Draft Lewisham's Partnership Commissioning Intentions for Adults 2016 - 2017

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1. Foreword

NHS Lewisham Clinical Commissioning Group (CCG) and Lewisham Council are responsible for commissioning (planning, buying and monitoring) the majority of health and care services in Lewisham.

This document sets out our plans to commission health and care for Lewisham adults in 2016/17. There are separate Commissioning Intentions for children and young people's services.

This year's Partnership Commissioning Intentions are a continuation of the journey to deliver our strategic vision for 'Health and Wellbeing for all Lewisham residents by 2023', which started in 2011, when the Council, the Lewisham Primary Care Trust and the former Lewisham Healthcare Trust agreed to develop and deliver an integrated health and social care model.

Our Partnership Commissioning Intentions for 2016/17, builds on last year's Joint Commissioning Intentions, and has been informed greatly by the feedback received from the public during 2015, the recently refreshed Lewisham Health and Wellbeing Strategy and the work of the Adult Integrated Care Programme Board on developing and implementing Neighbourhood Care Networks (section 7).

In 2016/17, our focus will be on how we can strengthen partnership working with the public (section 5) and with local providers (section 6). We believe that by working together, as equal partners, real solutions can be found to the complex challenges we face, to make sure our health and care systems are delivering the right care in the right place and at the right time to meet local needs.

We would welcome your views on this year's Partnership Commissioning Intentions - please see further information on how to be more involved in our commissioning work at www.lewisham.gov.uk/myservices/socialcare/our-approach or at www.lewishamccg.nhs.uk/get-involved

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2. Current Position

Lewisham has a growing population, projected to increase from 292,000 to 318,000 by 2021, and is the 15th most ethnically diverse local authority in England - 46% of the population are from black and ethnic minority groups. Around 27,400 residents are above 65 years of age and over 3,650 are aged over 85 years. This latter group is often the most complex and therefore bears a very high proportion of care costs.

The Index of Multiple Deprivation 2015 ranks Lewisham 48th of 326 districts in England and 10th out of 33 London boroughs. People living in the most deprived areas have poorer health outcomes and lower life expectancy compared to the England average.

Social housing comprises just over a third of all households in the borough. The private rented sector, the fastest growing housing sector in the borough, comprises some 24% of all households. There are nearly 40,000 one person households in Lewisham.

Lewisham has over 800 active voluntary and community sector organisations and more than 200 individual faith groups. All these groups and many others help to strengthen our communities by galvanising our citizens, addressing local concerns and advocating on behalf of some of the most vulnerable in society.

There have been some improvements in people's health and care in Lewisham. People in Lewisham are living longer because of the success in managing particular conditions such as stroke, heart disease and respiratory disease.

Overall more people who use Adult Social Care (ASC) services in Lewisham say they are extremely or very satisfied with their services compared to other London Boroughs. More people in contact with mental health services in Lewisham are living independently with or without support in comparison to the national average

More information is available about Lewisham's population at www.lewishamjsna.org.uk

3. Local Challenges

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.
- 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 2011-13 it had increased to 83.0 years and 78.7 years respectively, however, for both men and women life expectancy remains lower than the England average.
- 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.

There are significant health inequalities in Lewisham:

- People living in the most deprived wards, in Lewisham, have poorer health outcomes and lower life expectancy compared to England's average. For example premature death rates are significantly higher in Lewisham Central, Bellingham and New Cross wards compared to the Lewisham average.
- Health inequalities should also be considered by ethnic group. Lewisham is one of the most ethnically diverse areas of the country. The Department of Health has highlighted ethnicity as the major inequality in Severe Mental Illness. Black residents are disproportionately over-represented in mental health admissions.

Too many people live with preventable ill health:

- More people have one or more long term conditions - 29% of Lewisham's population have 1 LTC; about 86,570 people.
- 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

Demand for care is increasing, both in numbers and complexity:

- 14% of people in Lewisham identify themselves as having limitations in carrying out day-to-day activities. That is equivalent to around 38,000 people.
- Lewisham's over 60 population is projected to increase by around 15,000 by 2040 which will increase demand for the health and care services

High quality care is not consistently available all the time - too often, the quality of care that patients receive and the outcome of their treatment depends on when and where they access health and care services.

More information is available about trends in health and care at:

Lewisham's Health and Wellbeing Strategy

Add link

London Borough of Lewisham - Local Account 2014 - 2015
www.lewisham.gov.uk/myservices/socialcare

CCG's Strategic Plan 2013 – 18

www.lewishamccg.nhs.uk/about-us/our-plans

Our Healthier South East London's Strategy - www.ourhealthiersel.nhs.uk

4. The Financial Challenge

In England, a major challenge is that the amount of money we have to commission services is not keeping pace with demand and the rising costs of providing care. The costs of care are rising much faster because we are now caring for more people with more complex conditions and people are living longer.

Collectively the CCG, Adult Social Care (ASC) and Public Health have nearly £472.9 million to commission advice support and care on behalf of Lewisham people.

We are facing a funding gap of £15.6 million between the projected spending requirements and expected resources available in 2016/17 and a further £16.6m in2017/18 – see summary table opposite.

In addition local providers will be required to make efficiency savings. This financial gap, however, cannot be addressed by efficiency and productivity improvements only.

With the limited resources available to us, and demand increasing, the way we deliver health and social care will have to change.

	2016/17*	2017/18*
Estimated revenue budget**		
• **CCG**	£399.4m	£404.2
• **ASC and Public Health**	£ 73.5m	£ 69.3m
Total		
Total estimated health and care revenue budget	£472.9m	£473.5m
Net savings requirements		
• **CCG**	£11.4m	£10.9m
• **ASC and Public Health**	£ 4.2m	£ 5.7m
Total health and care savings requirements	£ 15.6m	£16.6m

*split between years to be confirmed
**This excludes additional external funding and NHS revenue budgets for 2016/17 remain estimates ahead of NHSE planning guidance expected in December 2015.

Better Care Fund – a pooled Better Care Fund has been established to provide resources to support a stepped change in the way that health and care is delivered and to reduce the demand for hospital based care.

5. Partnership approach with the Public

To address the above major challenges, the voice of the public and users is vital; effective public communication and engagement is essential.

We, the commissioners, are committed to developing stronger relationships with local people, community groups and voluntary organisations to connect with them in a more meaningful way.

Lewisham people have said 'prevention is better than cure' - we plan to have a much greater focus on prevention (see section 8.1 on Prevention and Early Intervention) to make choosing healthy living easier for the individual. We intend to commission greater support for people to look after their physical and mental health and wellbeing, by reducing the levels of smoking, obesity, alcohol intake and inactivity, which would reduce many deaths each year that could have been avoided.

Lewisham people have said 'we want more control of our condition' - we plan to improve the support provided to increase people's knowledge, skills and confidence to manage their own care and involve them in all decisions about their care and treatment, particularly those people with long term conditions (see section 8.3 on Neighbourhood Community Teams) and people with complex needs (see section 8.4 on Enhanced Care and Support).

Lewisham people want to build strong communities to give support to their neighbours. Specifically people have said that the role of the voluntary and community sector needs to be considered in supporting delivery of services, but also in reaching out to more people.

We want to work with local communities to harness the energy, skills and knowledge of local communities to reach out to all people, including marginalised groups, to co-design and co-deliver local neighbourhood care networks (see section 7 on Neighbourhood Care Networks).

Only by working in partnership with individual, local communities, voluntary organisation and Healthwatch will commissioners be able to ensure that the advice, support and care meets the diverse needs of individuals and communities.

More Information is available on the feedback from Lewisham People at:

Your Voice Counts – add link

'Have your say' a summary of public feedback on the Joint Commissioning Intentions for 2015/16 and 2016/17 – add link

London Borough of Lewisham - Local Account 2014 - 2015 www.lewisham.gov.uk/myservices/socialcare

CCG's AGM www.lewishamccg.nhs.uk/news-publications/Pages/Lewisham-CCG-AGM---slides.aspx

6. Partnership approach with Providers

In parallel to partnership working with the public, we wish to work in partnership with a broad range of statutory, voluntary and independent sector providers to tackle the way historically heath and care has been provided in a fragmented and disjointed way.

Many people have told us that their care is not joined up between different services. Service users and carers find it frustrating to have to continually provide the same information to different people. People with complex conditions are often passed from one service to another while the services do not always communicate with each other.

We plan to support providers to work in greater collaboration with other providers, to reduce the traditional barriers between organisations to develop 'One Lewisham Health and Social Care System' which is sustainable across the health and care services.

This will require:

- Joining up services between primary care, community services and hospital care, between physical and mental health and between health and social care, supported by different commissioning approaches .
- Well led organisations with strong leadership to support their staff to change the way in which care is delivered across the health and care system to provide person centred care (see section 8.7)
- Commissioning more care in the community, as part of developing our four Neighbourhood Care Networks. We are planning that more personalised, co-ordinated care will be provided by our primary care and neighbourhood community care teams, with extra enhanced care and support to help people to live independently in the community.
- Improving accessibility to advice, support and care so that a greater proportion of care is proactive and planned, thereby reducing the levels of unplanned and emergency hospital admissions which often result in poorer health outcomes.
- Commissioning less emergency inpatient care in acute and mental health hospitals as we plan that there will be a reduction in demand for emergency admissions due to there being earlier intervention and greater support based in the community.
- Some investment to develop community based care delivered by Neighbourhood Care Networks while in parallel hospital care is transformed.

7. Our Partnership Approach – Neighbourhood Care Networks

What are we doing	What the benefits
Improving quality and maintaining safety of today's services – we will continue to focus on greater consistency in the quality of care	You will have a more positive experience and services will be more reliable and of higher quality
Helping people to find the right information and to make decisions about their own health and care	You will be more able to help yourself to stay healthy and do more self-care
Places users at the heart - providing personalised advice , support and care	You will be able to direct your own care
Shifting the focus of services to prevention - there will be greater accessibility to preventative and early intervention support	Your problems will be dealt with at an early stage to stop them from getting worse
Developing the range of local primary and community based services in the Borough with a shift to out of hospital care	You will have a greater choice of high quality services closer to your home
Joining up health and social care services - there will be greater alignment of physical and mental health and social care, with the development of neighbourhood care networks	You will find your way between services and support more easily, with a quicker response to your needs
Targeting support to vulnerable people, their families and carers – there will be more effective coordination of care for people with complex conditions	It will be easier for everyone to remain independent for longer
Improving accessibility to planned care and making it easier to access urgent emergency care.	Services will be accessible and quick to respond to you when you need them

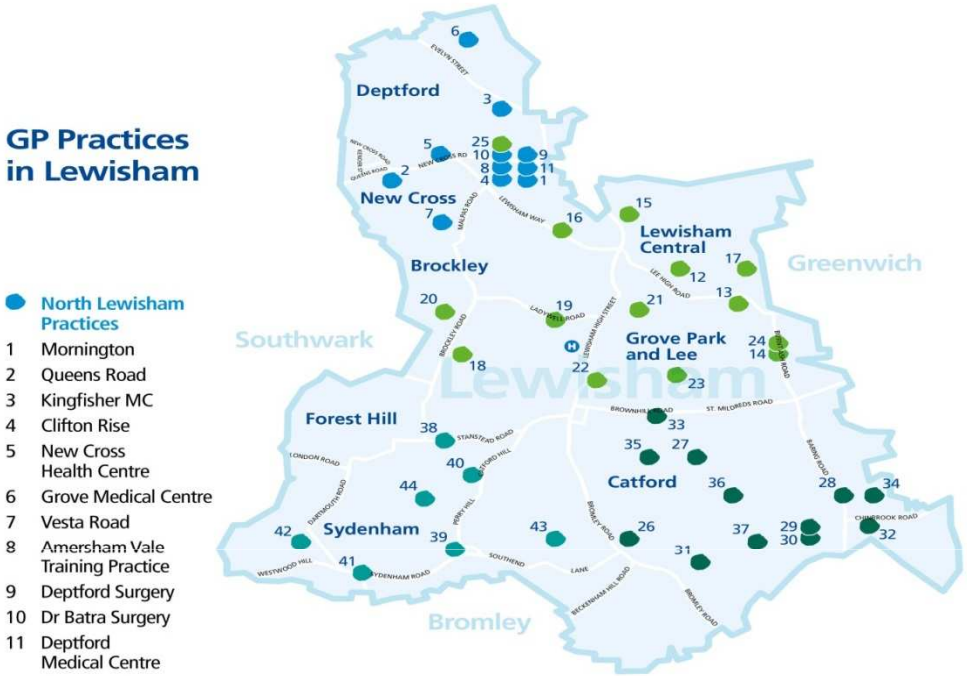
During the last year we have been putting in in place the foundations for Neighbourhood Care Networks based in the four local neighbourhood, across prevention and early intervention, neighbourhood community teams, general practice and enhanced care and support, on which we can build – see map on the next page

Each Neighbourhood has different populations with different requirements, so there is no single blueprint for the Neighbourhood Care Networks.

We believe by fully involving and engaging with service users, carers and other voluntary and community organisations in the co-design and co delivery that each Neighbourhood Care Network may be different.

We intend to ensure the following benefits to the population will be delivered, over time, by each Neighbourhood Care Network – see summary table opposite

Lewisham's Neighbourhood Care Networks



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

8.1 Prevention and Early Intervention

Why this is a priority

In Lewisham we have higher rates of the key risk factors for the major diseases. Reducing levels of smoking, obesity, alcohol intake and inactivity would contribute to improving health outcomes for Lewisham residents:

- Nearly 21% of adults in Lewisham smoke (about 59,800 people) which is above both the London (17.3%) and national (18.4%) averages. Smoking levels are even higher among people with mental health problems and routine, manual workers and lesbian, gay, bisexual, and transgender communities.
- The alcohol profile for Lewisham suggests that around 7% of the population who drink alcohol in Lewisham engage in high risk drinking. This equates to around 12,300 people.
- 61% of the adult population are overweight or obese -approximately 137,000 people in Lewisham.
- Over a quarter of adult residents are physically inactive - approximately 56,000 people in Lewisham.
- The number of people with high blood pressure (hypertension) in Lewisham is 11.3% (33,700 people) which is lower than the national average of 13.7% (2013/14). However, the growth has been 9% in Lewisham since 2009/10 compared with just 2% nationally and there are high levels of undiagnosed people with hypertension.

The rate of emergency hospital admissions for accidental falls also is significantly higher in Lewisham than the England average.

A key message from the 'Your Voice Counts' engagement event in July 2015 was 'prevention is better than cure'. Local people want a greater focus on prevention through, for example, proactive care and strong communities

Lewisham people also said that they do not always understand where to get help or how the health and care system works.

8.1 Prevention and Early Intervention

Priority Aim

- To encourage people to live well, stay healthy and independent longer
- To connect people to services and communities across the borough to promote physical and mental wellbeing; where people recognise their personal strength and abilities as well as those of their families, friends and communities.

What we are doing

Supporting people to look after and improve their own health and wellbeing by:

- providing clear information and advice about local health and social care services and information on benefits, debt and financial management through the redesign and promotion of the Social Care and Health website and directory of services
- making it simpler to access the right services by developing a 'Single Point of Access' which will provide the initial point of access for all district nursing and social work services
- making it easier to live a healthier lifestyle through increased access to advice and support to stop smoking, reduce alcohol misuse, promote mental and emotional well being, healthier eating, increase physical activity and improved sexual health. This will be through a range of interventions including face to face support, mobile applications and the internet
- ensuring that carers' advice, assessment and support meets their needs. Working with Carers Lewisham to enable carers to continue caring, but also to lead independent lives

Supporting people to live in their own homes safely and independently by :

- piloting a new contact and referral approach which will provide a quick and simple way for vulnerable older people, and those supporting them, to access a wide range of services to support safe and independent living
- redesigning fall's prevention and management services by establishing a community based falls team and improving interventions for those at risk of falling

8.1 Prevention and Early Intervention

What we are doing (continue)

Enhancing capacity in the community and voluntary sector to support a greater focus on prevention and early intervention by working with a range of voluntary and community sector organisations including Voluntary Action Lewisham (VAL) and Healthwatch Lewisham, building on work at a neighbourhood level through the Community Connections Team, health trainers and area based initiatives such as Well Bellingham and the North Lewisham Health improvement programme.

Developing low level proactive services and support, to enable people to continue to live in their own homes:

- providing the appropriate equipment at the right time
- undertaking minor housing improvements and adaptations

Implementing a new service model for sexual health. The London Sexual Health Transformation Programme has set out a Case for Change based on a needs assessment and review of current services. It is recognised that significant change is required to the historic models and patterns of service delivery. It is anticipated that by working together at both a London and SE London level the services for residents can be improved to be more responsive and easier to navigate whilst also being more cost effective.

8.2 General Practices and Primary Care

Why this is a priority

Public satisfaction with general practice remains high, but satisfaction with access is poor. People find it hard to get GP appointment when they need it and sometimes the length of appointment time is considered to be too short for complex issues. Accessing GP services has been a recurring theme at public engagement events in Lewisham.

In Lewisham some GP practices achieve excellent clinical outcomes and patient satisfaction, but there is significant variation in performance and quality. GPs have an important role in the earlier diagnosis for people with long term conditions to help them get better sooner and prevent their illness becoming more serious. The number of people with long term conditions is increasing in Lewisham.

Nationally GPs' workloads are increasing, with rising number of patients and growing complexity of their health needs

The public feedback on the service provided by pharmacists has been positive.

Transforming Primary Care in London: A Strategic Commissioning Framework outlines a new vision for general practice, sets out a new specification ('patient offer') around three aspects of care that matters most to patients:

- Proactive care
- Accessible care
- Coordinated care

Lewisham has higher rates for emergency admissions which usually would not be admitted to hospital (for example, conditions like influenza and pneumonia which can be preventable by vaccine, kidney and urinary tract infections, ulcers and Ear, Nose and Throat Infections, dental conditions). Lewisham's rate for these types of emergency admissions is 1005.9 per 100,000 population in comparison to the London rate of 717.5 per 100,000 and the England rate is 808.5 per 100,000 (2014-15) .

8.2 General Practices and Primary Care

Priority aim

- To provide strong GP practices and primary care 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 we are doing

Proactive care – primary care supporting and improving the health and wellbeing of its population and keeping people healthy by:

- increasing the earlier identification and diagnosis for people with Long Term Conditions - e.g. diabetes, Cardiovascular-disease (CVD), chronic-obstructive pulmonary-disease (COPD), dementia and cancer
- promoting immunisations to protect people from serious illness and preventing the need for admission to hospital
- Consolidating the current service offer for psychological support for individuals with long term condition through the expanded remit of Psychological Therapy services
- Promoting health through community pharmacies – healthy pharmacy champions and enhanced public services such as sexual health, smoking, health checks, drug misuse, as well as referring all heavily addicted smokers to stop smoking services

Accessible Care – primary care providing a personalised responsive, timely and accessible service by:

- reviewing and simplifying arrangements for the provision of extended primary care access as part of developing a new integrated urgent and emergency care offer to patients locally – (see Urgent Care section)
- increasing the utilisation of online services, specifically for booking an appointment, requesting a repeat prescription and accessing medical records
- improving the co-ordination with the wider primary care team – with community pharmacists (e.g. Pharmacy First for minor illnesses), general dental practitioners and optometrists

8.2 General Practices and Primary Care

What we are doing (Continue)

Coordinated Care – primary care providing patient centred, coordinated care and GP/patient continuity by:

- improving the management and consistency of care for people with Long Term Conditions - e.g. diabetes, cardiovascular-disease (CVD), chronic-obstructive pulmonary-disease (COPD), dementia, cancer and those at the end of life – and the behaviour changes towards healthier lifestyles
- promoting a proactive and holistic care approach working with the person, their carers and their families using risk profiling and collaborative care planning methodologies as part of the Neighbourhood Community Teams
- providing greater support to patients to self-manage their long term conditions by the re-procurement of structured education for COPD and type 2 diabetes

8.3 Neighbourhood Community Teams

Why this is a priority

In Lewisham people are living longer - there are around 27,400 residents are above 65 years of age and over 3,650 are aged over 85 years. An ageing population will increase the number of people with multiple chronic conditions and a growing number of functional and cognitive impairments. People over 85 years often have complex needs and have high use of health and care services.

The high premature mortality rates in Lewisham suggest that the proportion of people with LTCs who have poorly controlled disease is higher than elsewhere.

An increasing number of individuals need support to effectively managing their long term conditions. Current data suggests that:

- 8.6% of the population have 3 or more LTCs (about 25,700 people).
- 11.9% of the population have 2 LTCs (about 35,520 people).
- 29% of the population have 1 LTC (about 86,570 people).
- Rates are rising fastest for Type 2 Diabetes and Chronic Obstructive Pulmonary Disease (COPD).
- Lewisham's Black and Minority Ethnic communities have a greater risk from health conditions such as diabetes, hypertension and stroke.
- Level of mental health needs for both common and severe mental illness are significantly higher for adults in Lewisham compared to London and England.

Many people have fedback that they would like to have greater involvement and control of their own care and be supported to do more to care for themselves.

People want more joined up services between health and care with better information and advice to enable them to navigate to the right service at the right time; a common theme at public engagement events.

People have said also that there needs to be more support for people with mental health issues in Lewisham.

8.3 Neighbourhood Community Teams

Priority Aim

- To provide co-ordinated support and care 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 we are doing

Improving the effectiveness of Neighbourhood Community Teams by working towards the implementation of joint processes, underpinned by sharing of information across professional groups and organisations by:

- piloting the co-location of a Neighbourhood Community Team in one of the neighbourhoods in Lewisham
- having a common approach to identifying and targeting those people who will most benefit from the support of multidisciplinary meetings
- developing case management and key workers for those people with complex needs to support them to be more in control of their own care
- working towards a single assessment process with shared health and social care records and reviews, which streamlines the care planning processes across health and care
- ensuring that the Neighbourhood Community Teams have appropriate quality assurance processes across health and social care including for safeguarding
- maximising the effectiveness of medication reviews to optimise the use of medication with the expansion of the Lewisham Integrated Medicines Optimisation Service (LIMOS)

Increase the scope of Neighbourhood Community Teams currently comprising district nursing, therapy staff and social worker staff, working with general practices, by aligning them more closely with community mental health teams.

8.3 Neighbourhood Community Teams

What we are doing (continue)

Improving the consistency in the quality of care and patient experience provided by District Nursing based on the key audit findings undertaken in January 2016 and by:

- implementing the outcomes of the audit reviewing the wound care (tissue viability) service;
- re-procuring Lymphedema services
- implementing the recommendations of the January 2016 audit of District Nursing

Streamlining care pathways to ensure the right people at the right time receive the right support and care to manage their care better in the community, with an appropriate interface with the neighbourhood community teams, including for:

- people with dementia by ensuring timely access to assessment, diagnosis and community based support.
- people with diabetes by further developing the integration of specialist community and primary diabetic care and support across Lewisham, with the intention to commission the service differently in 2017/18
- Supporting individuals with common mental health disorders by Improving Access to Psychological Therapies (IAPT)
- Progressing the accepted recommendations from the Psychological therapies review (2015) to establish an integrated model of service
- 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 providing support to reduce relapse and need for hospital re-admission and the reliance on adult mental health inpatient beds

8.4 Enhanced Care and Support

Why this is a priority

The Lewisham population is projected to grow across all age groups over the next five years. Over the next fifteen years the greatest percentage increase will be in the 65+ age group.

The prevalence of having a long term condition increases with age and over fifty percent of those aged 75+ will have two or more long term conditions. The prevalence of dementia increases markedly with age, at about 1% of 65 to 69 year olds and almost one in four people aged over 90.

It is estimated that a third of patients admitted to hospital and care homes are already malnourished or at risk of malnutrition.

Lewisham has higher rates of emergency admissions rates for people over 65years in comparison to both London and England. In 2012/13 almost 8,000 Lewisham people aged 65 years and over had an unplanned admission to hospital. The most common diagnosis for admission for the over 65 years was pneumonia, Urinary tract infections (UTI) and COPD.

This suggests that in Lewisham a higher number of people are being admitted to an acute bed who could have been seen and cared for at home and in a way that optimised their independence.

Patients sometimes stay longer in hospital because joined up arrangements for their care in the community on and after discharge have not been put in place. This may be due to a number of reasons including co-ordination between different agencies, complexity of cases, patient and family wishes and provider capacity issues. Early supported discharge and a stronger focus on rehabilitation could help patients return home more quickly and safely, preventing unnecessary delays.

People in Lewisham strongly supported joined up health and social care (including the voluntary sector).

8.4 Enhanced Care and Support

Priority Aim

- To develop a coherent and co-ordinated set of services which avoid unnecessary admissions into a hospital or care home and facilitate early discharge into the community /home.
- To develop integrated physical/ mental health & social care pathways above and beyond "core" services, delivered in the most appropriate setting for the service user which optimises levels of independence.

What we are doing

Commissioning a range of joined up community based health and care services to improve the hospital discharge planning process and the effective follow up care for individuals with complex needs by:

- improving discharge planning and the utilisation of community beds (e.g. Brymore House, Sapphire ward), based on the findings of the 2015/16 discharge service audit
- streamlining the NHS funded continuing care process by the development of single assessment and review pathway, offering Personal Health Budgets to eligible clients
- increasing 7 day working arrangement to increase discharges at weekends
- implementing a new service model for domiciliary care with a focus on outcome based commissioning and neighbourhood lead providers
- reviewing the Early Supported Discharge pathway for COPD - with the intention to commission the service differently in 2017/18

8.4 Enhanced Care and Support

What we are doing (continue)

Commissioning a wider range of joined up community based health and care services which avoid unnecessary admissions into a hospital (acute or community) or a care home and support frail older people to be cared for in their own homes, informed by the audits and the evaluations of the winter scheme pilots undertaken in 2015/16. This is likely to include:

- strengthening the capacity and capability of a set of co-ordinated community based services which are able to respond quickly when a patient's conditions deteriorates and there is a need for rapid assessment and support. This may include a short hospital visit
- developing the Ambulatory Care model, to provide assessment and same day discharges, on the Lewisham hospital site, working with Lewisham and Greenwich NHS Trust
- piloting a community based 'home ward' providing enhanced health and care support for a short time to enable a person to stay at home with the necessary additional support
- providing additional support to care homes from GPs, community nursing, pharmacists, community dieticians and palliative care teams
- developing Extra Care services and Older Adults Housing to support people to stay in their own homes and out of residential and nursing care for longer. This will increase the availability of adapted and single level accommodation and the commissioning of 'care on demand' services to support a higher range of needs than those traditionally associated with Extra Care.
- expanding the scope of the Mental Health Crisis service to more effectively support people at times of crisis in line with the local Crisis Care Concordat plan.
- improving patient experience by enhancing the local service offer for mental health crisis care by establishing a whole system approach comprised of A&E Psychiatric Liaison, Peer Support & 24/7 Crisis Telephone Line
- implementing a community malnutrition care pathway

Improving the quality of community based specialist care services within the Borough:

- reviewing the community specialist palliative care services to ensure all people have equal access to high quality, responsive, 24/7 services, with the intention to commission the service differently in 2017/18
- reviewing the care provided for people with long term neurological conditions and acquired brain injury, specifically the balance of highly specialised rehabilitation bed provision, locally available specialist rehabilitation beds (2B) and community based neuro-therapy, as currently there is very limited provision capacity for people to receive specialist neuro rehabilitation within south east London

8.5 Urgent and Emergency Care

Why this is a priority

Many people are going to A&E unnecessarily when other more suitable care is available. Nationally nearly 40% of patients seen in A&E are discharged with no further input, indicating that potentially patients could have been seen away from A&E. Further analysis by the Royal College of Emergency Medicine estimates that 15% of patients attending A&E could have been seen elsewhere in the community.

Many A&E departments in London are having difficulty in meeting the target that 95% of people attending A&E should be seen within 4 hours.

No hospital in south east London fully meets the quality standards for emergency care as set out by the London Quality Standards. These include the requirement that senior doctors (consultants) are present on emergency wards a minimum of 16 hours a day, 7 days a week.

Patients with mental ill health often have longer waits to see a psychiatric liaison nurse.

People in Lewisham want greater information on how to access services out of hours and at weekends.

8.5 Urgent and Emergency Care

Priority aim

- Emergency care is for people who have a condition that is life-threatening or presents an immediate risk to long term health.
- Urgent care services are for people who have a problem that needs attention the same day, but is not life-threatening or life-changing

What we are doing

Developing an integrated Urgent and Emergency Care model and new offer to patients with primary care for Lewisham – this will operate 7 days a week over extended hours to offer a consistent Urgent Care service in the community. This will provide an alternative to A&E, accessible by both patients and clinicians for non-acute urgent cases. The potential for co-locating these services with the Emergency Department will be explored further.

Support the development of Ambulatory Care models across the integrated Urgent and Emergency Care Model in order to treat patients more quickly in the most appropriate setting. This should see an increase in the numbers of patients assessed, treated and discharged without the need for admission.

Improving quality standards in Lewisham's A&E department, working with Lewisham and Greenwich NHS Trust to achieve the London Quality Standards for emergency care and with the London Ambulance Service to improve 999 response times.

Undertaking the re-procurement of the south east London 111 service and the GP element of the Urgent Care Centre in line with the Urgent Care Model for Lewisham.

Exploring the opportunities for supporting people who have both physical and mental health problems and who need a hospital admission by testing out the concept of an all age Mental Health hospital liaison service building on the Core 24 Psychiatric Liaison Nursing service model.

8.6 Planned Care

Why this is a priority

There are differences in patient outcomes and experiences, depending on where and when they access care, for example screening for breast and bowel cancer.

Time from first appointment, to diagnostic test, to getting results could be quicker and more efficient leading to earlier diagnosis and better outcomes for patients.

Patients could be better prepared for their operation/ procedure which would help patients to recover more quickly.

8.6 Planned Care

Priority aim

- to ensure all people who need planned care the same quality of care and outcomes. Planned care is treatment that is planned in advance, such as an operation that is booked on a certain date

What are we doing

Improving the quality of hospital referrals and also patient experience of the appointment booking process (including proactive offer of choice) through the two year Referral Support Service pilot which will be fully evaluated to inform long term commissioning intentions.

Improving the patients' experience and delivering value for money by re-specifying the service requirements and evaluating the different models of commissioning and contracting for Musculoskeletal and Physiotherapy services.

Improving cancer care, working in partnership with the London Cancer Alliance by:

- earlier detection of cancer and increasing access to diagnostics
- reducing the variation in cancer care in hospitals
- supporting people with and beyond cancer

Reviewing the following clinical planned care pathways with the intention to commission these services differently in 2017/18:

- Dermatology
- Gynaecology
- Ophthalmology

Reviewing the feasibility of fast tracking surgery for uncomplicated procedures in surgically fit patients e.g. cholecystectomy, hernia repairs, working with Lewisham and Greenwich NHS Trust.

8.7 Supporting Strategies

Workforce Development

A modern workforce will be crucial to the delivery of person centred care, which is joined up across primary, secondary, community and social care. 'One Lewisham health and care system' will not become a reality without a workforce with the right numbers, skills, values and behaviours to deliver it.

This will require commissioners and providers to develop and implement a system wide workforce development plan. The first steps have been taken already to:

- bring groups of multidisciplinary staff together to develop local approaches on how they can better work as a team underpinned shared values and behaviours
- undertake a stocktake of current provider development activity to identify areas of overlap between different partner organisations, to achieve synergies and potential economies, and to identify shared or common priorities for further joint working

Our ambition is to:

- ensure that all staff are caring, compassionate and understand the importance of language and cultural differences
- develop new, effective ways of working using a different skill mix, introducing new roles and new competencies,
- change the relationship between the workforce and the people who use our services and carers, supporting greater empowerment and independence
- Staff are supported to lead healthy lives themselves
- support an open culture of evaluation, learning and continuous professional development

8.7 Supporting Strategies

Information Technology

Our ambition is to maximise the potential of technological advances to support:

- people who use our services to have access their health care record electronically
- people to look after themselves and self-manage their long term conditions by providing more appropriate information and greater use of technology
- people to navigate the right care at the right time with up to date information and advice about available support and services
- sharing information between care providers including GPs, pharmacists, secondary care clinicians, A&E, community care and social care. Lewisham heath and care providers have collaborated to begin to roll out a virtual patient record (Connect Care)
- mobile/remote working in the community by a greater number of staff

However we will need to take steps to ensure that we build the capacity of all citizens to use Information Technology, like the internet and smartphones, and train our staff so that they are able to support those who are unable or unwilling to use new technologies

Estates

Our plan is to ensure that estates planning is embedded within the wider service planning.

Representatives from the CCG, LGT, Council and SlaM are in discussions on how better use could be made of the estates across the system to deliver new models of care.

Estate audit work is being undertaken across the whole borough to support this work.

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