

NHS Lewisham Clinical Commissioning Group

Primary Care Strategy: Developing GP Services

2016 – 2021

Version 0.6
26th October 2016

Approvals

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

Contents page

Executive Summary	4
1. Introduction	6
2. Strategic context.....	8
3. Lewisham’s population and health needs	13
4. Current primary and community care provision.....	15
5. Drivers for change	17
Our approach to primary care transformation	20
6. Our strategic priorities for primary care.....	20
7. Our strategic plans	23
8. Delivery models.....	30
Future contracting and commissioning.....	34
Enabling infrastructure	36
Implementing our vision	38
9. Implementation approach	38
10. Conclusion	39
Appendix A - GP Forward View Summary.....	40

Executive Summary

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

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

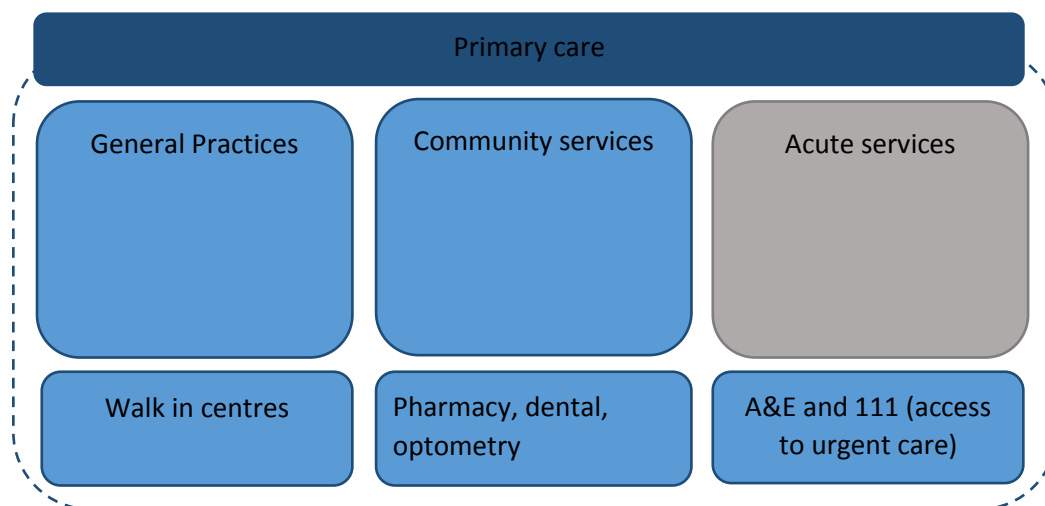
Lewisham CCG Primary Care Development Strategy 2016-2021 (SUMMARY)

Context	SEL Sustainability & Transformation Plan / GP Forward View / NHS 5 Year Forward View / CCG 5 Year Strategy / Strategic Commissioning Framework (London)		
Vision	To commission high quality primary care services to improve outcomes and reduce variation for our local population		
Delivering High Quality Care	<div style="text-align: center;"> <h3>Primary & Community Based Care (CBC)</h3> <p>Lewisham CCG will commission to achieve sustainable primary care. This care will increasingly be delivered at scale across local populations through GPs leveraging opportunities afforded by technology and working collaboratively through new models of care which deliver integrated services. Primary care will be integral to the neighbourhood care networks (NCNs) and multi-disciplinary teams (MDTs) that deliver community based care</p> <p><u>Neighbourhood Care Networks delivering CBC:</u></p> <ul style="list-style-type: none"> • Building strong & confident Lewisham communities • Delivery of consistently high standards of care, including London Strategic Commissioning Framework Specifications • Responsive services providing access from 8am-8pm, 7 days a week • Focus on physical health and wellbeing of patients with mental health problems • Proactive primary and secondary prevention • Systematic risk stratification /problem solving approach with shared care planning • Access to specialists in the community and increased accessibility to diagnostics • Working with wider local partners (including voluntary sector) <p>Primary care will need to be i) proactive, ii) accessible and iii) coordinated</p> <div style="display: flex; justify-content: space-around;"> <div data-bbox="300 906 703 1161"> <h4>Proactive Care</h4> <p>Including:</p> <ul style="list-style-type: none"> - Upstream interventions - Early Identification (eg LTCs) - Co-design approaches to health improvement - Collaboration around patient health goals - Support self-management </div> <div data-bbox="710 906 1113 1161"> <h4>Accessible Care</h4> <p>Including:</p> <ul style="list-style-type: none"> - Extended access - 8am-8pm, 7 days/week - Integrated Primary and Urgent Care - Choice of access options - Flexible access & continuity </div> <div data-bbox="1120 906 1523 1161"> <h4>Co-ordinated Care</h4> <p>Including:</p> <ul style="list-style-type: none"> - Integral part of neighbourhood care networks (NCNs) & MDT Working - Risk stratification - Care planning & review </div> </div> <div style="float: right; width: 25%;"> <div data-bbox="1547 421 2123 687"> <h4>Commissioning Approach</h4> <ul style="list-style-type: none"> • Core contract & enhanced/community services • Facilitating and supporting practices to work together at scale • Primary care as an integral part of the NCNs • Shift in resources (secondary → community/primary care) • Outlier management (support) to reduce variation and inequalities </div> <div data-bbox="1547 703 2123 1161"> <h4>New Models of Care</h4> <p>Providers of primary and community based care, offering population-based enhanced and community services</p> <p><u>Providers:</u></p> <ul style="list-style-type: none"> - GP Practices - Super-partnerships - Federations - Multispecialty community provider (MCP) / Primary and acute care systems (PACS) <p><u>Providing:</u></p> <ul style="list-style-type: none"> - List based care - At scale across local populations - Outcomes based - Core services/ Enhanced services / Community services </div> </div> </div>		
	Enablers	<h4>Contracting</h4> <p>Move to Level 3 Co-commissioning (2017/18) Contractual stability period for core contract for first 3 years</p>	<h4>Information Technology & Estates</h4> <p>IT – Local Digital Roadmap & shared medical records Enabling alternative consulting options for patients & professionals Estates – Including provision of hubs in neighbourhoods</p>

1. Introduction

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

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



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

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

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

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

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

2. Strategic context

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

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

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

Relevance for the future of primary care:

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

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

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

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

Relevance for the future of primary care:

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

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

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



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

Relevance for the future of primary care:

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

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

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

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

Relevance for the future of primary care:

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

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

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

Relevance for the future of primary care:

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

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

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

Relevance for the future of primary care:

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

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

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

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

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

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

XVII. Multidisciplinary teams will coordinate care for identified patients

Relevance for the future of primary care:

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

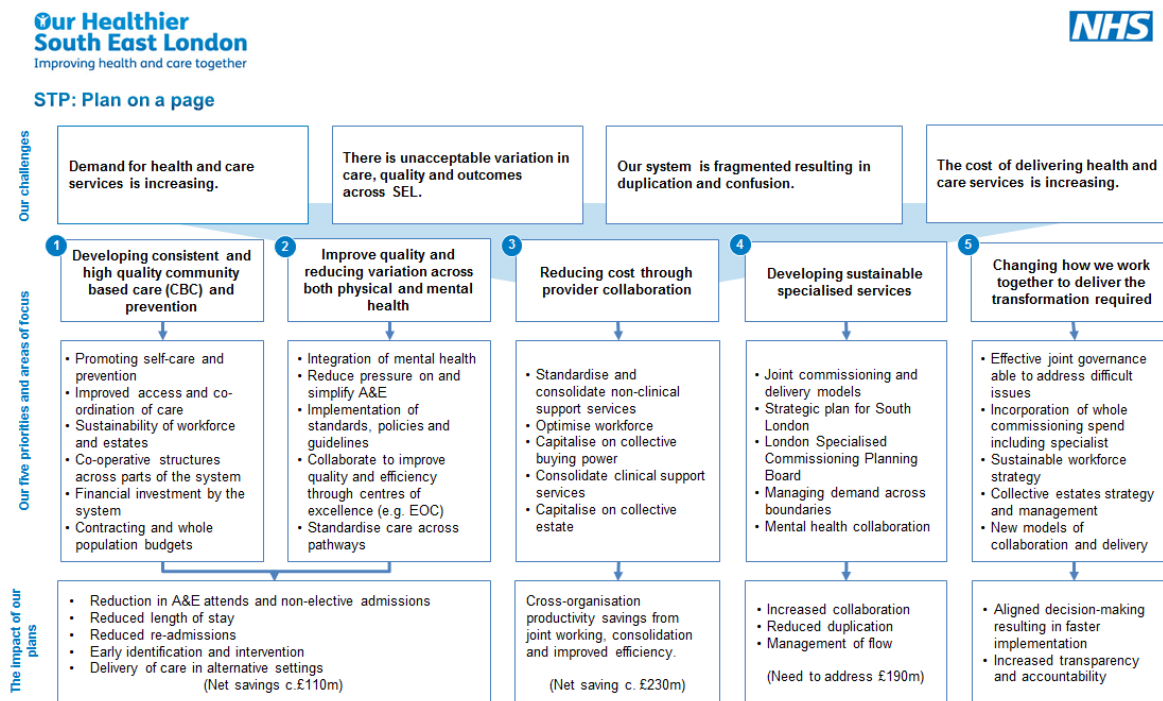
➤ **Delivering the Fiver Year forward View: Planning Guidance – NHS England, 2015**

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

The specific requirements for primary care are:

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

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



Relevance for the future of primary care:

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

➤ **GP Forward View, 2016**

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

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

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

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

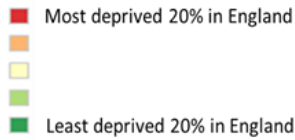
A summary of the GP Forward View can be found at appendix A.

Relevance for the future of primary care:

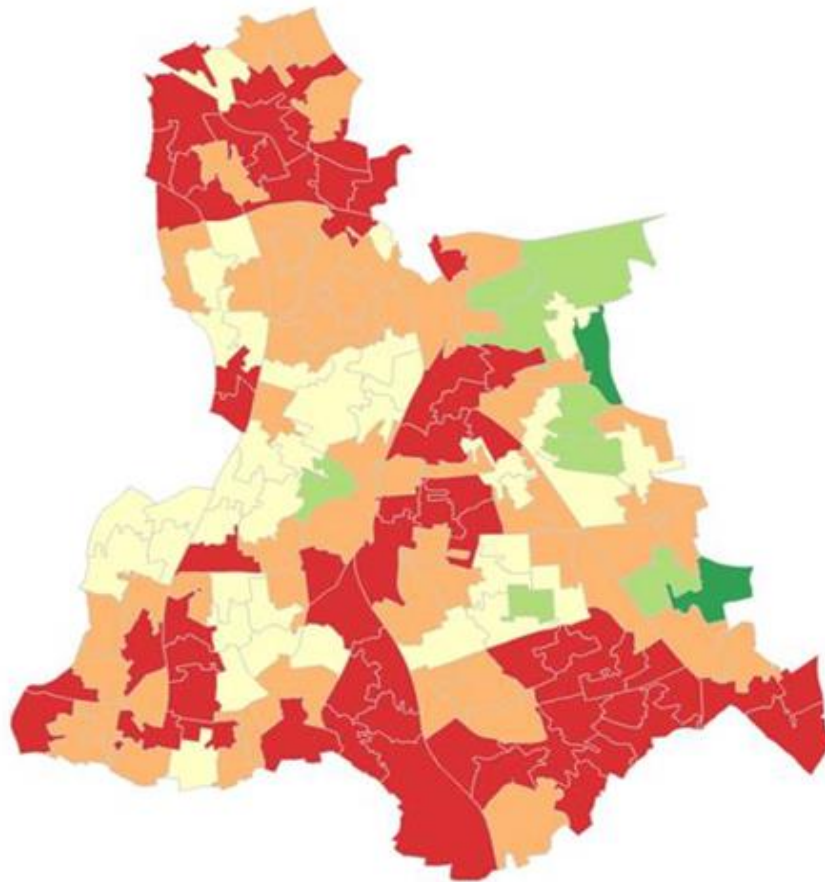
- *The Lewisham Primary Care Strategy will seek to ensure that all opportunities afforded through the GP Forward View are accessed locally with the impact of these nationally supported programmes maximised, especially where accompanied by funding.*

3. Lewisham's population and health needs

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



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



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

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

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

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

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

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

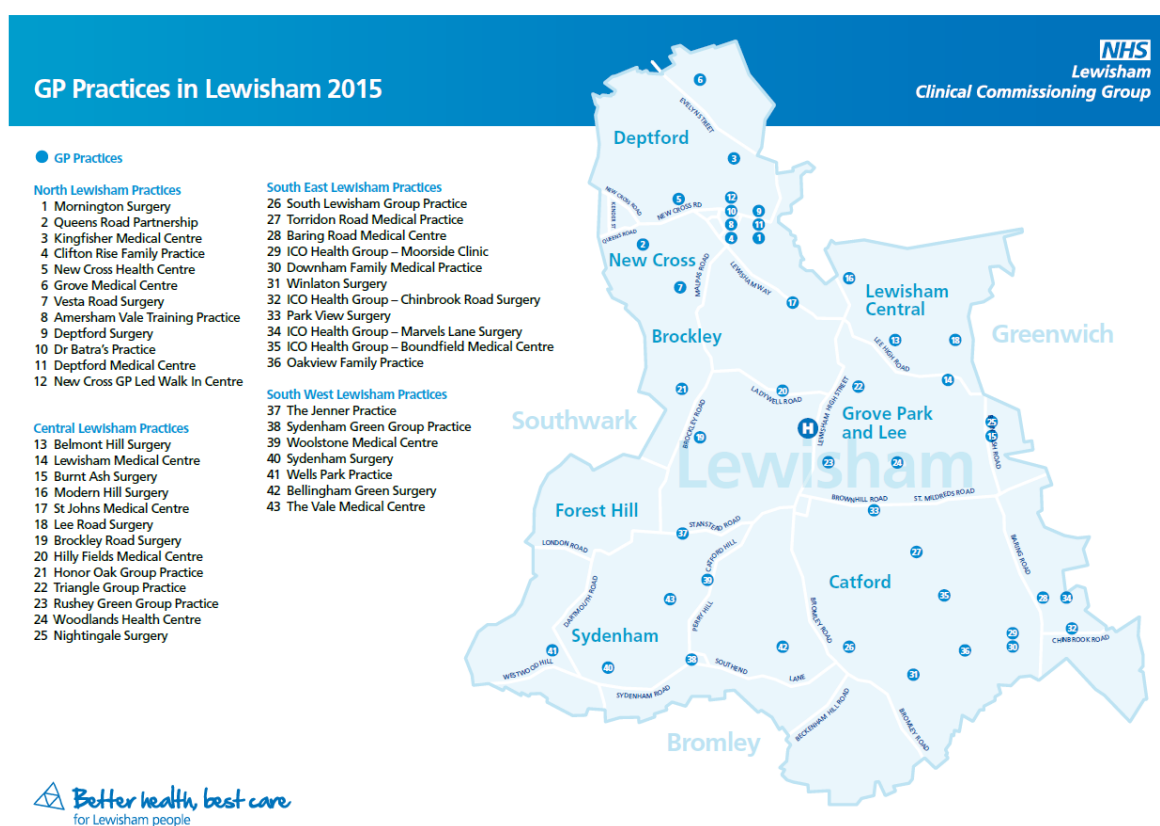
4. Current primary and community care provision

a. General Practice

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

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

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



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

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

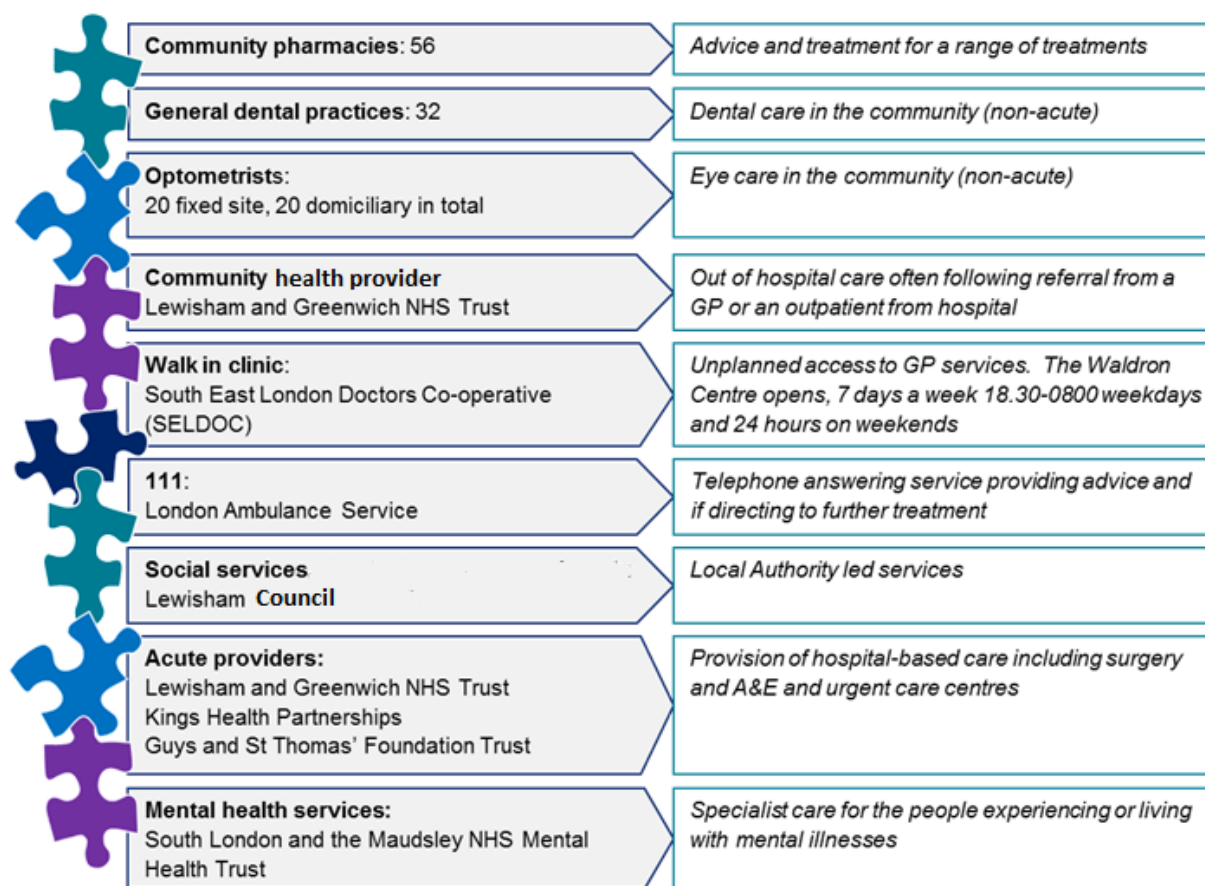
Neighbourhoods allow collaborative decision-making and planning of delivery over a wider population. Each neighbourhood has a neighbourhood community team (NCT) constituting of district and community nurses, social care professionals and occupational health. Regular MDTs allow the team to discuss their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

b. GP Federations

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

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

c. Other service providers in Lewisham



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

5. Drivers for change

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

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

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

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

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

a. National drivers

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

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

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

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

b. Locally led drivers

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

1) *Improving access and quality*

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

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

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

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

2) Variability in quality, access and outcomes

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

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

3) Addressing health challenges and inequalities

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

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

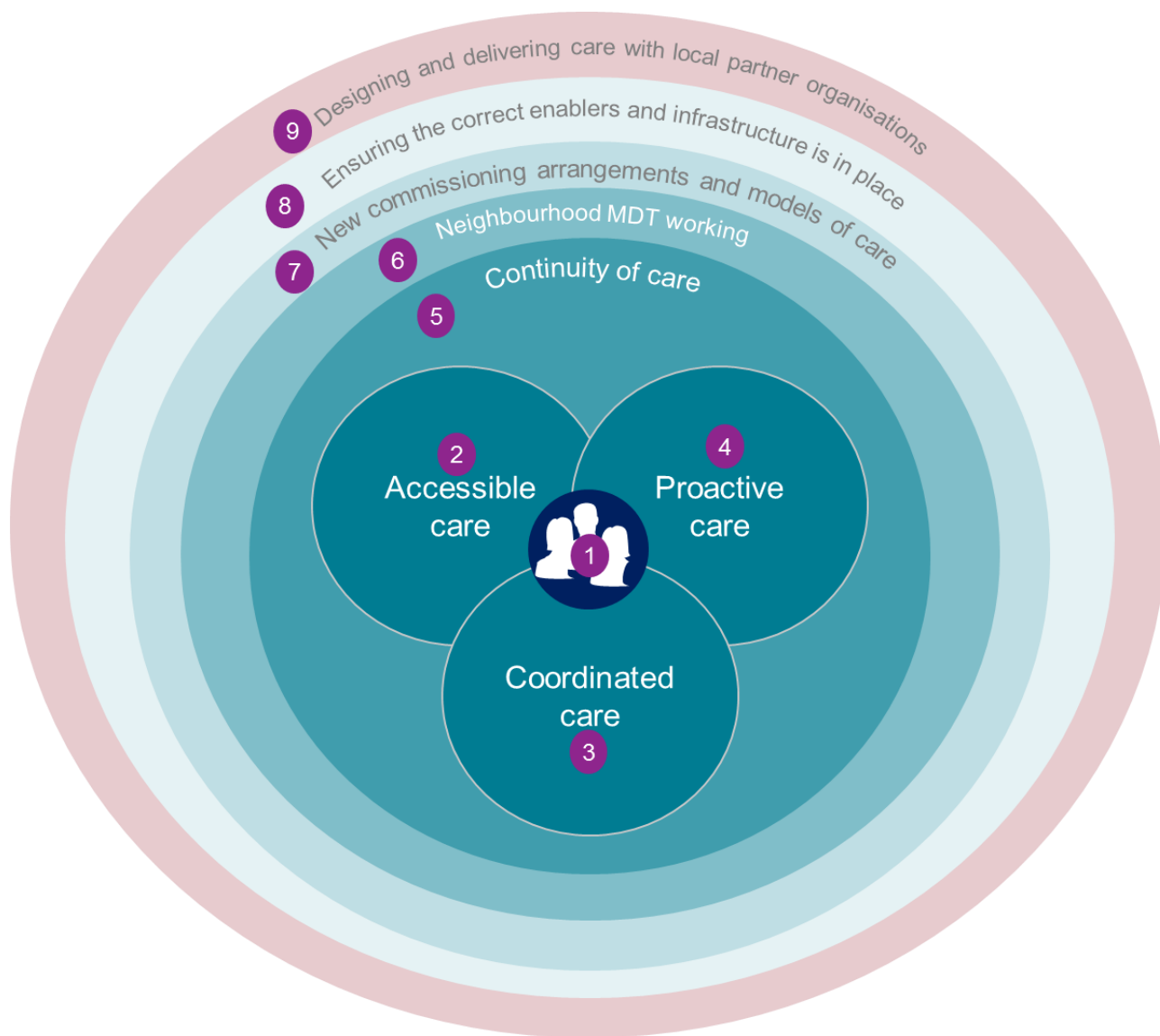
4) Supporting service integration

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

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

Our approach to primary care transformation

6. Our strategic priorities for primary care



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

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

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

Strategic priorities

What this will help us deliver

1

The population of Lewisham and their health challenges sit at the heart of our strategy

POPULATION FOCUS

2

We know that access is a key issue and so will improve the way appointments are booked and provide extended hours and same day access

3

We will improve the skill-mix in teams through MDT working and improve communication between GP practices and other parts of the system

4

We will explore and expand solutions to offering self-management advice, health education and community support

5

We will value continuity of care especially for patients with long term conditions

6

We will expand our neighbourhood models to develop the quality of care delivered, improve access and reduce variability in the care offer

7

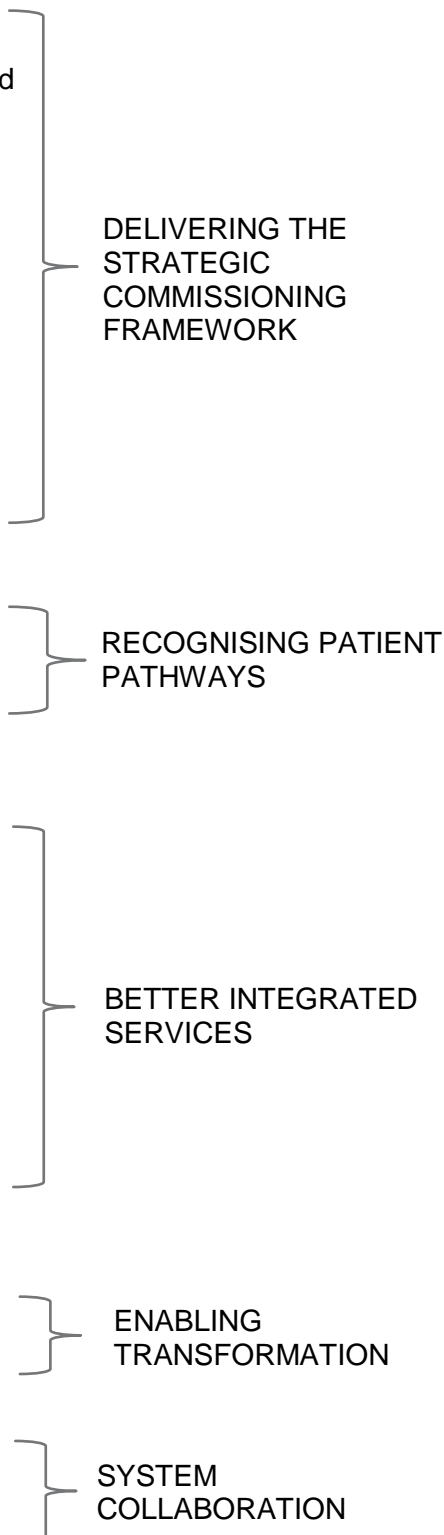
We will ensure our commissioning arrangements represent value for money and support the implementation of innovative care models that better integrate services

8

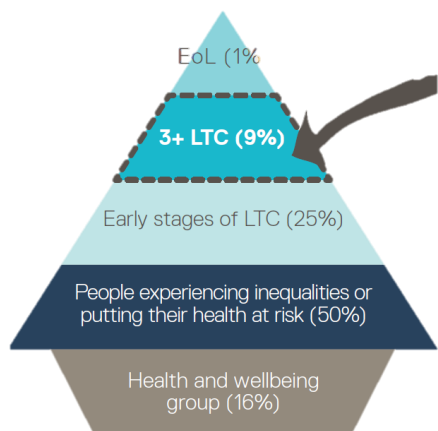
We will ensure that workforce, technology and estates are fit for the purpose of primary care transformation

9

We will continue to support the development of place-based plans across South East London in collaboration with our local partner organisations as part of the STP



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



VICTORIA, 71



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

What does this strategy mean for Victoria?

Strategic priorities

What this means for Victoria

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

7. Our strategic plans

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

a. Proactive Care

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

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

b. Accessible Care

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

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

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

c. Coordinated Care

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

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

8. Delivery models

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

a) Primary care working at scale

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

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

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

i. GP provider federations

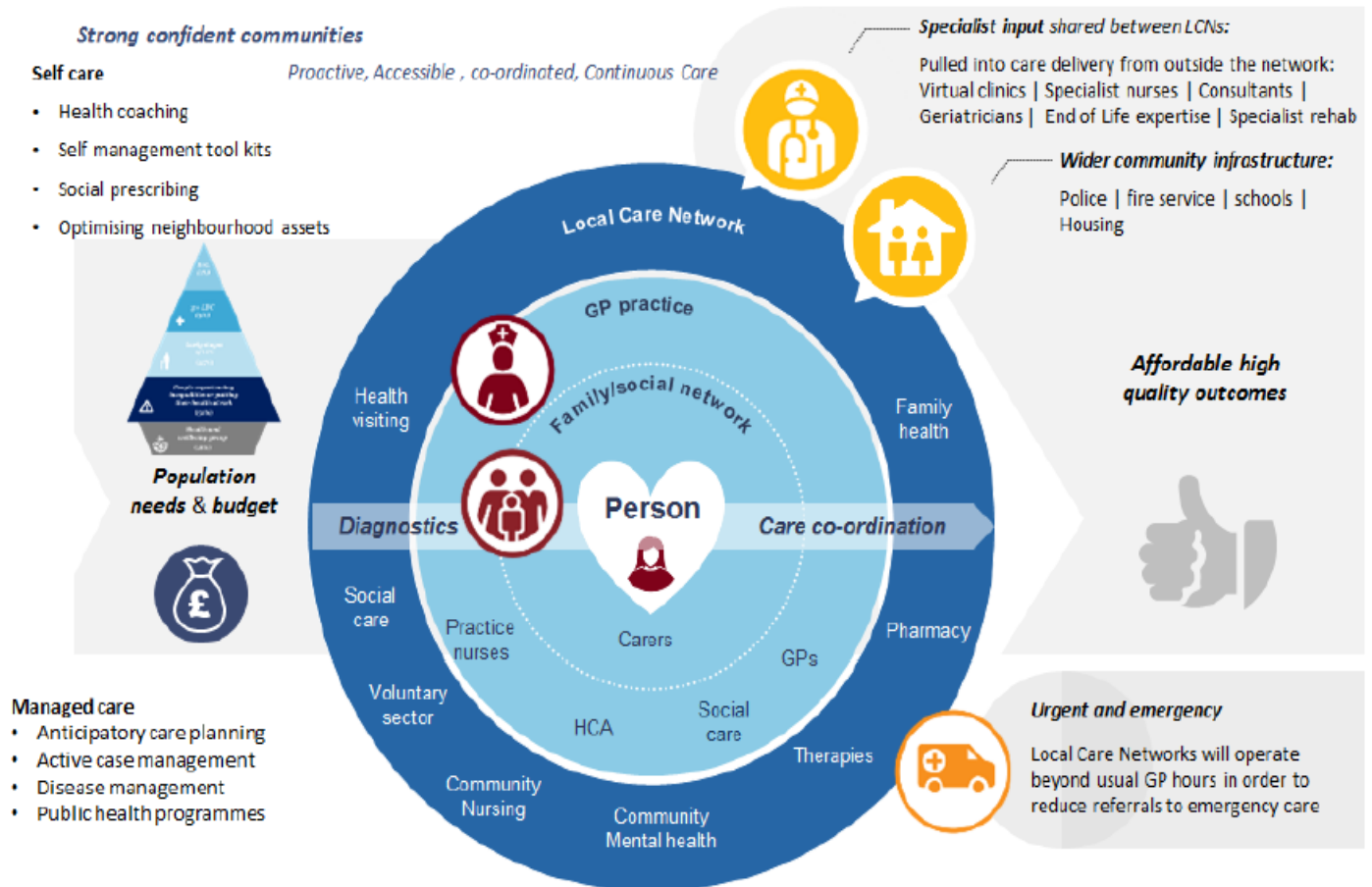
The CCG will continue to work with our GP provider federations to support their ongoing development and to deliver sustainable and credible organisations working as part of our NCN model.

ii. “Super-partnerships”

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

b) Neighbourhood Care Networks (NCNs)

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



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

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

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

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

c) Integrated Urgent and Primary Care Services

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

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

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

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

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

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

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

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

The benefits to both primary and urgent care would include:

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

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

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

Phase 1: Urgent Care Centre Streaming

- Review of UCC GP front end
- Implement UCC GP triaging and re-direction support pilot

Phase 2: Extended Access to General Practice

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

Phase 3: Integrated Primary & Urgent Care Service

- Develop and commission integrated primary and urgent care on the University Hospital (UHL) site.

Future contracting and commissioning

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

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

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

a. Primary care co-commissioning

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

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

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

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

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

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

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

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

b. PMS review

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

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

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

c. Management of variation

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

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

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

Enabling infrastructure

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

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

a. Workforce Development

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

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

b. Estates

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

c. Information Technology

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

Examples of technologies to be reviewed and adopted include:

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

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

Implementing our vision

9. Implementation approach

a. Governance structures

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

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

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

b. High level implementation plan

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

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

c. Top 5 risks, impact and mitigations

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

10. Conclusion

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

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

Appendix A - GP Forward View Summary

General Practice Forward View: On A Page

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

CHAPTER 1: £	<ul style="list-style-type: none"> Investing a further £2.4 billion by 2020/21 into general practice services. This means that investment will rise from £9.6 billion a year in 2015/16 to over £12 billion a year by 2020/21. This includes recurrent and transformational funding Additionally a review on Carr-Hill formula in progress to ensure it reflects derivation and workload etc
CHAPTER 2: WORKFORCE	<ul style="list-style-type: none"> Create an extra 5,000 additional doctors working in general practice by 2020 Attract an extra 500 GPs from abroad and targeted £20,000 bursaries that have found it hardest to recruit. A minimum of 5,000 other staff working in general practice by 2020/21 <ul style="list-style-type: none"> ❖ 3,000 mental health therapists ❖ 1,500 pharmacists £206 million in support for the workforce through: <ul style="list-style-type: none"> ❖ £112 million (in addition to £31m already committed) for the clinical pharmacist programme to enable a pharmacist per 30,000 population ❖ £15 million national investment for nurse development support including improving training capacity in general practice, increases in the number of pre-registration nurse placements and measures to improve retention of the existing nursing workforce and support for return to work. ❖ £45 million benefitting every practice to support the training of current reception and clerical staff to play a greater role in navigation. ❖ Investment by HEE in the training of 1,000 physician associates to support general practice. Introduction of pilots of new medical assistant roles that help support doctors. ❖ £6 million investment in practice manager development, alongside access for practice managers to the new national development programme.
CHAPTER 3: WORKLOAD	<p>Support for GPs to manage demand, unnecessary work, bureaucracy and integration with wider system</p> <ul style="list-style-type: none"> £16 million extra investment in specialist mental health services to support GPs with burn out and stress. £30 million 'Releasing Time for Patients' development programme, new standard contract measures for hospitals to stop work new four year £40 million practice resilience programme (including £16m in 2016/17) move to five yearly CQC inspections for good/outstanding practices introduction of a simplified system across NHS E, CQC and GMC, streamlining of payment for practices, & automation of common tasks.
CHAPTER 4: INFRA- STRUCTURE	<ul style="list-style-type: none"> £900m for premises and IT (this is the continuation of the Primary Care Transformation Fund, now renamed) £45m for e-consultation support New rules to allow up to 100% reimbursement of premises developments Over 18% increase in allocations to CCGs for provision of IT services and technology for general practice
CHAPTER 5: CARE REDESIGN	<ul style="list-style-type: none"> Support to strengthen & redesign general practice by commissioning and funding of services to provide extra primary care capacity across every part of England, backed by over £500 million of funding by 2020/21 incl. £171 million one-off investment by CCGs starting in 2017/18, for practice transformational support, introduction of a new voluntary Multi-speciality Community Provider contract from April 2017. New national three year 'Releasing Time for Patients' programme to reach every practice in the country to free up to 10 percent of GPs' ¹ time (£30m), building on recent NHS England and BMA roadshows.