Road Medical Centre, are inefficiently utilised. The provision of community and primary care estate does not align with the areas of high deprivation, which undermines our ability to address local health and social care inequalities.

We are committed to making efficient use of our existing estate, to make positive investments in areas of deprivation, and to incentivise services to locate to areas of greatest need. This may involve exploring how to integrate the 62 community pharmacies in Greenwich with NHS 111, out of hours and other urgent care provision. Our 2018 Estates Strategy aligns with this clinical commissioning strategy and supports transformational change, with more primary and community care provided closer to home.

Mental health provision
While mental ill-health is the biggest cause of poor health in Greenwich, we do not yet have a comprehensive network of mental health support in the borough. Mental health and learning disability services have historically had a low profile, there is a lack of out of hours urgent care and children and young people, including a lack of Tier 4 inpatient beds. Greenwich has 70% more mental health admissions than 10 similar CCGs and it is clear we need to be doing more as a system to prevent crisis and avoid admissions. The impact of drug and alcohol misuse is particularly pronounced within Greenwich. Demand for assessment and diagnosis services for autism has grown significantly and there is a waiting list of more than 2.5 years.

We will work with the Greenwich Mental Health and Wellbeing Partnership Board to address the wide range of issues that affect mental health and wellbeing in Greenwich. The Board leads work across Greenwich to improve and protect mental health and wellbeing for the population. People with lived experience of mental health problems are equal partners in the leadership of this work, together with the statutory sector and community and voluntary groups. We will work with the Board to transform pathways, including improving equity of access to mental health services, providing care closer to home and supporting networks that people with mental health problems already have. We will work with Oxleas NHS Foundation Trust and other local mental health providers to improve the range of services on offer to Greenwich residents. Priority two details our plans to strengthen support for people of all ages with mental illness, but particularly for children and young people – see page 34.

Planned care
Fragmentation and inconsistency in the planned care system is a problem. Too often, local residents often face lengthy waiting times for services. The Referral to Treatment (RTT) standard requires 92% of patients to be treated in 18 weeks from referral. Achieving this was particularly challenging in 2016/17 (NHS Greenwich CCG, 2017a). Lewisham and Greenwich NHS Trust has not met the target, and we will continue to work closely with the trust to ensure that it is able to achieve the target next year. During 2017/18, a small number of Greenwich patients waited more than 52 weeks for treatment, each month. Healthwatch Greenwich (2017b) has highlighted problems with discharge arrangements at Queen Elizabeth Hospital, including a high rate of readmissions, inappropriate use of the discharge lounge, inadequate information around medication and how to access support after discharge. Lewisham and Greenwich NHS Trust responded positively to the recommendations made by Healthwatch but there is more to be done to ensure that patients spend the shortest time possible in hospital. We are committed to reducing lengthy hospital admissions and to avoiding delayed discharges. Whilst Greenwich performs well in terms of avoiding delayed discharges, we are mindful of the impact that delays can have on patients and the wider health system. NHS Benchmarking (2018) has found that 45% of delayed transfers of care are in the 85+ age group. The reason for delay for this cohort is...
that the patient is awaiting a care home placement (29% of cases), a care package in their own home (18%) or awaiting family choice (19%).

Outpatient provision has changed little whilst other service transformation has been underway, and we need to make sure that patients attend hospital for follow-up appointments only where this is clinically necessary. There is underuse of mechanisms designed to support the planned care pathway, such as GP referral management systems and acute direct access services (for diagnostics and pathology). However, we need to go further than the way we access planned care, to explore new ways of providing planned care. Currently, services are not commissioned around the person, and patients end up with multiple care plans. This reflects how different players in the system have conflicting priorities. There are insufficient staff to deliver services and inflexibility of current roles and responsibilities.

We want to reduce fragmentation and increase coordination, with simpler, more streamlined pathways. System-wide transformation is needed to shift more services into the community, and for health and social care to be more joined up, with the patient at the centre. The image produced by The King’s Fund, figure 3, shows the wide range of sectors and services that deliver care and support in community settings. These aspirations will be reflected in our commissioning intentions for the coming years. Section three details our plans to commission integrated care pathways, closer to home.

Cancer care
Cancer is one of the main causes of people dying prematurely and living with ill-health in Greenwich (see Box B right). More cancer patients in Greenwich are diagnosed when their cancer is at a later stage than in other parts of Europe. This is the main reason why people in the UK have poorer short-term survival rates after receiving their diagnosis than people who live elsewhere in Europe.

Our performance against the national cancer standards requires improvement. We measure cancer waiting times performance against eight specific measures. We met the national target for five of the eight measures in 2017/18: cancer 2-week wait, breast cancer symptom 2-week wait, cancer 31-day definitive treatment, cancer 31-day sub treatment – surgery, cancer 31-day sub treatment – drug (NHS Greenwich CCG, 2018).

Our provider hospitals have found it difficult to meet the 62-day cancer wait target. This standard measures the wait from an urgent GP referral for suspected cancer to first treatment and covers all types of cancer. Over the last year, an average of 75.4% of people with an urgent GP referral had their first treatment for cancer within 62 days of referral – the standard is 85%. This standard has proved particularly challenging when patients are referred from one trust, usually Lewisham and Greenwich NHS Trust, to a tertiary provider (a specialist centre), such as King’s College Hospital NHS Foundation Trust and Guy’s and St Thomas’ NHS Foundation Trust. In order to improve this number, we need to continue to work with our commissioner and provider colleagues across south east London.

Our commitment to improving the prevention, detection and treatment of cancers is reflected in our decision to make this one of our top priority areas for the coming three years – see priority four, page 41.

BOX B: CANCER AT A GLANCE

Greenwich residents are more likely to have cancer:
• Every year about 900 Greenwich residents are newly diagnosed with cancer
• Our borough has higher cancer rates than London boroughs with similar levels of deprivation – we have the 6th highest rate out of the 32 London CCG areas

Residents living in the most deprived parts of Greenwich have poorer outcomes:
• People living in the most deprived 20% of areas in the borough are significantly more likely to die from cancer than those living in the least deprived 40% of areas

Greenwich residents are more likely to die of cancer:
• Cancer accounts for about a third of all deaths of people in Greenwich, with an annual death rate that is higher than both London and England – we have the 9th highest mortality rate out of the 32 London CCG areas

Survival rates are poorer in Greenwich
• One year survival rates in Greenwich in 2011 were (62%), compared to England (68%) and London (69%) – although, by 2016/17, our one year survival rate had increased to 70.9%

Source: Royal Borough of Greenwich (2016)

Financial pressures
Our commitment is to improve the quality of care and patient experience, and to meet the changing needs of the population; we need to achieve these objectives in ways that are financially sustainable. Commissioning services within a tight financial envelope is a challenge across the health and social care sector. The CCG incurred a deficit of £3.8m in 2016/17, which in part reflected a large and unforeseen rise in the costs of funded nursing care and an obligation to make a payment of £1.8m to Lewisham and Greenwich NHS Trust in respect of transitional support following the dissolution of South London Healthcare NHS Trust (NHS Greenwich CCG, 2017a). In short, we were unable to deliver a 1% surplus or to operate under our resource revenue limit. The CCG achieved its financial duties for 2017/18. The 2017/18 Annual Accounts show a surplus of around £0.7m, which is in line with the CCG’s financial target for the year (NHS Greenwich CCG, 2018). This is a result of sustained determination by our local and south east London contracting and finance teams, the efforts by all in the CCG to develop our savings schemes and support from our providers in implementing them.

The CCG budget for 2018/19 is around £419.8m. Our financial plan for 2018/19 is to deliver in-year financial balance, contingent on the delivery of significant Quality, Innovation Productivity and Prevention (QIPP) savings of around £14.6m (around 3.5% of the overall 2018/19 budget) and to manage other key financial risks.

We will build on the success we have had over the last two years to turn around our financial position. Funding for the CCG’s programme of expenditure is anticipated to remain flat in real terms over the planning period into 2022. It is anticipated that similar size QIPP plans will be required in 2019/20 and onwards. Financial savings plans of a similar size are being implemented across all local health and social care organisations. We need to work together across our organisations to deliver the scale of change needed and to make the best use of public resources.

Section 5, page 42, sets out our plans for a financially sustainable system. This includes using available levers to incentivise change, as well as introducing new contractual arrangements that support partnership working across CCGs and integrated models of care. The financial challenge means we must be innovative in designing solutions that offer long-term sustainability and in designing these we will consult and engage with stakeholders.

Section 3 sets out our ambition in tackling these challenges. Our plans for transformation build upon the successful projects that embody the type of community-based, multi-agency working needed to support system change – see successes to build upon, page 22. They also align with the national direction of travel, with respect to primary care at scale and federated and network arrangements. Importantly, our plans recognise that we are a system within a wider system – as shown in figure 4, below – and this will enable future resource flow. We need to address fragmentation of providers and of commissioning, and to wrap services around residents. The “system of systems” seeks to address the following simultaneously: for all commissioned services to work as efficiently as possible, to facilitate integration within boroughs across health and social care, and to enable integration across provider areas such as elective care with greater network provision delivered at a local level.
Some STPs and boroughs outside of SEL receive tertiary services from relevant providers within the Integrated Care System (ICS).

The interface between secondary care and mental health, and local care partnerships (LCPs), should have a local focus (based on population segmentation).

At scale general practice, coterminous with borough boundary and covering the whole borough population.

Local Care Networks (developmental) become LCPs (one or more dependent on borough likely to cover a population of c.250-350k). Includes: primary care, community services, social care, housing, leisure and secondary care provision (e.g. chronic care / new models of outpatient care).

Primary Care Home / clusters of multiple GP practices to provide enhanced personalised and preventative care for the local community. Likely to cover a population of c.30-50k.

Some boroughs, such as Greenwich and Bexley, share emergency services from the same hospital. Other boroughs are coterminous with their emergency department.

At multi-borough level, in partnership with Bexley and Lewisham to ensure areas like unscheduled care work effectively.

At STP level, by working in synergy with other commissioners to support re-designed pathways across multiple providers.

We recognise the importance of working with other commissioners and with providers of services to improve health and care for the populations we jointly serve. This means collaborating to manage the resources available to us. The King’s Fund (2015) has called this approach 'placed-based systems of care'. Our strategy seeks to act at every level in partnership with others:

- At populations of 30,000 to 50,000, by supporting multidisciplinary working in primary and community care.
- At general practice level, by supporting federated working at greater scale.
- At borough level, through local care networks that will over time work as partnerships.
- At multi-borough level, in partnership with Bexley and Lewisham to ensure areas like unscheduled care work effectively.
- At STP level, by working in synergy with other commissioners to support re-designed pathways across multiple providers.

Figure 4. A system of systems

STP as the organising function
2.3 Successes to build upon

Barnfield Well Community

The Well Communities programme is a community development programme targeting disadvantaged communities with high health needs. The aim is for disadvantaged communities and local organisations to work together to improve health and wellbeing, build community resilience and reduce inequalities.

Barnfield has a population of 2,290, living in 811 dwellings, of which 71.5% are social housing. The population has many young families, across a range of cultural groups (African, Caribbean, East European, Irish, English, Scottish, Somalian and Vietnamese).

Five themes were identified for Barnfield: mental wellbeing, open space, physical activity, healthy activity, culture and tradition. Initiatives included a DIY Happiness workshop for women, cookery club, Barnfield community website, and a play area.

The programme has led to several positive outcomes, including an improved relationship between the community and the local authority, better co-ordination, and more joined-up working at grassroots level. There is an improved environment, with a play area and open spaces, which has improved community safety and pride in the environment. The borough has invested £14 million in the area, and local funding supported the development of the Barnfield Hub. In all, 786 residents participated in Well Communities activities: 85% reported an increase in healthy eating, 72% reported an increase in healthy physical activity, and 80% reported feeling more positive.

Greenwich Musculoskeletal Service

The Greenwich Musculoskeletal (MSK) Service comprises community hubs and local providers that offer support and treatment for patients with musculoskeletal issues. Some patients are offered virtual consultations through a PhysioLine service where a physiotherapist will carry out a musculoskeletal assessment over the telephone and provide advice, exercises and guidance. Patients continue to have access to face to face physiotherapy assessments by local providers, and the local hubs provide more choice as to the location for treatment. Some patients have access to clinics provided by an Extended Scope Practitioner or a GP with a special interest at the main clinical hub in Eltham Community Hospital. Both carry out specialist musculoskeletal assessments on patients and can request diagnostics or provide injection therapy or ultrasound guided injections, where needed.

Consultant clinics are held at Eltham Community Hospital for rheumatology, orthopaedics and pain management, supported by consultants from Lewisham and Greenwich NHS Trust. This service has enabled rapid access to consultants for very complex patients, allowing them to be seen closer to home.

There are plans to launch additional community clinical hubs to expand MSK coverage across Greenwich to enable greater patient choice of locations and care closer to home. MSK practitioners (senior physiotherapists) will soon be supporting GP surgeries across the borough by seeing patients who would normally require a GP appointment.

Greenwich Time to Talk (IAPT)

Time to Talk is part of a national programme called Improving Access to Psychological Therapies (IAPT). It is for people with mild problems of anxiety or depression who are motivated to work to change the problem. Oxleas NHS Foundation Trust, our main provider of mental health services, has a team of therapists based in Eltham, who can see patients at other centres throughout the borough.

Greenwich Time to Talk offers free psychological treatment as recommended by the National Institute for Health and Clinical Excellence (NICE) guidelines for anxiety and depression. This is mainly cognitive behaviour therapy (CBT) and counselling, to help people feel more able to cope with problems. The service offers support for people over 16 (there is a specific service for 16 and 17 year olds).

Live Well Coaches

There are plans to launch additional community clinical hubs to expand MSK coverage across Greenwich to enable greater patient choice of locations and care closer to home.

Live Well Greenwich is system-wide change to embed prevention at individual, community and population levels. In addition to an online Greenwich community directory and the Live Well Line telephone support service, Live Well Coaches (LWCs) provide one-to-one intensive interventions, supported by community volunteers.

A network of LWCs are embedded in primary care and use motivational approaches and social prescribing to address wider social and economic needs. On average, clients have two appointments with a LWC, and outcomes data place 97% at least in the early stages of change and the majority (62%) at the action stage. Feedback from clients and GP practices has been very positive. By focusing on frequent attenders in primary care, telephone triage and a whole systems approach, the LWCs are having a real impact by finding solutions to complex problems.

METRO GAVS Greenwich

The voluntary sector is playing a vital role in supporting the health and social care system in Greenwich. METRO GAVS is central to this. It is providing strategic leadership in representing and building the capacity of the voluntary, community and faith sector in the Royal Borough of Greenwich. It provides a range of ‘capacity building’ support and training to local voluntary and community organisations as well as support to the sector to get its voice heard.

METRO GAVS has a strong working relationship with the local authority, police and the NHS, which is enabling the co-production of new services and policies to become a reality. The sector can reach parts that the NHS cannot, as well as supporting Live Well Greenwich, and other initiatives that rely on the input of voluntary sector organisations. Its onus, as reflected in this strategy, is on prevention, and working together to achieve this.
3. Our ambition for Greenwich 2018 to 2022

We will reduce health inequalities by taking a preventative, proactive approach. We will distribute resources in ways that lessen health inequalities and support initiatives that identify and eliminate discrimination. This includes being clearer about the outcomes we expect the services we commission to demonstrate with respect to health inequalities. We will focus particularly on the health needs of black and minority ethnic communities and ‘hard to reach groups’.

We will be outcome-focused in commissioning high quality services. We will work to deliver better health outcomes for the population of Greenwich, by focusing on evidence-based solutions that improve the quality of care, the patient and carer experience, and deliver the greatest health benefit. We will focus on outcomes for the whole population and key groups.

We will seek to add value, and to minimise waste and inefficiency. We recognise the tight financial context in which high quality services are to be commissioned. We will demonstrate clear and credible plans that meet the financial challenges. We will improve collaboration to harness economies of scale to best use available resources, including closer integration with social care, public health and other partners, and delivering primary care at scale.

We will work collaboratively with our partners to develop modern integrated commissioning arrangements. We will maximise resources by taking an integrated, whole-system approach to commissioning, where incentives are aligned, and clinical care pathways are simplified.

We will listen to those we serve. We are committed to involving local people to make sure there is a patient voice in the decisions we make. Our commissioning intentions will be informed by local views about what is working well, and what could be improved.

We will engage local people in improving their own health and wellbeing. We need to support people to be healthy and free from disease and the burden of ill-health. For those with long-term conditions, we will help them to maintain active and healthy lives. For those with acute illness or injury, we will increase understanding of self-help and support people to receive advice in the community as far as possible. We will encourage self-management of conditions wherever possible to reduce avoidable hospital admissions and to increase confidence in self-care.

We will demonstrate effective clinical leadership. We recognise that the challenges we face require whole system solutions, which rely on strategic leaders across health and social care (including the Royal Borough of Greenwich, and Lewisham and Bexley CCGs) working together with users and providers of services to co-design pathways and make best use of available resources.

We will demonstrate accountability to the local population and our partners through robust governance arrangements. We will ensure that our systems have sufficient capacity and capability to monitor outcomes effectively and provide us with information to understand the value we are achieving on behalf of the people of Greenwich.

At the heart of our ambition is a focus on prevention, living well and self-care. We want to drive an expansion of primary and community-based care, and for acute-based hospital care to require a smaller share of resources.

We will know that we are achieving our ambition when:

- We see improvements in health and wellbeing in the population of Greenwich, including an increase in healthy life expectancy, a reduction in health inequalities, and more people engaged in their own health and wellbeing
- Better patient experience is reported by users of health and social care
- We achieve financial balance and can work effectively with our partners to plan future investment
- We commission services in ways that meet the needs of our local population and demonstrates efficiency and impact
- We show a system-based approach to working with our partners

Our ambition, and the four priorities that flow from it, align with the five priorities identified by the Sustainability and Transformation Partnership (STP) for south east London, which are as follows:

1. Developing consistent and high-quality community-based care and prevention
2. Improving quality and reducing variation across both physical and mental health
3. Reducing cost through provider collaboration
4. Developing sustainable specialised services
5. Changing working relationships to deliver the transformation required
3.1 Integrated care Greenwich

The health system cannot continue to deliver services in the current way. The NHS Five Year Forward View (NHS England, 2014) and General Practice Forward View (NHS England, 2016a) are clear that the future focus must be on promoting wellbeing and preventing ill-health. This affects all health, social care and voluntary sector services, including primary care. As commissioners, it means we need to work collaboratively with all providers to change pathways and support population-based services. We will do this by having aligned budgets, underpinned by new contract models to ensure shared incentives are in place to deliver the best outcomes.

We are part of the South East London Commissioning Alliance – which recognises our role as a system within the bigger SEL system. We cannot make decisions in isolation to other parts of the wider system and need to take a ‘SEL perspective’ if we are to bring about transformational change. The next three years will see closer working with commissioners in neighbouring localities, particularly where we commission services from the same acute trusts (Lewisham and Bexley CCGs with respect to Lewisham and Greenwich NHS Trust, and Bexley CGG with respect to Oxleas NHS Foundation Trust). We have begun to work with Lewisham CCG to develop our approach towards integrated care, including exploring areas where we can begin to work together across the geography of Greenwich and Lewisham.

We support further integrated provision through local providers working together through their own joint approach. We have a good relationship with our local GP federation, Greenwich Health. Some NHS providers are also working together to deliver integrated care locally through local care partnerships, for example integrating mental health and acute provision.

As well as working with other NHS organisations, we will continue to work with the Royal Borough of Greenwich, to develop joint or integrated commissioning across the health and social care sector. Our vision is to have modern, integrated commissioning arrangements with a variety of partners along similar lines to our current arrangements for the Better Care Fund.

Integrated care systems (ICSs) are emerging across the country to take the lead in planning and commissioning care for their populations. Our local integrated system for Greenwich seeks to be a sustainable and accessible health and care system which will support people to maintain and improve their mental and physical wellbeing, live independently and access high quality care when they need it. We are at an early stage of development in this work in Greenwich, and we have good relationships with our partners.

We anticipate that integrated care will cover the whole population of Greenwich in the long term, starting with urgent and emergency care. Over the next three years we will focus on the priority areas identified by this strategy, and particularly mental health (priority two), including children and young people, and frail people (priority three). We want to move from a hospital-focused system to one that has the patient at its centre, as shown by figure 5.

We intend to become more strategic in our commissioning, focusing on the planning and funding of new models of integrated care using evidence-based approaches. It is likely to involve the use of longer term, outcome-based contracts.

Communication and engagement for integration is key to driving greater transparency, by working collaboratively with key stakeholders, including provider organisations.

Our aim is to consult with patients and providers, to ensure their involvement in the planning, procurement and monitoring process. For example, we will work with voluntary and community groups in shaping the structure of integrated services. We will ensure that the development of provider services enables effective use of the voluntary sector to support access for hard to reach or seldom heard communities.

Figure 5. A patient-based integrated care system for Greenwich.
3.2 Primary care at scale

Key to achieving our vision for integrated care is providing primary care at scale. It is primary care that will enable us to make transformational change happen. We will be commissioning primary care organisations that have the capacity to provide services at scale. Continuity of care is important to patients and has been associated with lower mortality rates (Periera Gray et al, 2018). Some services will best be provided at a GP practice level, some by practices working at scale (for example, networked practices covering a population of 30-50,000) and some, such as social care, on a borough wide basis.

Working at larger scale has been found to improve sustainability in core general practice through operational efficiency and standardised processes, maximising income, enhancing the workforce, and deploying technology (Rosen et al, 2016). It can also support a more sustainable primary care workforce by broadening skills, creating role flexibility and role enhancement through peer support (ibid). Additionally, working at scale can enable general practice to deliver extended services, with benefits not only for primary care, but for the wider health system. In short, we believe that primary care at scale is crucial to achieving the shifts we seek from hospital-based care to community and primary care. We will strike a balance between working at scale and ensuring services are responsive to local people.

Many GP practices are now collaborating with other practices, often to achieve efficiencies and to offer extended services in primary care – Box C highlights an example within Lewisham. Increasingly, Greenwich practices are looking to create ‘nested’ structures, to allow different functions to be performed at the most appropriate scale, including deliberately designing small clinical core teams for care where continuity is important. Greenwich Health GP federation is already taking an ‘at scale’ view of primary care across the patch. For example, the federation is working with local GPs to provide extended access to primary care at evenings and weekends and developing the ‘hub’ model to deliver public health services. We need to build on these developments and drive primary care at scale, as a cornerstone of our plans for integrated care.

We anticipate that primary care working at scale will provide the foundations for new integrated care systems across London, which will bridge the traditional provider-commissioner boundary to provide for the care needs of whole populations. Primary care at scale will be at the heart of transformation.

As delegated commissioners of primary care services, we will use our primary care Commissioning Intentions to incentivise new ways of working. In pursuing primary care at scale we will align our approach with the rest of London, guided by London-wide strategy intended to strengthen general practice collaboration in London. We will work with Greenwich Health and our 35 GP practices to develop the concept of primary care at scale. Central to our approach will be our four Local Care Networks.

BOX C: LEWISHAM ‘SUPER PARTNERSHIP’

Five practices in Lewisham are merging to become one super partnership that will become the second largest registered list size in London. The merger is designed to enhance patient experience and create benefits for staff and local commissioners.

Initially the five PMS contracts will remain as separate contracts, which the new entity holds in trust, allowing the practices to benefit from the integration of clinical and access services and systems. At a later stage it is envisaged they will move to one PMS contract or consider the new voluntary Multispecialty Community Provider contract. Further practices are expected to join the super partnership model over time.

Working at scale requires a completely new business model, and both clinical and non-clinical capacity to develop, consult and implement it. As part of the business case for the merger, seven day, 8am to 8pm access was proposed.

We will look to learn from the super partnership model and from other experiences of neighbouring areas in the delivery of primary care at scale.

3.3 Local Care Networks

Investment in community-based care is essential to transform our system and move towards lower cost, higher value care delivery. To this end, we will continue to support the development of four local care networks (LCNs); multi-disciplinary networks that work at scale to improve access, as well as manage the mental and physical health of their populations. The LCNs will draw together primary care at scale with other community-based provision to provide care at neighbourhood level.

Fully operational LCNs will deliver our new model of care and the full vision of the Primary Care Strategic Commissioning Framework (SCF). The LCNs will support practices to shift the focus to prevention, facilitated by Greenwich Health GP federation. We will give emphasis to adopting population-based budgets and risk-based contracts, and fully integrating information management and technology across organisations and pathways. It will mean removing barriers to professional roles and responsibilities, through joint education and training between primary and community care providers. The implementation plan will outline how changes will take place and there will be further discussion at that stage.

The minimum that LCNs should encompass is: all GPs working at scale, community pharmacies, specialist teams working in the community, voluntary and community sector, community nursing, social care, community mental health teams, community therapy, community-based diagnostics, and patient engagement groups.

Our vision is to establish long term condition (LTC) hubs within our LCNs, to improve the quality of care for people with LTCs by increasing access to community based multi-disciplinary services. This will require GP practices collaborating with each other, and with other health and social care providers, the third sector and community assets.

We will continue to focus on the following: diabetes; prevention; case management; reablement; medicines management; reduction in variation; and end of life care. In addition, LCNs will provide a full range of community-based services, including: support to patients to manage their own health, prevention, improved access to general practice, and support for vulnerable people.

The ultimate aim is for LCNs to integrate the entire community-based system and drive transformation. The availability of more community-based care will enable us to achieve simpler, more streamlined planned care pathways, to consolidate acute services and engineer shifts in activity to new models of primary and community care. As part of this, LCNs will help us to achieve greater consistency of access to high quality and safe planned care services, to manage demand for planned care and ensure that outpatient referrals are made only where appropriate. The pathway is not operating as planned and feedback we received at the listening events highlighted that one element that needs improving is for GPs to receive more training on how to use the system. We will work with GPs to ensure more effective use of the referral management system. We will also improve access to planned care services by working with our partners to align provision across boroughs, with the aim of making service provision more consistent and to improve clinical transitions from primary to secondary care and between all service providers.
3.4 Primary care workforce

Initiatives are already underway to address the GP workforce shortage in Greenwich, including offering mentoring for new GPs and a retainer scheme for GPs who do not want to work full-time.

The general practice workforce in some parts of the country is expanding to include physician associates working under a GP’s remit, paramedics employed by GPs to undertake home visits, pharmacists managing groups of patients with long-term conditions, advanced nurse practitioners supporting patients with minor ailments, and mental health therapists. Feedback from Greenwich patient groups has highlighted the benefit of expanding the skill mix in primary care in our locality.

To support primary care at scale, we will invest in expanding the primary care workforce. Pharmacists in primary care are being introduced during 2018/19 to support GPs, reduce demand for appointments, promote self-care, and support medicines management initiatives (including reducing medicines wastage and medicines optimisation) – see Box D. Community pharmacists can also provide an alternative triage point for many of the common ailments dealt with by out-of-hours services and A&E departments (Smith et al., 2013).

Medical Assistants are being trained nationally to work in primary care. Greenwich is part of a joint bid to increase the number of GPs through an international recruitment and retention initiative. We have advanced nurse practitioners and practice nurses, but the numbers are relatively low.

Live Well Coaches are one example of new roles effectively integrated into the primary care workforce – see page 23 for further details. Front-line primary care staff will be trained in care navigation. MSK physiotherapists in primary care are being championed through our MSK contract. Introducing new roles into primary care will be an ongoing programme, supported by Health Education England.

3.5 Primary care estate

An estates strategy for south east London is in draft, and a Greenwich estates working group has been set up with key stakeholders to ensure we are planning for the future.

Our estates plan will support our ambitions for more community-based care, including the rationalisation of inappropriate estate. We want to ensure comprehensive primary care and where branch surgeries are unable to do this we would want to review this in the context of the estates strategy. We will encourage greater GP networking arrangements and primary care working at scale through our estates plan.

We will work with the Royal Borough of Greenwich to improve the ability of our community and primary care health workforce to use their own transport to carry out their roles. We are also working closely with the local authority on the footprint of further housing developments where demand will be for primary and community services. Engagement on the estates strategy for Greenwich will take place in 2018/19.
Our four priority areas

The four priorities we have chosen for the next three years seek to shift the focal point from expensive hospital services to community-based care closer to home. We want to get upstream, to prevent ill-health as much as possible, intervene early to avoid hospital admissions, and to streamline service provision. The primary objective is to improve health and wellbeing for the Greenwich population. This will have a secondary gain in making best use of limited resources.

4.1 Priority one: To prevent illness and help our population to live well

Our first priority is to prevent illness and enhance wellbeing and healthy living, in collaboration with the Royal Borough of Greenwich, the Health and Wellbeing Board, and community and voluntary sector organisations. This means getting it right from birth and giving children from all backgrounds the best possible start in life, supporting them to live healthy and active lives, and to minimise ill-health and disability in older age.

We will focus upon the delivery of the existing strategies that have been developed by us and by our partners and be driven by the insights provided by our public health colleagues (for example, as highlighted in the annual report of the Director of Public Health for Greenwich).

Live Well Greenwich

We will support the continued development of Live Well Greenwich, empowering people to find the support they need to look after themselves, including telephone help (Live Well Line) and face to face support (Live Well coaches; for further details see page 23). We will work with our partners to increase the expertise and help people can access to make the best use of all these resources. This will include training (Making Every Opportunity Count (MEOC)) for front line staff, partners and residents in the community to help them to recognise when someone might need help and signpost them to a range of support services.

South East London Commissioning Alliance

A prevention board will be established which will work alongside the community-based care board. The focus of this board will be to roll out the ‘vital five’ areas of prevention across south east London to ensure that each health and care system addresses these risk factors more systematically and effectively. These are:

- Smoking
- Alcohol
- Mental health
- Hypertension
- Obesity

Our prevention plans

Our plans for prevention reflect the areas indicated, as follows:

- Reducing alcohol, through using levers, such as CQUINS (Section 5, page 42, explains this term), to embed alcohol screening, and support the roll out of the digital alcohol identification and brief advice programme (BA) in primary care
- Reducing smoking through using levers, such as CQUINS, to embed smoking screening and specialist advice across all our providers in primary care, community care and acute settings
- Promoting healthy weight, including through creating a pilot programme for Tier 3 weight management for children
- Improving mental health and wellbeing through Primary Care Plus (see page 35) and by supporting broader initiatives through the Thrive Greenwich programme. Priority two focuses on our plans for mental health
- Promoting a healthy workforce, through embedding Make Every Opportunity Count (MEOC), securing opportunities to promote work as a health outcome, and developing the Care Navigator workforce as part of Live Well Greenwich
- Sharing best practice and identifying possible areas for collaboration in our commissioning of public health services, such as health visiting, sexual health and smoking cessation
- Working together to implement public health campaigns, such as Stoptobep and Change for Life, amplifying the public-facing messages across south east London and reducing duplication of work at borough level

Other priorities for joint work include:

- Preventing diabetes, by improving uptake rates for the National Diabetes Prevention Programme by increasing primary care referrals
- Improving health protection arrangements, including improving immunisation uptake rates through primary care, improving cancer screening uptake rates, and continued rollout of the latent tuberculosis programme in general practice

Getting it right from birth

Greenwich Children and Young People Plan 2017-2020

We will work with our partners to support this plan, which has four priorities:

- Strong foundations for children from disadvantaged backgrounds – including fewer admissions to hospital and A&E, improved parental mental health, fewer neonatal mortalities and stillbirths, and increased uptake of immunisations
- Supporting disadvantaged boys and engaging well with men
- Healthy relationships, tackling violence and exploitation
- Children with special educational needs and disabilities – including more children having antenatal checks at 10 weeks, and early identification of speech, language and communication needs. For example, children with autism need an early identification process where appropriate services are wrapped around the child in order to achieve the best possible outcomes.

1001 critical days

The Greenwich Child and Young People Plan 2017-2020 commits to providing all children and young people in Greenwich with the best possible start in life, particularly during their first 1001 days. The 1001 days manifesto highlights the importance of intervening early in the 1001 critical days between conception to age two to enhance outcomes for children (Durkin et al, 2016). For example, the manifesto's vision provides for:

- Vulnerable families, or those experiencing difficulties, to be able to access specialist services which promote parent-infant interaction
- A range of services to be in place in every local area to ensure that parents who are at risk of or suffering from mental health problems are given appropriate support at the earliest opportunity
- All parents to be able to access antenatal classes which address both the physical and emotional aspects of parenthood, and the baby's wellbeing and healthy social and emotional development.

We will know that we are achieving our vision when:

- Children get the best possible start in life
- There is improvement in life expectancy, particularly for women
- We see reductions in alcohol consumption and smoking
- There is an increase in children and adults who are a healthy weight
- We see better mental health and wellbeing, and early identification of children with educational and communication needs, including autism
- There are reductions in diabetes and other long-term conditions
4.2 Priority two: To strengthen local support for people with mental illness, including children and young people

Our vision for the commissioning and delivery of mental health and learning disability services in Greenwich is to increase wellbeing, prevent ill-health, and to improve people’s quality of life. Our strategy, in tandem with the national direction, is to provide the wraparound health and social care needed by people living with a physical and mental health condition. To achieve this aim, we will continue to work with Greenwich Mental Health and Wellbeing Partnership Board, Royal Borough of Greenwich, Oxleas NHS Foundation Trust, GPs, and community and voluntary sector organisations, to coordinate services across health and social care.

We will undertake integrated commissioning with the Royal Borough of Greenwich, supported by staff jointly appointed to the CCG and the local authority. We will work with Oxleas NHS Foundation Trust, our provider of acute and community mental health services, to shift the focus more firmly into community provision. We want to ensure people with mental illness are properly supported, including new models of care (led by the South London Partnership) such as availability of alternatives to inpatient care.

We will continue to develop these pathways over the next three years.

At our listening events we heard that better signposting is needed and inaccurate communications around mental health services is an issue. Central to our plans is Primary Care Plus (PCP) – see Box E, page 35 – which is a community-based single point of access to mental health services that wraps around the patient, with all services brought into one operating arrangement. The PCP model places emphasis on holistic care and on mental health pathways that put the patient at the centre.

We will work to raise the profile of mental health services, by tackling stigma and integrating mental health with physical health services. We will meet the national Mental Health Investment Standard, which requires CCGs to increase investment in mental health services in line with their overall increase in allocation each year; this will help to bring parity with physical health.

We will work with our partners to develop the mental health workforce, to ensure that staff have the skills to identify mental health issues (and particularly those with complex presentations) and take appropriate action at the first point of entry into a service, whether an adult, child or young person. We will address mental health inequalities, including targeted activities at specific groups (for example, we will develop a specialist perinatal mental health service).

Mental health services for children and young people (CYP)

There is concern over the growth of mental health problems amongst young people. We will support Greenwich’s Child and Adolescent Mental Health Services (CAMHS) Transformation Plan (NHS Greenwich CCG, 2017b), which outlines the following local priorities:

- Helping CYP and families to access appropriate support and to build capacity across children’s services
- Increasing awareness amongst Black, Asian and minority ethnic CYP
- Improving outcomes for CYP with suspected eating disorders
- Developing the breadth and volume of support programmes for parents
- Improving significantly urgent and emergency mental health care
- Improving mental health care for CYP within the youth justice system
- Addressing the difficulties that CYP face when transitioning to adult services or back to primary care.

Our plans for CYP for 2018/19 include improving the urgent and emergency care pathway, meeting national access targets, increasing scrutiny of transitions in care, reviewing the community eating disorder service, and refreshing the Greenwich CAMHS Transformation Plan.

We want to work towards joint commissioning of mental health services, between the Royal Borough of Greenwich and the CCG, to address the challenges around transitions from children to adult services.

• Adults and older adults learning disabilities – including transforming care for people with learning disabilities and autism who have a mental illness or whose behaviour challenges services
• Children and young people mental health – including new models of care (led by the South London Partnership) such as availability of alternatives to inpatient care

We have identified four transformation pathways for 2018/19:

- Community mental health – including developing a holistic primary care health and wellbeing support pathway as an alternative to admission and secondary care support, and developing the Primary Care Plus model
- Crisis – including expanding provision of the Crisis Resolution and Home Treatment Team, suicide prevention, and a dedicated 24/7 crisis line
- Improving mental health care for CYP within the youth justice system
- Addressing the difficulties that CYP face when transitioning to adult services or back to primary care.

PCP team will have a full-time consultant psychiatrist, and a multidisciplinary team comprising a team manager, community psychiatric nurses, occupational therapists, psychologists and social workers. PCP staff will have expertise in social inclusion (including employment and housing issues), with an emphasis on early intervention (for example, 24 hour Home Treatment Team).

PCP staff will also provide regular teaching at borough-wide primary care events.


BOX E: PRIMARY CARE PLUS (PCP)

The Greenwich PCP service was first introduced in September 2015, providing a specialist in-reach mental health liaison service to primary care providers in the borough. It is a community-based, single point of access to mental health services. It takes an integrated approach, incorporating services necessary for maintaining good mental health and wellbeing, including social care, housing and employment support, and voluntary sector support.

The service will map to GP opening hours and provide a single point of access for all referrals to Oxleas Mental Health Services (specialist care services) from primary care.

Urgent referrals will be telephone triaged within 24 hours, and if needed, individuals will receive a same day face to face assessment from the crisis service.

Routine referrals to PCP will be triaged within two weeks. New referrals will be directed to the appropriate treatment pathway (psychosis, ADAPT [anxiety, depression, personality disorder and trauma], early intervention, older adults or memory services) for full assessment or treatment, as necessary.

The PCP team will have a full-time consultant psychiatrist, and a multidisciplinary team comprising a team manager, community psychiatric nurses, occupational therapists, psychologists and social workers. PCP staff will have expertise in social inclusion (including employment and housing issues), with an emphasis on early intervention (for example, 24 hour Home Treatment Team).

PCP staff will also provide regular teaching at borough-wide primary care events.
Adult mental health services

We will strengthen alternatives for admission for those needing immediate support, by shifting care closer to home. The Greenwich Improving Access to Psychological Therapies (IAPT) service has one of the best recovery rates in London and regularly delivers against its access targets for entering treatment.

In line with the Five Year Forward View (NHS England, 2014) we will expand the IAPT programme as first-line treatments for people experiencing depression and anxiety. This will include:
- Increasing the access rate from 15% to 16.9% in 2018/19
- Maintaining a minimum of 50% recovery rate for all service users
- Implementing a long term conditions pathway
- Developing a payment by outcomes mechanism

We will align our activities with the national Transforming Care Programme for people with learning disabilities and autism who have a mental illness or whose behaviour challenges services, with the aim of more people living in the community, with the right support, and close to home. Greenwich is one of six boroughs in the SEL Transforming Care Partnership with a commitment to working across organisational and borough boundaries, particularly where we can deliver more or better outcomes through joint initiatives.

Learning disabilities

People with learning difficulties often fall through the net, and equity of access into planned care is an issue. Our vision includes supporting people with learning disabilities by:
- Reducing the number of people receiving treatment outside of Greenwich
- Improving the crisis and acute care response
- Contributing to the local housing strategy

We will know that we are achieving our vision when:
- We see better mental health and wellbeing for both children and adults
- We see a decrease in A&E attendances for mental health issues
- We see a reduction in out of area treatment
- Services are joined up and well-coordinated
- Unnecessary hospital admissions and inappropriate discharges are reduced
- There is a decrease in people with learning disabilities in the justice system
- Providing care closer to home and alternatives to admissions
- Supporting the uptake of annual physical health checks
- Supporting use of personal health budgets to enable people with a learning disability to live in their own homes or with their families, rather than in institutions.

Transforming care sits at the heart of our plans here – see primary care at scale, section 3.2. This aligns with national policy for primary care and provides those living with complex health and care needs more personalised, proactive care to keep them healthy, independent and out of hospital (Department of Health, 2014). Integration across providers and with social care will also be a real enabler for change. We envisage staff delivering services through new integrated roles that span organisations. We will work with our partners to agree joint workforce plans focused on securing the right skills to best support patients.

We will undertake risk stratification to focus the work of the developing multi-disciplinary community hubs, which will enable staff to target services at those most at risk (for example, through falls management, diabetes care, and improved support to care homes).

4.3 Priority three: To better meet the needs of frail people with care closer to home, an integrated urgent care system, and stronger community-based care

We will place a much greater emphasis on promoting independence, dignity and choice, with care shifting away from institutions (i.e. hospitals) towards community and home-based support. Our vision is to commission more healthcare services closer to home rather than in acute hospitals. We want to work with service users, their families and carers, to design services that achieve this aim.

Frailty and older people

As we face an ageing population, so the number of people living with more than one long-term condition will rise. Currently, 44% of people over 75 now live with more than one long-term condition, and around 10% of people over 65 are living with frailty, a distinctive health state related to the ageing process (Royal College of General Practitioners and British Geriatrics Society, 2016). In Greenwich, there is also frailty in the younger population (aged 18 to 64).

We will plan and commission services to cover the whole frailty trajectory, from keeping people healthy and independent to supporting them in hospital, built around three pillars:
- Ageing well and staying well
- Extending primary and community support
- Integrated care in acute settings and beyond

Our principles for frailty care in Greenwich are set out in figure 6.

We want to invest in well-designed schemes to provide treatment, rehabilitation and reablement at home or in the local community. This approach should particularly benefit frail older people and those living with dementia. We want to reflect a person-centred approach, including supporting improvements in the availability of district and community nursing to help people with dementia receive better care, closer to home. To this end we will agree joint plans with our partners for how frail and older people are to be supported in their own homes and we will seek to maximise the contributions of voluntary, community and social enterprise organisations.

Transforming primary care sits at the heart of our plans here – see primary care at scale, section 3.2. This aligns with national policy for primary care and provides those living with complex health and care needs more personalised, proactive care to keep them healthy, independent and out of hospital (Department of Health, 2014). Integration across providers and with social care will also be a real enabler for change. We envisage staff delivering services through new integrated roles that span organisations. We will work with our partners to agree joint workforce plans focused on securing the right skills to best support patients.

We will undertake risk stratification to focus the work of the developing multi-disciplinary community hubs, which will enable staff to target services at those most at risk (for example, through falls management, diabetes care, and improved support to care homes).

Figure 6. Our principles for frailty care in Greenwich

1. Centred around the holistic needs of the service users and their carers, involving them in all decisions while providing simpler access and a shared care plan
2. Is personalised and tailored to changing health as well as social needs, covering both planned and reactive needs, and empowering self-care
3. Has a clear point of accountability (both for clinical & non-clinical outcomes) with a core team that reflects users’ needs and helps coordinate their care
4. Is supported by a number of local operational whole systems bases where joint teams work on a day to day basis coordinating care and tracking outcomes
5. Helps coordinate the services (via the base) as needed from different organisations, on behalf of service users and their carers
6. Is brought together by shared cultural values and ethos, organisations working as an Integrated Partnership that is commissioned to deliver a single set of outcomes and is enabled by shared systems and incentives
End of life care

We intend to better support people nearing end of life to be cared for and to die in their preferred place of care, which is usually their home, or other community-based settings such as a care home or sheltered housing. To achieve this, we will continue to work with our partners, including Greenwich and Bexley Community Hospice and Lewisham and Greenwich Trust, to commission planned 24/7 provision of community support, with advance care planning, co-ordination of care and effective multi-disciplinary team working.

Central to our aim to improve end of life care are our plans to further embed the skills and tools needed to identify individuals as they approach the end of their lives. Early identification will help to ensure that these patients receive the proactive support they need and have their wishes and plans for their care clearly documented and shared across organisational boundaries. We remain committed to promoting the use of Coordinate My Care (CMC), a clinical system where information about a patient’s wishes and care can be stored and shared between healthcare providers, with the aim of increasing the number of patients with a CMC record over the next three years. In addition to improving the quality of life for Greenwich residents in their final days, these plans will help to avoid unplanned visits to A&E and hospital admissions.

Integrated care hubs

We want to introduce integrated care hubs in Greenwich as part of our drive to strengthen and coordinate primary care around the needs of patients living with frailty. The integrated hubs will bring together a range of health and social care professionals, drawn from primary and secondary care, to work together to personalise, coordinate and enhance preventative care for their local population. An agreed approach to risk stratification will provide health and social care professionals with the toolkit they need to identify patients living with frailty and refer them into their local integrated care hub. The hub team will then work with the patient, their GP and other professionals already known to the patient, to understand the patient's needs and develop a care plan which focuses on planned and coordinated support for that individual. This will mean an annual discussion with a GP and Healthcare Assistant for some patients and a monthly appointment with a GP, social worker and geriatrician for others.

The hubs will adopt a case management approach to support patients living with frailty to remain happily independent for longer and reduce unplanned admissions to hospital. The key benefits for patients include access to a single integrated and multidisciplinary team, who will work together to personalise care and a single point of access into the healthcare system as needs change or urgent support is required.

The integrated care hubs, and improvements to wider pathways of care for people living with frailty will adhere to the six principles that guide the frailty model of care development in Greenwich. These principles were developed in early 2018 by a collaborative of over 100 health and social care professionals in Greenwich and describe our ambition for frailty care in Greenwich.

Primary Care Home

The development of integrated care hubs is a first step towards our longer-term ambition to introduce Primary Care Home into Greenwich. Primary Care Home is an innovative approach to strengthening and redesigning primary care. Developed by the National Association of Primary Care, the model brings together a range of health and social care professionals – drawn from GP surgeries, community, mental health and acute trust, social care and the voluntary sector – to work together to provide enhanced personalised and preventative care for their local community.

The key characteristics of Primary Care Home include:

- An integrated workforce, with a strong focus on partnerships spanning primary, secondary and social care
- A combined focus on personalisation of care with improvements in population health outcomes
- Aligned clinical and financial drivers through a unified, capitated budget with appropriate shared risks and rewards

The key benefits for patients are a single integrated and multidisciplinary team, working to provide comprehensive and personalised care to individuals. Working at this scale ensures everyone within the team knows everyone else and the patient has a more consistent experience of care, similar to having a named GP.

Urgent care

The number of patients attending A&E is increasing, as are unplanned admissions. Our first objective is to reduce demand for urgent care through prevention and early intervention – a frailty care pathway, better end of life care, and integrated care hubs should all help in reducing unnecessary hospital attendances. We also need to ensure that the Greenwich population has access to the highest quality urgent care.

We will work to the new national 111 specification across neighbouring areas, with full implementation by April 2019. The 111 service will be provided by a multidisciplinary clinical team, with one senior GP available 24/7. We will integrate GP out of hours and 111 to become Integrated Urgent Care Clinical Assessment Service (IUC CAS). It is expected that more than 50% of all calls to NHS 111 will involve a clinical consultation over the phone.

We will move to the national specification for Urgent Treatment Centres, which will serve as clinical advice service hubs, and provide a single point of access for care homes. When patients are discharged from the urgent care system, we want to ensure that frail people and those with long term conditions receive continuity of care from an appropriate team of health and social care professionals. As part of the development of Integrated Care Hubs, we will ensure that there are appropriate processes in place to alert the Hub should one of their patients attend a local urgent care centre or require an unplanned admission. We will improve management of frequent attenders to A&E and those who have repeat admissions, and we will work to reduce significantly patients being re-admitted to hospital within 30 days. Lewisham and Greenwich NHS Trust has already begun work to develop its plans for integrated discharge, and we will support the trust with this work.

Our approach to community services

We will focus on adopting preventative approaches, such as health trainers embedded in GP surgeries, social prescribing, Care Navigators (Age UK), housing and debt management. These and other measures, including health checks, early falls assessment, and preventative support in care homes will aim to avoid the need for emergency and urgent care. Working with our local authority and with community and voluntary sector organisations, we will adopt a holistic health model.

We will expand the range of services available in the community, including diagnostics, respiratory and cardiology services, pain management, MSK, and dermatology.

Community pharmacists working closely with GPs will also support people’s self-management of their conditions and undertake medication reviews and provide access to urgent medicines. We will be informed by the Pharmaceutical Needs Assessment for Greenwich, for 2018-2021 (Royal Borough of Greenwich, 2018), which examines the services provided by the existing 62 community pharmacies located within the borough and maps these against the needs of the local population. An extended primary care team will be able to broaden the offering to patients and free GPs to focus on those with complex needs. NHS England has commissioned a new pilot from November 2018 called Digital Minor Illness Referral Scheme (DMIRS) across London. Patients with minor illness or conditions that can be self-managed with advice from the local community pharmacies will be referred from NHS 111 to participating Greenwich pharmacies.
Greater use of technology

We will seek to harness technology to enhance access to services from home and increase self-care and self-management of conditions. Greenwich was an early adopter of Wi-Fi in general practice, which benefits both staff and patients, by enabling more mobile working and for practices to offer patients on-line services. E-consultations will be piloted in Greenwich during 2018/19 with the aim of all practices offering alternatives to face-to-face appointments by the end of 2018. Box F provides details of our new telehealth care system.

We will also be looking at how technology can support multi-disciplinary team-working in primary care and enable best use of the GP workforce. For example, using tools such as Skype to enhance health care in care homes as well as home care, by enabling GPs to interact with patients, facilitated by other health and social care staff. Other examples may include: home or portable diagnosticks; smart assistive technology that can help people with disabilities or long-term conditions perform tasks or activities, and digital therapeutics, such as computerised cognitive behavioural therapy (Gretton and Honeyman, 2016).

We will incorporate into pathway design the need for full IT interoperability between providers, integrated information sharing and coordinated flows of information. GP practices in the borough are not on the same system and IT problems are experienced that can impact on patient care and could hinder working at scale. We need to invest in better IT systems that provide a platform for modern clinical practice and meet the needs of our local population.

Improved access to primary care

In addition to strengthening community-based provision, we will improve access to primary care. Two GP Access Hubs were commissioned in 2016/17, with three-year funding. Patients can now see a GP seven days a week from 8am-8pm. Further work is needed to review the utilisation of the hubs and to increase access to the population who use urgent and emergency care services inappropriately. We will pay particular attention to equity of access for primary care services and ensure that services are targeted at patient groups in greatest need. We will invest in care navigation and better signposting to ensure that all Greenwich residents are directed to the most appropriate source of assistance for their needs.

BOX F: TELEHEALTH CARE SYSTEM

Greenwich CCG launched a new Telehealth Care System in the 12 care homes for the elderly in Greenwich. The telehealth system collates the results of vital observations undertaken by staff and then calculates the National Early Warning Score (NEWS). In doing so, the system helps staff to recognise early deterioration signs in their residents and informs the appropriate response (such as increased monitoring, calling a GP, 111 or other service), leaving 999 for life-threatening emergencies only.

GPs can remotely review the patient’s observations and discuss results with staff before deciding whether the patient requires a GP visit. The digital pad (see image, below), enables photographs to be taken.

One GP reported: “I was able to see the pictures very clearly and the evidence of cellulitis”. The patient was treated on the basis of the pictures and progress was monitored at the next routine visit. This saved an additional visit to the patient and avoided delay in starting treatment.

4.4 Priority four: To improve the prevention, detection and treatment of cancers for our local population

Tipping the balance against cancer (Royal Borough of Greenwich, 2016) emphasises that we need to act across the whole cancer pathway, from preventing cancer developing, to supporting earlier diagnosis to increase the chance of successful treatment and ensuring that people have access to the highest quality treatment. It involves a partnership of organisations and people, including the local authority, our provider trusts, the voluntary and community sector and local residents. For example, reducing smoking, which has a clear association with many cancers, requires a multi-agency approach, from smoking cessation services to reducing the amount of cheap tobacco sold locally. Nearly one in 10 cancers in the UK are caused by unhealthy diets, and a co-ordinated systems approach has a greater chance of improving diet for everyone in Greenwich.

Through our Local Cancer Steering Group and Bexley Greenwich and Lewisham (BGL) Cancer Collaborative Locality group we will work with the SEL Cancer Alliance to improve patient outcomes from cancer through better prevention of cancers, early detection through screening, and improved public awareness of cancer symptoms (South East London Cancer Alliance Delivery Plan). This will require continued education for primary care teams, including on lifestyle interventions to reduce the risk of cancer, recognising the symptoms, and best supporting people living with cancer, reflecting national and local strategy for cancer (NHS England, 2000; Royal Borough of Greenwich, 2016).

We will also work to ensure that patients have access to timely diagnosis and treatments in a place that best suits their needs (for example, lymphedema treatment services), and to improve patient experience throughout the cancer pathway. We will ensure that Greenwich achieves all eight targets and that we are achieving the 62-day referral-to-treatment cancer standard. We will also pursue initiatives specific to Greenwich, including:

- Tackling inequalities by reducing variations in cancer incidence and mortality, and by increasing public awareness and uptake of screening in social groups where this is low
- Supporting people living with, and beyond, cancer
- Reviewing pathway issues and barriers (for example, around radiology)

We will know that we are achieving our vision when:

- There is an increased uptake of screening for cancers
- Improvements are seen in addressing the factors associated with an increased cancer risk, including smoking, diet, alcohol, physical activity and healthy weight, the sun and sunbeds
- Increased public awareness of cancer symptoms and the importance of early diagnosis
- Patients report consistent access to high quality care, timely diagnosis and treatments in a location that best suits their needs
- There is an increase in the number of Greenwich people who survive cancer for 1-5 years
- Improved scores in the national cancer patient experience survey
## 5 A financially sustainable system

We need to do things differently; working with our partners, we will plan and commission services in ways that reflect our ambitions in this strategy. It is only by engineering shifts into community-based and primary care that we can develop a financially sustainable system.

Section 2 highlighted the financial challenges faced across the system. Pressures on the system are expected to continue to rise at a faster rate than funding, and we must deliver efficiency savings of around 3.5% of the budget for 2018/19 alone. This section outlines our plans to achieve this over the next three years.

We will continue to work to deliver the NHS 10 Point Efficiency Plan (NHS England, 2017a), which includes a range of measures from clamping down on temporary staffing spend and getting best value from medicines and pharmacy, to freeing up hospital beds and reducing unwarranted variation through the Getting It Right First Time (GIRFT) programme. We will also implement learning from the Carter Review (2016), regarding the productivity and efficiency of non-specialist acute hospitals, which account for half of the total health budget. Some of the levers we will use to commission high quality services are outlined at Box G.

Figure 7, page 43, sets out the forecasted financial position for the CCG from 2018/19 to 2022/23. The intention is for the CCG to deliver a 1% in-year surplus (£4.7m) by 2022/23 and a cumulative 1% surplus by the end of 2022/23. In order to achieve this financial performance, QIPP of between 3.5% and 3.75% (£15.0m to £17.6m) will need to be delivered on an annual basis over the period. The delivery of a cumulative 1% surplus is a key financial target for CCGs.

The CCG has produced a Financial Recovery Plan which sets out the financial position in greater detail.

### BOX G: COMMISSIONING FOR VALUE

We will use the following levers to commission high quality services:

- **QIPP** – Quality, Innovation, Productivity and Prevention programme to transform Greenwich CCG through quality care improvement and savings. The aim is to deliver a better service on a tighter budget.
- **QOF** – the Quality and Outcomes Framework is designed to drive ongoing improvements in standards and reward GPs for providing patients with good quality care. For Greenwich CCG it is designed to ensure that all patients receive a high level of treatment.
- **CQUINs** – Commissioning for Quality and Innovation framework supports improvements in the quality of services and the creation of new, improved patterns of care.

In addition to stimulating development of at scale providers to deliver extended access, we will invest to stimulate implementation of the 10 high impact actions to free up GP time (see Box H).

### BOX H: 10 HIGH IMPACT ACTIONS TO RELEASE TIME FOR CARE

1. **Active signposting:** Provides patients with a first point of contact to direct them to the most appropriate source of help, including web and app-based portals to provide self-help and self-management resources as well as signposting.
2. **New consultation types:** Introduce new communication methods for some consultations, such as phone and email, improving continuity and convenience for the patient, and reducing clinical contact time.
3. **Reduce Did Not Attend (DNAs):** Maximize the use of appointment slots and improve continuity by reducing DNAs. Changes may include redesigning the appointment system, encouraging patients to write appointment reminders by text message, and making it easy for patients to cancel or rearrange an appointment.
4. **Develop the team:** Broaden the workforce to reduce demand for GP time and connect the patient directly with the most appropriate professional.
5. **Productive work flows:** Introduce new ways of working to enable staff to work smarter, not harder.
6. **Personal productivity:** Support staff to develop their personal resilience and learn specific skills that enable them to work in the most efficient way possible.
7. **Partnership working:** Create partnerships and collaborations with other practices and providers in the local health and social care system.
8. **Social prescribing:** Use referral and signposting to non-medical services in the community that increase wellbeing and independence.
9. **Support self-care:** Take every opportunity to support people to play a greater role in their own health and care with methods of signposting patients to sources of information, advice and support in the community.
10. **Develop quality improvement (QI) expertise:** Develop a specialist team of facilitators to support service redesign and continuous quality improvement.

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1. [http://gettingitrightfirsttime.co.uk/](http://gettingitrightfirsttime.co.uk/)
6 From strategy to action

Taking forward these priorities will require close working with our partners across the system. We are part of an interdependent health and care system, and it is crucial that we work in partnership with our health and social care colleagues, our wider partners, our communities and patients to improve the health outcomes for our population.

Work is planned to take place during 2018 to build on the strategy and to set out and agree a detailed implementation plan which supports changes proposed in the four priority areas of the strategy and the system implementation areas of primary and integrated care.

There will be an action plan that supports this strategy. We will hold a series of meetings and events with our partners, with community groups and interested local residents to translate the four priorities into effective implementation plans. These plans will form the basis for our commissioning intentions over the next three years, which will provide a framework for delivering commissioning plans that enable us to concentrate resources to best effect.

In the light of the new NHS Long Term Plan we will review and align our current strategy. During the autumn of 2018 we will work to develop a road map for implementing the strategy. We have produced a shortened version of this document with our Review of the Year 2017/18 and we will continue to welcome feedback on our plans.

Greenwich Health and Wellbeing Executive Group

A new Greenwich Health and Wellbeing Executive Group is accountable to the Health and Wellbeing Board. This group comprises representatives of the CCG and the Royal Borough of Greenwich, as well as Lewisham and Greenwich NHS Trust and Oxleas NHS Foundation Trust, METRO GAVS and Greenwich Health. It will be instrumental in driving forward transformation across the system.


References


Greenwich Health. It will be instrumental in driving forward transformation across the system.

Greenwich Health and Wellbeing Executive Group

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The Great Get Together on 30 June brought the CCG together with many members of the public, and provided future models of care delivered through pharmacy. Royal Pharmaceutical Society. www.rpharms.com/resources/reports/now-or-never-shaping-pharmacy-for-the-future (accessed 26/06/18).

South East London Cancer Alliance. Delivery Plan Update: Early Diagnosis and LBWC priorities Update to the London Cancer Commissioning Board (24 May 2018).


The checklist is to enable the policy lead and the relevant committee to see whether an EIA is required and to give an indication of any impacts and any valid legal and/or justifiable exception. It is not a substitute for an EIA which is required unless it can be shown that a proposal has no capacity to influence equality.

The checklist is to enable the policy lead and the relevant committee to see whether an EIA is required and to give assurance that the proposals will be legal, fair and equitable.

1. Does the proposal affect one group more or less favourably than another on the basis of:

   Age - Consider and detail (including the source of any evidence), cross age ranges of old and younger people, including safeguarding, consent and child welfare.

   no This document refers to targeting approaches both towards children and young people as well as those who are frail and/or elderly
| Disability (including learning disabilities, physical disability, sensory impairment and mental health problems) - Consider and detail (including the source of any evidence), on attitudinal, physical and social barriers. | no | The strategy recognises the particular needs of those with learning disabilities and particular consideration is documented on pages 33 to 36. |
| Sex - Consider and detail (including the source of any evidence) on men and women (potential to link to carers below). | no | Priority One of the strategy considers the differences in life expectancy for men and women. |
| Gender and gender re-assignment - Consider and detail (including the source of any evidence), on transgender and transsexual people. This can include issues such as privacy of data and harassment. | no | Page 24 states the ambition for Greenwich CCG to lessen health inequality and eliminate discrimination. |
| Marriage or civil partnership - Consider and detail (including the source of any evidence), on people with different partnerships. | no | Page 24 states the ambition for Greenwich CCG to lessen health inequality and eliminate discrimination. |
| Pregnancy and maternity - Consider and detail (including the source of any evidence), on working arrangements, part time working, infant caring responsibilities. | no | Page 24 states the ambition for Greenwich CCG to lessen health inequality and eliminate discrimination. |
| Race - Consider and detail (including the source of any evidence) on different ethnic groups, nationalities, Roma gypsies, Irish travellers, language barriers. | no | Page 24 states the ambition for Greenwich CCG to lessen health inequality and eliminate discrimination. |
| Religion or belief - Consider and detail (including the source of any evidence), on people with different religions, beliefs or no beliefs. | no | Page 24 states the ambition for Greenwich CCG to lessen health inequality and eliminate discrimination. |
| Sexual orientation (including lesbian, gay bisexual and transgender people) - Consider and detail (including the source of any evidence), on heterosexual people as well as lesbian, gay and bi-sexual people. | no | Page 24 states the ambition for Greenwich CCG to lessen health inequality and eliminate discrimination. |

2. **Will the proposal have an impact on lifestyle?**  
   Consider and detail (including the source of any evidence) e.g. diet and nutrition, exercise, physical activity, substance use, risk taking behaviour, education and learning.  
   **Yes**  
   Priority One in the strategy aims to prevent illness and help our population to live well.

3. **Will the proposal have an impact on social environment?**  
   (Consider and detail (including the source of any evidence) e.g. social status, employment (whether paid or not), social/family support, stress, income Carers and general caring responsibilities.  
   **Yes**  
   Priority One in the strategy aims to prevent illness and help our population to live well.

4. **Will the proposal have an impact on physical environment?**  
   e.g. living conditions, working conditions, pollution or climate change, accidental injury, public safety, transmission of infectious disease.  
   **Yes**  
   Priority One in the strategy aims to prevent illness and help our population to live well.

5. **Will the proposal affect access to or experience of services?**  
   e.g. Health Care, Transport, Social Services, Housing Services, Education.  
   **Yes**  
   Page 27 of the strategy states our ambition to focus on outcome-based commissioning of high quality services.

**By using evidence and insight to assess and grade our equality performance, NHS Greenwich can generate much of the information we will require to demonstrate compliance with the Public Sector Equality Duty (PSED). The checklist is to enable the policy lead and the relevant committee to see if a particular policy or project will provide the relevant evidence to assist NHS Greenwich CCG meet the set-out EDS goals to achieve better outcomes for patients and staff.**

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**The goals and outcomes of EDS2**

<table>
<thead>
<tr>
<th>Description of outcome</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Services are commissioned, procured, designed and delivered to meet the health needs of local communities</td>
<td>Yes</td>
</tr>
<tr>
<td>1.2 Individual people’s health needs are assessed and met in appropriate and effective ways</td>
<td>Yes</td>
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<tr>
<td>1.3 Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed</td>
<td>Yes</td>
</tr>
<tr>
<td>1.4 When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse</td>
<td>Yes</td>
</tr>
<tr>
<td>1.5 Screening, vaccination and other health promotion services reach and benefit all local communities</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Improved patient access and experience**

| 2.1 | People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds | Yes |
| 2.2 | People are informed and supported to be as involved as they wish to be in decisions about their care | Yes |
| 2.3 | People report positive experiences of the NHS | Yes |

**A representative and supported workforce**

| 3.1 | Fair NHS recruitment and selection processes lead to a more representative workforce at all levels | Yes |
| 3.2 | The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations | Yes |
| 3.3 | Training and development opportunities are taken up and positively evaluated by all staff | Yes |
| 3.4 | When at work, staff are free from abuse, harassment, bullying and violence from any source | Yes |
| 3.5 | Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives | Yes |
| 3.6 | Staff report positive experiences of their membership of the workforce | Yes |

**Inclusive leadership**

| 4.1 | Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations | Yes |
| 4.2 | Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed | Yes |
| 4.3 | Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination | Yes |

**Policy Author**

<table>
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<tr>
<th>Signature: Virginia Morley</th>
<th>Date: 15.08.2018</th>
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**Equality Lead (Carol Berry)**

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We aim to design and implement policies, procedures and functions to meet the diverse needs of our service users, population and workforce, ensuring that they receive good access, outcome and experience. We have developed and instigated a rolling Equality Impact Assessment Programme for this purpose and also to ensure that it complies with the general duties referred to in the Equality Act 2010. Policies, procedures and functions of the CCG are impact assessed by Equality, Health Inequality, Quality and Privacy. Risk assessments are completed, and any mitigations of negative impacts are monitored. Full Equality Impact Assessments will be undertaken if impact cannot be mitigated and the recommendations will be used to inform new proposal, projects and business cases.