NHS
Lewisham
Clinical Commissioning Group

Better health, best care
for Lewisham people

# Operating Plan: 2014/15-2015/16

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# INTRODUCTION

## ❑ National Requirements

All CCGs are required to produce a two year Operating Plan which sets out the CCG's key objectives which will be delivered during 2014/15 and 2015/16. CCGs also are required to ensure that their Operating Plan is informed by national planning guidance and financial parameters, as set out by NHS England.

## ❑ Lewisham CCG's five year Strategic Plan

Lewisham CCG's five year Strategic Plan sets out the following strategic vision with Lewisham people at the centre of everything the CCG does:

- **Better Health** - to improve the health outcomes for the Lewisham population by commissioning a wide range of advice, support and care to make choosing healthy living easier, for people to keep fit and healthy and to reduce preventable ill health and health inequalities;
- **Best Care** - to ensure that all commissioned services are of high quality –safe, evidence based and provides a positive patient experience. But also to shift the focus of support and care to prevention, self-care and planned care in the community.
- **Best Value** - to commission services which are integrated and sustainable so delivering high quality, effectiveness and value for money.

## ❑ Developing the CCG's Operating Plan (2014/15 and 2015/16)

Lewisham CCG's Operating Plan is a two year implementation plan to deliver the CCG's strategic vision and it has been informed by the views of our Members, our Governing Body and the Public feedback from the Commissioning Intentions engagement exercise.

## ❑ Operating Plan's key objectives

Lewisham CCG's Operating Plan comprises fifteen commissioning objectives which are considered to be of particular significance for Lewisham. The 15 commissioning objectives are not an exhaustive list, but instead aim to identify those commissioning areas where we believe that the CCG will deliver the biggest impact on 'better health outcomes, best care and best value' for all Lewisham people.

# CANCER

COMMISSIONING OBJECTIVES

| Commissioning Objectives | Operating Plan - outputs |
|---|---|
| ***Support the Health and Wellbeing Board deliver its strategy to address wider determinants of health and wellbeing promote health and tackle health inequalities*** | *Reduce all premature mortality and reduce health inequality by supporting the Health and Wellbeing Board deliver its strategy* |
| | *Health prevention - support Public Health to ensure that wider health promotion programmes are in place at the scale and pace required to:*<br>• *Achieve a healthy weight;*<br>• *Reduce alcohol harm;*<br>• *Prevent the uptake of smoking among children and young people and reducing the numbers of people smoking;* |
| **Increase the rate of early diagnosis and detection of cancer in Primary Care**<br>(Cancer Survivorship is part of the Long Term Conditions work) | Cancer - improved rates of cancer detection in primary care by monitoring variation in referral and diagnosis rates amongst local practices and working with local GPs to understand the reasons behind variance, to reduce variation in comparison with good practice. |
| | Cancer Commissioning Intentions:<br>• sets out the development of integrated care pathways, working with Public Health, London Cancer Alliance and NHS England;<br>• secures improvements in cancer outcomes in 2015/16<br>• overseen by a new Health and Wellbeing subgroup |
| | • Robust acute contract management is in place, with the setting up of the Cancer Services Review Groups, as a subgroup of the Clinical Quality Review Group, lead by the South London CSU working with London Cancer Commissioning Team |

# CANCER

COMMISSIONING OBJECTIVES

## DRAFT KEY OUTCOMES

NHS Constitutional standards for cancer waiting and treatment times are met
To achieve better than Lewisham's 'peer' average performance for key cancer outcome measures by the end of 2015/16 ('commissioning for value'):

- Practice's cancer 2 week wait detection rate;
- Practice's cancer 2 week wait conversion rate;
- Number of emergency admissions with cancer.;

To support the reduction in levels of obesity, alcohol harm and smoking

## DRAFT KEY RISKS

- Increased detection of cancer cases as emergency cases, as a result of under referral of cancer cases from primary care;
- Members inadequately actively promote cancer screening within their practice to address historically low screening rates
- Lack of Public Health capacity to provide regular cancer monitoring information to individual GP practices;
- Lack of commissioning capacity to support individual practices to improve their outcome measures –as part of the wider Primary Care Development;
- Public Health Prevention implementation programmes are not at sufficient scale or pace to be effective;
- The 'whole system working' is not effective to improve the commissioning of integrated cancer care pathways.
- Failure to recruit to GP Macmillan cancer lead.
- SL CSU does not work effectively with London Cancer Alliance to monitor and manage acute cancer contracts.

# MATERNITY AND CHILDRENS CARE IN HOSPITAL

COMMISSIONING OBJECTIVES

| Commissioning Objectives | Operating Plan - outputs |
|---|---|
| **Develop and implement Integrated team 'mother centred' approach for pre and post-partum care and providing continuity of services** | • Strengthening the community midwifery team and improving continuity of care from preconception to the postnatal period;<br>• Integrate the community midwifery team into other child and mother-centred community teams e.g. HVs, Children's centres, GPs:<br>  • Pilot model;<br>  • Evaluate project;<br>  • Commission new model<br>• Normalise birth and pregnancy by reducing interventions (e.g. antenatal admissions and caesarean sections) by monitoring service delivery<br>• Give women choice and autonomy in their care by improving capacity planning across SEL |
| ***Implementation of the Children's and Young Peoples Commissioning Intentions priorities for all children*** | • *To develop and implement children's integrated care pathways to ensure that children with chronic diseases receive the best care in the most appropriate setting lead by the Children's' Joint Commissioning;* |

# MATERNITY AND CHILDRENS CARE IN HOSPITAL

COMMISSIONING OBJECTIVES

## DRAFT KEY OUTCOMES

- Higher levels of satisfaction to 'x' with maternity services and better experience of child birth as women receive the support they need throughout their pregnancies, based within community settings – 'Friends and Family Test' from October 2013.
- Every women has a named midwife who is responsible for her care throughout pregnancy, childbirth and during the post natal period .
- 'x ' % women booking early antenatal appointments enabling earlier identification of women at high risk and better long term health outcomes for both mother and child by 'y'.
- Improved health outcomes, including - 'x' % more women initiating breastfeeding by 'y' resulting in better long term health outcomes for both mother and child; reduced level of postnatal depression through earlier diagnosis and better intervention and support.
- Maternity services tariff reduced without a negative impact on quality– QIPP £860k in 2014/15.
- Reduction of unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s;
- Reduction in emergency admissions for children with lower respiratory tract infections;

## DRAFT KEY RISKS

- Lack of engagement with the workforce;
- Lack of workforce capacity and skill, particularly skilled midwives, to deliver the new model of care
- Insufficient investment available to support the mother centred model;
- Public expectation is for greater changes in the way maternity services are delivered;
- Continuity of care is not delivered;
- A quality failure that undermines the confidence of the public;
- The 'whole system working' does not happen effectively (integration) to make a reality for patients and health care professionals within South East London.
- Lack of capacity of the commissioning teams – CCGs; Public Health, Joint Children's commissioners and the Three Borough team.

# END OF LIFE CARE

COMMISSIONING OBJECTIVES

| Commissioning objectives | Operating Plan - outputs |
|---|---|
| **Improve systems processes and care pathways to support more people to die in the place of their choice** | • Coordinate My Care to be fully used across Lewisham by GPs, Community Nursing, Hospice and Specialist Palliative Care Teams.<br>• Improved use of Do Not Attempt Resuscitation (DNAR) Guidelines<br>• Increased education and training in nursing homes; (*subject to approval of Business Case by CCG*)<br>• Model developed for future delivery of end of life services and service specifications developed/reviewed. |

# END OF LIFE CARE

COMMISSIONING OBJECTIVES

## DRAFT KEY OUTCOMES

- An increased  to 'x' proportion of patients able to die in their own home or place of choice by 'y' – including care and residential homes.
- Service users and their families/carers more involved in service development and delivery.
- A non-diagnosis specific end of life care pathway agreed in Lewisham.
- An increase in the quality of care of end of life care services in Lewisham with all providers performance monitored against a revised Service Specification.

## DRAFT KEY RISKS

- If there is not sustained commitment and focus of leaders to oversee the transformational change in end of life care.
- If the changing provider landscape patient flows change.  Any pathways/procedures or pathways that are developed need to take account that an increasing number of local residents may be receiving care in out of borough settings.
- All stakeholders may not to be fully engaged at the beginning of the transformation process. Lewisham borough is in the unusual position of having several specialist palliative care providers
- May not recruit to Transformation Project Officer Post and GP Macmillan End of Life Facilitator.
- Capacity and capability of care homes to support end of life care

# INTEGRATED CARE PATHWAYS
# LONG TERM CONDITIONS

COMMISSIONING OBJECTIVES

| Commissioning Objectives | Operating Plan: Outputs |
|---|---|
| **Secure the sustainable improvement in the integration of services to deliver co-ordinated care pathways for adults with long term conditions.**<br><br>**Part of the Adult Integrated Care Programme's workstream on 'Streamlining care Pathways ' – no .4** | LTCs Pathways (COPD, Diabetes, Asthma) are integrated and secure sustainability (e.g. Contractual)<br>• Increase Self Management for COPD/Diabetes via LEEP & DESMOND training. Implementation via commissioning contractual/leavers (E.g. Service Developments in Community Contract).<br>• scope Prime Contractor Integrated Model for LTCs for implementation in 2015/16<br>• Review psychological report for patients with LTCs<br>• Implementation of redesigned Asthma Pathway<br>• Rollout of Respiratory Community Champions<br>• Ambulatory Care Unit and Ambulatory Emergency Unit (National Programme Team)<br>• Implementation of Integrated Pathway Coordinator in ED (7/7) – signposting for long term conditions (including mental health)<br>• Ambulatory Care Pathways: expand to include COPD, Diabetes and Falls<br>• Evaluate virtual GP surgery model<br>• Development of a comprehensive Pneumonia Programme<br><br>Prevention: BAU CCG led Flu and Pneumonia<br><br>Care pathway for older people in care homes is improved to reduce unnecessary emergency admissions.<br><br>Dementia action plan is implemented which improves dementia diagnosis rates and earlier referral to appropriate care pathways |

# INTEGRATED CARE PATHWAYS
# LONG TERM CONDITIONS

COMMISSIONING OBJECTIVES

## DRAFT KEY OUTCOMES

- Improved service users' and carers' experience by 'x' of being supported to manage and make decisions about their own care and treatment by 'y'.
- Improved quality of life for people with long-term conditions by 'x'(measured using the EQ5D tool in the GP Patient Survey) by 'y'
- A reduction in emergency admissions for acute conditions that should not usually require hospital admissions as support and care is better planned in community based services resulting in reduced expenditure of £1,240k and £520k (frail older people) in 2014/15 and £1,450k in 2015/16;
- Increase diagnosis rate for people with dementia to 67 per cent by March 2015 and with COPD offered Lung Exercise & Education Programme (LEEP);
- Increase in uptake of seasonal flu immunisation by 'x' by 'y' for the over 65s and at risk groups;
- Diabetes - vulnerable people with diabetes will have access to dedicated psychological support as required; Increase number of patients with hypo/hyper glycaemia will be triaged for treatment outside of hospital (subsequent to A&E attendance/LAS call out);Increase number of 'x' 'new insulin starts' by 'y' within Emergency Department; Access to DESMOND will increase by 50% in 2014-15 and the programme will be offered in two other (than English) languages.
- Improved dementia diagnosis rate from 'x' to 'y'

## DRAFT KEY RISKS

- Scale, pace and investment of QIPP to be delivered with regard to the reduction emergency admissions ;
- Capacity and capability of membership to enact delivery;
- Insufficient range of support is available for people to have confidence to choose to manage their own care
- Lack of alignment of contracts' levers to support the integration of care pathways eg QOF/QP indicators; community contract ;
- Insufficient detailed monitoring of improvements information eg coding;
- Ineffective whole-system working, including inability of implementing culture change for healthcare professionals ;
- Lewisham and Greenwich Trust is not able to fully lead or engage in the co-design and delivery of commissioning plans, specifically the transformation of community services and their integration with primary and social care.
- Longer Term Plans to continue to improve the quality, innovation , productivity and prevention agenda for LTC

# INTEGRATED NEIGHBOURHOOD BASED MULTI-DISCIPLINARY TEAMS

COMMISSIONING OBJECTIVES

| Commissioning Objectives | Operating Plan: Outputs |
|---|---|
| **Establish and sustain effective, integrated multi-organisational and multi-disciplinary teams based in the neighbourhoods, supported by joint approaches and tools**<br><br>**Part of Adult Integrated Care Programme workstreams' 'Transforming care pathways (no 3.)**<br>**Inspiring the workforce (no 5**<br>**Maximising the potential of Information and Communication Technology (no 6)** | • Risk profiling is developed and implemented<br>• Collaborative Care Planning is rolled out and fully implemented<br>• Integration of risk profiling and care planning<br>• Outcomes of the 2013/14 Proactive Primary Care Pilot have been reviewed to promote self care<br>• Neighbourhood network model is embedded to provide MDT working centred around GP Practices to deliver integrated case management<br>• *A* single assessment record across health and social care has been developed and implemented<br>• VPR implemented to support the establishment of shared records and tracking of patients across health and social care system.<br>• Patients are supported more to ensure that they understand their treatment and how to best take their medicine<br>• Promote the uptake of personal health budgets;<br>o All patients who are eligible for fully funded continuing health care are offered the option of a personal health budget including the option using a direct payment to purchase their own;<br>o Work with the 3rd sector to develop the market for personnel assistants to support those who chose a personal health budget<br><br>*Note this commissioning objective is supported by transform the nursing workforce – the skills and capabilities and proactive discharge planning and implementation* |

# INTEGRATED NEIGHBOURHOOD BASED MULTI-DISCIPLINARY TEAMS

COMMISSIONING OBJECTIVES

## KEY OUTCOMES

- All people with a long-term condition to have a personalised care plan which is accessible, available electronically and linked to their GP health record by 'x'
- Reduction in avoidable emergency admissions and A&E attendances (acute contract)
- 'X' Increased independence and improved self management by 'y'(GP Survey)
- 'X' Improved case management by 'y' (clinical audit)
- 'X' Reduction in the duplication of interventions by 'y'(clinical audit)
- Improved prescribing which is both clinically appropriate and cost effective - it is estimated that this could save up to £2 million (5% of the CCG's planned expenditure on the prescribing of drugs) over 2014/15 and 2015/16. (Prescribing Spend)
- Increased 'x' numbers of eligible adults offered/are in receipt of NHS personal health budgets, including those who chose a direct payment to mange their own care by 'y'

## DRAFT KEY RISKS

- Scale, pace and investment required to embed change;
- Scale and pace of the QIPP financial challenge and alignment of/with local authority financial challenge;
- Insufficient range of support available for individuals to have confidence to take greater control of their care.
- Insufficient cross organisational commitment to partnership working to take forward the integration agenda, supported by the Better Care Fund;
- Ineffective whole-system working, including inability of implementing culture change to support multi-disciplinary working;
- Inability to visibly embed and measure the benefits realised of the network neighbourhood model which can be seen by Members;
- Insufficient Members capacity and capability to work differently;
- Difficulties in IT access and incompatibility with different approaches to tools/systems
- Lack of capability of collective workforce to respond effectively and consistently to the transformational and cultural change and the delivery of high quality care;
- Failure to develop the market to offer increased choice and control for those who chose a personal health budget to manage their own care.

# CONTINUUM OF FLEXIBLE, INNOVATIVE COMMUNITY BASED CARE SERVICES

COMMISSIONING OBJECTIVES

| Commissioning Objectives | Operating Plan: Outputs |
|---|---|
| **Commission a continuum of high quality, effective community based care services, to reduce unnecessary emergency admissions**<br><br>**Part of Adult Integrated Care Programme - Supporting Independence workstream 2** | • Commissioning of equipment is reviewed to ensure timeliness of delivery and reduced shared cost by joint working<br>• Effective Admission Avoidance services are an integrated part of the wider system of intermediate care<br>• Rehabilitation (Health) services are commissioned, 7 days a week which are integrated with enablement (Social Care) to provide care at the right stage of the patients pathway by the right integrated health and social care team<br>• Support is provided to Public Health with the implementation of a preventative Falls Programme, including improved Community Multidisciplinary Team service and Alternative Care Pathways (ACPs) for falls patients working with LAS<br>• Nursing homes' quality of care is improved and variation reduced by increasing number of Lewisham homes on AQP ;<br>• A Quality Assurance Framework is implemented for residential, nursing and domiciliary care across health and social care.<br>• Single continuing care team is implemented to be responsible for all CHC assessments to enable faster turn around for health panels and quicker referral to social care panels. Both in hospital and in the patients' homes.<br>• Improved commissioning of community services to make a stepped change in quality, responsiveness and 7 day working.<br>• Increased support to carers and preparation completed for the Carers Bill by reviewing the arrangements for the provision of Carers assessments, increasing access to support and planning and increasing access to direct payments for carers.<br>• The greater use of new technologies jointly with adult social care e.g. telecare,<br><br>*Note this commissioning objective is supported by transform the nursing workforce – the skills and capabilities and proactive discharge planning and implementation* |

# CONTINUUM OF COMMUNITY BASED CARE SERVICES

COMMISSIONING OBJECTIVES

## DRAFT KEY OUTCOMES

- Improved service users' and carers' experience of being supported to manage and make decisions about their own care and treatment including those in care homes by 'x' by 'y;
- Improved quality of life for people with long-term conditions by 'x' by 'y'(measured using the GP Patient Survey).
- A reduction in emergency admissions for acute conditions that should not usually require hospital admissions (including those from care homes) as support and care is better planned in community based services – it is estimated that this is expected up to £3.75 million in 2015/16.
- Nursing homes' quality of care and value for money is improved by improving continuing care and increased of Lewisham homes on AQP , equivalent to £480k reduction in expenditure in 2014/15;
- 'x' Number of fast track/non fast track Continuing healthcare assessments completed each quarter.
- 'x' Number of eligible/non eligible patients who receive a written letter about outcome of their Continuing healthcare assessment per quarter;
- Reduced 'x' delayed transfers of care by 'y';

## DRAFT KEY RISKS

- Scale, pace and investment required to embed change and to reduce emergency admissions;
- Scale and pace of the QIPP financial challenge and alignment of/with local authority financial challenge;
- Insufficient range of easy accessible and appropriate information to support individuals to use services effectively.
- Insufficient cross organisational commitment to the integration agenda;
- Inability to engaged all providers in system change including voluntary organisations E.g. Registered Social Landlords;
- Ineffective whole-system working, including inability of implementing culture change to support multi-disciplinary working;
- Acute hospital capacity is not reduced as alternative services are provided within the community
- Difficulties in IT access and incompatibility with different approaches to tools/systems;
- Negative impact of Market factors (outside of South-East London) on AQP by Lewisham providers;
- Possibility of moving costs across the health and social care economy rather than saving money.

# MENTAL HEALTH

COMMISSIONING OBJECTIVES

| Commissioning Objectives | Operating Plan - outputs |
|---|---|
| **Commission a mental health service system where all providers whether statutory, independent or third sector are focused on the key aims of outcomes, safety, choice and access** | • SLaM delivery of adult mental health services is transformed to offer a wider range of services in the community resulting in less reliance on inpatient mental health bed based care, working jointly with the CCG.<br>• Service user and carer involvement in all aspects of service development and delivery is increased.<br>• Physical health outcomes for those with severe mental illness are improved including ensuring equity of access to primary and secondary care.<br>• Mental health crisis services are supported to deliver safe and effective services ensuring the implementation of robust systems to ensure provider accountability<br>• Improving Access to Psychological Therapies (IAPT)Plan is implemented to ensure that the appropriate people enter IAPT with the expected recovery rates |

# MENTAL HEALTH

COMMISSIONING OBJECTIVES

## DRAFT KEY OUTCOMES

- People will feel supported to maintain the best possible quality of life and feel more involved in their care
- People using mental health services will be at the lowest possible risk of suicide, deliberate self-harm or self-neglect;
- People using mental health services will have access to appropriate high quality physical health care by ensuring that mental health services are part of the wider integration agenda.
- People using mental health services will be seen in the least restrictive setting that appropriately meets their needs
- IAPT roll-out: achieve nationally expected target rates ('x') for the appropriate people entering into IAPT with the expected recovery rates ('x') by 2015/16.
- A wider network of community based mental health services with effective interfaces including the provision of mental health care in a crisis and reduced waiting times for access to mental health services.
- SLaM implements QIPP plans which deliver system changes and releases an estimated £2 million in savings (equivalent to 2% of the SLaM current contract value) over 2014/15 and 2015/16.

## DRAFT KEY RISKS

- SLaM's implementation of the AMH Model of delivery will fail to deliver within the exacting time line;
- Demand for mental health services is not effectively managed;
- Failure to achieve the significant culture change required to deliver a different model of adult mental health care;
- Capacity and capability of primary care to deliver management of mental health service users within primary care services;
- Broader socio-economic challenges including changes in the benefit system, increased unemployment and access to affordable housing which could have a detrimental impact for mental health clients.
- Mental Health hospital capacity is not reduced as appropriate alternative services are provided within the community.
- Inability to have timely, robust information which will demonstrates effective care is being delivered across the whole system.

# PRIMARY CARE DEVELOPMENT AND PLANNED CARE

COMMISSIONING OBJECTIVES

| Commissioning Objectives | Operating Plans: Outputs |
|---|---|
| **Implement with Members the priorities for local primary care development and quality improvement strategy with a specific focus on population based commissioning approach to improve outcomes** | **ACCESS**<br>• Supporting practices in the review and improvements of their access arrangements (including mental health users)<br><br>**COLLABORATIVE WORKING**<br>• Supporting practices to explore and implement different models of working together to enable greater sustainability;<br>• Supporting collaborative practice working through a population based commissioning approach (E.g. not commissioning services on an individual practice basis)<br><br>**QUALITY**<br>• Quality improved and variation reduced in outcomes supported through the development of neighbourhood and practice based 'development plans' (CBC Strategy).<br><br>**PLANNED CARE**<br>• Develop and implement Referral Support Service for outpatient attendances<br>• Procurement of alternatives to secondary care<br>  • Scope<br>  • Implementation<br>• Improved Physiotherapy direct access<br>• Improving the choice in prescribing of medicines<br>• Shift to prevention and self care by promoting it with patients and sign posting patients to alternative advice, support and care |

# PRIMARY CARE DEVELOPMENT AND PLANNED CARE

COMMISSIONING OBJECTIVES

## DRAFT KEY OUTCOMES

- All patients are offered the ability to book appointments, order repeat prescriptions and access their medical notes online by 'y'
- Improved patient experience and feedback with better access to GP practices for all of Lewisham's registered population by 'x' by 'y'(GP Survey);
- Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community - Composite indicator comprised of (i) GP services, (ii) GP Out of Hours by 'x' by 'y'.
- Consistently good quality standards across all primary care services – reducing the number of "outlying practices' by 'x' by 'y'
- CCG members effectively respond to the increasing demands of Lewisham population, by implementing a long term sustainable way of working
- 25% reduction in number of patients being referred for a specialist opinion and treatment in outpatients with more care provided in the community – it is estimated that this could save up to £5.61 million over 2014/15 and 2015/16; (Provider Activity) with a further direct access price efficiency of £280k in 2014/15.
- Prescribing is both clinically appropriate and cost effective - it is estimated that this could save up to £2.3 million (5% of the CCG's planned expenditure on the prescribing of drugs) over 2014/15 and 2015/16. (Prescribing Spend).

## DRAFT KEY RISKS

- Dis-engagement of primary care;
- Capacity and capability of Members;
- Wider sustainability of primary care, including the potential impact of significant changes to practice incomes;
- Ability for all providers to deliver required scale and pace of change;
- Insufficient/ineffectual contractual levers and incentives to deliver and enforce change;
- Engagement with the public and patients with service change;
- Insufficient investment and /or contractual levers available to deliver change;
- Capacity and capability of CCG commissioning staff to deliver change;
- Political implications of delivering change through the CCG as a membership organisation (E.g. referral management approaches);
- Inability to quantify impact on local providers where extensive QIPP opportunities have been identified;
- Dependency on successful implementation of neighbourhood networks model;
- Dependency on successful implementation of Choose and Book to support referral management approach

# URGENT CARE

COMMISSIONING OBJECTIVES

| Commissioning Objectives | Operating Plan: Outputs |
|---|---|
| **Commission a simpler, more effective, integrated urgent care network, working with local providers** | • Re- procure both in and out of hours primary care provision within the UCC to identify a prime contractor model;<br>• Review, evaluate and recommend next steps for the current Walk in Service;<br>• The best urgent care system is commissioned providing the highest quality of care which is simple to navigate, integrated and provides value for money;<br>• The re-procurement of SEL 111 is supported;<br>• Effective public engagement and information to promote self-care and reduce confusion across healthcare working with the Local Authority and the Public, is supported;<br>• Local planning is led effectively through the urgent care working group and urgent care network, particularly regarding winter planning;<br>• The assess, redirect and treat model is embedded. |

# URGENT CARE

COMMISSIONING OBJECTIVES

## DRAFT KEY OUTCOMES

- NHS Constitution standard of 95% for patients being seen and discharged within 4 hours from Accident and Emergency; the London Ambulance Service to ensure that 75 per cent of Category A calls are responded to within eight minutes and 95 per cent of Category A calls within 19 minutes.
- Simpler and improved access for all to urgent and emergency care services in Lewisham – it is estimated this save about £1.3 million during 2014/15 and 2015/16 by streamlining current services;
- Reduction in patients by 'x' using urgent and emergency care services in Lewisham, that have non-urgent / non-life threatening conditions, so reducing demand for these services by 'y';
- Improved models of urgent care to ensure streamlined and improved access with good clinical standards across all urgent and emergency care services by 'y';
- Reduced confusion for the people of Lewisham by informing them how to access the right health and social care services to support their health and wellbeing;
- Improved access to information to improve quality and outcomes by GP practices.

## DRAFT KEY RISKS

- A procurement process may have risks in terms of commissioning capacity and capability, if not provided by CSU;
- If urgent care markets is not developed there may be not suitable providers for urgent care;
- If redesign of urgent care services could result in a shift of demand to other services leading to an increased cost pressure on parts of the system and possible patient dissatisfaction /challenge;
- Increased costs of 111 due to possible inappropriateness of the outcomes of the 111 calls and where patients are directed to;
- Poor quality information provided to the public about access of urgent care services;
- The CCG does not develop effective processes or approaches to engaged all members of the community and therefore will not gain changes to use of urgent care services;
- Urgent care network is ineffective in supporting commissioners and providers to plan effective for winter 2015 and2016;
- Poor performance in A&E with long waits for patients to be seen and admitted.

# HIGH QUALITY CARE
# WORKFORCE DEVELOPMENT – NURSING

CROSS CUTTING OBJECTIVES

| Commissioning Objectives | Operating Plan - outputs |
|---|---|
| **Commission high quality care services – safe, effective and improved patient experience**<br><br>**Transform the nursing workforce – the skills and capabilities and the culture and behaviours across primary , community secondary and social care.**<br><br>**Part of the Adult Integrated Care Programme - workstream on 'Inspiring the Workforce – no. 5** | • Audit completed of nursing acuity- all community nurses- district nurses, community matrons and practice nurses. Identify the overlaps in care and Domains of care in community settings.<br><br>• Analyse the data and identify nursing need at qualified and unqualified levels.<br><br>• Audit repeated for social care support workers and social workers<br><br>• The common areas of both workforces and areas of duplication and integration are identified. Based on the results of the audit, redesign the service specification for district and community nursing to inform the contract rounds in 15/16<br><br>• Competency framework for health and social care generic workers developed.<br><br>• Training gaps identified and training programmes developed to support the new integrated teams<br><br>• Notice and Tendering process set out to providers for 2015/16<br><br>• Quality monitor template for district, community nursing services developed and implemented throughout the transition and afterwards. |

# HIGH QUALITY CARE
# WORKFORCE DEVELOPMENT – NURSING

CROSS CUTTING OBJECTIVES

## DRAFT KEY OUTCOMES

- A leaner community workforce that is transformed and integrated health and social care team based around the patient and his/her carer .
- Seamless services based around group practices with single assessments and a single referral processes into health and social care services.
- A single pint of access referral service
- Risk stratification identifying the patients at risk of admission into acute services.
- CHC assessments undertaken by specialist team in and out of acute care
- Community matrons case loading discharged patents to ensure they are not readmitted through any breakdown in care outside of hospital

## DRAFT KEY RISKS

- Retendering takes place with current service community nursing model
- Integration of the community nursing workforce does not deliver required savings for both health and social care
- Difficulties in the recruitment and retention of community nursing staff staff
- Failure of the provider to engage with commissioners to deliver the community services changes required

# HIGH QUALITY CARE
# DISCHARGE PLANNING AND IMPLEMENTATION

CROSS CUTTING OBJECTIVES

| Commissioning Objectives | Operating Plan – outputs |
|---|---|
| **Commission high quality care services – safe, effective and improved patient experience**<br><br>**Implement effective discharge planning and rehabilitation which delivers the objectives on admissions and maximises the potential for re-enablement** | • An integrated health and social care team is in place that is dedicated to the proactive discharge of patients from the moment they enter into acute care (links with community workforce redesign )<br>• Performance report of all planned discharges against actual discharges with detailed exception reports for lessons learned.<br>• Equipment orders are placed in a timely way prior to discharge to ensure timeliness of delivery and reduced shared cost by joint working.<br>• Single team is implemented to be responsible for all CHC assessments to enable faster turn around for health panels and quicker referral to social care panels. Both in hospital and in the patients' homes.<br>• Rehabilitation/ enablement services are provided 7 days a week, at the right stage of the patients pathway by the right integrated health and social care team<br>• All post discharge care packages are reviewed jointly within 6 weeks to ensure they are meeting the patients' needs or still required.<br>• Strengthen care pathways by sharing the learning from the delayed discharges processes (sections 2s and 5s) where there are gaps and opportunities<br>• VPR implemented to support the establishment of shared records and tracking of patients across health and social care system. |

# HIGH QUALITY CARE
# DISCHARGE PLANNING AND IMPLEMENTATION

CROSS CUTTING OBJECTIVES

## DRAFT KEY OUTCOMES

- Patients are discharged in a timely way during daylight hours in a controlled way that gives maximum optimal benefit and quality
- Focussed care in the first 6 weeks after discharge which prevents readmission and clogging up of the acute care system. This will include leaving hospital with a discharge plan covering the first 6 weeks of care.

## DRAFT KEY RISKS

- Longer lengths of stay as if patients transfer to place of discharge is delayed this may increase the length of stay and affect the acute bed days occupancy so hindering the ability to admit patients through A&E, so the system becomes blocked;
- Poorer outcomes as if patients length of stay is prolonged, the patients needs may become greater as a result;
- Difficulties in changing the workforce culture to start proactive discharge planning on first day of admission and review patients outcomes 6 weeks after discharge.

# PUBLIC ENGAGEMENT

CROSS CUTTING OBJECTIVES

| Commissioning Objectives | Operating Plan - outputs |
|---|---|
| **Ensure that public engagement is intrinsic to all commissioning activities**<br><br>*'putting the views of patients at the heart of everything we do'* | • A clear dialogue is created with all our communities;<br>o Increased number of individuals registered to participate;<br>o Increased engagement of partner organisations.<br>• Public are involved in setting organisation strategy and commissioning priorities demonstrated by:<br>o 6 monthly reports to Governing Body, which include analysis of public feedback and impact of public view's on policy development and CCG's decision making;<br>o Publish a Volunteer Participation policy<br>• Assurance and public accountability is provided by:<br>o Annual Engagement Report;<br>o Annual Patient Engagement Event/Summit;<br>o Development of a patient reference group, involving a range of individuals.<br>• Patients are involved in decision about their care:<br>o GP colleagues are supported in their development of joint decision making with patients, including rolling out the Diabetes Collaborative Care Plans pilot on Shared Decision Making;<br>o Promoting 'self care' to patients to support them to stay healthy and look after themselves<br>• All CCG engagement activities are monitored and evaluated by:<br>o Robust recording of engagement activities delivered;<br>o Participant analysis is systematically undertaken after each engagement event.<br>• Develop and implement a CCG's Communication Framework÷ |

# PUBLIC ENGAGEMENT

CROSS CUTTING OBJECTIVES

## DRAFT KEY OUTCOMES

- Public Engagement systematically informs the CCG's strategic priorities, operational service redesign to improve quality and individual's care planning and decision making;
- Public Engagement involves more people in Lewisham and a genuine dialogue is created with all our communities;
- Patients are involved in decisions about their care
- All CCG Public Engagement activities are monitored and evaluated
- Public attitudes and behaviours shift towards taking greater care of themselves;
- CCG's Communication Framework is in place

## DRAFT KEY RISKS

- The CCG does not establish open processes to facilitate an dialogue with all communities so that their views are considered at an early stage in developing commissioning plans and improving the way local services are delivered.
- The CCG does not develop processes or approaches to engaged all members of the community and therefore will not gain reflective participation
- The public do not consider that the CCG's engagement is open and genuine and therefore: challenges the outcomes and process; and do not adequately engage
- The CCG does not establish ways of working which provides assurances and accountability to the public.
- The CCG does not ensure that the individual patient, their carers and representatives are involved in the decisions and choices about their care.
- There is not a change in behaviour of the public to support themselves to stay healthy and active ;
- The CCG does not have the capability and/or capacity to develop and implement the CCG's Communication Framework

# BETTER OUTCOMES FOR PATIENTS

CROSS CUTTING OBJECTIVES

| Commissioning Objectives | Operating Plan - outputs |
|---|---|
| **Demonstrate the delivery of better health outcomes for Lewisham people** | Strategic Plan is refreshed to ensure that plans are in place to deliver better health outcomes for Lewisham's population, informed by:<br>o Lewisham's Health and Wellbeing Strategy and JSNA<br>o SE London Strategic work<br>o Members Engagement<br>o Public Engagement<br>o Stakeholder Feedback<br>o Impact assessment of Strategic Plan to take account of CCG's Equalities Duty<br><br>Strategic Plan is 'translated' to Commissioning Intentions for 2015/16 and 2016/17 which effectively balances the quality, financial and health outcomes, which are :<br>o Consulted on with the Public;<br>o Shared with providers, with a particular focus on QIPP schemes;<br>o Considered by other Commissioners to ensure consistency in approach to common issues.<br><br>Better health outcomes for patients are secured by effective contract management of the CCG's contract portfolio;<br>o Negotiation strategy for key contacts agreed – November 2013<br>o Appropriate contractual levers to deliver Commissioning Intentions are agreed – December 2013<br>o Contracts agreed – March 2014<br><br>Better outcomes for patients are monitored:<br>o Whole Population basis with an integrated strategic outcomes framework, which includes focusing on reducing inequalities in Lewisham – six monthly<br>o Neighbourhoods and practice level – to work with primary and community staff to understand the reasons behind variance in outcomes, to reduce variation and improve overall outcome measures - quarterly;<br>o Individual QIPP schemes – impact on better patient outcomes – monthly<br>o Public Engagement events - six monthly reports |

# BETTER OUTCOMES FOR PATIENTS

CROSS CUTTING OBJECTIVES

## DRAFT KEY OUTCOMES

- Health outcomes in Lewisham improve, including reducing health inequalities.
- Strategic Plan sets out the level of ambition to improve health outcomes for the Lewisham population;
- Strategic Plan is informed and owned by Members, Public and other stakeholders.
- Operating Plan set out the effective balance of quality, financial and health outcomes.
- QIPP schemes are delivered with proven improvement in quality, innovation, productivity and prevention.
- Contracts secure improvement in health outcomes and deliver high quality care and value for money, in line with the Operating Plan's objectives.

## DRAFT KEY RISKS

- The CCG's Strategic Plan does not deliver the improvements in health outcomes and reductions in inequalities as planned;
- The CCG's refreshed Strategic Plan is not informed and owned by Members, Public and other stakeholders;
- The lack of analytical and business intelligence capability and capacity to inform the refreshed strategic plans;
- There is disconnect between the CCG's Strategic Plan, commissioning Intentions, Operating Plan and agreeing contracts, which effectively, efficiently and economically secure the delivery of the CCG' s Operating Plan;
- The CCG's QIPP plans do not deliver the required level of improvement in quality, financial and health outcomes;
- The joint work on Integration with the Local Authority does not add value and /or slows the pace of change;
- SEL Strategic work insufficiently incorporates the priorities of Lewisham CCG, as the majority view of CCGs dominants;
- The SEL Strategic work does not secure a sustainable acute provider landscape across South East London (post TSA);
- Local Providers capacity to work to transform the health and social care system is limited due to their priority of implementing internal Cost Improvements Programmes.

# ROBUST GOVERNANCE ARRANGEMENTS

CROSS CUTTING OBJECTIVES

| Commissioning Objectives | Operating Plan - outputs |
|---|---|
| **Ensure the CCG have robust governance arrangements for quality, equality, finance, risk management and constitutional requirements** | • Appropriate financial controls and assurance frameworks in place to achieve financial balance<br>• Effective management of risks including exception reporting and appropriate escalation<br>• Effective corporate governance arrangements are maintained to ensure that the CCG discharges its statutory functions in accordance with the agreed CCG's Constitution, including:<br>o Refreshing the CCG's Constitutions;<br>o Proactive management of Conflict of Interests;<br>o Annual review of Governance arrangements;<br>o Meeting the CCG's public sector equality duty;<br>o Information Governance level 2 accreditation maintained<br>• Integrated Governance and exception reporting in place to ensure national targets, local quality improvements and QIPP schemes are delivered within the 2014/15 resource allocation<br>• Quality Assurance Framework in place to monitor and address quality issues, which includes:<br>o Safeguarding Framework adults and children and young people;<br>o Francis Action Plan implementation;<br>o Effective Clinical Quality Review Groups arrangements.<br>• The CCG secures the appropriate the range of commissioning support services and monitor their delivery effectively.<br>• CCG's Information Strategy is in place<br>o sharing to the Public consistent, high quality information and communication about living healthy and staying well;<br>o providing users access to their own heath and care records<br>o sharing of information between professionals. |

# ROBUST GOVERNANCE ARRANGEMENTS

CROSS CUTTING OBJECTIVES

## DRAFT KEY OUTCOMES

- The Governing Body receives a fair, balanced and understandable assessment of the CCG's current and future projected position;
- the Governing Body is effective in holding the executive function to account to deliver the CCG's operational and objectives.
- The CCG has in place the appropriate policies, processes ,structures and expertise in line with Good Governance best practice
- Delivery of the Virtual Patient Record project by Lewisham and Greenwich NHS Trust during 2015/16

## DRAFT KEY RISKS

- The Governing Body does not operate within the CCG's Constitution's framework and the legal framework
- The Governing Body does not receive information in a timely manner in a form and of quality to enable it to discharge its duties;
- The CCG does not have in place appropriate arrangements to ensure its expenditure does not exceed the aggregate of its allocations for the financial year.
- The CCG does not have in place appropriate arrangements to manage effectively its commissioning to reduce the likelihood of over performance in year, reduction in quality and /or performance
- The Governing Body is insufficient aware of the nature and level of risk it is willing to take to achieve its strategic objectives and ambition and of the assurances on mitigation and control;
- The CCG does not have in place arrangements to manage effectively its corporate governance function including, Conflict of Interest, emergency planning, public sector equality duty, information strategy, information governance etc
- The CCG does not have in place appropriate arrangements for Quality Assurance including its adult and children's safeguarding duties
- The CCG does not have in place appropriate arrangements for commissioning support services.
- Lack of clinical buy in and behaviour change to support the integrated ways of working required to realise the benefits of the Virtual Patient Record.

# PARTNERSHIP WORKING WITH OTHERS

CROSS CUTTING OBJECTIVES

| Commissioning Objectives | Operating Plan - outputs |
|---|---|
| **Ensure that the CCG works effectively in partnership with others to realise benefits, including improving population outcomes.** | The CCG works effectively with other commissioners In Lewisham by being clear on responsibilities, priorities and resource implications, so that partnership and collaborative work adds value by streamlining and integrating care pathways<br>o Adult Social Care – taking forward the integrated adult health and social care is underpinned by an agreed work plan and shared understanding of resource implications, as set out in the Better Care Fund submission;<br>o Children's' and Young Peoples partnership - taking forward the work to improve the support and care for all children and families in Lewisham, is underpinned by agreed commissioning intentions priorities which include addressing the high level of chronic diseases;<br>o Section 75 agreements with the Local Authority are managed under appropriate governance arrangements;<br>o Public Health – the work to take forward the wider health prevention programme, is supported by a jointly agreed work programme.<br>The CCG works effectively with other CCGs, NHS England and providers in South East London to develop and implement the wider SEL Strategic Plan, which includes community based care.<br>The CCG's work effectively with other CCGs to contract effectively for acute, community and mental health contracts.<br>The CCG works effectively with NHS England in its role as commissioner for primary care, screening and specialised services by establish fora for regular discussions of the integrated care pathway and using the commissioning intentions process. |

# PARTNERSHIP WORKING WITH OTHERS

CROSS CUTTING OBJECTIVES

## KEY OUTCOMES

- The CCG achieves better health outcomes for Lewisham people, by working in collaborative and partnership with other commissioners;
- The CCG achieves holds itself and other commissioners to account to ensure that collaborative working adds value by streamlining and integrating care pathways;
- The joint work with partners on the Adult Integration Programme and Better Care Fund results in a greater pace and scale of service change, than could have been achieved by the CCG alone;
- SEL Strategic work supports the successful delivery of Lewisham CCG's Strategy and secures a sustainable acute provider landscape across South East London.

## DRAFT KEY RISKS

- The CCG does not have agreements in place setting out the different responsibilities, objectives and expectations of different commissioning organisations.
- The CCG does not set out clearly its commissioning plans for other commissioners to consider and does not review other NHS organisations' Commissioning Intentions sufficiently;
- The CCG does not have in place arrangements to discuss effective ways of working across the care pathways and populations and current delivery against objectives.
- The joint work on Integration does not add value and slows the pace of change;
- The lack of CCG capacity and capability to participate effectively in the SEL Strategic work to ensure that the key priorities of Lewisham CCG are incorporated , so that the work adds value.
- SEL Strategic work insufficiently incorporates the priorities of Lewisham CCG, as the majority view of CCGs dominants.
- The SEL Strategic work does not secure a sustainable acute provider landscape across South East London (post TSA).
- Local Providers capacity to work to transform the health and social care system is limited due to their priority of implementing internal Cost Improvements Programmes

# STRONG LEADERSHIP AT EVERY LEVEL

CROSS CUTTING OBJECTIVES

| Commissioning Objectives | Operating Plan - outputs |
|---|---|
| **Ensure the CCG have strong and robust leadership at all levels to proactively respond to strategic opportunities and challenges effectively** | • Membership engagement is strengthened, developed and widened including succession planning and elections;<br>• Members engagement informs the CCG's response to the strategic opportunities and challenges :<br>o Annual Report and the Annual General Meeting<br>o Refreshed strategic plan and priorities;<br>o Commissioning Intentions for 2015/16 and 2016/17<br>• Members Engagement supports the CCG to improve the integration of care and support and the provision of high quality care.<br>• All Governing Body members have clear role description and person specification and are supported with additional training and development, as required<br>• Corporate Objectives 2014/15:<br>o Corporate Objectives are agreed and delivery is monitored on a quarterly basis<br>o Clinical Directors and other Directors have clear portfolios of areas of responsibilities and agreed corporate objectives.<br>o All Staff are developed to ensure that staff are valued and their full potential is achieved by implementation of the appraisal system with Personal Development Plans<br>o The Organisational Development Plan is implemented to ensure that the CCG's full potential is achieved. |

# STRONG LEADERSHIP AT EVERY LEVEL

CROSS CUTTING OBJECTIVES

## DRAFT KEY OUTCOMES

- Members are engaged in the CCG to inform decision making and to hold the Governing Body to account.
- Members representatives, Directors and Governing Body members work together effectively to deliver the CCG's objectives.
- The CCG develops strong and resilient commissioners at all levels in the organisation.
- The CCG achieves its full potential as an effective clinical commissioning group for the Lewisham population;
- The CCG's clinical leadership is visible to the public and NHS England

## DRAFT KEY RISKS

- The CCG does not put in place the appropriate structures and processes to ensure that the added value of being a clinically led, members organisation is realised.
- Members, Directors and the Governing Body are unclear about the roles and responsibilities for running the CCG's business;
- Members representatives, Directors and Governing Body members do not have the appropriate balance of skills, experience, independence and knowledge.
- Members representatives, Directors and Governing Body members do not have sufficient time to discharge responsibilities properly
- The CCG is not seen as local health leader with patient centred culture ('values) by the Public, local stakeholders and NHS England;
- The CCG's Organisation Development Plan does not ensure that the CCG as a whole has the appropriate capability and capacity to deliver its strategic ambition and values as set out in the CCG's Constitution;
- The CCG does not sufficient reflect and learn from its first year in operation to build on its successes and address identified weakness.

# QIPP 2014/15 & 2015/16

| Commissioning Priority | Commentary | Total | 2014/15 Updated | 2015/16 |
|---|---|---|---|---|
| | | £000's | £000's | £000's |
| Health Promotion | | 0 | 0 | 0 |
| Maternity and Children's | Tariff reductions | 860 | 860 | 0 |
| Frail Older People | Emergencies reductions | 520 | 520 | 0 |
| | Continuing Care/AQP | 480 | 480 | 0 |
| Long Term Conditions | Emergencies reductions | 2,690 | 1,240 | 1,450 |
| Mental Health care | Inpatient stays reductions | 2,000 | 1,000 | 1,000 |
| Adult Integrated care | Emergencies reductions | 3,750 | 0 | 3,750 |
| Primary Care – prescribing | Improved Patient Concordance | 4,000 | 2,000 | 2,000 |
| | Joint Pharmacy | 300 | 300 | 0 |
| Primary Care – outpatients | Reduced Appointments | 3,890 | 1,590 | 2,300 |
| | Tariff reductions | 280 | 280 | 0 |
| | reduced new to follow up rates etc | 1,720 | 820 | 900 |
| Primary Care – Electives | TBC | 500 | 0 | 500 |
| Urgent Care | Reduced activity | 1,300 | 300 | 1,000 |
| Trust Guarantee | Contract arrangement | 600 | 600 | 0 |
| | | | | |
| **TOTAL** | | **22,890** | **9,990** | **12,900** |

# BETTER CARE FUND – WORKSTREAMS

| WORKSTREAMS | SCOPE OF WORKSTREAM |
|---|---|
| 1. Providing high quality information and advice | involving the co-ordination of health and wellbeing campaigns; health promotion and self- help initiatives; and access to information and signposting about services; |
| 2. Supporting independence | the development of effective systems and processes for the identification of need and support, diagnosis and management, including enablement, telecare, and equipment, with a specific focus to support admission avoidance and hospital discharge; |
| 3. Transforming care planning | the development of single assessments, including risk profiling, joint care plans, joint reviews, direct payments, personal budgets, personalised health budgets and the development of a single health and care record; |
| 4. Streamlining care pathways | the streamlining of key pathways across health and social care from initial contact to ongoing care eg dementia, falls, COPD, Heart Failure and Diabetes; |
| 5. Inspiring the workforce | working with patients and local providers to develop new ways of working and culture and behaviour changes to proactively manage health and wellbeing; |
| 6. Maximising the potential of Information and Communication Technology (ICT) | involving a joint approach to collection, use and sharing information and joint care records; |
| 7. Building stronger communities | coordinated work to develop vibrant connected local communities and strong neighbourhood networks; |
| 8. Developing excellent commissioning | to develop more innovative commissioning approaches and contractual models to support the transformation of services. |
| 9. Securing wider partnerships | With an initial focus on the interface with housing and supported accommodation; |
| 10. Managing the programme | Including programme support; sources of programme funding; financial modelling and forecasting; risk management, programme consultations and communications. |

# Premature mortality – potential years of life lost

**Commentary:**

This indicator is a measure for the ambition to secure additional years of life for people with treatable mental and physical conditions.

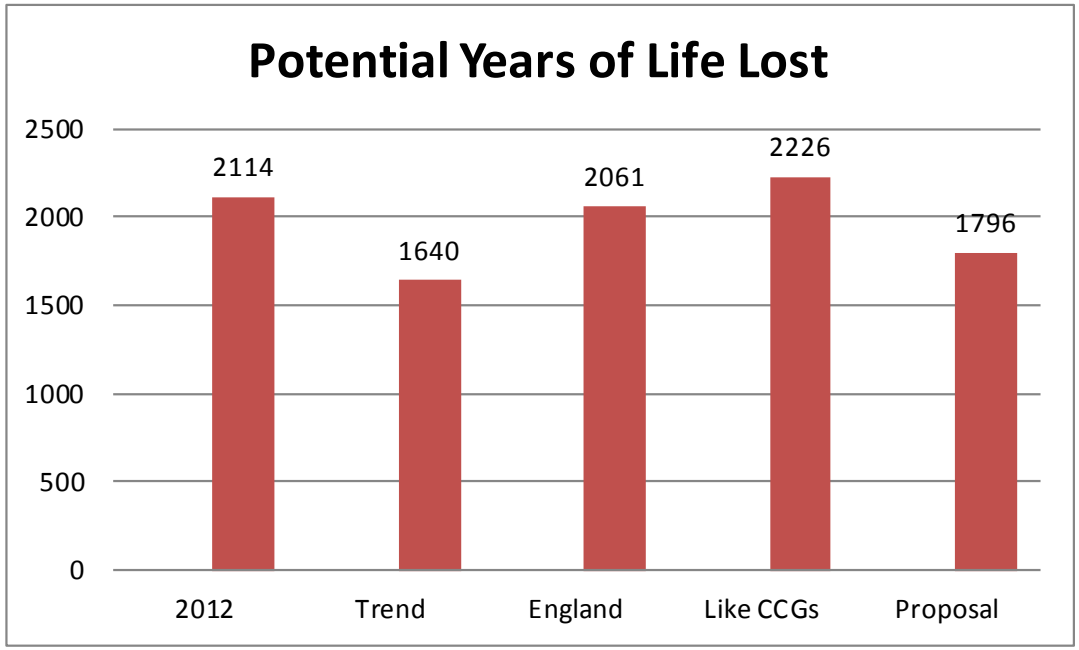
The rate shown is the total per 100,000 population

Recent trend is nearly 5% reduction per annum for last two years.

Trend appears to be continuing the same level of reduction.

Proposal is slowing this to 3.2% reduction per annum, as previous gains may be linked to smoking ban and provider changes (e.g. hyper acute stroke units) may not be as fast, especially as Lewisham is now statistically no different to the England level.

Local ambition is to achieve 1796 by 2019




Measure compares expected mortality to actual in 5 year cohorts through the population e.g a child death would lose 70 years of expected life, but a 70 year old death may lose 8 years.

Numbers are standardised per registered population.

# Emergency Admissions Composite Indicator

**Commentary**:

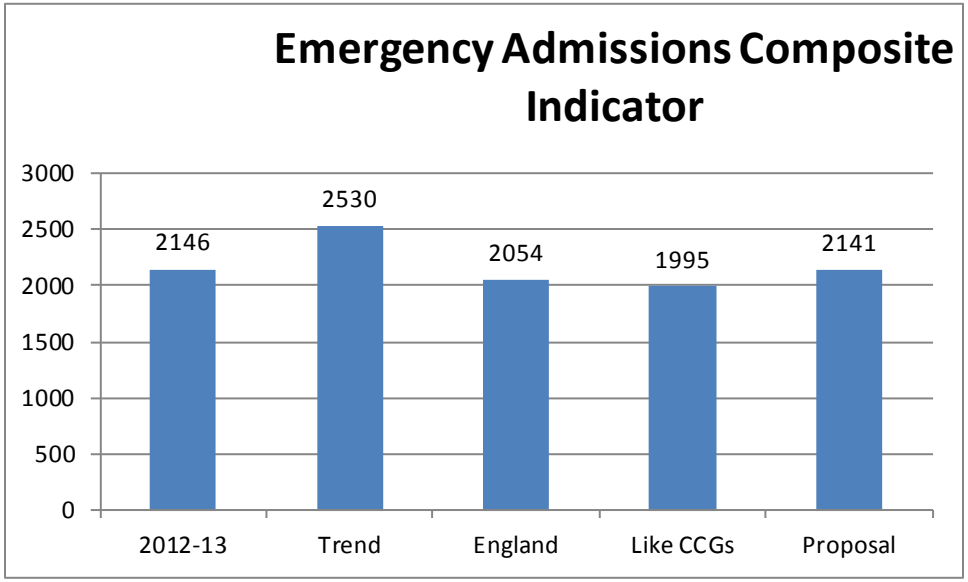
This indicator is concerned with reducing the amount of time people spend avoidably in hospital, through better and more integrated care in the community outside of hospital

The rate is per 100,000 population, indirectly age-sex standardised to the England population, covering:

- Unplanned hospitalisation for chronic ambulatory care sensitive conditions
- Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s
- Emergency admissions for acute conditions that should not usually require hospital admission
- Emergency admissions for children with lower respiratory tract infections (LRTI)

The current trend is a rise of 3.3% per annum;

The proposal is to flatten growth i.e. 15% less than trend over 5 years to maintain the current level (2141)




This is the combination of admissions that should not be admitted e.g. for those should have alternative care pathways (e.g. COPD) or children with asthma

# Improving patient experience of primary care and out of hours

**Commentary**:
Indicator is measure of the ambition to increase the number of people having a positive experience of care outside hospital, in general practice and in the community

This measures the poor outcomes, so 6.7 would be that Lewisham patients in the survey identify on average 6.7% of times as negative (or poor performance).

From recent analysis (reported to FLAG and PEG) the two biggest gaps are:

- Convenience of getting an appointment;
- Getting through to someone at the surgery on the telephone

Proposal would be to get half way to the England average (given the poor performance of like CCGs to Lewisham)

Local ambition is to achieve 6.3 by 2019