1. Purpose
The NHS is required to make £20 billion of QIPP efficiency savings by 2014/15 due to increasing demand for services. Lewisham Clinical Commissioning Group (LCCG) has begun the process of identifying a number of ways we can improve the quality of services through innovation, greater productivity and prevention (QIPP) using an integrated approach – whilst acknowledging the financial limitations.

The purpose of this briefing paper is to provide the Healthier Communities Select Committee with an overview of the following areas;

- QIPP 2012/13 Successes
- The CCGs Strategic Framework 2013/14
- Headline QIPP 2013/14 plans
- Future planning processes to incorporate the NHS SEL Community Based Care Strategy

It is our view that Lewisham CCG has made significant progress in improving care and the quality of services for patients and productivity in 2012/13 saving £9.8m in the process.

Our aim is to continue to build on the progress to date and work with patients, the public and our partners in the wider local health economy to improve health outcomes for our community.

2. Recommendations
Members of the Healthier Communities Select Committee are recommended to note the achievements and challenges in delivering the QIPP programme in 2012/13, the plans for 2013/14 and the CCGs intention to provide details of its strategic approach to the SEL Community Based Care Strategy.

3. Context
National
The Health and Social Care Act (2011) will see Lewisham PCT close in April 2013 and the Lewisham Clinical Commissioning Group (LCCG) – led by our local GPs take over responsibility for planning and commissioning local healthcare services. Remaining PCT functions will transfer to the new NHS Commissioning Board, other NHS bodies, and the local authority.
The NHS Outcomes Framework 2013/14 underpinned by The White Paper: Liberating the NHS moves the focus to delivering and measuring improved outcomes for patients. Consequently, focussing on outcomes is integral to our strategic framework and plans for 2013/14.

**Local**
In Lewisham demand for healthcare services are increasing driven by population growth, demographic changes, advances in health technologies and drug therapies that help with health problems. As the Healthier Communities Select Committee (HCSC) is aware, Lewisham is amongst the 31st most deprived borough in England – about 18,300 children live in poverty. It has a lower life expectancy than England for both men and women. Early death rates from cancer and from heart disease and stroke have fallen but remain worse than the England average.

The increased health risk factors (obesity, smoking, alcohol consumption) also continue to drive demand for services.

It is against this backdrop that our future plans are based.

4. **QIPP 2012/13 Successes**

The 2012/13 QIPP programme focussed on increasing the level of integrated services and ensuring that services were accessible and met the health needs of local people. The Lewisham Clinical Commissioning Governing Body receives a monthly performance report on QIPP at all meetings, including those held in public. In addition, through the CCG’s new governance structure a review of the performance of schemes takes place.

4.1. **COPD Pathway:** This programme has been one of the truly ‘integrated’ successes for both Lewisham CCG and Lewisham Healthcare NHS Trust – encompassing primary, secondary and community care. The steering group supported by the Director of Public Health and the Lead CCG Clinical Director and senior consultants through a series of initiatives including; the introduction of a key workers in all GP practices for patients with COPD, a consistent and well developed education programme (competency framework) to support key workers, investments in early supported discharge capacity and triaging of all referrals to support the pathway.

In 2012/13 emergency admissions related to COPD reduced by 22% (Year to date) in comparison to 2011/12. Early review of the available Secondary User Service (SUS) data suggests that the reduction in emergency admissions have specifically been for patients over 65 years. In addition, there is an indication that the COPD programme has also positively impacted on reducing emergency admissions for other respiratory conditions across all providers.

For patients this has meant a single point of access, a bespoke package of care for their condition and being treated in the most appropriate care setting.

4.2. **Diabetes – Improving Care:** In 2012 Lewisham CCG established a multi-disciplinary taskforce from the local health economy. The taskforce developed the strategy for improving care for people with diabetes in Lewisham. There are a number of work streams and implementation plans have been developed with many being realised in 2013/14. However, the programme got off to an excellent start in 2012 with its first phase of ‘getting basic right’, which centres on improving care in primary care to enable patients to feel better supported in managing their own condition. The vision and strategy were developed in consultation with wider health economy, patients and the public.
4.3. **Heart Failure Pathway:** A new pathway for Heart Failure was developed by a joint steering group with Lewisham Healthcare NHS Trust and Lewisham CCG. The pathway was supported by investments made by Lewisham CCG for a dedicated multidisciplinary team. The development of the pathway was a direct response to an increase in the number of emergency admissions and readmissions for patients with this condition.

4.4. **MSK Pathway:** A single point of access was developed in partnership with clinicians from Lewisham Healthcare NHS Trust and Lewisham CCG for all MSK referrals and the revised pathway went live in April 2012. Referrals are triaged to the most appropriate service.

4.5. **Telehealth Pilot:** The Lewisham CCG in partnership with Lewisham Healthcare NHS Trust completed a 12 month pilot funded by the CCG. This innovative technology enabled 100 patients with COPD and Heart Failure to better self-manage their conditions by providing them with monitoring devices in their own home. The pilot involved community matrons and GPs working together to support patients. An evaluation of the pilot is currently being conducted by Public Health. It is envisaged that the outcomes of the evaluation will inform future commissioning intentions.

4.6. **Proactive Primary Care:** Lewisham CCG completed a Proactive Primary Care feasibility study in 2012 with a local GP practice. Proactive Primary Care is essentially the use of routine telephone call follow-up with patients using motivational interviewing techniques. The concept is to support patients to self-manage through regular telephone contact initiated by the local GP practice. Lewisham CCG’s feasibility study focussed on 70 patients with co-morbidities aged between 45 and 65 years and was evaluated with the support of the London School of Economics.

4.7. **Urgent Care:** Worked continued on refining the Urgent Care Centre, which is delivered in partnership with Lewisham Healthcare NHS Trust by local GPs located in the centre. In July 2012 our evaluation of the centre, which included user and staff feedback showed that patients were confident in the service, were seen by the most appropriate person and that many were aware of the Choose Well Campaign.

4.8. **Mental Health:** Reconfiguration of Mental Health of Older Adults (MHOA) Continuing Healthcare with the closure of Granville Park. Over £800k reinvested back into MHOA services. Continuation of the Lewisham forensic triage model for those requiring a hospital admission from prison. This has saved over £1.3m from commissioning budgets and diverted over 75% of people away from medium secure services. This therefore ensures that people are in the right place from both a clinical and risk perspective. Reduction in Adult Mental Health complex residential placements to ensure that people are in the right place at the right time via regular clinical review. Part year savings have been recouped by the reconfiguration of the Adult Mental Health Communities Opportunities Service (COS) in 2011/12. This has ensured that people are provided with Individual Budgets to use in the voluntary sector to support them to increase their wellbeing. Reduction in Adult Mental Health specialist activity through referral management and review of high cost placements.

4.9. **Medicines Management:** In 2012/13 the Lewisham CCG and Lewisham Healthcare NHS Trust medicines management and prescribing teams were successful in their collaborative approach in delivering a number QIPP schemes, which focussed on reducing expenditure in prescribing by utilising the clinical specialist knowledge of
primary and secondary care and the procurement advantages and formulary controls of secondary care.

4.10. **End of Life Care**: End of Life CQUINs (Commissioning for Quality and Innovation) were agreed with Lewisham Healthcare around three specific areas: (1) Identification and registration of EoLC patients; (2) Communication and (3) Implementation of the Liverpool Care Pathway.

Processes and protocols to guide Community Nurses on the inclusion of patients on the End of Life Register have been developed and targets have been met for the number of nurses attending training on the Gold Standard Framework and Liverpool Care Pathway.

Data from the current End of Life Care Electronic Register has been migrated to the new system “Coordinate My Care”. (CMC) (February 2013). This system will be able to share information with all care providers including 111, LAS and OOH.

The PEACE (Proactive Elderly Care Planning) document has been piloted on elderly care wards at UHL for patients being discharged to nursing homes who are likely to die within the next 12 months.

Following the success of the pilot with two Residential homes in 2010/11, St Christopher’s has been engaged to facilitate a programme aimed at improving Palliative care in care homes. All 9 Residential Care Homes (RCHs) in Lewisham have passed the “Steps to Success” RCH programme for end of life care, and number of residents enabled to die in the home (as opposed to hospital) has significantly increased.

4.11. **Financial Challenge**

Lewisham CCG met its QIPP challenge of efficiency savings totalling 9.8m as outlined in the table below:

<table>
<thead>
<tr>
<th>Schemes</th>
<th>Savings £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long Term Conditions</td>
<td>(932)</td>
</tr>
<tr>
<td>Urgent Care and Unplanned Care</td>
<td>(1,658)</td>
</tr>
<tr>
<td>Integration of services with LHNT and sustainable locally accessible services</td>
<td>(810)</td>
</tr>
<tr>
<td>Acute Productivity and Efficiency</td>
<td>(3,131)</td>
</tr>
<tr>
<td>Mental Health</td>
<td>(1,350)</td>
</tr>
<tr>
<td>Overhead Efficiency</td>
<td>(200)</td>
</tr>
<tr>
<td>Prescribing and Primary Care</td>
<td>(1,738)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>(9,819)</strong></td>
</tr>
</tbody>
</table>

5. **Strategic Framework 2013/14**

Lewisham CCG’s strategic framework encompasses the organisation’s mission, desired outcomes, clinical priority areas, and enabling work streams, which is underpinned by the vision developed in 2012. The framework has been developed as a part of the NHS Commissioning Boards (NHSCB) planning process.
5.1. Mission

The overall purpose of the organisation is described in the CCG’s constitution and summarised as:

- To improve health and reduce inequalities
- To commission highest quality health services
- To ensure good governance and proper stewardship of public resources

5.2. Improved Outcomes: Better Health

The CCG will be assessing its improvement against the NHS Outcomes Framework for 2013-14. This contains indicators and improvement areas that are grouped into five domains that focus on improving health and reducing health inequalities:

- **Domain 1**: Preventing people from dying prematurely
- **Domain 2**: Enhancing quality of life for people with long term conditions
- **Domain 3**: Helping people to recover from episodes of ill health or following injury
- **Domain 4**: Ensuring that people have a positive experience of care
- **Domain 5**: Treating and caring for people in a safe environment and protecting them from avoidable harm

Additionally the CCG has identified three particular outcome measures that reflect local priority needs:

<table>
<thead>
<tr>
<th>No.</th>
<th>Area</th>
<th>Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Alcohol</td>
<td>Reduction in the rate of hospital admissions per 100,000 for alcohol attributable harm</td>
</tr>
<tr>
<td>2</td>
<td>Smoking</td>
<td>Increase the number of smoking cessation quits</td>
</tr>
<tr>
<td>3</td>
<td>Long-term conditions</td>
<td>Increase the proportion of people feeling supported to manage their long term condition</td>
</tr>
</tbody>
</table>

5.3. Clinical Priorities: Best Care

Reflecting the findings of the Joint Strategic Needs Assessment (JSNA) and alignment with the Health and Wellbeing Board’s nine priorities, three strategic clinical areas have been identified: healthy living for all, the frail and vulnerable elderly (including end of life care), and people with long term conditions. The clinical areas provide the framework for our 2013/14 QIPP programme.

<table>
<thead>
<tr>
<th>HEALTH &amp; WELL BEING BOARD</th>
<th>LCCGs CLINICAL PRIORITIES 2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Reduce uptake of smoking among Children &amp; Young People</td>
<td>1. Healthy Living</td>
</tr>
<tr>
<td>2. Reduced harm caused by alcohol</td>
<td>• Smoking</td>
</tr>
<tr>
<td>3. Promote Healthy Weight</td>
<td>• Alcohol</td>
</tr>
<tr>
<td>4. Increase uptake of immunisation</td>
<td>• Obesity</td>
</tr>
<tr>
<td>5. Improve mental health, well being &amp; prevention</td>
<td>• Children under 5 including immunisation</td>
</tr>
<tr>
<td>6. Improve sexual health</td>
<td>• Mental Health promotion</td>
</tr>
<tr>
<td></td>
<td>• Sexual health</td>
</tr>
</tbody>
</table>
7. Increase number of people who survive colorectal, breast & lung cancer
6. Delay & reduce need for long term care and support
9. Reduce number of emergency admissions with long term conditions

5.4. Enablers
Successful delivery of the service transformation plans and achievement of the outcome measures will be dependent on a number of enabling areas, which for 2013-14 will focus on:

- Collaboration with other CCGs
- Workforce development, particularly in primary and community care
- Self management: increasing the confidence and capability of people with long-term conditions
- Information and infrastructure, for instance for shared records and a single point of access
- Contractual levers, such as risk sharing and incentivising continuous improvement in quality
6. QIPP 2013/14

The challenges for 2013/14 will particularly see the CCG focussing its attention on reducing the number of inappropriate emergency admissions for those with long-term conditions, reducing readmissions and the length of stay for the frail and elderly, A&E attendances, and GP outpatient referrals.

The QIPP challenge this year will underpin the clinical priorities as set out in the CCGs Strategic Framework and the 9 priorities of the Health & Wellbeing Board.

Our programme will build on our work to continue to integrate our health delivery models and provide the vehicle for all health care professionals to begin to have joined up considerations about patient care with each other and more importantly with patients by sharing information. For patients this will facilitate being at the centre of their care and having the right care at the right time in right place.

6.1. Long Term Conditions (LTCs)

Care Plans for all patients with LTCs: The evidence base suggests that better outcomes for people with long term conditions can be achieved when there is partnership working between an ‘engaged’, ‘empowered’ or ‘activated patient’ and an organised proactive health care system.

Care Planning is a process which offers people active involvement in deciding, agreeing and owning how their condition will be managed. It is underpinned by the principles of patient-centredness and partnership working. It is an on-going process of two-way communication, negotiation and joint decision-making in which both the person with an LTC and the health care professionals make an equal contribution to the consultation.

Lewisham CCG recognises that in order to realise the full potential and benefits to patients in enabling them to self-manage their condition that an integrated approach across the wider health economy to delivering care plans is fundamental. Specifically, in the context of the 2012 White Paper – Caring for our future: Reforming Care & Support where measures are aimed at the integration of health and social care, including the sharing of information across organisational and professional boundaries in support of integrated services. Consequently, the CCG held its first taskforce in February 2013 with representation from the wider health economy on delivering care plans for patients with LTCs. One of the key outcomes from the taskforce was to commence delivering care plans for patients with Diabetes. However, it is recognised that a number of patients will have multiple long term conditions.

Risk Stratification in Primary Care: The use of risk stratification is one of the key platforms for our approach to integrated care in order to deliver improved outcomes for patients. It focuses on ensuring that commissioners understand the needs of their population. There are a variety of risk prediction tools available however the basic principle is to identify patients at risk of having unplanned hospital admissions enabling the supporting of individuals at the highest risk, with preventive care interventions and more importantly promote proactive condition management and self-management.

Risk stratification can also be employed to assess the future healthcare needs of a population, and therefore can inform the planning of healthcare services in collaboration with Joint Strategic Needs Assessments (JSNA).
**Improving care for people with Diabetes:** In 2013/14 Lewisham CCG will commence full implementation of its Diabetes Strategy developed in partnership with the local health economy, patients and the public in 2012. The programme for improvement has five core work streams;

1. **Empowered patients at the centre of care:** which includes improved access to education and information via increased access to DESMOND for patients. The implementation of collaborative Care Plans for all people with Diabetes as referenced earlier. The roll out of the Community Champions Programme aimed at the BAME community with support from Diabetes UK. Diabetes Patient Focus Group will be launched in March.

2. **Equitable access to high quality diabetes care across all providers:** which includes the rollout of the standardised implementation of the 3Rs (Register, Review & Recall) in primary care.

3. **Finding the undiagnosed and reducing poor outcomes associated with delay detection:** It is envisaged that the implementation of Risk Stratification will support this work stream.

4. **Right person, right place, right time:** Development of an integrated model of care. A process mapping event took place in January 2013 for Lewisham health professions led by NHS Diabetes to identifying the gaps in moving towards integration.

5. **Diabetes care is high quality, value for money and affordable:** which includes a review of the referral triage implemented in 2012.

**COPD:** The work of the COPD Steering group has proved that joint efforts in primary, secondary and community care can produce reductions in emergency admissions, improved quality of care and ensuring that patients get the right care in the right place. The programme of work for 2013/14 will continue focusing on the following areas; Opportunistic Screening – Developing an annual programme of events to capture the ‘working well’ to include a process for integrated follow-up with primary care once diagnosis is complete via the screening programme. Education and training for primary care and the implementation of care plans for patients with LTCs.

**6.2. Frail Elderly**

Lewisham CCG held its first taskforce on the Frail Elderly in February 2013, which was attended by the representatives from secondary, primary, social and community care. One of the key outcomes from this initial taskforce was that collectively all agencies needed to better understand the wealth of initiatives taking place to support the Frail Elderly and how in partnership could build on and improve the inter and co-dependent work streams. In addition, that Public Health would be producing a JSNA on the Frail Elderly to support better understanding of our population and their needs. It is also envisaged that our proposals to implement care plans for all LTCs will have a positive impact for the Frail Elderly.

**6.3. End of Life Care**

An End of Life Strategic Group has been established and is chaired by the Lewisham CCG Clinical Director with lead responsibility for this work stream. This will support the involvement of the CCG Clinical Directors in setting targets and monitoring the performance of all providers (health, social care and the voluntary sector) involved in the end of life care pathway.

Funding has been obtained from the National End of Life Programme for some work using their “Commissioning Tool Kit” for a short audit on end of life patient’s place of death as well as some patient/carer and stakeholder engagement events.
A bid has been submitted to Macmillan Cancer Care for an End of Life Practitioner post (2 years) which offers an opportunity for Lewisham to benefit from a Specialist Nurse with experience of clinical service, strategic whole system approach, system redesign, motivational change management, peer support, mentoring and education and use of patient and carer feedback.

Training provided in 2012 to senior Social Care staff (via St Christopher’s) will be cascaded throughout social care teams.

A Lewisham Incentive Scheme (LIS) is being developed to encourage GPs to sign up to Co-ordinate My Care and use the Register appropriately to identify record and coordinate care for end of life patients at a neighbourhood level.

The one year pilot of the Overnight District Nursing Service will be evaluated to ensure it met the needs of end of life patients and decide if this should be re-commissioned on a permanent basis.

6.4. Healthy Living
Lewisham CCG will consider how it contributes to the Local Authority health outcomes as outlined in the Health Well Being Board priorities. The CCG has already commenced contributing to this agenda by supporting primary care to fully engage in the joint Healthy Living outcomes. E.g. In 2012/13 Lewisham CCG developed a Lewisham Incentive Scheme (LIS) to enable local practices to support people to quit smoking. It is our plan to roll this scheme into 2013/14.

6.5. Mental Health
To continue with the schemes started in 2011/12 to tackle high benchmarked programme budget for mental health and improve the involvement of primary care.

There will be a significant focus in 2013/14 onwards to provide appropriate referral routes and ensure people are receiving the right services at the right time that appropriately meet their needs. This complements both the long term conditions and healthy living programmes as it is assessed that 40% of tobacco use is by people with mental health conditions.

6.6. Medicines Management
Following on from the successful collaborative work in 2012/13 the Lewisham CCG medicines management and the pharmacy teams at the Lewisham Healthcare NHS Trust have developed outline plans to cover a 2 year QIPP of further areas of shared work. The programme should further support across the health economy an overall improvement to the quality of medicine management (prescribing by the clinicians, and supporting patients to take their medicine), coupled with overall effective control on medicine expenditure for our population.

6.7. Proactive Primary Care Pilot
In 2013 Lewisham CCG successfully bid for and was awarded £150K from the NHS London Primary Care Innovation Fund as result of our earlier transformational feasibility study. The pilot will be rolled out in one of our neighbourhoods, with go live scheduled for summer 2013.

6.8. Urgent Care
Lewisham CCG will be reviewing how it provides Urgent Care in light of the NHS SEL Community Care Based Strategy (see section 8). A pilot commenced this year to increase the availability of urgent care appointments in primary care with funding awarded from NHS London and 39 local practices have signed up to the scheme. Lewisham CCG in partnership with Lewisham Healthcare NHS Trust are developing a See, Assess, Redirect or Treat (SART) Pilot, which is likely to be provided by primary care located in the UCC. The pilot is scheduled to commence in May 2013.
The National 111/DOS (Directory of Service) is scheduled to go live in March 2013. Lewisham CCG will be facilitating the development an A&E Forum for high users, which is a multi-disciplinary group reviewing high users of A&E with input from social services. Thames reach Project: Pilot underway across 3 practices in Neighbourhood 2 reviewing top 10 users of A&E, which is funded until September 2013. A Thames reach support worker provides intense 1 to 1 engagement/support to patients. Lewisham CCG will be reviewing the pilot in 2013 in order to inform future commissioning intentions.

6.9. Financial Challenge
The Lewisham CCG embraces the concept of QIPP in that it provides a well rehearsed framework to consider transformational change to deliver improvements in the quality of care received by our community. It reducing costs by making efficiency savings – reinvestments can made in our front line services. However, conversely there is a financial challenge and our QIPP financial target for 2013/14 is 12m. Further confirmation of the underlying components supporting this figure is currently the subject of the acute contracting rounds/negotiations for 2013/14. This is due to be finalised in the line with the commissioning cycle by 31st March 2013 with all providers when contracts are expected to be signed.

6.10. Integration of services between Lewisham Healthcare NHS Trust, Social Care and Primary Care
The work with partners to develop more integrated services continues, and is perhaps best demonstrated by the joint decisions taken through the Whole Systems Group, where reablement and readmissions resources have been used to pilot and establish a range of new services or facilitate significant change within existing services. The most significant example of this has been the work around a revised COPD pathway, with investment in primary and community services. Similar approaches have been adopted for Heart Failure and Diabetes.

The Joint Service Redesign Group, which involves senior level discussion between Lewisham Healthcare NHS Trust and Lewisham CCG has continued to meet to identify the main themes going forwards, including issues around the TSA Recommendations.

The main focus of investigation continues to be the exploration of service developments which are in the interest of Lewisham residents and the Lewisham health economy, specifically around implementing pathway redesign, where specialist centres can be used effectively. Specific examples of this work include:

- Neurology – the development of a pathway to allow GP direct access to MRI for patients with headaches, which will be implemented from the 1 April
- Medicines management – a range of opportunities have been taken forward where the Lewisham Healthcare NHS Trust and the CCG have been able to identify service efficiencies, which have contributed to reductions in costs

During 2012/13 a number of services have commenced providing Lewisham residents better local access, these include:

- Dexa Scanning
- Level 3 GUM
- Early Medical Abortions
- Local Cancer: Oncology service and access to chemotherapy
A number of service opportunities were not realised in 2012/13 and therefore have been rolled forward into 2013/14, with discussions under way on an implementation date in year. These include;

- Community Lymphoedema Services
- Cardiology Testing: prospectively a shift of activity away from KCH to local provision

6.11. Acute Productivity and Efficiency Thresholds

Each year a range of productivity and efficiency indicators are agreed with providers. Though there is a common suite of indicators impact at different providers varies because they depend on past performance. At present the indicators under discussion include;

- Appropriate levels of emergency admissions compared to people attending A&E.
- An appropriate level of hospital appointments relating to the patient’s condition with the right level of follow up and consultant to consultant referrals.
- Reviews of acute prescribing and drugs and devices expenditure.
- Appropriate lengths of stay on admission to hospital.
- With advanced technology ensure that treatments take place in the best setting, particularly the balance of day case and outpatient procedures.

7. Patient and Public Involvement

Lewisham CCG has continued to build on its engagement and outreach programme to ensure that patients, the public are involved in designing and delivering health services for our population. In 2012 the CCG held a series of engagement events with patients, carers, the public and key stakeholders in developing its programme to improve care for people with diabetes in our community and in development of the CCGs Strategic Framework.

In 2013/14 Lewisham CCG will be reviewing in partnership with patients how it develops its strategy for ensuring that we involve patients and the public in improving the quality of care that we deliver.

**Improving Diabetes Care:** In developing its strategy and implementation plans Lewisham CCG held two events in 2012 for health professionals and key stakeholders and for patients their carers and the public. The summary report of the events and outcomes is located in Appendix A.

**Shaping Your Health Services:** On the 31st January 2013 over 50 Lewisham patients, members of the public, carers and local councillors filled the Lewisham Town Hall Civic Suite. The engagement event was to enable discussions on the CCGs Integrated Plan to improve services and patients health in 2013/14.

The plans were based on an extensive outreach programme in 2012, which utilised the ‘Have Your Say’ patient survey – presenting the outcomes across the borough; asking patients about what they do and don’t value in their health service. Patient’s feedback was collated and fed directly into Lewisham’s Integrated Plan.

The purpose of the PPI event held on the 31st January 2013 was to consult on 3 key themes;
1. To complete the engagement cycle by ensuring that we feedback on what patients heard, how the CCG listened and how patients feedback influenced the plans.
2. Check we heard it correctly and patients were happy with the priorities we have set.
3. Ask patients their thoughts on rolling the plans out, considering good practice, expectations and barriers.

People attending the event were a good reflection of our diverse population and involved some key representatives of patients that otherwise find it difficult to be involved E.g. people with learning disabilities and stroke patients.

The outcome was that patients and the public reaffirmed their support for our strategic framework and intentions and their involvement in how we embed this process in our ongoing patient involvement programme to deliver, plan and improve services.

8. The SEL Community Based Care Strategy

The Community Based Care Strategy (CBC) is a part of the TSA recommendations and outlines a 5 year plan for commissioning care in South East London. The strategy is underpinned by 5 strategic goals and key aspirations that will enable commissioners to ensure a consistent standard of care across the whole of SEL.

The six SEL CCGs have worked together through a number of workshops aligning their aspirations against the delivery of the strategic goals, which focuses on 3 main areas; 1. Primary and Community Care, 2. Integrated Care and 3. Planned Care. How these services are delivered across SEL will require a change in the way services are currently provided and commissioners will be required to deliver the aspirations as outlined in the CBC Strategy.

Lewisham CCG will be proactively and robustly defining its strategic approach over the coming weeks and months on developing heath and community care models in the new landscape. Our strategic approach will be to develop plans for urgent care, maternity and paediatric services.

It is our aim to develop our plans in partnership with the wider local health economy, patients and the public to deliver the strategic goals of the CBC. More so it is also our intention as a part of the process to engage with the Healthier Communities Select Committee at the earliest opportunity, which is likely to be by September 2013.