Lewisham

NHS
Lewisham
Clinical Commissioning Group

DRAFT
Lewisham's Partnership Commissioning Intentions for Adults 2017/2018 and 2018/19

Contents

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 shared plans and priorities to commission health and care for adults for the next two years. There are separate Partnership Commissioning Intentions for children and young people's services.

These Commissioning Intentions are a continuation of the journey to deliver our strategic vision for 'One Lewisham Health and Social Care System' by 2020 . Since 2010, Lewisham Council and the Clinical Commissioning Group have been working with our provider partners to develop integrated services for the population of Lewisham to improve health and care outcomes and reduce inequalities. This work now is being taken forward by the Health and Care Partners, who are leading the development of a whole system model which fully integrates physical and mental health and care delivery to the whole population in Lewisham.

Our Partnership Commissioning Intentions for 2017-19 is intended to give our health and care partners and the public an initial understanding of the specific commissioning areas we are focusing on - Prevention and Early Action (section 8.1), Planned Care (section 8.2) and Urgent and Emergency Care (section 8.3) – in order that they may feedback their comments to inform our future planning.

The successful development and implementation of these plans and priorities rely on our strong partnership relationships. It requires us to work together with the public, local communities, voluntary organisations and Healthwatch to hear their views on how best to reshape our future services. We believe that by working together, as partners, health and care can improve and sustainable solutions can be found to the complex challenges Lewisham faces.

Also it requires strong, mature relationships with our providers. We wish to change the historical way we have commissioned and decommissioned services to move towards outcomes and population based contracts. It is our intention to redefine the traditional commissioning/provider relationship and find new ways of effective collaboration across the health and care system. Our aim is for health and care to be delivered around the needs of the population and the individual, irrespective of the existing institutional arrangements and provided in a joined up, safe, effective and sustainable way.

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 297,300 to 318,000 by 2021, and is the 15th most ethnically diverse local authority in England - 46% of the population are from black and minority ethnic groups. Around 27,600 residents are above 65 years of age and over 3,700 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. In 2014/15:

- more than 6,100 people received social care services within their communities
- 67% of those people who were in contact with mental health services were living independently
- 10% of people with learning disabilities were in paid employment

More information is available about Lewisham's population at www.lewishamjsna.org.uk and about Lewisham's Adult Social Care at http://councilmeetings.lewisham.gov.uk/documents/s39784/Item%206%20Local%20Account%202015-16%20Appendix.pdf

3. Local Challenges

Health and care commissioners and providers recognise that Lewisham's health and care system needs to change. The current system is not sustainable and we are not achieving the health and care outcomes we should.

Too many people die early in Lewisham from deaths that could have been prevented by healthier lifestyles:

- Life expectancy has been improving, however for men, it remains lower than the England average in 2012-14. The life expectancy at birth was 78.8 years for women and 72.3 years for men in 1992-94. In 2012-14 it had increased to 83.4 years and 79.0 years respectively.
- 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.
- Many of these deaths could have been prevented by healthier lifestyles - 80% of heart disease, stroke and type 2 diabetes and 40% of cancers could be avoided if common lifestyle risk factors were eliminated*:
  - unhealthy diet
  - physical inactivity
  - tobacco use
  - excess alcohol and drug use

*Reference: World Health Organisation 2005- Preventing Chronic Disease: a Vital Investment

Too many people live with poor physical and mental health:

- 28.7% of Lewisham's population have one or more Long Term Condition (LTC) - about 86,570 people – such as diabetes, high blood pressure or mental illness.
- 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 LTCs.
- 44% of people do not feel supported to manage their long term condition in Lewisham.

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. Life expectancy for men is five years longer in Crofton Park, than in New Cross. For women the gap is even bigger between both Perry Vale and Crofton Park wards (joint highest life expectancy) and New Cross (the lowest), the difference is 8.5 years.
- Health inequalities are considered by ethnic group too. Lewisham is one of the most ethnically diverse areas of the country. Mental ill health is more prevalent in some black and minority ethnic groups. Black residents are disproportionately over-represented in mental health admissions.
- Lesbian, gay or bisexual people and those who are divorced/widowed/separated also have poorer health outcomes than the general population.

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 Lewisham's population and health and care services at www.lewishamjsna.org.uk

4. The Financial Challenge

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

Resources across the health and care system are finite and very stretched. Collectively the CCG, Adult Social Care (ASC) and Public Health have nearly £510 million to commission advice, support and care on behalf of Lewisham people.

The budget for delivering adult social care services has been reduced already by £22 million over the last 4 years. This has been saved through achieving better value for money when buying services, from meeting need in more cost effective ways and from increasing income. NHS savings of 2% to 3% each year have been required to balance budgets.

We are facing a joint financial challenge of £17.9 million in 2017/18 and a further £16.1 million in 2018/19 between the projected spending requirements and expected resources available – see summary table opposite.

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

The Health and Care Financial Challenge	2017/18	2018/19
Estimated revenue budget		
• **CCG**	418.7	429.1
• **ASC and Public Health**	91.2	88.8
Total estimated health and care revenue budget	509.9	517.9
Net savings requirements		
• **CCG**	12.9	13.1
• **ASC and Public Health**	5.0	3.0
Total health and care savings requirements	17.9	16.1

With the limited resources available to us, and demand increasing, the current way we deliver health and social care is not sustainable and will have to change.

5. Partnership approach with the Public

To address the above major challenges, the involvement of the Lewisham people is vital; effective public communication and engagement is essential.

We, the commissioners, are committed to involving Lewisham people, local community groups and the voluntary sector in continuous two way dialogue to develop the understanding and trust to work effectively together and to connect in a more meaningful way. We believe that by working together, as partners, sustainable solutions can be found to the complex challenges we face.

During 2015 and 2016, there were a series of engagement exercises to listen to feedback from service users of health and care in Lewisham. The most common problems cited were:

- The information or advice which best meets your needs to keep fit and healthy can be hard to find.
- The experience of care is variable - for example the quality of care can vary between different hospital sites.
- Access to services can be confusing and difficult – for example accessing a GP or other health or care professional when you need to, especially if you want to see someone urgently; more information about accessing mental health services has been highlighted particularly.
- The care received often is fragmented and not coordinated, resulting in duplication and confusion, particularly if you have more than one Long Term Condition.

Only by working in partnership with individuals, local communities, voluntary organisations and Healthwatch - hearing your views, involving you in reshaping of your services - will commissioners be better able to commission the advice, support and care which meets the diverse needs of individuals and communities in Lewisham.

During 2016 progress has been made to improve the delivery of services in many of the areas highlighted by service users, for example:

- **Prevention and Early Action (section 8.1**) describes the improvements to the Single Point of Access service and the new online service to help people to understand where they should go for treatment. Also the work which is being undertaken to improve GPs earlier identification and management of long-term conditions and to widen the range of self management advice and courses commissioned to support people with long term conditions.
- **Planned care (section 8.2)** describes how we plan to improve the quality of orthopaedic care, improving access to care and developing services closer to home, for example diabetes care.
- **Urgent and Emergency Care, which includes Enhanced Care and Support (section 8.3)** describes the Integrated Primary and Urgent Care Service which is being developed, the GP Extended Access Pilot which will operate from 8.00 to 8.00, seven days a week, to be piloted from April 2017 and the work we are doing to improve the emergency care with a particular focus on mental health emergencies

Information is available on Lewisham People's feedback at:

London Borough of Lewisham - Local Account 2015 - 2016 - add reference

Lewisham CCG's Annual Engagement Report 2015/16 – add reference

6. Partnership approach with Providers

6.1 Lewisham Health and Care Partners

Lewisham Health and Care Partners are working together to take forward the integration of health and care. The partners are Lewisham Clinical Commissioning Group, Lewisham Council, GP Federation and local GPs, Lewisham and Greenwich NHS Trust and South London and Maudsley NHS Foundation Trust.

Lewisham Health and Care Partners recognise that Lewisham's health and care system needs to change. We are not achieving the health and care outcomes we should. There are significant health inequalities in Lewisham - too many people live with ill health, high quality care is not consistently available and demand for care is increasing, both in numbers and complexity.

Lewisham is developing an integrated whole system model which fully integrates physical and mental health and care delivered to the whole population by 2020. Health and Care Partners are focused on the redesign and reshaping of services to transform the way in which residents are encouraged and enabled to maintain and improve their own health and wellbeing, the way in which local health and care services are delivered within the Borough and the way in which people access and are connected to the assets that are available within their own communities and neighbourhoods.

Transforming Community Based Care is a critical part of this overall vision to achieve a sustainable system which better supports people to maintain and improve their physical and mental wellbeing, to live independently and to access high quality care when they need it.

6.2 Lewisham Commissioners' Expectations of Providers for 2017-19

Lewisham Commissioners' expectations of all its providers is to deliver advice, support and care that is :

- **Population based** – which is a way of looking at patients/service users not just as individuals but as a part of a wider population. The neighbourhood care networks are mainly based on the general practice registered list, including primary, community, mental health and care
- **Expanding and strengthening primary and community care** - shifting the majority of outpatient consultations and ambulatory care out of hospital. This will result in most of care being provided at home or near to people' homes
- **Promoting healthy living** - helping people to get the right advice, support and care in the right place, first time with a shift towards proactive and preventative services and supporting community development
- **Providing an integrated response to the needs of the individual**– a holistic response -physical, mental and social needs - giving people control of their own care and empowering them to be independent, make informed choices and take control to meet their individual needs
- **Evidence based and outcome focused** - meeting the needs of whole population, addressing inequality and equalities issues
- **Co produced with patients, service users, carers and wider communities** - in partnership with the people and communities. As Commissioners we believe it is only by the engagement of the current and potential service users to help reshape services that we can achieve better outcomes
- **A whole system approach** - a health and care system that is safe, sustainable and provides high quality care consistently

7. Community Based Care and Neighbourhood Care Networks

7.1 What we mean by Community Based Care

Community based care is the advice, support and care which is provided outside a traditional hospital setting. In Lewisham this includes services provided by GPs, social workers, pharmacists, other NHS and local authority services, as well as that provided by the voluntary and community sector and those provided by private organisations like care homes.

We want to commission joined up care that is preventative, high quality and efficient where:

- The majority of health and care services are accessed outside the hospital at a neighbourhood level.
- Health and care services are coordinated around the person.
- Individuals, their families and carers have a stronger network of support within their local communities to help them proactively maintain their health, wellbeing and independence.

We are delivering community based care in four neighbourhood areas in Lewisham. The Borough's neighbourhood care teams, community mental health teams and existing voluntary and community assets are organised on the same four neighbourhood footprints as the four federated groups of GP practices - North Lewisham, Central Lewisham, South East Lewisham and South West Lewisham – see map on next page. Also some Children's health and early intervention services are co-located already on a neighbourhood basis through our children's centre services. There is opportunity to develop this further, including services for children with complex needs.

7.2 What we mean by Neighbourhood Care Networks

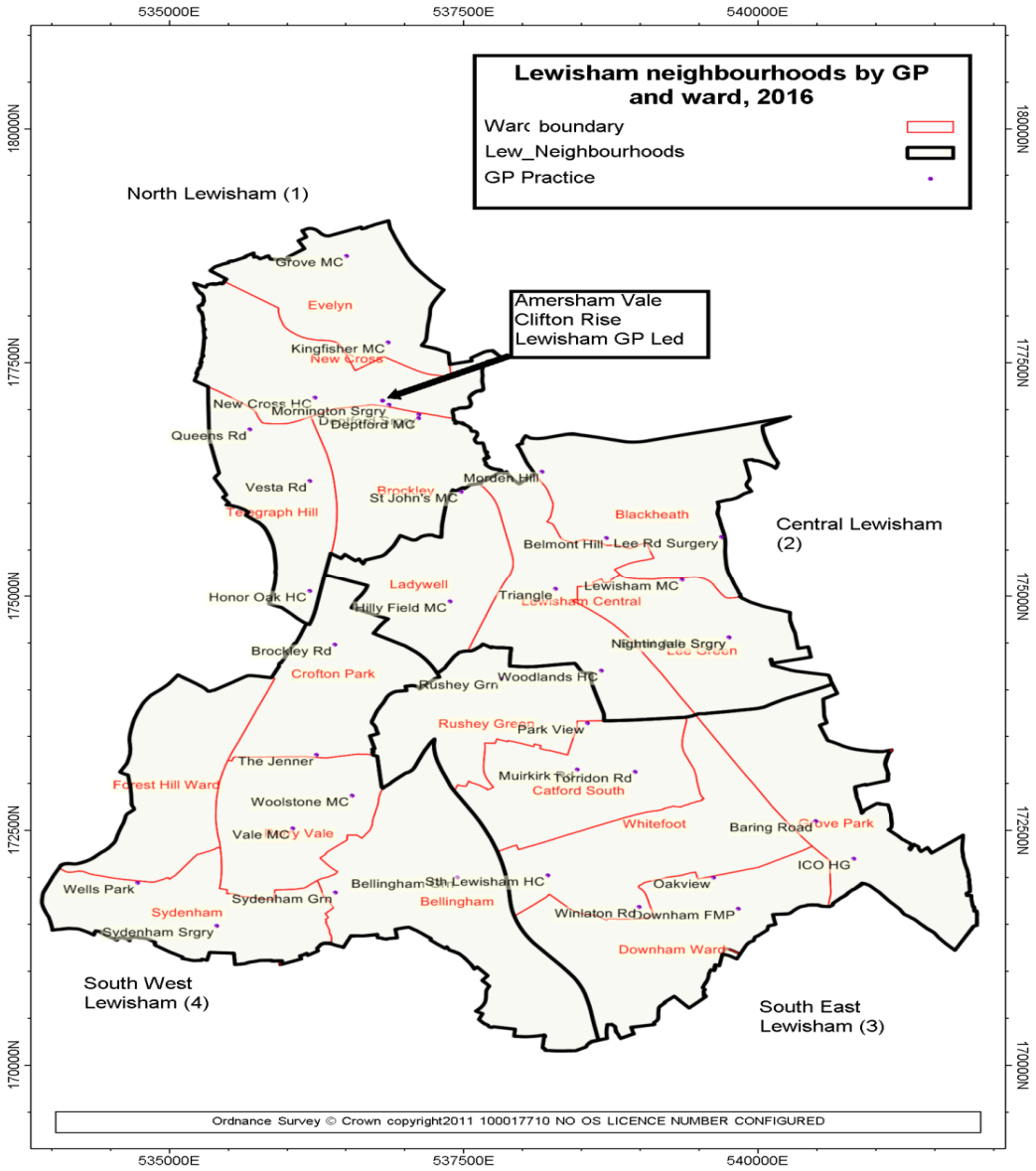
In these neighbourhood areas we are developing Neighbourhood Care Networks as a way of strengthening connections and links between those providing community based care, including those connections between statutory and voluntary providers.

Each Neighbourhood has different populations with different requirements; there is no single blueprint for the Neighbourhood Care Networks in Lewisham. Each Neighbourhood Care Network may be different. We are involving and engaging with service users, carers and other voluntary and community organisations in the co-design and co delivery for their Neighbourhood Care Network.

Our work on Community Based Care and Neighbourhood Care Networks has been informed by and is aligned to the plans and priorities of wider south east London's draft Sustainability and Transformation Plan, developed in collaboration with south east London's commissioners and providers. The Sustainability and Transformation Plan is a NHS requirement to produce five year Sustainability and Transformation Plans (STP), which are place based, whole system plans to achieve the Five Year Forward View.

Lewisham's Neighbourhood Care Networks

The four groups of GP practices shown on the four Lewisham neighbourhood footprints



7. Community Based Care

7.3 Why we are transforming Community Based Care

Consistent public feedback has stated that support and care in the community is not delivered always in the most effective or integrated way.

The most common problems are:

- The experience of care is variable - for example the quality of services can vary between different hospital sites and for different GP practices.
- Access to services can be confusing and difficult – for example accessing a GP or other health or care professional when you need to, particularly if you want to see someone urgently; more information to access mental health services particularly has been highlighted.
- The care received is fragmented and not coordinated, resulting in duplication and confusion, particularly if you have more than one long term condition.
- The information or advice which best meets your needs to keep fit and healthy can be hard to find.

There is increasing demand for health and care which the statutory organisations are increasing unable to afford to provide:

- Demand for care is increasing, both in numbers and complexity, particularly for urgent and emergency care.
- The cost of delivering health and care services is increasing.
- Many people are going to Accident and Emergency departments unnecessarily when other more suitably care is available.
- People are frequently admitted to hospital when this is not clinically justified because of a lack of alternative community based options.
- Some health and care problems are not detected early enough and there is not proactive early intervention which would improve the person's health and care outcomes and reduce cost of care.

7. Community Based Care

7.4 Our Aim

Our strategic aim is to work in partnership with local providers and the public to transform the environment in which people live and the way in which health and care is delivered so local people:

- live healthier lives and maintain their independence
- have better health and care outcomes
- have access to more effective, better quality, more affordable services

We believe that we can achieve this at a system level by creating an environment that promotes and facilitates health and wellbeing, and prevents illness and dependence. This is achieved through whole system transformation across all sectors, not just health and care, and by commissioning advice, support and care that is accessible, proactive and co-ordinated:

- **Proactive and Preventative** – by creating an environment which promotes health and wellbeing, making it easy for people to find the information and advice they need and the activities, opportunities and support available, to maintain their health and wellbeing and to manage their own health and care more effectively. And for people to be part of resilient communities, working with and alongside voluntary and community organisations.

- **Accessible to all** – so that adults have improved access to local health and care services through for example neighbourhood care hubs, and so that children have increased access to community health services and early intervention support through, for example, the re-procurement of children's centres and health visiting. And for everyone to have clear access to urgent care and specialist advice when needed.

- **Coordinated** – so that people receive personalised care and support, closer to home, which integrates physical and mental health and care, to help them to live independently for as long as possible.

7. Community Based Care

7. 5 What are we doing

These Partnership Commissioning Intentions for 2017-19 set out the key commissioning priority areas, where progress is being made and where our future plans are being developed. The Partnership Commissioning Intentions summarise how services are being reshaped and organised at a neighbourhood level to transform the delivery of our health and care system, particularly Community Based Care.

The three commissioning priorities are:

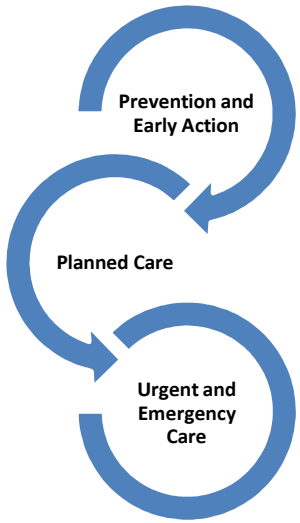
- ❑ Prevention and Early Action (section 8.1)
- ❑ Planned care (Section 8.2)
- ❑ Urgent and Emergency Care (section 8.3)

The key building blocks for the delivery of community based care at a neighbourhood level are already in place. Multi-disciplinary Neighbourhood Community Teams have been established in each of the neighbourhood areas bringing together district nurses, community matrons, social work staff and therapists. These teams are aligned to the four GP Federations which have been formed within Lewisham and the community mental health services. This has enabled:

- The provision of holistic care
- Greater sharing of information and collaboration across the system
- Developing of joint approaches to risk stratification, care planning and case management
- Exploring more effective ways of multi-disciplinary working, including new ways of working and new joint roles

Prevention and Early Action, Planned Care and Urgent and Emergency Care are interdependent.

Our strategic aim is to have a greater focus on prevention and proactive and coordinated planned care, to reduce our need and demand for emergency care.



7. Community Based Care

7.6 What are the Expected Benefits on Community Based Care

We will know that we are being successful in transforming and delivering effective Community Based Care by monitoring our performance closely and by seeing improvements in key outcome measures such as:

Better health and care outcomes, including reducing inequalities through:

- A reduction in the gap in key health outcomes between Lewisham and England by 10% over the next 5 years
- A reduction in potential years of life lost from causes amenable to health care
- A reduction in under 75 years mortality from cancer
- An increase in health related quality of life for those with long term conditions (physical and mental health)

Better service user and patient experience of health and care through service user and patient surveys:

- Consistent, high quality care, localised where possible and in the most appropriate setting – 'Right care, right time, right quality'
- Holistic care where their mental health needs are treated with equal importance to their physical needs and which integrates physical and mental health and care services
- Personalised care which is co-produced and empowers them to have choice and control over their care

Sustainability across health and care in Lewisham:

- An increase in the proportion of people feeling supported to manage their long term conditions
- A reduction in avoidable emergency admissions
- An increase in the proportion of older people (65 & over) who are still at home 91 days after discharge
- A reduction in delayed transfers from hospital
- A reduction in the number of people admitted to residential care or nursing homes
- A reduction in the number of people requiring on-going care and support

8. Local Commissioning Priorities 2017-19

8.1 Prevention and Early Action

Why this is a priority

In Lewisham we have higher rates of the key risk factors for the major diseases. Reducing these key risk factors - levels of smoking, obesity, alcohol intake and inactivity- would contribute significantly to people in Lewisham not dying so early :

- Smoking - 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, routine/manual workers and lesbian, gay, bisexual, and transgender communities.
- Alcohol - 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.
- Obesity - 61.2% of the adult population are overweight or obese -approximately 137,000 people in Lewisham.
- Inactivity - Just over half (57%) of Lewisham adults are classified as Physically Active (that means achieving at least 150 minutes of exercise a week)
- Mental health - One in five people living in the community and 40% of older people living in care homes are affected by depression (Five Year Forward View for Mental Health 2016); *check for a local statistic*
- Blood Pressure - 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
- Cancer - screening rates for both breast and cervical cancer in Lewisham are significantly lower than England

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.

At the system level, a population based approach to prevention and reducing health inequalities will achieve the greatest impact on health and wellbeing. For example through local policy actions to reduce sugar, control tobacco and encourage physical activity. Health and care commissioners and providers have a key role to play in system transformation.

Preventative interventions also are critical in managing the increasing demand in health and social care services, reducing the overall burden of disease in the population and have the potential to underpin the financial sustainability of the NHS. It is well evidenced that by investing more in prevention costs can be reduced further down the care pathway and improve outcomes for individuals. However, this approach requires joined-up care and treatment, across a range of service providers and centred around a patient's needs.

8. Local Commissioning Priorities 2017-19

8.1 Prevention and Early Action – Our Aims

Our strategic aim is to promote and facilitate health and wellbeing and prevent illness and dependence. This will require changes in the way prevention is commissioned and delivered, given the level of public sector resources available. It will require also whole system transformation across all sectors, not just health and care.

We aim to embed prevention in all our commissioned services to promote health and wellbeing (primary prevention) and to prevent the need for treatment and care (secondary prevention), that is evidence based or based on best practice, cost effective and sustainable.

What we are doing

1. We are making it easier to access the right information and services to live a healthier lifestyle by commissioning:

- The 'Single Point of Access' for Health and Social Care, which has been established to provide the initial point of access for all district nursing and social work services, is being redesigned further to improve the coordination and provision of health and social care information to provide a better response to customers and one number to act as a gateway for new contacts. This will be supported by the online offer.
- The Digital Front Door Project which is refreshing the information and guidance available on the health and social care pages of the Lewisham website. As part of this work, an online wellbeing assessment has been designed to improve the triage of cases and to provide an opportunity to personalise advice, signposting, activities and promote healthy lifestyles. Underpinning this work will be a digital inclusion strategy that will enable the transition to self-managed care in the future.
- Work with Carers Lewisham to enable carers to continue caring, but also to support their health and wellbeing and to lead independent lives. Also an education course has been developed to support carers to effectively manage their own health
- The new mobile app and online service which is available to help people in Lewisham to understand where they should go for treatment, especially when they need healthcare in a hurry, late at night or at the weekend. It helps people check their symptoms and find the best place for treatment – showing which nearby services are open. Importantly, it will help people to know when to go to A&E and when not to. www.healthhelpnow-nhs.net

8. Local Commissioning Priorities 2017-19

8.1 Prevention and Early Action

What we are doing (continued)

2. We are commissioning a range of interventions to make it easier to choose to live a healthier lifestyle.

- **Our approach to prevention is to be holistic and whole system by contributing directly to the creation of a healthier environment, for example through the Sugar Smart campaign and Tobacco Control Alliance:**
  - Tackling Obesity in Lewisham is a multifaceted strategy for obesity prevention. The Borough is one of four areas across the country piloting a whole system approach to tackling the issue. For example the Local Authority and CCG are working across a range of sectors to encourage a reduction in the sale of high sugar products through the Jamie Oliver Foundation's Sugar Smart campaign. GP practices offer brief advice and referrals to weight management and physical activity programmes and the Local Authority is working with primary schools to promote the mile a day initiative.
  - The Tobacco Control Alliance in Lewisham is increasing the number of smoke free homes and premises and the SEL Illegal Tobacco Network is working with partners to reduce the supply of illegal tobacco.
  - Reducing Alcohol Harm is being undertaken by a multi agency group by regulating the safe supply of alcohol, raising the awareness of the risks by consistent communication and by commissioning treatment for those misusing alcohol. The core contract for the specialist substance misuse service is currently being re-procured for 2017/18.

- **At the same time we are commissioning for health improvement, for example through greater use of technology to stop smoking, reduce alcohol misuse, promote mental and emotional wellbeing, increase healthier eating and physical activity and improve sexual health and health issues including:**
  - 'Making Every Contact Count' by training staff to encourage people to make healthier lifestyle choices.
  - The Lewisham Stop Smoking service which assists dependent smokers to quit provided through GPs and pharmacies including a hub based model in each neighbourhood. This service is primarily targeted at heavily dependent smokers, including pregnant smokers, smokers with mental health problems and smokers with long term conditions.
  - NHS Health Checks in Lewisham are available from GPs and pharmacies to those people aged 40-74 years to detect a wide range of potential problems before they can do real damage, including developing heart disease, stroke, type 2 diabetes, kidney disease and some forms of dementia. The Council will be re-commissioning this service as an integrated pathway to better target high risk groups and follow-up referrals for those identified as at risk.
  - Public Mental Health and Wellbeing Strategy is being developed to support the improvement of mental health and wellbeing for all Lewisham residents through promoting evidence-based approaches to public mental health at an individual, community and organisational level across the life course.
  - Sexual Health services in Lewisham are offering online screening for chlamydia and gonorrhoea, shifting services to primary care and working to establish an integrated sexual health tariff across London.
  - Healthy Living Pharmacies – most pharmacies in Lewisham are accredited to deliver health and wellbeing advice and brief interventions, for example, for alcohol and smoking. Also pharmacists will be commissioned to support people with dementia through the medicines utilisation review and the development of dementia friendly community pharmacy services.

8. Local Commissioning Priorities 2017-19

8.1 Prevention and Early Action

What we are doing (continued)

3. **We are supporting people to live in their own homes safely and independently** by commissioning :

- Sail Connections a community referral pilot which provides a quick and easy way for vulnerable older people and those supporting them to access a wide range of services to support safe and independent living in the form of a simple first contact checklist. Sail supports a holistic approach, addressing unmet needs amongst the older population to facilitate access to appropriate services at the earliest point. The core function of the service will focus on prevention, early intervention and targeting the most vulnerable to reduce further escalation of their health problems.

- Community Falls service which is being redesigned to prevent the numbers of falls and falls related injuries for people over 65 by establishing a community based Falls team. The Community Falls team will support the development of a screening tool to identify better those people that are at risk, will provide proactive outreach into the community, primary care and care homes and establish physical activity programmes for people who have fallen or who are at risk of falls in 2017/18.

- Community Connections which supports Lewisham residents to access local services that meet their needs around the priorities which are centred on the "Five Ways to Wellbeing"- Connect; Stay Active; Keep Learning; Take Notice; Give. It is delivered by Age UK Lewisham and Southwark in conjunction with a consortium of voluntary sector partners in Lewisham.

- We are supporting the Borough wide Community Development work that already exists in Lewisham, such as Well Bellingham and the North Lewisham Health improvement programme, where communities help each other to look after their health and wellbeing.

- We are working together with a range of voluntary and community sector organisations, including Voluntary Action Lewisham (VAL) and Healthwatch, to test out new ways of working at a neighbourhood level which have a greater focus on prevention and early action, within the constraints of limited resources.

8. Local Commissioning Priorities 2017-19

8.1 Prevention and Early Action

What we are doing (continued)

4. We are commissioning a range of information, advice and care to support people with long term conditions to make it easier to self-manage their health and wellbeing, when appropriate including:

- **Earlier identification, diagnosis and management of long term conditions:**
  - GPs are being commissioned differently to ensure standards and population outcomes are consistently good across general practice by reducing variations in the early identification, diagnosis and collaborative care planning for those people with long term conditions.
  - The Co-ordinated Care Service is planned to be commissioned from General Practice, for a two year period, focused on the diagnosis and management of patients with long term conditions and the provision of an enhanced level of care in other clinical areas such as cancer, vaccinations and childhood immunisations. It has 4 key objectives, which are to:
    - Improve the health outcomes for people in Lewisham
    - Reduce variation in outcomes amongst Lewisham practices
    - Support and sustain collaborative practice working within neighbourhoods in Lewisham as part of the wider Neighbourhood Care Networks
    - Support a reduction in avoidable unplanned admissions
  - Primary Care Mental Health Service is to be established from April 2017 to transform the current Low Intensity Treatment Service into a primary care based service working with SLaM, primary care representatives and the voluntary sector.
  - Earlier detection and diagnosis for cancer in south east London by:
    - A single Acute Oncology Service telephone line with linked e-prescribing system will be established. This will triage patients, carers and GPs to the appropriate facilities and enable sharing of information between providers.
    - Improving the coordination of care during diagnosis and treatment so that care is streamlined to ensure all patients have a holistic needs assessment and care plan from diagnosis to treatment to support the delivery of the 62 day cancer wait in 2017/18.

8. Local Commissioning Priorities 2017-19

8.1 Prevention and Early Action

What we are doing (continued)

5. We are commissioning a range of information, advice and care to support people with long term conditions to make it easier to self-manage their health and wellbeing, when appropriate including:

- **Reframing self-management education programmes to embody a holistic approach by expanding, re-specifying and testing out new ways of engaging with structured education, including:**
  - Piloting 'Self-Management UK', which uses local facilitators to empower those people with LTC to be able to self- care and self-manage by using a menu of self-management education activities matched to the person's needs, including online education, support for carers and structured community based education, as well as linking with local initiatives that address the whole person and not a disease in isolation. It is hope that this more holistic approach it will result in greater engagement of the BME group, who have been found to be less engaged with disease specific self-management support in Lewisham.
  - Re-procuring DESMOND (Type 2 Diabetes self-management programme) against a new specification during 2017/18 and commissioning a new online structured education programme for adults with Type 2 Diabetes HeLP Diabetes (Healthy Living for people with Type 2 Diabetes) that will take a holistic view of self-management and address a wide range of patient needs.
  - Reviewing the current COPD pathway including enhancing engagement with LEEP (Lung Exercise Education Programme) that supports patients to better manage their condition through gentle exercise and education. Also we are developing LEEP Champions, who are patients who have successfully completed programme, to encourage and support new patients to complete the LEEP programme.
  - Improving uptake for self-management programmes by co-designing self-management with service users and improving appropriate referrals from local GPs.

- **Moving away from single disease specific interventions for people with long term conditions towards a holistic, person centred care approach that is built around the service user:**
  - Community Health Services are supported to move towards more outcomes focused delivery with a great focus on a holistic approach to prevention and proactive care.
  - Lewisham's Integrated Medicines Optimisation Service (LIMOS) which helps people manage their medication and remain independent, empowered and in control of their treatment
  - Integrating Psychological therapies - work is being undertaken to develop integrated care pathways for all psychological therapies for individuals with common mental illness working with SlaM and voluntary sector partners, with the intention to establish a formal Provider Alliance contract for Psychological Therapies, including Improving Access to Psychological Therapies (IAPT) during 2017/18.

8. Local Commissioning Priorities 2017-19

8.2 Planned Care

What we mean by Planned Care

Planned care is treatment that is planned in advance, such as an operation that is booked on a certain date or a routine planned appointments at a GP surgery, health centre or other community facilities.

Why this is a priority

There are a number of reasons for planned care being a priority :

- There are differences in patient outcomes and experiences, depending on where and when they access care.
- The time from first appointment to diagnostic test, to getting results could be quicker and more efficient leading to early diagnosis and better outcomes for patients.
- There is unnecessary duplication of paperwork and diagnostic tests, causing delays in patient care because different services use different IT systems that are not compatible.

One of our biggest priorities in planned care is to improve the way we provide **orthopaedic care** – treating injuries and conditions that affect the musculoskeletal system (bones, joints, ligaments, tendons, muscles and nerves). We are trying to improve these services in south east London for those patients who have their care planned in advance. This mainly includes routine procedures like hip and knee joint replacements and also some specialist procedures.

Our proposal, which has been developed by senior doctors and nurses with input from patients and local residents, considers consolidating planned inpatient orthopaedic surgery into two elective orthopaedic centres. We believe that by doing this there may be a number of important benefits which could improve the quality of care for every patient and make the service sustainable in the long term, including:

- More procedures could be carried out to cope with increasing demand.
- There would be fewer cancelled operations as theatres and beds in an elective orthopaedic centre would be ring-fenced.
- There would be shorter waiting times for patients needing this type of surgery.
- Better infection control.
- Patients would spend less time in hospital.
- The quality of care would be more consistent so all patients get a similar experience and outcome from their operation.
- Lower costs and more investment because of things like prescribing fewer antibiotics, standardising the type of replacement joints used by surgeons and reducing the length of time patients stay in hospital.

8. Local Commissioning Priorities 2017-19

8.2 Planned Care – Our Aim

Our aim is to commission services so that all people who need planned care have appropriate, timely access to high quality of care and excellent patient outcomes.

What are we doing

Elective orthopaedic centres – south east London commissioners and providers have been working together to:

- Consolidate planned inpatient orthopaedic surgery at fewer sites in south east London – called elective orthopaedic centres – by creating two elective orthopaedic centres. These would be shared facilities with a dedicated team on site, including nursing, anaesthetic staff and therapists. Surgeons would carry out both routine and complex surgery (excluding spinal procedures) at these centres, in a highly specialised environment supported by this core team. The remaining sites in south east London would stop providing this planned adult inpatient orthopaedic surgery
- Develop a clinical network to ensure standards are consistently excellent and that clinicians share learning and expertise.
- Before any changes could be made there would be a full public consultation, which could take place later in 2016/17.
- More details can be found at http://www.ourhealthiersel.nhs.uk/orthopaedics.htm.

Improving access to care:

- 18 week referral to treatment waiting times standard – currently the delivery of this waiting time target is variable with historical challenges at Kings College Hospital. Commissioners are working with providers to ensure during 2017/18 that recovery plans are in place to meet this national target with a focus on:
  - Robust demand and capacity planning at a Trust and speciality level
  - Developing virtual outpatient clinics, effective triage and assessment services and a shift to day case and outpatient rather than inpatient care
- Referral Support Service - improving the quality of hospital referrals and also patient experience of the appointment booking process through centralising the function that receives referrals electronically to the most appropriate place and time for the patient. The Referral Support Service has been a two year pilot which is being fully evaluated to inform the procurement approach in 2017/18.
- Diagnostic Cancer Centre of excellence is to be established at South East London Cancer Centre at Guys and St Thomas Trust.

Development of services closer to home, supported by specialists, to enable the management of people with more complex health and care needs out of hospital:

- Musculoskeletal and Physiotherapy services - improving the patient's experience and delivering value for money by re-specifying the community based Musculoskeletal Assessment and Treatment Triage service (MCATTS) service requirements for 2017/18 which is currently provided by Lewisham and Greenwich Hospital Trust (LGHT).
- Diabetes – developing an integrated specialist, community and primary diabetic model of care to include diabetes prevention as well as delivering all general and complex diabetes care in the community, transforming how diabetes is delivered.
- Improving access to specialist advice and support for GPs.
- Dermatology and Respiratory services - reviewing the benefits and feasibility of developing community based services.

8. Local Commissioning Priorities 2017-19

8.3 Urgent and Emergency Care

What we mean by Urgent and Emergency Care

Urgent and Emergency Care includes the advice, support and care provided by health, social care and the third sector to those people with urgent or emergency physical or mental health needs, defined as:

- **those people with urgent care needs**, who require a highly responsive service that delivers care as close to home as possible, minimising disruption and inconvenience to individuals, their families and their carers.
- **those people with more serious or life threatening emergency care needs**, who require treatment in centres with the very best expertise and facilities in order to maximise the chances of survival and a good recovery.

Why this is a priority

There is a **rising demand for urgent and emergency care** which increasingly statutory organisations will not be able to afford:

- The number of emergency attendances at Lewisham Hospital increased by 12% between 2014/15 and the same period in 2015/16 , even though there were more suitable services available to be used instead. In Lewisham we have a GP led walk in centre at the Waldron, out of hours care provided by SELDOC and NHS 111 service
- A review of Accident and Emergency (A&E) attendances at Lewisham A&E Department found that 35% of patients presenting were classified as having needs that could have been met at the Urgent Care Centre (UCC). Of the same 35% attendances nearly half did not have any investigation or treatment suggesting that they could have been managed in a more appropriate care setting that provides better value for money
- Some people are admitted to hospital when this is not clinically required because of a lack of alternative community based options - referred to as Ambulatory Care Sensitive Conditions (ACSCs) emergency. National benchmarking has identified that Lewisham has a higher number of emergency admissions for the top 10 ACSCs, such as Influenza and pneumonia, diabetes complications, COPD and heart failure, when compared to other similar CCGs. This indicates that the number of emergency admissions could be reduced.

Lewisham people consistently have fedback that they find the urgent and emergency care system **confusing and fragmented**. The public are not clear about what to do, who to call or where to go for urgent and emergency care.

People can have **long waits** in Accident and Emergency departments, particularly those people with mental health issues.

8. Local Commissioning Priorities 2017-19

8.3 Urgent and Emergency Care - Our Aim

Our aim is to commission urgent and emergency services across the whole system which are co ordinated, consistent, clear and affordable, helping people to get the right advice and care in the right place first time, particularly for those with urgent or emergency physical and/or mental health needs.

What we are doing

We are developing, piloting, evaluating and contracting for a range of community based services which will enhance the care and support available to help to avoid or reduce the need for emergency admissions . The specific services which are under review and being redesigned :

- An Integrated Primary and Urgent Care service located on the Lewisham Hospital site. Currently we are engaging with clinicians and the public how this service will operate. The intention is that the Primary and Urgent Care Service will:
  - Replace existing access to A&E for all walk in attendances
  - Provide extended hours access to primary care (walk in and appointments)
  - Deliver rapid clinical assessment and appropriate redirection of patients (if necessary) to, for example A&E, Ambulatory Care, Neighbourhood Community Teams, patient's own GP
- GP Access - extending primary care access by piloting a GP Extended Access Pilot from April 2017, which will operate from 8.00am to 8.00pm, seven days a week.
- Rapid response teams - piloting the operation of combined medical and social care teams who will provide rapid assessments for those patients in the community identified to be at risk of an emergency admission on a 7 day week and pro-active co-ordinated planning to reduce the need for emergency care. The pilot is planned to start in November 2016 . This pilot will be aligned to the mental health Crisis Resolution and Home Treatment teams (CRHTT), who also deliver care in communities and homes, with the intention to develop an integrated multidisciplinary team.
- Home Ward – piloting the provision of enhanced support for those patients in the community who require more medical and social care ('step up' care) and for those patients who are ready for discharge but who require ongoing medical intervention ('step down' care) in 2017.
- Continuing Health Care – piloting a dedicated Continuing Health Care team to improve the quality of assessments and care for people with complex health needs living at home or in care homes in the Borough
- Care homes – improving the quality assurance and enhancing primary care (GP and LIMOS) support to nursing and residential care homes
- Pharmacy – reviewing the potential opportunity for greater use by those people with urgent care needs, building on the Pharmacy First scheme which provides advice, treatment and medicines for common ailments from your local pharmacy.
- End of Life Care – commissioning a new single Community Palliative Care Team. This will ensure that all our residents with specialist palliative care needs have access to 24 hour, 7 days a week advice and support across the Borough.

8. Local Commissioning Priorities 2017-19

8.3 Urgent and Emergency Care

What we are doing (continued)

We are working with partners to improve the Emergency Care provided in Lewisham by:

- Working with Lewisham and Greenwich Trust by:
  - Commissioning an improved emergency care pathway within hospitals to enable effective streaming and management in A&E and better hospital flows from A&E, assessment and admissions
  - Delivering the NHS Constitutional Standard of a maximum 4 hour A&E waiting time
  - Improving the quality of care provided, as set out in the London Quality Standards.
- Improving the mental health interface with the A&E Department by:
  - Establishing a Liaison Psychiatry Service which operates twenty-four hours, seven days a week to improve access and standards of care (CORE 24).
  - Supporting earlier recognition of mental health issues and onward referral at the front door of the Emergency Department. Achieving parity of esteem by working towards mental health emergencies being treated with the same urgency and seriousness as physical health emergencies in terms of a maximum 4 hour A&E waiting time. The ability of services to meet this standard will be monitored in 2017 and refined for implementation from 2018-19.
  - Commissioning a 24 hour Crisis line to provide professional mental health advice to professionals, individuals and carers that may be experiencing or are affected by someone in a mental health crisis and a Peer-Support Crisis Line called Solidarity in a Crisis that operates at evenings and weekends. In addition to offering telephone support the service also provides A&E peer support and community follow up appointments.
  - Developing a pan-London Health Based Place of Safety (HBPoS) specification and wider section 136 care pathway. Commissioners are working with South London and Maudsley (SLaM) to provide an integrated section136 suite in response to the Crisis Care Concordat.
- Re-procuring NHS 111 Service, planned to go live in June 2017.
- Working with the London Ambulance Service to deliver the standards for ambulance response and to reduce the number of ambulance 999 calls that result in a person being taken to an A&E department.

We are developing further Supported Discharge Services so that discharge planning is consistent and begins as early as possible to facilitate early discharge from hospital and reduce avoidable admissions into hospital:

- Community Discharge Team - remodelling the existing Community Discharge team to provide an extended service targeted at people who are being discharged, but require further rehabilitation in the community. It will operate 7 days a week (8.00am to 6.00pm) starting in 2017.
- Emergency Discharge Team-- redesigning the existing Emergency Discharge Team to identify people aged 60 and over coming into the A&E departments with heath conditions which could be more appropriately managed in the community and linking them to these alternative community based care services. The new service will be in place in 2017.

Getting More Involved

You can play an active role in the decisions we make and shape future services in Lewisham

You can help improve health and care in Lewisham by sharing your ideas and experiences.

There are many ways you can get involved in our commissioning work. Find out more at:

www.lewisham.gov.uk/myservices/socialcare/our-approach

or at www.lewishamccg.nhs.uk/get-involved

We would welcome your views on this year's Partnership Commissioning Intentions

Glossary of Terms

A&E - Accident and Emergency
ASC – Adult Social Care
ACSC - Ambulatory Care Sensitive Conditions
BME - Black and Minority Ethnic
CCG - Clinical Commissioning Group
COPD - Chronic Obstructive Pulmonary Disease
CHC – Continuing Healthcare
CRHTT - Crisis Resolution and Home Treatment Team
DESMOND - Diabetes Education and Self Management for Ongoing and Newly Diagnosed
GP - General Practitioner
GSTT - Guy's & St. Thomas's NHS Foundation Trust
IAPT - Improving Access to Psychological Therapies
JSNA - Joint Strategic Needs Assessment
KCH - Kings College Hospital NHS Foundation Trust
LA – Local Authority
LAS - London Ambulance Service
LCCG - Lewisham Clinical Commissioning Group
LGT - Lewisham and Greenwich NHS Trust
LIMOS - Lewisham's Integrated Medicines Optimisation Service
LTC – Long Term Conditions
MCATS - Musculoskeletal Community Assessment and Treatment Service
MSK – Musculoskeletal
NCN – Neighbourhood Care Network
NCT – Neighbourhood Community Team
OHSEL – Our Healthier South East London
PH – Public Health
QIPP - Quality Innovation Productivity and Prevention
RTT - Referral to Treatment
SLaM - South London and Maudsley Mental Health Foundation Trust
SEL – south East London
SELDOC - South East London Doctors Co - Operative
UCC - Urgent Care Centre
UHL – University Hospital Lewisham