Lewisham

NHS
Lewisham
Clinical Commissioning Group

Draft Joint Commissioning Intentions for Integrated Care

2015-16 and 2016-17

Updated: 28th October 2014

Version 12

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1. Executive summary

This document sets out our draft Joint Commissioning Intentions for Integrated Care. It is a framework for how we intend to commission local health and care services for 2015/16 and 2016/17. It covers the whole of Lewisham's adult population with a particular focus on:

- frail and vulnerable people;
- adults with complex needs and disabilities;
- older people;
- people with long term conditions and/or mental health problems;
- people with alcohol problems;
- pregnant women.

The draft Joint Commissioning Intentions includes the interface with children and young people's services that are commissioned by the health service. The Children and Young People's plan (2012–2015) - 'It's everybody's business' - sets out the strategic aims and the detailed priorities and plans for all agencies working with children and young people across Lewisham.[1]

It is a single plan with one set of priorities. This is the first time we have brought together the collective resources available to Lewisham Council (Adult Social Care and Public Health) and NHS Lewisham Clinical Commissioning Group (CCG). We aim to use these resources, of nearly £490 million, to their best effect to reshape the advice, support and care services provided across health and social care, working together with our public and partners, to improve health and care and reduce health inequalities.

It sets out how our population's physical, mental and social care needs will be better met through coordinated advice, support and care. Our approach is to commission person-centred care, that through early intervention and integrated care pathways helps Lewisham residents – from birth and throughout life - to enjoy a good quality of life, to make choosing healthy living easier, and to support local people and neighbourhoods to do more for themselves and one another.

It is an ambitious commissioning plan. We believe that by transforming systems and organisations we will be able to respond effectively to the following significant challenges facing health and social care in Lewisham:

- people are living longer.
- more people have one or more long term conditions.
- deprivation is increasing.
- too many people die early from deaths that could have been prevented by healthier lifestyles.
- people's experience of care is very variable.
- services are under increased strain due to a rising level of demand and limited resources.

[1] http://www.lewisham.gov.uk/myservices/socialcare/children/Documents/CYPP2012-15.pdf

- people's expectation of services and the cost of services are increasing.
- there is an affordability gap which cannot be addressed by efficiency and productivity improvements only.

We have chosen six priorities which align with the Better Care Fund submission:

1. prevention and early intervention(section 5.1)
2. GP practices and primary care (section 5.2)
3. Neighbourhood community care for adults (section 5.3)
4. Enhanced care and support for adults (section 5.4)
5. Children and young people's care (section 5.5)
6. Supporting enablers (section 5.6)

The proposed action plans for these priorities will allow us to achieve our ambition and are realistic and feasible to deliver within the expected resources.

These proposed priorities build on and embed the work of previous health and care plans (see box below) all of which have been informed by our Joint Strategic Needs Assessment[2] and the views of local people in Lewisham.

Relevant Lewisham Strategic and Operational Plans
• Health and Wellbeing Strategy • Children's and Young People's Plan 2012-2015 • CCG's Commissioning Strategy 2013-18 • Last Years CCG's Commissioning Intentions 2014/15 – 2015/16 • CCG's Operating Plan 2014/15-2015/16 • Draft south east London commissioning strategy The relationship between these different plans is shown at Appendix A

A financial gap remains between the draft action plans, as set out in these draft Commissioning Intentions, and the resources we expect to have for the next two years. Given these significant challenges, these draft joint Commissioning Intentions are part of a continuing journey of planning, engaging, prioritising and reviewing how best we use our joint resources, of nearly £490 million, to provide quality care with improved health and care outcomes for all in Lewisham. It is part of our ongoing dialogue with the Lewisham people and partners together to determine the way integrated care will be provided in Lewisham. We remain committed to fully engage in an open and transparent way with the public and our providers to discuss the way we can best meet the serious challenges that face statutory health and social care organisations in Lewisham

We know we can find local solutions to the significant challenges we face, today and in the future, by continuing to:

[2] www.lewishamjsna.org.uk and see Glossary of Terms, Appendix F

- work in partnership with Lewisham residents.
- work effectively with the CCG's member practices, both as local commissioners and providers of services.
- work collectively with other CCGs and NHS England, across the south east London health economy as a whole, on the elements of our strategy that cannot be addressed at a Lewisham borough level alone.
- work collaboratively with our local providers, including voluntary and community organisations, to support them to integrate care across organisational boundaries and respond effectively to our commissioning expectations as set out in section 6.

Thus, it is vitally important that we the local health and care commissioners, the CCG's members, Lewisham residents and local providers continue to work together to effectively reshape future health and care systems and organisations locally in Lewisham.

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2. Who we are

NHS Lewisham Clinical Commissioning Group (CCG) and the London Borough of Lewisham (LBL) are responsible for commissioning (planning, buying and monitoring) the majority of health and care services in Lewisham. LBL and Lewisham CCG have co-terminus boundaries.

Residents access acute and community health care mainly from Lewisham and Greenwich NHS Trust and mental health care from South London and Maudsley Foundation Trust. Health and care work together in four geographical neighbourhoods as shown at Appendix B.

NHS Lewisham Clinical Commissioning Group (CCG) is a membership organisation made up of the GP practices in the borough. NHS Lewisham CCG commissions most of the healthcare services for Lewisham residents, including:

- hospital care
- rehabilitation care
- urgent and emergency care
- most of community health services
- mental health
- learning disability services

NHS England commission primary care services such as GPs, pharmacists, dentists and opticians and some other specialist services.

London Borough of Lewisham (LBL) commissions and in some areas provides a wide range of services including:

- adult social care, community and cultural services, public health
- children's social care - targeted and early intervention services for children and young people
- housing and homeless
- education; environment and waste
- planning economy and regeneration
- finances for payment of council tax and benefits

Health and Wellbeing Board – NHS Lewisham CCG and the London Borough of Lewisham work in partnership with other stakeholders[3], as members of Lewisham's Health and Wellbeing Board. The Health and Wellbeing Board is a statutory committee of the London Borough of Lewisham (LBL). It promotes greater integration to improve health and wellbeing in Lewisham and produces the joint strategic needs assessment (JSNA). The Council, the CCG and partners use this information to develop strategies to meet the identified needs of Lewisham people. The Health and Wellbeing Board oversees the Adult Integrated Care Programme, and works alongside the Children and Young People's Strategic Partnership to deliver the priorities in the Children and Young People's Plan:

[3] Health and Wellbeing Board's membership – see Glossary of Terms, Appendix F

- The Children and Young People's Strategic Partnership (CYPSP) brings together all organisations working with and for children and young people in Lewisham, so that services are well placed to deliver our vision that - 'Together with families, we will improve the lives and life chances of the children and young people in Lewisham'.

- The Adults Integrated Care Programme (AICP)[4] covers all adults in Lewisham. It is a whole system approach covering most services and activities across the health and care sector, including public health. It is aligned with universal services such as Supporting People, housing, employment, adult education, culture and leisure and is underpinned by joint commissioning, local pooled budgets (section 75 agreements)[5] and Better Care Funding.

South East London - the six CCGs in south east London are working together with NHS England commissioners (specialised services and primary care), the six London Boroughs and the public to deliver elements of the strategy that cannot be addressed at CCG level alone, or where there is common agreement that there is added value in working collectively. There is a public consultation process underway for the south east London commissioning strategy[6] - 'Our Heathier South East London. Appendix A shows how the different strategic plans fit together.

[4] Adult Integrated Care Programme – see Glossary of Terms, Appendix F
[5] Section 75 Agreements – see Glossary of Terms, Appendix F
[6] http://www.lewishamccg.nhs.uk/get-involved/improving-south-east-Londons-health-services-together/Documents/SEL%20Strategy%2020%20June%202014.pdf

3. Our vision for health and care in Lewisham

Lewisham's vision is to deliver joined up and co-ordinated health and social care to all residents in the borough.

Our overall ambition for adults is for adults to be more in control of their care, to understand what services are available to them and know how to access urgent support. People who use services experience person-centred support and care provided closer to home by joined up teams of staff, working proactively, to reduce the need to attend or be admitted to hospital in an emergency.

Our vision for adult health and care in Lewisham

Better Health – to make choosing healthy living easier - providing people with the right advice, support and care, in the right place, at the right time to improve their health and wellbeing.

Better Care - to provide the most effective personalised care and support where and when it is most needed - giving all adults control of their own care and supporting them to meet their individual needs.

Stronger Communities – to build engaged, resilient and self-directing communities - helping local people and neighbourhoods to do more for themselves and one another.

Our overall ambition for children and young people is that together with families, we will improve the lives and life chances of the children and young people in Lewisham. We will target support to the children, young people and families who need it most, intervening early so that their needs do not escalate and outcomes are improved. We will achieve this through effective joint commissioning and the better alignment of resources across different agencies to deliver the partnership's shared outcomes across health, social care and education.

Our vision for children and young people is underpinned by three shared values:

We will put children and young people first every time.

We will have the highest aspirations and ambitions for all our children and young people.

We will make a positive difference to the lives of children and young people.

4. Local challenges

Local challenge in Lewisham:

- changes in our population's health and social care needs
- Lewisham residents' views of their service is that greater improvement is required
- performance of our current services
- financial position over the next two years

4.1 Population trends and health and social care needs

Key population and ethnicity profile change

Lewisham is a diverse inner London borough with a growing population, projected to increase from 286,000 to 318,000 by 2021. Lewisham is the 15th most ethnically diverse local authority in England - 46% of the population are from black and ethnic minority groups. Lewisham's population is relatively young, with one in four aged under 19 years.

Lewisham's population is projected to grow across all age groups over the next five years. In this period the largest will be in the 20-64 year old age group. The ethnic profile of those aged 20-64 will be increasingly diverse with a greater proportion of people from black and ethnic minority groups.

However, over the next fifteen years the greatest percentage increase will be in the 65+ age group. The ethnic profile of the older population which had been previously predominantly white will also change.

Challenge – people are living longer

Around 26,000 residents in Lewisham are above 65 years of age and over 3,400 are aged over 85 years. In 2012/13 almost 8000 Lewisham people aged 65 years and over had an emergency admission to hospital. The most common diagnosis for admission for those aged over 65 years was pneumonia, urinary tract infections (UTI) and COPD

There have been improvements in the health of Lewisham residents. However Lewisham people still have significantly worst health outcomes than the rest of London and England.

Challenge – more people have one or more long term conditions

The likelihood of having a long term condition, including dementia increases with age; over 50% of those aged over 75 are likely to have two or more long term conditions. Long term conditions account for £7 of every £10 spent on health and care in England.

Deprivation

Deprivation is increasing in Lewisham. The Index of Multiple Deprivation 2010 ranks Lewisham 31st of 326 districts in England and 9th out of 33 London boroughs.

Challenge – increasing deprivation

People living in the most deprived wards have poorer health outcomes and lower life expectancy compared to England's average

The areas of the highest deprivation are found in Evelyn (the most culturally diverse ward in the borough) and Whitefoot and Bellingham (wards with the highest proportion of older people). Even within wards there can be very wide and potentially increasing variation in the wellbeing and life chances experienced by residents.

Mortality

Life expectancy has been improving. The life expectancy at birth was 76.7 years for women and 72.3 years for men in 1991-93; in 2008-10 it had increased to 81.3 years and 78.8 years respectively, however, for both men and women life expectancy remains lower than the England average. Also there are even greater differences in life expectancy rates in different wards within the borough. Life expectancy is 6.6 years lower for men and women in the most deprived areas of Lewisham than in the least deprived areas.

Challenge – too many people die early from deaths that could have been prevented by healthier lifestyles

Cancer is now the main cause of death (28.3%), followed by circulatory disease (28.1%), respiratory disease (13.8%) and dementia (9%) in Lewisham.

A fifth (21%) of Lewisham population smoke, which is more than the national average. About a third of adults in the borough are overweight or obese, compared to just under a quarter in England as a whole. Lewisham also has a high level of childhood obesity - over 25% of Reception children and 37% of Year 6 are overweight or obese. Alcohol related harm is significant and increasing in Lewisham.

The main health risks by age group	
Children • premature delivery • low birth weights of babies • high levels of obesity • exposure to toxic stress • the level of child poverty in Lewisham is significantly worse than the England average • the rate of family homelessness is also worse than the England average	**Young people** • mental health issues, often as a consequence of exposure to toxic stress during early development • sexual ill-health - high levels of teenage pregnancy and rates of sexually transmitted infections (STIs) • high levels of obesity • tobacco, alcohol and cannabis use also adversely affect young people's health in Lewisham
Adults • increasing numbers of people diagnosed with long term conditions and their management, in particular, diabetes, COPD, CVD and hypertension • level of mental health needs for both common and severe mental illness is significantly higher for adults in Lewisham than comparative borough • Lewisham is only identifying 52.9% of people with dementia; increasing the low diagnosis is a national challenge • high levels of drug and alcohol misuse	**Older people** • the likelihood of having a long term condition increases with age, with over 50% of those aged 75+ having two or more long term conditions. • dementia as it increases markedly with age and the level of diagnosis is low (see Adults section) • accidental falls - the rate of emergency hospital admissions for accidental falls is significantly higher in Lewisham than the England average, at 3,367 per 100,000 in 2012/13

Further information is available from Lewisham's Joint Strategic Needs Assessment.[7]

4.2 Lewisham residents' views of our service

There has been an ongoing dialogue with the people of Lewisham and local providers about our proposed commissioning priorities and plans through a wide programme of engagement, including the Quality Summit[8], joint workshops on integrated care[9], focus groups[10], online surveys [11]as well as a range of consultation

[7] http://www.lewishamjsna.org.uk/
[8] Quality in Health and Social Care – a People's Summit – 29th March 2014
[9] Joint Integrated Workshops have been held to map care pathways; review information and advice and develop neighbourhood community vision during 2014

events. We have worked closely with Lewisham Healthwatch and with the many voluntary organisations and community groups in Lewisham to capture the views of local people about their local services, which are summarised at Appendix C.

This engagement work has confirmed that the people in Lewisham support the key priorities of the Adult Integrated Care Programme including:

- individuals making choices and decisions for themselves -which requires better information to support people to have greater confidence to make choices and take control of the management of their own care.
- individuals looking after themselves more and a willingness to self-manage their health and wellbeing – but again this requires better information and advice which is personalised and access to the right support.
- better co-ordination and joined up health and care services which includes the voluntary sector.
- personalised care which is holistic – where the user of the service is in control, supported with individual care planning and shared decision making.

This engagement work has confirmed that further improvements are required in local services. Lewisham Healthwatch recently provided an overview of the key messages from Lewisham people during 2013-14, which was reinforced at the People's Quality Summit in March 2014, as summarised in the box below:

How to improve health and care outcomes -

Summary feedback from local residents:

- **More information** – Lewisham residents want greater information on:
  - how to access services and activities - to know how to access services out of hours and weekends; more information on how services are performing against standards
  - how to do more self-care and manage their own care; there is a strong willingness to self-manage and support for 'every contact counts'; people want more information about their medication and discharge information
  - how to get involved in community activities.
- **Caring staff** – local people who use services want competent staff who are courteous and compassionate and treat the person as an individual; who listen and keep the user, carers and family members informed throughout the planning, care and treatment
- **Better coordinated services** – Lewisham residents strongly supported joined up health and social care, specifically improving the coordination between district nurses, care workers and other agencies

Source: Healthwatch Lewisham (July 2014); People's Quality Summit (March 2014)

[10] Focus Groups with different specific groups (reflecting our seldom heard and equalities protected characteristics) as part of developing the CCG's Commissioning Strategy

[11] Online survey of the CCG's Commissioning Intentions – January 2014

The above views of Lewisham residents have informed the development of the proposed implementation plans for 2015/16 and 2016/17 as summarised in Section 5.

See Appendix C for more information which shows the Lewisham people have informed the development of specific action plans for 2015/16 and 2016/17.

4.3 Performance of our services

We have seen improvements in services already during 2013/14 with the alignment of acute and community health and care teams and the pilot of an integrated multi-disciplinary team in one neighbourhood:

- people with long term conditions feel more supported.
- emergency admissions for chronic conditions have reduced.
- 87% of the people who were supported through Enablement Care Services were able to remain in the community at the end of the service provision.
- although our older people population has risen, there has been a decrease in the numbers entering residential or nursing care. Therefore more people have remained in their own homes also the number of emergency admissions has reduced for people over 65 years.
- mothers who smoke at time of delivery has decreased from 8.7% in March 2012 to 4.4% in March 2014. This is significantly lower than the average in England at 12%.
- the number of Looked After Children (LAC) who have completed annual health assessments rose from 80.9% in March 2012 to 92.8% as at August 2014, and 100% of Looked After Children aged 0-4 have had annual health checks.
- percentage of LAC who received intervention for substance misuse is 100%, exceeding the target of 80%.

There are many examples of excellent services in Lewisham; but we have not succeeded in rolling out best practice and innovation uniformly across the borough, and some unacceptable variation in services and outcomes remains, for example:

- the NHS Constitutional standard that Lewisham residents should start their consultant led treatment within a maximum of 18 weeks from GP referral for non-urgent conditions is not being met fully – in August 2014 the overall performance was 89%.

- some Lewisham people have difficulty in accessing primary care services.

- a high proportion of children in Lewisham are not being vaccinated, especially the uptake of the pre-school booster and the MMR2 by the age of five remain below target.

Challenge – people's experience of care is very variable

Reduce the current variation in the quality of care and experience for all Lewisham residents

Given the rising pressure on health and care services, we need to ensure that a consistent high quality care is provided within the finite resources.

Challenge – increasing pressure on services

Maintain high quality services which are safe when services are under increased strain due to a rising level of demand and limited resources

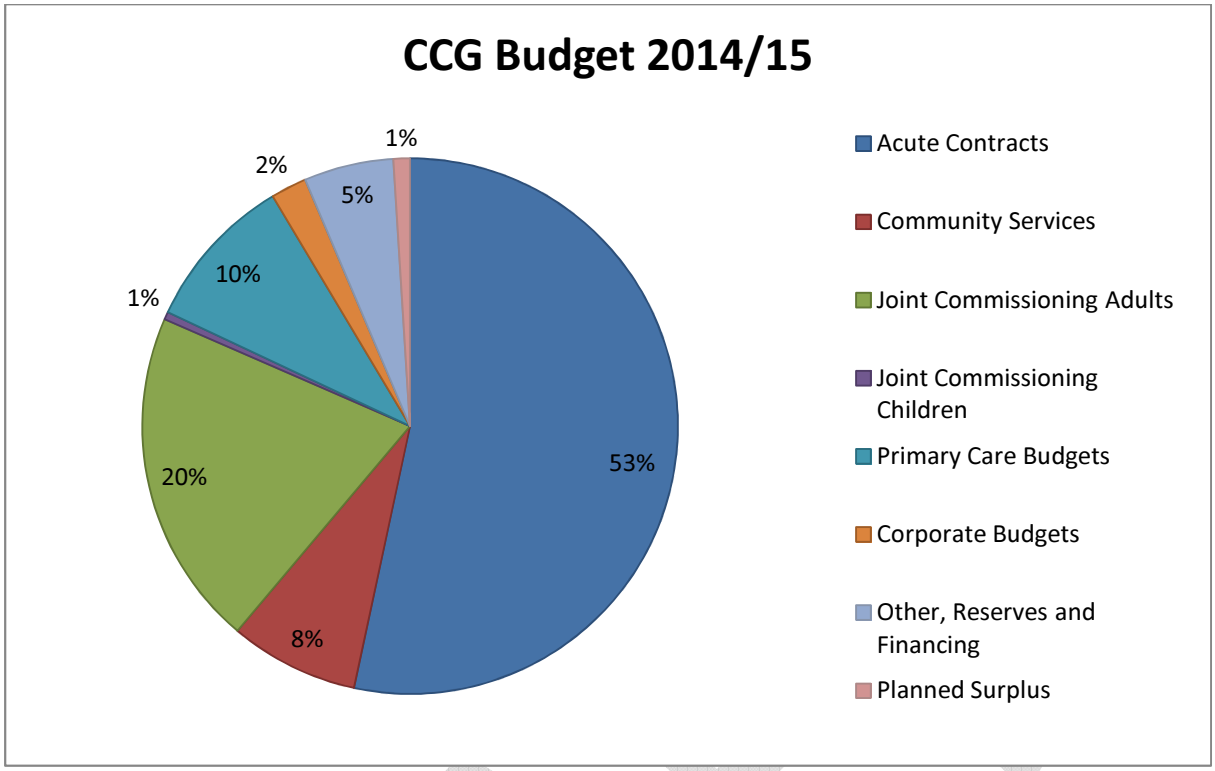
The cost of providing care is getting more expensive. The health service can now treat illnesses that previously were undiagnosed or were simply untreatable. People with more complex conditions can be supported in the community due to better drugs, equipment and skilled staff. It is good that more people are receiving health and care, but we cannot afford to keep treating more and more people. We need to work together to improve the performance of some services, but also provide services in a different way in the future.

Challenge – rising expectations of people and increasing cost of services

The cost of delivering health and care services is increasing - we need to work together to improve the performance of some services, but also provide services in a different way in the future.

4.4 Financial position over the next two years

NHS Lewisham Clinical Commissioning Group (CCG) receives around £384m (2014/15) to commission most of the healthcare services in Lewisham which we allocate as follows:



53% of the CCG's budget is spent on acute hospital care equivalent to £205 million.

If NHS Lewisham CCG continues to commission in the same way as today it will result in the CCG facing a funding gap between projected spending requirements and resources available of around £27.5 million between 2015/16 and 2016/17.

NHS Lewisham CCG	2014/15 (this year)	2015/16 (year 1)	2016/17 (year 2)
Net spend budget	£377.826 million[12]	£391.633 million	£398.595 million
Savings required	£9.990 million	£13.557 million	£13.964 million

Source: NHS Lewisham CCG's Governing Body March 2014

This estimate is made taking into account current expected productivity improvements and the expected annual out-turn expenditure in line with contracts, and assumes that the health budget will remain protected in real terms and is based on national guidance[13].

Lewisham Council has a net spend budget of £268 million in 2014/15. It needs to make £85 million savings over the next three years due to reduced government

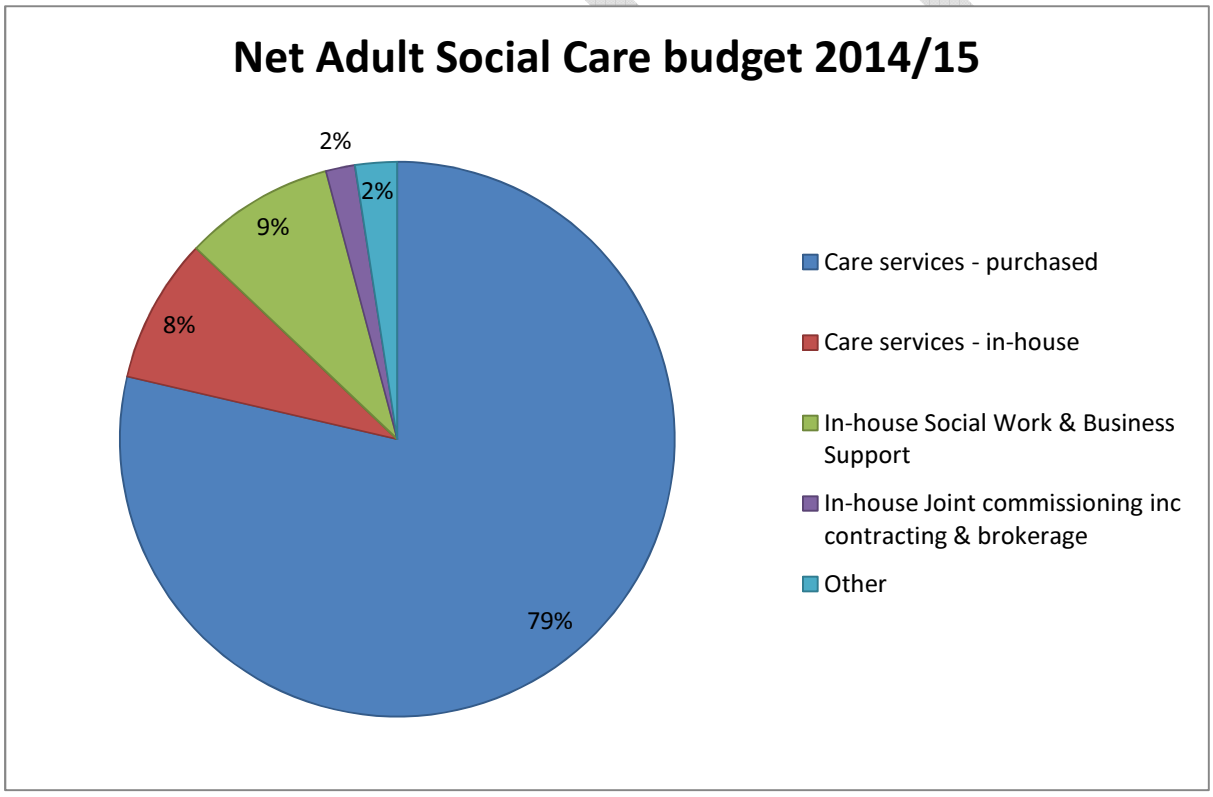
[12] As at March 2014, since then additional budget adjustments have been made.
[13] 'Everyone Counts: Planning for Patients 2014/15 - 2018/19' – see Glossary of Terms – Appendix F

funding – as shown below. The Council is engaging with Lewisham residents on how these savings can be made as part of the 'Lewisham's Big Budget Challenge'[14]

Lewisham Council	2014/15 (this year)	2015/16 (year 1)	2016/17 (year 2)
Savings required	£39.0 million	£26.0 million	£20.0 million

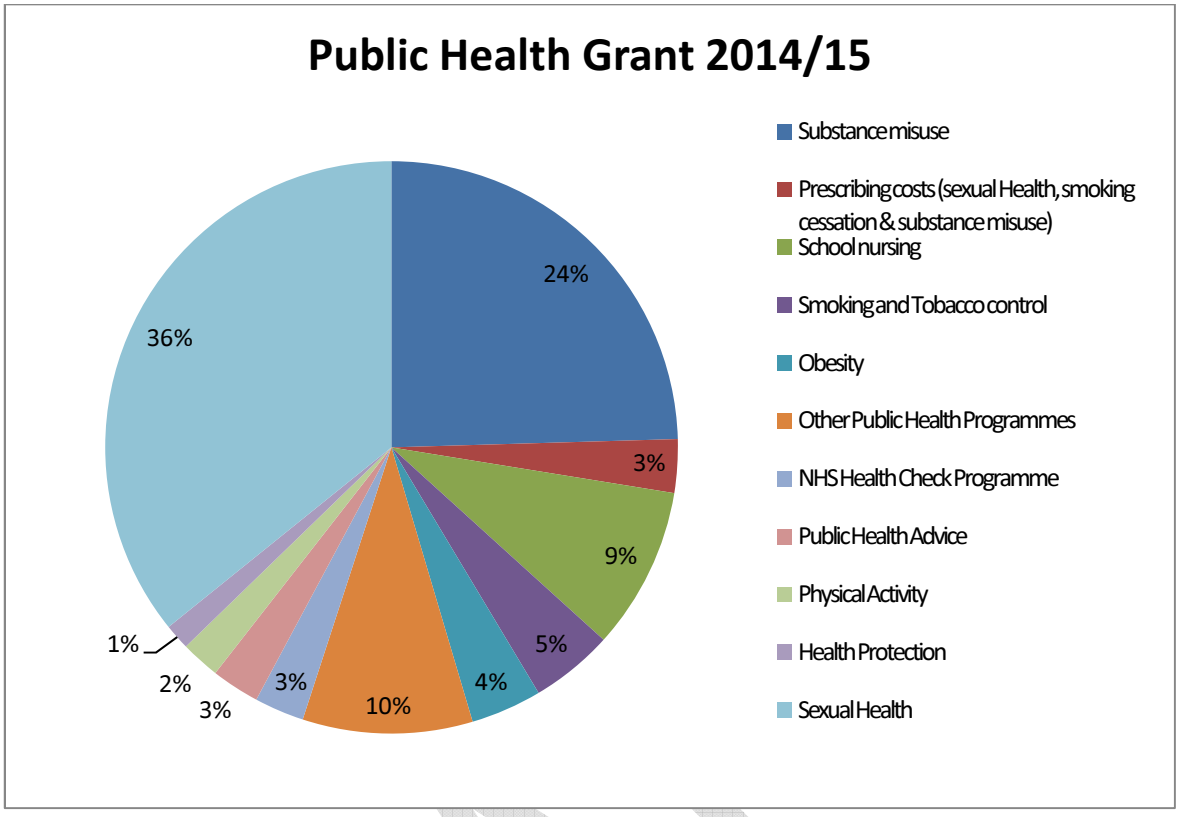
Source: Healthier Communities Select Committee, 21st October 2014, item 5, Lewisham Futures Programme

Lewisham Council's Adult Social Care (ASC) has a net budget of £84.57 million. The majority (87%) of the ASC's budget is spent on the provision of care to individuals, either in their own homes or in community settings – as shown below. As the largest service area, adult social care will be required to make a substantial contribution to the Council savings programme over the next two years.



Lewisham Council's Public Health budget is £20 million in 2014/15. It is currently a 'ring fenced budget' so this money has to be invested in Public Health. The main areas of Public Health expenditure are

[14] http://www.lewisham.gov.uk/getinvolved/influence/Pages/The-Lewisham-Big-Budget-Challenge.aspx



Integrated care has delivered some efficiency savings and reshaped some services already. But improved productivity and efficiency savings alone will not be sufficient action to address the significant financial pressures and to respond to increases in the level and complexity of demand.

Challenge – affordability gap

Greater efficiency and productivity improvements will not be sufficient to address the significant financial challenges Lewisham faces.

This means the solution is to work together to change what we do and how we do it.

5. Proposed commissioning priorities and plans for 2015/16-2016/17

This section describes the six proposed commissioning priorities for 2015/16-2016/17 to deliver integrated care across Lewisham, which is centred around the individual, their family and their carers:

1. prevention and early intervention(section 5.1)
2. GP practices and primary care (section 5.2)
3. Neighbourhood community care for adults (section 5.3)
4. Enhanced care and support for adults (section 5.4)
5. Children and young people's care (section 5.5)
6. Supporting enablers (section 5.6)

5.1 Prevention and early intervention

Our aim for prevention and early intervention
To connect people to services and communities across the borough to promote wellbeing; where people recognise their personal strength and abilities as well as those of their families, friends and communities. To encourage people to stay independent longer and to find creative solutions to individual and collective challenges.

What actions do Lewisham commissioners intend to implement over next two years?

The proposed action plan for Prevention and Early Intervention is to:

- establish a Single Point of Access to improve the coordination and provision of information and advice, borough wide, with a single phone number for social care and health, to provide more detailed information about services available and advice on how to stay healthy.

- provide a borough wide information and advice gateway to provide specialist advice and signposting for carers. This information will support self- help and self-care and be the access point for care accounts, as required by the Care Act 2014.

- promote healthy life styles to support Lewisham people to have greater engagement in and control of their own health and care by**:**

- improving the provision and access to preventative services, low level equipment and rehabilitation and reablement of people following a fall, to reduce the number of falls.

- increasing the support to people to enable them to stay in their own homes by investing in minor housing improvements such as those achieved through “warm homes” and handyperson schemes, low level equipment and telecare.

- integrating health improvement services with the neighbourhood community networks so that interventions and services can facilitate and support life style and behaviour changes - to reduce smoking, alcohol and drug misuse; promote mental and emotional wellbeing healthy eating, exercise and cancer screening - through making ‘every contact count’.

- extend Lewisham’s Community Connections project to connect people to local support and activities, reduce isolation and improve wellbeing for the people who use services and carers.
- Children and Young People:

  - promote emotional wellbeing of our young people through delivery of our Headstart programme and submission to The Big Lottery for further work in 2015.
  - implement the expansion of health visitors and transfer of responsibilities to Local Authorities.
  - reduce preventable childhood illness by promoting the uptake of infant and child vaccinations and a wider model of intervention.

5.2 GP practices and primary care

Our aim for GP practices and primary care
To provide strong GP practices and primary care[15] focused on delivering continuity of care which is proactive, co-ordinated and accessible to deliver improved outcomes, working in partnership with patients and in collaboration with other practices and neighbourhood community teams.

What actions do Lewisham commissioners intend to implement over next two years?

The proposed action plan for GP practices, working with neighbourhood community teams, supported by local improvement funding, is to:

[15] Primary Care services includes GP practices, community pharmacists, general dental practitioners and optometrists

- increase the level of proactive, preventative care focused on 'every contact counts'; health checks, promoting immunisation and vaccination, to promote better health.
- increase earlier identification, diagnosis and intervention for people over 75 - diabetes, Cardiovascular-disease (CVD), chronic-obstructive pulmonary-disease (COPD), dementia and cancer, to improve health outcomes.
- provide greater support to patient self-management of long term conditions, to increase individual choice and control.
- ensure that patients have collaborative care plans, identify people who will benefit from continuity of care and ensure that these people have a named professional accountable for their care.
- reduce variation in care between GP practices by supporting GP practices:
  - make appropriate outpatient referrals by improving the pathways of care and evaluating the Referral Support Service pilot[16].
  - effective medication reviews and prescribing of medicines.
  - address quality standards, diagnosis and management of disease as highlighted in neighbourhood population profiles.
  - improve the patient's experience with better access in hours and out of hours and continuity of care, using the information gained from the public about the barriers to accessing GP services.
  - support NHS England's consultation on the London draft standards and specifications for primary care.
- improve the quality and accessibility of urgent care by redesigning current services, like 'walk in centres' [17], to make them simpler to navigate, with a common specification and with the roll out of NHS 111 In Lewisham working with neighbouring CCGs.
- enhance access to Mental Health Specialist advice and support to primary care via neighbourhood link workers and consultants supporting the seamless and effective transition of individuals with mental health needs into primary care.
- support specialist provision within primary care to provide enhanced treatment for drug and alcohol problems with a particular focus on increasing and higher risk drinkers.
- support the implementation of End of Life - "One Chance to Get it Right" and the opportunities of better care with Coordinate My Care.
- take forward the potential opportunities of primary care co-commissioning including developing the appropriate governance arrangements, working collaboratively across south east London.

[16] Referral Support Service – see Glossary of Terms – Appendix F
[17] Walk in centres in Lewisham - see Glossary of Terms – Appendix F

- support GPs to continuously improve the quality of services they provide by implementing an education and training programme.
- increase the co-ordination of care working with the wider primary care team – with community pharmacists for minor illnesses, general dental practitioners and optometrists.

5.3 Neighbourhood community care for adults

Our aim for neighbourhood community care for adults
To provide co-ordinated support and care, by locally based multi-disciplinary teams, for people with long term physical and/or mental health conditions and vulnerable people, with their carers, families and communities to effectively manage their own care, where possible, and maintain their independence.

What actions do Lewisham commissioners intend to implement over next two years?

The proposed action plan for Neighbourhood Community Care is to:

- embed and enhance the effectiveness of the Neighbourhood community teams which are aligned to General Practice (GP) clusters with the integration of mental health workers to co-ordinate both physical and mental health care. These multi-disciplinary teams have already brought together district nurses, all therapies, social workers and care workers. The core neighbourhood community teams are linked with the wider neighbourhood community network. The functions of the neighbourhood community teams are to provide:
  - preventative care through the early identification of risks and deterioration.
  - admission avoidance using local multidisciplinary teams (MDTs) centred around person centred care and collaborative care plans.
  - support following hospital discharge to remain well and supported in the community.
  - short-term enablement support to enhance independent living skills.
  - joint medication policy and medication reviews to optimise the use of medication.
  - increase people's confidence and motivation to manage their condition by extending peer support and self-management.
  - provision of 'hub' services for drug and alcohol misusers in the community.
- Take a shared approach to care management across health and social care, including:
  - same approach to risk stratification to identify those people at higher risks of a deterioration in their health.
  - sharing of information, resulting in individuals only having to tell their story once.

- single assessment and co-produced health and social care records.
- single reviews undertaken by trusted reviewers on behalf of health and social care whenever possible.
- personal budgets are offered to all to adults and children who are eligible for NHS Fully Funded continuing healthcare.

- workforce training to ensure that all staff have the appropriate capability, capacity and engagement to ensure an equitable service for all users of services, including strengthening working practices through leadership and supervision to heath and care staff who work in people's homes and in isolation.

- realignment of care packages for people with learning and/or physical disabilities to meet their needs in the most cost effective way. This will include potentially taking forward preliminary work to develop new integrated personal commissioning for people with complex needs, working with people who use these services, their families and the voluntary sector.

- give equal status to mental health with physical health, by enhancing the range of community mental health services and interventions that are tailor-made to the needs of individuals and their aspirations for long term recovery and provide support to reduce relapse and need for hospital re-admission.
- support the development of Lewisham's Maternity Care Model to promote normalised child birth and improve continuity of care for mothers.
- review of current services and procurement approaches for community based services:

  - review community health services to ensure that the delivery of these services are fully integrated with the neighbourhood community teams and to identify areas for potential future market testing, which is likely to include diabetes, pressure ulcer and tissue viability services.
  - Review acute services to ensure that the delivery of these services are fully integrated across health and social care to identify areas for potential innovative contractual models which is likely to include the care pathway for musculoskeletal[18], direct access physiotherapy, dermatology and cardiology.
  - review of talking therapies services in the borough to inform future service development.
  - review mental health voluntary contracts to increase the opportunity for community support for people with mental health problems and reducing the reliance on secondary care services.

[18] MSK – Musculoskeletal - see Glossary of Terms Appendix F

5.4 Enhanced care and support for adults

Our aim for enhanced care and support for adults
To refocus and redesign the current community based intermediate tier of services to better provide enhanced care to support people to continue to live at home and to prevent people requiring a hospital admission and ensuring effective structured discharge to avoid re-admission.

What actions do Lewisham commissioners intend to implement over next two years?

The proposed action plan for enhanced care and support is to:

- provide additional community based support by responding rapidly to changes in circumstances and providing alternative services to acute hospital care, to maximise the opportunity for people to remain in their own home or within a community setting.
- refocus and reshape existing community based care services that contribute to admission avoidance across Lewisham's health and care sector to improve their responsiveness, application and outcomes. This will include redesigning access to and pathways through such services. New approaches will be piloted over the winter period and, where successful, new contracts for services will be put in place from 2015/16 with a focus on enhancing 'step up' facilities[19].
- review, develop and enhance support available to and within care homes to ensure that unplanned admissions from such settings can be reduced.
- improve the structures around discharge planning and its associated services to reduce unnecessary delay and readmission. This covers assessments of need, home preparation services and night sitting services.
- streamline the process and application for the Disabled Facilities Grant to ensure that it is used to best effect to maximise the benefits for residents working with housing services.
- work in partnership with Housing – to deliver alternative service models to support people to live longer in the community
    - Implement new model for extra care housing including remodelling existing sheltered assets developed jointly with Lewisham Homes
    - Explore alternative models of housing and support for vulnerable groups including people with learning disabilities and mental health problems
- review and evaluate the implementation of the adult Mental Health model to ensure that it is improving outcomes for services users and reducing the reliance on bed based care.
- improve continuing healthcare (CHC) processes for assessment and case management by:

[19] Community Based 'Step up' services – see Glossary of Terms Appendix F

- reviewing the CHC process from checklist/referral to decision making in order to improve processes.
- reviewing placement activity (AQP via spot purchasing vs home care packages) in order to identify current trends and projections for future demand.
- developing a joint funding policy with the London Borough of Lewisham for patients who do not meet the eligibility criteria for NHS Fully Funded Continuing Care but have significant health care needs.

- recomission our nursing home contracts to ensure that we have access to sufficient high quality cost effective which offer choice to service users and their families.

- review the provision of specialist continuing care services for older adults with severe mental health problems to ensure that these specialist services are commissioned in the most clinically appropriate and cost effective way.

- End of Life – to ensure the NHS London Strategic Clinical End of Life Network Guidance on Commissioning Intentions is implemented locally
- Neuro-rehabilitation to ensure that Lewisham residents have access to a range of neuro-rehabilitation services including specialist bed based, currently commissioned by NHS England, lower acuity bed based services, slow stream rehabilitation and community based neuro-rehabilitation

- re-commission the existing domiciliary care framework to move from a model which delivers care in a 'time and task ' approach to one which focuses on delivering outcomes which are important to individuals and their families'.
- explore the opportunities for supporting people who have both physical and mental health problems and who need a hospital admission by developing a different model of care between acute care and mental health focusing on rapid assessment and discharge planning (RAID).

5.5 Children and young people's care

Our aim for children and young people's care
To provide integrated care pathways that provide high quality support – with choice and control for children, young people and their families at the right time, in the right place for all our children and young people, ensuring that needs do not escalate.

What actions do Lewisham commissioners intend to implement over next two years?

The proposed action plan for Children's and Young People is to:

- shape the development of regional health service provision through the south east London Clinical Commissioning Strategy – ensuring that our existing areas of good practice are emphasised and replicated.
- deliver high quality and integrated care pathways in the community to ensure that all children receive excellent and complementary care from different services, partners and providers - including children's community nursing, school nurses, therapies, and special needs nursing.
- develop the process and mechanisms through which to deliver personal health budgets to children, including those with Education, Health and Care Plans.
- secure high quality community health services through re-modelled and effective service delivery with commissioned providers, including school nurses, therapies, and special needs nursing.
- Commission a new drug and alcohol treatment service for Children and Young People up to the age of 25

5.6 Supporting enablers

Our aim for supporting enablers
To ensure that the necessary tools and infra-structure are in place to achieve the cultural changes and working practices required to support integrated care, including public communication and engagement, Information Technology, commissioning tools, estates utilisation

What actions do Lewisham commissioners intend to implement over next two years?

The proposed action plan for Supporting Enablers is to:

- improve the communication with the public to promote system wide change in the way advice, support and care is provided.
- implement a joint workforce development plan to support the ambition of integrated care and the proposed action plans set out in the Commissioning Intentions:
  - new ways of working, - different skill mix, new generic roles; new competencies.
  - different relationship with patients - a cultural change in the relationship with people who use our services and carers supporting empowerment and independence.

- maximise the potential of technological advances to support people who use our services and professionals, specifically the delivery of Connect Care[20], to provide health and care professionals with more complete information about a person's needs and to support and facilitate, amongst other things, joint assessments, joint care planning and swifter interventions.
- use different commissioning, procurement and contractual tools to secure the potential benefits of integrated care:
  - sharing of risks and incentives between commissioners and providers;
  - joint procurement.
  - the opportunities of Payment by Results (PbR)[21] flexibilities.
  - the commissioning of support service using the opportunities to buy from the Commissioning Support Lead Provider Framework[22].
- provide programme support for Adult Integrated Care Programme[23] to ensure implementation is paced and mainstreamed and evaluations are undertaken and learning shared
- better utilisation of our collective estates by statutory and voluntary organisations – to work with providers to undertake a review of estates in Lewisham Borough to maximise their effective.

[20] Connect Care – see Glossary of Terms, Appendix F
[21] Payment by Results - see Glossary of Terms, Appendix F
[22] Commissioning Support Lead Provider Framework – see Glossary of Terms, Appendix F
[23] Adult Integrated Care Programme - see Glossary of Terms, Appendix F

6. Commissioners' ambition for 2015/16 and 2016/17

6.1 Commissioner's ambition for Lewisham residents

As commissioners we intend to bring together the collective resources available to Lewisham Council (Adult Social Care and Public Health) and NHS Lewisham Clinical Commissioning Group (CCG), of nearly £490 million, to use them to the maximum benefit to support people to live well in all aspects of their lives. Our ambition is to achieve better outcomes than we do now for Lewisham residents by:

- making choosing healthy living easier - providing people with the right advice, support and care, in the right place, at the right time to improve their health and wellbeing and help people live independently.

- providing the most effective personalised care and support where and when it is most needed, so giving all adults control of their own care and supporting them to meet their individual needs.

- helping to build engaged, resilient and self-directing communities - enabling and assisting local people and neighbourhoods to do more for themselves and one another.

6.2 Commissioners' ambition for system wide change

Our ambition is to deliver the six system wide changes across health and social care, summarised below, working together with the people of Lewisham and partners, to achieve improved health and care and reduced inequalities.

Commissioners' ambition for system wide change in 2015/16 and 2016/17
1. Commission advice, support and care services for the **whole population** using techniques of risk stratification, patient segmentation and evidence based care to ensure our collective, limited resources are most effectively used to meet the local health and care needs and challenges. 2. Use an **outcome based approach** to commissioning to ensure that advice, support and care is person centred and delivered earlier and more effectively resulting in: • consistent high quality of care and patient experience whenever and wherever care is provided. • reduced variation and inequalities in health and care outcomes. • increased focus on proactive, preventative care. 3. Work in **partnership with Lewisham residents** to empowering users of services to help reshape their services to achieve better outcomes. 4. **Shift the focus of resources** to invest in joined up primary care, social care and

community care, for both physical and mental health, so that people receive the support they need when they need it and to reduce the growth in demand for acute (hospital based) services.

5. **Spend our collective resources wisely** to deliver better outcomes and avoid waste by working collaboratively with current and future providers to develop the local market and to identify the procurement approach most suitable to achieve and secure the above system wide transformation.

6.3 Commissioners' ambition for all providers

We wish to commission from a wide range of statutory, voluntary and independent sector providers to support us to deliver the proposed priorities and plans as set out in these Commissioning Intentions and to transform systems and organisations to deliver integrated advice, support and care across Lewisham.

We want to work in partnership with all our local providers to support them to embed, within their organisations, systems and processes to ensure that users of the service views are listened to and acted on in order to achieve continuous improvement in the quality of care, which is proactive, self-monitoring and managed - as an effective organisational response to the Francis recommendations[24] and the Winterbourne View report[25].

We would like to work together with our providers to support them to use the opportunities to develop services that help people to live well in all aspects of their lives and to have strong, effective leadership at every level throughout the organisation, to lead the cultural change in the way in which care is delivered across the health and care system

Finally, we are keen to demonstrate to Lewisham residents that not only do we commission services that provide good value for money and are efficient and effective, but also 'add value' and are financially sustainable.

Commissioners' ambition for all local providers in 2015/16 and 2016/17

1. Continuous improvement in quality of care for all – "getting the basics right every time" monitored and reported publicly:

- **Safety** – have robust systems in place to protect people from abuse and avoidable harm, with an open culture to learn when mistakes do occur.
- **User experience** – develop robust systems to find out about the experiences of all people who use our services, including those who are unlikely to complain or voice their views, triangulated with other quality information.
- **Effectiveness** – have a programme of audits to test that advice, support and care achieves good outcomes, promotes good quality of life and is based on the best

[24] Francis Report – see Glossary of Terms, Appendix F
[25] Winterbourne View report – see Glossary of Terms, Appendix F

available evidence; working towards real time information.

- **Workforce** – ensure care is provided by staff who are caring, compassionate and understand the importance of language and cultural differences; staff who are supported to be confident, engaged, motivated, knowledgeable and properly skilled; staff who have shared values and are empowered to be innovative, creative and to learn.

2. Strong leadership at every level throughout the organisation to support the culture and practice in the way in which care is delivered across the health and care system:

- **Person centred** – where the 'person is in control'; the professional is focused on the total needs of the individual, which empowers the individual to be independent, make informed choice and take control; a behavioural change in the relationship between the person and the professional.
- **Proactive, preventative care focused on better outcomes and reducing inequalities** provided in the community setting, supporting health and wellbeing.
- **Provided in cooperation and collaboration** with other professions and coordinated across organisations (health, social care and the voluntary sector) so that it is seamless to the user, supported by Connect Care[26].
- **Co-produced with people who use the services and the public**, with specific consideration to engage with people from protected characteristics, to proactively reduce inequalities of access and outcomes.
- **Supports learning and innovation**.

3. Added Value

- **Increasing value for money** – demonstrate good value for money, efficiency and effectiveness compared to similar services and avoid waste.
- **Move towards an integrated performance management approach** that focuses on improving 'value', for example, by using a scorecard of outcome metric that relate to safety and effectiveness, patient experience and costs.
- **Develop financially sustainable services** working with commissioners.

[26] Connect Care – see Glossary of Terms, Appendix F

7. Measuring the benefits of integrated care

We wish to use the National Voice "I statements"[27] to make sure that we are measuring what Lewisham residents consider to be the most important benefits to achieved by joined up, integrated care. We want to work with the people of Lewisham to build on the initial work undertaken as part of the CCG's Annual General Meeting (AGM) – see table below – as a basis for further engagement.

Summary of the prioritised "I statements" from NHS Lewisham CCG AGM
• I have an understanding and know what is in my Care Plan • I have the information, and support to use it, that I need to make decisions and choices about my care and support • I have the information, and support to use it, that helps me manage my condition • I tell my story once • I want to be involved in discussions and decisions about my care, support and treatment • I know in advance where I am going, what I will be provided with and who will be my main point of professional contact • Taken together, my care and support help me to live the life I want to the best of my ability. Source: National Voices A narrative for person-centred coordinated ('integrated') care - 'I statements' 2012

Also we will use the NHS, Public Health and Adult Social Care outcomes frameworks and the local communities' feedback to measure success. The majority of these measures are included within the Health and Wellbeing Board Performance Dashboard which is monitored by the Health and Wellbeing Board on a regular basis – See Appendix D.

[27] National Voice 'I Statements' – see Glossary of Terms, Appendix F

8. Engagement process

This draft Joint Commissioning Intentions for Integrated Care sets out our proposed priorities and accompanying draft action plans for local services for 2015/16 and 2016/17, which commissioners consider are most feasible and realistic within the collective, expected resources and best addresses the local challenges we face in Lewisham.

These joint Commissioning Intentions and proposed action plans, however, only partially address the financial challenges that face Lewisham health and care system. A 'financial gap' still remains. The exact size of the remaining 'gap' is difficult to determine precisely, but it will become clearer in January 2015 when it is expected that further national guidance will be available.

The challenge continues:

A financial gap still remains between the proposed action plans as set out in these draft joint Commissioning Intentions and the collective resources we expect to have for the next two years

Therefore it is vitally important that the Council, CCG's members, the public and local providers continue to work together to effectively reshape future health and care systems and organisations locally in Lewisham. Only together will we be able to make sure that the local health and care services are financially sustainable.

We are committed to build on our good communication and engagement to date and to engage fully with you, the public and our providers, to discuss openly and transparently the way we can best meet the serious challenges that face the statutory health and social care sector, to find jointly local innovative solutions. We are putting in a place a programme of engagement events, working with Lewisham Healthwatch, to seek your views and comments during the November and December 2014.

We would welcome your views on the following three issues:

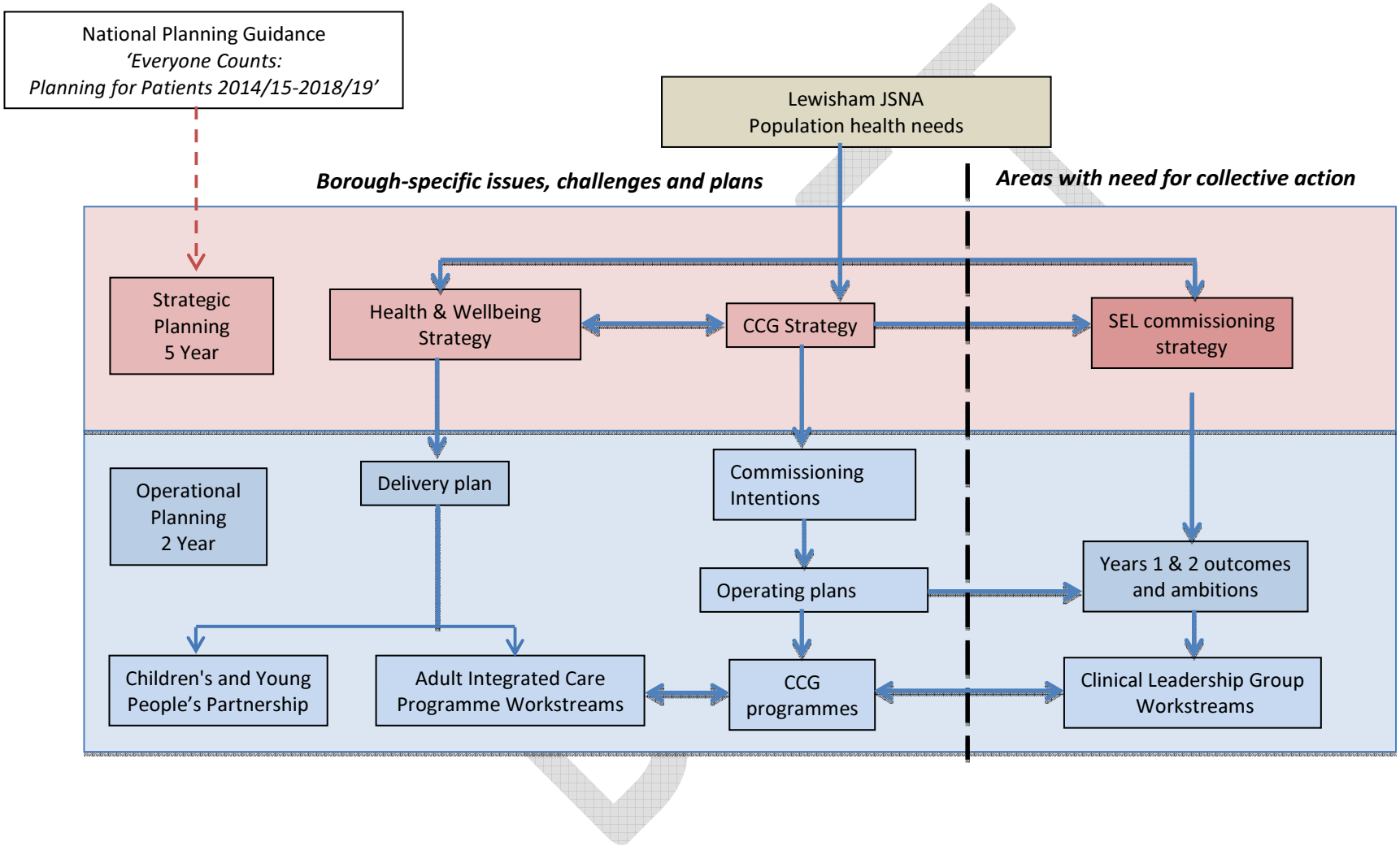
Three engagement Issues
1. Are these the best action plans to deliver the priorities within the limited resources available, for 2015/16 and 2016/17, as set out in section 5? 2. Do you agree that the most important 'I Statements' for us to achieve as a result of joined up, integrated care are those set out in section 7? Or are there other important issues you wish to highlight, from the Lewisham Healthwatch and the Quality Summit summary (section 4.2) 3. Do you support the commissioners' ambition for whole system and providers

changes, as set out in section 6?

Discuss with communications how best to phrase these engagement questions

Please contact XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX with your views before 31st December 2015.

APPENDIX A


National Planning Guidance
'Everyone Counts:
Planning for Patients 2014/15-2018/19'
Lewisham JSNA
Population health needs
Borough-specific issues, challenges and plans
Areas with need for collective action
Strategic Planning 5 Year
Health & Wellbeing Strategy
CCG Strategy
SEL commissioning strategy
Operational Planning 2 Year
Delivery plan
Commissioning Intentions
Operating plans
Years 1 & 2 outcomes and ambitions
Children's and Young People's Partnership
Adult Integrated Care Programme Workstreams
CCG programmes
Clinical Leadership Group Workstreams

GP Practices in Lewisham

North Lewisham Practices

1 Mornington
2 Queens Road
3 Kingfisher MC
4 Clifton Rise
5 New Cross Health Centre
6 Grove Medical Centre
7 Vesta Road
8 Amersham Vale Training Practice
9 Deptford Surgery
10 Dr Batra Surgery
11 Deptford Medical Centre

Central Lewisham Practices

12 Belmont Hill
13 Lewisham Medical Centre
14 Burnt Ash Surgery
15 Morden Hill
16 St Johns Medical Centre
17 Lee Road
18 Brockley Road
19 Hilly Fields Medical Centre
20 Honor Oak
21 Triangle
22 Rushey Green
23 Woodlands Health Centre
24 Nightingale
25 Hurley Group Practice

South East Lewisham Practices

26 South Lewisham
27 Torridon Road
28 Baring Road
29 ICO Moorside Clinic
30 Downham Family Practice
31 Winlaton
32 ICO Chinbrook
33 Parkview
34 ICO Marvels Lane Health Centre
35 Muirkirk Road
36 ICO Boundfield Road Medical Centre
37 Oakview

South West Lewisham Practices

38 Jenner
39 Sydenham Green
40 Woolstone Medical Centre
41 Sydenham Surgery
42 Wells Park
43 Bellingham Green
44 Vale Medical Centre

APPENDIX C

How the views of Lewisham people have an impact on developing the action plans for 2015/16 and 2016/17

Priority	Local service Issues	Public Feedback on local issues	Action planned to be implement during 2015/16 and 2016/17
Prevention and Early Intervention	Information and advice on staying healthy and well.	Strong view that individuals should be making choices and decisions for themselves. This requires better information to give people confidence to make choices and take control of the management of their own care. Clear and consistent information to support health promotion and self-management in appropriate format	Establish a Single Point of Access to improve the coordination and provision of information and advice, borough wide with a single phone number for social care and health, to provide more detailed information about services available and advice on how to stay healthy
	Information and advice on accessing services	Improve the information about accessing services - how to access services out of hours and weekends especially about changes to access to GP out of hours and emergency services;	
	Information and advice on accessing community activities	Want to be able to find out how to get involved in communities activities and co-produce new services;	Extend Lewisham's Community Connections project to connect people to local support and activities, reduce isolation and improve wellbeing for service users and carers.
	Access to performance data about local services	More information about how services are performing which is transparent and easy to access	Commissioners' Ambition for all Local Providers to work in partnership with all local providers to support them to embed, within their organisations, systems and processes to ensure a continuous improvement in quality of care for all – "getting the basics right every time" - monitored and reported publicly

	Health Promotion - general	Strong support for 'every contact counts' ethos; strong willingness to self-manage (eg health trainers);	Integrating health improvement services with the neighbourhood community networks so that interventions and services can facilitate and support life style and behaviour changes - to reduce smoking and alcohol misuse; promote mental and emotional wellbeing healthy eating, exercise and cancer screening - through making 'every contact count'
	Health promotion – mental health	There should be increased awareness about mental health and more done to prevent the onset of mental health;	
General Practice and Primary Care	General Practice - access	Primary Care access continues to be difficult and frustrating, particularly telephone access and for certain groups of the population including carers, young persons, older people and people who do not speak English as a first language;	Reduce variation in care between GP practices by supporting GP practices to improve the patient's experience with better access in hours and out of hours and continuity of care, using the information gained from the public about the barriers to accessing GP services. Support GPs to continuously improve the quality of services they provided by implementing an education and training programme
	General Practice - quality	Improve the continuity of care from general practice Improve the service and communication from practice staff	
	Wider Primary Care - quality	Positive feedback about community pharmacy and the services it provides	Increase the co-ordinating care working with the wider primary care team – with community pharmacists, general dental practitioners and optometrists
Neighbourhood Community Care	Community based care – quality	Improve the quality of district nurses and social work provision; Better coordination between district nurses, care workers and other agencies; Poor experience for mental health users; seem to	Embed and enhance the effectiveness of the Neighbourhood community teams which are aligned to General Practice (GP) clusters with the integration of mental health workers to co-ordinate both physical and mental health care, linked with the wider neighbourhood community network

		be not treated with the same priority as people with physical health needs	Give equal status to mental health with physical health, by enhancing the range of community mental health services and interventions that are tailor made to the needs of individuals and their aspirations for long term recovery and provide support to reduce relapse and need for hospital re-admission
	Integrated community based care	Strong support for better co-ordinated, joined up health and social care including involving and supporting the voluntary sector; but need to make sure that person who uses the service understand who is responsible;	
	Community based care – personalised	Lewisham residents want personalised care across all settings which is holistic – with individual care planning, shared decision making and patients in control; Service users want greater empowerment by being given more information about their care and medication without use of technical language; Adequate time and information needs to be given to support patient understanding and role in decision making;	Implement a shared approach to care management across health and social care including: - Same approach to risk stratification to identify those people at higher risks of a deterioration in their health - sharing of information, so that individuals tell their story only once - single assessment and co-produced health and social care records - single reviews undertaken by trusted reviewers on behalf of health and social care whenever possible - personal budgets to adults and children rolled out to those who receive continuing healthcare
Enhanced Care and Support	Enhanced care and support - quality	Reduce the variability of quality of care provided in hostels and care homes;	Review, develop and enhance support available to and within care homes to ensure that unplanned admissions from such settings can be reduced.
	Enhanced care and support - Inequality	Emerging concerns about equity and equality for some specific groups eg HIV, Substance Misusers, people living in hostels, people in care	Undertake an equalities impact assessment of our joint Commissioning Intentions for Integrated care

		homes, Vietnamese speakers and parents of children with complex needs	
	Enhanced care and support – discharge planning	Users, carers (unpaid) and family members want better inclusion in care planning and process and discharge planning Improve the discharge particularly for vulnerable groups eg hostel residents and mental health patients	Improve the structures around discharge planning and its associated services to reduce unnecessary delay and readmission. This covers assessments of need, home preparation services and night sitting services
Children's and Young People		Positive feedback continues about Lewisham's birthing unit (Ref 1) Young people want to engage with health dialogues to influence services and make sure their needs are understood Mental Health services – improve the access to MH and CAHMs; Greater focus on the transition (16-25 years)	

Public's future expectations		Users experience of care is variable and could be made better Strong desire for improved communication from staff - with improved interpersonal skills, where staff are caring, courteous and compassionate; service users are treated with dignity and respect and listened to	Commissioners' Ambition for all Local Providers to work in partnership with our local providers to support them to embed, within their organisations, systems and processes to ensure continuous improvement in quality of care, which is proactive, self-monitoring and managed: to have strong, effective leadership at every level, throughout the organisation, to lead the change in the culture and practice in the way in which care is delivered across the health and care system.

APPENDIX D

Key Performance Indicators to measure progress

Improved health and care outcomes - to improve outcomes and reduce the gap of equality of opportunities:

- Potential years of life lost from causes amenable to healthcare
- Life expectancy at birth – including inequality in life expectancy at birth
- Premature mortality - under 75 Mortality Rates from CVD, cancer, respiratory disease, Lung Cancer, serious mental illness
- Infant Mortality (under I years)
- Children in Poverty (Under 16s)

Prevention and Early Intervention

- Low birth weight of all babies
- Uptake rates of Immunisation for infants and children
- Cancer screening coverage - breast cancer, cervical cancer, bowel cancer
- Proportion of physically active and inactive adults
- Uptake of Influenza vaccine in those over 65 years of age
- Number of practitioners skilled in identifying those at risk from alcohol harm and delivering brief interventions
- Smoking
    - Level of smoking in the population (18+)
    - 4 week smoking quitters
    - Number of 11-15 year-olds who take up smoking
    - Number of children in smoke free homes
    - Smoking at time of delivery
- Mental Health
    - Level of Serious Mental Illness, dementia, depression in the population
    - Suicide rates
- Sexual Health
    - Rate of chlamydia diagnoses per 100,000 young people aged 15 to 24
    - Level of diagnosed HIV infection in the population
    - Percentage of people presenting with HIV at a late stage of infection(Legal Abortion rate for all ages
    - Teenage conceptions

Better User Experiences

- Long Term Conditions - increase the number of people who feel supported to manage their condition;
- Patients with Long-Term conditions actively engaged in self-care
- Primary Care Access - ease to speak to someone on the phone – CCG Dash Board
- Friends and Family test- hospitals, maternity, GPs mental health and communities – CCG Dash board
- Breastfeeding Prevalence 6-8 weeks

- Self-reported well-being - people with a low happiness score
- Proportion of people using social care who receive self-directed support, and those receiving
- direct payments
- End of life – people dying in their usual place of residence – CCG Dash board

Changes in the way people can obtain advice care and support – provide more community based services and reduce unnecessary hospital admissions

- Reduction in avoidable emergency admission using three measures:
    - Reducing unplanned hospitalisation for chronic ambulatory care sensitive conditions
    - Reducing emergency admissions that should not usually be admitted to hospital
    - Emergency readmissions within 30 days of discharge from hospital
    - unplanned hospitalisation for asthma, diabetes and epilepsy in children
    - emergency admissions for children with lower respiratory tract infection
    - Alcohol related admissions
- Increase in the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
- Delayed transfers of care from hospitals
- Improved access to psychological therapists – CCG Dash Board
- Two week wait referrals for cancer services
- Early diagnosis of cancer

Appendix E

How will we know we have achieved out ambition of integrated care – National Voices "I Statements"

Category	"I" Statement
Overall	I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me.
Goals and outcomes	All my needs as a person are assessed.
	My carer/family have their needs recognised and are given support to care for me.
	I am supported to understand my choices and to set and achieve my goals
	Taken together, my care and support help me live the life I want to the best of my ability.
Care Planning	I work with my team to agree a care and support plan.
	I know what is in my care and support plan. I know what to do if things change or go wrong.
	I have as much control of planning my care and support as I want.
	I can decide the kind of support I need and how to receive it.
	My care plan is clearly entered on my record.
	I have regular reviews of my care and treatment, and of my care and support plan.
	I have regular, comprehensive reviews of my medicines.
	When something is planned, it happens.
	I can plan ahead and stay in control in emergencies.
	I have systems in place to get help at an early stage to avoid a crisis.
Communication	I tell my story once.
	I am listened to about what works for me, in my life.
	I am always kept informed about what the next steps will be.
	The professionals involved with my care talk to each other. We all work as a team.
	I always know who is coordinating my care.
	I have one first point of contact. They understand both me and my condition(s). I can go to them with questions at any time.
	I have the information and support to use it, that I need to make decisions and choices about my care and support.
	I have information, and support to use it, that helps me manage my conditions.
	I can see my health and care records at any time. I can decide who to share them with. I can correct any mistakes in the information.

Information	Information is given to me at the right times. It is appropriate to my condition and circumstances. It is provided in a way that I can understand.
	I am told about the other services that are available to someone in my circumstances, including support organisations.
	I am not left alone to make sense of information. I can meet/phone/email a professional when I need to ask more questions or discuss the options.
Decision making	I am as involved in discussions and decisions about my care, support and treatment as I want to be.
	My family or carer is also involved in these decisions as much as I want them to be.
	I have help to make informed choices if I need and want it.
	I know the amount of money available to me for care and support needs, and I can determine how this is used (whether it's my own money, direct payment, or a 'personal budget' from the council or NHS).
	I am able to get skilled advice to understand costs and make the best use of my budget.
	I can get access to the money quickly without over---complicated procedures.
Transitions	I can get access to the money quickly without over---complicated procedures.
	When I move between services or settings, there is a plan in place for what happens next.
	I know in advance where I am going, what I will be provided with, and who will be my main point of
	I am given information about any medicines I take with me – their purpose, how to take them, potential side effects.
	If I still need contact with previous services/professionals, this is made possible.
	If I move across geographical boundaries I do not lose me entitlements to care and support.
Emergencies	I could plan ahead and stay in control in an emergency.
	I had systems in place so that I could get help at an early stage to avoid crisis.

Appendix F

Glossary of Terms

Adult Integrated Care Programme

Lewisham's Adult Integrated Care Programme (AICPB) builds on work undertaken within the borough since November 2011 to develop and deliver an integrated health and social care model. This work brought together teams of district nurses, all therapies, social workers and care workers. Building on this, further integration took place through the establishment of multi-disciplinary teams to align with GP neighbourhoods. Subsequently, members of the Health and Wellbeing Board agreed to increase the scale and pace of integration.

Better Care Fund

The Better Care Fund (BCF) was announced as part of the 2013 Spending Round and is a core element of the 'Everyone Counts' planning guidance. The national policy guidance stated that 'the Government will introduce a £3.8 billion pooled budget for health and social care services, shared between the NHS and local authorities, to deliver better outcomes and greater efficiencies through more integrated services for older and disabled people, with the resultant reduction in unnecessary hospital admissions and inappropriate lengths of stay.

Care Act (2014)

The Care Act has created a single law that makes it clear what kind of care people should expect. The Care Act consolidates previous adult social care legislation and sets out a number of new duties, including:

- A duty on Councils to consider the physical, mental and emotional wellbeing of individuals in need of care;
- A duty to provide preventative services to maintain people's health and to support them to live independently for as long as possible;
- A cap on care costs of £72,000 and monitoring an individual's progress towards the cap;
- New rights for carers, who will be put on the same legal footing as the people they care for, with extended rights to assessment and rights to support if eligible;
- The provision of information and advice about care and support services to help people navigate the system and make the best choices

Commissioning Support Lead Provider Framework

NHS England has developed a new framework agreement for commissioning support services – the Lead Provider Framework – that enables CCGs, NHS England and other customers to source some or all of their commissioning support needs, ranging from back office support services to more bespoke services that support local and large scale transformational change projects.

Chronic conditions

Chronic conditions require ongoing management over a period of years and cover a wide range of health problems, such as heart disease, diabetes and asthma. These

conditions require a complex response over an extended time period that involve coordinated inputs from a wide range of health and care professionals and access to essential medicines and monitoring systems.

Connect Care
Connect Care, previously known as the Virtual Patient Record, allows patient information to be shared across organisations. It pulls together patient data from acute, community and primary care providing organisations in Lewisham with a read only record at the point that clinical decisions are made.

Enablement care services
Enablement is about helping people become more independent and improve their quality of life. It focuses on helping patients relearn how to do everyday tasks, such as making a meal, getting out of bed and personal care for themselves rather than having someone else doing the tasks for them.

Everyone Counts: Planning for Patients 2014/15 - 2018/19 (December 2013)
Everyone Counts is planning guidance from NHS England that outlines the ambition, priorities and financial planning requirements for the NHS in England.

Francis Report (2013)
The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry 2013 (The Francis Report) chaired by Robert Francis QC made 290 recommendations to the Secretary of State for Health to improve patient safety in the NHS. All NHS organisations have been required by NHS England to respond to the "Francis Report" and to publish an action plan detailing how the recommendations will be implemented.

Health and Wellbeing Board
Health and Wellbeing Boards bring together key leaders from the NHS, public health, adult social care, children's services and Healthwatch, to plan how best to meet the needs of their local population and tackle local inequalities in health. Its main functions are to undertake a Joint Strategic Needs Assessment, develop the Joint Health and Wellbeing Strategy and encourage integrated health and social care.

Integrated Personal Commissioning (September 2014)
NHS England, the Local Government Association, Think Local Act Personal and the Association of Directors of Adult Social Services are formally inviting health and social care leaders to help build a new integrated and personalised commissioning approach through an Integrated Personal Commissioning (IPC) programme which will, for the first time, blend comprehensive health and social care funding for individuals, and allow them to direct how it is used.

Lewisham's Joint Strategic Needs Assessment
Our Joint Strategic Needs Assessment pulls together information about local health and social care needs and is a vital tool to help us plan future services. It explores how Lewisham compares with other areas locally, regionally and nationally. It also

examines what services we are currently providing, what works well and what could be improved.

MSK
MSK is shorthand for Musculoskeletal. MSK disorders cover any injury, disease or problem relating to our muscles, bones or joints.

National Voice "I statements"
"I" statements are indicators for measuring people's experience of integrated care and support. National Voices developed these statements through consultations with patient and user organisations, and from patient experience indicators. They tested and refined them in two workshops involving system leaders, patients, people who use services, carers and patient organisations.

NHS 111
NHS 111 is a new national service aimed at making it easier to access local NHS healthcare services in England. People can dial 111 when they need medical help fast but it's not a 999 emergency. NHS 111 is available 24 hours a day, 365 days a year. At the moment, NHS 111 is being rolled out in different parts of England but is not fully 'live' in Lewisham, Lambeth and Southwark.

NHS Constitution (2013)
The NHS constitution brings together in one place details of what staff, patients and the public can expect from the National Health Service. It also explains what you can do to help support the NHS, help it work effectively, and help ensure that its resources are used responsibly.[28]

Payments by Results
Payments by Results (PbR) is the payment system in England under which CCGs pay healthcare providers for each patient seen or treated, taking into account the complexity of the patient's healthcare needs. PbR currently covers the majority of healthcare in hospitals. For example, £119 for an outpatient attendance in obstetrics or £5,323 for a hip operation.

Referral Support Service
Lewisham's Referral Support Service is a two year pilot to support the GP referral process from referrer to the patient's first outpatient appointment. It offers patients a choice of location, date and time for their appointment, using the electronic referral system 'Choose and Book'.

Section 75 Agreement
An agreement made under section 75 of National Health Services Act 2006 between a local authority and an NHS body in England. Section 75 agreements can include arrangements for pooling resources and delegating certain NHS and local authority health-related functions to the other partner(s) if it would lead to an improvement in the way those functions are exercised.

[28] www.gov.uk/government/uploads/system/uploads/attachment_data/file/170656/NHS_Constitution.pdf

'Step up' and 'step down' services
'Step up' is a short term provision of up to six weeks provided to prevent an admission into a hospital bed. 'Step down' is a provision to speed up discharge from a hospital bed by helping the patient to return to their own home.

Walk in Clinics in Lewisham
The New Cross GP Led Walk-in Centre is a medical practice whose services are available to all, whether they are registered as a patient or not. Patients are able to walk-in, sign in at reception and see the next available clinician. The service offered to patients using the walk-in centre is limited to immediate or same day treatment only and is not suitable for on-going treatment for chronic conditions.

Winterbourne View Report (2012)
The report sets out steps to respond to failings following the abuse revealed at Winterbourne View hospital. The report lays out clear, timetabled actions for health and local authority commissioners working together to transform care and support for people with learning disabilities or autism who also have mental health conditions or behaviours viewed as challenging.