Key Messages

Delayed Transfer of Care (DTOC) bed delays

- Lewisham and Greenwich Trust hold a weekly DTOC meeting in order to further facilitate DTOC monitoring & issue resolution/escalation for Greenwich clients who are DTOC or Ready for Discharge (RFD).

- Delayed transfers of care (DTOCs) remains below trajectory - 577 bed days for Q3 18/19 is lower than the nationally set target 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 have had a big impact on this important agenda.

Transfer of Care Collaborative

- 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.

- 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 Q2, there is no significant change compared to Q3 with 87% of patients being seen or treated within the four hour emergency standard. Ahead of winter, the trust (with support from the CCG and RBG) 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 performance report.

- Patient numbers to the Urgent Care Centre across November 2018 were 8,696, a decrease on the previous month (8,762), and an increase on the same time the previous year (8,592).

- Streaming performance has deteriorated on the previous month for paediatrics, 89.5% of paediatric patients being streamed within 15 minutes (compared to 90% previous month). There has been improvement for adults with 92.1% of adult patients being streamed within 20 minutes (compared 91.2% previous month).

- The overall breach performance has again decreased at 97.8% for the month of December. This dip in performance is against a background of high activity in the UCC immediately following the Christmas
period which did not follow expected levels based on previous years. The UCC team have responded by increasing rotas whilst new doctors are being trained, they have also been working closely with ED to review patient flows as part of the wider improvement plan in order to achieve the streaming targets:

- A second UCC streaming process is being introduced
- The referral pathway to CDU has been implemented to avoid the need for referral back to ED which is expected to improve quality through reduction in patient waiting times
- A weekend dressings clinic was introduced via the GP Hub in mid-December

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.
- There has a significant improvement for hub utilisation with 80.5% of hub utilisation in Q3 compared to 55% from the previous quarter. With further improvement required the Federation is considering implementing SMS text messaging as a way to remind patients of appointments and to allow cancellation. Slots are now ring fenced for the 111 service to enable them to directly book appointments for patients they have assessed on the telephone.

National Diabetes Participation Programme
- Responsibility for NDPP now sits with Greenwich CCG, supported by RB Greenwich Public Health.
- Referrals to NDPP from NHS Health Checks and Primary Care in Greenwich continue to be well below target, with only 45 new referrals in Q3. Greenwich CCG, in partnership with RB Greenwich Public Health and Greenwich Health (the GP Federation) have been implementing a recovery plan to increase referrals.
- Practices are being financially supported through additional funding secured for NDPP implementation to write to eligible patients encouraging them to contact Live Well Greenwich to find out about NDPP and other diabetes prevention support. However, piloting this approach in Primary Care took longer to implement than anticipated due to capacity issues in the pilot GP practice.
- A Protected Learning Time (PLT) on Diabetes Prevention and Treatment is planned for February 2019, which will promote NDPP and encourage practices to undertake the searches, highlighting the financial support that is available to them to contact eligible patients. This PLT will also highlight GP responsibility to opportunistically check “at risk” patients for pre-diabetes and refer to NDPP if eligible.
Further communications to practices promoting NDPP are planned for early 2019 with the intention of increasing referrals.

If referrals in Q4 remain low, the CCG may require practices to directly contact eligible patients to request consent to make a NDPP referral as the current process of searches and invitations relies on patients taking action.

Integration

- The aim of integration is to improve services for citizens; making the experience more seamless and joined up. There is also the aspiration that integration produces efficiencies across the whole Health and care system. There has been a strong emphasis on Social care supporting the acute NHS system and driving down bed blocking or Delayed Transfer of Care (DTOC’s). Some of the resources that have come to Council’s have been directly linked to reducing DTOC’s.
- The NHS Long Term Plan (LTP) continues this trend and proposes more integration between Council’s and the NHS. The current push is toward the development of Integrated Care systems.
- This is NHS England’s description of integrated Care Systems:
  - “NHS organisations and local councils in England are joining forces to coordinate services around the whole needs of each person. Their aim is that people can live healthier lives and get the care and treatment they need, in the right place, at the right time.”

Integrated care systems - Discharge to access (Duncan house)

- Greenwich’s Discharge to Assess unit, jointly commissioned by Greenwich CCG and Royal Borough of Greenwich (RBG,) was opened in Duncan House, in January 2018. The aims of this unit are:
  - Support Lewisham and Greenwich NHS Trust (L&GT) to reduce DTOCs and excess bed days.
  - To facilitate an environment where more accurate assessments of long term care needs can be made.
  - To reduce projected dependence, and subsequently expenditure, on higher-level care services (e.g. care home placements and large packages of care at home) through earlier intervention, and allowing sufficient time for recuperation and convalescence following prolonged hospital admissions.
- It has very high satisfaction ratings, with 93% of residents saying that they would recommend it.
- It has improved the performance of Greenwich CCG and RBG, by helping to reduce DTOCs significantly, and saving 5230 bed days so far.
- 22 people (25%) were discharged with a lower level of care than was anticipated on admission, and 55 (63%) achieved their discharge anticipated goals. Just 10 patients (11%) left Duncan house needing more care than was originally anticipated.
- The reduction in care needs has resulted in savings for the system, which have been estimated at £462k per year. If these savings are netted against the cost of running Duncan House it would give a net cost of £730 per bed per week, which is comparable to placing people in a nursing home without the likelihood of the individual improvements or the ability to live independently.

Budgets and costs.

- Adult Social care budgets are a matter of national as well as local interest. The extra funding for the NHS that is linked to the NHS LTP has not yet been matched by a long term settlement for Adult
Social Care. The Local Government Association estimates that the Social care funding gap will be £3.5 Billion by 2025. Currently around £21 Billion is spent on Adult Social Care in England.

- Extra resources have been made available to ASC since 2014 through the Social care precepts and the various iterations of the Better Care Fund, The Council’s ASC spend is under significant pressure.
- The financial position of Adult Social care is reported as part of the Council’s revenue budget monitor. The most recent report went to the Council’s Cabinet on 20th Feb 2019.

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 was 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 3 data is not yet available. 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 13th 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.

Key Service Updates

Safeguarding

- November 2018 marked the Royal Borough’s Inaugural Adult Safeguarding Month and featured 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 included fire safety, rogue traders, introductions to adult safeguarding and deprivation of Liberty Safeguards.
- Events were run for both professionals and members of the public, including service users. Safeguarding Month culminated with the Greenwich Safeguarding Adults Board Annual Conference on 28th November at Charlton Athletic, where this year’s theme was Domestic Violence.

Greenwich comes top in London for good food

- The Royal Borough of Greenwich has topped the Good Food for London league table for the second consecutive year, highlighting its commitment to helping residents eat healthily and combat poor nutrition.
- Good Food for London charts the progress made by London’s 33 boroughs in making London’s food system healthier and more sustainable.
• Royal Greenwich is one of only half of councils to be an accredited Living Wage employer and to have Fairtrade status.
• Many local organisations and businesses in the borough are part of initiatives such as the Good Food in Greenwich network, the Greenwich Sugar Smart pledge scheme, the Healthier Catering Commitment and Breastfeeding Welcome.

Alcohol Advice Roadshow
• Public Health Greenwich launched an alcohol awareness roadshow.
• The roadshow aims is to help people understand the impact of alcohol and what this means to help stay in control of their drinking and stay healthier longer. People have the opportunity to work out what type of drinker they are, how many units they consume and how that might impact upon their health.
• The roadshows are run at locations across the borough including: Thamesmead (Morrisons), Chartlon (ASDA), Eltham (Passey Place), Woolwich Market, and General Gordon Square.

Transformation
• The Adults Transformation Board was set up in May 2016 to support the Transformation of Adult Social Care in Greenwich. It is a multi-agency partnership which provides leadership to the Adult Transformation Programme. The Director, chairs the Board, other DMT members attend and key partners involved include Oxleas, CCG, Finance, HR, Healthwatch and GAVS. The Board has oversight of the development of the Adults Transformation Programme and will respond to emerging priorities and escalations.
• Transformation has been designed to deliver; greater user voice, increased focus on prevention, working closer with partners, improving customer experience, financial efficiencies and more sustainable models.
<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>Not available</td>
<td>7400 (Q1 18/19)</td>
<td>7751</td>
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<tr>
<td></td>
<td>Delayed Transfer of Care (bed days) per 100,001</td>
<td>577 (Q3)</td>
<td>891 (Q2)</td>
<td>1140</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Live Well Greenwich Line total contacts</td>
<td>6796 (Q3)</td>
<td>5949 (Q2)</td>
<td>7400</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>(Q3 Cumulative)</td>
<td>(Q2 Cumulative)</td>
<td>386 (18/19)</td>
<td>49</td>
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<tr>
<td></td>
<td>% of children born at a low birth weight</td>
<td>7.5% (2016)</td>
<td>8.1% (2015)</td>
<td></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>25.7% (17/18)</td>
<td>24.1% (16/17)</td>
<td></td>
<td>21.8% London</td>
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<td></td>
<td>% of overweight or obese children at year 7</td>
<td>40.4% (17/18)</td>
<td>42.7% (16/17)</td>
<td></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% (16/17)</td>
<td>63.0% (2015-16)</td>
<td></td>
<td>55.2% London</td>
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<tr>
<td></td>
<td>A&amp;E Time to treatment (% admitted, transferred or discharged within four hours)</td>
<td>87% (Q3)</td>
<td>89% (Q2 18/19)</td>
<td>95% (National standard) 87.8% (Locally agreed target)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Left department before being seen for treatment rate</td>
<td>2.8% (Q2 18/19)</td>
<td>2.2% (Q1 18/19)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>% of Hub Utilisation</td>
<td>80.5% (Q3)</td>
<td>55.1% (Q2)</td>
<td></td>
<td></td>
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<tr>
<td>Safeguarding</td>
<td>Number of safeguarding concerns recorded in Qtr</td>
<td>227 (Q3 18/19)</td>
<td>227 (Q2 18/19)</td>
<td></td>
<td></td>
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<td></td>
<td>Number of safeguarding enquiries completed in Qtr</td>
<td>45 (Q3 18/19)</td>
<td>67 (Q2 18/19)</td>
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<tr>
<td></td>
<td>% of Concerns from BME/White ethnicity in Qtr</td>
<td>18% (Q3 18/19)</td>
<td>13% (Q2 18/19)</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>87% (Q3)</td>
<td>89% (Q2 18/19)</td>
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<td>80.5% (Q3)</td>
<td>55.1% (Q2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Independence &amp; Community Resilience</td>
<td>Admissions to 24h care</td>
<td>155 (Q3 Cumulative)</td>
<td>103 (Q2 Cumulative)</td>
<td>217</td>
<td>London Average</td>
</tr>
<tr>
<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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<tr>
<td></td>
<td>% of community contacts leading to full assessment</td>
<td>21% (Q3 Cumulative)</td>
<td>21% (Q2 Cumulative)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>% of comprehensive assessments with an outcome of services</td>
<td>Not available</td>
<td>Not available</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>% leading to community based services</td>
<td>88% (Q3 Cumulative)</td>
<td>88% (Q2 Cumulative)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>% leading to res/nursing placement</td>
<td>7% (Q3 Cumulative)</td>
<td>6% (Q2 Cumulative)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Number of people provided with OT equipment with no other long term care packages</td>
<td>69% (Q3 Cumulative)</td>
<td>69% (Q2 Cumulative)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Analysis

Project Updates

Adult Customer Journey (ACJ)
• The main purpose of the Adult Customer journey is to improve the customer journey, service efficiency and reduce duplication of process through the reorganisation of adult social care in the Royal Borough of Greenwich.

Background:
• The ACJ Project began in July 2016. A series of events over 18 months has been held to share the “as-is” and receive feedback from service users, staff and stakeholders. Following consultation, a series of change management processes are being implemented, in liaison with the Union, staff, HR, Finance, facilities management, Oxleas, CCG.LGT and other stakeholders.
• The consultation led to a consensus view on key areas that required focussed attention and improvement:
  1. Systems and processes: Current systems were deemed cumbersome, complicated and repetitive assessment forms and administration processes involved too many handovers of service users.
  2. Learning from experience: Staff wanted to be empowered to make decisions and enhance practitioner knowledge and incorporate lessons learned from previous organisational changes/approaches.
  3. Communications: Ensuring better communications is needed both internally and externally and clearer communication is needed with users and carers regarding pathways.
  4. Adult Customer Journey launched in January. Key deliverables included:
     - Three service areas and eight teams with health and Social Care teams being co-located.
     - Staffing restructure complete – 90% of people were given their first choice of role (the remainder got their second)
     - IT and change infrastructure being implemented
     - Workforce development plan includes generic and team specific training.
     - New performance measures developed with service user input.
     - Ongoing review of new pathways and processes to ensure smooth transition with a formal review at 6 months

LD Integrated Customer Journey
• The LD Integrated Customer Journey aims to ensure that people with Learning Disabilities who need social services support have a good experience when they are in contact with the CLDT Team, in developing a seamless journey.
• It is also aimed at ensuring that people experience health and social care outcomes in line with the wider general population. Both RBG and Oxleas recognise that a more co-ordinated approach in delivering their services to people with learning disabilities is best served by developing a fully integrated model of care for people with learning disabilities.

ITEM NO: 9 (Appendix A)
The Customer Journey has been designed to: re-organise the Community Learning Disability Team (CLDT) to meet the identified needs while promoting independence and choice for those needing support. A clear care co-ordination framework is integral to making this work and expected to deliver:

- Cost effective services for people with a learning disability and their carers to promote good health, independence, choice, control and wellbeing in their lives.
- One integrated assessment process, one principal identified worker, one care plan and one review process including joint documentation, commonly agreed aligned eligibility criteria and an integrated IT solution to enable access to seamless information.
- CLDT are replacing the current arrangements of Fast and Long-term teams with a Single Point of Access (SPA) and two fully inter-disciplinary Functional teams that include specialist health and social care professionals who have developed expertise in Mental Health and Challenging Behaviour and Complex Physical Health. The Single Point of Access (SPA) Team will coordinate access to these services.
- A functional Team developed for young people, Preparing for Adulthood, previously known as Transition Services has its own panel which means there will be no need to go through the SPA as the panel will determine, with the appropriate functional team manager, where the young person should be referred.

LD Housing Strategy
- The LD Housing Strategy addresses two key challenges facing RBG in the provision of accommodation-based services for people with a learning disability. Much of the existing housing in which RBG accommodates people is not considered fit for purpose. There is a lack of capacity to accommodate people in the borough. Golden Lane has been appointed to support RBG on the delivery of the new offer.
- Currently, the combined, average unit cost of Greenwich Living Options and the Learning Disability Accommodation block contract is £81,000, a total spend of approximately £10million a year to accommodate 125 people.
- The council has chosen a partner to deliver specific objectives; this partnership arrangement is in three distinct phases.
  - Phase 1-The selection of our preferred partner (completed).
  - Phase 2 –Collaboration with our partner to identify our priorities, consult with service users and families, develop our delivery plans and publish our formal strategy (completed).
  - Phase 3-The delivery of housing solutions. The final phase will be broken up into separate projects, each of which will require appropriate procurement processes to select developers etc. Our preferred partner may have a role in the actual delivery of people’s housing solutions but their primary role will be in project managing the delivery of our strategy.

LD Day Opportunities
- LD Day Opportunities seeks to address the issues around service users with learning disabilities making use of the Day Opportunities services available within the borough; and to ensure the service supports the current need for outcomes focused, person centred services. Reasons for transformation include: not accessing enough community options, traditional elements still being in place, ineffective joined up working and traditional transport being costly.

ITEM NO: 9 (Appendix A)
The outline for the project
- October 2016 - Communication and Engagement Strategy
- Dec 2016 - April 2017 - Engagement process
- May 2017 - DMT Options Paper
- June- September – Engagement continues
- November 2017 - DMT Pilot proposal paper
- January - October 2018 - Pilot completed
- November 2018 - DMT Pilot update and Phase 2 paper
- January 2019 – Phase 2 Commences