A Healthier Greenwich

Key Messages

Non-elective Admissions (NEA)

- 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. Key schemes to support a reduction in non-elective admissions include:

  - **Ambulatory care pathways** – continued work by Lewisham and Greenwich Trust to divert patients onto ambulatory care pathways to allow them to receive the assessment and care they need without the need for admission to a hospital bed. Where patients do require additional step-up support, pathways are being put in place to ensure that they receive this outside of the hospital setting i.e. frail patients seen in ambulatory care can be transferred directly to Eltham Community Hospital for inpatient support.

  - **Care home support programme** – a multi-agency transformation programme is well underway to engage and support Greenwich’s 12 care homes. The programme includes the roll-out of telehealth to all homes, promoting the use of 111*6 (which connects care home staff directly to a GP) and the provision of education to prevent and detect deterioration in residents’ health. If a resident does need hospital treatment, the red bag programme is fully established in Greenwich meaning that the person is conveyed to hospital with all the relevant information relating to their health, medications and preferences, and with their personal effects contained within a clearly marked and identifiable bag.

  - **High intensity user (HIU) programme** – using a nationally recognised approach, the existing HIU programme in Greenwich is being developed to include a community coach. The coach will provide direct 1:1 support to vulnerable service users who repeatedly call on the ambulance and hospital services to address their health and social needs.

  - **Extended access to GP appointments** – following the successful implementation of evening and weekend appointments at two hubs in Greenwich, plans are in development to further extend access to GP services across the borough.

  - **Therapy support to ED** – over the coming months, a pilot will be launched to provide intensive therapy support within the emergency department with the aim of providing patients with a rapid assessment and initial intervention with a view to them receiving their ongoing care outside of the hospital setting.
Reablement

- 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) clients of all hospital discharges into reablement were still at home.

Delayed Transfer of Care (DTOC) bed delays.

- Delayed transfers of care (DTOCs) remains below trajectory - 636 bed days for Q1 18/19 is lower than the trajectory for the quarter (1128). Further work is underway to reduce this further however it is clear that the introduction of 20 discharge to assess beds at Duncan House 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 an 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. 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. The programme includes the following workstreams;

  - **London Streaming Model compliance** – work is underway to move the A&E department at QEH towards the London Streaming Model of practice. The model sets out the best practice for triaging, assessing and redirecting patients from A&E and urgent care, with the aim of supporting more patients to identify and access services in the community.
- **Minors breach reduction programme** – encompassing a number of work streams to ensure that patients attending A&E with minor illnesses, injuries or social complexities are seen and treated within the four hour A&E standard. This work includes identifying opportunities to use nurse and advanced clinical practitioners to provide a rapid see-and-treat service to people presenting A&E who are unlikely to require specialist intervention or inpatient care.

- **Increase in acute mental health and learning disability support** - the capacity of the psychiatric liaison service at QEH has been increased to include additional specialist mental health nursing support and a dedicated learning disabilities nurse to improve the experience, appropriate diversion and outcomes for patients experiencing a mental health crisis.

- **Achieving ambulance service standards** – Lewisham & Greenwich Trust (LGT), is undertaking focused work alongside the London Ambulance Service (LAS), to ensure the smooth and efficient handover of patients at the hospital’s front door. A ‘Fit to sit’ approach will be adopted at QEH during periods of high demand to ensure that cubicle space is available for patients requiring emergency treatment.

**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.

- DNAs remain an issue and 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).

• In Q2 (July – September) our Greenwich target was 134 referrals, of which 49 were made (so 36% of target). The target referrals for Greenwich for 18/19 is 386, so we are at 13% for the year.

Key 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 mark National Dementia Action week, the Royal Borough of Greenwich organised a community event on 24th May 2018, attended by over 250 professionals and members of the public, and publicised in local news.

• To date, there are 28 businesses engaged with the initiative and working towards receiving the Dementia Inclusive Greenwich award and the following eight businesses and services have been presented with the award by Cllr Averil Lekau:
  - Woolwich Centre Library
  - Stir café
  - ArtFix café and workspace
  - St James Pharmacy
  - Page and Small optician
  - Advocacy for Older People in Greenwich
  - Grant Saw solicitor
  - Greenwich Peninsula Ecology Park

Safeguarding

• November 2018 marks the Royal Borough’s Inaugural Adult Safeguarding Month and will feature 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

• 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 will be 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 5 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.

All Services Information Hub

- Health and Adults Service and Children’s Services are working together to merge three separate directories to create one information, advice and guidance website with a shared back end database known as an ‘All Services Hub’. There are currently three separate directories: the Greenwich Community Directory, The Family Service Directory (including the Local Offer) and the Greenwich Domestic Violence and Abuse Services directory.
- Such an approach is increasingly being adopted by local authorities as streamlined approach to their information advice and guidance offer. With the move to online services and increased digitalisation in local government services it is important that the Royal Borough of Greenwich’s information, advice and guidance offer is appropriate for the current digital climate – an ‘All Services Hub’ is one approach to ensure this. Clear benefits for service users, providers and officers include:
  - Streamlining of systems
  - Improved user journey – coherent information, advice and guidance offer.
- Improved provider experience
- Reduced administrative burden for officers and provider.
<table>
<thead>
<tr>
<th>Subject Area</th>
<th>Indicator</th>
<th>Value</th>
<th>Previous Value</th>
<th>Target</th>
<th>Comparator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heath &amp; Wellbeing</td>
<td>Non-Elective Admissions - Reduction in non-elective admissions</td>
<td>7400 (Q1 18/19)</td>
<td>7605 (Q4 17/18)</td>
<td>7751</td>
<td></td>
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<tr>
<td></td>
<td>Delayed Transfer of Care (bed days) per 100 001</td>
<td>636 (Q1 18/19)</td>
<td>1122 (Q4 17/18)</td>
<td>1128</td>
<td></td>
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<td></td>
<td>% of patients who were admitted as an emergency within 30 days of being seen by the JET team</td>
<td>26.5% (Q1 18/19)</td>
<td>31.8% (Q4 17/18)</td>
<td>28.60%</td>
<td></td>
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<tr>
<td></td>
<td>Live Well Greenwich Line total contacts</td>
<td>4,524 (Q1 18/19)</td>
<td>Measure has changed since last report</td>
<td>386 (18/19)</td>
<td>A new target is under development, in response to developments in the Live Well Greenwich Line contract</td>
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<tr>
<td></td>
<td>National Diabetes Participation Programme</td>
<td>414 (Q4 17/18)</td>
<td>386 (18/19)</td>
<td>386 (18/19)</td>
<td>London = 7.2% (2016)</td>
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<tr>
<td></td>
<td>Percentage of overweight or obese children at reception</td>
<td>26.5% (17/18)</td>
<td>24.3% (16/17)</td>
<td>21.8% London</td>
<td></td>
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<td></td>
<td>% of overweight or obese children at year 7</td>
<td>40.5% (17/18)</td>
<td>43.0% (16/17)</td>
<td>37.7% London</td>
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<tr>
<td></td>
<td>Percentage of adults (aged 18+) classified as overweight or obese, 2015-18</td>
<td>58.9% (2016-17)</td>
<td>63.0 (2015-16)</td>
<td>58.9% (2016-17)</td>
<td>55.2% London</td>
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<tr>
<td>NHS</td>
<td>A&amp;E Time to treatment (% admitted, transferred or discharged within four hours)</td>
<td>89.3% (Q1 18/19)</td>
<td>84.1% (Q4 17/18)</td>
<td>95% (National standard) 87.8% (Locally agreed target)</td>
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<td></td>
<td>Left department before being seen for treatment rate</td>
<td>2.2% (Q1 18/19)</td>
<td>2.2% (Q4 17/18)</td>
<td>2.2% (Q1 18/19)</td>
<td>2.2% (Q4 17/18)</td>
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<tr>
<td></td>
<td>% of Hub Utilisation</td>
<td>86.3% (June 2018)</td>
<td>85.3% (March 2018)</td>
<td>86.3% (June 2018)</td>
<td>85.3% (March 2018)</td>
</tr>
<tr>
<td>Safeguarding</td>
<td>Number of safeguarding concerns recorded in Qtr</td>
<td>241 (Q1 18/19)</td>
<td>224 (Q4 17/18)</td>
<td>241 (Q1 18/19)</td>
<td>224 (Q4 17/18)</td>
</tr>
<tr>
<td></td>
<td>Number of safeguarding enquiries completed in Qtr</td>
<td>96 (Q1 18/19)</td>
<td>58 (Q4 17/18)</td>
<td>96 (Q1 18/19)</td>
<td>58 (Q4 17/18)</td>
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<td>% of Concerns from BME/White ethnicity in Qtr</td>
<td>15% (Q1 18/19)</td>
<td>16% (Q4 17/18)</td>
<td>15% (Q1 18/19)</td>
<td>16% (Q4 17/18)</td>
</tr>
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<td>Independence &amp; Community Resilience</td>
<td>Admissions to 24h care</td>
<td>161 (Q1 18/19)</td>
<td>160 (Q4 17/18)</td>
<td>217</td>
<td>London Average</td>
</tr>
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<td></td>
<td>Reablement (older people still at home 91 days after discharge)</td>
<td>82.3 (17/18)</td>
<td>81.5% (16/17)</td>
<td>83.10%</td>
<td>London Average 85.4%</td>
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<td></td>
<td>% of community contacts leading to full assessment</td>
<td>22% (Q1 18/19)</td>
<td>Not available</td>
<td>Not available</td>
<td></td>
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<td></td>
<td>% of comprehensive assessments with an outcome of services</td>
<td>Not available</td>
<td>Not available</td>
<td>Not available</td>
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<tr>
<td></td>
<td>% leading to community based services</td>
<td>89% (Q1 18/19)</td>
<td>Not available</td>
<td>Not available</td>
<td></td>
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<tr>
<td></td>
<td>% leading to res/nursing placement</td>
<td>6% (Q1 18/19)</td>
<td>Not available</td>
<td>Not available</td>
<td></td>
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<tr>
<td></td>
<td>Number of people provided with OT equipment with no other long term care packages</td>
<td>70.1% (Q1 18/19)</td>
<td>70.9% (Q1 17/18) 68.6% (Total 17/18)</td>
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</tr>
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</table>
Male life expectancy (at birth) in Greenwich increased in 2014-16 compared to 2013-15. This is the highest rate to date for the Royal Borough, although in comparison to other London boroughs, performance fell slightly to 25th of all London authorities.
Female Life Expectancy (at birth) fell slightly in 2014-16 to 82.4 years compared to 2013-15. The greatest rate was in 2011-13 when female life expectancy reached 82.7 years. In 2014-16, Royal Greenwich fell a place and was 30th out of all London boroughs on this indicator.

Healthy Life Expectancy at birth

- Healthy Life Expectancy measures the average number of years a person would expect to live in good health based on contemporary mortality rates and prevalence of self-reported good health.

- It is an estimate of the average number of years a new-born baby would live in good general health if he or she experienced the age-specific mortality rates and prevalence of good health for that area and time period throughout his or her life, but it does not indicate the actual number of years a baby born in the area will live in good general health, both because the health prevalence and mortality rates of
the area are likely to change in the future and because many of those born in the area will live elsewhere for at least some part of their lives.

- In 2014-16, the average age a Greenwich man is estimated to remain in good health until would be 60.7 years, a slight decrease compared to 61.3 in 2013-15, (and down from 62.3 in 2010-12). The average age a Greenwich woman is estimated to remain in good health until would be 58.5 in 2014-16, a fall since 2012-14 when the estimate was 64.5 years.

Slope index of inequality in life expectancy at birth

- The local authority results are based on local deprivation deciles within each local authority area.

- For each local authority, life expectancy at birth is calculated for each local deprivation decile based on Lower Super Output Areas (LSOAs). The slope index of inequality (SII) indicates the range in life expectancy across the social gradient from most to least deprived decile within that authority. It does not indicate whether a local authority has greater life expectancy compared to another local authority, (or whether life expectancy has decreased or increased from the previous period) just whether the range is narrower or wider within that local authority compared to another local authority, or a previous period.

- The gap in life expectancy between Greenwich men from the bottom and the top deciles increased from 5.5 years to 6.9 years between 2013-15 and 2014-16. It decreased slightly amongst Greenwich women from 4.7 years to 4.6 years, but in 2012-14 was only 3.9 years.

- The figures for England are based on deciles within England. This indicates that in England as a whole men in the least deprived decile will have 9.3 years more life expectancy than men in the most deprived decile. The gap for women is 7.3 years.

Potential of Years Life Lost.

- The number represents the total years of life lost per 100,000 of the standard European population.

- It is based on the total number of deaths in an area and how many years of life were lost in each case based on the persons age at death and how long someone of that age group would be expected to live on average at that period in time, and then summing the years lost by sex and age group.

- This indicator has not been updated by NHS Digital since 2016. At that time it was indicated that PYLL had decreased amongst Greenwich men and Greenwich women compared to the previous year by 1.6% and 12.6% respectively.