Key Messages

Non-elective admissions

- Providing care and support in the community and reducing the burden on hospital services remain system priorities in Greenwich.
- With oversight from the A&E delivery board, partners across health and social care continue to deliver a programme of work to reduce the number of people requiring hospital admission.
- There has been a reduction in admissions in quarter one 18/19 when compared to the same period in 17/18, suggesting that this work is having an impact in Greenwich. Quarter 2 data is not available yet. Key schemes to support a reduction in non-elective admissions were reported in the quarter 1 performance report.

Reablement- No change - Annual figure

- The proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services (ASCOF 2Bi & 2Bii). This measures the benefit to individuals from reablement, intermediate care and rehabilitation following a hospital episode, by determining whether an individual remains living at home 91 days following discharge.
- There has been an increase in the number of clients who are at home on the 91 day point. In 2016/17 we ranked 14th out of 16 in our comparator group. 82.3% (2017/18) compared to 81.5% (2016/17) of clients of all hospital discharges into reablement were still at home.

Delayed Transfer of Care (DTOC) bed delays.

- Delayed transfer of care (DTOCs) remains below trajectory - 891 bed days for Q2 18/19 is lower than the trajectory for the quarter (1140). Further work is underway to reduce this further however it is clear that the introduction of 20 discharge to assess beds at Duncan House continues to have had a big impact on this important agenda.
- The beds at Duncan House enable patients who would normally wait in a hospital bed to be assessed for residential or nursing home care, to be discharged. Duncan House provides a more home like environment in which a more robust assessment can be made.
- Following the introduction of Duncan House, a number of patients have been able to return home with a smaller package of care than would have been put in place had they been assessed in a hospital setting. Early data shows that the service is effective in enabling people to gain more independence through a multi-disciplinary team supportive approach.
- In addition, the Transfer of Care Collaborative (ToCC), a multi-disciplinary and organisation team comprising professionals from health and social care, continues to work to reduce DTOC.
- The ToCC was developed to foster an integrated approach to discharge planning, with a focus on developing a better understanding between professionals of the different, complementary roles they play in this process. The ToCC team works to streamline discharge pathways and processes, with a view to reducing lengths of stay and avoidable readmissions, and improving the system of support available to people in the community.

- As part of the ToCC programme, four workstreams are currently underway to identify high impact short and long-term system improvements that can be made in the hospital and community settings across the Bexley and Greenwich health and social care system.

A&E Time to treatment

- In 17/18, pressure on the Accident and Emergency (A&E) department at Queen Elizabeth Hospital (QEH) meant that more people waited longer than they should for treatment or admission to a hospital bed. Compared to Q1 there is no significant change compared to Q2 with 89% of patients were seen or treated within the four hour emergency standard. Ahead of winter, the trust (with support from the CCG and RBG) has put in place a programme of work to reduce overcrowding and delays in A&E to ensure that more patients are seen and treated within the four hour emergency standard. This programme was detailed in this year's Q1 report performance report.

Access Hubs

- The NHS England mandate sets out a requirement to ensure that everyone has easier and more convenient access to GP services, including appointments at evening and weekends.
- All London CCGs have successfully established extended access services which allow for 8am till 8pm, 7 days a week, GP services for their local populations. London has achieved this ahead of the rest of the country and is in a good position to move forward in the continued delivery of a joined up service which provides choice, additional capacity to the system, supports improved access and outcomes for its population.
- Activity data for the Access hubs continues to show good usage for the weekday and most Saturday sessions. Appointment uptake on Sundays remains poor, despite an intensive advertising campaign directed at patients and practices. All 35 practices are now actively using the hubs.
- Did not attends (DNAs) remain an issue with 55% of hub utilisation in Q2. The Federation is close to implementing SMS text messaging as a way to remind patients of appointments and to allow cancellation. Work is currently ongoing with regard to the direct booking of slots by 111, with slots to be ring-fenced for this on Sundays.

National Diabetes Participation Programme

- The delivery of the NHS Diabetes Prevention Programme (NDPP) sits with the Greenwich CCG. There is a robust recovery plan in place to drive up referrals by the CCG, supported by RBG Public Health.
- A new provider has been commissioned for South London, and the CCG with support from RBG Public Health is managing the local transition and engagement with Primary Care to ensure that our residents can fully benefit from this evidence-based programme.
- For Q1 18/19 (April – June) there were no referrals, this was an agreed South London position to allow outgoing provider (Reed Momenta) to address backlog, and new provider (ICS from 01/05/18) to get systems in place for new referrals.
- Referrals are coming from NHS Health Checks (which are commissioned by RB Greenwich) but currently few from Primary Care. A protected learning time (PLT) session on Diabetes Prevention was held in April 2018 attended by around 50 Primary Care staff, promoting referrals. Discussions are taking place with the CCG and a further plan is being developed to drive up referrals from Primary

Care, through contacting eligible patients (those identified as being at high risk of developing Type 2 Diabetes within the last 12 months).

- For Q2 (July – September) 49 referrals were made. The target referrals for Greenwich for 18/19 is 386.

External Updates

- The Secretary of State for Health and Social Care has launched his prevention vision. The document sets out the government's vison for:
    - stopping health problems from arising in the first place
    - supporting people to manage their health problems when they do arise
- The goal is to improve healthy life expectancy by at least 5 extra years, by 2035, and to close the gap between the richest and poorest.
- A collection of case studies has been published, showing examples of good practice in preventing health problems from happening. The Secretary of State's vision recognises this and advocates the need for integration of services, highlighting particularly the critical role and contribution of local government working inseparably with their local NHS.

Service Updates

Dementia Inclusive Greenwich Initiative

- The Royal Borough is one of three authorities in London where the dementia diagnosis rate is predicted to increase 30% by 2021 with numbers estimated to increase to 2,512. To support people affected by dementia to continue living an active life, live well and feel part of the community the 'Dementia Inclusive Greenwich initiative' was set up in 2016.
- In 2018, the Royal Borough of Greenwich were awarded National Dementia Friendly Community status by Dementia Friends, an Alzheimer's Society initiative.
- To date, there are 28 businesses engaged with the initiative and working towards receiving the Dementia Inclusive Greenwich award.

Safeguarding

- November 2018 marks the Royal Borough's Inaugural Adult Safeguarding Month and features a programme of events designed to improve practice amongst professionals working with adults at risk of abuse or neglect and to increase general awareness. Subjects will include fire safety, rogue traders, introductions to adult safeguarding and deprivation of Liberty Safeguards. Each week focusses on different themes including: learning disabilities, mental health, older people and physical disabilities.
- Events will be run for both professionals and members of the public, including service users. Safeguarding Month will culminate with the Greenwich Safeguarding Adults Board Annual Conference on 28th November at Charlton Athletic, where this year's theme is Domestic Violence.

Thrive (Mental Health)

- The Royal Borough is adopting the Thrive LDN approach to improving mental health and wellbeing. The approaches being developed under Thrive Greenwich are an integral part of the Mental Health and Wellbeing priority in the new Health and Wellbeing Strategy 2019-2023.
- We are working with local residents and service users to gather their views on what needs to change in Greenwich to support better mental health and wellbeing. This is being taken forward through:
    - Engaging with service user groups, including GAIN, to identify challenges with the mental health services system;

- Working with local people with lived experience of mental health problems who are equal partners in the leadership of the Mental Health and Wellbeing Partnership Board;
- Establishing a Lived Experience Forum, which is owned and controlled by people with Lived Experience, and can feed views and issues into both the Mental Health and Wellbeing Partnership Board and the Mental Health Strategic Leadership Group.

Sugar Smart Greenwich

- Sugar Smart Greenwich is part of the whole systems approach to improving healthy weight in Greenwich, one of key priorities of the Royal Borough's Health and Wellbeing Strategy. Sugar Smart is one of a broad range of intervention within the Royal Borough's Healthy Weight action plan, now overseen by the Member level Healthy Weight Taskforce.
- There are currently 80 organisations in the borough who have signed up to the Good Food in Greenwich website to make a Sugar Smart pledge and there are also 25 'Sugar Smart' Royal Greenwich schools pledging to make a wide range of healthy food related changes.
- Greenwich Young People's Council is the most recent organisation to join the Sugar Smart movement. They have committed to change the food and drinks they share during meetings.
- Sugar Smart September has recently been promoted across the Woolwich Centre, with nearly 10 staff teams committing to reduce their sugar intake throughout the month
- Next steps for Sugar Smart Greenwich, include optimising existing partnership and commissioning arrangements to engage more organisations and to specifically recruit more schools.

Blood Pressure Roadshow

- The Royal Borough of Greenwich worked with Charlton Athletic Community Trust and The British Heart Foundation for the 'Be Sure of your Blood Pressure' roadshow.
- Following on from last year's successful roadshow, the campaign ran throughout September and October and gave residents the chance to get a free blood pressure check and receive tailored health advice and support from friendly trained advisors.
- The roadshow supports two national campaigns launching at the same time - Public Health England's 'Heart Age' and Blood Pressure UK's 'Know Your Numbers' week. Over 140 events were attended with over 5700 blood pressure checks completed during the roadshow.

Safe Places

- Living with a learning disability can change how people experience everyday things. It is easy to feel scared or nervous when out in the community, but hard to know where to go for help.
- Now through Safe Places, a scheme set up by Advocacy in Greenwich and supported by the Council, if someone with a learning disability feels scared or intimidated they can take refuge in any of the shops, cafes, pubs or community buildings that are displaying a Safe Places window sticker. There are 31 places so far with the aim of recruiting 100 across the borough.
- The Council is inviting more businesses in the borough to become a Safe Place. Shops, cafes, pubs and community buildings can make a difference by signing up the scheme and agreeing to:
  - Display the window sticker
  - Take part in a short on-site training session

  - Offering assistance when a person with a learning disability needs it
  - Making a phone call to the person's emergency contact or the police (if appropriate).
- Safe Places in Greenwich is run by Advocacy in Greenwich with funding from The Mayor's Office for Policing and Crime (MOPAC) and support from the Council and the Metropolitan Police.

Subject Area	Indicator	Value	Previous Value	Target	Comparator
Heath & Wellbeing	Non-Elective Admissions - Reduction in non-elective admissions	Q2 not available	7400 (Q1 18/19)	7751	
	Delayed Transfer of Care (bed days) per 100,000	891 (Q2 18/19)	636 (Q1 18/19)	1128	
	% of patients who were admitted as an emergency within 30 days of being seen by the JET team	22.7% (Q2 18/19)	26.5% (Q1 18/19)	28.6%	
	Live Well Greenwich Line total contacts	5949 (Q2 18/19)	4,524 (Q1 18/19)	A new target is under development, in response to developments in the Live Well Greenwich Line contract	
	National Diabetes Participation Programme	49 (Q2 Cumulative)	414 (17/18)	386 (18/19)	
	% of children born at a low birth weight	7.5% (2016)	8.1% (2015)		London = 7.6% (2016)
	Percentage of overweight or obese children at reception	26.5% (17/18)	24.1% (16/17)		21.8% London
	% of overweight or obese children at year 7	40.5% (17/18)	42.7% (16/17)		37.7% London
	Percentage of adults (aged 18+) classified as overweight or obese, 2015-18	58.9% (2016-17)	63.0% (2015-16)		55.2% London
NHS	A&E Time to Treatment (% admitted, transferred or discharged within four hours)	89% (Q2 18/19)	89.3% (Q1 18/19)	95% (National standard) 87.8% (Locally agreed target)	
	Left department before being seen for treatment rate	2.8 (Q2 18/19)	2.2% (Q1 18/19)		
	% of Hub Utilisation (no benchmarking available – data goes to Sustainability Transformation Partnership)	55.1% (Q2 18/19)	86.3% (June 2018)		
Safeguarding	Number of safeguarding concerns recorded in Qtr	227 (Q2 18/19)	241 (Q1 18/19)		
	Number of safeguarding enquiries completed in Qtr	67 (Q2 18/19	96 (Q1 18/19)		
	% of Concerns from BME/White ethnicity Qtr	13% (Q2 18/19)	15% (Q1 18/19)		
Independence & Community Resilience	Admissions to 24h care	101 (Q2 Cumulative)	57 (Q1 18/19)	217	London Average
	Reablement (older people still at home 91 days after discharge)	82.3% (17/18)	81.5% (17/18)	83.10%	London Average 85.4%
	% of community contacts leading to full assessment	21% (Q2 Cumulative)	22% (Q1 18/19)		
	% of comprehensive assessments with an outcome of services	Not available	Not available		
	% leading to community based services	88% (Q2 18/19 Cumulative)	89% (Q1 18/19)		
	% leading to res/nursing placement	6% (Q2 18/19 Cumulative)	6% (Q1 18/19)		
	Number of people provided with OT equipment with no other long term care packages.	69.4% (Q2 18/19 Cumulative)	70.1% (Q1 18/19)		

Analysis

Contacts

- The Contact Assessment process aims to get an initial understanding of the service user's situation to find out any concerns. The contact assessment team screens for strengths and support and eligibility for assessments. They establish and identify existing support around a person's family, friends and other support networks. The team then provides information and advice.
- On average 570 new client contacts are made at the front door each month. This has remained relatively stable since a new workflow process was introduced in November 2017.
- 50% of new client contacts are made via the main Contact Assessment Team (CAT), 28% via the Joint Emergency Team (JET), 18% via Hospital Integrated Discharge (HID) and 4% direct to Community Learning Disability Team.
    - JET is a multi-professional team including nurses, physiotherapists, occupational therapists and social workers. They respond to situations where vulnerable adults require some form of urgent intervention (health and/or social services) within 24 hours of the referral being made. JET consider options for re-ablement/rehabilitation and intermediate care.
    - The HID team co-ordinates responses to referrals from NHS acute hospital beds, with the aim of facilitating a safe and timely discharge to the patient
- So far this year, 54% of new client contacts are made by people aged 75+. This figure has been slowly increasing over the last three years (51% in 2015/16)
- On average, 8.3% of new clients made more than 3 contacts with Adult social care in a six month period. This proportion has remained fairly stable since the new workflow was introduced last year.
- Since the beginning of the financial year, 660 (out of 3,206) new client contacts have led to an offer of comprehensive assessment (21%) Of which 8 are to the Community Learning Disability Team (CLDT).
- 536 support plans have been created following a first assessment so far this year.
- 1,951 support plans were created following reviews so far this year.
- 327 support plans were amended outside of the formal review process.

Occupational Therapy

- The Occupational Therapy team carries out specialist functional assessments with people of all age groups with physical disabilities, and their carers. This includes the provision of advice, information and recommendations for ways of promoting their independence in everyday activities within the home environment.
- 880 referrals received since April 2018 – 4% reduction compared to 2017/18, 71% of the referrals come from CAT.
- 605 assessments started – 3 times more than the same period last year.
- 64% of referrals led to a provision of equipment - 53% increase compared to the same period last year.
- 69% of people provided with OT equipment are not in receipt of long term services. This has remained stable over the past 18 months.