

Greenwich Market Position Statement



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GREENWICH

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Introduction

1.1 Foreword from Director of Integrated Commissioning Adults

I'm pleased to introduce the Royal Borough of Greenwich's Adult Social Care Market Position Statement for 2025-26. This document reflects a major step in our shared journey, built through close collaboration with providers, commissioners, and most importantly, the people who use our services and their families.

Greenwich is a vibrant and diverse borough, home to resilient communities with unique strengths. Our residents deserve a care system that reflects this diversity and enables everyone to thrive. This Market Position Statement is rooted in [Our Greenwich](#), our corporate plan for 2023-34, which places health and wellbeing at the heart of everything we do. It is also guided by the Integrated Care Board and the NHS 10-Year Plan, ensuring our local ambitions align with system-wide priorities.

We are shifting from transactional relationships toward genuine partnerships not just with providers, but with residents themselves. We are committed to sharing power with people who use services, giving them a real voice in decisions about their health and care. Partnership means co-designing support together, not delivering services decided for them.

Our vision is a health and care system that is equitable, preventative, and person-led. We want to help people overcome barriers and lead the lives they choose, in communities where they feel connected. This means moving away from crisis responses and focusing on preventing poor health, reducing risks, and promoting long-term independence.

We recognise the real challenges ahead. Our population is ageing, mental health demand is rising in both numbers and complexity, and cost pressures are significant. We are committed to understanding these dynamics and making evidence-based commissioning decisions that are sustainable for the long term.

Supporting a sustainable market is essential. This year, we have worked transparently with providers to agree fair, consistent fee uplifts that reflect real cost pressures. We will continue to engage openly, monitoring market health and working collaboratively to address challenges before they impact quality or continuity of care.

This Market Position Statement is an invitation to providers, partners, innovators, and the people of Greenwich themselves to shape the next chapter of adult social care in our borough. I encourage you to read this document, engage in our forums, and work with us to build a care system that truly works for everyone.

Lisa Wilson

**Director of Integrated Commissioning Adults
Royal Borough of Greenwich and South East
London Integrated Care Board (SEL ICB)**

1.2 What is a Market Position Statement?

A Market Position Statement, also known as an 'MPS', is information produced by local authorities to support the formation and development of local provision that meets residents' needs. This helps providers understand residents' needs, our preferred ways of working and expectations for service delivery. It also enables us to comply with our market shaping duties under the Care Act 2014. The content reflects the local authority's understanding of its existing markets and provides information about the current supply and demand forecasts for Greenwich.

The Market Position Statement enables the Royal Borough of Greenwich to effectively inform existing and prospective providers about:

- Our current demand in existing markets
- Critical information about our forward strategy, and
- Future development of adult social care services and new opportunities available for providers.

We want providers to use their knowledge and experience in conjunction with this MPS to think creatively about business models and different solutions which will respond to the challenges we are facing. The Royal Borough of Greenwich recognises that social care providers play an important role not only to adult social care but also to the NHS.

1.3 Who is the Market Position Statement for?

- Existing providers working with Royal Greenwich Council
- New providers who are looking for opportunities within Royal Greenwich
- Other businesses or organisations such as health services, community health providers and voluntary or community organisations working in partnership with Royal Greenwich Council.

1.4 Policy Context

1.4.1 Care Act 2014 Market Sustainability Obligations

The [Care Act 2014](#) places a legal duty on local authorities to ensure a sustainable, diverse, and high-

quality market for adult social care. Key obligations include:

- Section 5: Requires local authorities to promote the development of a vibrant, responsive care market that offers choice, quality, and sustainability. This includes supporting innovation, workforce development and ensuring that people have access to information to make informed choices.
- Sections 48-56: Impose a temporary duty to ensure continuity of care in the event of provider failure, regardless of whether the individual is publicly or privately funded. This ensures that no one is left without essential care due to market instability.

These responsibilities are balanced against the Council's obligations to maintain a balanced and affordable financial position, and any sustainability decision must be made in this context of wider financial affordability for the Council.

1.4.2 Public Services (Social Value) Act 2012

The Social Value Act requires commissioners to consider how procurement can improve the social, economic, and environmental wellbeing of their communities. In adult social care, this means:

- Supporting local employment, fair pay, and ethical practices.
- Encouraging providers to deliver added value beyond core services.

This aligns with the Care Act's emphasis on quality, diversity, and sustainability. Providers should demonstrate how they contribute to social value when tendering or delivering services, such as through local employment and training, fair pay, community partnerships, and environmental sustainability. For Greenwich's full social value approach and expectations, see [Greenwich social value framework](#).

1.4.3 The Casey Commission: Independent Commission on Social Care

The Prime Minister has agreed that Baroness Louise Casey will chair an independent commission into adult social care. The commission will be undertaken in two phases with the final phase reporting back by 2028 into the Prime Minister.

Phase 1 (medium term)

The purpose of the first phase of the commission is to set out the plan for how to implement a National Care Service, a government manifesto commitment. This should report in 2026.

The commission should start a national conversation about what adult social care should deliver for citizens and build consensus with the public on how best to meet the current and future needs of the population. It will consider older people's care and support for working age disabled adults separately, recognising that these services meet different needs.

The commission should produce tangible, pragmatic recommendations that can be implemented in a phased way over a decade. It will aim to make adult social care more productive, preventative and to give people who draw on care, and their families and carers, more power in the system.

The commission should seek to understand the current adult social care landscape and identify a commonly agreed picture of the problems faced, before making recommendations for medium term improvements, building on work being undertaken by the Department of Health and Social Care. The focus will be to support the delivery of the health mission, in the context of ongoing reforms relating to the NHS, local government and the Employment Rights Bill and Fair Pay Agreement for care workers, and deliver tangible improvements for the public with regards to adult social care.

The commission's work on medium term reform will be a data driven deep-dive into the current system. It will focus specifically on existing funding for local authority adult social care services, together with NHS funding for services at the interface of health and care (e.g. intermediate care), and whether they are being best used. It will seek to identify what changes can be made to funding flows and accountability mechanisms to improve quality and productivity. It will recommend reforms that help government to hit the 18-week standard for elective care and deliver a neighbourhood health service – by reducing unnecessary hospital admissions and addressing delayed discharges.

The commission's recommendations must remain affordable, operating within the fiscal constraints of Spending Review settlements for the remainder of this parliament.

Phase 2 (long-term)

The second phase should then make longer term recommendations for the transformation of adult social care, reporting back by 2028. This should build on the commission's medium-term recommendations to look at the model of care needed to address demographic change, how services must be organised to deliver this and discuss alternative models that could be considered in future to deliver a fair and affordable adult care system.

Baroness Casey will lead work fully independently with the Department of Health and Social Care as the lead-sponsor department and be based in the Cabinet Office.

The commission must also work closely with relevant other government departments, including HM Treasury, the Ministry of Housing, Communities and Local Government and the Department for Work and Pensions to discuss findings. All relevant government departments will cooperate fully, be transparent, and provide all data and analysis needed to support the commission.

1.4.4 Better Care Fund (BCF)

The Better Care Fund (BCF) is a national programme that brings together NHS and local authority resources to deliver integrated care. In Greenwich, it is jointly managed by the Royal Borough of Greenwich and the South East London Integrated Care Board (SEL ICB).

The BCF supports a person-centred approach that prioritises prevention, early intervention, and care closer to home. It enables investment in services that reduce hospital admissions, improve discharge pathways, and promote independence through digital innovation and community-based care. What This Means for Providers:

- Align services with prevention-first, community-focused models.
- Innovate using digital tools to improve access and outcomes.
- Work collaboratively to integrate with health and social care systems.

For more information, see the [BCF Policy Framework](#).

1.4.5 NHS 10-Year Health Plan - Fit for the Future (2025)

The NHS 10-Year Plan published in July 2025 sets out three major shifts that shape local commissioning:

1. Hospital to Community: Moving care closer to home, with a focus on prevention and early intervention.
2. Analogue to Digital: Embracing digital tools to improve access, efficiency, and patient empowerment.
3. Sickness to Prevention: Prioritising proactive, personalised care to reduce health inequalities and improve outcomes.

For providers, this means opportunities to develop community-based services, digital solutions, and preventative care models that align with these priorities. Read the full plan here: [NHS 10-Year Health Plan - Fit for the Future](#).

1.4.6 Integrated Care Systems (ICS) and Neighbourhood Health - South East London ICS

[The South East London Integrated Care System \(ICS\)](#) brings together health, social care, and community partners to deliver joined-up care closer to home. In Greenwich, we work in partnership through the [Healthier Greenwich Partnership](#), which brings together the Royal Borough of Greenwich, Oxleas NHS Foundation Trust, Lewisham and Greenwich NHS Trust, and the voluntary and community sector to deliver integrated health and care services.

This collaborative approach is central to transforming local services and improving outcomes for residents. Key features of the ICS model include:

- Neighbourhood Teams: Multi-disciplinary teams working across health, social care, and voluntary sectors to provide coordinated, place-based support
- Community-Based Services: A strategic shift from hospital-centric care to accessible services delivered within neighbourhood health centres and community settings
- Personalised Support: Tailored interventions for individuals with complex needs, long-term conditions, or frailty, ensuring care is responsive and holistic
- Whole-System Collaboration: Active involvement

of councils, voluntary organisations, and local communities in co-designing and delivering services

Providers working in Greenwich should understand how their services connect to these integrated pathways and be prepared to work collaboratively across organisational boundaries to deliver coordinated care.

1.4.7 Promoting Equality, diversity & Inclusion and quality in provision of services

The [Royal Borough of Greenwich](#) is committed to ensuring the efficient and effective operation of care and support services, with a clear focus on promoting diversity, quality, and informed choice within the local care market.

In line with its statutory duties under the Care Act 2014 and the Equality Act 2010, the borough aims to ensure that:

- Individuals have access to a diverse range of providers, offering varied models of care and support.
- There is a consistent standard of high-quality services available to meet different needs and preferences.
- People are equipped with clear and accessible information to make informed decisions about how best to meet their care and support needs.

This approach supports a vibrant, responsive market that reflects the borough's values of inclusion, transparency, and person-centred care.

Our Commitment to Equality

The Royal Borough of Greenwich is firmly committed to tackling discrimination and promoting equality of opportunity and good community relations. Our commitment applies to all areas of our work including service provision and commissioning, employment, regulation and in our roles as landlord and community leader. We will work with our partners in the private, public and community sectors to achieve our objectives. We believe that the diversity of Royal Greenwich is one of our greatest assets and should be celebrated and valued.

Our equality policy sets out our key commitments and identifies who is responsible for ensuring they are implemented.

The Royal Borough as a duty under the Equality Act 2010 to “have due regard to the need to”:

- eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010
- advance equality of opportunity between people who share a protected characteristic and those who do not
- foster good relations between people who share a protected characteristic and those who do not.

The duty applies in respect of:

- age
- disability
- race

- sex
- religion or belief
- sexual orientation
- gender reassignment
- pregnancy and maternity
- marriage and civil partnership (employment only).

The Royal Borough of Greenwich seeks to work with organisations that share our commitment to equality, diversity and inclusion. We are proud to support providers of all backgrounds and walks of life and similarly look for providers who understand our diverse population and how best to support residents of different backgrounds and needs.

Providers are asked to contact markets.commissioning@royalgreenwich.gov.uk to find out more about Residential, Nursing and Supported living placements.

Our Vision

2.1 Our Greenwich

The Royal Borough of Greenwich's corporate plan, named [Our Greenwich](#), sets out the vision and priorities that will guide our organisation through the next four years. We aim to develop our services and improve the lives of our residents by focusing our actions and resources on the things that matter to the residents of Royal Greenwich.

One of the core focuses of Our Greenwich is Health and Wellbeing. Good health is the foundation of a happy life. When we are sick it reduces our ability to do the things we enjoy. Ill health goes beyond identifiable disease, it is also about our mental, physical and social wellbeing.

Across the UK there are inequalities in health and wellbeing. People living in the poorest neighbourhoods are becoming sick earlier and living much shorter lives. Greenwich is no exception healthy life expectancy here is notably worse than regional and national averages.

But these inequalities are neither natural nor inevitable. They are unfair and avoidable.

We do not shy away from acknowledging that structural inequalities such as racism, discrimination, poverty, personal and intergenerational trauma, and socially divisive contexts have a profound effect on individuals' wellbeing and health. These are not individual failings; they are the conditions created by systemic barriers that concentrate disadvantage in particular communities.

In the aftermath of the pandemic, the importance of supporting people to live in good health has gained even greater focus. At the same time, the growing demand on NHS and social care services means that we need to think about the best ways to help people.

Health is complex, with multiple overlapping factors influencing outcomes. These factors include not only personal circumstances but also the structural conditions in which people live: access to stable housing, secure employment, quality education, safe environments, and freedom from discrimination. To address these issues, people need to be supported

as a whole person, not as isolated conditions or symptoms to be treated. This requires an understanding of the challenges, desires, strengths, resources and support networks of each individual.

It also requires understanding the broader social, economic, and political contexts that shape those individual circumstances. Residents have told us directly about the impact of the cost-of-living crisis, racial trauma and discrimination, financial insecurity despite full-time employment, and barriers to accessing healthcare and support services. These aren't problems that can be solved through individual behaviour change alone. They demand systemic responses.

Providing flexible services that meet an individual's circumstances is key to giving people greater control over managing their health and wellbeing. Equally important is our commitment to co-production and community engagement. Communities facing the greatest structural disadvantage are not "problems to be fixed", they are experts in navigating barriers that should not exist in the first place. Our role is to resource community strengths, amplify existing networks of mutual support, and dismantle the structural barriers that create unfair and avoidable inequalities.

We will seek to tackle the root causes of ill health by preventing issues from developing in the first place. This means not only creating conditions for people to be more active, eat well, and manage their mental wellbeing, but also addressing the upstream determinants of health: ensuring access to affordable housing, secure employment with living wages, safe and inclusive neighbourhoods, and freedom from discrimination.

This is the difference between equality and equity. Equality offers the same resources to everyone, regardless of starting position. Equity recognises that structural barriers create different starting points and demands we redistribute resources and dismantle those barriers to achieve fair outcomes.

This will help us to build a borough where everyone's health is the very best it can be, not by asking individuals to overcome structural barriers alone,

but by collectively removing those barriers and creating the conditions for all residents to thrive.

[You can download Our Greenwich here.](#)

2.2 Adult Social Care Vision

Royal Borough of Greenwich adult health and social care services collaborate with residents so they can live the best lives they can, by working together to identify strengths and support independence.

Our Vision for Health and Adult Services 2026-2031 represents our strength in people, communities and the diversity of Greenwich.

Our ambition is for all of us to live well, by focusing on what matters to you, what you can do and your connections to the world around you.

You can download a copy of the [vision here](#).

2.3 Joint Health and Adult Social Care

In Greenwich Health and Adult Social Care work in close collaboration to meet the needs of our residents. There are several strategic documents which outline our priorities and strategy to meeting resident need.

[The Royal Greenwich Joint Health and Wellbeing Strategy 2023-2028](#) sets out our shared ambition for the borough. As a joint commissioning team, and as part of the SEL ICS we have determined our cross system priorities for health and social care. [Our priorities - South East London ICS \(selondonics.org\)](#).

Healthier Greenwich Partnership formally reports into the Greenwich Health and Wellbeing Board and brings together partners from the NHS, local council, social care, and the community and voluntary sector. [Healthier Greenwich Partnership - South East London ICS \(selondonics.org\)](#).

Healthier Greenwich Partnership's aims include:

- Improve health and care services to better meet local needs.
- Empower people to take better care of their own health and reduce their dependency on services.
- Provide support from health and care professionals who act as one team and work for organisations that behave as one system.
- Improve performance of local services.
- Reduce duplication. Enable more people to be cared for in the community.

2.4 Joint Strategic Needs Assessment

The Royal Greenwich Joint Strategic Needs Assessment (JSNA) brings together a wide variety of information relating to health, wellbeing and social care to identify the current and future health and well-being needs of our local population. [Joint strategic needs assessment | Royal Borough of Greenwich \(royalgreenwich.gov.uk\)](#).

All providers working with the Council are required to understand Greenwich's population and be able to demonstrate how their services respond to identified needs, health inequalities, and priorities outlined in the Joint Strategic Needs Assessment.

All of the above provide valuable information tools for the council, and our partners, to use in developing our joint priorities, interventions and services to effectively meet the needs and improve the lives of our local people and communities.

2.5 OUR vision for commissioning in Greenwich

We want to ensure that in Greenwich, people's health, care, learning, wellbeing and relationships support them in living their best lives.

- To do this we need to be commissioning for transformational change in the way we deliver our services for people, neighbourhoods and place.
- Our ambition is to enable our residents, providers and other stakeholders to co-design the development of our services, based on what matters most to Greenwich people.
- This will mean a far greater focus on local services, join-up, outcomes, collaboration and impact.
- Preventing avoidable poor outcomes, promoting and protecting good health, learning, safety and wellbeing and tackling health and care inequalities will remain key priorities.

In order to achieve this vision we are shifting our approach to commissioning across 6 distinct ambitions. These are:



Figure 1 - Our Commissioning Ambition

Ambition 1: Genuine co-production

- Resident engagement is fully interwoven into all commissioning activity - whether that is intensive co design and co creation, or consultation, as appropriate
- Engagement is inclusive, and draws on a diverse range of voices in a way that encourages friendly criticism, and leads to genuine changes to commissioned services
- Engagement is not just limited to specific services, but also to system-wide, innovative change across different areas Resident engagement reflects the diverse voices of RBG

Ambition 2: Outcomes-focused, innovative and agile commissioning

- 100% of service specifications and contract management arrangements are based on outcomes that matter to people
- Decisions are balanced and made based on qualitative and quantitative evidence, focused on the resident experience
- Staff are empowered to innovate, and take positive, well-judged risks - even if they don't always work as we had planned
- We work shoulder-to-shoulder with providers, balancing accountability with empowerment, and work with them to incentivise the right outcomes

Ambition 3: Breaking down organisational siloes to enable partnership working

- Work is structured around outcomes, not historical arrangements/contracts
- We work across different teams and disciplines to get the right input, by the right people, at the right time
- We trust VCS groups as equal partners, who have frequent opportunities to input their invaluable expertise
- We draw on our resources and assets in the widest sense - including people, VCS, money etc. - to improve outcomes

Ambition 4: Working closely with the market

- Market providers are trusted partners, who are given space to honestly feed back the challenges they are facing and the insights from the services they are delivering
- Greenwich is welcoming to new market entrants, who may be able to improve outcomes, innovate or enhance service delivery
- Commissioners have a 'finger on the pulse' of the financial sustainability of all providers that deliver services locally

Ambition 5: Highly skilled, motivated workforce open to adapt to meet needs of residents

- Commissioners across all teams and areas are engaged, and have the right skills, insights and experience to maximise their contributions to their roles
- Staff feel fully supported to work in a new way, and feel able to raise any opportunities or challenges they see that might affect them
- Senior leaders visibly role-model these new behaviours, and provide supportive, helpful challenge to facilitate positive change

Ambition 6: Tangible impact for the people of Greenwich

- Tangible improvement in outcomes for Adults, Children's and Public Health services
- Health and social inequalities are reduced in Greenwich
- Demand into health and social care prevented, reduced and delayed - meaning that outcomes are improved, and contribute to the financial sustainability of RBG and Greenwich ICB
- A vibrant community offer that supports our outcomes: whether that is supporting children and young people and their transition to adulthood, or thriving neighbourhoods

Figure 2 - Our Commissioning Ambition in Detail

2.6 Resident Engagement and Co-Production

The Royal Borough of Greenwich places residents at the centre of service design and delivery. We actively engage service users, carers, and communities to gather insights and involve them in shaping services. Co-production is a core principle, ensuring services are responsive, inclusive, and empowering. Our ambition to be a Co-operative Borough reflects this commitment, promoting democratic participation, shared ownership, and mutual support to transform relationships between the Council and communities.

2.7 Equality, Inclusion and Tackling Inequalities

Addressing health and social care inequalities is a strategic priority.

We expect services to be culturally competent, accessible, and inclusive.

Commissioning decisions are shaped by multiple sources of insight: data on disparities in outcomes, direct engagement with residents and those with lived

experience, and ongoing partnerships with community organisations and groups. This ensures we respond to both the evidence of inequality and the expertise of those experiencing it, particularly residents from marginalized or underserved communities.

2.8 Provider Expectations and Market Development

Providers must deliver high-quality, inclusive, and outcome-focused services aligned with borough values. Innovation, co-design, and responsiveness to feedback are encouraged. Affordability and transparency are essential to ensure services remain accessible and public funds are used effectively. Our market development approach supports a diverse, resilient care sector that adapts to changing needs and fosters collaboration.

For more information on providing services in this area, contact can be made by emailing markets. commissioning@royalgreenwich.gov.uk.

Royal Borough of Greenwich Demographics and Demand

3.1 Population Projections

3.1.1 Neighbourhood-Based Care

As South East London transitions to neighbourhood-based delivery through Integrated Neighbourhood Teams (INTs), population planning must align with local service footprints. Greenwich has established 4 neighbourhoods, designed around population health management principles to proactively identify and support residents with complex needs, long-term conditions, and rising risk.

We will form Neighbourhood Wellbeing Networks (aka INT Team of Teams) in each of the four neighbourhoods.

Each network will have NHS, Council, VCSE, providers and residents working collaboratively to address health & care needs across a neighbourhood.

Overview of Neighbourhood Wellbeing Networks:

1. Neighbourhood Wellbeing Network - West
2. Neighbourhood Wellbeing Network - Central
3. Neighbourhood Wellbeing Network - East
4. Neighbourhood Wellbeing Network – South

Population projections will inform:

- Priority cohorts by neighbourhood (e.g., frailty, children with complex needs)
- Local health needs and infrastructure gaps
- Preventative, community-based service models delivered through INTs

This approach ensures commissioning responds to neighbourhood-level dynamics, supporting equitable access and improved outcomes across Greenwich and SEL.

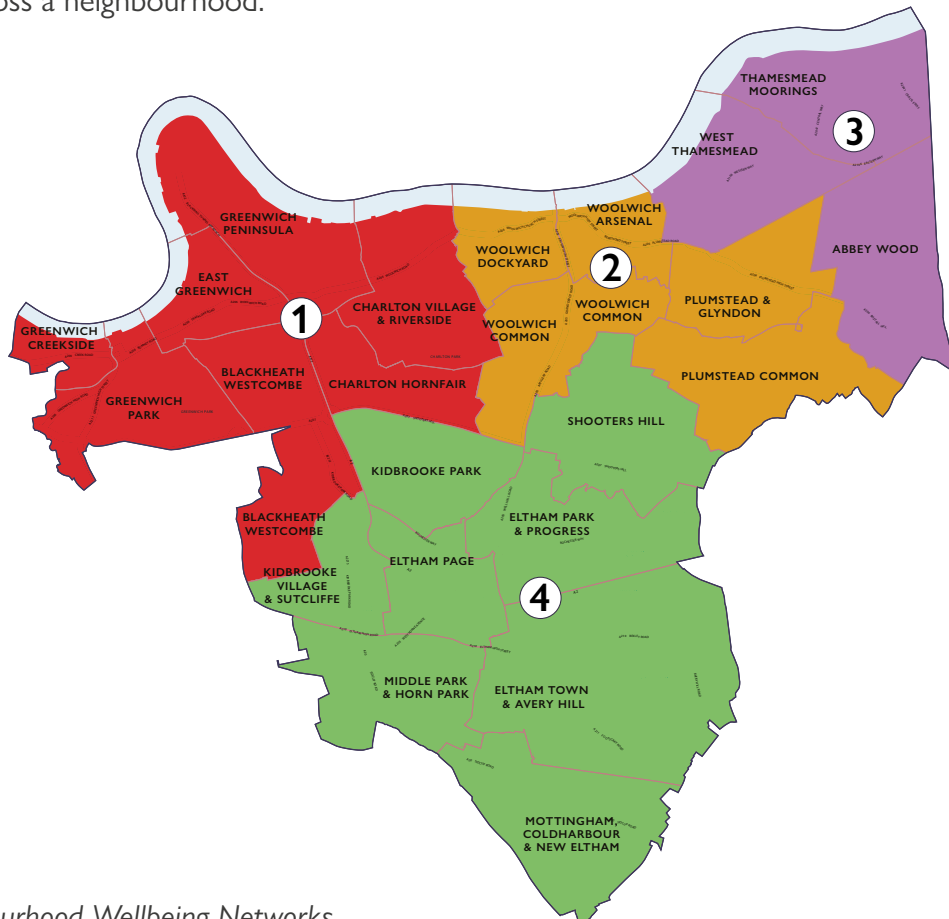


Figure 3 - Neighbourhood Wellbeing Networks

3.1.2 Health in Greenwich

Greenwich has a diverse health population. Almost half (49%) of residents are aged 20-49, and the 75+ age group is projected to grow by 18% by 2030. Around 40% of residents identify as Black, Asian, or Multi-Ethnic, which is higher than the national average. One in five residents live in areas ranked among the 20% most deprived in England. These demographic and socio-economic factors should be considered when planning and delivering services. [Click link](#) to Greenwich data observatory.

3.1.3 Poppi and Pansi Data

Greenwich's population of people aged 65 and over between 2025 and 2029, is projected to increase from 32,900 to 36,100 an overall increase of 9.7%. There is noticeable growth the people 65-69 age (+15%) and the people 80 -84 (+19.5%), while people age 75-79 is expected to decline slightly (-4.5%). Looking further ahead to 2040, the 65+ population is projected to reach 44,700, a 35.9% increase from 2025. The largest proportional increases are seen in the 90+ age group (+61.5%) and the 70-74 group (+46.2%), indicating a significant ageing trend across the borough.

Between 2025 and 2045, Greenwich's working-age population (18-64) is projected to grow by 9.9%, rising from 208,200 to 228,800. Growth is strongest in the 35-44 and 45-54 age bands, which together account for nearly three-quarters of the total increase. In contrast, the 18-24 population is expected to decline by 8.9%. Over time, the age profile of the working-age population shifts slightly older, with the share of 18-24s falling from 13.4% to 11.2%, while 45-54s rise from 18.9% to 20.5%. Short-term growth (2025-2029) is modest at 2.5%, with the largest increases seen in the 35-44 and 45-54 groups.

As of February 2025, PANSI and POPPI estimate that 5,515 people in Greenwich have a learning disability, including 4,829 aged 18-64 and 686 aged 65 and over. Of these, 1,205 are predicted to have a moderate or severe learning disability. Locally, 1,134 individuals are known to the Royal Borough of Greenwich, with 1,025 on the LD register and 732 receiving ongoing services. In addition, 41 people with Autism or Asperger's are supported with long-term services outside the CLDT.

Table 1 - Learning Disability and Autism Population

Learning Disability and Autism Population (as of 06/02/2025)	
Category	Count
Estimated LD population (18-64)	4,829
Estimated LD population (65+)	686
Total LD population	5,515
Predicted moderate/severe LD	1,205
Known to RBG (LD register/ services)	1,134
On LD register	1,025
Receiving ongoing services	732
Additional Autism/Asperger's cases receiving ongoing services	41

3.2 Adult Social Care Forecast Spend Pressures

The 2025/26 forecast (as at Period 9) compared with the 2024/25 outturn shows adult social care spend pressures concentrated in Home Care, Supported Living and Nursing services. Home Care spend is projected to

increase by £2.7m and Nursing by £1.2m, with growth evident across Learning Disability and Mental Health client groups. While overall activity growth has stabilised since Q2, Mental Health and Supported Living costs continue to rise, driven by increased placements and service demand. Direct Payments remain broadly stable, and Residential care trends are mixed, with easing pressures.

Change in expenditure compared to last year						Finance data							
		This year	Last year	Year on year change	Movement				This year	Last year	Year on year change	Movement	
PD	Nursing	£1,660,963	£1,545,032	£115,931	8%	↑	MH	Nursing	£628,953	£180,655	£115,931	248%	↑
	Residential	£1,822,336	£1,774,706	£47,630	3%	↔		Residential	£4,962,751	£4,064,559	£898,192	22%	↑
	Supported living	£5,509,972	£4,402,362	£1,107,609	25%	↑		Supported living	£3,596,709	£2,284,739	£1,311,970	57%	↑
	Home care	£4,985,634	£4,906,805	£78,829	2%	↔		Home care	£568,045	£488,553	£79,492	16%	↑
	Direct payment	£5,139,665	£4,830,273	£309,392	6%	↑		Direct payment	£28,238	£23,083	£5,155	22%	↑
LD	Nursing	£309,066	£104,334	£204,732	196%	↑	OP	Nursing	£8,719,140	£8,269,752	£449,388	5%	↑
	Residential	£6,058,870	£5,964,011	£94,859	2%	↔		Residential	£6,108,248	£6,366,638	£-258,390	-4%	↓
	Supported living	£16,595,970	£16,569,067	£26,903	0%	↔		Supported living	£218,344	£162,768	£55,577	34%	↑
	Home care	£1,939,546	£1,649,890	£289,655	18%	↑		Home care	£20,074,885	£17,729,651	£2,345,234	13%	↑
	Direct payment	£4,857,359	£4,557,650	£299,709	7%	↑		Direct payment	£4,856,642	£5,342,144	£-485,502	-9%	↓

Figure 4 - Adult Social Care Expenditure Forecast (2025/26 vs 2024/25 Outturn)

3.2.1 Adult Social Care Activity and Expenditure

In 2024–25, Royal Borough of Greenwich received 7,830 requests for support from new clients aged 18–64 and 6,505 requests from those aged 65 and over. During the same period, 2,465 working age adults and 2,900 older people received long term support. While demand for assessment and support was higher among adults aged 18–64, older people accounted for a greater proportion of clients in receipt of long term support, reflecting more sustained care needs within this group.

In 2024–25, Royal Borough of Greenwich received 7,830 requests for support from new clients aged 18–64 and 6,505 requests from those aged 65 and over. During the same period, 2,465 working age adults and 2,900 older people received long term support. While demand for assessment and support was higher among adults aged 18–64, older people accounted for a greater

proportion of clients in receipt of long term support, reflecting more sustained and intensive care needs within this group.

Total net current expenditure on adult social care in 2024–25 was £126.4m, the majority of which (£98.2m, 77.6%) related to long term care, aligning with the higher prevalence of ongoing support among older residents. Short term care accounted for a comparatively small proportion of expenditure (£5.1m, 4.0%), consistent with its role in time limited interventions and reablement. The remaining £23.2m (18.0%) was attributable to other adult social care expenditure, including assessment activity, support services, and non care costs.

See below table for summary and click [link](#) to the ASC Activity and Financial return data.

Table 2 - Net current expenditure, by care type, year on year comparison, 2024 to 2025

Care type	2023-24 (£000s)	2024-25 (£000s)	Year-on-year change (£000s)
Long-term care	£89,631.00	£98,158.20	£8,527.20
Short-term care	£1,288.80	£5,068.90	£3,780.10
Other	£23,126.10	£23,200.60	£74.50
Total	£114,046.00	£126,427.60	£12,381.60

Table 3 - Net current expenditure per 100,000 adults, year on year comparison, 2024 to 2025

Category	Value
Net current expenditure: 2023 to 2024	£114,046
Population 18 and over: 2023 to 2024	229,068
Net current expenditure per 100,000 adults (£): 2023 to 2024	£49,787
Net current expenditure: 2024 to 2025	£126,428
Population 18 and over: 2024 to 2025	234,203
Net current expenditure per 100,000 adults (£): 2024 to 2025	£53,982

Table 4 Net current expenditure on long and short term care, by care type and age band, year on year comparison, 2024 to 2025

Care type	Value
Long term care 18–64 2023–24 (£000s)	£53,436
Long term care 65+ 2023–24 (£000s)	£36,195
Long term care total 2023–24 (£000s)	£89,631
Short term care 18–64 2023–24 (£000s)	£404
Short term care 65+ 2023–24 (£000s)	£885
Short term care total 2023–24 (£000s)	£1,289
Long term care 18–64 2024–25 (£000s)	£58,840
Long term care 65+ 2024–25 (£000s)	£39,318
Long term care total 2024–25 (£000s)	£98,158
Short term care 18–64 2024–25 (£000s)	£1,388
Short term care 65+ 2024–25 (£000s)	£3,681
Short term care total 2024–25 (£000s)	£5,069
Total 2023–24 (£000s)	£90,920
Total 2024–25 (£000s)	£103,227

3.3 Market Landscape and Emerging Needs

Table 5 - Market Landscape and Emerging Needs

Service Area	Current Provision	Gap/Need
Mental Health Residential Homes	17 SPOT purchase homes, 117 beds	Additional providers registered with the Care Quality Commission to provide regulated activities and specialist care for Residents with a mental health condition
Mental Health Supported Living	11 SPOT purchase homes, only 3 are registered with the Care Quality Commission to provide regulated activities	Additional providers registered with the Care Quality Commission to provide regulated activities and specialist care for Residents with a Mental Health condition
Wheelchair Accessible Properties	No wheelchair-accessible Supported Living accommodation are currently available in the Borough. Our Older Persons care homes are wheelchair accessible, and most facilities have accessible ground floor bedrooms. While some Learning Disabilities and Mental Health care homes have wheelchair accessibility, we expect all provision to meet approved accessibility standards.	Dedicated wheelchair-accessible homes as outlined in government guidance approved document BR PDF AD M1 2015 with 2016 amendments V3.pdf
Supported Living, and Residential Care homes, with the Care Quality Commission Service Specialism of: - 0–18 years - Caring for adults under 65' - Learning disabilities - Autism This is to support transition cases eligible for Adult Social Care funding from Children's Services	Matching younger residents with those already living in Residential and Supported Living homes presents a challenge, as care needs can differ significantly between residents. This is further complicated by the fact that only two homes currently hold the CQC service specialism for ages 0–18.	Additional providers for both Supported Living and Residential Care homes, for transitions cases from Children's Services. The residents are at the age of 17/ 17.5 years old at the time of referral.
Care Homes for residents under the age of 65 with a dual diagnosis	Three Spot homes in borough	Care Homes with the CQC Service Specialism of 'caring for adults under 65', for residents with complex needs needing the category of care of: - Residential Dementia - Residential - Nursing - Nursing Dementia - Neuro support - Mental Health - Learning Disabilities - Autism

Service Area	Current Provision	Gap/Need
Supported Living for residents under 65 who express behaviours that can be described as 'challenging' with Learning disabilities, Autism and Mental health	Current lack of adaptations and training in the market can result in property damage resulting in some residents being evicted	Specialist homes with adaptations for behaviours that can be described as 'challenging', such as padded walls, sensory rooms and specialised training to provide de-escalation and redirection techniques.
Homes for Younger People with Mild Learning Disabilities and or Autism	Limited provision	Dedicated homes for younger residents with Mild Learning Disabilities and or Autism who need minor support to live an independent life.
Homes with Drug & Alcohol Specialism	No dedicated homes	Specialist homes for residents with drug and alcohol needs. mes for residents that need support with alcohol, there is a need for providers that both allow drink and disallow drinking on site.
Homes for adults with Autism	Limited provision	Homes for adults with Autism
Forensic Providers		Forensic Providers, both Supported Living and Residential, across all categories including Learning Disability, Autism Spectrum Disorder and Mental Health
Permanent BSL Provision		Supported living providers, to provide skills training programmes to residents, to enable them to move on to live independently in their own home/or with a decreased reliance on care and support. For Learning Disability, Autism Spectrum Disorder and Mental Health, Under and over 65.
Extra Care Sheltered Housing	Three extra care schemes in the borough comprising 161 flats total	Extra Care Sheltered Housing – aiming for an additional 240 flats in the borough over the next 15 years
Dementia- Capable Care (Over 65s)		Dementia-Capable Care - Rising 65+ population (projected +36% by 2040) requires expanded homecare and nursing capacity

Service Area	Current Provision	Gap/Need
Greenwich is already leading with its Digital Health and Care Technology Service, enabling residents to live independently through smart devices and remote monitoring		Digital-Ready Workforce - Skills and provider capability to embed technology-enabled care
Self-Directed Support	Limited provision	More Personal Assistants (PAs) to support self-directed support
Micro Enterprises	Limited provision	Increased number of micro-enterprises to support choice and access to the community

3.4 Greenwich Health and Social Care Workforce Context

The Health and Social Care workforce is a vital asset in the Royal Borough of Greenwich, employing many people locally. The labour market is globally competitive, and demographic shifts mean countries we recruit from may retain more of their own workers, while we may face competition for ours.

In 2023-24, adult social care nationally had 131,000 daily vacancies (8.3% vacancy rate), nearly three times the national average. Over 25% of staff leave annually, and about a third exit the sector. Around 29% of the workforce about 440,000 people are over 55 and could retire within ten years. There are not enough staff now and more will be needed in future.

Skills for Care reports Greenwich had around 7,300 social care posts in 2023-24: 6,900 filled and 475 vacant. Compared to the previous year, total posts rose by 425 (6%), filled posts by 475 (7%), and vacancies fell by 50 (10%). Of the filled posts, 7% were in local authorities, 74% in independent providers, 11% with direct payment recipients, and 7% in other sectors.

In 2023-24, Greenwich had 144 regulated services (43 residential, 101 non-residential). If workforce growth matches the projected increase in the 65+ population, adult social care posts in London could rise by 33% (from 255,000 to 340,000) by 2040.

Greenwich had an estimated 5,600 filled posts in the local authority and independent sectors: 550 managerial, 225 regulated professionals, 4,200 direct care (including 3,700 care workers), and 650 other non-care roles. [Click for more information.](#)

3.5 Quality Threshold and Criteria for New to Market Provider

RBG operates a robust new to market accreditation process for any new providers seeking to work with the Council.

For Residential and Nursing placements, providers are asked to contact the council at markets.

commissioning@royalgreenwich.gov.uk.

Commissioners will then seek to confirm whether additional services are necessary and work with you to accredit new provision.

For Home-based Support services such as Homecare and Extra Care, the Council is not currently looking to commission additional providers.

For supported living services opening within the borough boundaries, providers are asked to contact the markets.commissioning@royalgreenwich.gov.uk inbox, where commissioners will be able to advise whether new services are required.

Only once a Provider is successful would we add the service to our listing of locally approved sites where we would make placements.

The process includes on site evidence gathering on several key health and safety areas as well as the legalities of insurance and landlord HMO licensing requirements.

Linked to a successful application the provider would be expected to evidence experience in the social care field of supporting learning disability or mental health clients.

We support the guidance from the Care Quality Commission Right Support Right care, Right culture, in that we encourage providers to discuss their proposal or development ideas with the Council's Lead Commissioner at the earliest opportunity prior to committing to property leasehold agreements.

A successful accreditation is not a guarantee of usage, our supported living marketplace has seen significant expansion in the past 5 years, and it is known that many approved providers carry voids.

Since early 2025 we have temporarily suspended our new to market accreditation process while we review and consider our future commissioning needs and intentions as detailed in this Market Position Statement.

For more information on providing services in this area, contact can be made by emailing markets.

commissioning@royalgreenwich.gov.uk.

Commissioning Intentions and Contract Opportunities

4.1 Current Contracting Framework

The Royal Borough of Greenwich publishes all formal tender opportunities on the London Tenders Portal, powered by the Proactis ProContract eProcurement system. Providers can register for an account, search for live opportunities and apply for contracts directly via the portal. To learn more and set up your account, visit our [how to do business with the council page](#) or register directly [here](#).

We encourage all providers to create an account and set up notifications to stay informed of relevant opportunities as they are published.

4.2 Upcoming Tender Opportunities

We believe effective commissioning begins before tenders are published. Through our provider forums and market engagement events, we share advance notice of upcoming procurement activity, indicative timelines, and opportunities to shape service specifications. Details of contract end dates and recommissioning plans are outlined in individual service sections throughout this Market Position Statement.

Our regular forums will be used to give you updates on how preparations for different tenders are progressing, and as we draw closer to publication we will do our best to keep you informed of likely submission dates.

We also use the London Tenders Portal to engage with the market as we develop new services and specifications, and to share future intentions. We welcome providers who are able to support our design work and contribute to viability discussions. For enquiries about procurement opportunities or service development, please [contact us](#).

4.3 Social Value

Greenwich's approach to social value is guided by the [Council's Social Value Framework](#) Policy, which ensures that every contract delivers measurable benefits for residents and communities alongside core service outcomes. In Adult Social Care, this

means commissioning services that promote inclusion, wellbeing, and independence, while contributing to local priorities such as skills, fair work, and sustainability.

The Council seeks to work with providers that share this commitment, encouraging initiatives that create local employment and training opportunities, pay the London Living Wage, and strengthen links with the voluntary and community sector. Social value also includes promoting environmental sustainability and supporting community-based activities that reduce isolation and improve wellbeing.

Social value commitments are embedded in procurement processes and proportionately monitored through contract management. The focus is on achieving meaningful, long-term outcomes rather than volume-based targets, ensuring providers can deliver genuine and lasting impact for local people.

4.4 Procurement

Procurement within Adult Social Care is driven by the principles set out in the [Council's Procurement Strategy 2026 - 2031](#), including transparency, value for money, collaboration, and social impact. The aim is to ensure every contract delivers quality services that are financially sustainable, inclusive, and responsive to the needs of residents.

The Council takes a strategic, outcome-focused approach, working closely with providers and Residents to shape markets, promote innovation, and ensure services are person-centred. Early engagement, co-production and co-design are encouraged wherever possible, particularly when designing or recommissioning care models.

Procurement decisions are made in line with the Procurement Act 2023, balancing competition with the need to maintain continuity of care. Through this approach, Greenwich aims to develop a resilient local care market that supports long-term partnerships, fair employment practices, and the delivery of high-quality, value-driven care.

4.5 What Quality Means in Greenwich

Quality in Greenwich means services that deliver positive outcomes and enable people to live fulfilling, independent lives. We expect all providers to be person-centred, focusing on what matters most to individuals and involving them actively in decisions about their care. Services must be safe, well-managed, and rated Good or Outstanding by the CQC where under CQC regulation, with robust safeguarding practices that balance protection with choice and dignity.

We value providers who are inclusive and culturally competent, reflecting Greenwich's diverse communities and promoting equality and human rights. Quality services are collaborative, working in partnership with health, social care, families, and the wider system to deliver coordinated support. Providers must demonstrate clear evidence of positive impact through regular monitoring and feedback, using this to drive continuous improvement and innovation.

Financial transparency and sustainability are essential. We expect providers to be open about costs, demonstrate value for money, and maintain sustainable business models that ensure service continuity. Fair employment practices, including payment of London Living Wage where specified, are fundamental to quality provision.

We monitor quality through regular provider reviews, CQC outcomes where appropriate, safeguarding reporting, and feedback from people using services. Quality assurance is a partnership where concerns arise, we work collaboratively with providers to address issues and support improvement. Where provision falls under CQC regulation, all providers must maintain at least a CQC Good rating, participate in quality monitoring activities, and engage openly when challenges emerge.

Providers can find specific quality outcomes and requirements within individual specifications alongside the standards held by the Quality Assurance team.

4.6 Ethical Care Framework

The Royal Borough of Greenwich is committed to commissioning care and support services that uphold dignity, quality, and fairness, not just for residents, but for the workforce that delivers care.

We recognise that the quality of care is intrinsically linked to the working conditions of care workers.

UNISON's research demonstrates that poor terms and conditions for workers directly contribute to lower standards of care. Practices such as rushed visits, unpaid travel time, inadequate training, and poverty wages create a system where both workers and clients suffer.

Our commissioning approach is guided by [UNISON's Ethical Care Charter](#) principles:

- Dignity and Time to Care – Support based on client need, not rushed tasks; workers paid for travel time
- Continuity and Quality – Same support workers wherever possible; no exploitative zero-hour contracts; quality training at no cost to workers
- Fair Pay and Sustainability – London Living Wage minimum (£13.15/hour); occupational sick pay; terms that support workforce retention

Our commitment:

We will work with providers to progressively adopt these standards, recognising that ethical care requires adequate funding and sustainable employment practices. We will monitor compliance through regular workforce surveys, transparent reporting on provider adherence to Charter standards, and integration of workforce conditions into our quality assurance processes.

Greenwich's commitment to becoming an Ethical Care Council means refusing to build our social care system on the exploitation of low-paid workers.

In addition to this the Royal Borough of Greenwich is committed to working with partners across the system to address the workforce challenges of health and social care in the borough, including but not limited to the recruitment, retention, wellbeing and training of frontline staff.

We have also established a Greenwich Care Workers Network in collaboration with the Co-operative Councils Innovation Network to provide a space and a voice for our care workers directly.

For more information on providing services in this area, contact can be made by emailing markets.

commissioning@royalgreenwich.gov.uk

Market Innovation & Structure

5.1 Micro-enterprises

Micro-enterprises are small, local initiatives that provide flexible, highly personalised support rooted in the community. They can offer what larger services often cannot such as bespoke timetables, creative activities, and specialist support for people with autism or complex needs.

In Greenwich, families and self-advocates have said they value services that feel “human-sized” and personal. Current examples include gardening projects, arts workshops and social groups that combine skill-building with friendship and belonging. Through the Community Catalysts programme, the Council is helping to grow these opportunities in the health and care sector, many of which can be sustained through Direct Payments or Individual Service Funds (ISFs).

A notable example of grassroots innovation is Headlinerz Barbershop in Greenwich ([Headlinerz Barbershop | Bringing back the community](#)), run by Jesse Ashiegbu. More than a place for haircuts, it has become a safe space where men talk openly about mental health and wellbeing. Oxleas NHS has recognised the barbershop for “championing men’s health by offering free blood pressure checks in the barbershop,” showing how trusted community spaces can promote both physical and mental health (Oxleas NHS, 2023).

This illustrates how small businesses and community ventures can play a vital role in inclusion and wellbeing. By linking ISFs to micro-enterprises, people can commission tailored packages of support that reflect their interests anything from gardening or music to joining a local social enterprise. This approach keeps funding closer to communities and gives people genuine control over shaping their day opportunities.

5.2 Cooperatives

The adult social care system is predominately served by private providers. The Royal Borough of Greenwich is facing increasing challenges from providers valuing

profit over quality of care due to a saturated and invariable market. Hence, it is crucial we promote the development of new models of care, that are community-rooted and person-centred. Co-operatives play a leading role in resolving this crisis and their expansion will provide alternative options and contribute to a robust social care system that empowers everyone.

The Royal Borough of Greenwich Co-operative Commission launched the Together for Greenwich: Co-operation for the future report focusing on implementing co-operative principles in three main areas: supporting new and existing co-operative start-ups, social care and community energy. As part of the social care workstream, we are developing a Co-operative Care Compact. This will be co-produced with existing co-operatives and organisations that abide by co-operative values to establish our shared values and commitments in supporting existing and upcoming co-operatives. This will enable us to progress towards the borough’s long-term goals of expanding the number of high-quality organisations that are rooted in co-operative values, ethics and principles.

To ensure and maintain success of this work, we are building strong relationships within the council and community through the development of a Health and Care workforce board and a Care Workers Network which will review progress, address blockers and identify gaps for future work. The Care Workers Network launch event was well-received by attendees who highlighted the need for the network. Valuable insights and experiences were shared from frontline care workers during a workshop exercise that covered the following themes: Network goals, wellbeing and challenges to delivering good care. The feedback from attendees demonstrated support for a dedicated worker-led space for shared learning and peer support, with responses expressing a clear desire to remain involved as the network develops.

Funding of £2000, awarded from the Cooperative Councils' Innovation Network, will assist coproduction and engagement activities with key stakeholders to obtain buy-in and expert knowledge. Alongside this, the council has worked in partnership with the University of Greenwich to deliver a Hackathon aimed at raising awareness amongst students about the crisis of the adult social care system driven by profit. The Hackathon challenged students to devise solutions and approaches to overcome barriers and encourage the growth of more co-operatives in the social care market in Greenwich.

The Hackathon delivered a number of positive outcomes, including generating fresh insights into supporting co-operative social care organisations to thrive within the borough. Furthermore, the event provided students with valuable mentoring support and learning opportunities from industry experts and Council officers throughout the day. It also shed light on the career pathways within the Council and social care sector which students were previously unaware of. The Hackathon has strengthened the Council's relationship with the University of Greenwich, and could create opportunities for continued collaboration, potentially encouraging the introduction of co-operative models into the Business school curriculum. Findings will also be drawn to the microenterprise development programme as it provides an avenue that could help drive the adoption of new models of care based on co-operative model and principles.

5.3 ISF - Individual Service Funds Overview

Individual Service Funds (ISFs) give people a flexible way of using their personal budget. Instead of the Council commissioning a standard service, the budget is held and managed by a provider on the person's behalf, then spent according to their choices.

Providers who can manage ISFs include established care organisations, voluntary and community sector groups, co-operatives, and micro-enterprises, as long as they can show strong financial governance, accountability, and a commitment to co-designing support. These providers act as the budget holder, working with the person (and their family or advocate, where relevant) to shape a personalised package of support.

The Council itself would not normally manage an ISF, as this blurs the line between commissioning and provision. However, people can use their ISF to purchase Council-run services, such as places at the Sherard Road Hub, alongside activities offered by other providers. In this way, the Council remains a service provider within the market, but not the ISF manager.

In practice, an ISF might cover a blend of:

- Specialist support at Sherard Road Hub,
- Sessions at a local micro-enterprise such as a gardening or arts group,
- Evening or weekend social opportunities,
- And funding for travel training or transport.

This approach is in line with national guidance. Think Local Act Personal (TLAP) is a national partnership of organisations promoting personalisation in social care which describes ISFs as a way to “give people genuine control over their support while providers take responsibility for managing the money safely and flexibly” (TLAP, 2015). Similarly, In Control, a social care charity that helped pioneer personal budgets in England, defines ISFs as “where a provider holds the budget, but the person decides how it is used,” emphasising flexibility, transparency and co-production (In Control, 2014).

ISFs provide families with the reassurance of professional budget management, while ensuring people retain choice and control over their support. For providers, they create opportunities to work more flexibly, collaborate with micro-enterprises, and design support around individual lives rather than fixed service slots. Over time, ISFs can help move the market away from block contracts and “one-size-fits-all” models towards a more diverse, person-centred system.

For detailed information on current ISF provision, demand, spend, and commissioning intentions in Greenwich, see Section 15.

For more information on providing services in this area, contact can be made by emailing markets.

commissioning@royalgreenwich.gov.uk

Prevention and Early Help

6.1 Day opportunities

6.1.1 Day Opportunities for People with Learning Disabilities

Alongside provision for older residents, Greenwich is strengthening its approach to day opportunities for people with learning disabilities and /or autism. Day opportunities support people to do things that matter to them, including building friendships, pursuing interests, learning skills, engaging in creative activity, volunteering and, where appropriate, preparing for employment.

Building on local consultation and national evidence, Greenwich has developed and begun delivering a hub-and-spoke model of day opportunities. This model connects a multi-purpose hub with a wide range of community-based activities and opportunities ('spokes') to increase choice, reduce isolation and support inclusion in everyday community life.

The Sherard Road Hub plays a central role in this model, providing:

- A safe and welcoming base for people with more complex physical and communication needs
- Space for creative, social and peer-led activity
- Coordination and oversight of community-based opportunities
- A point of connection for families, carers, providers and multi-disciplinary professionals.

Community-based spokes include creative arts, gardening, fitness, social groups, volunteering, skills-based activities and emerging micro-enterprise opportunities. These are delivered by the team at Sherard Road and a diverse mix of voluntary organisations, community groups, social enterprises and small businesses, strengthening the local care market and widening choice.

6.1.2 Co-production and Inclusion

Co-production is central to Greenwich's approach to day opportunities. People with learning disabilities, families and carers are actively involved in shaping

the offer, including the design of activities and the development of services. There is a clear ambition to expand peer-led and co-facilitated opportunities, ensuring that services are relevant, inclusive and responsive to lived experience.

Focused support is provided for:

- People with profound and multiple learning disabilities (PMLD)
- Autistic adults, including those with complex needs
- Young people transitioning from children's to adult services

These groups have historically faced barriers to accessing meaningful day opportunities, and future service development will focus on reducing exclusion and improving access.

Co-production in Practice

As part of this approach, a co-production group, Great Future Ahead, has been designed and established within the Greenwich day opportunities hub. The group supports people with learning disabilities to directly shape service improvements and is being sustained as an ongoing forum. Its current focus includes planning visits and activities within the local community, strengthening connections beyond the hub.

Evidence has also been gathered on how day opportunities are delivered across the borough, with learning applied to support collaboration across council teams and local partners. This has included workshops and engagement events to prioritise improvements to the hub-and-spoke model.

In addition, a qualitative evaluation has been delivered to explore staff perspectives on changes to day services and priorities for the future. This involved in-depth interviews with 15 people across senior leadership, day opportunities management, hub-based staff and the Heart n Soul team, ensuring a strong organisational and practice-based evidence base.

Day Opportunities continue their partnership with the arts organisation Heart N Soul, evaluating the

provision of the new service, Community Voices, and the ongoing work to improve the service and offer residents more choice and control regarding the activities and opportunities they engage in. Residents play a pivotal role in leading service development and delivery.

6.1.3 Direction of Travel

The Council is reviewing its overall day opportunities offer to ensure it:

- Expands meaningful, community-based activity alongside building-based provision
- Strengthens connections between hubs and local community opportunities
- Improves access, including through transport solutions, travel training and flexible use of Individual Service Funds
- Delivers clear outcomes related to choice, inclusion, independence and wellbeing
- Learning from local engagement and national evidence will continue to inform future commissioning and market development, ensuring day opportunities in Greenwich support residents to live connected, purposeful and fulfilling lives.

There are 2 Day centres for older residents in Greenwich, one at Ashgreen house care home and one at Meadows house care home. The 2 centres cater for people in need of social interaction and time away from their home environment, whilst also offering respite for their carers. They are open weekdays and offer a variety of engaging activities, including arts and crafts, games, group singing, karaoke, puzzles, bingo and quizzes. For people who are unable to get to the day centres independently, transport is provided.

Whilst Ashgreen house caters for all older residents in need of the day service, Meadows caters to residents who have dementia.

Meadows day centre can welcome up to 30 people per day, and Ashgreen up to 42 people. There is a waiting list for residents wishing to attend the Day centres due to limited capacity in transport.

There is a comprehensive review of the Day centres offer underway to assess how effectively they meet the needs of attendees and Greenwich residents. This includes exploring whether day centres are still the answer to social engagement within the community, or

whether a new model and new opportunities should be created for Greenwich residents.

6.2 Voluntary and Community Sector

6.2.1 Current Demand and Capacity

The Voluntary and Community Sector (VCS) is recognised as a key strategic partner in supporting the delivery of Health and Adult Social Care priorities and ambitions. The VCS market continues to deliver vital community-based projects to promote prevention and early intervention services that enable residents to maintain independence, reduce isolation and improve overall wellbeing.

The VCS Grants Programmes is a council wide programme, there are 18 different funding streams across various directorates, with 54 organisations in total receiving funding in this commissioning cycle. Under the current VCS Grants Programme (2023-2027) the Health and Adult Services workstream stream is Strength in People, Strength in Communities, Strength in Diversity, we currently fund 11 projects delivered by 8 providers. These projects collectively deliver a range of priority areas, including:

- Provision of information, advice and guidance to improve access to mainstream services.
- Befriending and social inclusion activities to address loneliness and promote community engagement
- Support for unpaid carers, including outreach and respite opportunities.
- Employment and welfare rights support

The Council also operates the Greenwich Neighbourhood Growth Fund (GNGF), which provides capital grants (£2,500 to £35,000) for local community infrastructure projects using Neighbourhood Community Infrastructure Levy (CIL) funding. While GNGF primarily funds physical infrastructure improvements such as facility upgrades, sensory gardens, park improvements, and equipment—rather than ongoing service delivery, it plays an important complementary role in strengthening the community asset base that VCS organisations and residents rely on.

To date, over £2.5m has been awarded to 157 projects across the borough through six funding rounds, with £1 million available in Round 7 (launching September 2025). GNGF is allocated across four neighbourhood

zones (£250,000 per zone), aligning with Greenwich's emerging neighbourhood-based approach to service delivery and community engagement.

Providers delivering health and adult social care services may benefit from GNGF-funded infrastructure improvements in community facilities and should be aware of this resource when considering capital needs for community-based provision.

More information: Greenwich Neighbourhood Growth Fund

Demand for these services has remained consistently high throughout this current cycle. Befriending services and carer respite services have experience significant and sustained demand, likewise, projects providing support with welfare rights and benefits entitlements continue to report high levels of engagement, reflective of the ongoing financial pressures and changes in welfare benefits.

Many of the services operate at or near to full capacity, with some experiencing waiting lists at peak times. While demand remains relatively stable year-round, some seasonal variations are evident. These natural peaks and troughs are managed effectively by the market who consistently demonstrate strong flexibility and resilience in meeting residents' needs throughout the year.

6.2.2 Outline spend

The current Health and Adult Services spend under the VCS Grants Programme is £810,074, funding 11 active projects across 8 VCS partners. This represents a significant investment in preventative and community-based services which complement statutory provision and contribute to reducing wider demand on health and social care systems.

These grants are awarded on a four-year funding cycle, providing stability to the sector and enabling services to plan and deliver sustainable long-term support for residents.

6.2.3 Current requirements

The current funded projects within the Strength in People, Strength in Communities, Strength in Diversity funding stream are due to continue to March 2027 and are currently aligned to support a number of wider strategic aims. The relationship between

commissioning and the voluntary and community sector remains a critical part of our commissioning priorities. The VCS sector offers a unique reach into communities, and they have built trusted relationships with residents. We will continue to work with partners to deliver on the current priorities assigned within this commissioning cycle.

6.2.4 Future requirements (or timeline to any recommissioning)

A notable gap in current provision is VCS support for people with Autism. We are currently planning to begin work to review and evaluate the existing services, including assessing the impact and outcomes achieved, identifying gaps in provision or unmet needs within communities and engaging with partners across Health and Adult Services to identify future priorities, this will include considering how future funding can be best aligned with strategic priorities, prevention and the new or emerging needs of residents.

This review process will inform the next commissioning round for the VCS grants programme. Engagement and co-production with the market, wider partners and residents will be central to this process to ensure future services are well-targeted, effective and sustainable.

6.3 Community Equipment

6.3.1 Current Demand and Capacity

The Greenwich Integrated Community Equipment Service (ICES) supports people to live as independently as possible in their own homes by providing essential community equipment. This equipment may form part of a broader package of support for individuals and their carers, and includes delivery, collection, repair, and maintenance activities. ICES serves approximately 1,600 people each month, with around 6,700 unique Residents annually.

Following the liquidation of NRS, the service was significantly impacted by changes in the market. In response, Greenwich worked collaboratively with national, regional, and local partners to establish a replacement service, ensuring continuity of care for residents in Greenwich and surrounding areas. The new service delivered by Inspire launched on 1 August 2025 and can run until 31st January 2028.

6.3.2 Outline spend

The community equipment spend comprises of a pooled budget between health and social care. This pooled budget includes a range of spend associated with delivery of a community equipment service. Projected spend for 2025-26 is £3.7m which is above our initial budget allocations and includes a range of spend associated with the collapse of NRS. We anticipate that once the service and market stabilise costs should reduce as we return to a more business as usual service.

6.3.3 Current requirements

As part of our service continuity planning we have a service with one provider for the core community equipment service in Greenwich. This is supplemented with wider support from our Council Housing Adaptations team and smaller providers where specialist needs have been identified.

6.3.4 Future requirements (or timeline to any recommissioning)

In partnership with South East London partners Greenwich have completed an options appraisal of the future commissioning intention. This appraisal will form the basis of the next phase of our review that will determine our future commissioning intentions. The new service is anticipated to start in August 2027 and will likely operate across a Bexley, Bromley and Greenwich footprint. The new service will build on our learning from the current provision and will include a focus on embedding equipment services within our neighbourhoods and effective facilitation of hospital discharge.

6.4. DHACT (Digital Health and Care Technology)

6.4.1 Current Demand and Capacity

Greenwich's DHACT service launched on 31st March 2025, as a joint initiative across RBG, Oxleas and SEL ICB. The service provides eligible residents in Greenwich with digital technology devices to support their identified health and/or care needs, to empower them to live healthier, safer and more independent lives.

The service is enabled by the DHACT team, the RBG Monitoring and Response team, and two

commissioned suppliers - Rethink Partners for transformation and strategic support, and Alcove Group Limited for end to end service management include technology and data.

The service has seen significant demand in the first year, with over 2,000 referrals received to date against a projected 900 in the first 12 months. There is a programme of work to support impactful referrals and provision, and associated benefits to people and the system.

6.4.2 Outline spend

DHACT has a spend position of £2.8m in FY25/26, which is above the allocated first year budget. Additional funding has been identified in year to support the demand, including from slippage in care and support forecasts which are attributed in part to the impact of DHACT in supporting cost avoidance by providing different ways to meet needs.

6.4.3 Current requirements

DHACT is currently in "phase 1", supporting referrals from agreed RBG, Oxleas and SEL ICB teams. The focus of the programme and service at present is consolidation of practice and process. In FY26/27, it has been agreed through DHACT governance that the service will "focus and grow", consolidating existing activity to ensure it is appropriately impactful for residents while accommodating new pathways and growth in the Greenwich system, including Integrated Neighbourhood Teams.

6.4.4 Future requirements (or timeline to any recommissioning)

DHACT will look to expand into other teams and pathways over time, with an agreed phasing plan across the first 3 years.

From April 2026, the DHACT service will provide virtual ward and clinical monitoring capabilities for Greenwich.

6.5 Carers

6.5.1 Current demand and capacity

Our current commissioned carer's support is spread across multiple providers. Our core carer's contract is with Greenwich Carer's Centre, who provide a range of support focused interventions including casework,

advocacy, mentoring, crisis intervention, and short, medium, and long term support. In addition, we also commission Mobilise to provide digital support to unpaid carers with their extensive library of guides and resources, online events, and out-of-hours support. Finally, we support local carer's organisations through our Voluntary Community Sector Grants Programme, including work from the Greenwich Carer's Centre to do outreach across carers communities and give support around end of life and bereavement, and from Carer's Support Bexley to undertake the Greenwich Volcare project which provides respite to carers in their homes.

Demand for carers support services in the borough remains consistently high and continues to increase year on year. During the 2024-2025 financial year, the digital carers support service engaged with over 1,600 carers. In the current financial year (2025-2026) to date, more than 1,200 unpaid carers have already accessed support on the digital platform. Analysis of usage patterns demonstrates that a significant proportion of carers are engaging with digital services outside of standard working hours, highlighting the importance of maintaining accessible, flexible and out of hours provision. This reflects the reality that many carers balance employment, caring responsibilities and personal commitments, often leaving limited opportunities to access support during traditional service hours.

Our commissioned place-based carers service has also seen sustained and rising demand. Carer attendance has increased across all service areas, and they continue to welcome a significant number of new carers. There has been an 18% increase in carers registered for the supported casework service over the last contract period, indicating both an increase in the identification of new carers and higher levels of complexity among those seeking support. Carers services remain a critical part of the borough's strategic focus on prevention and wellbeing, supporting individual to maintain their caring roles while protecting their own health and wellbeing.

6.5.2 Outline spend

The combined spend on our core contracts amounts to £503,000 per annum (this does not include our VCS Grants Programme). The value of unpaid care in

the borough is estimated to be between £215 million and £1.1 billion annually. Our commissioned carer's support ensures that carers can be supported in their caring role and reduces demand on our wider health and social care systems.

6.5.3 Current Requirements

Our current core and VCS contracts are due to continue until March 2027. Our current focus is on working collaboratively with our partners through our Carer's Partnership Board as we continue delivering on our Joint Adults Carer's Strategy.

6.5.4 Future Requirements

We are currently shaping what our future commissioned carer's support will look like, to do this we are presently undertaking engagement activities with carers across the borough. Through these activities, we are exploring what carers feel is working well within the current provision, what may be missing and what could be improved. We are taking a coproductive approach to designing our future support offer and are actively exploring different commissioning approaches that recognise the challenges in this area and ensure that carer outcomes remain at the heart of our work.

6.6 People Living with Dementia

6.6.1 Current demand and capacity

Our current commissioned carer's support consists of two parts. Firstly, we work with South East London Mind to run the Greenwich MindCare Dementia Information & Advice Service. They offer personalised advice, information, support planning, and follow-up support for those who are diagnosed with dementia and their carers. This service works in close partnership with the Oxleas Memory clinic and runs a monthly Memory Café for people living with a dementia diagnosis at the Greenwich Carer's Centre. We expect around 80 referrals to be made to this service per quarter.

In addition, we commission Dementia Dialogue to run our Dementia Inclusive Greenwich initiative. This work seeks to support our residents, community partners, and internal staff to be more inclusive of people with dementia. This work includes running dementia awareness events, co-ordinating the Dementia Reference Group and the Dementia Action Group,

delivering tailored dementia awareness training to businesses in the borough, carrying out building audits for their accessibility, and giving recommendations to local businesses/services to make them more dementia inclusive.

6.6.2 Outline spend

Our combined spend on our commissioned dementia support is around £164,000 per year. This is not inclusive of wider NHS/Oxleas services which support those living with dementia (including the Memory Clinic).

6.6.3 Current requirements

Our current commitments are to continuing to champion our Dementia Inclusive Greenwich initiative, support those in the borough who are living with dementia, and work across system partners to improve our local dementia diagnosis rates.

6.6.4 Future requirements

We have started a joint research project with local partners including Public Health, Oxleas, Dementia Dialogue, and University of Greenwich to better understand the experiences of people living with dementia in the borough. We are carrying out a series of workshops with residents with the hope that we can use these insights to inform our approaches to supporting people with dementia in our respective areas. For commissioning, we hope to understand how we can better support people living with dementia, understand their journeys, and strengthen the partnerships across health, social care, and local communities.

For more information on providing services in this area, contact can be made by emailing markets.commissioning@royalgreenwich.gov.uk.

with responses expressing a clear desire to remain involved as the network develops.

Home First Programme

7.1 Strategic direction

Home First is an approach adopted by health and social care partners in Greenwich since 2021. It prioritises care at home or as close to home as possible, helping residents recover from illness or accidents, maintain independence, and avoid unnecessary hospital admissions or prolonged stays.

Resident engagement confirms a strong preference for home-based care. The Home First Programme Board brings together Adult Social Care, Integrated Commissioning, Oxleas NHS Foundation Trust, Lewisham and Greenwich NHS Trust, Greenwich and Bexley Community Hospice, and Healthwatch to deliver this vision.

The programme focuses on four aims:

- Identify people at risk of a hospital admission and provide care that prevents their condition from worsening.
- Enable people to receive a high level of care in their own homes instead of being admitted unnecessarily to hospital.
- Enable advanced discharge from hospital so that people can recuperate in the comfort of their home while receiving high quality care.
- Preferred Place of Death - Give people real choice to die in their preferred place of residence without unnecessary admissions to hospital

7.2 Homecare and Neighbourhood developments

As of the 28th of September 2025, 26,408 hours of domiciliary homecare are delivered each week to 1,685 residents across the Royal Borough of Greenwich. This represents a 0.27% increase in total care hours and a 10% increase in the number of people supported compared to the same period in 2024.

The Borough operates a closed Framework of homecare providers, established following a contract award in October 2022. The Framework is designed to meet growing demand, with 80% of all commissioned

care delivered by Framework providers. The remaining 20% is provided by a small number of 'spot' providers, used to support capacity and flexibility.

The Framework is structured around six neighbourhoods, covering the entirety of the Borough. This model promotes consistency in care delivery and aims to provide an equitable share of the market across providers.

- In addition to Framework provision, the Local Authority operates a 'bridging' service, which offers a rapid response for community-based care, particularly supporting hospital discharge and rapid response teams. This service enables care to commence within hours and holds care packages for several days before they are transferred to a Framework provider. The bridging service delivers approximately 600 hours of care per month, ensuring timely care delivery while maintaining the sustainability of the neighbourhood-based model.
- Framework providers are paid at varying rates depending on the neighbourhood served. The average hourly rate paid to Framework providers is £23, while spot providers are paid an average of £19.50 per hour. The total annual expenditure on homecare services is £26,898,707.
- Framework providers are required to pay their care staff London Living Wage and adhere to large aspects of the Ethical care charter. The Framework required providers to relocate within the Borough to support the local recruitment and provide a local operation base.
- There are strong links between Framework providers and the Council's in-house Reablement service, facilitated through a Reablement rotation model. This rotation allows the Reablement team to share outcome-focused, goal-oriented skills and approaches with Framework providers, thereby enhancing the quality of care delivered in the community.
- The current Framework contract is due to expire in October 2026, with the option to extend for up to a further four years. The Local Authority is actively

exploring the future of neighbourhood-based care, including alternative models of home care. Services will operate on a neighbourhood footprint, covering one of the four neighbourhoods in Greenwich. The new model will include the development of co-operative care models, aimed at strengthening local networks and supporting innovation in care delivery. Delegated health tasks will form a core part of the new model, designed in partnership with the department of health and social care and local district nursing services. This will upskill care staff to complete tasks while relieving demand on district nursing. Any new models of home care will be extensively co-designed with residents and the care market.

7.3 Intermediate Care Beds

Greenwich have a Home First approach to supporting people to return home and maximise independence through a range of support such as reablement. This ensures our capacity within our pathway 2 bed based intermediate care is prioritised for people who need a further period of recovery, rehabilitation or assessment of their long-term care needs.

Greenwich currently has a range of pathway 2 bed-based rehabilitation, Discharge to Assess and admission avoidance bed-based capacity models to support timely hospital discharge, admission avoidance, and short-term recovery and rehabilitation for adults. These include:

- 36 Intermediate care beds shared with the London Borough of Bexley
- 10 Discharge to assess beds in one of the nursing homes in Greenwich.
- Step up / step down provision - this service flexes between 10-15 beds

7.3.1 Intermediate Care Bed Capacity

Following a rightsizing of Intermediate care in 2022 Greenwich shares bed based intermediate care capacity with the London Borough of Bexley at Meadowview. The total capacity of the service is 36 beds which flexes based on the need of both Bexley and Greenwich.

The service aims to achieve length of stay at under 20 days to enable demand to be managed within existing bed capacity. Current average length of stay is 19 days. Occupancy of the unit has been consistently over 70%

with an average of 74%. The number of Greenwich referrals to the service averages at 15 per month which is 36% of total monthly referrals indicating a slightly higher usage by Bexley.

7.3.2 Discharge to Assess and Step-Up Step-Down Beds

These services are designed for individuals identified for discharge who are expected to return home but are currently unable to do so due to clinical, social, or other factors. They also support those who are not expected to return home and now require alternative care arrangements.

The core approach of the assessment unit is to foster partnership working that supports residents in achieving personal goals outlined in their rehabilitation plans, before any long-term care decisions are made.

Integrated GP and therapy provision are essential components of the service model.

These services contribute to the borough's wider strategic commitment to improving outcomes for residents through integrated health and social care pathways. Discharge to Assess (D2A) and step-up/step-down services are consistently well utilised and in high demand, with occupancy rates ranging from 85% to 90%.

Greenwich currently invests approximately £1.7 million annually to operate the two services. However, the current operating model is not sustainable in the long term. There are currently two Discharge to Assess pathways: Charlton Park D2A beds and Langton Way step down beds (10 to 15 beds)

The physical environment is a key enabler in delivering a service that promotes independence and recovery. Planning is therefore underway to consolidate the two services into a single site at Eltham Community Hospital, subject to a lease agreement. The new model will offer up to 20 beds, flexibly allocated across both pathways to support hospital discharge, admission avoidance, and short-term rehabilitation with wrap-around primary care (GP provision). This service is due to launch in November 2026.

A Digital Health and Care Technology Service will also be embedded in the new model, further enhancing residents' independence, rehabilitation, and recovery during their stay.

7.3.3 Better Care Fund Review of Intermediate Care

In 2025, Greenwich undertook a comprehensive review of discharge pathways to improve patient flow and discharge outcomes. The diagnostic focused on three key areas: discharge and flow, demand and capacity, and leadership.

The review identified several strategic opportunities, including the need for an options appraisal for Pathway 2 Intermediate Care services, to ensure future sustainability and improved service delivery.

7.4 Reablement

Reablement is a short-term, intensive service that helps individuals regain skills and confidence to perform daily tasks independently. It is often provided after a hospital stay, illness, or injury and can involve support with personal care, preparing meals, and moving around the home. The goal is to maximize a person's independence and autonomy, often through strategies like adapting to new equipment or finding new ways to do tasks.

Reablement in Greenwich is provided by the Local Authority in-house reablement team, supported by Occupational Therapy and the reablement rotation.

7.4.1 Current Demand and Capacity

In 2024-25, 679 referrals were accepted for Reablement, while there were 527 finishers. Finishers exclude any residents who returned to hospital or passed away during their provision. Demand for reablement is growing in the borough, with our focus on home first.

7.4.2 Current Requirements

Data shows that the reablement service currently accepts an average of 60 referrals per month. Of these packages, the majority are as a result of hospital discharges, with an average of 48 referrals accepted per month. Analysis suggests there is potential for an additional 52 packages of care per month from the HIDT pathway to be redirected to the Reablement Service, enabling more residents to benefit from short-term, outcome-focused interventions that promote recovery and independence. It should be noted that this figure does not include additional referrals that could be generated from other community-based teams, suggesting further potential to increase throughput and optimise the use of the Reablement pathway.

7.4.3 Future Requirements

The Local Authority is currently undertaking both short-term and long-term reviews of the Reablement service and its rotational model. The short term work is focusing on maximising use of existing provision to meet the identified areas of opportunity for more people to access reablement services. The long term review will inform future commissioning decisions and ensure the service remains responsive, sustainable, and aligned with strategic goals and may align to our homecare recommissioning timelines.

For more information on providing services in this area, contact can be made by emailing markets.commissioning@royalgreenwich.gov.uk.

8.1 Residential and nursing care

Greenwich is home to 11 older people's care homes, offering a total capacity of 630 beds. The borough is committed to ensuring a sufficient and diverse choice of nursing and residential care options for individuals with complex needs, so that every person requiring a care home placement can access a suitable local option aligned with their or their family's preferences.

A key priority is to ensure placements are made in care homes rated at least 'Good' by the Care Quality Commission (CQC).

Three of the eleven care homes operate under a Private Finance Initiative (PFI) block contract and are known as Neighbourhood Resource Centres (NRCs). These NRCs account for 167 beds, representing 24% of the total market capacity, and receive approximately 45% of all placements. The current contract for these homes is set to expire in December 2034.

Outside of the NRC block contract, Greenwich commissions spot placements, primarily in nursing dementia, nursing care, and residential dementia settings. Over recent years, demand for traditional residential care has been limited compared to these other categories.

The borough's commissioning strategy is informed by a deep understanding of local needs and is focused on expanding provision where it is most needed, while working in partnership with providers to ensure services are appropriate and responsive to residents' needs.

As of September 2025, there are:

- 155 older adults in receipt of residential care (a slight decrease from 167 in 2024)
- 212 older adults in receipt of nursing care (down from 221 in February 2024)
- In 2024-25, projected spend was approximately £5.9 million on residential care and £8.1 million on nursing care.

We will always require residential and nursing care services that can meet the diverse needs of our population. We however have a sufficient supply of basic residential care provision. In the future we need:

1. Less standard residential care placements, as alternative provision such as extra care supports people to remain independent in their own home with intensive support in place.
2. More nursing, residential dementia and nursing dementia beds, especially for people who have complex needs and behaviours that challenge.
3. Dementia friendly environments to be considered during developments of service delivery models.

We are keen to work with local care homes which seek to upgrade, reconfigure and specialise in these above areas to develop capacity in the areas that meet our resident need and increasing demand. We recognise this may require a review of workforce plans and want to work together to ensure that there is a sustainable and well-trained workforce that are able to meet the diversity of needs.

8.2 Extra Care

- There are three Extra Care Homes schemes within the Borough, with a total capacity of 160 flats. As of April 2025, there are 48 applicants on the waiting list. On average 7 referrals are made each month post assessment.
- The overall 2024-25 spend on the three extra care schemes within the Borough was £3,305,000.
- The three Extra Care Schemes in the Borough are run by the same homecare providers, within the Homecare Framework, that provide the community support in the allocated neighbourhoods. As with the Homecare framework contracts, the providers are required to pay care staff London Living Wage, adhere to aspects of the Ethical Care Charter and work within a specification that is designed to improve the outcomes of residents living within the schemes.
- The contracts are linked to the same Homecare framework contracts awarded in October 2022. They are due to expire in October 2026, with the option to extend for a further four years. The Local

Authority is actively exploring further commissioning options for the Extra Care Schemes in the Borough, linking further to ICB integration and expanding on the Neighbourhood care model and supporting improved outcomes for those who live in Extra Care Housing. The Local Authority is undertaking a review of the use of ECH, exploring alternative pathways of care and ensuring that the available spaces within the schemes are allocated to maximise outcomes for residents.

- The Council are developing a new extra care site in Blackheath on Langton Way in partnership with Anchor housing. Development on this site will commence in 2027 and will offer approximately 50 additional extra care flats in the borough. Conversations are ongoing with developers on other sites in the borough, including Eltham Park.

For more information on providing services in this area, contact can be made by emailing markets.commissioning@royalgreenwich.gov.uk.

Community Health

9.1 Wheelchairs

The Community Wheelchair Service provides assessment, prescription, and maintenance of wheelchairs and mobility aids for adults and children in Greenwich. It supports independence, mobility, and quality of life

9.1.1 Strategic Direction

- Ensure equitable access to wheelchairs and mobility aids.
- Enhance integration between health and social care for seamless delivery.
- Streamline assessment and delivery processes to reduce waiting times.

9.1.2 Current Demand

- Increasing need among older adults and people with physical disabilities.
- High volume of referrals causing potential delays in assessment and provision.
- Efforts ongoing to balance demand with available resources.

9.1.3 Current Challenges

- Waiting times for assessment, particularly for children who outgrow equipment quickly.
- Equipment downtime due to maintenance or repair delays.
- Coordination between healthcare, social care, and providers.

9.1.4 Opportunities

- Streamlining assessment and repair processes.
- Enhancing patient and carer involvement in equipment choice.
- Integrating data collection to inform service planning.

9.1.5 Commissioning Priorities

- Timely access to equipment and repairs.
- Equitable service provision, including domiciliary visits where appropriate.
- Responsive service with robust safety and quality standard
- Design is underway to develop a new service when

the current contract expires the new service will likely operate across a Bexley, Bromley and Greenwich footprint. The new service will build on our learning from the current provision

9.2. Musculoskeletal (MSK) Service

Community-based MSK services manage conditions such as back, neck, joint, and soft tissue disorders. Services focus on assessment, treatment, rehabilitation, and prevention.

9.2.1 Strategic Direction

- Expand services to community settings for improved accessibility.
- Promote self-management and rehabilitation programs.
- Strengthen integration with primary care and wider health pathways.

9.2.2 Current Demand

- High incidence of MSK conditions in the population.
- Increasing referrals for assessment and treatment.
- Capacity challenges in meeting demand while maintaining service quality.

9.2.3 Current Challenges

- Potential delays due to high demand.
- Need for integration with physiotherapy and mental health services.
- Limited patient awareness of self-management strategies.

9.2.4 Opportunities

- Digital triage and remote consultations.
- Strengthening patient self-management and preventive education.
- Closer collaboration with GP practices and community services.

9.2.5 Commissioning Priorities

- Timely, patient-centred care reducing unnecessary hospital referrals.
- Evidence-based treatment and rehabilitation.
- Support for patient independence and long-term outcomes.

9.3 Continence Services

Provides assessment, advice, and products for adults with bladder and bowel issues to improve dignity, independence, and quality of life.

9.3.1 Strategic Direction

- Deliver comprehensive support from assessment to product provision.
- Provide training and education for patients, carers, and staff.
- Ensure accessibility, including domiciliary visits where needed.

9.3.2 Current Demand

- Rising numbers of adults seeking continence support.
- High demand for products with a need for standardisation.
- Limited access in some areas, with scope to expand clinic locations.

9.3.3 Current Challenges

- Variability in product provision and specialist advice.
- Coordination between primary care, social care, and suppliers.
- Limited patient education on self-management.

9.3.4 Opportunities

- Standardising access and guidance.
- Training for carers and frontline staff.
- Supporting patients to self-manage and reduce service pressure.

9.3.5 Commissioning Priorities

- Equitable access to high-quality assessment and products.
- Timely response to changing needs.
- Integration with wider health and social care pathways.

9.4 Frailty Services

The NHS 10-year health plan includes a focus on integrating neighbourhood teams (INTs) and addressing frailty as part of the 'left shift' from hospital to community care. In Greenwich development of INTs includes a key focus on identifying and supporting frailty as part of our prevent, maintain and regaining independence missions. Our initial focus is on supporting residents with mild and moderate frailty,

reversing frailty where possible and supporting residents to maximise their independence.

Supports older adults at risk of or living with frailty, focusing on prevention, early intervention, and multi-disciplinary care.

9.4.1 Strategic Direction

- Implement proactive identification and early intervention.
- Develop integrated multi-disciplinary care pathways.
- Emphasise prevention and rehabilitation to maintain independence.

9.4.2 Current Demand

- Increasing numbers of older adults presenting with frailty.
- Growing need for services addressing complex needs.
- Ongoing efforts to allocate resources efficiently.

9.4.3 Current Challenges

- Early identification across primary and community care.
- Coordination between health, social care, and voluntary sector.
- Supporting independence while preventing hospital admissions.

9.4.4 Opportunities

- Proactive assessment and care planning.
- Personalised, integrated care pathways.
- Support for carers through education and respite services.

9.4.5 Commissioning Priorities

- Multi-disciplinary, coordinated care.
- Early intervention to prevent deterioration.
- Patient-centred support maximising independence and quality of life.

9.5 Community Ear Wax Removal (CEWR) Service

The CEWR service provides safe, effective, and timely removal of ear wax for adults and children in the community, reducing unnecessary hospital referrals and improving patient experience. Domiciliary visits are included for homebound patients and care home residents.

9.5.1 Strategic Direction

- Community-based delivery to improve accessibility and reduce hospital demand.
- Explore self-referral pathways in future phases.
- Ensure integration and communication with GPs and ENT services.

9.5.2 Current Demand

- High incidence of ear wax requiring removal.
- Increasing secondary care referrals, highlighting need for community provision.
- Service accessibility improvements ongoing, including domiciliary services.

9.5.3 Current Challenges

- Limited access for patients unable to travel.
- Variable awareness among patients and primary care staff.
- Potential delays in ENT referral pathways for complex cases.

9.5.4 Opportunities

- Introduce self-referral pathways to improve access.
- Strengthen integration with primary care and patient education.
- Clear communication of abnormal findings and ENT referral pathways.
- Expand domiciliary provision to ensure equitable access.

9.6.5 Commissioning Priorities

- Equitable, timely access to high-quality care.
- Minimise hospital referrals through effective community interventions.
- Support patient self-management and education.
- Robust referral pathways to ENT and primary care for complex cases.
- Collect data to monitor outcomes and inform future service planning.
- Design is underway to develop a new service when the current contract expires the new service will likely operate across South East London footprint. The new service will build on our learning from the current provision and resident engagements.

For more information on providing services in this area, contact can be made by emailing markets.commissioning@royalgreenwich.gov.uk.

Learning Disabilities

10.1 Strategic Direction

The Borough's strategy is to reduce reliance on traditional residential care and expand models of support that promote independence, choice and inclusion. Our focus is on early intervention, flexible pathways, and community-based options that allow people to live in their own homes with the right support.

We will continue to work with a diverse mix of providers, encouraging investment in Greenwich and strengthening specialist capacity, particularly for people with a learning disability, autism, complex needs and dual diagnoses. Clear expectations will be set around value for money, transparency of costs, and contribution to the local offer.

10.2 Current Demand

National estimates and local performance data indicate that there are approximately 1,111 adults aged 18–64 in Greenwich with a moderate to severe learning disability.

Of this population, around 730 to 750 adults with learning disabilities are currently known to or receiving support from Adult Social Care, reflecting both assessed eligibility and engagement with statutory services. This means that approximately two-thirds of the estimated population with moderate to severe learning disabilities are actively supported by the Council, through a combination of accommodation-based services, community support, day opportunities, employment support, direct payments and self-directed support.

Around 316 adults are supported in funded accommodation, including supported living, residential care and nursing provision. Supported living is the largest service type, with approximately 204 adults currently placed, representing the primary accommodation model for working-age adults with learning disabilities in Greenwich.

While current service levels broadly align with population estimates, demand continues to increase due to:

- rising numbers of autistic adults and people with dual diagnoses entering adulthood

- increased longevity among adults with learning disabilities
- sustained pressure from transition cohorts aged 18–25

These factors indicate ongoing growth in demand for flexible, community-based support and specialist accommodation, particularly for people with more complex needs.

10.3 Current Services

10.3.1 Supported Living and residential care

Demand and Capacity: As of September 2025, we are supporting 203 individuals in Supported Living due to a learning disability or autism. This represents growth from 201 in the previous year. This increase has so far been met by our existing provider market, which currently consists of 157 sites operating within Greenwich.

Spend: In 2024-25, the Borough projected spend of approximately £16.3m on Supported Living for individuals with a learning disability or autism.

In February 2025 there were 114 in receipt of Residential Care due to a Learning Disability or Autism, a decrease of 2 from 2024 and this market has remained stable over the past 12 months. There was 1 individual in receipt of Nursing Care due to a Learning Disability or Autism.

Recent growth has been met by our existing market. Our market currently consists of 157 sites in our existing market.

10.4 Current Requirements

There is an ongoing need for accessible housing, flexible packages of support, and providers who can support people with complex needs. We have sufficient current provision of low to medium needs supported living placements, and the market is currently closed to new entrants.

Royal Borough of Greenwich has an independence first approach to supporting people with learning disabilities, and their families/carers. We have slightly more residential care provision than other London Boroughs,

and we are expecting this to reduce over the next few years, particularly among

working age adults. However, over the next 15 to 20 years, we are expecting a large increase in the number of older people (65+) with learning disabilities to need greater levels of support, including residential care.

We have a recognised shortage of providers that can provide cost effective supported living placements with the following requirements.

- Fully adapted (M4(3)) standard properties that are accessible for people with medium to severe mobility and accessibility issues.
- Providers who can support people with complex needs and behaviours including people with dual/multiple conditions. For example, learning disabilities and mental health, autism and mental health, physical disabilities/serious health conditions and learning disabilities.
- Forensic provision for people with autism and/or learning disabilities.
- Over the next 12 to 18 months, we will be:
- Recommissioning our learning disability residential care block contracts, with current spend estimated to be £3.4m per year.

- Introducing a spot purchased accommodation contract to all of our spot purchased supported living and residential care providers. This will ensure greater consistency of delivery and improved quality standards.

10.5 Future Requirements

Future commissioning will prioritise service models that offer independence, personalisation and value for money. We intend to explore a community partnership approach, enabling longer term investment and joint working. This recommissioning will start with market engagement to encourage provider investment in Greenwich for long term benefit and security of tenure for residents.

- We are keen to work with social care providers and social investors who can help the council ensure that our accommodation-based services are modern, fit for purpose and future proof.

For more information on providing services in this area, contact can be made by emailing markets.commissioning@royalgreenwich.gov.uk.

Shared lives

11.1 Current Demand and Capacity

Shared Lives provides a valued option for people who benefit from a family-based environment. Current numbers remain stable but small in scale compared to supported living and residential care. In Greenwich, Shared Lives currently supports around 55 people with learning disabilities, delivered through 34 self-employed Shared Lives carers (Care Quality Commission, 2024).

11.2 Outline Spend

Spend on Shared Lives is modest relative to other forms of provision. The controllable budget for 2024-25 was £390,930 (Royal Borough of Greenwich, 2025). Local strategic documents describe Shared Lives as a cost-effective, non-institutional model of care (Royal Borough of Greenwich, 2024). National evidence further indicates that Shared Lives schemes are highly effective: 97% of schemes in England are rated Good or Outstanding by the CQC (Shared Lives Plus, 2023), and the model can deliver average savings of between £8,000 and £30,000 per person per year when compared with alternative forms of provision (Local Government Association, 2025)

11.3 Current Requirements

The scheme requires continued promotion and active carer recruitment to expand its reach. There is demand locally for both long-term arrangements and short

breaks/respite. Delivery depends on strong matching processes, adequate training and support for carers, and robust quality management. Clear communication with families and potential users about what Shared Lives can offer is also important.

- We will continue looking for more local residents to become Shared Lives Carers to support the council's independence first ambitions. Click this link to discover more about Royal Greenwich Shared Lives services.

11.4 Future Requirements

There is potential to grow Shared Lives over the next three to five years, supporting both permanent placements and respite. Future commissioning will focus on strengthening recruitment, training, carer matching capacity, and monitoring outcomes. Strategic frameworks, such as Greenwich's Innovative Care Models programme, position Shared Lives as part of the wider shift towards non-institutional models of support (Royal Borough of Greenwich, 2025)

For more information on providing services in this area, contact can be made by emailing markets.commissioning@royalgreenwich.gov.uk.

Day Activities and Respite

12.1 Day Activities

12.1.1 Current Demand and Capacity

Day activities in Greenwich range from traditional building-based services to community groups, skills programmes, creative arts, volunteering, and employment support. In recent years, people have moved away from large day centres, preferring flexible, personal, and community-based options. This was strongly reflected in the 2021–22 consultation and co-production work led by Ideas Alliance, where over 100 people with learning disabilities, their families, and providers took part in ‘100 Day Challenges’ to reimagine services. People expressed a desire for more choice, inclusion, and activities that reflect the whole day, not just short time slots. They also emphasised the importance of being part of mainstream community life, including leisure, arts, sport, and learning, and called for more evening and weekend activities.

As of February 2025, the Council’s in-house Sherard Road Hub supports around 50 adults with complex needs, with attendance often slightly higher (around 53). A network of ‘spokes’ offers activities such as gardening at Lodge Hill Gardens, fitness sessions, and arts and pottery workshops. Sherard Road staff also run the Friends United social group. While peer-led groups remain an aspiration, families and advocates have consistently raised concerns about transport access to community spokes. For example, the GS Plus service has reduced from five vehicles to four, creating bottlenecks and risking exclusion.

12.1.2 Current Requirements

The “100 Day Challenges” consultation and ongoing engagement have highlighted consistent priorities. Families and people with learning disabilities have called for more provision for those with complex needs and autism, as many community spokes lack the specialist skills or capacity to include everyone.

Transport remains a major concern. As noted in the Royal Greenwich Local Account 2023–24, the Day Opportunities service was “reimagined following a comprehensive 100 Day Challenge.” Families have made clear that the reduction in GS Plus vehicles has left some people unable to attend activities, increasing the risk of exclusion (Market Engagement Workshops, 2024).

Employment and skills development are also key themes. Feedback from the Working Together Plan: Day Opportunities Consultation (2022) noted a “lack of a bridge between day opportunities and meaningful work,” with calls for structured links to volunteering, training, and supported employment.

Consistency and collaboration were emphasised during the 2025 market engagement workshops. Participants stressed the need for better monitoring of community spokes, clearer communication about opportunities, and stronger partnerships between voluntary organisations and statutory services.

Friendship, continuity, and safe, welcoming spaces are valued as much as the activities themselves. In the HAS Vision 2021–24 consultation, “having family, friendships and/or companions” and “being able to engage in the community” were top priorities. Families expressed concern that relationships built in day centres could be lost without careful planning—a theme echoed in the Ideas Alliance co-production work. The Council has committed to embedding social opportunities across both the hub and spokes.

Effective transitions at different life stages are also essential. Families want smoother pathways into adult day opportunities (SEND Transition Feedback, 2023), and older people with dual diagnoses such as learning disability and dementia need more flexible support that adapts as needs change (Market Engagement Workshops, 2024).

12.1.3 Future Requirements

The Borough aims to consolidate and expand the Hub and Spoke model, maintaining building-based services for those with complex needs while broadening community-based opportunities.

Providers will be expected to diversify their offer, including more evening, weekend, and outdoor activities. Micro-enterprises and community catalysts will help create bespoke opportunities, many of which can be funded through Direct Payments or Individual Service Funds (ISFs). Employment pathways must be embedded, with closer partnerships with GLLaB and supported employment programmes to link day activities with skills development, volunteering, and paid work.

Accessibility and transport solutions remain central. Future provision must include travel training, taxi-card style support, local delivery models, and better integration with ISFs to ensure transport is not a barrier.

Co-production will remain central. The Ideas Alliance led work on the activities offer showed that trust and collaboration are as important as the service model. Relationships between families, providers, and the Council must continue to be rebuilt. The ongoing Day Opportunities Demonstrator Project (2024–25) is testing new partnership approaches, with findings expected to shape the 2025-26 recommissioning cycle. The Council has also commissioned work with Heart N Soul, whose nationally recognised co-design programmes — such as Do Your Own Thing and Inclusive Futures — show how creative practice led by people with learning disabilities and autistic people can generate fresh ideas for inclusive, person-centred services.

This direction aligns with national best practice. For example, Developing Shared Lives for people with a learning disability (LGA & Shared Lives Plus, 2025) highlights how community-based, relational models are replacing institutional provision, delivering personalised support and enabling people to live “ordinary lives” in their communities.

12.2 Care breaks (respite)

While there is some in-borough accommodation-based care break capacity for adults with learning disabilities, this is not always fully utilised. Anecdotal feedback from families and carers indicates that this may relate to concerns about the suitability and perceived quality of local provision, alongside challenges in matching provision to individual needs and timing, rather than a complete lack of local availability. The nature and type of carebreaks needed is currently under review.

12.2.1 Current Requirements

There is a pressing need for more high-quality, flexible respite services within Greenwich. Provision should cover both planned breaks and emergency support.

12.2.2 Future Requirements

Expanding local respite is a commissioning priority for the next cycle. The Borough will work with providers to increase capacity and reduce reliance on out-of-borough options. A recommissioning timeline will be developed, informed by further work on demand, capacity and options appraisal, and subject to agreement through appropriate governance.

For more information on providing services in this area, contact can be made by emailing markets.commissioning@royalgreenwich.gov.uk.

Mental Health

13.1 Outline of strategic direction

We aim to foster a mental health system that is inclusive, recovery-focused, and rooted in community. Our strategic direction prioritises early intervention, personalised support, and integrated care that addresses the social determinants of mental health. We will work collaboratively with providers, people with lived experience, and system partners to co-design innovative, trauma-informed services that reduce inequalities, promote resilience, and enable people to thrive.

The Royal Borough of Greenwich Adult Mental Health review takes a structured, evidence-led approach to analysing and prioritising learning and insights. This iterative process will inform future commissioning opportunities, ensuring that service development remains responsive to emerging needs and aligned with our ambition to improve outcomes through innovation and collaboration.

We are seeking providers who are committed to active partnership engaging in both formal governance structures and informal, day-to-day dialogue to help shape and deliver high-quality, efficient outcomes for our residents. We value open communication, shared learning, and co-production, and expect providers to contribute meaningfully to strategic planning as well as operational problem-solving. This collaborative approach ensures services remain person-centred, adaptable, and reflective of evolving local needs.

13.2 Current Demand

13.2.1 Population, service demand and spend

Mental health need in Greenwich significantly exceeds the number of people receiving statutory support. It is estimated that approximately 46,000 working-age adults (16–64) are living with a common mental health condition, representing around 18–19% of the working-age population. At any given time, around 9,000

adults are estimated to be in contact with mental health services across primary care, community provision and specialist pathways.

The majority of people experiencing mental health difficulties do not require long-term statutory support. However, a smaller cohort of residents with complex, enduring or acute mental health needs accounts for a disproportionate share of system activity, cost and risk.

People supported by Adult Social Care

As of 2025–26, Adult Social Care supports approximately 255 working-age adults primarily recorded under the mental health cohort, across a mix of community-based support, supported accommodation, residential and nursing care.

Supported accommodation and placement-based services continue to grow. Supported living placements for adults with a primary mental health need increased from 50 to 69 placements year on year, while residential and nursing placements have also risen. This reflects increasing acuity, co-occurring needs, and housing instability among people entering the system.

Complexity, acuity and system pressure

Across the wider system, around 650 residents are supported with complex or acute mental health needs, including those in supported accommodation, inpatient care, secure settings and high intensity community services. Within this group, approximately 135 individuals are supported at acute or secure levels of care, representing the highest-cost segment of the pathway.

Many people within this cohort present with co-occurring needs, including autism, learning disability, substance misuse and physical health conditions. These combinations increase the likelihood of crisis, placement breakdown and reliance on bespoke or spot-purchased provision.

Spend and financial context

Adult Social Care spend on mental health services is projected at £9.3m in 2025–26, representing a large year on year increase, driven by growth across supported living, residential and nursing provision.

When considered across the whole health and care system, (including NHS-funded services, local authority provision and jointly commissioned pathways), total mental health spend in Greenwich is estimated at approximately £80m per annum, covering NHS-funded services, local authority provision and jointly commissioned pathways. While Adult Social Care accounts for a minority of this total, its spend is highly concentrated on residents with the most complex and enduring needs, where cost avoidance and effective move-on opportunities have the greatest system impact.

Demand outlook

Demand for mental health support continues to rise faster than population growth. Key drivers include increasing illness severity at point of referral, widening health inequalities, housing insecurity, and gaps in local provision for people with dual diagnoses. Without strengthened early intervention and more flexible, recovery-focused accommodation and support models, pressure on high-cost placements is expected to continue.

13.2.2 Accommodation Based Services

Supported Accommodation Pathway

The Greenwich Mental Health Supported Accommodation Pathway (SAP) is a needs-based move on service where clients are supported to develop skills to integrate and live independently in the community, including managing their mental and physical health. Residents accommodation in the supported accommodation pathway is intended to be temporary and not for the whole life.

The current pathway is a combination of high support 24-hour accommodation with staff presence, medium support accommodation with staff from 9am to 5pm/9pm with 24 hours on call and including some services with concierge presence. There is also flexible community support for people living in the community who need short term support to aid their recovery.

People move through and out of the pathway. Capacity is required to meet the growing need to accommodate

new referrals from hospital, other settings, or out of borough.

Where a resident does not meet the eligibility criteria for SAP, or where their needs cannot be appropriately met within the existing SAP provision, a spot purchase arrangement is made to secure suitable accommodation and support. This reflects a growing demand for more flexible, personalised options outside of structured pathways, particularly for individuals with complex or fluctuating mental health needs.

There are 102 units of Supported Accommodation provided through the SAP.

There are currently around 128 spot purchased units of Mental Health Supported Accommodation in use (in and out of borough.)

Flexible Community Support (FCS) can support a range of 80 to 120 people from the pathway depending on the level of support needed/provided. The service delivers 1 to 20 hours of support based on assessed needs, 7 days a week, in the resident's home.

Bridge Back Home

Bridge Back Home supports residents with mental health conditions to transition safely and sustainably from Mental Health hospitals back to their home or into supported accommodation. The service offers intensive social care support with housing issues; appointments; correspondence; social interaction; community activities; and advocacy. Therefore, avoiding unnecessary inpatient stays and promoting recovery in the community. The service provides flexible, non-clinical tailored support to resident's recovery journey. The expected activity is to accept 40 to 50 new referrals per month and manage a working caseload of 55 to 65 people.

13.3 Community based services

13.3.1 Greenwich Mental Health Hub

This service is delivered through a strategic partnership between the NHS Trust and the Voluntary and Community Sector, combining clinical expertise with community-based support to provide a holistic, person-centred approach to mental health care. It is the main front door and first point of contact for mental health services in Greenwich.

The hub focuses on addressing the wider determinants of mental health, offering integrated assessments

and interventions that consider social, emotional, and practical needs. Multi-disciplinary teams deliver both clinical and non-clinical support, ensuring residents receive comprehensive care tailored to their circumstances.

In addition, the hub operates a step-down service for individuals transitioning from community mental health teams. This supports residents who no longer require intensive clinical input but would benefit from structured assistance as they move back to being supported in primary care, helping to maintain stability and prevent relapse.

13.3.2 Mindline

There is a growing demand for accessible, preventative mental health support within the community. This dedicated telephone counselling service is designed to meet that need by:

- Reducing risk for individuals experiencing crisis, offering immediate emotional support and intervention.
- Empowering residents to manage emotional difficulties and mental distress, helping them build resilience and coping strategies.
- Equipping people with tools to maintain their mental wellbeing, thereby reducing the likelihood of hospital admissions and long-term clinical interventions.

The service provides timely support, information, and signposting to relevant services, including for those awaiting access to Crisis Counselling. With a target of supporting 3,000 calls annually, the service plays a critical role in bridging gaps in mental health provision and ensuring residents receive the help they need when they need it most.

13.3.3 Crisis Counselling

This counselling service delivers timely psychological interventions to residents experiencing varying levels of emotional distress. It provides short-term, focused support during periods of acute need or significant life changes, helping to prevent deterioration in mental health and reduce escalation to crisis services. Residents are offered between one and six counselling sessions, tailored to their individual needs. With a minimum of 200 appointments available annually, the service plays a vital role in offering early intervention, promoting

emotional stability, and supporting recovery within the community.

Peer support options include attending groups and taking up hobbies such as creative writing; yoga; and arts and crafts.

13.3.4 Counselling and Therapeutic Groups

Our counselling services provide a safe, confidential space where residents can explore personal challenges, emotional difficulties, and mental health concerns. Each year, approximately 400 residents benefit from a diverse range of therapeutic interventions, including general counselling, culturally specific support, crisis response, relationship counselling, and group-based therapy. These services are designed to promote emotional wellbeing, resilience, and improved quality of life across our communities.

13.4 Individual Placement Support

13.4.1 Current Services and requirements

Supported accommodation, residential and nursing care

In 2024-25 it was projected that the Royal Borough of Greenwich would spend approximately £2.3m on Supported Living for individuals with a mental health need.

- As of September 2025, we are supporting 69 individuals in Supported Living due to a mental health need. This represents a large increase from the same point in 2024, from 50 to the current 69 placements.

In 2024-25 it was projected that the Royal Borough of Greenwich would spend approximately £4m on Residential Care for individuals with a mental health need and approximately £175k on Nursing Care

- In September 2025 79 individuals were in receipt of Residential Care due to a Mental Health need, an increase of 1 from September 2024.
- The number of individuals in receipt of Nursing Care due to a Mental Health need has seen an increase from 2 to 6 as of September 2025 from September 2024.

This growth across supported living, residential and nursing has been met by our existing market. Our market currently consists of 61 sites with some providers having multiple sites within Greenwich.

13.4.2 Future requirements

Our future commissioning approach will focus on:

- Tailored and cost-effective care for individuals with complex needs.
- Flexible models of housing support, where staffing levels can be adjusted to meet changing client needs.
- Outcome-focused provision with transparent cost structures.
- Improved care pathways that are accessible, coherent, and responsive to service resident' journeys.
- Creative and recovery-oriented practices that empower individuals and promote long-term wellbeing.
- We will be seeking to expand our mental health alliance, bringing more partners and a wide range of services and providers to assist with more person centred, needs led services.

The Mental Health Review has highlighted the importance of co-design with residents and the provider market. We expect providers to engage in meaningful

collaboration and offer both informal and formal updates on resident progress and satisfaction, ensuring services remain responsive and person-centred.

Our drivers for change include:

- Maximising resources to meet growing demand for community provision.
- Enhancing continuity and quality across the care pathway.
- Embedding innovation and flexibility in service delivery.

We are seeking providers who share our vision and can deliver high-quality, adaptable, and outcomes-driven support that reflects the needs and aspirations of our communities.

For more information on providing services in this area, contact can be made by emailing markets.commissioning@royalgreenwich.gov.uk.

Autism and Transition

14.1 Autism

14.1.1 Strategic Direction

Greenwich is committed to becoming an autism-inclusive borough, where autistic individuals are empowered to lead fulfilling, independent lives. Our strategic vision is rooted in the principles of early identification, timely intervention, and inclusive service design. We recognise that supporting autistic people and their families from the earliest stages is critical to enabling individuals to reach their full developmental and long-term potential.

To achieve this, we aim to strengthen local service provision, reduce reliance on out-of-borough placements, and ensure that services are responsive to the diverse and often complex needs of autistic residents. In May 2025, Greenwich relaunched the All-Age Autism Partnership Board, a collaborative forum that brings together professionals, voluntary sector partners, individuals with living experience, and carers. This board has played a pivotal role in shaping the Greenwich All-Age Autism Strategic Plan, which outlines six core ambitions:

- Improving access to services: ensuring autistic people have timely access to health, education, and social services tailored to their unique needs
- Promoting inclusivity: creating environments where autistic individuals feel valued and included, both in educational settings and the workplace.
- Supporting Families and Caregivers: offering resources, training, and support to families and caregivers to help them provide effective care.
- Raising awareness: educating the public about autism to reduce stigma and promote acceptance.
- Encouraging self-advocacy: empowering autistic individuals to advocate for themselves and make informed decisions about their lives
- Enhancing lifelong learning: providing opportunities for continuous learning and development to help autistic individuals achieve their full potential.

14.1.2 Current Demand

As of February 2025, the demand for autism-related services in Greenwich is significant and growing:

- 5,547 individuals (across all age groups) have a formal

autism diagnosis.

- 1,787 children are currently awaiting an autism assessment.
- 134 adults are awaiting an autism assessment.

This data highlights the urgent need to expand diagnostic capacity and develop a robust local service offer that can meet increasing demand.

14.1.3 Current Services

Currently, Greenwich does not have any autism specific services. Existing support is largely delivered through Learning Disability, Complex Care or wider community services. Specific services can be limited in scope and do not adequately reflect the diversity of needs, particularly for individuals with more complex presentations. This gap in provision contributes to increased reliance on bespoke care packages and out-of-borough placements, which are often costly and disruptive to families.

14.1.4 How we are currently performing

Since the relaunch of the All-Age Autism Partnership Board, there has been a marked improvement in cross-sector collaboration. The board has fostered strong relationships between statutory services, voluntary organisations, individuals with lived experience, and carers. There is a shared commitment to identifying service gaps and co-designing solutions that reflect the needs of the local population.

However, it is widely acknowledged that Greenwich lacks affordable, in-borough autism-specific services. With diagnostic rates rising, the demand for such services is only going to increase.

14.1.5 Direction of Travel

Our aim is to develop a comprehensive local offer that enables autistic individuals to remain within their communities, supported by services that promote independence and wellbeing. This includes:

- Reducing reliance on residential care and out-of-borough placements.
- Expanding community-based support options.
- Developing autism-specific services that are flexible, inclusive, and responsive to individual needs.

14.1.6 Commissioning Intentions

- Commissioning priorities will focus on:
- Early Intervention: Investing in services that identify and address needs at the earliest opportunity to prevent escalation.
- Respite and Day Opportunities: Developing high-quality, autism-inclusive respite care and day services that cater to a wide range of needs.
- Community Support Models: Supporting transitions from residential care to community living where appropriate, with tailored support packages.

14.1.7 Housing & Accommodation Standards

There are currently no autism-specific accommodation options within Greenwich. We are exploring opportunities to commission specialist housing that is designed around the sensory, social, and emotional needs of autistic residents. Providers must demonstrate a deep understanding of autism and evidence-based approaches to support.

14.1.8 Co-production & Partnership Boards

Co-production is central to our approach. The development of the forthcoming Neurodiversity Strategy will be underpinned by meaningful engagement with autistic individuals, families, and carers. The All-Age Autism Partnership Board will continue to serve as a key platform for shaping service design and delivery.

14.1.9 Provider Forums & Market Engagement

While there is currently no autism-specific provider forum, we recognise the value of establishing one. In the interim, we will explore synergies with the existing Learning Disability Provider Forum to ensure autism-related issues are addressed.

14.1.10 Challenges and Risks (Financial, Workforce and UKVI related Issues)

Lack of autism specific provision is resulting in costly out-of-borough placements, or individual packages of care to meet needs, as there is not currently autism specific provision within the borough.

14.1.11 Include threshold for new to market accommodation

Currently not applicable; however, future commissioning may include setting clear thresholds and quality standards for new autism-specific accommodation providers entering the Greenwich market.

14.2 Transitions (18-25 year olds)

14.2.1 Strategic Direction

In Greenwich, we are committed to ensuring that the transition from childhood to adulthood is a well-supported, empowering experience for all young people. Our aspiration is to create a system where transitions are not only seamless but also proactive, transparent, and tailored to individual needs. This means that young people and their carers are informed early in the journey, with clear pathways and opportunities that reflect their aspirations and potential.

Our approach is firmly rooted in person-centred planning, beginning well before the age of transition. It focuses on nurturing autonomy, building essential life skills, and supporting wellbeing across key domains such as education, employment, social participation, and independent living. We recognise that successful transitions require:

- Joined up working across services, including health, education, social care, and the voluntary sector
- Accessible and timely information for young people and their families
- Ongoing, dynamic planning that places the young person's voice at the centre of all decisions

This holistic approach ensures that transitions are not treated as a single event, but as a gradual, supported process that prepares young people for adulthood in a meaningful and sustainable way.

14.2.2 Current Demand

Greenwich has a growing cohort of young people aged 18 to 25, alongside a significant number of 14 to 17-year-olds who are being tracked in preparation for transition (136 as of April 2026). These figures reflect the increasing need for targeted support and planning. (Further data could be obtained through Mosaic or by engaging with the Moving to Adulthood (MtA) team.)

14.2.3 Current Services

Currently, Greenwich does not have services specifically designed to support young people through the transition to adulthood. While some generic services exist, they often lack the flexibility and specialisation needed to address the diverse and complex needs of this age group.

This gap is particularly evident for young people with additional needs, including those with neurodevelopmental conditions, mental health

challenges, or disabilities. The absence of tailored support at this critical life stage can lead to fragmented experiences, delayed progress, and increased reliance on costly out-of-borough placements.

14.2.4 How we are currently performing

We recognise that the current system does not offer sufficient variety or depth to meet the full range of needs for young people transitioning to adulthood. There is a lack of dedicated services that focus on developing life skills, promoting independence, and supporting young people to thrive in their communities.

Feedback from professionals, families, and young people themselves highlights the need for earlier engagement, clearer pathways, and more responsive services that reflect the realities of transitioning into adult life.

14.2.5 Direction of Travel

Our aim is to develop local, targeted provision for the transition age cohort. This includes:

- Reducing reliance on out-of-borough placements by building capacity within Greenwich
- Creating services that support young people to move away from residential care, where appropriate, and into community-based living
- Strengthening partnerships across sectors to ensure continuity of care and support
- Empowering young people to lead fulfilling lives through access to education, employment, housing, and social opportunities

14.2.6 Commissioning Intentions

We intend to commission services that:

- Establish a clear and consistent transition pathway, starting from age 14
- Enable early involvement of relevant professionals in planning and decision-making
- Provide timely access to information and options for young people and their carers
- Promote independence and resilience, with a focus on long-term outcomes

14.2.7 Housing & Accommodation Standards

At present, Greenwich does not offer transition-specific accommodation. We recognise the need for housing solutions that are tailored to the needs of young adults, particularly those with additional support requirements.

Future provision should include:

- Supported living environments that promote independence
- Accommodation designed with input from young people and families
- Providers with expertise in transitional support and autism-informed practice

14.2.8 Co-production & Partnership Boards

Greenwich has established a Moving to Adulthood Protocol and a revised Moving to Adulthood Programme Board, which provides strategic oversight of transition-related activity and workstreams. We are committed to embedding co-production in all aspects of service design, delivery, and review. The Learning Disability Partnership Board and the Autism Partnership Board guide the decision making boards.

This means working collaboratively with young people, carers, and professionals to ensure services are relevant, effective, and responsive to lived experience.

14.2.9 Provider Forums & Market Engagement

There is currently no dedicated provider forum for transition services. However, there may be opportunities to build on existing forums, such as those for learning disabilities, to create a space for dialogue, innovation, and collaboration around transition support.

14.2.10 Challenges and Risks (Financial, Workforce and UKVI related Issues)

Lack of appropriate transition focused provision is resulting in costly out-of-borough placements, or individual packages of care to meet needs.

As part of future commissioning, Greenwich may introduce thresholds and quality standards for new accommodation providers entering the market. These could include:

- Demonstrated experience in supporting young people through transition
- Evidence of co-produced service models
- Commitment to promoting independence and community integration

For more information on providing services in this area, contact can be made by emailing markets.commissioning@royalgreenwich.gov.uk.

Self-Directed Support

15.1 Strategic Direction

As part of our vision in Greenwich, we want to see an increase in the number of individuals utilising their funds to receive more personalised support. We refer to this as self-directed support and this allows our residents to be more creative in the ways that they meet the needs identified in their care and support plan, moving outside of traditional services.

Increasing take-up of self-directed support is essential for the community well-being, economic viability and social well-being of our residents. To achieve this, we want to engage with the community to identify priorities and what types of services are most needed. We need to work with our voluntary sector as these may have valuable local intelligence and can be champions for these initiatives.

We are working to develop our local market of alternative and community enterprises and assets to increase the level of choice and control for residents, as well as improving the support systems within the Council that enable residents to take on self-directed support.

15.2 Direct Payments

One way in which we enable self-directed support is to support individuals in using Direct Payments. This is when, instead of the Council buying care services for residents, residents receive a Personal Budget and will be in charge of arranging their own care. That way, they have more control over their support and can figure out what works best for them.

More information on Direct Payments can be found in our Direct Payments Booklet.

15.3 Individual Service Funds (ISFs)

Individual Service Funds (ISFs) are a flexible way for people with a personal budget or direct payment to arrange and manage their support. Instead of the council commissioning a block of care, the funding is held by a chosen provider on behalf of the individual. This allows the person to make day-to-day decisions about how their support is delivered, while still

benefiting from the provider's management and safeguarding responsibilities.

ISFs give people more choice and control, particularly those with complex needs who may not want, or be able, to manage a direct payment on their own. They also encourage providers to be more creative in tailoring support to the individual, for example combining personal care with opportunities for employment, volunteering, or social activities. This flexibility can help people build more independent and fulfilling lives, while still offering accountability for how public funds are used.

Greenwich is prioritising ISFs as a key part of our self-directed support strategy, enabling us to move toward more personalized, outcome-focused provision. ISFs support access to community-based services and micro-enterprises, while meeting our Care Act obligations to offer genuine choice and control.

Over the next one to two years, the Borough will work with providers to build capacity and confidence in delivering ISFs, linking this to wider programmes such as micro-enterprise development and Direct Payments.

A key ambition is for ISFs to act as a bridge between people's personal budgets and the growth of local micro-enterprises. This will allow individuals to use their ISF to purchase tailored support from smaller, community-based ventures, for example, arts or gardening groups, social enterprises, or innovative wellbeing projects such as Headlinerz Barbershop.

In doing so, ISFs will not only give people more control and choice but will also help sustain a diverse and inclusive local market.

Recommissioning activity will include clear expectations around offering ISFs as part of standard provision, ensuring more people can access them as a mainstream option. All providers will be required to sign up to the Greenwich ISF Policy as a condition of participation in the market. They will also be expected to demonstrate how they will use ISFs to deliver person-centred, cost-effective support that promotes independence, widens community connection, and reduces reliance on traditional residential care.

15.3.1 Current Demand and Capacity

Use of ISFs in Greenwich is still limited with only 11 Residents utilising the service, but demand is increasing as people look for more flexible alternatives to traditional care models. ISFs are particularly attractive for people with learning disabilities and autism who want greater choice and control, but who may not wish to manage a direct payment themselves. Capacity in the local provider market to hold and manage ISFs remains under-developed, with only a small number of providers offering this as a core option.

15.3.2 Outline Spend

At present, spend through ISFs represents only a small fraction of the overall learning disability and autism budget. Most expenditure continues to flow through block or spot-purchased residential and supported living services. However, national evidence shows that ISFs can achieve better value for money by tailoring support to individual outcomes, reducing reliance on higher-cost placements, and encouraging more creative use of personal budgets.

15.4 Current Requirements

To make self-directed support a success, we need:

Direct Payments:

- A variety of local, non-traditional services for people to choose from
- Enhanced local directory: We want to build on our local directory that we already have in place, so it creates a local marketplace and promotes local services
- Workforce development: Train social work staff and appoint Self-Directed Support Champions within the council to lead culture change and address scepticism

Individual Service Funds:

- More providers who are able and willing to operate ISFs effectively (currently only two). This includes having the systems to manage budgets transparently, the flexibility to tailor support creatively, and the capacity to work directly with individuals and families to co-produce care plans
- Clearer guidance for staff and residents on how ISFs work, how they differ from direct payments, and how they can be used to support independent living

15.5 Future Requirements

Progressing our self-directed support strategy is critical. The risk of not completing this work has significant consequences:

- Financial impact: Traditional care packages are often more expensive and less flexible
- Legal obligations: Councils risk breaching Care Act obligations by failing to offer genuine choice and control
- Reputational risk: Awareness is growing and individuals and families expect councils to support personalisation; inaction risks reputational damage and dissatisfaction among our residents.

Market Quality and Sustainability

The Royal Borough of Greenwich is committed to moving away from transactional relationships with our provider market and towards stronger partnerships focused on vibrant, sustainable markets that prioritise the outcomes of our residents.

Our vision is to create a market environment where providers are trusted partners, given space to honestly share the challenges they face and insights from the services they deliver. We want Greenwich to feel welcoming to new market entrants who can improve outcomes, drive innovation, or enhance service delivery where there is demand for these services.

This vision will be delivered through how we commission our providers and how we engage and communicate with our markets. Whilst we acknowledge that achieving the full vision may take time, we are committed to going on this journey with our providers as genuine partners in delivering high-quality care and support to Greenwich residents.

16.1 Fair Cost of Care & Market Sustainability

In line with our Care Act responsibilities, we want to ensure that we have a vibrant and diverse market that can meet the needs of our residents both now and in the future. Central to this is supporting the financial sustainability of our provider market.

We are committed to understanding the true cost of delivering quality care in Greenwich. Our approach to fair cost of care is based on robust cost-of-care methodology that reflects the real costs providers face, including workforce costs, overheads, and the investment needed to deliver quality services that meet regulatory requirements.

We want to move to a position where we can have open and honest conversations about sustainability, where commissioners have their finger on the pulse of the financial health of all providers delivering services locally. This transparency will enable us to work proactively with providers facing challenges and to make informed commissioning decisions that support a stable, sustainable market.

Our approach to market sustainability includes regular provider sustainability assessments, enabling us to identify risks early and work collaboratively with providers to address financial pressures before they impact service delivery or quality.

16.2 Uplift Schedule

The Royal Borough of Greenwich is committed to fair, transparent and defensible fee setting. We recognise the cost pressures providers face, including inflation, workforce challenges and changes to the National Living Wage. At the same time, we must ensure value for money and maintain a sustainable care market. We are committed to providing providers with as much notice as possible regarding fee changes to support their business planning and workforce management.

Our annual uplift schedule for 2025-26 onwards takes into account inflationary pressures, changes in the National Living Wage, workforce challenges, and other cost drivers affecting the care market. We engage with providers throughout the fee-setting process to understand the challenges they face and to ensure our uplifts support market sustainability.

We assess uplift requests based on commissioned rates, service type and financial risk. We do not apply blanket uplifts. We prioritise support for providers at risk of market exit / sustainability concerns and we do not uplift rates above the median unless exceptional circumstances are evidenced.

Our approach includes a clear uplift policy, engaging providers early and operating an exceptions panel. We require financial evidence and impact statements for uplift requests outside the standard model. We differentiate and assess uplift eligibility based on ownership model, financial resilience and service type, to ensure fairness across the market.

This process allows us to meet our Care Act duties while protecting public funds and supporting smaller providers who deliver essential services under tighter margins. We provide clear communication and as much notice as possible to support provider planning and workforce stability.

The uplift offers for 2025-26 will be shown in an updated version of the Market Position Statement in Q1 2026-27.

16.3 Provider Sustainability Assessment

The Royal Borough of Greenwich proactively monitors the financial health of our provider market to identify risks early and support market stability.

We conduct regular sustainability assessments considering financial health, workforce stability, occupancy levels, and external cost pressures. Where concerns are identified, we work collaboratively with providers to explore solutions, including fee reviews, business support, and contingency planning.

We encourage open dialogue with providers about sustainability challenges. Early engagement enables us to address issues before they impact service delivery, supporting a resilient market that continues to deliver quality care to Greenwich residents.

For more information on providing services in this area, contact can be made by emailing markets.commissioning@royalgreenwich.gov.uk.

Supporting Data

Total Adults by Service Area

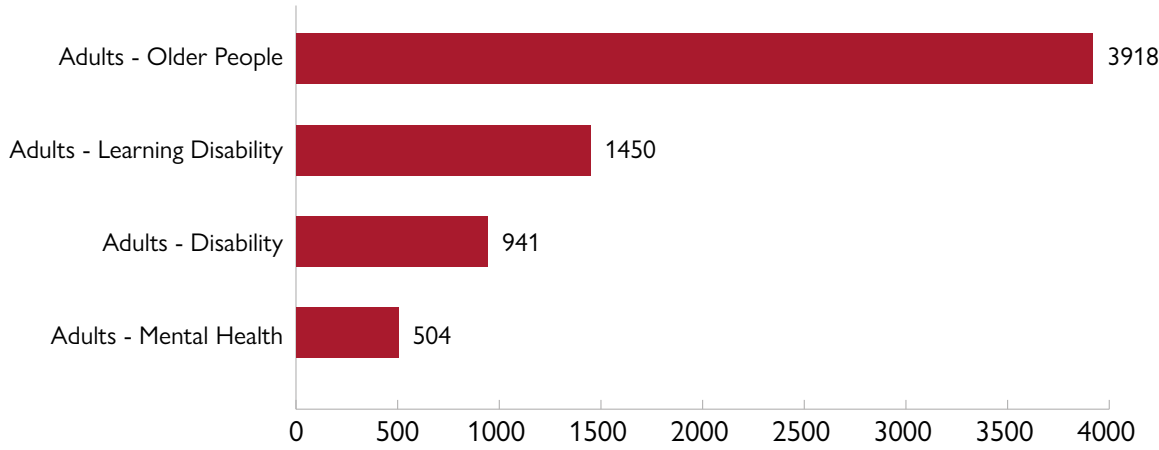
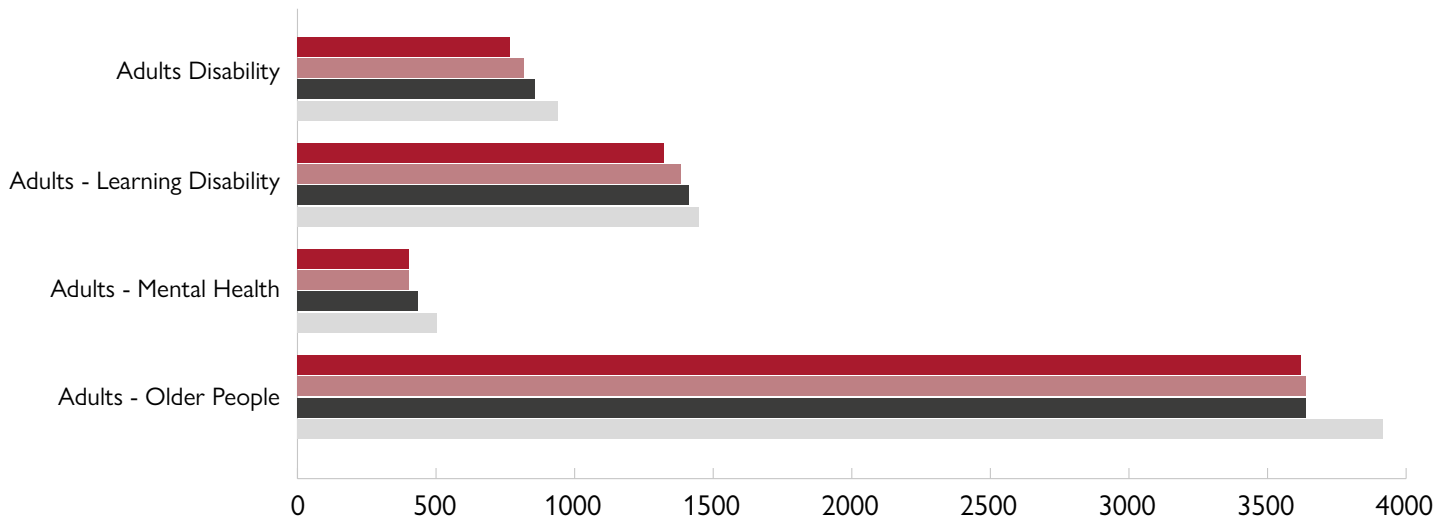


Figure 5 - Total Adults by Service Area Snapshot as of March 2025-26; includes both long- and short-term services

Total Adults Social Care by Service Area at Year End



	Adults - Disability	Adults - Disability	Adults - Mental Health	Adults - Older People
2022-23	768	1323	402	3621
2023-24	816	1382	402	3640
2024-25	856	1413	436	3639
2025-26	941	1450	504	3918

Figure 6 - Total Adults by Service Area Financial Year Comparison Snapshot as of March; this figure excludes Mental Health Supported Accommodation Pathway and includes both long- and short-term services

Table 6 - Adults Older People includes both long- and short-term services

Adults - Older People	Number of Residents as of March 2025-26
Community Based Services	1391
Home care	1142
Placements	448
Nursing care	256
Residential care	192
Extra care - Flex hours	135
Extra care	126
Day services	105
Direct payments	100
One to One	15
Client support	4
Supported living	2
Extra care - Sheltered	1
Respite	1

Table 7 - Adults Mental Health includes both long- and short-term services

Adults - Mental Health	Number of Residents as of March 2025-26
Community Based Services	163
Home care	87
Placements	84
Residential care	76
Supported living	73
Direct payments	11
Nursing care	8
One to One	1
Shared lives	1

Table 8 - Adults Learning Disability includes both long- and short-term services

Adults - Learning Disability	Number of Residents as of March 2025-26
Community Based Services	427
Direct payments	272
Supported living	202
Day services	147
Placements	121
Residential care	118
Home care	90
Shared lives	26
Client support	24
One to One	7
Other	7
Nursing care	3
Respite	3
Extra care	2
Extra care - Flex hours	1

Table 9 - Adults Physical Disability includes both long- and short-term services

Adults – Physical Disability	Number of Residents as of March 2025-26
Community Based Services	427
Direct payments	272
Supported living	202
Day services	147
Placements	121
Residential care	118
Home care	90
Shared lives	26
Client support	24
One to One	7
Other	7
Nursing care	3
Respite	3

Timeline & Version History

1. *November 2025: Update V.1.0 Greenwich Market Position Statement*
2. *April 2026: Update V.1.1 Greenwich Market Position Statement*



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