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Healthier Communities Select Committee Supplementary Agenda

Thursday, 12 January 2017
7.00 pm,
Civic Suite
Catford
SE6 4RU

For more information contact: John Bardens (02083149976)

This meeting is an open meeting and all items on the agenda may be audio recorded and/or filmed.

Part 1

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Healthier Communities Select Committee			
Title	Health and adult social care integration – third evidence session		
Contributor	Scrutiny Manager		Item 4
Class	Part 1 (open)	12 January 2017	

1. Overview

As well as the written evidence the committee has already received, the Lewisham Pensioners Forum have also submitted the attached document.

2. Recommendations

The Committee is asked to:

- note the information included in the attached submission
- ask questions of the witnesses giving evidence
- and to consider their responses as part of the review.

If you have any questions, please contact John Bardens (Scrutiny Manager) on 02083149976.

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Who we are

The "Save Our NHS" Group was formed as a working party of the Lewisham Pensioners Forum in 2008 to raise awareness and campaign against the perceived pressures of the internal market and privatisation, as exemplified by the "Picture of Health" initiative and moves to establish Foundation Trusts. We campaigned against the passage of the Health and Social Care Act 2012 through parliament and were a key partner working with the Save Lewisham Hospital Campaign in 2012 to 2013 to counter the threat to healthcare in the borough represented by the TSA proposals. Since that time the SLH campaign has continued vigilant on health matters locally and nationally and the Forum's "Save our NHS" Group has worked with them, serving on committees and working parties and attending Council and CCG meetings with a watching brief and feeding into correspondence generated and questions asked.

The survey/questionnaire

In the late spring of 2016 campaigning groups were aware that the Healthier Communities Select Committee had some hard decisions to make with regard to adult social care and the Forum and the "Save Our NHS" Group hoped to be able to contribute by gathering data on:

- people's support networks – partners, friends and families
- social care needs
- correlation of the above
- whether there is factual basis for the perception that lack of social care packages impacts on the length of stay in hospital.

Two members of the group – with input from others – devised a questionnaire covering these issues. The Forum had 1500 copies printed in September and by the end of that month had distributed them widely to our 300+ individual members, the 600 individuals who received the "information bags" prepared for Pensioners Day and a few copies to 100+ networked groups and organisations working with the elderly. Copies were also given to all Ward Councillors to make them aware of the work and its potential relevance to constituents. All such distribution went out with the double message: to hand the survey on to a friend or neighbour if the questions did not apply to you and that returned surveys would be entered into a prize draw. Further copies have been printed throughout the autumn and given out or taken to any group who asked, and given out to members of the public in the Riverdale Shopping Centre. An on-line version of the survey was also prepared and distributed.

The response has been negligible. Although the on-line survey has been "viewed" 285 times and started nearly 40 times only 27 have been completed – most being the authors of the survey entering the data received from the 25 or so hard copies returned. While these provide one or two interesting anecdotes and examples, and presenting the survey opened up the opportunities referred to below for some in-depth interviewing, such a tiny sample cannot be extrapolated from to provide statistically relevant insight on the matters we hoped to explore and so, regrettably, the Forum's "Save Our NHS" Group cannot provide the exact contribution to the HCSC discussion that had been planned.

What we can do, however, is report on the further research that we carried out, pull together other information on these matters and, highlighted in bold below, indicate the concepts that could usefully be explored and questions perhaps to be answered before the HCSC is fully informed to make its recommendations and the Mayor some difficult decisions.

Further Research

In-depth interviews

We held some in-depth interviews with some of the people who completed our survey and took note of the comments of other older people who had made use of various adult services where people were concerned about what was not working.

The pointers are:

- When the meals-on-wheels service was withdrawn some people were not given any notice so that they could make other arrangements,
- After an operation one lady was told she no longer qualified for a taxi card even though she still had problems getting on some buses.
- Someone who offered to pay for after care in a nursing home following an operation because she altruistically wanted to save the NHS money, was told that if she did that she would not receive any care when she returned home.

Liaison between hospitals over the care of a patient post treatment are not straight forward.

- Patients who are residents of another borough but are registered with a Lewisham GP can find themselves being visited by Lewisham staff which can cost the borough money when previous arrangements had been made by their home borough.
- Any vulnerable person, especially one suffering from dementia, can find that their drugs are going missing.
- Any vulnerable person may find that someone in their family or a caring role can be misusing their funds. There needs to be some advice to help concerned others on how such a situation can be dealt with and who to turn to for help.

Follow up with other agencies in the Borough

Our survey has had a very small response, mainly from ex-carers and people who had a planned hospital admission. Whilst this is valuable we have not been able to contact those currently in receipt of care or those who no longer receive care because of the reduction in the number of packages provided in the borough. Follow up with other agencies in the borough indicates:

- Lunch clubs and social groups are rarely attended by the frailest people (including those in receipt of social care packages) so do not have members who give feedback. Non-attendance may be linked to the difficulty of accessing cheap and reliable transport.
- People in receipt of care tend not to bother with questionnaires and their relatives/unpaid carers are often too occupied with day to day support to give feedback.

The National Statements on the Crisis in Care

We approached both Age UK and the Red Cross.

Age UK gave us access to the data they have compiled from a wide range of sources. Many of the figures we have used in this submission are taken from their factsheet which is updated monthly.

The Red Cross put us in touch with the relatively local group who assist people being discharged from King's College Hospital where about 15% of their referrals are for Lewisham residents.

This group made the following comments in an e-mail exchange:

'This year we have supported 60 patients in Lewisham who were directly discharged from King's College Hospital. Where we are unable to support or may not be the best service for the patients we would always signpost on to a more appropriate service. Our service is also not solely limited to the below and we do help patients to support them to live as independently as possible.

'Supporting patients from hospital to home can often be an unsettling and distressing experience. By providing transportation home, emotional support and practical assistance with activities such as shopping, prescription collection and settling in; the service is designed to reduce the length of time patients spend in acute units and help prevent them from being unnecessarily readmitted to hospital.

'Nationally, we operate more than 160 'home from hospital' and 'support at home' services in the UK and supported over 80,000 people last year. Through this work we have seen first-hand the results of social care cuts; people not taking their medicine or being washed because there is no carer there to help them, people falling and not found for days, family members struggling to help their partner or parent eat, wash, go to the toilet, and get to vital medical appointments.'

They also went on to express their concern about the cut in prevention spending. The British Red Cross produce in-depth reports on what their researches show into the implementation of the Care Act's prevention duty. The report looked at the 3 levels of prevention. They reported Lewisham's response that providing information could not be done merely online. As the Pensioners Forum commented orally at the last meeting of the Committee, too many older people do not have the financial and skills resources to use computers confidently, if at all. Yet it is older people who are most in need of this information.

The Red Cross report highlighted the third level of prevention which focuses on needs such as reablement and found that this is greatly neglected in local authority and Health and Wellbeing Board policies. (*Prevention in Action* report by the British Red Cross, February 2016)

The Forum would invite the Committee to look at the tertiary level of prevention as part of its examination of the borough's care services across all disciplines.

The King's Fund *Home Truths* report

The King's Fund *Home Truths* report (included in the last Healthier Communities Select Committee Public Document Pack) states

The social care system in its current form is struggling to meet the needs of older people. Six consecutive years of cuts to local authority budgets have seen 26 per cent fewer people get help. No one has a full picture of what has happened to older people who are no longer entitled to publicly funded care: the human and financial costs to them and those who care for them are mounting.

The need for a better understanding of the current pressures facing care services and the implications for their future sustainability has never been greater. Yet evidence about the relationship between changes in public spending on social care, the quality and quantity of services and the impact on the health and wellbeing of people who use them is extremely limited. More older people are falling outside the social care system, either because their financial means are too high for publicly funded help or their care needs are not high enough, yet knowledge about what happens to them is limited (Baxter and Glendinning 2014; Institute of Public Care 2012).

Whilst the King's Fund report is national, the findings mirror the Forum's concern that it is difficult to find out what has happened to this group as well as those currently in receipt of care who may also

be impacted by budget reductions in Lewisham and who constitute some of the most vulnerable people. Of particular concern are those who for whatever reason slip under the radar.

If you do not meet the level of assessed need but still have the need for help, you have to pay for your help, find a willing but free helper, depend upon family or neighbours or manage on your own. This hits people who do not qualify for a full state pension. Many women did not work the hours per week or earn enough to reach the level of contribution to pay National Insurance. As 6.5 million pensioners live on less than £11,000 per year and we are one of the poorest boroughs where 26% of children live in poverty, it behoves us to identify how many people will fall into this level of poverty and need. The poorest fifth of single pensioners had median net incomes of £106 a week after meeting housing costs; for couples £233.

This means that many people in this Borough will become much frailer before they can qualify for help. Yet helping these people at the lower level of need would mean that they would need less help in the long term. And because women are often the carers and the survivors they are being discriminated against. We have not seen any equalities impact assessment done on this aspect of the reduction in spending on care.

In surveying our members and talking to other pensioner groups, we have found it difficult to easily contact people who face these difficulties. They become excluded from many community activities that would otherwise keep them in contact because so many groups have had to begin charging for membership and these essential and preventative activities. By way of illustration, since the Forum brought in membership fees, our membership has been much reduced with more fall-out year on year as people do not renew, made perceptibly worse by the loss of readily accessible office and meeting space. Nationally, the DWP have found that 24% of pensioners do not go out socially at least once a month.

On the Lewisham website, the page describing integrated health and social care states *"We will be working with local residents, community groups and service users more closely over the next four years to make sure you are involved in planning changes and to support you to adapt to those changes. There will be the chance for you to share your views and opinions over the course of the programme."*

This begs the question: How are the London Borough of Lewisham getting feedback and consulting with the older people identified above?

The Social Care economy

Prevention and community models

Integrated care requires developing the prevention and early intervention offer for adults– including improving access to information and advice to support self-care and self-management. We believe this requires a healthy and well-funded voluntary and community based sector. However:

- In terms of prevention, £1m in savings from voluntary sector (out of an overall budget of £3.9) in 17-18. (Children and Young People's Select Committee Supplementary Agenda 8.9.15) This was subject to consultation and exact implications will depend on the final outcome. The report states:

  Given the profile of the currently funded groups it is likely that older people and those with disabilities will be negatively affected by this reduction in funding.

- We appreciate the Importance of services like Community Connections(CC) in this prevention and early intervention agenda, but we believe that the pressure on the voluntary sector has impact on their effectiveness. For example CC may refer an older person to local community/voluntary services e.g. an exercise class or lunch club. The reality is that these services are often under enormous financial pressure with reduced funding and some face closure. This will also have an impact on older people's levels of isolation with all the negative impacts for individuals' mental and physical well-being

- Lewisham residents also face a loss of premises to provide community services. Lewisham are currently looking for providers to take on their libraries at Manor House, Torridon and Forest Hill – this currently means that more resources are currently being lost e.g. a Pilates class at Manor House.

- The Council has also proposed changes (Children and Young People's Select Committee papers Sept 2015) in contractual arrangements relating the leisure services, with the council giving more freedom of delivery to leisure centre providers in return for reducing their subsidy.

  The impact and risks are set out as

  LBL's ability to dictate terms in relation to the day to day operation of leisure services will be reduced. This may lead to price increases across sites (although this is likely to be limited by market forces/demographics), limited concession rates, changes in leisure programmes (e.g. the loss of less marketable classes) and less favourable terms for local clubs using the facilities.

  Less accessible/affordable leisure provision is likely to impact on a range of Public Health outcomes including obesity levels, prevalence of diabetes/COPD etc. although this is very difficult to quantify.

- The Supporting People programme also focuses on prevention; but the proposal is that these services will lose £2.5m over the next 2 years.

Local Health Economy

We have asked about the local health economy. This has been highlighted by a number of organisations, including the King's Fund report included in the agenda of October 2016. No report has been given to the HCSC that sets out an assessment of the local health economy and its strengths and weaknesses. The King's Fund Report *Home Truths* drew attention to the risks that poorer areas will face.

Already we can see what is happening with care homes. In July 2015, Ranyard Charitable Trust went into liquidation. This charity ran two homes in Blackheath: Dowe House and Mulbury House. The properties were owned by Merchant Taylors charity. 100 beds were lost and the 60 elderly residents lost their accommodation. Now we understand that the homes are to be reopened under a new regime as luxury care homes.

Many of the displaced residents were there through placements by our Adult Care Services. They had to be relocated at short notice. The consequences for one elderly resident were terrible. She was accommodated out of the borough and very quickly she changed from a lively lady in her 90s to someone needing sedation. The details of her case were written about by a member of her family in the Guardian on 29/7/15.

Delivery of an Adult Integrated Care Programme

Introduction

We welcome principles of integration and are aware that there are many good examples of integrated working between health and social care. However, there is the question of whether good models are necessarily cheaper e.g. Buurtzorg seems really good model but as it has been explained to date it may be expensive to fund fully.

Also to be considered is the impact of other initiatives STP, One Public Estate, Devolution, OHSEL – how do these other strategies and initiatives impact on the integrated care model and how is this being coordinated and monitored?

Wider consultation and targeting support

In addition to the groups we have tried reaching out to, we believe that most older people generally living in Lewisham have little or no awareness of what integration means and have not been properly consulted (on Devolution, the STP etc.). To achieve this for more active residents, there need to be daytime meetings in places in accessible locations. Older people also often have little access to computers and the internet or the skills to use them. On line consultations are therefore unlikely to be an effective option, particularly for "hard to reach groups".

Although we are unsure of the extent of this consultation the September Healthier Communities Select Committee has moved to discussion about engagement and messaging

"Lewisham's Health and Care Partners have recognised the need to improve the communication and engagement on the long term vision for Lewisham's health and care system/whole system model of care and on the range of activity that is being progressed within partner organisations in line with that vision.

To facilitate consistent and coherent messaging to staff, residents and other stakeholders on the activity taking place or planned to deliver a whole system model of care, a joint strategic communications group has been established. A joint communication and engagement plan will align key transformations and integration activity taking place across the system and set out key milestones for delivery"

This sounds as if final decisions have been made and it is now a matter of delivering the message.

We share the belief that successful models start from a premise, e.g. what would help you/make a change and support local communities. We are unsure about targeting support if there has not been effective consultation with key groups. Are the Council starting from the premise "what would make a difference to you" and, if so, on what are they basing this?

Given the growth in numbers of older people living with dementia, is there enough emphasis on supporting people living with dementia and their families/carers or on building dementia friendly communities in Lewisham?

Impact of budget reductions

By 2016/17, Lewisham Council will have made £95m of "savings" in budgets, as a result of reduced central government funding. According to Lewisham's Corporate Budget Books, over £34m has been cut from the Community budget (which includes Adult Services) and £12m from the Adult Services budget itself between 2011-2016. Committee papers state that £3m will be cut from Adult Social

Care in 16/17 and it is predicted that over £3m will be cut in 17/8 and £3m in following years. (87% of budget is reported as being spent on packages of care and on placements in residential care and nursing homes)

At the same time the CCG is making QIPP savings of £7.84m in 205/16 and £6.8m in 2016/17.

Detailed proposals in Lewisham budgets include the following savings:

2014/15

Redesign and Care Assessment reconfiguration of staffing structure including amalgamation of teams and a reduction in duplication and cost of assessments	£1.015k
Reducing expenditure on packages and placements by range of measures and greater use of prevention and reablement and use of care fund calculator, increasing proportion of care delivered by personal assistants. Also re-tendering and reviewing use of a number of contracts	£930k
Day care provision (in house and purchased) and associated transport costs	£900k
Charging for non-residential services, inconsistency in charging policy, increasing charges for clients and higher levels of income etc	£107k

2015/16

Charging for Adult Care Services	£275k
Mental health provision	£250k
Consistent approach taken in meeting care and support needs in the most cost effective way. This may result in some community based packages of care ending or being reduced where needs can be met in different or more cost effective ways (referred to Cabinet)	£2,680k
Negotiated reduction in 24hr individual prices of care packages (referred to Cabinet)	£900k

2016/17 and projected 17/18 (Returning to Mayor and Cabinet for approval)

	16/17	17/18
Alternative Delivery Models for the provision of care and support services, including mental health	£1,100k	£700k
Achieving best value in care packages	£600k	£500k
New delivery models for extra care – Provision of Contracts	£100k	£900k

The Forum understands that integration will mean different ways of working but would question whether integration can be successful faced with loss of income on this scale. Arguably a successful model requires increased funding initially – a dual system of funding as integrated care initiatives move to a more preventative model and that these are "front loaded", shifting the focus to community services, rapid response, enhanced care, 7 day response and service, step up and step down care. What will an integrated budget initially look like? Is there an overall budget proposal post integration?

The Better Care Fund is supporting the integration programme in Lewisham. In 2015-16 it was worth £25.84m**. However, it should be noted that this is not new money but from existing CCG funding.**

Budget constraints and the future programme

Lewisham Council sets out the following vision for integrated care:

In accordance with the Care Act 2014 and the Council's political priority to strengthen community resilience, adult social care will continue with its approach to assessment and support planning. This encourages people to utilise their existing resources by linking them to the support available within their own families and communities, thus reducing the need for formal social care services. The demand for services will continue to be managed more effectively by supporting people who meet the eligibility criteria to be as independent as possible with minimal interference from, or reliance on, the Council. Support for these residents will be focused on the provision of assistance at the time of crisis and by offering help in a way that reduces the need for the person to require long term support.

Achievement of this proposal requires a different approach and relationship with residents so they do not rely on the Council for the provision of all support to meet their needs. It also requires a different approach from practitioners who undertake the assessment and support planning function to ensure they consider an individual's own resources before determining the package of care. In accordance with the Care Act, training has been provided to practitioners to help them identify the potential risks to an individual in relation to their care and support needs and to determine what services are required to respond promptly and appropriately to those needs. This includes assisting people to access and utilise opportunities and support within their own families and communities.

Most people in receipt of care and support from adult social care will have a disability or a frailty that relates to older age or disability. However, the assessment and care planning process will ensure that eligible needs continue to be met, although not necessarily from Council resources. When deciding how best to meet an individual's care needs, the Council is entitled to take into account its own resources as well as the client's stated preferences. In planning to meet an individual's needs, the Council may consider the most cost effective way in which this can be done and can take into account the individual's resources and contributions. This may include considering their family and support networks, their welfare benefits and the community resources available.

Wider evidence and concerns

The King's Fund *Home Truths* report also states:

The funding outlook for the next five years looks bleak. The measures announced by the government will not meet a widening gap between needs and resources set to reach at least £2.8 billion by 2019. Public spending on adult social care is set to fall to less than 1 per cent of GDP. The potential for most local authorities to achieve more within existing resources is very limited and they will struggle to meet basic statutory duties.

If the government is unwilling to provide adequate public funding to support the current system, it must be honest with the public about what they can expect from publicly funded services. This would mean establishing a fresh and more explicit policy framework, which makes it clear that primary responsibility for funding care sits with individuals and families, creating incentives for people to plan ahead for their care needs and revisiting some of the new duties and rights created by the Care Act 2014 so that expectations are aligned more realistically with what the government is prepared to fund and local authorities can afford. This will be an unpalatable future but it is one that is already upon us.

The Forum would question whether the Council's statement above regarding the future does not require this fuller honesty with Lewisham residents, especially older people and their families and

carers. If the reality is that they will inevitably need to bear more responsibility for funding and providing care, then this must be explicit in any communications and consultation or engagement.

A further "reality check" is offered by the Care Quality Commission (CQC). When it launched its report *State of Care* in October 2016 it stated the following:

State of Care finds that the sustainability of the adult social care market is approaching a tipping point. This view is based on the evidence of inspections, information received through our market oversight function, and external data.

The fragility of the adult social care market is now beginning to impact both on the people who rely on these services and on the performance of NHS care. The combination of a growing and ageing population, more people with long-term conditions, and a challenging economic climate means greater demand on services and more problems for people in accessing care.

This is translating to increased A&E attendances, emergency admissions and delays to people leaving hospital, which in turn is affecting the ability of a growing number of trusts to meet their performance and financial targets.

In an October 2016 internal briefing paper leaked to the BBC, the CQC expressed concerns even more directly:

Providers are in trouble because their costs have increased by up to 30% in the past year while their profit margins have fallen by more than 40%, [the CQC] warned. It pinpoints the national living wage (NLW) and the inability of cash-strapped local councils to pay higher fees for these services as the main causes of a growing problem.

It is alarming to learn that the number of care homes overall in England has fallen from 18,068 in September 2010 to 16,614 in July this year, at a time of growing need linked to the ageing population, according to figures released by the CQC.

The total number of beds available in care homes also fell between 2010 and 2016 from 255,289 to 235,799 this summer – a fall of 19,490. While the number of nursing homes increased slightly, from 4,387 to 4,623 in that time, more than one in 10 residential homes – for elderly, often frail, people – have closed. The total of those available has fallen from 13,681 to 11,991 – a drop of 1,690. (www.theguardian.com/society/2016/oct/11/elderly-and-disabled-people-put-at-risk-by-care-homes-closures):

And, quoting direct from the CQC briefing paper,

Provider exit and large-scale contract handbacks demonstrate the fragility of this market. At what point can the replacement providers only make the returns work by compromising on the quality of care?

The Forum would like to be clear what Lewisham Council's position is in mitigating this threat to quality, e.g. will it set out the Living Wage, pension changes, travel time for carers working in the community and care slots of at least 30 minutes in its invitations to tender and make these matters contractual requirements?

Questions to be answered and information to be at hand before strategic decisions in the area can be taken

The Forum's "Save our NHS" Group, having worked on these matters over the past six months or so, would respectfully suggest that, as well as consideration of the matters highlighted in bold throughout this submission, the following information needs to be to hand before the HCSC and Mayor and Cabinet can make properly informed proposals and decisions on these difficult matters.

Residential Care Homes

1) **How many residential care homes are there in the borough?**
2) **How many beds are there in average and in total?**
3) **Are there any distinctions in the type of care given?**
4) **How many beds in each home (or on average and in total) does the Council have under contract?**
5) **How many care homes have opened in the last five years?**
6) **How many care homes have closed over the same period?**
7) **Have any care homes withdrawn from or refused to consider contracts with the Council? And if so how many and what reasons were given?**
8) **How does the Council receive and monitor feedback from service users (and/or their families)?**

Care in the home

1) **What has the budget been for social care each year since 2010?**
2) **How many individual care packages and how many total hours have been provided in the community each year?**
3) **How many care agencies providing care in the person's home are there in the Borough?**
4) **How many of these have started up in the last five years?**
5) **How many agencies have closed in the same period?**
6) **Have any withdrawn from Council contracts? And if so how many and for what reasons?**
7) **Have any refused to consider Council contracts? And if so how many and for what reasons?**
8) **Are there distinctions in the range of work the care agencies provide? And if so what are they?**
9) **How does the Council receive and monitor feedback from service users (and/or their families)?**

and, crucially,

10) **If someone no longer can qualify for help with social care but cannot afford to pay commercial rates what happens to them and does the Council arrange any monitoring of their situation? If so, what monitoring is done and by whom?**

Generally

1) **What is happening on the "front-line" with the "preventative" services given cuts to the voluntary sector (e.g. the closure of small lunch clubs)?**
2) **Do you have any data on attendance at A&E by Lewisham residents over 65 and delayed discharge at Lewisham Hospital?**

Judy Harrington and Cathy Ashley
"Save our NHS" Group of the LPF
December 2016

HEALTHIER COMMUNITIES SELECT COMMITTEE			
Report:	Lewisham Clinical Commissioning Group: Primary Care Strategy Refresh – Developing GP Services		
Ward:	All	Item No.	5
From:	Dr Marc Rowland, Chair, Lewisham Clinical Commissioning Group Dr Jacky McLeod, Clinical Director, Primary Care Lead, Lewisham Clinical Commissioning Group		
Class:	Part 1 (open)	Date:	12th January 2017

1. Purpose

1.1 The purpose of this paper is to provide the Healthier Communities Select Committee with an overview of developments taking place both nationally and locally with regard to primary care. The paper focuses specifically on the refresh of the Lewisham Clinical Commissioning Groups (LCCG) Primary Care Strategy – Developing GP services and progress made towards implementation.

1.2 Nationally, there are two recent developments that will have an impact on how local primary care services (GP practice services) are commissioned, delivered and more so how the quality of services will be improved to meet the needs of the local population; (i) Primary Care Co-commissioning; and (iii) General Practice Forward View (April 2016).

2. Recommendations

2.1 Members of the Healthier Communities Select Committee are recommended to note;

2.1.1 LCCGs progress on delivering its refreshed Primary Care Strategy – Developing GP Services (2016 – 2021);

2.1.2 That LCCG submitted an application on 5th December 2016 along with the other five CCGs in South East London for level 3 delegated commissioning of general practice services to NHS England. If the application is approved LCCG will have delegated responsibility for General Practice from the 1st April 2017. The NHS England Regional Moderation panel have recommended the application for consideration in the National moderation process on 4th January 2017.

3. Lewisham Clinical Commissioning Group Primary Care Strategy Refresh – Developing GP Services

3.1 The LCCG Primary Care Strategy (See Appendix 1) details how the CCG plans to meet its statutory responsibilities in supporting and driving improvement in the quality of primary care services delivered by General Practice. The CCG is responsible for improving the quality of local GP services, working closely with NHS England as level 2 joint commissioners.

3.2 The strategy predominantly focuses on the development of General Practice within the wider context of primary and community based care, with key interfaces made to other care services and settings where appropriate.

3.3 It is a refresh of the Primary Care Strategy originally approved by NHS Lewisham Clinical Commissioning Group in 2014 and builds on the existing vision, whilst also ensuring alignment with local and national plans that have since been published, including the following:

- Transforming Primary Care in London: Strategic Commissioning Framework

- Our Healthier South East London (OHSEL): Sustainability & Transformation Plan
- Lewisham Health and Wellbeing Board Strategy
- Lewisham Health & Care Partners
- NHS Five Year Forward View
- NHS GP Forward View

3.4 Primary care delivery tends to be centred on general practice as 90% of activity takes place in this setting, supported by practice nurses, community services and health visitors. It is widely recognised in London and in Lewisham that general practice is under significant and growing pressure due to population growth, widening health inequalities, patient/public expectations and more patients with increasingly complex needs.

3.5 The Lewisham population is projected to continue to grow by a further 20,000 residents over the next five years. Growth is predicted in across almost all age brackets, with the exception of residents aged 20-29 years, where a small decrease is projected.

3.6 Lewisham is the 14th most ethnically diverse local authority in England and Wales, Black, Asian and Minority Ethnic (BAME) groups make up 49.3% of the population, the largest groups are Black African (12%) and Black Caribbean (11%).

3.7 There are 40 GP practices in Lewisham providing primary care services out of 44 surgeries (sites) and are arranged in four neighbourhood groups (See Pg. 15 of the Primary Care Strategy). This pragmatic geographical grouping has been in place in Lewisham for more than ten years and has enabled the development of relationships between practices resulting in agreeing collective goals and improvements, which is now underpinned by GP Federations.

3.8 LCCGs vision for primary care is to ensure the systematic development of primary and community care to produce; (a) a network of advice, support, education physical/mental health and social care hubs embedded in activated communities; and (b) work together to maximise health and well-being of the population, with access to specialist and diagnostic services when needed.

3.9 The LCCG Primary Care Strategy continues to focus on the four key high impact changes for General Practice, in summary;

1. Proactive Care	*Work to ensure that 'every contact counts', seeing each contact with a patient as an opportunity to address preventative health needs, to provide brief interventions or to sign post the patient to other services within network.*
2. Accessible Care	*Support people to access care appropriately by working to simplify access points so that people can easily navigate the system and care in a timely way.*
3. Co-ordinated Care	*Identify people that will benefit from co-ordinated care and a care plan.*
4. Continuity of Care	*On identifying patients care plans will be co-designed with patients and carers. Ensuring that patients have a named skilled professional accountable for their care.*

3.10 The strategy supports the existence of Integrated Health and Social Care neighbourhood community teams wrapped around a registered list held by GP practices.

3.11 Lewisham CCG will commission services to achieve sustainable General Practice delivering primary care. This care will increasingly be delivered at scale across local

populations through GPs leveraging opportunities afforded by technology and working collaboratively through new models of care, which deliver integrated services.

3.12 In line with Our Healthier South East London Sustainability & Transformation Plan, primary care (general practice) will form a key component of Neighbourhood Care Networks who will be delivering Community Based Care, which includes;

- Building strong and confident Lewisham communities
- Delivery of consistently high standards of care, including London Primary Care Standards
- Responsive services providing access from 08:00 – 20:00, 7 days a week
- Focus on physical health and wellbeing of patients with mental health problems
- Proactive primary (and secondary) prevention
- Systematic risk stratification and problem solving approach with shared care planning
- Access to specialists in the community
- Increased accessibility to diagnostics

3.13 The four core components of the CCGs commissioning approach for the lifetime of the strategy for General Practice are;

1. Supporting GP practices to work together and provide care and services at scale;
2. GP practices delivering primary care are an integral part of Neighbourhood Care Networks;
3. Shifting resources from secondary care to primary care to support care in the community;
4. Supporting outlier GP practices to reduce variation and the improve quality of services provided.

3.14 The CCGs aim is to support development of the provider landscape to provide primary and community based care via appropriate population based services. The table below lists the providers and new models of care, which will be delivering services and the characteristics;

Providers	**Providing**
• GP Practices • GP Super-partnerships • GP Federations • Multispecialty Community Providers (MCP)/Primary and Acute Systems (PACS)	• GP List based care • At scale across local populations • Outcomes based • Core, Enhanced and Community services

3.15 The CCGs local approach to new models of care is based on working with the Lewisham Health & Care Partners, which includes the GP Federation.

3.16 There are a number of critical enablers required to support implementation of the strategy are; (i) utilising contracting opportunities; (ii) improved information technology and better management and use of the local estate; and (iii) supporting the development of the local workforce. The CCG will utilise these enablers working collaboratively with local partners.

4. Benchmarking General Practice in Lewisham

4.1 As a part of the CCGs responsibility for improving the quality of primary care services (specifically GP practice services), national benchmarking data (GP National Patient Survey) is reviewed, as is individual GP practice performance under level 2 co-commissioning at the Primary Care Joint Committee with NHS England held in public. In addition, 'soft intelligence' from Lewisham Healthwatch on patient views is also reviewed.

4.2 The national GP patient survey provides information to patients, GP practices and Commissioning organisations on a range of aspects of patients' experience of their GP

services and other local primary care services. The survey provides information on patients' overall experience of primary care services and their overall experience of accessing these services. The results of the survey are publically available and published on a quarterly basis. The next survey results will be published in January 2017.

4.3 The total number of respondents to the July 2016 patient survey for Lewisham was 4,125, which is slightly down on July 2015. In Lewisham, the GP patient survey for July 2016 evidenced that Lewisham General Practices had improved performance compared with July 2015 and in a number of indicators performed 'better' than the national average;

- **Overall experience of GP surgery:** In July 2016 more than half of Lewisham GP surgeries performed above the national average with respondents having a very good or good experience and the overall performance has improved when compared with July 2015.
- **Helpfulness of receptionists at GP surgery:** Overall performance for all GP surgeries was equal to the national average, again with more than half of all surgeries performing above the national average and respondents finding receptionists very or fairly helpful. However, there was a slight decrease in performance when compared with July 2015; 87% of respondents found receptionists at GP surgeries helpful in July in 2016 compared with 88% in July 2015.
- **Awareness of online services:** Lewisham GP Surgeries continue to perform above the national average for awareness of booking appointments online and actual booking of those appointments online.
- **Satisfaction with opening hours:** Overall performance for all GP surgeries was equal to the national average; 76% of respondents were either very or fairly satisfied. Performance for this indicator has improved when compared to July 2015 and similarly the numbers of respondents who were dissatisfied has decreased.
- **Quality of care in GP surgeries:** Overall once patients attended the GP surgeries for their appointments – generally the quality of care experienced is rated as either good or very good by respondents to the survey; with patients feeling listened to, being involved in decisions about their care, being treated with care and concern and being given enough time.

4.4 Indicators where Lewisham GP surgeries performed 'below' the London average in July 2016 were;

- **Success in getting an appointment:** Overall Lewisham GP surgeries performed slightly below the national average 90% (Lewisham) compared to 92% (National) of respondents found their appointment very or fairly convenient. However, performance has remained static when compared to July 2015 and where respondents were unable to get a convenient appointment, double (8%) the national average chose to attend A&E instead.
- **Overall experience of making an appointment**: Overall Lewisham GP surgeries performed slightly below the national average 70% (Lewisham) compared to 73% (National) of respondents found their experience of making an appointment very or fairly good. This performance has decreased slightly when compared to July 2015; however those respondents who found the experience 'poor' had reduced.
- **Waiting times at the GP surgery**: Overall Lewisham GP surgeries performed below the national average; 52% (Lewisham) compared to 58% (National) of respondents 'did not' feel that they waited too long to be seen in the surgery. This performance

has improved slightly when compared to July 2015; similarly the performance for those who 'believed they waited too long' has improved.

4.5 It is recognised that there is variation in the GP patient survey indicators across individual GP practices.

4.6 The majority of areas and those requiring improvement provided by the quantitative national GP patient survey of 4,125 Lewisham residents – is supported by the qualitative engagement undertaken by Healthwatch Lewisham.

4.7 The Healthwatch Lewisham Intelligence Report 2016/17 (1st July 2016 to 30th September 2016), which is based on gathering feedback from patients within 6 specific GP practices, in addition to the Waldron Centre, (which hosts 4 GP practices and the Walk-in Centre) – the key messages for General Practice;

- Overall a substantial amount of respondents were happy with quality of treatment or service they were receiving from GP practices;
- However, 53% of the comments about GP services were negative and centred on respondents being; (i) Irritated about the limited number of appointments; (ii) Frustration about being unable to book appointments; and (iii) Length of time it takes to book an appointment.

4.8 The CCG has commenced patient engagement on how our population accesses primary and urgent care services as part of its review and intentions to develop Integrated Primary & Urgent Care Services in the borough. The patient engagement programme will encompass a wide range of groups and individuals, including seldom heard groups to get their views on primary and urgent care services. Specifically, the CCG will be engaging on the provision of Extended Access to General Practice. This will also include understanding what information our local population requires to support them in their choices about primary and urgent care.

4.9 The CCG established a Public Reference Group (PRG) in December 2015, which is reflective of the borough's diverse population. The role of the PRG includes;

- Ensuring that public engagement is integrated into the commissioning cycle;
- Acting as a 'critical friend' across all commissioning services in respect of patient and public engagement;
- Supporting the CGG in engaging and communicating more widely with the public to gather their views, and to inform the public of the challenges facing the NHS and any proposed changes to services.

4.10 Discussions have been held with the PRG on the refresh of the Primary Care Strategy and level 3 delegated commissioning of General Practice. The CCG will continue to work with the PRG as the primary care implementation plan progresses.

4.11 *Care Quality Commission (CQC)*

4.12 The Care Quality Commission (CQC) is the independent regulator of healthcare and adult social care in England. The organisation was established by the Health and Social Care Act 2008 to ensure that healthcare and social care services provide people with safe, effective, compassionate, high-quality care.

4.13 In primary care, the CQC has the responsibility for regulating general practices, out-of-hours services, urgent care services, NHS 111, dental practices, prison medical services, and independent primary care doctors. The largest part of this work is the regulation of general practices, of which there are approximately 8,000 in England. The CQC plan to have inspected all of these practices at least once by April 2017.

4.14 The CQC first started to regulate and inspect general practices in April 2013. The aim of these inspections was to assess compliance with the essential standards of care

outlined in the Health and Social Care Act 2008. A new methodology was piloted in April 2014 which was fully rolled out nationally on 1st October 2014.

4.15 The CQC use a combination of intelligent monitoring data and information gathered from inspections to make judgements. Intelligent monitoring data is used to prioritise practices for inspection based on nationally available data sets – the new inspection methodology involves asking five key questions:

- is a practice safe?
- is it effective?
- is it caring?
- is it responsive to people's needs?
- is it well led?

4.16 As well as focusing on the five key questions, the CQC will also look at how services are provided to people in the following specific population groups:

- older people
- people with long-term conditions
- families, children, and young people
- working-age people
- people in vulnerable circumstances, who may have poor access to primary care
- people experiencing poor mental health

4.17 Practices are rated as 'Outstanding', 'Good', 'Requires Improvement', or 'Inadequate' for each of the five key questions and for each population group. Practices will also receive an aggregate overall rating.

4.18 Current overall ratings across Lewisham's 40 GP Practices are as follows:

Overall Rating	Number of practices
Outstanding	1
Good	29
Requires improvement	4
Inadequate	0
In progress	6

5. Primary Care Co-commissioning

5.1 *Delegated Commissioning (level 3)*

5.2 Since the 1st April 2015, Lewisham CCG has been responsible for the co-commissioning of primary care services provided by GP practices with NHS England. NHS England has asked CCGs to consider whether they wish to move from this arrangement (level 2 joint commissioning) to delegated commissioning (level 3) from 1st April 2017 and on 5th December 2016 Lewisham CCG submitted its application after approval from its Governing Body on 10th November 2016.

5.3 Co-commissioning of primary care services provided by GP practices is a key enabler in developing seamless, integrated out-of-hospital services based around the diverse needs of local populations in line with the *NHS Five Year Forward View.* It is synonymous with developing consistent and high quality community based care and prevention as part of the *Our Healthier South East London* (OHSEL) programme. The intended benefits of co-commissioning are:

- Improved **access** to primary care and wider out-of-hospital services, with more services closer to home
- High **quality** out of hospital care
- Improved health **outcomes**, equity of access and reduced inequalities
- A better **patient experience** through joined up services

5.4 Level 3 delegated commissioning functions for primary care (General Practice) offers CCGs the opportunity to assume full responsibility for commissioning general practice services, whilst NHS England will legally retain liability for the performance of primary medical care commissioning.

5.5 To that end, NHS England will require robust assurance that their functions will be effectively carried out. The functions to be included are:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing breech/remedial notices and removing a contract)
- Newly designed enhanced services
- Design of local incentives schemes as an alternative to Quality Outcomes Framework (QOF)
- The ability to establish new GP practices in an area
- Approving practice mergers and
- Making decisions on 'discretionary' payments (e.g. returner/retainer schemes).

5.6 NHS England would remain accountable for outcomes and therefore would continue its assurance role of CCGs to ensure responsibilities are being adequately discharged and well managed to yield the intended outcomes.

5.7 On moving to level 3 the following responsibilities would remain with NHS England:

- Holding the medical performers' list
- Performers' appraisal and revalidation
- Pay and rations
- Complaints
- Commissioning of dental, community pharmacy and eye health services

5.8 With regard to governance arrangements for level 3, which includes the impact of the Revised Statutory Guidance on the Management of Conflicts of Interest for CCGs issued on the 28th June 2016 (https://www.england.nhs.uk/commissioning/pc-co-comms/coi/); on the 10th November 2016 CCG received approval from its Governing Body to;

(i) Change the composition of the Governing Body to include a third Lay Member;
(ii) Enhanced the role of the Lay Member, who leads on audit, remuneration and conflicts of interest matters (deputy chair) to become the Conflicts of Interest Guardian; and
(iii) Amendment of both the CCG Conflicts of Interest and Procurement Polices to reflect the guidance (Procurement Policy: http://www.lewishamccg.nhs.uk/about-us/Who-we-are/Governing%20Body%20papers/Enc%2013.2%20Appendix%20II%20Procurement%20Policy%20Draft.pdf and Conflict of Interest Policy: http://www.lewishamccg.nhs.uk/about-us/Who-we-are/Governing%20Body%20papers/Enc%2013.1%20LCCG%20COI%20Policy.pdf).

5.9 Resulting amendments to the CCG Constitution will be submitted to the Governing Body in March 2017.

6. Improving the quality and patient experience of General Practice

6.1 *Co-commissioning of General Practice (level 2)*
Under level 2 co-commissioning of General Practices services have afforded the both NHS England and the CCG the opportunity to; more effectively plan and improve the provision of out-of-hospital services and enable the pooling of funding for investment in primary care.

6.2 Lewisham CCG has developed its commissioning intentions for General Practice (as a part of the Personal Medical Services (PMS) contract) as outlined in the refreshed

Primary Care Strategy, under level 2 co-commissioning arrangements with NHS England. The development of the commissioning intentions has been supported by Public Health colleagues, particularly with regard to proactive care.

6.3 The commissioning intentions for PMS are now subject to discussions with the Local Medical Committee, which represents GP practices and are likely to be contracted from July 2017 subject to agreement.

6.4 The CCGs commissioning intentions for General Practice support the core areas of the strategy, specifically Accessible, Co-ordinated and Proactive Primary Care. The intention is to reduce variation amongst individual practices that results in differential outcomes for our population and facilitate more outcomes based improvements as opposed to being process driven.

6.5 There will be a focus on the Patient Voice and improving their experience of General Practice as a direct response to the national GP patient survey indicator outlined in Section 4.4; *Overall, how would you describe your experience of making an appointment?*

6.6 For Accessible care the CCG will continue to support the Referral Support Service (RSS), which assists GPs with referrals to secondary care and delivers on patient choice with regard to booking appointments for care that is convenient for them. As a direct result of the implementation of RSS electronic-referrals usage amongst Lewisham GP practices increased from 7% (one of the lowest rates in the country) to over 35%.

6.7 Raising awareness and access to GP online services (appointment booking, repeat prescriptions and access to medical records) continues to be a priority for the CCG as it is nationally, however recognising that for some members of our population accessing services online may not be appropriate.

6.8 Proactive Care will continue to focus on early detection and prevention – in recognition and refection of the following Health & Wellbeing Board priority areas;

- *achieving a healthy weight*
- *increasing the number of people who survive colorectal, breast and lung cancer for 1 and 5 years*
- *improving immunisation uptake*
- *reducing alcohol harm*
- *delaying and reducing the need for long term care and support*
- *reducing the number of emergency admissions for people with long-term condition*

6.9 Individual GP practices will be required to improve on; brief interventions for Childhood Obesity; screening, intervention and specialist referral for Alcohol; Cancer Screening rates (Bowel and Cervical); Pre-Diabetes detection and registration; Childhood Immunisation rates; and Vaccinations for Flu and Pneumonia.

6.10 Co-ordinated Care requirements will continue to complement the priorities of the Lewisham Health & Care Partners – specifically with regard to Risk Stratification and Multidisciplinary working as a part of Neighbourhood Community Teams. Supporting patients at the End of their life (EoL) will have dedicated requirements for GP Practices to record EoL care plans for those patients. GPs will also be required to continue to support providing care in patients own homes through appropriate home visits.

6.11 Clarity on the full financial implications and challenges of delegated commissioning of General Practice is still emerging.

6.12 The CCG is successfully accessing national funding streams as a part of the GP Forward View and has been awarded funding for individual GP Practice Resilience Plans and Estates and IT developments via the national Primary Care Estates & Technology Transformation Fund.

7. Supporting 'at scale' General Practice delivering primary care

7.1 *GP Federations*

7.2 The CCG has supported the formation of four local GP Federations (North Lewisham Health Ltd – covering the North; Lewisham Primary Care Partnership Ltd – covering Central Lewisham; Lewisham Healthcare Ltd – covering the South East; and Lewisham 4 Health Ltd – covering the South West), with a fifth (One Health Lewisham Ltd) recently formed borough-wide organisation delivering enhanced primary care services.

7.3 The CCG has contracted the four GP Federations (based on the GP registered list) to deliver Co-ordinated Care Services to the local population for two years. The service commenced in 2016/17 with for overall aims;

- Improve the health outcomes for people in Lewisham
- Reduce variation in outcomes amongst Lewisham GP practices
- Support and sustain collaborative practice working as part of the wider Neighbourhood Care Networks
- Support a reduction in avoidable admissions

7.4 Year 1 of this population (raising the quality of care at borough level) and outcomes based service has delivered the following improvements at month nine of the contract;

- *Closing the gap:* Since the 1st April 2016 at borough level those patients on GP registers for diabetes has increased by 577 patients. Similarly, for GP registers for Chronic Pulmonary Disease (COPD) increased by 163 patients and for Hypertension, the register increased by 932 patients.
- *Prevention*: A total of 34 out of 191 newly diagnosed COPD patients have stopped smoking (e.g.18%).
- *Patient Voice:* Four neighbourhood level Patient Participation Groups (PPG) were held in September 2016, engaging with patients on the new GP Federations and providing feedback on current and future services.
- *Reducing avoidable emergency admissions and attendances*: GP Federations have started to proactively manage patients who frequently attend A&E and those who are frequently admitted as emergencies and have established a cross borough clinical multidisciplinary team to review and coordinate care for these patients.

7.5 Year 2 (2017/18), will continue to focus on; increasing the recorded prevalence of long term conditions (LTC) to support closing the gap between recorded and expected prevalence at borough level – early detection and prevention. Support patients with LTC to better self-manage through GP increased referrals to self-management courses and appropriate support. Improve on Childhood Immunisations specifically Measles, Mumps & Rubella (MMR). Continuation of the proactive case management of patients who frequently attend A&E and those who are frequently admitted as emergencies. The GP Federations will proactively support the Patient Voice via the neighbourhood level patient participation groups.

7.6 *Super-partnerships*

7.7 St John's Medical Centre, Hilly Fields Medical Centre, Brockley Road Medical Centre, Morden Hill Surgery and Honor Oak Group Practice have, over the past 12 months, agreed to pursue a merger of their individual practices into one partnership. This will result in the second largest registered list size in London.

7.8 The practices propose, with effect from 1st April 2017, to work under a 'super-partnership model', initially retaining each of the current PMS contracts held by the 5 existing practices, which the new entity will hold in trust; and at a later stage moving on to one PMS contract, or consider the new voluntary Multispecialty Community Provider contract. This would involve the 5 current PMS contracts remaining initially as separate contracts but benefiting from the integration of clinical and access services and systems.

7.9 The proposal fits strategically with local priorities as set out in the CCG's Primary Care Strategy for General Practice, Our Healthier South East London – Community Based Care, Sustainability & Transformation Plan; delivering core general practice 'at scale'. This is also supported nationally, as articulated in the General Practice Forward View, specifically with regard to the sustainability of General Practice.

7.10 The CCG welcomes the proposal for a 'super-partnership model' and both NHS England and the CCG will work with the practices to support formal approval by the Primary Care Joint Committee in February 2017.

8. Integrated Primary & Urgent Care

8.1 *The Model*

8.2 The CCG has commenced a review of all urgent care services that will support the design and development of an Integrated Primary & Urgent Care Model. This has been supported by patient engagement on primary and urgent care, the national requirement to deliver extended access to General Practice, review of patient activity and access to services and the local Estates Strategy.

8.3 The Model will support delivery of Integrated Primary & Urgent Care Services at the University Hospital (UHL), Lewisham & Greenwich Trust – with a second site in the borough to be identified. The identification of the UHL site is supported by the local Estates Strategy, due to; its location and transport links. The new model will;

- Replace existing access to A&E for all walk-in (non-emergencies) attendances
- Provide extended hours access to General Practice (walk-in and booked appointments);
- Deliver rapid clinical assessment and appropriate redirection of patients (where appropriate) to, for example; A&E, Ambulatory Care, Neighbourhood Care Networks, Patients own GP and additional access through neighbourhood hubs.

8.4 The CCGs intention is to commission a fully integrated Primary & Urgent Care Service in 2018/19.

8.5 The CCG has commenced commissioning of services that respond to the key concerns raised by our local population with regard to improving access to General Practice. However, it is important to consider that as part of delivering to General Practice 'at scale', that further engagement and the development of clear and accessible messages is required to complement these new services for our local population on; making and appropriate choices and accessing primary and urgent care services in Lewisham.

8.6 *Primary Care Assessment Pilot at the Urgent Care Centre (UCC)*

8.7 Phase 1 of the review of the Urgent Care Centre (UCC) is complete and the Primary Care Assessment Pilot was launched on 3rd October 2016. This service provides patients attending the UCC on the UHL site with direct access to GPs as the first point of contact and assessment and is available from 10:00 to 22:00, 7 days per week. To date 1,763 patients have been seen by GPs. Approximately 60% of those patients were seen and treated by a GP or where appropriately redirected to an alternative service. These patients did not require access to the Emergency Department at UHL. An evaluation of the pilot will commence this month, which includes targeted patient engagement on the service.

8.8 *Extended Access to General Practice*

8.9 In line with delivering the Primary Care Strategy and the London Commissioning Framework and the Our Healthier South East London Sustainability Transformation Plan; For Phase 2 the CCG intends to commission an additional **27,036 bookable appointments per year** with General Practice, which will be in place from 1st April 2017 at the University Hospital (UHL) site and from July 2017 an additional **4,914 bookable appointments** from a second site.

8.10 The service will be available between 08:00 – 20:00, 7 days per week.

8.11 This extended access service will be commissioned from One Health Lewisham Ltd (GP Federation).

8.12 Appointments will be face to face, accessible by GP practices, Integrated Urgent Care (formerly 111), online and diversions from the Urgent Care Centre (UCC) at UHL.

8.13 The CCG will begin an extensive public/patient engagement programme with the local community on accessing extended access to General Practice from January to March 2017.

9. Financial Implications

There are no specific financial implications arising from this report.

10. Legal Implications

There are no specific legal implications arising from this report.

11. Crime and Disorder Implications

There are no specific crime and disorder implications arising from this report.

12. Equalities Implications

12.1 There are no specific equalities implications arising from this report, however addressing health inequalities is a key deliverable of the Lewisham Clinical Commissioning Group and Lewisham Borough Council's 'joint' Partnership Commissioning Intentions.

12.2 The CCG has developed a two year programme to reduce inequalities in General Practice now in its second year, which is a focused and specific response to the national GP patient survey and the CCG commissioned review by Goldsmiths College. Findings on the experience of Black Asian & Minority Ethnic (BAME) Groups (specifically Black Caribbean residents) of General Practice and feeling supported to manage their long term conditions were significantly below those of other groups in the borough.

12.3 In addition, CCG analysis to support the development of the Integrated Primary & Urgent Care Model has demonstrated that disproportionate numbers of BAME groups (specifically Black African and Black Caribbean residents) attend A&E. The CCG will be commissioning Healthwatch Lewisham and the local Community Provider Education Network (CEPN) to support with better understanding how these groups access both primary and urgent care and what service developments and/or training might be required for General Practice.

13. Environmental Implications

There are no specific environmental implications arising from this report.

14. Background Documents

Care Quality Commission (CQC)
GP Intelligent Monitoring – full reports and ratings.
Link: http://www.cqc.org.uk/

Our Healthier South East London Sustainability & Transformation Plan
Following publication of the NHS Five Year Forward view, all NHS regions in England are required to work together and with their local councils to produce a Sustainability and Transformation Plan (STP) for local services.

This work is being jointly carried out by south east London Clinical Commissioning Groups (CCGs), hospitals, community health services and mental health trusts, with the support of local councils and members of the public.
Link: http://www.ourhealthiersel.nhs.uk/

NHS GP Forward View
The General Practice Forward View, published in April 2016, commits to an extra £2.4 billion a year to support general practice services by 2020/21. It will improve patient care and access, and invest in new ways of providing primary care.
Link: https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf

Transforming Primary Care in London: Strategic Commissioning Framework
This document provides both a new vision for general practice, and an overview of the considerations required to achieve it. It details a specification for Londoners in the future, and begins to articulate how these changes fit within the wider out-of-hospital context. The document also considers how this specification might be delivered with regard to cost, workforce, contracts, and other key enablers.
Link: https://www.england.nhs.uk/london/wp-content/uploads/sites/8/2015/03/lndn-prim-care-doc.pdf

NHS Five Year Forward View
The purpose of the Five Year Forward View is to articulate why change is needed, what that change might look like and how we can achieve it. It describes various models of care which could be provided in the future, defining the actions required at local and national level to support delivery.
Link: https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

15. Contact/s

Dr Jacky McLeod, Clinical Director & Primary Care Lead, Lewisham CCG
Diana Braithwaite, Director of Commissioning & Primary Care, Lewisham CCG
Ashley O'Shaughnessy, Deputy Director of Primary Care, Lewisham CCG

NHS
Lewisham
Clinical Commissioning Group

NHS Lewisham Clinical Commissioning Group

Primary Care Strategy: Developing GP Services

2016 – 2021

Version 0.6
26th October 2016

Approvals

Version	Approver	Role	Date
0.5	Primary Care Programme Board	Recommend approval to the Governing Body	26.10.2016
0.6	CCG Governing Body	Approval	11.11.2016

Contents page

Executive Summary

- This is a refresh of the primary care strategy originally approved by NHS Lewisham Clinical Commissioning Group (CCG) in 2014.
- The strategy predominantly focuses on the development of general practice within the wider context of primary and community based care, with key links made to other care services and settings where appropriate.
- The refresh takes into account the changes across South East London, London region and nationally. Specifically, the document aligns with policy initiatives that have been announced since the original strategy was agreed, namely; *The Five Year Forward View, the South East London Sustainability & Transformation Plan (STP), The GP Forward View and the Transforming Primary Care in London: A Strategic Commissioning Framework*.
- The **d**evelopment of Neighbourhood Care Networks (NCNs) is also at the heart of the refresh. Through these networks, more care and support will be provided in a community and primary care setting – to help Lewisham residents to stay fit and healthy in their own homes.
- The strategy is consistent with other CCG strategies particularly Estates and ICT as well as the overarching 5 year CCG Commissioning Strategy.

A one page visual summary of the strategy can be found overleaf.

Lewisham CCG Primary Care Development Strategy 2016-2021 (SUMMARY)

NHS Lewisham Clinical Commissioning Group

Context: SEL Sustainability & Transformation Plan / GP Forward View / NHS 5 Year Forward View / CCG 5 Year Strategy / Strategic Commissioning Framework (London)

Vision: To commission high quality primary care services to improve outcomes and reduce variation for our local population

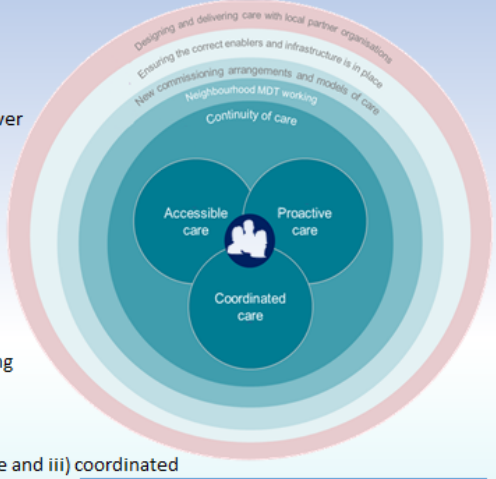
Delivering High Quality Care

Primary & Community Based Care (CBC)

Lewisham CCG will commission to achieve sustainable primary care. This care will increasingly be delivered at scale across local populations through GPs leveraging opportunities afforded by technology and working collaboratively through new models of care which deliver integrated services. Primary care will be integral to the neighbourhood care networks (NCNs) and multi-disciplinary teams (MDTs) that deliver community based care

Neighbourhood Care Networks delivering CBC:

- Building strong & confident Lewisham communities
- Delivery of consistently high standards of care, including London Strategic Commissioning Framework Specifications
- Responsive services providing access from 8am-8pm, 7 days a week
- Focus on physical health and wellbeing of patients with mental health problems
- Proactive primary and secondary prevention
- Systematic risk stratification /problem solving approach with shared care planning
- Access to specialists in the community and increased accessibility to diagnostics
- Working with wider local partners (including voluntary sector)



Commissioning Approach

- Core contract & enhanced/community services
- Facilitating and supporting practices to work together at scale
- Primary care as an integral part of the NCNs
- Shift in resources (secondary → community/primary care)
- Outlier management (support) to reduce variation and inequalities

New Models of Care

Providers of primary and community based care, offering population-based enhanced and community services

Providers:

- GP Practices
- Super-partnerships
- Federations
- Multispecialty community provider (MCP) / Primary and acute care systems (PACS)

Providing:

- List based care
- At scale across local populations
- Outcomes based
- Core services / Enhanced services / Community services

Primary care will need to be i) proactive, ii) accessible and iii) coordinated

Proactive Care

Including:

- Upstream interventions
- Early Identification (eg LTCs)
- Co-design approaches to health improvement
- Collaboration around patient health goals
- Support self-management

Accessible Care

Including:

- Extended access - 8am-8pm, 7 days/week
- Integrated Primary and Urgent Care
- Choice of access options
- Flexible access & continuity

Co-ordinated Care

Including:

- Integral part of neighbourhood care networks (NCNs) & MDT Working
- Risk stratification
- Care planning & review

Enablers

Contracting

Move to Level 3 Co-commissioning (2017/18)
Contractual stability period for core contract for first 3 years

Information Technology & Estates

IT – Local Digital Roadmap & shared medical records
Enabling alternative consulting options for patients & professionals
Estates – Including provision of hubs in neighbourhoods

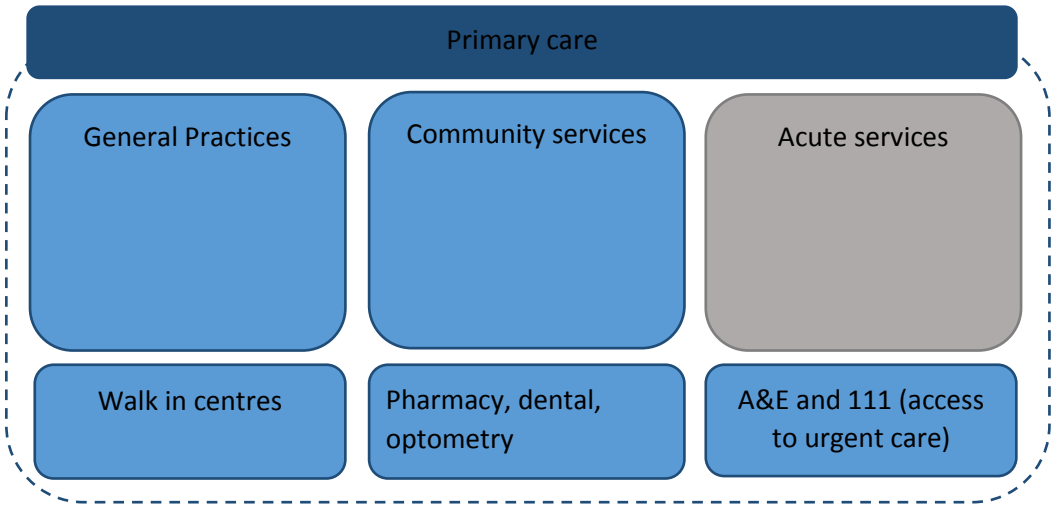
Workforce

More diverse workforce, functioning in an integrated way with extended roles
Collaborative working with Lewisham CEPN (Community Education Provider Network)

1. Introduction

This 2016-2021 strategy describes our vision for primary care services for the population of Lewisham. It is a refresh of the 2014-16 strategy and therefore builds on the originally agreed vision. Our local definition of primary care is services which are typically the first point of contact with the health service, providing an approach to health and wellbeing that focuses on the whole person, managing disease, and promoting healthy behaviours and self-management. This definition emphasises the importance of primary care as not only the universal access point but also the central coordinator of services provided across multiple providers and settings. Strong, sustainable primary care is therefore vital to successfully managing population health.

To date, these services have typically been delivered through General Practices with responsibility for the health and wellbeing of their registered patients. GP practices form the foundation of primary care and for many people constitutes the main or only interaction with the health and care system. However, our definition also extends to community-based services and those providing access to unplanned or urgent care such as walk in centres, 111 and A&E. Primary care also includes community pharmacies, dental clinics and optometry although are referenced to a lesser extent within this strategy.



Primary care is changing and so are the needs, requirements and expectations of our local population. We know that Lewisham residents value accessing services closer to their own homes and that they want their GP to know about the care received in other parts of the system. We are also aware that there is no 'one size fits all' approach to designing primary care. Individual preferences are important and we want to do more to recognise them by offering a range of solutions to provide people with the care that's right for them. We therefore envisage personalised care remaining at the heart of every GP practice with additional population health benefits being derived by practices working more closely together where appropriate supported by integrated community services, social services and specialists in the community. This is the essence of the primary care strategy refresh.

Expectations are also changing in relation to the role that pharmacy can play in supporting people. Pharmacies locally are federating to offer more services to people and the CCG welcomes this move as it seeks to commission new services to meet changing needs. The CCG will also be working to improve medicine optimisation by working closely with primary care pharmacies. The strategy outlined in this document has a range of opportunities for the CCG and the pharmacy services to work more closely to benefit local people. The work on pharmacy development will build on the Public Health England 'Healthy Living Pharmacy' initiative

We also need to 'think big' in terms of the geography we plan across, the innovation we utilise and the transformation we want to see. The CCG believes this strategy will allow primary care to remain at the centre of Lewisham's health and care system but make it more work better for local residents now and in the future. The overall aims are to improve health outcomes, reduce inequalities and unwarranted variation in people's health and provide local residents with a better experience of primary care services.

Whilst there are opportunities ahead with regards to primary care (eg an increased range of alternative treatments and new technologies to support health) we also have to recognise that primary care in Lewisham and nationally is facing some significant challenges at present. These include:

- An immediate unsustainable crisis of workload, resulting in morale and staffing shortages
- The financial challenges facing the wider NHS but primary care in particular
- An increasingly elderly population across Lewisham with more complex health needs
- Changing patterns of care
- Rising public expectations of their health service

2. Strategic context

This strategy is in full alignment with both local and national policy direction towards better integration between organisations, place-based planning relevant to the needs of specific populations and a greater focus on patient outcomes. Key messages from relevant policy documents are summarised below:

➢ **Lewisham Health and Wellbeing Board Strategy - Lewisham Health and Wellbeing Board, 2013**

The strategy sets out the vision for improving the health and wellbeing of Lewisham's population. Due to the breadth of organisations involved from across the system, the strategy looks at the wider determinants of health, how to reduce inequalities and their impact on key social factors such as unemployment and housing. There are 8 priority areas set out including improving mental health and wellbeing and reducing the incidence of emergency admissions for people with long term conditions.

Relevance for the future of primary care:

- *Desire to have increased management of long term conditions in primary care settings, with specific reference to cancer and cardiovascular disease*

➢ **Lewisham CCG Adult Integrated Care Programme – December 2013**

This programme has been established by the Health and Wellbeing Board to increase the pace of integration across health (primary, community and social care) and social care. There are three specific objectives, all of which are important to the success of the primary care strategy:

- To make choosing healthy living easier
- To provide the most effective care and support where and when it is needed
- To build engaged, resilient and self-directing communities

***Relevance for the future of primary care*:**

- *Better co-ordination of health and care services will provide the right care at the right time, reduce duplication, utilise resources more effectively and reduce unnecessary demand on primary care*

➢ **Lewisham CCG Commissioning Intentions – Lewisham CCG, 2014**

Commissioning intentions set out how we intend to fulfil our statutory duty to plan, buy and manage the majority of health services delivered to our population. The population of Lewisham is at the centre of the CCG's strategic vision to provide 'Better Health, Best Care, Best Value' as represented below:

In fulfilling this, the CCG produced a list of 8 strategic priorities based upon the areas of most urgent need for improvement one of which included 'Primary Care development and planned care'.

Relevance for the future of primary care:

- *Supporting GP practice members to ensure high quality of care for all by levelling up standards and reducing variations between practices – this includes improving access, better technologies and expansion of self-management programmes with Lewisham Council*

➢ **The Five Year Forward View - NHS England, 2014**

The Five Year Forward View (FYFV) is based upon the principles of proactive care, promoting independence and the construction of a seamless journey for patients that is not constricted by organisational boundaries.

Whilst noting the requirement for radical system-wide change in order to manage the national £30 billion funding gap by 2020, it recognises that local CCG geographies need to consider their specific priorities as they seek to manage the health and wellbeing of their local population.

Relevance for the future of primary care:

- *Innovative delivery models including: Multispecialty Community Provider (MCP), Acute Care Systems (PACS) and Urgent and Emergency Care Centres (UEC) all aimed at allowing better service integration and greater flexibility*
- *Commitment to the stabilise core funding make transformation funding available*
- *National scheme to aid recruitment and retention of General practitioners*
- *CCGs to have greater influence over NHS budgets with the objective of supporting grater investment in primary care*

➢ ***Better Health for London - London Health Commission, 2014***

The Commission was launched by the Mayor to tackle issues in access, quality and outcomes by outlining 10 key aspirations in a bid to make London a healthier city.

Relevance for the future of primary care:

- *Promotion of primary care networks*
- *Announcement of additional £1 billion funding to support improvements to GP premises*
- *Quality standards for General Practice*

➢ ***Our Healthier South East London (OHSEL) – Partnership of South East London CCGs and NHS England, 2014/15***

A five year strategy was produced in the aim of improving health and care services across South East London (including CCG catchment areas of Bexley, Bromley, Greenwich, Lambeth, Lewisham, Southwark) in close partnership with Local Authorities. A major theme of the strategy is development of Neighbourhood (Local) Care Networks in each borough to respond to the differing needs within each community, provide person-centred services and ensure that health and care is joined-up.

Relevance for the future of primary care:

- *The successful construction and operation of* Neighbourhood *Care Networks will require General Practice to operate at scale i.e. practices working together over a larger patient population leading coordinated care for people with complex health and care needs.*

➢ **Transforming primary care in London: Strategic Commissioning Framework- Primary Care Transformation Boards, 2015**

The framework was developed to support primary care transformation across London and is based upon extensive clinical and patient engagement to establish priorities. At its core is a new primary care offer to patients centred around three key aspects of care; proactive care, accessible care and coordinated care.

The Strategic Commissioning Framework (SCF) also recognises the requirement for capable technology systems, a greater skill-mix at the practice level and estates that are fit for purpose as local areas progress with transforming the way in which primary care is delivered.

The seventeen requirements of the framework are all relevant to Lewisham and are:

I. Co-design of primary care with local communities
II. Developing assets and resources for improving health and wellbeing
III. Personal conversations focused on an individual's health goals
IV. Health and wellbeing liaison and information
V. Primary care to focus on reaching people who don't access services
VI. Patients given a choice of access options
VII. Contact with the practice will be streamlined
VIII. Routine opening hours will be pre-bookable
IX. Patients will be able to access a GP or primary care professional 12 hours a day
X. Same day access will be available
XI. Patients with urgent or emergency needs will be clinically assessed rapidly
XII. Patients will have continuity of care
XIII. Practices will identify patients who would benefit from coordinated care
XIV. Coordinated care patients will have a named professional to link with
XV. Such patients will be invited to participate in the creation of a single care plan
XVI. Patients will be supported to manage their health and wellbeing

XVII. Multidisciplinary teams will coordinate care for identified patients

Relevance for the future of primary care:

- *'Specifications' for what proactive, accessible and coordinated care should look like (local areas must determine how they will be delivered to patients)*
- *17 key elements that commissioners across London have signed up to delivering*

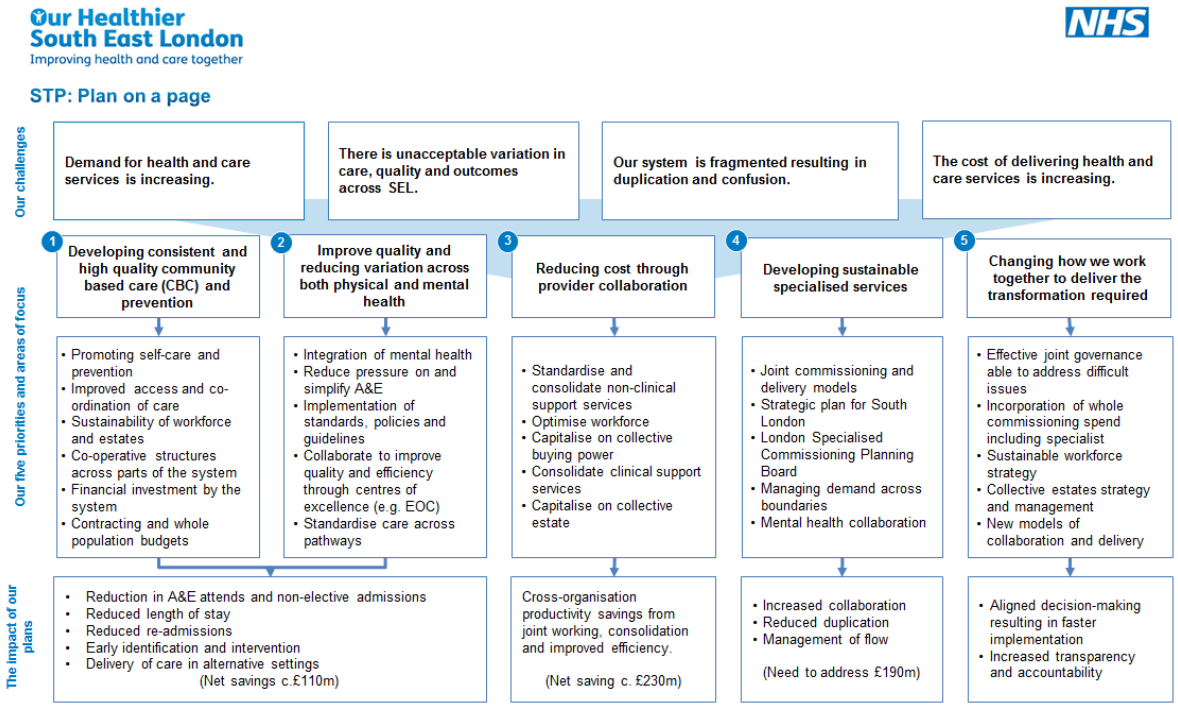
➢ **Delivering the Fiver Year forward View: Planning Guidance – NHS England, 2015**

In December 2015, planning guidance was issued to all commissioners, NHS Trusts and NHS Foundation Trusts to outline the requirement for health and care systems to design 5-year place-based Sustainability and Transformation Plans (STPs) showing how commissioners and providers intend to come together to improve population outcomes. These plans are intended to consolidate existing transformation plans and from 2017/18 will be used as the sole method for obtaining the additional money released into the NHS for service transformation.

The specific requirements for primary care are:

- 20% of the population will have enhanced access to primary care by March 2017
- Have a local plan in place (by April 2016) to address the sustainability and quality of general practice locally. This plan should include workforce and workload issues.
- Contribute to the Sustainability and Transformation Plan with a focus on closing the gaps on health and wellbeing, quality of care and financial efficiency
- CCGs to be transparent about the allocation of resources into primary care

Our local footprint of the STP is that of South East London (SEL). It will need a strong primary care component. A summary of the STP for SEL is shown below.



Relevance for the future of primary care:

- *Development of a system focused on community based care and prevention.*

➢ **GP Forward View, 2016**

The General Practice Forward View, published in April 2016, sets out a plan, backed by a multi-billion pound investment, to stabilise and transform general practice. It has been developed with Health Education England and in discussion with the Royal College of GPs and other GP representatives.

It commits to an extra £2.4 billion a year to support general practice services by 2020/21. This means spending will rise from £9.6 billion in 2015/16 to over £12 billion by 2021 – a 14% real terms increase.

This investment will be supplemented by a one off five-year £500 million national sustainability and transformation package to support GP practices, and includes additional funds from local clinical commissioning groups (CCGs).

The plan also contains specific, practical and funded steps to grow and develop workforce, drive efficiencies in workload and relieve demand, modernise infrastructure and technology, and support local practices to redesign the way modern primary care is offered to patients.

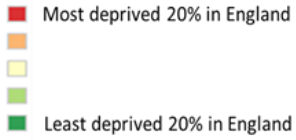
A summary of the GP Forward View can be found at appendix A.

Relevance for the future of primary care:

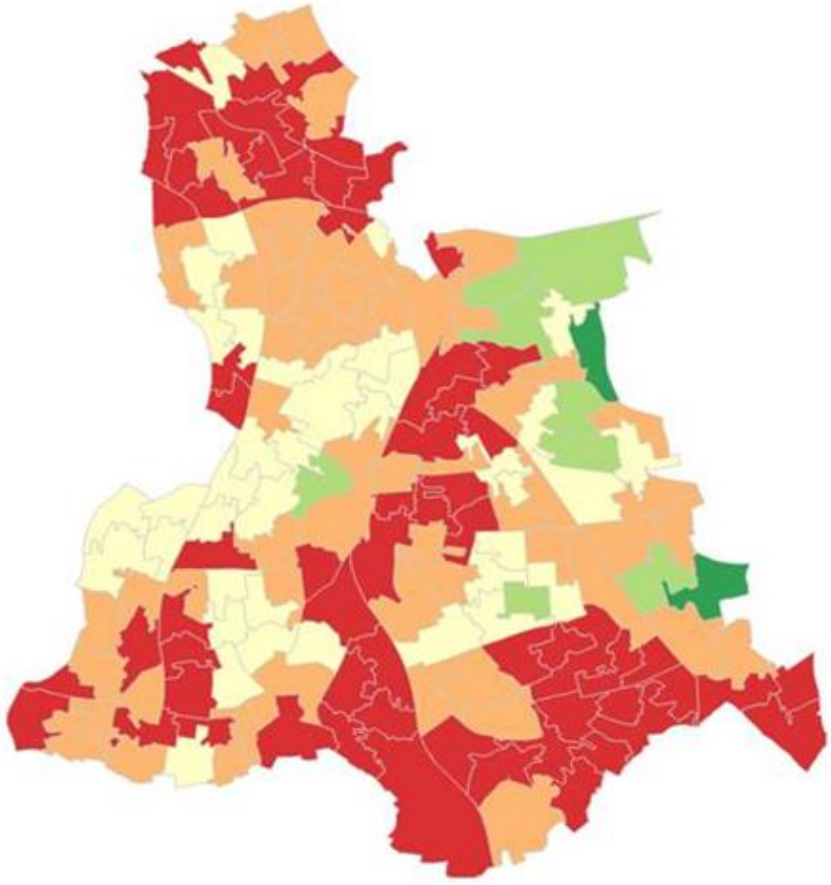
- *The Lewisham Primary Care Strategy will seek to ensure that all opportunities afforded through the GP Forward View are accessed locally with the impact of these nationally supported programmes maximised, especially where accompanied by funding.*

3. Lewisham's population and health needs

Primary care is often the first point of contact for people seeking health or care support. It is important that our primary care services are able to meet the needs of such a varied population. Some of the health challenges for Lewisham's population are:



Lewisham is the 48th most deprived of all 326 Local Authorities (one being the most deprived)



Source - English Indices of Deprivation, Communities and Local Government, 2015

Examples of the needs of the Lewisham population are detailed below:

- The Lewisham population is projected to continue to grow by a further 20,000 residents over the next five years. Growth is predicted across almost all age brackets, with the exception of residents aged 20-29, where a small decrease is projected.
- Lewisham is the 14th most ethnically diverse local authority in England and Wales. Black and Ethnic Minority (BAME) groups make up 49.3% of the population, the two largest groups are Black African (12%) and Black Caribbean (11%).

- The premature mortality rate for Lewisham is significantly higher than that of London. There are higher rates of overall and specific causes of mortality in the more deprived areas of the borough
- In addition to deprivation impacting on inequalities in health outcomes, other populations such as those with mental health problems, homeless people, asylum seekers and black and minority ethnic groups experience health inequalities
- There will be increasing numbers of people who have long-term conditions and this will further increase with the ageing population, particularly the likelihood of having more than two conditions. Currently 28.9% of residents have a long term condition and 11.2% have two long term conditions.
- Cancer is now the main cause of death (28.3%), followed by circulatory disease (28.1%), respiratory disease (13.8%) and dementia (9%).

A full assessment of the health challenges for Lewisham can be found at the Joint Strategic Needs Assessment (JSNA) website - http://www.lewishamjsna.org.uk/.

Neighbourhood based health profiles developed by Public Health enable appropriate service provision to demographic need. Although initially the primary care focus will be on overarching challenges, it is envisaged the specific neighbourhood challenges will be addressed through appropriate design of the NCN model

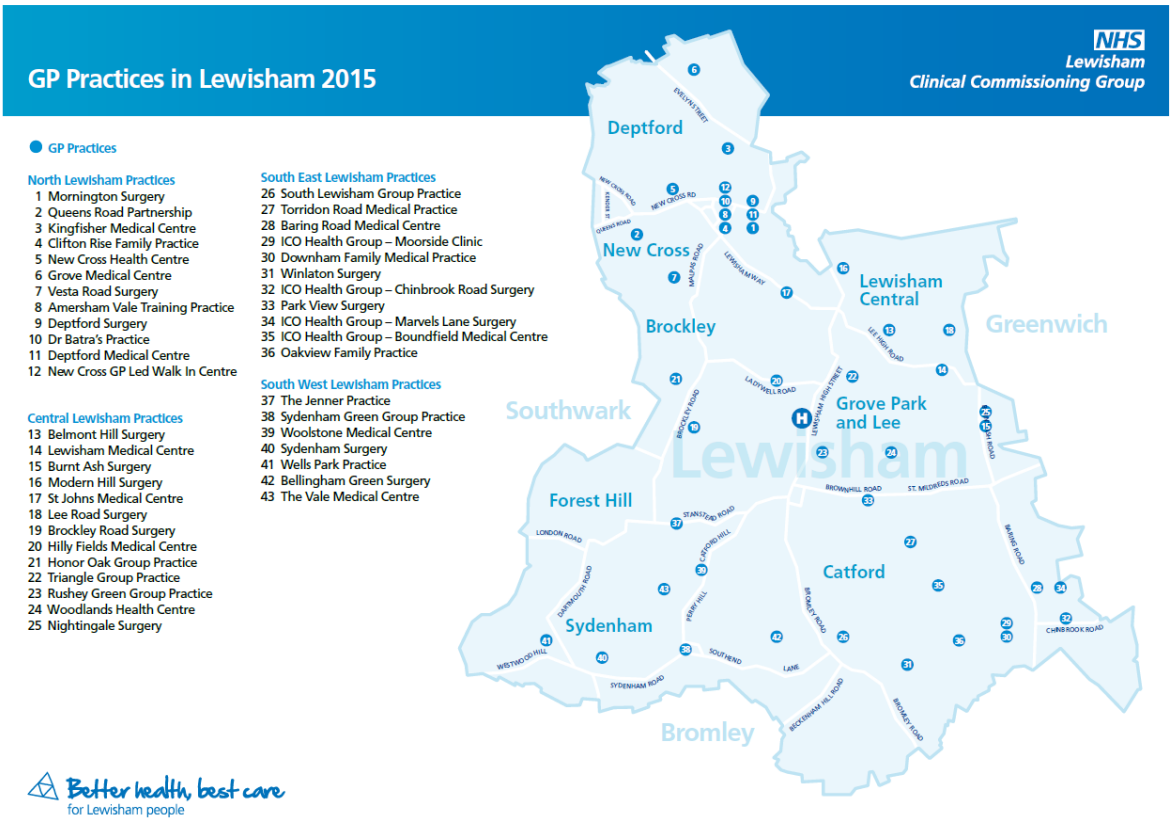
4. Current primary and community care provision

a. General Practice

There are 40 GP practices in Lewisham with a combined raw registered list size of 316,475 as of April 2016. Every practice is responsible for delivering a set of national 'core' services to their registered population and some are also commissioned to deliver certain 'enhanced' services above the core contract.

There are variety of staff working within GP practices including salaried GPs, nurses, health care assistants, allied health professionals (e.g. physiotherapists) as well practice managers and administrators. The size and skill-mix of the team will vary amongst practices.

The location of these practices is shown on the map below:



Practices in Lewisham are arranged into four neighbourhood groups. These groups have been formed based upon geographical location and have aided the development of relationships between practices through collective goal setting and MDT working. Examples of this include setting collective goals for effective medicine usage and flu immunisation uptake.

	Neighbourhood 1 (North Lewisham)	Neighbourhood 2 (Central Lewisham)	Neighbourhood 3 (South East Lewisham)	Neighbourhood 4 (South West Lewisham)
GP Practices	12	13	8	7
Population	70638	114970	61021	69846

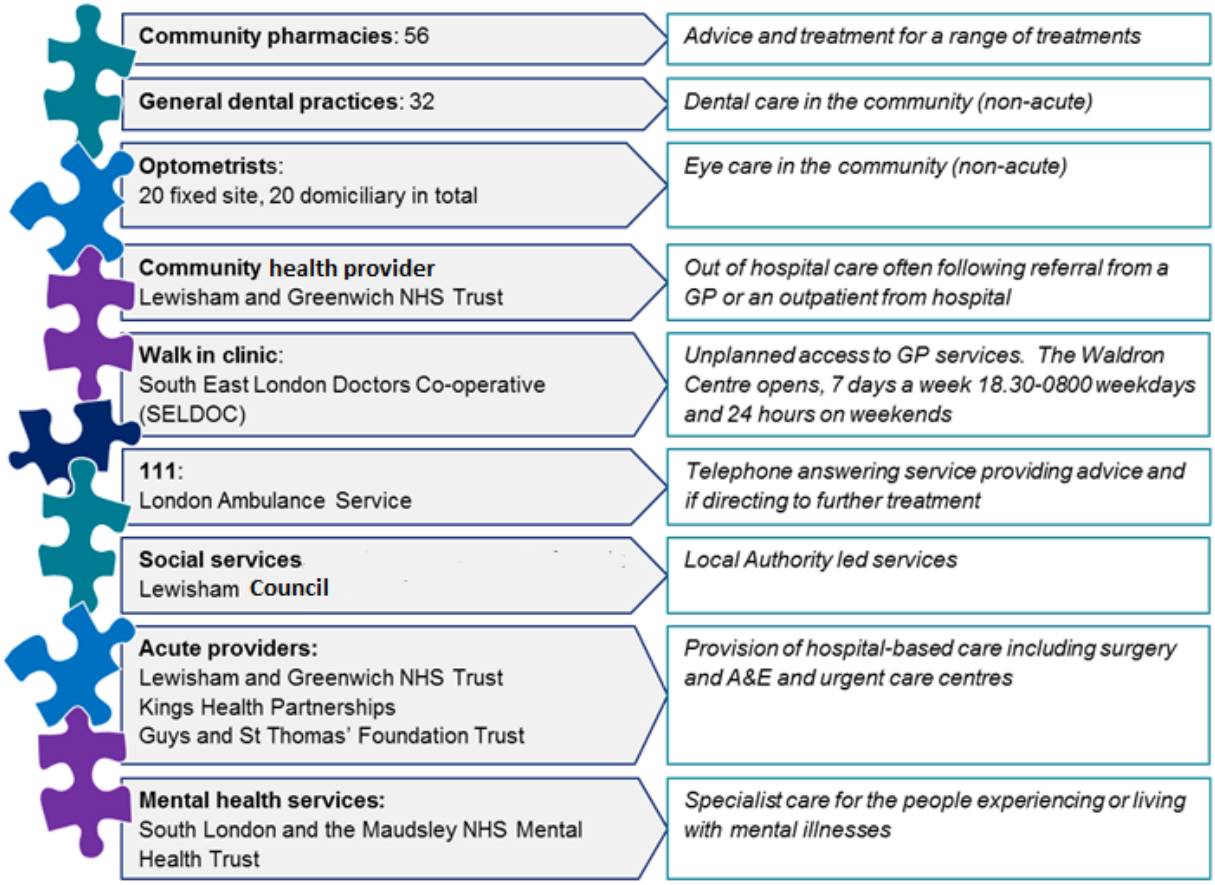
Neighbourhoods allow collaborative decision-making and planning of delivery over a wider population. Each neighbourhood has a neighbourhood community team (NCT) constituting of district and community nurses, social care professionals and occupational health. Regular MDTs allow the team to discuss their case load at a practice level and facilitate better integration and person-centred care. The longer term vision is that a range of providers will contribute to the delivery of care in the neighbourhood care networks.

b. GP Federations

Lewisham now has 4 legally formed GP federations covering the same geographically coherent neighbourhood groupings described above and comprising of all practices and so their registered patients. The formation of a borough wide GP federation is also in development.

The existence of these GP federations provides an opportunity to commission services at scale, drawing on the registered lists of the practices that make up the federations.

c. Other service providers in Lewisham



In addition to the service providers listed above, various providers of public health services and voluntary sector organisations also operate locally.

5. Drivers for change

This primary care strategy refresh is being developed from a position of strength. Significant improvements that have been made to Lewisham's health and care system over recent years including developments in primary care. There have been a number of successful pilots which demonstrate the willingness in the system across commissioners and providers to be innovative, explore new ways of working and find new ways of delivering services to our population.

We also have great examples of practices working together, in a forerunner to the neighbourhood care networks, to deliver improved health outcomes for the local population.

Examples of working together in 2015/16 to deliver improved outcomes across Lewisham include:

- **Pneumococcal Vaccine:** Lewisham vaccinated 72.6% of its over 65s with the pneumococcal vaccine. This is the highest across all London CCGs.
- **Flu Over 65s:** Lewisham achieved 1.6% uptake above the London average by immunising 68% of patients (despite fall across London)
- **Flu Under 65s at risk:** Lewisham achieved above the London average by immunising 44.3% of patient in this cohort
- **Flu Pregnant Women:** Lewisham vaccinated 43.6% of pregnant women, 5% more than the London average and 5th highest in London

Whilst progress against the broad objectives for primary care is evident, we know that we can do more to make sure services meet the needs of local residents now and in the future.

a. National drivers

As mentioned in section 1, there have been a number of strategically important policy papers issued since the last iteration of this strategy which require us to reassess priorities and consider what mechanism different services should be funded through. The urgency to respond to the Five Year Forward View and deliver the London-wide Strategic Commissioning Framework means that the CCG must deliver change with an increased pace and scope.

The national goal is that services are coordinated at a local area so that health and social care operate as one. This means that patients and citizens can receive care or support that is organised around them. This should mean only giving your health details once and receiving care from professionals who carry out broader roles. The aim is that this new approach transforms the services offered and health outcomes improve. These themes have been present in the policy environment for many years, however, there is a renewed sense of urgency to deliver better outcomes.

For primary care this means adapting the traditional model of care delivery. Historically GPs were seen as the gate keeper to other services which served to draw a distinct boundary between primary care and the rest of the health system. Increasingly, the integration of services provided within practices and community settings is becoming increasingly blurred with GPs playing more of a central coordinator role. For patients this means that there is a greater focus on providing the right care in the right place at the right time. For commissioners this means bringing together various professional groups, funding sources and workstreams to provide a single cohesive vision for primary care that reflects the changing policy environment.

We welcome the latest planning guidance and the requirement to produce a 5 year Sustainability and Transformation Plan as a clear indication of the need to bring together existing plans, programmes and strategies. We have already demonstrated our commitment to working in partnership and recognise the benefits possible from designing care models using a place-based approach. The CCG has a strong history of working with local partners in Lewisham and across South East London and therefore these plans will help to cement these relationships and help us to fulfil our aim of having a healthier Lewisham population in five years' time.

b. Locally led drivers

As well as the requirement to respond to the national policy context, there are a number of local drivers illustrating why primary care services need to adapt. These are outlined briefly below:

1) Improving access and quality

The July 2016 GP Patient Survey highlighted that residents in Lewisham showed slightly lower levels of patient satisfaction when compared to both the London and national averages. Key issues that were highlighted include:

- The level of confidence and trust in the practice nurses was below the London and national average
- The ease of getting through on the telephone was below the London and national average

- Support to help manage long-term condition in the last 6 months also continues to be below the London and national average

Issues with access were also identified at numerous engagement events held by Healthwatch Lewisham over 2015 with many noting the frustration of trying to book appointments and lack of awareness about how to access out of hours appointments. Issues with quality of GP appointments were also noted with some patients feeling they were not being listened to, not being referred when required or experiencing the lack of communication with other health and social care providers.

2) Variability in quality, access and outcomes
Although improvement in key primary care outcomes is evident there is still variability across general practices as demonstrated by the patient satisfaction results above. It is clear that some practices are achieving excellent clinical outcomes and patient satisfaction but there is significant variation in performance, quality and access to services. For instance, in the north of the borough there is lower coverage of Bowel, Breast and Cervical screening compared to the rest of Lewisham. In the centre of Lewisham more than half the practices have a higher screening rate than Lewisham as a whole.

The CCG is also aware of the variability in outcomes across the borough. This is demonstrated in the south east of the borough there was a higher percentage of smoking quitters compared to Lewisham and a lower percentage of 4 week smoking quitters in the south west of the borough. We must be better at learning from each other to improve care outcomes for the local population.

3) Addressing health challenges and inequalities
Whilst the outcomes for the most prevalent conditions (cancer, heart disease and stroke) are improving, the mortality rates for people living with these conditions in South East London are amongst the worst in London. For Lewisham, the health challenges depicted in section 3 represent an urgent need to make improvements that will provide the best possible chance of living longer, healthier lives.

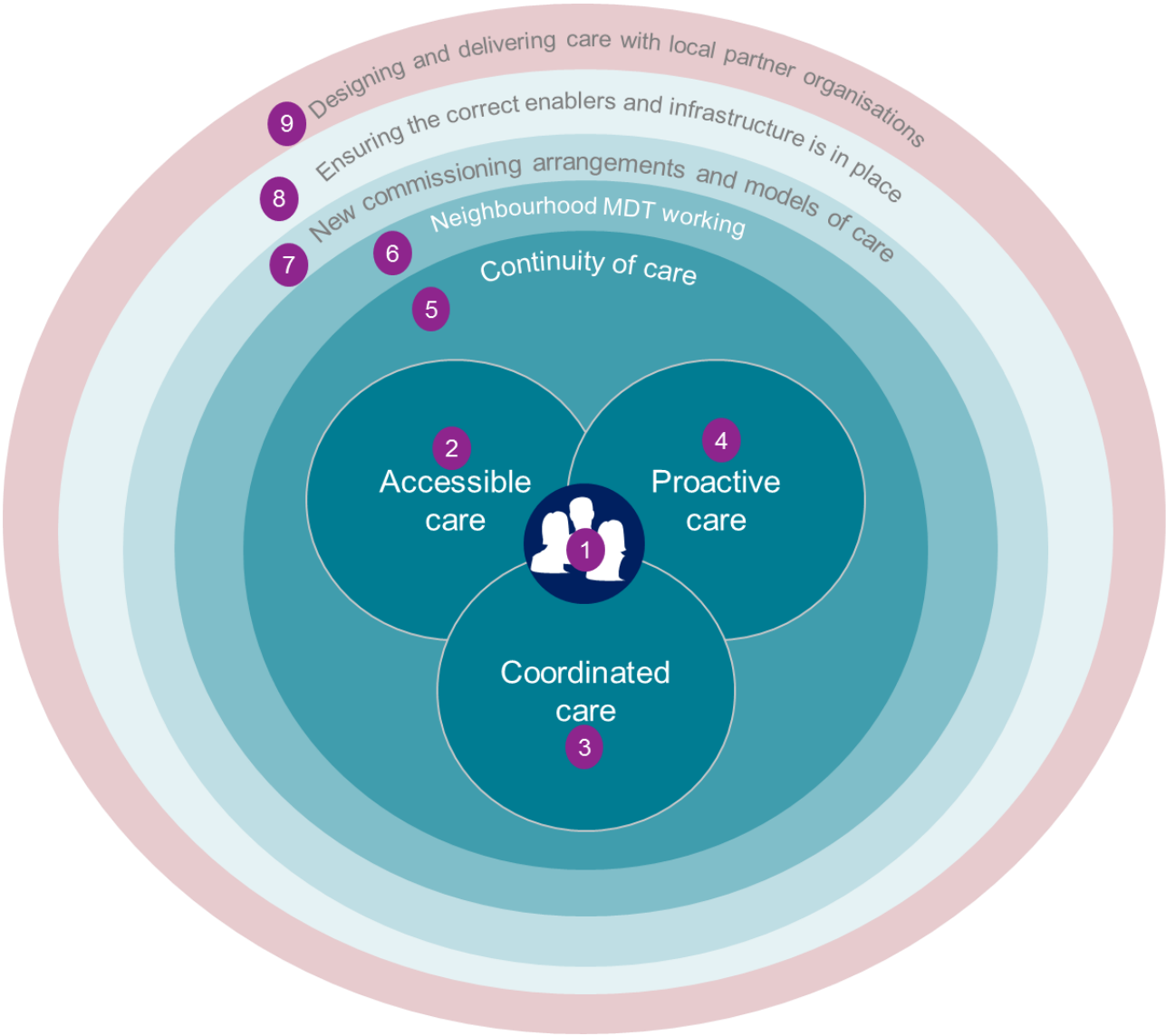
These challenges extend beyond health service delivery to the wider determinants of health. Primary care needs to be equipped to recognise these contributory factors and signpost people to places they can access the support they require. In order to combat these challenges the CCG needs to work closely with the rest of system including public health and social care to promote healthier lifestyles and provide targeted support to those most in need.

4) Supporting service integration
Primary care is facing unprecedented strain and the issues described here cannot be solved in isolation. Lack of communication is a problem frequently mentioned by patients, especially those with complex long-term conditions who most value continuity of care. For primary care, integration means, changing organisational and professional boundaries, adapting to new ways of working and designing care around the needs of individual people.

Better integration will also bring financial efficiencies through managing demand and capacity with a view of whole system. The aim is to ensure resources utilised in way that maximises benefits to patients and represents value for money.

Our approach to primary care transformation

6. Our strategic priorities for primary care



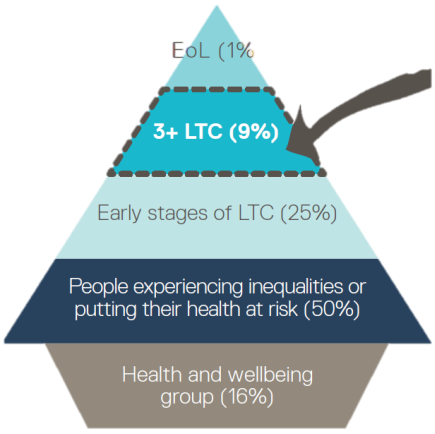
This section of the strategy details Lewisham's response to meeting the primary care requirements in the Fiver Year Forward View and explain how we will implement the London Strategic Commissioning Framework. Our vision for primary care is the same as when we published the CCG's first primary care strategy in 2014.

Our vision is to develop primary and community care to be the best in the NHS at supporting people to maximise their own health. This will be achieved by primary care working together across practices and developing neighbourhood care networks of support for the local community. At the heart of our vision is to provide early care and support as close to people's homes as possible. We know that intervening sooner can improve health outcomes and release resources to be invested in other health initiatives. This is a key goal.

Here are our nine high-level primary care commissioning priorities for the next five years:

Strategic priorities	What this will help us deliver
1 The population of Lewisham and their health challenges sit at the heart of our strategy	POPULATION FOCUS
2 We know that access is a key issue and so will improve the way appointments are booked and provide extended hours and same day access	DELIVERING THE STRATEGIC COMMISSIONING FRAMEWORK
3 We will improve the skill-mix in teams through MDT working and improve communication between GP practices and other parts of the system	
4 We will explore and expand solutions to offering self-management advice, health education and community support	
5 We will value continuity of care especially for patients with long term conditions	RECOGNISING PATIENT PATHWAYS
6 We will expand our neighbourhood models to develop the quality of care delivered, improve access and reduce variability in the care offer	BETTER INTEGRATED SERVICES
7 We will ensure our commissioning arrangements represent value for money and support the implementation of innovative care models that better integrate services	
8 We will ensure that workforce, technology and estates are fit for the purpose of primary care transformation	ENABLING TRANSFORMATION
9 We will continue to support the development of place-based plans across South East London in collaboration with our local partner organisations as part of the STP	SYSTEM COLLABORATION

From a patient perspective, a question we often get asked is **"what does this mean for me?"** just one example is provided below:



VICTORIA, 71

Victoria has lived in Lewisham all her life. She lives with multiple long terms conditions including type 2 diabetes, cancer and high blood pressure, placing her in the top 9% of need. She lives an active lifestyle despite her conditions and is very active within the community.

What does this strategy mean for Victoria?

	Strategic priorities	What this means for Victoria
1	The population of Lewisham and their health challenges sit at the heart of our strategy	Victoria's individual needs and lifestyle will always be considered as the first priority
2	We know that access is a key issue and so will improve the way appointments are booked and provide extended hours and same day access	Victoria will be able to access primary care services at time that are convenient to her and she will know how and where to access urgent care
3	We will improve the skill-mix in teams through MDT working and improve communication between GP practices and other parts of the system	Victoria will have a named person responsible for coordinating her care and receive care from a variety of professionals who work together
4	We will explore and expand solutions to offering self-management advice, health education and community support	Victoria will be supported and empowered to manage her conditions to the best of her ability allowing her to remain as independent as possible
5	We will value continuity of care especially for patients with long term conditions	Victoria will have relationships of trust with professionals who are familiar with her conditions, needs and preferences
6	We will expand our neighbourhood models to develop the quality of care delivered, improve access and reduce variability in the care offer	Victoria's health and wellbeing will be regularly reviewed and planned for and the services received will be of consistently high quality
7	We will ensure our commissioning arrangements represent value for money and support the implementation of innovative care models that better integrate services	Victoria will notice changes in her care system and see different services coming together, making it easier for her to navigate
8	We will ensure the workforce, technology and estates are fit for the purpose of primary care transformation	All professionals involved in her care will be up to date with information, trained in the necessary skills and operating from suitable premises
9	We will continue to support the development of place-based plans across South East London in collaboration with our local partner organisations	As an active participant in the community she will notice organisations working more closely together and working towards common aims

7. Our strategic plans

Specifically in relation to the Transforming Primary Care in London: A Strategic Commissioning Framework, the following local implementation approaches will be adopted:

a. Proactive Care

Requirement	Summary	Local approach
P1: Codesign	Primary care teams will work with communities, patients, their families, charities and voluntary sector organisations to co-design approaches to improve the health and wellbeing of the local population	Patients, carers/family, community groups, voluntary organisations and other stakeholders will be involved in care design. Members of the neighbourhood care networks will be engaged as appropriate in the commissioning or redesign of services and local care pathways. Champions and advocates will be utilised for particular clinical areas. Existing engagement mechanisms will be used to facilitate this i.e. PPGs/CCG public Reference Group.
P2: Developing assets and resources for improving health and wellbeing	Primary care teams will work with others to develop and map the local social capital and resources that could empower people to remain healthy; and to feel connected to others and to support in their local community.	Assets and resources to improve health and wellbeing will be developed and mapped locally to enable the population to remain healthier for longer. New ways of working will be advanced and a network of local health and wellbeing champions, advocates and volunteers will be utilised to engage with various communities and forums. This will be driven through the Adult Integration Programme.

P3: Personal conversations focused on an individual's health goals	Where appropriate, people will be asked about their wellbeing, capacity for improving their own health and their health improvement goals.	Primary care will develop collaborative care plans with patients who's health is at risk of deteriorating. Patients who suffer from long term conditions will be offered appropriate self-management programmes to enable them to learn about and manage their condition(s). Signposting will take place where appropriate.
P4: Health and wellbeing liaison and information	Primary care teams will enable and assist people to access information, advice and connections that will allow them to achieve better health and wellbeing. This health and wellbeing liaison function will extend into schools, workplaces and other community settings.	Health and wellbeing liaison and information will be available locally for patients. A variety of support and interventions will be available for various levels and type of need. This function will incorporate a proactive element and be extended into local community settings such as schools, workplaces etc. This will be driven through the Adult Integration Programme.
P5: Patients not currently accessing primary care services	Primary care teams will design ways to reach people who do not routinely access services and who may be at higher risk of ill health.	People who do not routinely access health services who may be at higher risk of ill health will be targeted for appropriate proactive interventions in order to promote and improve their health. For those who are registered with a GP, such interventions will be proactive and preventative in nature. Examples include in-reach services for care home patients, interpretation provision for those who don't speak English and chaperoning services for vulnerable patients. For those who are unregistered, appropriate homelessness provision will be available as well as other services (eg detention services)

b. Accessible Care

Requirement	Summary	Local approach
A1: Patient Choice	Patients will be given a choice of access options and should be able to decide on the consultation most appropriate to their needs.	GP Practices will have a variety of access options for their patients. Having a flexible approach to access will ensure that patients have a choice as to their preferred access route and when their appointment is scheduled. Methods for scheduling appointments will include telephone and online booking, and consultation will be face-to-face as well as virtual (eg telephone or video-call). Patients presenting with needs requiring continuity of care will be able to access their preferred or named clinician. Practices will also ensure that they have appropriate provision for those who may have barriers to accessing primary care services (e.g. non English speakers and the homeless).
A2: Contacting the practice	Patients will be required to only make one call, click or contact in order to make an appointment. Primary care teams will maximise the use of technology and actively promote online services to patients including appointment booking, prescription ordering, viewing medical records and email consultations.	Practices will ensure systems are in place to minimise the number of contacts a patient needs to make in order to access the appropriate care for their needs. Technology will be maximised to achieve this and electronic and online services will also play a role. Within one call, click or contact a patient will be able to make an appointment to see or speak to someone.

A3: Routine opening hours	Patients will be able to access pre-bookable routine appointments with a primary health care professional (see 'workforce implications' for the proposed primary care team) at all practices 8am – 6.30pm Monday to Friday and 8am to 12 noon on Saturdays. An alternative equivalent patient offer may be provided where there is a clear, evidenced local need.	Saturday morning access will be provided in a locally tailored way to suit the needs of our local population which is not anticipated to be at an individual practice level. The service(s) will be accessible to all patients registered with a Lewisham GP, and form part of the 'extended opening hours' specification (A4).
A4: Extended opening hours	Patients will be able to access a GP or other primary care health professional seven days per week, 12 hours per day (8am to 8pm or an alternative equivalent offer based on local need) in their local area, for pre-bookable and unscheduled care appointments.	It is anticipated that pre-bookable appointments will be available utilising a hub based model (2-4 sites across the borough). Unscheduled care appointments will be available from 8am-8pm, 7 days a week on one central site (*see Integrated Urgent and Primary Care Service model*)
A5: Same day access	Patients who want to be seen the same day will be able to have a consultation with a GP or appropriately skilled nurse on the same day within routine surgery hours at the practice at which they are registered (see Specification A3: Routine opening hours).	Same day appointments and consultations will be offered to patients with a clinicians at either their registered practice or through the hub based model where appropriate. Triage and clinical assessment will be utilised.
A6: Urgent and emergency care	Patients with urgent or emergency needs will need to be clinically assessed rapidly. Practices should have systems in place and skilled staff to ensure these patients are effectively identified and responded to appropriately.	Practices (supported by integrated IT systems) will have mechanisms and processes in place to ensure that if they are contacted by, or presented with, a patient who has an emergency or urgent care need they will efficiently identify and respond to these patients appropriate. This process will include a rapid clinical assessment and can include forwarding them on to other urgent care services in a timely manner.

A7: Continuity of care	All patients will be registered with a named GP who is responsible for providing an ongoing relationship for care coordination and care continuity. Practices will provide flexible appointment lengths as appropriate.	Practices will ensure that all registered patients have a named GP who will be responsible for ensuring patients experience continuity in their care. Named GPs will oversee care but may not always be the direct care provider or coordinator. A range of mechanisms will be developed in practices, utilising technology where appropriate, to afford patients this continuity and flexible appointment lengths will be offered to patients.

c. Coordinated Care

Requirement	Summary	Local approach
C1: Case Finding & Review	Practices will identify patients who would benefit from coordinated care and continuity with a named clinician, and will proactively review those that are identified on a regular basis.	Building on the Avoiding Unplanned Admissions ES, mechanisms will be in place whereby patients who would benefit from proactive coordinated care receive such care (whether through risk stratification or another process), and this care is reviewed on a regular basis by an individual clinician providing continuity. This care will be preventative as well as reactive in nature and will focus on reducing avoidable emergency care.
C2: Named Professional	Patients identified as needing coordinated care will have a named professional who oversees their care and ensures continuity	Identified primary care clinicians will oversee the care of patients who would benefit from more coordinated care to ensure there is continuity. The patient will be aware of, or will be able to easily identify, who their care coordinator is when required and how to access them. This professional will be a named clinician, but not limited to GPs and may be other healthcare professionals.
C3: Care Planning	Each individual identified for coordinated care will be invited to participate in a holistic care planning process in order to develop a single care plan that can be shared with teams and professionals involved in their care.	Patients (and their carer/family where appropriate) will be able to input into their coordinated care planning. The approach will be collaborative in nature (building on the extensive local training that has been undertaken) and the resulting care plan will be reviewed and updated as necessary. The care record will be available to various healthcare teams and clinicians so that it is accessible to whoever is caring for the patient in a variety of settings.

C4: Patients supported to manage their health and wellbeing	Primary care teams will create an environment in which patients have the tools, motivation and confidence to take responsibility for their health and wellbeing.	Primary care will foster an environment (with partner organisations/services eg voluntary sector) whereby patients are able to take responsibility for aspects of their care. This can be done in a variety of ways for a variety of patient groups depending on their needs. Patient activation will be key and motivating individuals to be more involved in their care will support the delivery of improved outcomes. Evidenced based methods to activation such as self-management education; peer support; health coaching; group activities that promote health and well-being; and asset-based approaches in a health and well-being context will be utilised. Once activated, interventions such as self-management courses for those with long term conditions and healthy lifestyle programmes will be utilised.
C5: Multidisciplinary working	Patients identified for coordinated care will receive regular multidisciplinary reviews by a team involving health and care professionals with the necessary skills to address their needs. The frequency and range of disciplines involved will vary according to the complexity and stability of the patient and as agreed with the patient/carer.	Building on the work of the Adult Integration Programme, multi-disciplinary team meetings (MDMs) will take place for patients who have been identified as requiring coordinated care. Appropriate healthcare professionals from various disciplines (therapies, mental health, GPs, social care, nursing etc) will be present according to the needs of patients. Locally agreed protocols shall be in place for such MDMs and their nature and form will be flexible for local clinicians to tailor as appropriate in order to best meet the immediate and future care needs of the patients. IT will support as appropriate.

8. Delivery models

In order to acknowledge the changes taking place in the sector and allow us to fulfil the strategic priorities outlined we need to test new models for delivering primary care.

a) Primary care working at scale

Planning at scale for population based commissioning is a key theme throughout this strategy refresh and we envisage our neighbourhood care network model as a vital enabler to delivery of our aims and objectives. Working at scale to benefit the population is not new to Lewisham. Practices have been working collaboratively in recent years as a forerunner to the creation of neighbourhood care networks.

Proof of concept has been achieved through the LNPCIS which has supported practices to collaboratively deliver at-scale change in the delivery of, for example, pneumonia immunisations to high-risk groups such as 65 years+ adults improving performance to the best in London. It has also helped deliver training essential to deliver the transformation in service delivery by ensuring that > 95% of clinical practice workforce have undertaken collaborative care planning training.

GP practices across the country have been coming together into larger groups over the past five years with a wide variety of aims and forms. Over the next five years we will support further development of our four neighbourhoods in order to maximise the benefits of practices planning and delivering care in collaboration, whilst having due regard for the necessary clinical governance arrangements.

i. GP provider federations

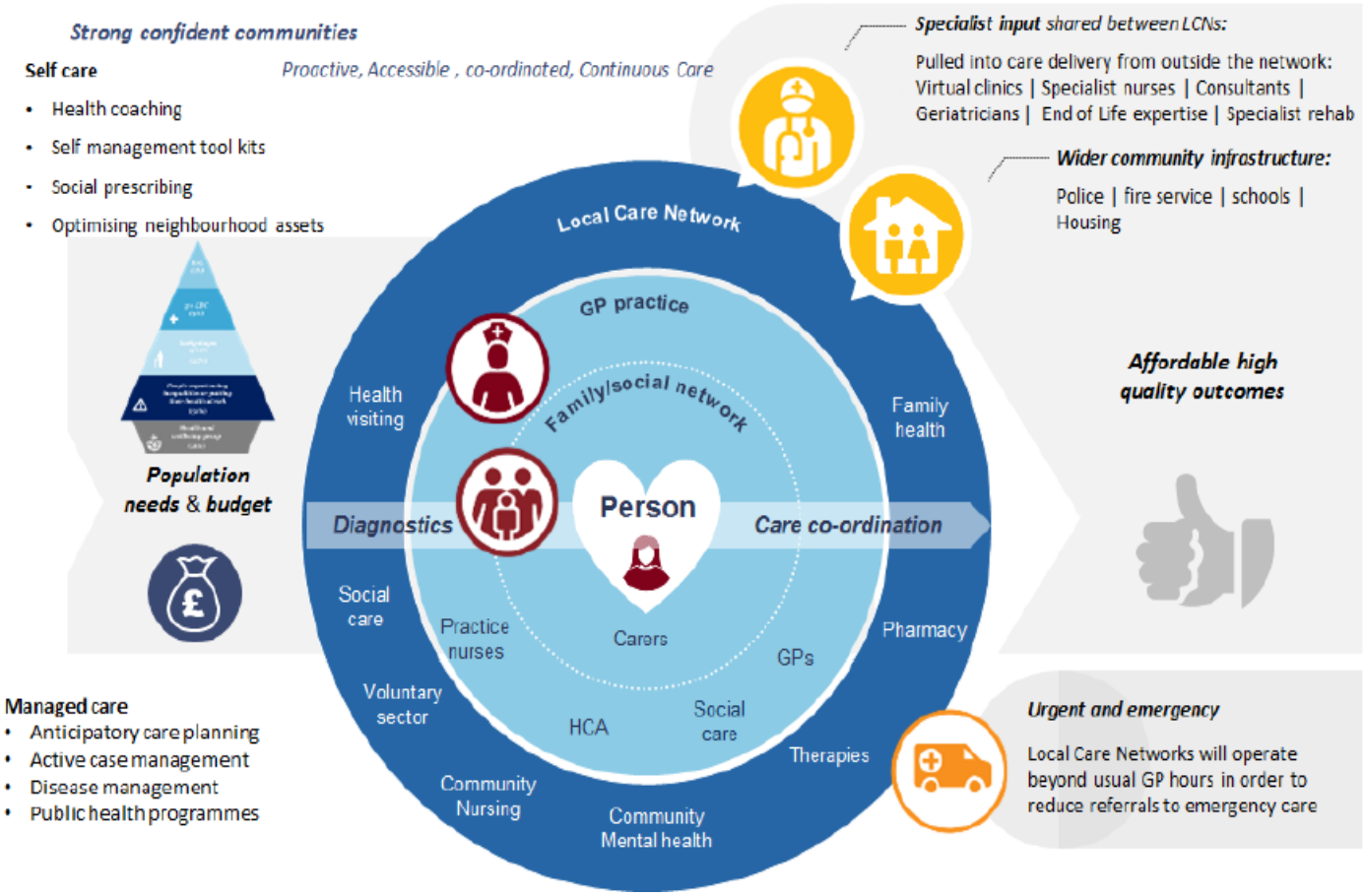
The CCG will continue to work with our GP provider federations to support their ongoing development and to deliver sustainable and credible organisations working as part of our NCN model.

ii. “Super-partnerships”

Where GP Practices wish to merge their core contracts (and not merely form an alliance or informal partnership) and become a single entity, the CCG may support this where there are clear benefits to patient care and improved outcomes as a result.

b) Neighbourhood Care Networks (NCNs)

As shown by the diagram below, multidisciplinary working is a key part of our neighbourhood care network model. As part of the Our Healthier South East London strategy, neighbourhood care networks have been developed offering specialist services such as end of life care and rehabilitation, extended opening hours and links to wider community services such as the police and education as well as those in the voluntary sector.



These networks were designed to provide a standard offer including a single leadership team, IT system and diagnostics in the community. Some of the key benefits of the model include:

- Support patients to manage their health through signposting to mapped community assets and early access to self-management education and training
- Access to consistent, coordinated and integrated prevention advice i.e. obesity, smoking, drugs and alcohol
- Extended access to primary care
- Provision of focused support to vulnerable people in the community including those in care homes or domiciliary care
- Reduction in variation in management of all LTCs (with initial focus on diabetes, hypertension and COPD).
- Admissions avoidance and early discharge services
- Multidisciplinary team working

Primary care will lead the neighbourhood care networks in Lewisham. As the holders of registered lists and the gatekeepers to secondary care as well as an array of other services,

GP Practices are the best placed to hold this position in the community. Practices working together at scale across their respective neighbourhoods will be a core, stable and reliable component of the networks, as well as potentially being the provider of a large proportion of community based care as described in the SEL STP.

c) Integrated Urgent and Primary Care Services

There are number of similarities between the pressures faced by primary care services and those faced by the urgent and emergency care system. Pressures in urgent care lead to patients experiencing difficulties in accessing unscheduled care due to the rise in demand for such services, long waits for planned care, duplication and communication issues between services.

In Lewisham, a number of new models have developed to provide more capacity. These models include the GP-led walk in centre, out of hours care and 111 services. Although they have been designed to reduce pressure on the A&E Department, there is some debate as to whether this additional capacity has helped to meet demand or created additional demand by establishing multiple access points and duplication.

There is analytical evidence to suggest that the latter may be the case:

- The number of emergency appointments at Lewisham Hospital increased by 12% between 2014/15 and the same period in 2015/16.
- A review of attendance at Lewisham Hospital's A&E Department and co-located Urgent Care Centre (UCC) identified that 35% of patients presenting were classified as having needs that could be met at the UCC, with 65% A&E care.
- Of the 35% of UCC attendances nearly half were categorised as having no investigation or treatment suggesting that they could have been managed in a more appropriate care setting that provides better value for money.
- The GP-led walk in centre has consistently over-performed against plan with data showing that a significant proportion of patients are registered with a GP and accessing the clinic during routine hours.

Our evidence suggests that building a single model with a single point of access could streamline the patient pathway and mange demand more effectively giving patients better access to both primary care and urgent care services when required. This, accompanied by appropriate IT integration to improve communication and further Referral Support Service (RSS) implementation to increase primary care capacity and capability, will also have a positive impact on waiting experiences.

Following the evaluation of numerous options, an Integrated Urgent and Primary Care Service could deliver the scale of transformation required to significantly change the way in which patients can access their local services.

The development of an Integrated Primary & Urgent Care Service on the Lewisham Hospital site would:

- Replace existing access to A+E for all walk (non-emergencies) in attendances
- Provide extended hours access to primary care (walk in and booked appointments);
- Deliver rapid clinical assessment and appropriate redirection of patients (if necessary) to, for example;
    - A+E
    - Ambulatory Care
    - Neighbourhood Care Networks
    - Patients own GP
    - Additional access through neighbourhood hubs.

The benefits to both primary and urgent care would include:

- improving access to primary care services, especially access to services outside of routine hours
- more appropriate and cost effective management of urgent care
- providing advice and reassurance even when treatment is not deemed necessary
- aid integration of primary, urgent and emergency care and support system-wide planning
- support delivery of the 4 hour A&E wait target, with only patients who require ED treatment being directed there

Our intention is to test the approach and design by piloting the model before full implementation. This will involve interim arrangements for 2016/17 during a period of transition to the new arrangements. This is large scale transformation and therefore will require some degree of system reorganisation but we intend to consult and communicate at earliest opportunity as plans progress.

Detail of the proposed phasing of the change is given below:

Phase 1: Urgent Care Centre Streaming
- Review of UCC GP front end
- Implement UCC GP triaging and re-direction support pilot

Phase 2: Extended Access to General Practice
- Pilot extended access to General Practice, 08:00 – 20:00, 7 days per week for both pre-bookable appointments and unscheduled care
- Support the development of the second 08:00 – 20:00 site

Phase 3: Integrated Primary & Urgent Care Service
- Develop and commission integrated primary and urgent care on the University Hospital (UHL) site.

Future contracting and commissioning

Our commissioning intentions for primary care are based upon the requirement to bring together the various workstreams, programmes and their enablers into one cohesive vision. It is vital that commissioning remains in line with the CCG's strategic priorities and does not hinder achievement of this vision. Over recent years there been a shift away from the traditional model of commissioning to allow better system planning and closer collaboration with the provider sector. It is essential that commissioners work proactively with primary care as well as other partners to ensure a comprehensive range of joined up services that work in union to the meet the needs of the local population.

Historically, the method of funding additional services, over and above the core primary care contract, has been through voluntary enhanced services and incentive schemes. As these agreements were drawn up in isolation, this has added to the variation in the breadth of services offered from each practice and contributed to the fluctuation in practice staff where additional funding is only secured one year at a time. This short-term approach was not sufficiently supportive of long term strategic workforce and service development.

It is expected that future services the CCG will commission from primary care will be done at-scale. Hence, it is not anticipated that new services will be commissioned for practice populations – these will be increasingly commissioned across a neighbourhood population as a minimum with due regard to inequalities impact. This is not to say however that individual Practices could not provide these services, but that services would be for the neighbourhood population (or borough) and not only for patients registered at that particular practice. Where services are being delivered for smaller populations, the CCG reserves the right to retain these commissioning arrangements where it can be evidenced that the service is delivering successful outcomes for patients and the variation of such a service may risk the achievement of these in future. The CCG will determine this on a case-by-case basis for such contracts as and when appropriate.

a. Primary care co-commissioning

As of the 1st April 2015, Lewisham CCG entered into Level 2 co-commissioning arrangements with NHS England. This means that the CCG and NHS England are now jointly responsible for commissioning primary care services in the borough. Co-commissioning offers the CCG various opportunities including:

- greater influence on how primary care is organised and funded
- better alignment to local priorities and challenges
- greater ability to develop primary care in alignment with the rest of the system
- greater collaboration with other commissioners in South East London to support primary care transformation and delivery of population health outcomes

The CCG are currently assessing a move to Level 3 fully delegated commissioning arrangements with the intention being that this will take effect from 1st April 2017. Any decisions will be communicated in due course following a thorough assessment of the potential for additional opportunities and additional duties and responsibilities.

This assessment will also include a pragmatic review of how we manage potential conflicts of interest without losing the experience and expertise of the membership.

Once fully delegated co-commissioning arrangements take effect, the CCG will have the power to influence and vary the core contracts of GP Practices. This present us with the opportunity to ensure our enhanced and community care offering complements the offerings in core contracts.

The CCG anticipates the number of core contracts (currently 40 at the time of writing) to be consolidated over the course of this strategy. This is for a number of reasons.

1) The benefits to patients of commissioning at scale as opposed to small populations
2) The CCG will support super-partnerships (ie mergers between practices)
3) The CCG does not anticipate any 'new' GP Practices opening in the borough
4) Ability for CCG to effectively manage multiple small contracts

Furthermore, the CCG does not envisage that the core contract (or components of it such as QOF) will be modified within the first 3 years of this strategy under level 3 co-commissioning arrangements. The purpose of this is to provide a degree of stability to primary care providers in the borough and enable appropriate focus on transformation and NCN development.

b. PMS review

NHS England are also in the process of completing a review of all GP practices operating under a Personalised Medical Services (PMS) contract during 2016/17. As the last review in Lewisham delivered a reduction in the large-scale variation between PMS practices, this review presents the CCG, as a level 2 co-commissioner, an opportunity to ensure that premium element of the contract reflects value for money and strategic priorities of the CCG. During this review, the CCG will ensure that services do not duplicate with those already part of the core contract, contribute towards improving patient outcomes and are designed in such a way to reduce inequalities.

We believe it is vital that all patients are able to access the same service offer irrespective of the practice they are registered at and therefore this review must also offer non-PMS contract owners the same opportunity to deliver services. Whist progressing with the review we will maintain our focus on outcomes rather than process indicators and in doing so ensure that all services selected as part of the 'premium' element of the PMS contract will strengthen the primary care offer.

Looking forward, particularly in the context to moving to a level 3 co-commissioner of primary care, the PMS premium will offer an opportunity to ensure continued alignment of contractual outcomes with local priorities.

c. Management of variation

GP Practices are responsible for delivering the services under their core contracts. As a co-commissioner with NHSE, the CCGs role will increasingly be to performance manage this to ensure patients are receiving the required level of care no matter where they are registered.

Practices across the borough will have varying levels of achievement across a number of indexes and measures, and where practices are identified as outliers the CCG will, where appropriate, support them to improve their performance. The successful management of these practices will improve the quality of primary care in Lewisham and reduce variation as well as health inequalities. This support may take the form, but is not limited to, the following:

- Direct support from the CCG
- Local peer support/collaboration with other GP Practices/federations
- National support programmes as associated with the GP Forward View
- Formal contract performance management

Enabling infrastructure

In order to fulfill our five year vision for primary care services in Lewisham the correct enabling structures need to be in place. In particular, structures must be in place that enable system integration and allow organisations to support one another to achieve common goals. As such, the CCG has developed workforce, information technology and estates plans in line with our strategic priorities.

Innovation shall also be encouraged and fostered to deliver the work of this strategy and appropriate bids and networks shall be tapped into where possible (eg CLARHC, HIN etc).

a. Workforce Development

The development of the primary care workforce, and its retention, is crucial to delivery of this strategy. The skill-mix within the primary care workforce is changing, with the introduction of care coordinators, specialists and therapists into practice or community neighbourhood teams. The competencies required to meet the new commissioning framework have also changed and therefore professional education must supply the necessary training to up-skill teams in skills such as self-management and triage protocols.

Across London, Community Education Provider Networks (CEPNs) are being established to allow training to be more locally tailored. The CEPN for Lewisham will be responsible for commissioning training for the primary care workforce and developing the training and education strategy. The CCG will therefore work in close partnership and welcome the opportunities presented by this new organisation. Furthermore, it is anticipated that the CCG and CEPN will also forge links with other appropriate training organisations (eg universities) to ensure talent is retained and developed locally.

b. Estates

There is a need to ensure that premises where primary care services are delivered are fit for purpose and provide people with a good experience of care. The CCG published an interim estates strategy in June 2016 which encompassed primary care. The CCG is supporting practices to apply for and utilize all forms of development and transformation funding that has been made available nationally. One example of this is the Estates and Technology Transformation Fund which will release money for premises improvements that will directly benefit patient care. A number of practices in Lewisham have already applied and we are expecting a number of successful applications.

c. Information Technology

Technology and information systems also play a vital role in new care models and although there has been significant improvement over the past decade, there is outstanding potential for technology to increase the pace of change and support innovation. The CCGs IT strategy will support recommended improvements in primary care and integration/optimal connectivity of IT systems that enable seamless care provision for patients across the Lewisham healthcare system.

Examples of technologies to be reviewed and adopted include:

- telehealth
- patient portals (accessing their records)
- shared electronic health records
- predictive analytics e.g. risk stratification
- remote consultations e.g. skype consultations

Interoperability is a key enabler and a major priority for the OHSEL programme as it will enable the organisations within South East London to work together across organisational boundaries and deliver health and care more effectively. Sharing information can improve care quality by ensuring professionals can access information on the 'whole' patient and it also improves the efficiency of care delivery by ensuring information is timely and reducing the amount of duplication within the system. An interoperability programme is in place to improve record sharing across GP Practices and other providers (and providing connectivity to mobile workers via appropriate solutions eg EMIS Health) and this will be informed by robust information governance processes to make sure patient information is managed appropriately.

Implementing our vision

9. Implementation approach

a. Governance structures

The approval of and thereafter accountability for delivery of this strategy will sit with the CCG Primary Care Programme Board underpinned by the CCG Primary Care Operational Group.

Under Level 2 joint co-commissioning arrangements, relevant issues will need to be discussed and agreed by the Primary Care Joint Committee with NHS England.

As Lewisham CCG moves to full delegated commissioning of primary care under level 3, governance arrangements will need to be reviewed to ensure they are fit for purpose and in particular that any real or perceived conflicts of interest for the CCG as a GP membership organisation are appropriately identified and managed.

b. High level implementation plan

The implementation plan at Appendix B details the key activities and milestones that will drive delivery of this strategy and which are aligned to the London Strategic Commissioning Framework and SEL STP.

Any local primary care programmes/projects that are not specifically encompassed as part of this wider implementation plan will be appended to ensure that any dependencies are identified and managed accordingly.

c. Top 5 risks, impact and mitigations

- Competing priorities (insufficient time)
- Lack of funding
- Lack of engagement/ stakeholder buy-in
- Scale of transformation not achieved
- Enablers not in place quickly enough to support transformation

10.Conclusion

This strategy refresh builds on the work set out by the CCG in the 2014-16 strategy. The vision for vibrant, sustainable primary care in Lewisham that facilitates the best quality and the best health remains the same for the Lewisham population. It positions primary care clinicians at the heart of neighbourhood care networks providing clear leadership and retaining responsibility and accountability for the wider care team. The growth of neighbourhood care networks and the wider deliverables of the SEL STP are all aligned with the direction that primary care in Lewisham is heading.

The coming months will see significant activity to create the detailed plan of action to put the strategy into place. The opportunities to improve the health of the local population are significant and the implementation of this strategy will help achieve this.

Appendix A - GP Forward View Summary

General Practice Forward View: On A Page

Maureen Baker (RCGP President) called this **"the most significant announcement for general practice since the 1960s."**

CHAPTER 1: £

- Investing a further **£2.4 billion by 2020/21 into general practice services.**
- This means that investment will rise from **£9.6 billion a year in 2015/16 to over £12 billion a year by 2020/21.**
- This includes recurrent and transformational funding
- Additionally a review on Carr-Hill formula in progress to ensure it reflects derivation and workload etc

CHAPTER 2: WORKFORCE

- Create an extra **5,000 additional doctors working in general practice by 2020**
- Attract an extra 500 GPs from abroad and targeted £20,000 bursaries that have found it hardest to recruit.
- **A minimum of 5,000 other staff working in general practice by 2020/21**
  - ❖ *3,000 mental health therapists*
  - ❖ *1,500 pharmacists*
- **£206 million in support for the workforce through:**
  - ❖ ***£112 million (in addition to £31m already committed)*** *for the clinical pharmacist programme to enable a* ***pharmacist per 30,000 population***
  - ❖ ***£15 million national investment for nurse development support*** *including improving training capacity in general practice, increases in the number of pre-registration nurse placements and measures to improve retention of the existing nursing workforce and support for return to work.*
  - ❖ ***£45 million*** *benefitting every practice to support the training of current reception and clerical staff to play a greater role in navigation.*
  - ❖ *Investment by HEE in the training of* ***1,000 physician associates to support general practice.*** *Introduction of pilots of new medical assistant roles that help support doctors.*
  - ❖ ***£6 million investment*** *in practice manager development, alongside access for practice managers to the new national development programme.*

CHAPTER 3: WORKLOAD

Support for GPs to manage demand, unnecessary work, bureaucracy and integration with wider system

- **£16 million extra investment** in specialist mental health services to support GPs with burn out and stress.
- **£30 million** 'Releasing Time for Patients' development programme,
- new standard contract measures for hospitals to stop work
- new four year **£40 million** practice resilience programme (including **£16m in 2016/17**)
- move to five yearly CQC inspections for good/outstanding practices
- introduction of a simplified system across NHS E, CQC and GMC, streamlining of payment for practices,& automation of common tasks.

CHAPTER 4: INFRA-STRUCTURE

- **£900m for premises and IT** (this is the continuation of the Primary Care Transformation Fund, now renamed)
- **£45m** for e-consultation support
- New rules to allow up to **100% reimbursement of premises developments**
- Over **18% increase in allocations to CCGs** for provision of IT services and technology for general practice

CHAPTER 5: CARE REDESIGN

- **Support to strengthen & redesign general practice by** commissioning and funding of services to provide extra primary care capacity across every part of England, backed by over **£500 million of funding by 2020/21** incl.**£171 million one-off investment** by CCGs starting in 2017/18, for practice transformational support, introduction of a new voluntary Multi-speciality Community Provider contract from April 2017.
- **New national three year 'Releasing Time for Patients' programme to reach every practice in the country to free up to 10 percent of GPs' time (£30m),** building on recent NHS England and BMA roadshows.

Dr Jean Parker (Female) **(GP PARTNER)**
GMC No. 2212155 MBBS; LRCP; MRCS (London 1974); DRCOG, DCH, MRCGP (1987)
Dr Gisbert Waschk (Male) **(GP PARTNER)**
GMC No. 3621893 State Exams Medicine, Cologne 1989 MRCGP (1999)
Mr Colin H Stears (Male) **(MANAGEMENT PARTNER)**
FFA. FMAAT. IHM. MCMI. RSPH
Dr Chrisanthan Ferdinand (Male) **(GP PARTNER)**
GMC 6104427 MB BS (London 2004), MRCGP 2009
Dr Shivanjali Rajeswaran (Female)
GMC No. 6038798 MBBS (London 2001), MRCGP 2007
Dr Madeleine Bennett (Female)
GMC No. 6128040 MB BS (London 2005), MRCGP (2011)
Tel: 020 8692 1354 Fax: 020 8694 1434

St Johns Medical Centre

56 - 60 Loampit Hill Lewisham SE13 7SX

Dr Esther Appleby (Female)
GMC No. 4301602 MB BS (London 1996), BSc 1995, MRCS 2000, DLO 2003, MRCGP 2005, DFSRH
Dr Emily Willson (Female)
GMC No. 7039935 MB ChB (Sheffield 2009), MRCGP 2014
Dr Nadia Tavares (Female)
GMC No. 6130065 MBBS (London 2005), MRCGP 2009
Dr Claire Windsor (Female)
GMC No. 4446718 MB ChB (Edinburgh 1997), BSc, MRCP, MSc, DRCOG, DFFP, DGM
Dr Nadia Yousif (Female) GMC No. 7084658 MBBS (London 2010), MRCGP 2015
Dr Samuel Savage (Male) GMC No. 7082759 MBChB (Bristol 2010), MRCGP 2015
www.stjohnsmedcentre.co.uk

Chair
Health Communities Select Committee
London Borough of Lewisham

18/11/2016

RE -Merger of Partnerships- Hillyfields/Brockley Road, Honor Oak, Morden Hill and St Johns Medical Centre General Practices. To be known as the Central Lewisham Care Partnership

I have been advised by NHS England (NHS E) and Lewisham CCG (CCG) to inform you of the above proposal which we hope will be affective from the 1st April 2017

I am the Management Partner at St Johns Medical Centre and lead the team of mandated representative partners ,one each from the 4 partnerships involved.
The GP sites at Hillyfields and Brockley Road are run by the same group of partners and as such there are 5 sites and 4 partnerships involved in this development.

We have been discussing the opportunity to work at scale for nearly 2 years. All the signals coming from Simon Stevens CEO NHS E say we should be working at a scale of over 30,000 patients to deliver good quality care in the community and with the DoH pushing for integration with Social Services the partners of the above practices saw the opportunity to lead the working at scale in General Practice in Lewisham.

Our proposal is to merge the 4 partnerships into one partnership covering all the sites.
The model is taken from the Birmingham area where practices merge the legal entity (the partnership) but retain the individual contracts with NHS E/CCG unlike the Southwark merger in August where the contracts were handed back and a new overarching one issued by NHS E
The main aim of our model is to simplify the merger but also retain the individual style that each practice offers its patients

Patients will see very little change to the care they receive at their chosen practice indeed our aim is for continuity of care whilst streamlining the back office function in order to put more resources into out front line..

This proposal fits with the Lewisham Health Care Partners (LHCP) vision and in fact I represent Lewisham General Practices on the Board of that partnership.

This is not a change in the delivery of services to residents but is an attempt to make general practice in Lewisham more sustainable and controlled by the partners that choose to come at work in central Lewisham rather than multi nationals such as Virgin Medical and others.

We will, in time, be expanding service across the sites to deliver quality care closer to home for all our patients

Our time line for approval by NHS E and CCG is tight as the joint committee sits on the 15th December but it is important to stress that residents will see no change in the place or from the people they see now. We are having an engagement event early December (before the joint committee) with key people from each of the practices current patient groups to explain the plan. We envisage keeping the individual patient groups at each delivery site (current practice) and having a partnership

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Tel: 020 8692 1354 Fax: 020 8694 1434

St Johns Medical Centre

56 - 60 Loampit Hill Lewisham SE13 7SX

Dr Esther Appleby (Female)
GMC No. 4301602 MB BS (London 1996), BSc 1995, MRCS 2000, DLO 2003, MRCGP 2005, DFSRH
Dr Emily Willson (Female)
GMC No. 7039935 MB ChB (Sheffield 2009), MRCGP 2014
Dr Nadia Tavares (Female)
GMC No. 6130065 MBBS (London 2005), MRCGP 2009
Dr Claire Windsor (Female)
GMC No. 4446718 MB ChB (Edinburgh 1997), BSc, MRCP, MSc, DRCOG, DFFP, DGM
Dr Nadia Yousif (Female) GMC No. 7084658 MBBS (London 2010), MRCGP 2015
Dr Samuel Savage (Male) GMC No. 7082759 MBChB (Bristol 2010), MRCGP 2015
www.stjohnsmedcentre.co.uk

level group they can feed their ideas into.

In context al the proposed sites are situated in central Lewisham and form 45% of Neighbourhood 2 within the CCG and will serve approximately 50,000 patients from its 5 sites. This proposal will certain enable us to work more closely with our social services and community colleagues.

Whilst this model is not new we are the first to propose at this scale in Lewisham, although there was a merger of 4 practices in the south of the borough a few years ago that was not called into OSC. Our plan has 100% backing from the CCG indeed we are being used as the pilot template should other practices consider working at scale.

We are asking that this is not called in formally by OSC as this would mean our time line was unachievable but we are happy to discuss either with you or committee what benefits accrue to your residents from such a development.

In closing I would add as an elected councillor myself in London Borough of Sutton and holding the position of Chair of Adult Social Service and Health Committee (equivalent to your cabinet post) and lead Cllr for Public Health and Vice Chair of the Health and Wellbeing Board I understand only too well concerns that members might have hence our offer for a wider dialogue should you so wish with a request for you to consider if a formal call in is really necessary.

Yours sincerely

Colin Stears
Management Partner St Johns Medical Centre
Lead Proposed Merger Development Group