Improving Health, Improving Quality in Lambeth

Lambeth Clinical Commissioning Collaborative Commissioning Strategy Plan Refresh

2012/13-2014/15
Foreword

I am delighted to introduce our refreshed Commissioning Strategy Plan to 2014/15. We are now entering year three of our five year Commissioning Strategy to improve health, reduce health inequalities and improve the quality of health services available to Lambeth communities.

This Refresh has been led by the Lambeth Clinical Commissioning Board. It has been informed by our progress to date, latest evidence from our Joint Strategic Needs Assessment and the views of our partners and of our local communities. Our Refresh builds upon the work undertaken since 2009/10 to establish our priorities for health in Lambeth, developed through extensive engagement and consultation with Lambeth people and patients, as well as with all of our partners.

Our focus continues to be on improving services and increasing the opportunities for individuals to make healthier lifestyle choices. Our Refresh has confirmed that the six priority health goals we identified in 2009/10 remain the right ones if we are to maximise health improving health outcomes in Lambeth and these are all retained in the latest Commissioning Strategy Plan. We have however further extended our ambition by;

- The addition of a seventh priority aimed at addressing the impact of alcohol on the health of Lambeth people, working in partnership with all Lambeth agencies, including Lambeth Council, the police and health providers.

- Seeking to further enhance our work to reduce health inequalities by identifying specific equality objectives within each of our priority health goals.

- Reviewing our specific outcome measures within each of our health goals to ensure they reflect best practice and remain both stretching in their ambition and achievable.

Our Strategy is set within a context of increasing resource constraint and increasing demand for health services. We have a clear duty to deliver within our resource limits and to maximise the use of the £600m made available to Lambeth in order to deliver the best possible support and care. Our Commissioning Strategy Plan sets out how we are seeking to deliver improved value for money through our Quality, Innovation, Productivity and Prevention (QIPP) proposals: in particular by developing higher quality and better integrated services and by supporting people to stay healthier for longer.

Throughout the CSP you will see many examples of how we are working, both with local clinicians and with local people, to innovate and make services more accessible, more effective and more responsive to the specific needs of Lambeth patients and of our diverse communities. We are working ever more closely with a wide range of primary care clinicians and we have been able to bring a much
greater focus on clinical quality and to engage more successfully with colleagues from across all parts of the local NHS and social care. We are supported in this by the role King's Health Partners with its tri-partite vision to deliver excellence across research, education and training and service quality.

We clearly recognise the critical importance of shaping and designing local services with the active involvement of local people and with patients. We are ambitious to expand on the innovative approaches we have developed over the past year, such as through the Lambeth Living Well Collaborative in mental health, and to build upon these. Each of our health programmes will address how we can better engage local people in taking forward our Commissioning Strategy and to shape our future priorities.

We also recognise that we will not be able to deliver the health ambitions we have set out on our own. We value the effective partnerships we have developed over a number of years and the commitment shown by all of our partners to improving the health of Lambeth people. We also recognise that we cannot achieve our ambitions by only working with partners in Lambeth. We will need to build upon our effective collective commissioning partnerships with neighbouring CCGs, and in future with the National NHS Commissioning Board if we are to deliver the strategic transformational change, at scale and in a coordinated approach across both commissioners and providers of care.

I hope you will join with us in delivering on our vision for the improved health for Lambeth people.

Adrian McLachlan
Chair
Lambeth Clinical Commissioning Collaborative Board
Lambeth Clinical Commissioning Collaborative
Commissioning Strategy Plan Refresh 2012-15

1. Introduction
The Commissioning Strategy Plan (CSP) sets out the priorities for the Lambeth Clinical Commissioning Collaborative Board (LCCCB) over the next three years up to the next national comprehensive spending review. It represents the third year of our previously agreed five year strategy. It draws from information on health needs set out in the Lambeth Joint Strategic Needs Assessment, experience and progress to date and views of Lambeth stakeholders. The Plan sets out the income and expenditure assumptions for the newly developing Clinical Commissioning Group as the body delegated to undertake commissioning by Lambeth PCT and as the emerging successor organisation leading health commissioning. In the context of a challenging financial climate nationally, it also sets out our plans for Quality, Innovation, Productivity and Prevention (QIPP) to address the gap between growing demands on healthcare and the resources available to commissioners.

2. Clinical engagement in our CSP
The development of clinical commissioning in Lambeth has been a key means by which we have been able to enhance clinical involvement in the development of our CSP refresh. While clinical design and involvement has always been part of our strategic planning in Lambeth, through the leadership of the LCCCB we have increased the depth of clinical involvement. As part of the development of the CSP we have undertaken a series of clinical discussions:

31 August 2011
Lambeth & Southwark clinical leads meeting
Discussed high level priorities and possible joint QIPP
Attended by clinical commissioning board members from Lambeth & Southwark

14 October 2011
Informal LCCCB board seminar
Joint Strategic Needs Assessment (JSNA) refresh presented and discussed
Confirmed health improvement priorities and identified further areas for testing.
Attended by clinical board members.

5 October 2011
Formal LCCCB meeting
Progress update on Strategic Plan updating on areas identified for further work and agreed engagement process.
Attended by clinical board members.
12 October 2011
Lambeth all practice event
Half day workshop for practices to discuss our Commissioning Strategy Plan priorities and implementation. Discussions helped shape our programmes of work. Attended by representatives from 34 of our 52 practices.

The development of our CSP has also been informed by work within each of our 4 programmes:
Planned care
Unplanned care
Mental Health
Staying Healthy

Each of these programmes has a clinical lead from the clinical commissioning board. The memberships include a range of clinicians including hospital consultants, nurses, AHPs, GPs, Practice nurses, Pharmacists, Dentists and Optometrists, social workers, paramedics and voluntary sector providers. They have shaped our pathway redesign work to inform our priorities, QIPP assumptions and work programmes.

3. Patient and public engagement
LCCC recognises the challenge for the future set down in the NHS White Paper, Equity and Excellence to ensure that ‘no decision about me without me’ is the norm at all levels of healthcare decision-making in the NHS. We aim to demonstrate to our communities in Lambeth how their input has influenced decisions through a rigorous approach that is embedded into our work and its governance.

We know that excellent engagement will help us to better understand the needs of local people and guide us in responding to those needs. We appreciate, too, that an excellent standard of communication and engagement with our communities is critical to our success in driving forward change and delivering better services and outcomes.

We use a range of approaches to engage with Lambeth’s diverse population. Whether through formal consultation events or informal conversations at community festivals, the views of local people have played a key role in how healthcare is developed and delivered to Lambeth residents.

Engagement work has been guided by NHS Lambeth’s Communications and Engagement Strategy and this year we have taken the opportunity presented by achieving pathfinder status as a clinical commissioning-led body to take stock of our ways of working and refresh our approach to engagement.

A framework for patient and public engagement during 2011-12 was agreed at a meeting of the Lambeth Clinical Commissioning Collaborative Board in June 2011. Implementing this has entailed each of our programmes developing and
reporting on engagement plans and ensuring that engagement forms an integral part of our performance reporting to the LCCCB and PCT boards, and is a required element of our business case development. Examples include:

- Appointment of user representatives to lead engagement work with people with diabetes. People with diabetes attended our all practice event on 12 Oct 2011 to talk about their experiences and aspirations. Service users have been involved in training clinicians in co-creating approaches
- People with musculo-skeletal conditions have been involved in the redesign of services which had led to the revision of information provided, changes in access to tests, service locations and opening hours
- An HIV service user reference group has been established to inform decision making and the HIV care support review jointly with London Borough of Lambeth.

We have taken a proactive approach to involving Lambeth’s elected representatives in our organisational change arrangements in Lambeth and in our commissioning plans, initiating an early induction with Health and Adult Social Care Scrutiny sub-committee members and NHS Lambeth’s clinical board Chair and MD. During 2011-12 we have provided information and presented on public health, mental health, HIV care and support services and our integrated health and social care commissioning work. We presented recent public health developments and our Strategic Plan in November and December 2011. We took part as witnesses in the committee’s Special Health Commission that looked at the implications of the NHS White Paper (now Health & Social Care Act 2012) on the local healthcare provision. We had early meetings with Lambeth LINk this year to establish effective communication channels with our new structures in order to support our joint commitment to maximising opportunities for Lambeth residents to influence commissioning decisions. We supported the LINk’s application to become a Local HealthWatch Pathfinder and committed as part of this to running training workshops for LINk Steering Committee members to develop their understanding of commissioning processes – the first session took place on ‘what is commissioning?’ in August 2011. The Lambeth LINk Chair is a co-opted member of the Lambeth Clinical Commissioning Collaborative Board. We take part in regular discussions with the LINk membership, attending Steering Committees and presenting to public meetings including one in September 2011 to discuss strategic priorities and our plans to improve health and the quality of health services for Lambeth’s population that builds on the joint LINK/NHS Lambeth event with local residents in the summer of 2010 on ‘right care, right place’.

We have ongoing involvement with a wide range of third sector organisations through our public health and wellbeing work, and in our core commissioning and programmes. We liaise with Lambeth’s Health and Wellbeing Voluntary and
Community Sector Forum and took part in a discussion on strategic priorities and clinical commissioning in October 2011.

More broadly, we have taken opportunities to engage with Lambeth residents on health priorities through the use of large-scale community events such as the Lambeth Country Show over the last three years to conduct structured conversations on health needs, health priorities and people’s experience of the services we commission.

NHS Lambeth’s second Annual report on consultation was published in September 2011. This provides detailed information on how Lambeth residents have influenced the development of our commissioning strategies and plans at both organisational and programme level and is available at: http://www.selondon.nhs.uk/index.php?assetId=402&assetGroupId=111

The NHS Constitution brings together in one place what patients, the public, and staff can expect from the NHS. It sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively. All NHS bodies, as well as private and third-sector providers supplying NHS services are now required by law to take account of the Constitution in their decisions and actions. The Government will have a legal duty to renew the Constitution every 10 years. No Government will be able to change the Constitution, and therefore how the NHS works, without the full involvement of staff, patients and the public. More information is available at www.nhs.uk/nhsconstitution

As part of the refresh of the CSP in 2011 we have undertaken a specific programme of engagement with Lambeth residents, voluntary and community organisations and elected representatives involving a discussion of ideas and principles of the Plan:

11 October 2011 partnership event with Lambeth LINk
Presentation and workshops on key aspects of the Strategic Plan.
Feedback given on availability and access to urgent care and primary care including pharmacies, staying healthy, outpatients, engagement and communications.

20 October 2011 Health and Wellbeing Voluntary and Community Sector Forum
Question and answer session on the role of Lambeth clinical commissioning group, strategic priorities and plans.
Feedback on older people and the Integrated Care Pilot, cancer services and screening, mental health and diabetes. Discussion of co-creating principles across a wider range of care pathways.
4. LCCCB Mission and Vision
Our mission is to improve the health and reduce health inequalities of Lambeth people and to commission the highest quality health services on their behalf.

LCCC commissions health services on behalf of all patients registered with Lambeth practices, and for unregistered Lambeth residents including the vulnerable and homeless. Lambeth is characterised by a relatively young, diverse and mobile population. There are high levels of deprivation and of population density. These factors bring a wide range of significant health needs and a complex range of commissioning challenges. Over recent years in Lambeth we have been successful in increasing life expectancy, reducing health inequalities and tackling complex health issues, such as teenage pregnancy. Our health challenge, however, remains extremely stretching. It includes addressing unique levels of sexual and mental health needs and the high levels of health risk-taking behaviour in our communities. People in Lambeth currently develop health conditions at a younger age and live with these conditions for longer, often undetected until their condition is well advanced.

We believe the health in Lambeth can only be improved through effective working with our local partners, and by fully engaging clinicians to work with local communities and patients to co-design services. This will require us to further develop new and innovative approaches, building on the start we have made in areas such as the Lambeth Living Well Collaborative.

We have been working hard to build upon, influence and sustain the strong local partnership working that currently exists and we also recognise that we will need
to develop new partnerships as the new commissioning arrangements are created.

King's Health Partners (KHP), our main NHS provider, brings clinical excellence to local services. KHP's tripartite mission; enabling excellence in clinical services, teaching and research with both local and global ambitions, brings us both tremendous opportunity and added complexity. The delivery of Lambeth community health services provided through KHP supports our vision for the transformation of local health care through integrated provision of services and through learning.

Primary care in Lambeth is characterised by strong examples of high quality provision, but with a wide range in the quality in care. We recognise our critical role to enable a consistently high standard of quality in primary care services across the Borough if we are to address improved health and more effective care pathways for patients.

We share many of these characteristics with our near neighbours, particularly Southwark Clinical Commissioners. We are seeking to further develop our joint working through our shared programmes and through a common contracting approaches across the two clinical commissioning teams and beyond. We are further developing our commissioning partnerships across Lambeth, Southwark and Lewisham and clinical strategy across South East London.

5. Our Vision:
- Health improvement is at the heart of all we do. We will increase life expectancy for all and reduce the difference in life expectancy between the most and least deprived in our diverse communities.
- We will maintain a thriving, financially viable, health economy delivering safe and effective high quality care.
- We will commission comprehensive integrated care that meets the needs of local people. We will value diversity amongst providers, but will expect excellent outcomes.

In delivering this vision we recognise the need:
- for a rigorous, population needs based approach to commissioning, supported by public health expertise.
- to work with Lambeth people and their representatives to commission services that best meet their needs.
- to work in partnership with colleagues, across geographic, organisational and professional boundaries. This will include primary care practitioners, the London Borough of Lambeth, King’s Health Partners and neighbouring health commissioners.
- to support innovation in workforce development and in the local application of teaching, training and research.
- to look first to local colleagues for management support
6. Health need in Lambeth
Lambeth is an inner London borough with a growing population. It has 21 wards, comprising six town centre areas namely: North Lambeth, Stockwell, Clapham, Brixton, Streatham and Norwood. Health services are organised around three localities. Key features include high relative deprivation, population mobility, diversity and density. It has a breadth of ethnic and cultural traditions which have established their presence in particular town centre areas and quarters. The census area classifications describe Lambeth as a London Cosmopolitan area similar to Southwark, Lewisham, Hackney, Islington, Haringey and Brent.

Population Key Facts
- 283,300 residents in Lambeth in 2009 – with projected growth by a further 15% to 317,000 by 2028.
- 370,000 General Practice registered population.
- An even split of males / females.
- A younger population than seen nationally with over 50% aged 20-44.
- 37% of the population is from Black & Minority Ethnicity (BME) communities.
- 80,000 residents classified as Black African or Caribbean.
- Increasing Black African population projected till 2031.
- 137 different first languages spoken by children in schools
Deprivation
Poverty and social exclusion are some of the social challenges in the borough. Lambeth was the 9th most deprived borough in London in 2010. In England, Lambeth is the 29th most deprived. Income deprivation is relatively worse in both older people and children compared to London and England as a whole as shown below.

<table>
<thead>
<tr>
<th>Deprivation index</th>
<th>Lambeth</th>
<th>London</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income Deprivation Affecting Older People Index</td>
<td>37%</td>
<td>27%</td>
<td>21%</td>
</tr>
<tr>
<td>Income Deprivation Affecting Children Index</td>
<td>38%</td>
<td>30%</td>
<td>20%</td>
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Source: IMD 2010

In the South East Region this represents the Strategic Health Authority average.
Health Status of Lambeth Population

We have a good understanding of the health issues impacting on local people, built up over successive years through our JSNA and through analysis by our public health team and working with local partners.

Progress overall

We are proud of our achievements in improving health and reducing health inequalities in Lambeth over recent years.

Life expectancy – Overall NHS Lambeth is one of the few spearhead areas to have increased life expectancy in both men and women as a result of reduced premature deaths from cardiovascular diseases, cancers, infant deaths and other causes. Between 1995-97 and 2007-09 life expectancy at birth increased

- for men by 5.4 years to 76.4 years
- for women by 2.7 years to 81.1 years
- Compared to England the gap in life expectancy has reduced in the same timeframe for both men (by 37%) and women (by 7%).

- Infant mortality – Infant mortality rate has been declining steadily from 8.8 per 100 live births in 1995-97 to 5.5 per 1000 live births in 2006-08 (just above that of England - 4.8). However recently it has increased to 6.2 per 1,000 live births in 2008-10 (compared to England 4.6 per 1,000 live births).

- Premature deaths from circulatory diseases –
The three year average mortality rates for circulatory diseases (for those under 75) have fallen from 175.3 deaths per 100,000 population in 1995-97 to 87.8 deaths per 100,000 in 2008-10.

The absolute gap in mortality rates between England and Lambeth has reduced by 42% from a baseline gap of 34 deaths per 100,000 in 1995-97 to 20 in 2007-09.

**Premature deaths from cancer** – The three year average premature mortality (< 75 years) from all cancers has fallen by 15% from a baseline 161.8 per 100000 in 1995-97 to 137.9 per 100000 to 2007-09. However for the latest period the overall absolute gap between Lambeth and England has worsened by 25%.

**Our case for change**
The refresh of our Joint Strategic Needs Assessment (JSNA) demonstrates that despite this progress in key areas the health burden and inequalities remains a challenge. The main causes of death leading to the life expectancy gap are heart disease, stroke, cancer of the lung, respiratory disease and peptic ulcers and liver cirrhosis. In addition to the mortality gap people in Lambeth are living longer with one or more long term conditions. Mental illness forms the largest component of this burden but people are also living longer with cardiovascular disease, cancers, and chronic respiratory and digestive system disorders as survival improves. It is important to consider promotion of healthy lifestyles, prevention, early active case-detection, case management, improved medicines management and referral quality to avoid unnecessary hospital admissions and improve quality of life. It is also important to consider end of life care provision and support and the role of carers.

7. **Key strategic priorities and health goals**
Our CSP identifies our key health goals and associated outcome measures which we believe will, if achieved, have the biggest impact on the health of people in Lambeth within available resources. These health goals and the specific interventions to support their delivery were determined through a systematic process of prioritisation, working with Lambeth stakeholders. We have taken the opportunity of this refresh to assess delivery of these health goals and to review the goals, interventions and outcome measures. Our assessment is that the core goals should remain unchanged, but with an added partnership priority around addressing the impact of alcohol on health and more widely upon the wellbeing of our local communities. Within our existing health goals we have suggested some changes including refocusing children’s health priorities beyond addressing childhood obesity measures to include other aspects of early intervention

**Mental Health**
Lambeth has one of the highest rates of diagnosis for serious and common
mental illness compared with London and England. This is associated with our comparatively younger working age and more mobile population and higher rates of diagnosis in the black and ethnic minority population. Mental health is a key strategic priority in Lambeth for two reasons

- Mental ill health is the biggest cause of years of life lost to disability locally. It is also a leading contributor to premature death in people with other long term conditions such as diabetes and cardiovascular disease.
- The costs of disability due to mental ill health are very high, not only to the NHS and social care but also to the wider economy and to families and individuals on a social level.
- Lambeth partners (including voluntary sector and service users and carers) are collaborating on a substantial service redesign ‘the Lambeth Living Well Collaborative’ (LLWC) for people with severe mental illness (SMI) which has been awarded £100k by NESTA as one of six pilot projects in their People Powered Health Programme. The aim of the LLWC is to ‘change the rules’ about services and use co-production to develop a culture where people receiving services are at the heart of strategic direction and decision making as well as planning their own recovery.

Cardiovascular disease (CVD)
Cardiovascular disease is a key strategic priority. We have set a target based on hypertension (blood pressure) management as a proxy for support people with Coronary Heart Disease. Having reviewed the evidence on progress and to impact on other cardiovascular disease such as stroke we have decided to change the target to improving control for all patients with diagnosed raised hypertension. Management of hypertension will prevent people going on to develop heart disease and stroke. It is also crucial for people with diabetes who already have a raised risk

- There are just over 5000 detected cases of heart disease and over 3000 detected cases of stroke in Lambeth. Other areas of importance in this condition include heart failure and heart arrhythmias (particularly atrial fibrillation)
- Premature mortality is reducing significantly especially among men.
- Key issues are under detection and variation in the management and control of people with CVD.
- Early detection and reduced variation in the management and control of risk factors (secondary prevention) remains an important challenge and in particular implementation of NHS Health checks for early detection and management of risk.

Diabetes
- Diabetes is a key strategic priority
There are 13600 people with diabetes in Lambeth and the prevalence and numbers of detected cases is increasing. Obesity is a major risk factor for type 2 diabetes.

Key issues are the lower detection rates and the variation in management of diabetes.

NHS Lambeth is working with the Guy’s & St Thomas’ Charity funded Diabetes Modernisation Initiative to improve the detection and management of diabetes.

Early detection and reduced variation in the management and control of risk factors (secondary prevention) remains an important challenge. Capacity to deal with the rising prevalence will also be an important challenge.

HIV Prevention and Sexual Health

HIV - NHS Lambeth has identified HIV as a strategic priority. Lambeth, Southwark and Lewisham have one of the highest prevalence of HIV in the UK. Two main affected population groups are men having sex with men (MSM), and black African heterosexuals. Late diagnosis of HIV is the most important factor associated with HIV related morbidity and mortality and inpatient care in the UK. HIV testing is key to reducing late diagnosis of HIV and in preventing secondary transmission. NHS Lambeth has set up an HIV testing pilot in primary care and aims to expand this pilot to all practices.

Teenage Conceptions - The under 18 conception rate is 59.5 per 1000 females aged 15-17 (267 conceptions). The under 18 conception rate has declined by 30.2% since 1998, the baseline and by 42.1% since 2003 when the rate was at its highest. Lambeth has traditionally had one of the highest rates of under 18 conceptions. However, data from 2009 shows that Lambeth has now the 11th highest rate in England

Lambeth has significant numbers of STIs diagnosed in local residents, high rates of teenage conceptions and high rates of terminations. Therefore we have invested significant energy in developing local services to meet these needs. In the last five years we have made significant progress. Lambeth has the highest Chlamydia screening uptake rates in England, has increased numbers of TOPs before 10 weeks gestation and has introduced successful HIV testing pilots in primary care.

Smoking

Lambeth has made good progress in reducing smoking prevalence with the development of a Lambeth wide tobacco control strategy and sustained efforts to support smokers to quit. However smoking related deaths and hospital admissions remain high and smoking remains an important priority for Lambeth as it is a major risk factor for cancer and cardio-vascular
disease and the main cause of Chronic Obstructive Pulmonary Disease (COPD). We are working with our partners to promote tobacco control in the borough and to ensure that people do not start smoking. In the NHS our focus has been on developing and extending services to support people to quit smoking. We are significantly increasing the numbers of people who have been through structured programmes to help them quit and have increased our target of the number of people coming through these programmes. We are focusing now on improving the quit rates. We have failed to achieve our local target for the numbers of quitters, although we have exceeded our Department of Health target. We have therefore revised downwards slightly our quit target.

**Obesity, physical activity and healthy eating**
The level of obesity in Lambeth adults (18.6%) is lower than the England average (23.6%) but is worsening. Obesity in children aged 10-11 is high with up to 1 in 4 obese. 13.3% of children at reception level are obese in Lambeth compared with 11% in London, and 9.9% in England.

**Alcohol**
As part of the refresh of the CSP we have identified alcohol as a key strategic priority across Lambeth partners including the impact of alcohol on communities and the environment. This has been identified through LCCCB working with health partners, the Safer Lambeth Partnership and the Health and Wellbeing Board Partnership. We are undertaking further work to identify the specific interventions that would impact on the health and lifestyles of Lambeth communities, but our initial priority is to support the delivery of brief intervention advice and identification of people at risk from their drinking. Alcohol and substance misuse is an important problem in the borough. It is estimated that 23%-24% of Lambeth’s population (~70,000) drink excessively and Lambeth has higher levels of alcohol-related hospital admissions than both London and England.

**Cancer – South east London wide priority**
Early detection and prevention of cancer is a key strategic priority for the South East London area and we have been supported in our work to save lives has been led by the South East London Cancer Network. Cancer accounts for approximately 25% of deaths in Lambeth. Over the last decade there has been a steady in decline in the rate of cancer death in those aged under 75 in line with the national target with the exception of a rise in 2008. The uptake of cervical, breast and colorectal screening is below the national average although improving slowly. Initiatives to improve uptake, targeted at Primary Care, are planned. Raising awareness of cancer and its early
detection are priorities. Lambeth has had a number of successful bids from the National Raising Awareness and Early Detection Initiative (NAEDI) and run a social marketing campaign for head and neck cancer. Plans are being formulated for the national bowel cancer campaign which will be launched in January 2012.

We have identified key outcome measures associated with our key health priorities. These are based on the refresh of the Joint Strategic Needs Assessment described above, focusing on causes of death and ill health in Lambeth and those areas which can be addressed by effective and evidence based approaches. These are set out overleaf.
## Our Strategic Vision and Goals

**Mission**

To improve the health and reduce health inequalities of Lambeth people and to commission the highest quality health services on their behalf.

**Vision**

**Health**: Men will live 17 months longer and women 7 months longer; and the gap in life expectancy between most and least deprived will be reduced by 2 months

**Access**: Comprehensive, round the clock access to integrated pathway based care, general and specialist; delivered through neighbourhood networks

**Affordability**: A thriving, financially viable health economy delivering safe, effective, high quality care.

**Cutting edge**: Local services grounded in world class research, innovation and clinical education; in partnership with Kings Health Partners

### Health goals

<table>
<thead>
<tr>
<th>Serious mental illness</th>
<th>Cardio Vascular Disease</th>
<th>Diabetes</th>
<th>HIV</th>
<th>Smoking</th>
<th>Childhood obesity</th>
<th>Alcohol (to be confirmed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enable 1000 people with people with serious mental illness to move on from secondary care by accessing a new asset / recovery based service offer.</td>
<td>Improve hypertension control of 1000 more people in Lambeth</td>
<td>Help 5000 more people with diabetes bring their blood sugar under control</td>
<td>Halve the proportion of Lambeth residents diagnosed very late with HIV (&lt;200 CD4 cells/mm3)</td>
<td>Help over 12500 more people in Lambeth quit smoking</td>
<td>Help 900 more children overcome or avoid obesity; and help over 10000 children maintain a healthy weight</td>
<td>Increase the number of frontline staff who have received training in screening and brief intervention for alcohol misuse</td>
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### Outcomes 2010-15 as reviewed

| 98% users in CPA with HONOS | 76% of people with hypertension with BP <= 150/90 | 74.5% for HbA1c <8 | 26% (2009) to 13% (by 2015) | 1062 smoking quitters per 100,000 | 22.3% Year 6 obesity prevalence in children | 90% of the identified frontline staff have received training in screening and brief intervention for alcohol misuse |

| Life expectancy | Health Inequalities | Patient experience |
**Table 1: NHS Lambeth Commissioning Strategy Plan – World Class Commissioning Outcomes**

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<tr>
<td>Health Inequalities (Males)</td>
<td>Difference between life expectancy in most and least deprived areas</td>
<td>6.4 (2003-2007 Result)</td>
<td>6.3</td>
<td>6.2</td>
<td>6.1</td>
<td>6.1</td>
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<tr>
<td>Apr 2012 update (Published data)</td>
<td>Source: Association of Public Health Observatories (APHO)</td>
<td>6.0 (2004-2008 result)</td>
<td>5.9 (2005-2009 result)</td>
<td>5.3 (2006-2010 result)</td>
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<td></td>
</tr>
<tr>
<td>Health Inequalities (Females)</td>
<td>Difference between life expectancy in most and least deprived areas</td>
<td>5.5 (2003-2007 Result)</td>
<td>5.4</td>
<td>5.3</td>
<td>5.3</td>
<td>5.2</td>
<td>5.2</td>
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<tr>
<td>Life Expectancy (Males)</td>
<td>All age all cause mortality rate (per 100,000)</td>
<td>785</td>
<td>764</td>
<td>744</td>
<td>718</td>
<td>700</td>
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<tr>
<td>Apr 2012 update (Published data)</td>
<td>Source: National Compendium for Health Outcomes Development (NCHOD)</td>
<td>818 (2006-08 Rate)</td>
<td>779 (2007-09 Rate)</td>
<td>751 (2008-10 result)</td>
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<tr>
<td>Life Expectancy (Females)</td>
<td>All age all cause mortality rate (per 100,000)</td>
<td>536 (2006-08 Result)</td>
<td>521</td>
<td>513</td>
<td>504</td>
<td>496</td>
<td>488</td>
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<tr>
<td>Apr 2012 update (Published data)</td>
<td>Source: National Compendium for Health Outcomes Development (NCHOD)</td>
<td>534 (2007-09 rate)</td>
<td>529 (2008-2010 result)</td>
<td></td>
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<tr>
<td></td>
<td>Prevalence of obesity in Year 6 children</td>
<td>Prevalence of obesity in year 6 (%) as measured by NCMP</td>
<td></td>
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<td>3</td>
<td></td>
<td>Apr 2012 update (Published data)</td>
<td>25.1 (2009-10 Result)</td>
<td>24.02 (2010-11)</td>
<td></td>
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<td></td>
<td></td>
<td>Source: National Obesity Observatory - National Child Measurement Programme (NCMP)</td>
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<tr>
<td>4</td>
<td>Smoking quitters</td>
<td>Smoking quitters per 100,000 population</td>
<td>1097</td>
<td>1111</td>
<td>1129</td>
<td>1155</td>
<td>1186</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Apr 2012 update (Published data)</td>
<td>613 (2009-10 result)</td>
<td>964 (2010-11 result)</td>
<td>No. quitters = 1427</td>
<td>No. quitters = 2258</td>
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<td></td>
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<td>Source: NHS Information Centre</td>
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<tr>
<td>5</td>
<td>% late diagnosis for HIV</td>
<td>%Late diagnosis for HIV (Target is to reach 15% by Mar 2011 available by Mar 2013)</td>
<td>25</td>
<td>20</td>
<td>18</td>
<td>14</td>
<td>10</td>
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<tr>
<td></td>
<td></td>
<td>Apr 2012 update (Published data)</td>
<td>Baseline 2004-05 = 27% 2006=30% 2007=18% 2008=21% 2009=26%</td>
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<td></td>
<td>26% (2009 data)</td>
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<tr>
<td>6</td>
<td>The proportion of users on new Care Programme Approach with a HoNOS assessment in the last 12 months</td>
<td>% Users on new Care programme approach with a HoNOS assessment in the last 12 months</td>
<td>60</td>
<td>75</td>
<td>80</td>
<td>90</td>
<td>95</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Apr 2012 update (Published data)</td>
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</table>

|   |   |   |   |   |   |   |

Table 1 continued
<table>
<thead>
<tr>
<th></th>
<th>Diabetes controlled blood sugar</th>
<th>% patients with diabetes who have an HbA1c of 8 or less (Revised in Sep 2010)</th>
<th>73.43</th>
<th>74.66</th>
<th>76.38</th>
<th>77.5</th>
<th>78.61</th>
<th>79.7</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Nov 11 update (Published data)</td>
<td>Source: NHS Information Centre, Qualities and Outcome Framework (QOF)</td>
<td>73.4</td>
<td>73.1</td>
<td>67.9</td>
<td>70.2</td>
<td>72.4</td>
<td>74.5</td>
</tr>
<tr>
<td></td>
<td>% of patients with diabetes who have an HbA1c of 8 or less (revised April 2011)</td>
<td>66.3 (2009-10 result) 65.8 (2010-12011 result)</td>
<td></td>
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</tr>
<tr>
<td>8</td>
<td>CHD Controlled blood pressure</td>
<td>% patients with CHD in whom last blood pressure reading &lt;=150/90</td>
<td>86</td>
<td>87</td>
<td>88</td>
<td>89</td>
<td>90</td>
<td>91</td>
</tr>
<tr>
<td></td>
<td>Nov 11 update (Published data)</td>
<td>Source: NHS Information Centre, Qualities and Outcome Framework (QOF)</td>
<td>88.3</td>
<td>88.6</td>
<td>75.9</td>
<td>76.7</td>
<td>77.5</td>
<td>78.3</td>
</tr>
<tr>
<td></td>
<td>% of patients on the BP register whom the last blood pressure reading ,=150/90</td>
<td>73.1 (2009-10 result) 75.1 (2010-11 result)</td>
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</tbody>
</table>

The key messages on progress against our health outcomes targets are:

- Life expectancy for people in Lambeth has increased and there has been a reduction in the gap between life expectancy in Lambeth and other areas
- Childhood obesity at Year 6 is marginally decreasing
- More people are being helped to stop smoking
- There is significant variation on a year to year basis in late diagnosis for HIV so in future we will look at a 3 year rolling average
- We are underachieving our diabetes target, but we have reduced the numbers of people excluded from the measure (‘exception reporting’ under the GP Quality and Outcomes Framework)
- We are achieving higher than our target for blood pressure control in people with CHD
8. **Addressing Health Inequalities**

In 2011, we adopted the Equality Delivery System (EDS) which aims to achieve positive cultural change in the NHS by creating an environment where services for patients and workplaces for staff are more equitable, diverse and that fairly represent the wider community.

The EDS will enable us to meet the aims of the Equality Act 2010 which is a legal requirement of all public organisations to take the necessary actions to achieve:

- Elimination of unlawful discrimination.
- Advancement of equality of opportunity.
- Fostering of good relations between individuals and communities.

NHS Lambeth has set equality objectives that, over the next three years, that can be delivered as part of mainstream commissioning and partnership work. The approach has been to identify at least one equality objective for each of the priority areas in the Strategic Plan.

The process for developing the equality objectives:

- As part of health needs assessment and development of commissioning plans an equality screening (plus in some cases an equality impact assessment) was completed in each priority area to identify the main health inequalities and service inequities. This stage took account of any public and patient engagement completed to date.
- A summary of the main areas of concern and opportunities was completed with an outline of potential for action, again taking into consideration the views of interested parties including patients and the public.
- A workshop held with LINk at the end of March 2012.
- Objectives recommended to the Clinical Commissioning Collaborative Board (4th April 2012)

The equality outcomes are different in nature for each health priority. They reflect the stage of development of the respective priority area. For instance the objectives in mental health are relatively specific because substantial work has already gone on to understand the inequalities in health that people with mental health problems experience and what needs to be done. In childhood obesity the objective is less specific because this is an area where the evidence base is less developed; for instance what sorts of interventions might work best for which groups (e.g. for boys and girls)? A more specific objective will be set after an evaluation has been completed. The same is the case for alcohol which is a new priority in 2012.

In all areas of work it is recognised that improvements need to continue both in how information is gathered on population groups protected under the Equality
Act\(^1\) and how information is used to promote and assure equality through both the Joint Strategic Needs Assessment and the commissioning processes.

Life Expectancy - this target focuses on geographical differences between Lambeth and England as a whole as well as within Lambeth differences. The former is much more greater and therefore important and the cause of the gap is due to premature deaths from Cardio-Vascular Disease (CVD), Cancers, respiratory disease and Gastro Intestinal tract disease - all areas that we have prioritised in our CSP.

CVD – Blood Pressure (BP) – there is higher expected prevalence/need in the black and ethnic minority (BME) population and locally there is evidence of poor outcomes in BME groups - poorer BP control and premature strokes and deaths from stroke; differences in control. This requires further equity profile using local data for some aspects of the protected categories. A previous smaller equity profile identified practice systems and processes as important in supporting improved control. Therefore we are focusing on reducing practice variation.

Diabetes - prevalence is higher in BME groups and locally there is some evidence that glycaemic control varies by age, gender, ethnicity, deprivation and practice characteristics. Further work is required to determine what are the key characteristics and what is confounding.

HIV – the proposal is to look review the proportion of Lambeth residents diagnosed very late with HIV via heterosexual acquisition to see if this can be a measurable proxy indicator for Black African Communities and access to treatment.

Smoking – Higher proportions of people from lower socio economic groups are smokers and within this population there are pregnant women (with the associated impact on children) and people with mental illness and higher numbers of people from black and ethnic minority communities. By focusing on routine and manual workers we would aim to increase the quit rate amongst these priority groups.

Mental Health – The strategy developed by Lambeth Living Well Collaborative LLWC explicitly aims to address the current variability that exists in terms of access and quality of services available to people with SMI across the voluntary sector, primary care and secondary care. The new service offer has been developed in order to address these deficits and ensure a common standard of service across all sectors. Traditional health and social care commissioning strategies primarily focus on need, often determined by professionals. The LLWC strategy aims to take an asset based approach which seeks to maximise value by supporting people and communities to realise their

\(^1\) Age, Disability, Gender Reassignment, Marriage and Civil Partnership, Pregnancy and Maternity, Race, Religion and Belief, Sex, Sexual Orientation
assets, skills and talents. It is expected that an increase in "asset" based self care and management amongst the population with seriously mental illness will mitigate against the reduction in state funded health and social care. This will support an increase in recovery rates as people's holistic needs including ethnic and cultural needs are more appropriately met. The programme aims to reduce the demand for acute mental health provision and residential care by developing community based, user led alternative support arrangements. The metrics underpinning the key outcomes developed by LLWC are currently being worked up, which will include impact measurement via: service take up, patient reported experience.

Childhood obesity - An equality impact assessment was done on the childhood obesity programme and the set of interventions were informed by the EIA. Equality considerations will form a key part of the Childhood Obesity Programme evaluation to provide more understanding of what further equality/equity actions may be needed locally for the successful implementation of the Lambeth Childhood Obesity Programme. To ensure effective consideration of equality issues within the Childhood Obesity Programme Evaluation, appropriate monitoring systems will be established and the contract monitoring process used to improve data quality from providers.
Our Equality Objectives 2012-15

Equality goal

To improve life expectancy in Lambeth, narrowing the within-Lambeth gap in premature death between men and women and reducing the gap in premature death between Lambeth and nationally by at least 10%, as measured by the slope index\(^1\) of premature death which demonstrates the gap between the health of the best and the worst groups in Lambeth.

<table>
<thead>
<tr>
<th>Equality objectives</th>
<th>Serious mental illness</th>
<th>Cardio Vascular Disease</th>
<th>Diabetes</th>
<th>HIV</th>
<th>Smoking</th>
<th>Childhood obesity</th>
<th>Alcohol</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>To improve the physical health of people known to have mental health problems especially people with severe mental illness (SMI) as measured by: (\bullet) the proportion who smoke aiming to reduce the numbers who smoke and narrow the gap between people with SMI (44.2% known to be smokers according to GP records) and the general adult population of Lambeth (23% smokers) (\bullet) (in people with SMI and diabetes) improving diabetic control from the beyond the Lambeth average (66% achieving good control as measured by HbA1C) towards that of the highest performing practices in Lambeth of 80% or above.</td>
<td>To improve control of high blood pressure (defined as less than 150/90) in Lambeth, specifically to reduce the between practice variation by achieving measurable change in the poorest performing practices towards the Lambeth average of blood pressure controlled in at least 75% of people known to have hypertension, and to improve the quality of care for all.</td>
<td>To improve the detection and control of diabetes in Lambeth (as defined by achieving HbA1c of less than 8), specifically to reduce the between practice variation in control achieving measurable change in the poorest performing practices towards the Lambeth average of 66% of people known to have diabetes achieving good control and between different population groups focusing on some ethnic minority populations and people with mental health problems known to have increased prevalence, earlier onset and higher rates of complications.</td>
<td>To ensure the revised HIV treatment and support services are informed both by detailed evidence on which populations are experiencing the highest prevalence, the highest transmission rates and the highest social needs profile, and by a diverse Service User Reference Group (SURG) indicative of the different communities affected in Lambeth</td>
<td>To enable all smokers to have equal opportunity to quit through the Lambeth stop smoking service focusing particularly on particularly on lower socio economic groups who are more likely to smoke</td>
<td>To reduce any inequality experienced by different population groups in their ability to benefit from the Childhood Obesity Programme and to promote equality and equity as a key element to successful delivery of the Programme overall</td>
<td>To promote equity of access to information on alcohol and safe drinking, and to alcohol misuse services for population groups at higher risk of alcohol related harm</td>
</tr>
</tbody>
</table>
9. Implementing the Plan

Our CSP is delivered through our programme approach which we have developed over the past year and is set out in the diagram overleaf. The programmes are clinically led and use evidence of best practice and innovation. There are four programmes and the key objectives are outlined below.

**Planned Care**
To develop and deliver an outpatient strategy, which reduces the risk of premature mortality and improve the quality of life by: sustaining the control of long term conditions (including HIV) and preventing risk of acute events in people with long term conditions.

- To deliver reductions in variation in outpatient attendances through working with practices and localities
- To redesign and recommission care pathways for elective and long term conditions
- To improve the quality and effectiveness of care pathways across sexual health and HIV provision
- To develop and implement local networks including estate

**Unplanned Care**
To improve the quality of care for those with dementia and reduce the number of avoidable hospital admissions and readmissions for frail older people.

- To reduce the number of avoidable hospital admissions for conditions that can be managed in the community
- To develop a virtual hospital home service
- Roll out of reablement programme
- Review commissioning of intermediate care
- To reduce the number of people dying in hospital who would prefer to die at home

**Mental Health**
To redesign mental health care pathways (severe mental illness) in order to improve patient outcomes.

- To develop and implement new service offer targeting people with severe and enduring mental illness including the Lambeth Living Well Collaborative
- To develop and implement recovery focussed care pathways for people with mental health problems in contact with the Criminal Justice System
- To implement payment by Results and the self directed care programme
• To develop and integrated approach to the delivery of therapy and counselling services for people with anxiety and depression
• To implement the national dementia strategy

**Staying Healthy**

Improve health outcomes for Lambeth residents through the commissioning of systematic health promotion and prevention services that have the effect of improving mortality rates, reducing morbidity and reducing the prevalence of key risk factors.

• To reduce health inequalities and improve health, identifying the need for interventions that improve population health such as environment (physical activity) nutrition, etc and linking these wider determinants to the delivery and management of preventable Long Term Conditions
• Tobacco control measures including increasing the numbers of people stopping smoking
• Promotion of sensible drinking including ensuring all first contact health professionals deliver brief intervention training and support work in A&E
• Preventing infant mortality (e.g. screening, immunisation, maternal health, childhood poverty strategy)
• Integrated approach to addressing the needs in Early Years, including increasing capacity and skills of Early Years workforce to ensure implementation of Healthy Child Programme.
• Adolescent health - early intervention and prevention. Approach to reduce risk-taking behaviour: sexual health & teenage pregnancy, youth violence, substance misuse, emotional & mental well being and obesity
PCT Boards

Lambeth Clinical Commissioning Collaborative Board

Operations Group

Joint Lambeth and Southwark Clinical Leads Groups Leads

Planned care *joint with Southwark*
- management of long term conditions (including HIV)
- early detection
- secondary prevention
- management of elective care in the most appropriate settings
- shifting service provision promoting appropriate referral
- reducing inappropriate variability in care

Unplanned Care *joint with Southwark*
- Urgent Care
- Frail Older People

Mental Health
- Lambeth Living Well Collaborative
- Forensic services
- Payment by Results
- Talking Therapies/Counselling
- Dementia

Staying Healthy
- Tobacco and alcohol
- Adult and Childhood obesity
- Physical activity
- Health Checks
- Access to prevention
- Mental well-being
### 10. Lambeth Clinical Commissioning Group Commissioning Intentions

Set out below are the key commissioning intentions for the LCCCB. Key milestones and timescales are set out in Appendix I.

<table>
<thead>
<tr>
<th>Service area/ Treatment function</th>
<th>Commissioning Intention</th>
<th>Rationale</th>
<th>Outcome</th>
<th>Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staying Healthy &amp; living well with long term conditions</td>
<td>Commissioning of systematic health promotion and prevention services to reduce the prevalence/incidence of key risk factors of main causes of excess mortality, reduce morbidity and in turn improve life expectancy whilst reducing health inequalities</td>
<td>People in Lambeth have relatively lower life expectancy than other areas in London and England and a population at higher risk of morbidity. The greatest contributors to premature mortality are vascular disease and cancer which can be prevented by addressing some common risk factors through an integrated and systematic approach</td>
<td>● Long term outcome of improved health of the population through A reduction in long term condition (LTC) risk (particularly in relation to CVD, respiratory disease and cancer) by the prevention of common risk factors (tobacco &amp; alcohol use, inactivity and poor diet) Reduction in premature mortality / disability adjusted life years (DALY) Reduction in health inequalities within Lambeth &amp; between Lambeth and England</td>
<td>● Tobacco control next stage implementation including further development of stop smoking services Alcohol workstreams: ● Alcohol work in A&amp;E to reduce harm and target younger people ● Scale-up and improve the quality of Screening and Brief interventions ● Increase specialist treatment in community settings ● Health information and social marketing to support the strategy ● Develop acute and community CQUINS ● Pilot Healthy Living Pharmacy ● Embed health checks</td>
</tr>
</tbody>
</table>
- Commission extension of HIV testing using evidence from primary care pilot
- Further development of communication and information sharing with the local population through campaigns, publications and social networking
- Review of implementation of Lambeth Early Intervention and Prevention Service
- Complete commissioning of childhood healthy weight services and scope review and evaluation of these services
- Increase numbers of women breastfeeding as confirmed at 6-8 week check to 90%
- Develop work on screening and earlier detection of cancer and supporting patients to present earlier (to be advised by cancer network)
- Recommission GP practices and revise local PMS contracts
- Increase uptake of flu immunisation to 75% in over 65 y & under 65 y at high risk
- Increase uptake of MMR to 95% in preschool and primary school
- Increase/maintain uptake of
<table>
<thead>
<tr>
<th>Planned care - Long term conditions detection and management</th>
<th>Improve health outcomes for people with long term conditions</th>
<th></th>
<th>HPV vaccine to 90% in teenagers &amp; young people (12-18 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Low prevalence of LTCs compared with expected prevalence.</td>
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<tr>
<td>• Expected increases in prevalence of long term conditions.</td>
<td></td>
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<tr>
<td>• Increasing numbers and cost of emergency admissions and readmissions for LTCs.</td>
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<tr>
<td>• Patient feedback on current and proposed services</td>
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<td>• Poor primary care premises impacting on ability of general practice to provide the full range of high quality</td>
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<tr>
<td>• Early detection and treatment to prevent long term complications</td>
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<tr>
<td>• Secondary prevention of disease</td>
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<tr>
<td>• Improved patient experience</td>
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<tr>
<td>• Reduction in emergency admissions.</td>
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<tr>
<td>• Improved clinical outcomes</td>
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<tr>
<td>• More productive use of skills and resources across the clinical pathway</td>
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<tr>
<td>• Reduce health inequalities</td>
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<tr>
<td>• Improved access to integrated sexual health services</td>
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<tr>
<td>• Focus on next stages of pathway redesign for diabetes, cardio-vascular disease and respiratory services</td>
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<tr>
<td>• Increase access to patient education</td>
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<tr>
<td>• Commission specialist multi-disciplinary community based services with a remit to support and develop skills in general practice</td>
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<tr>
<td>• Agree medicines management guidelines across pathway to optimise cost effectiveness</td>
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<tr>
<td>• Identify patients at an earlier stage of disease and get them into to treatment</td>
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<tr>
<td>• Identify undiagnosed patients from known risk factors</td>
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<tr>
<td>• Improve primary care detection and management of hypertension and raised cholesterol</td>
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<tr>
<td>• Review and re-commission support services for people with HIV</td>
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<tr>
<td>• Scope work to review in sickle cell anaemia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• To commission Clapham One, Akerma Road and</td>
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</tbody>
</table>
| Planned care – elective services | Improve effectiveness of elective care pathways | | Norwood Hall to provide a base for improved primary care
- Recommission GP practices and revise local PMS contracts
- Completing LSL sexual health need assessment and update LSL sexual health & HIV strategy based on recommendations including HIV as long term conditions
- Implement recommendations from the HIV care & support review
- *NB* cancer and cardiac and stroke commissioning priorities to be added to be advised by networks |

|  | • Lambeth as an area and local trusts have higher benchmarked outpatient and elective attendances at hospital
• Variation in numbers and quality of referrals between practices
• Variation in numbers of consultant to consultant referrals and outpatient follow ups
• Some scope for | • Reduced variation in numbers and quality of referrals (using outpatients attendances as a proxy)
• Reduced procedures of limited clinical effectiveness
• More cost effective spend on prescribing | • Scope potential for care pathway development for ENT, paediatrics, dental, ophthalmology and neurology
• Commissioning community based services for dermatology and gynaecology
• Review scope for tele-dermatology
• Agree and commission next stages of development for gastro-enterology
• Re-commission musculo-skeletal clinical assessment and treatment services
• Implement Area Prescribing |
| Mental Health | Improving health outcomes for people with mental health problems | reduction in procedures of limited clinical effectiveness  
- Evidence of opportunities for improving cost effectiveness of prescribing across care pathways | Committee across South East London  
- Review further scope for QIPP in acute drugs and devices  
- Review scope for enabling work and QIPP savings in diagnostic services  
- Re-commission services through Any Qualified provider |

Mental Health

Improving health outcomes for people with mental health problems

- High prevalence of mental illness
- High numbers of people experiencing specialist and acute mental health services
- Benchmarked high levels of spend per head of population
- Engagement with mental health service users and carers
- National dementia strategy

- Increased numbers of people supported by primary care and community based services
- More cost effective pathways
- Improved experience of service users and carers
- Reduction in acute beds
- Progress in implementing dementia strategy

- Implementation of the next stage of the Living Well Collaborative co-production approach and new service offers to people with long term mental illness in partnership with SLaM, social care, primary care and the third sector
- Support and develop self management through personalisation and peer support

- Decommissioning specialist mental health services
- Re-commissioning of talking therapies
- Review need for institutional care for people with dementia & implement alternative models
- Review admissions into long
<table>
<thead>
<tr>
<th>Unplanned care</th>
<th>Improve the cost effectiveness of care and move people into planned care</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Benchmarked high levels of emergency admissions and readmissions</td>
<td></td>
</tr>
<tr>
<td>• Poor patient experience</td>
<td></td>
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<tr>
<td>• Local trust 4 hour A&amp;E wait performance</td>
<td></td>
</tr>
<tr>
<td>• High levels of admission into long term care at an earlier stage</td>
<td></td>
</tr>
<tr>
<td>• High numbers of people dying in hospital</td>
<td></td>
</tr>
</tbody>
</table>

| • Reduction in emergency admissions and readmissions |
| • Increased numbers of people supported at home |
| • Trusts continuously meeting waiting times targets in A&E |
| • Reduced A&E attendances |
| • Increasing the number of people supported to die at home |

| • Review of implementation of pilot of Virtual Ward and commission extension if evidence of impact |
| • Develop single point of access for community based services |
| • Review implementation of population health management tool and recommission/extend if evidence of impact |
| • Develop community based long term conditions support (See planned care -LTCs) |
| • Review commissioning and provision of adult continuing care |
| • Work with Kings Health partners to improve admitted emergency pathways and further alternatives to admission based on emerging findings of integrated care pilot |
| • Re-commissioning end of life care based on the findings of the |
| Urgent care | Improve the cost effectiveness of care and move people into planned care | Benchmark high A&E attendances  
Complex network of services to support people at home or in the community | Reduced numbers of A&E attendances | Pilot PALS support in St Thomas and recommission if evidence of effectiveness  
Pilot diversion to primary care through access to local practices and recommission if prove effective  
Commission implementation of 111 model linked to developed single point of access to community based services  
Recommission urgent care centre at St Thomas’ and Kings  
Review provision of the GP walk in centre at Gracefield Gardens  
Commission urgent care centre at St George’s (led by SW London) |
11. Financial Case for Change and Delivery of Financial Balance

Current Financial Position
NHS Lambeth has a strong track record of financial delivery. In 2011/12, NHS Lambeth is projecting that we will deliver our planned 1% surplus. There are significant financial risks associated with this position which require close coordination and management for the remainder of the financial year.

The process of updating Financial Plans
Financial plans have been updated in line with NHS London guidance in respect of assumptions around PCT uplifts, tariff efficiency and other inflationary cost changes, required contingencies and surpluses.

Operating Framework guidance for 2012/13 was issued on 24th November 2011. This includes some further clarity on finance and business rules for 2012/13 with further guidance during December, particularly in relation to PCT uplifts and reductions and changes to national tariffs. While most of the guidance is consistent with planning guidelines used to inform the CSP, there may be some additional flexibility from confirmed PCT uplifts and tariff deflators. There is, however, also the additional financial pressure relating to the fact that CQUIN will be increased by 1% to 2.5%. Detailed financial plans for 2012/13 will need to be updated as finance rules are confirmed and negotiations with providers progress. We clearly therefore need to continue to review cost pressures, investments and the delivery of QIPP savings plans to address the level of financial challenge.

Aims of the NHS Lambeth 3 Year Financial Plans
The aim of the NHS Lambeth financial plan is to:

i. Ensure financial balance and stability through the effective management of available resources and financial risks to ensure statutory duties are met each year.

ii. Support the 2012/13 Operating Plan, Commissioning Strategy Plan and individual service strategies through the effective use of available resources on a one-off (invest to save) and recurrent basis and to support innovation in service redesign and health improvement.

iii. Secure value for money and efficiency through enhanced Quality, Innovation, Productivity and Prevention (QIPP) in our
The Financial case for Change

NHS Lambeth faces continuing growth in demand and cost of acute services, driven by population growth, demographic changes and the expansion of available health technologies. There is also an increased expectation of the quality and extent of health service delivery. At the same time the rate of increase of funding for the NHS has considerably slowed down to just above inflation. This means that the underlying rate of deficit will increase if no action is taken.

It is clear that the level of financial challenge facing the NHS over the next few years is unprecedented, especially when compared to the significant levels of financial growth enjoyed by the NHS over the last decade. A step change in how we approach the development and delivery of QIPP plans is therefore required to address the level of financial deficit in the “do-nothing” scenario.

The financial challenge facing NHS Lambeth is therefore to secure significant QIPP savings over the course of the next three years to provide the financial resource to support delivery of our vision and the supporting strategies. If no action is taken then the underlying financial positions will deteriorate, year on year resulting in a worsening in the current cumulative position from 2012/13 to 2014/15 and a deficit in 2014/15 for Lambeth PCT of £17.566m. In order to achieve the required 1% surplus in 2014/15, QIPP savings totalling £24.171m will need to be delivered over the three year period.

In order to achieve the 1% surplus in every year the required QIPP savings will need to be front loaded, with £11.974m of the savings requirement being in 2012/13 as set out below:

Table 1: The Financial Case for Change – NHS Lambeth

<table>
<thead>
<tr>
<th></th>
<th>£'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forecast Surplus/ (Deficit) 2011/12</td>
<td>6,605</td>
</tr>
<tr>
<td>QIPP savings requirement 2012/13</td>
<td>-11,974</td>
</tr>
</tbody>
</table>
The financial challenge in 2012/13 is the most challenging and delivery of QIPP savings and the overall delivery of planned surpluses in 2012/13 are crucial to the achieving financial balance over the medium term and also in ensuring a sound and sustainable financial legacy to Lambeth CCG.

It is important to note that the delivery of the required QIPP savings are not only across the acute/primary care interface but across all areas of commissioning spend including mental health, community and primary care contracts. As commissioning responsibilities are transferred across the new commissioning authorities, QIPP savings requirements will also need to be transferred.

**Summary Income and Expenditure Plan**

Financial Plans have been updated for each of the three years based on NHS London planning guidance and our local investment and QIPP savings plans.

The CSP as presented here reflects the financial framework submitted on 30th November 2011. The agreement of the 2012/13 Operating Plan and changes to the overall CSP financial plan will be incorporated into the refreshed Medium Term Financial Strategy (MTFS).
Table 2: CSP Summary Income & Expenditure 2012/13 – 2014/15

<table>
<thead>
<tr>
<th></th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£’000</td>
<td>£’000</td>
<td>£’000</td>
</tr>
<tr>
<td>Closing Recurrent Revenue Resource Limit</td>
<td>626,911</td>
<td>642,082</td>
<td>659,033</td>
</tr>
<tr>
<td>Income</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recurrent Uplift</td>
<td>13,375</td>
<td>15,171</td>
<td>16,951</td>
</tr>
<tr>
<td>Prior Year Surplus brought forward</td>
<td>6,605</td>
<td>7,000</td>
<td>7,000</td>
</tr>
<tr>
<td>Total Income Changes</td>
<td>19,980</td>
<td>22,171</td>
<td>23,951</td>
</tr>
<tr>
<td>Expenditure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full year effect of 2011/12 outturn</td>
<td>12,489</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Net Generic Uplifts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tariff and generic uplifts</td>
<td>14,179</td>
<td>14,476</td>
<td>14,802</td>
</tr>
<tr>
<td>Efficiency with Tariff</td>
<td>(20,262)</td>
<td>(20,671)</td>
<td>(21,054)</td>
</tr>
<tr>
<td>Net Tariff/ Generic Uplift</td>
<td>(6,083)</td>
<td>(6,196)</td>
<td>(6,252)</td>
</tr>
<tr>
<td>Demographic &amp; Non-Demographic Growth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>demographic Growth</td>
<td>3,156</td>
<td>3,195</td>
<td>3,246</td>
</tr>
<tr>
<td>Non-demographic growth</td>
<td>6,815</td>
<td>6,910</td>
<td>7,057</td>
</tr>
<tr>
<td>Total Demographic &amp; Non-Demographic Growth</td>
<td>9,970</td>
<td>10,105</td>
<td>10,303</td>
</tr>
<tr>
<td>Investment Proposals and cost pressures</td>
<td>8,577</td>
<td>18,824</td>
<td>17,535</td>
</tr>
<tr>
<td>QIPP Savings Initiatives</td>
<td>(11,974)</td>
<td>(7,562)</td>
<td>(4,635)</td>
</tr>
<tr>
<td>Change in Recurrent Expenditure</td>
<td>12,980</td>
<td>15,171</td>
<td>16,951</td>
</tr>
<tr>
<td>Surplus/ (Deficit)</td>
<td>7,000</td>
<td>7,000</td>
<td>7,000</td>
</tr>
<tr>
<td>Planned Surplus</td>
<td>7,000</td>
<td>7,000</td>
<td>7,000</td>
</tr>
<tr>
<td>Planned surplus as % of Recurrent RRL</td>
<td>1.1%</td>
<td>1.1%</td>
<td>1.1%</td>
</tr>
</tbody>
</table>

This is summarised in the ‘waterfall diagram’ below:

Table 3: Income and Expenditure 2012/13 – 2014/15 – Waterfall Diagram
The assumptions included in the CSP are set out below.

**Recurrent Uplifts, Tariff and Generic Uplifts, Demographic & Non-Demographic Growth and Primary Care Prescribing Uplifts**

*Table 4: NHS Lambeth Uplift Assumptions*

<table>
<thead>
<tr>
<th></th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recurrent uplift</td>
<td>2.18%</td>
<td>2.42%</td>
<td>2.64%</td>
</tr>
<tr>
<td>demographic Growth</td>
<td>0.51%</td>
<td>0.51%</td>
<td>0.50%</td>
</tr>
<tr>
<td>Non-demographic growth</td>
<td>1.10%</td>
<td>1.09%</td>
<td>1.09%</td>
</tr>
<tr>
<td>Total population &amp; incidence growth</td>
<td>1.61%</td>
<td>1.60%</td>
<td>1.59%</td>
</tr>
<tr>
<td>Prescribing growth</td>
<td>5.00%</td>
<td>5.00%</td>
<td>5.00%</td>
</tr>
<tr>
<td>Tariff/ Inflation Uplift</td>
<td>2.26%</td>
<td>2.27%</td>
<td>2.27%</td>
</tr>
<tr>
<td>Tariff efficiency assumption/ Price Efficiency applied</td>
<td>(3.24%)</td>
<td>(3.24%)</td>
<td>(3.22%)</td>
</tr>
</tbody>
</table>
Recurrent Uplifts
PCT Revenue Resource Limit (RRL) uplifts are in line with NHS London guidance. This sets uplifts at a national average allocated growth of 2.38% in 2012/13, 2.62% in 2013/14 and 2.84% in 2014/15. NHS Lambeth is currently over the weighted capitation targets so was funded 0.2% less uplift than average in 2011/12, so 0.2% less than average uplifts have been assumed going forward.
It should be noted that actual RRL uplifts for 2012/13 and beyond are not yet confirmed.

- **Tariff and Generic Uplifts**
  Tariff uplifts have been assumed at a net -1.5%, including a built in 4.0% efficiency assumption. This has been applied to acute, mental health and community expenditure.

- **Demographic & Non-Demographic Growth**
  Detailed work has been undertaken to review planning assumptions relating to demographic and non demographic acute growth for the CSP. This has been to ensure robust and realistic planning assumptions related to population and incidence factors, which take account of demographic growth estimates and historic acute demand trends. To do so the following process has been undertaken:

  - A review of population growth assumptions by borough (including GLA and ONS figures) for acute services.
  - A review of historic demand trends by borough for acute services, with supporting trend analysis completed for the following key areas of acute activity – outpatients, elective, A&E attendances, and emergency admissions, maternity and other.
  - The development of proposed demographic and non demographic growth assumptions by admission method.
  - The testing of assumptions with CCGs and CSP leads, to confirm proposed planning assumptions.

This process has resulted in a consensus agreement, supported by robust analytics, on the demographic and non demographic assumptions to be utilised for the CSP.
• **Brought Forward Surpluses**  
  Forecast surpluses for 2011/12 have been assumed to be carried forward into 2012/13. This assumption has also been made for future years.

• **Full Year effect of 2011/12 outturn**  
  The full year recurrent impact of 2011/12 forecast outturn expenditure has been included within 2012/13 expenditure plans, including the costs of reinstating PCT contingencies at 0.5% of recurrent resource limits.

• **Investment Proposals and Cost Pressures**  
  Investments and cost pressures have been included in the financial plan for all years. While detailed expenditure plans are in place for 2012/13, these remain draft pending the release of all detailed planning guidance for 2012/13 and also while detailed implementation plans are put in place for the delivery of QIPP savings initiatives.

• **QIPP Savings Initiatives**  
  We have reviewed our existing detailed QIPP savings plans in conjunction with the Cluster teams. New QIPP schemes have been initiated and included in financial plans. In total QIPP savings schemes across 2012/13 – 2014/15 total £34.836m, however schemes have been RAG rated to deliver savings of £24.171m and it is this total that is assumed to be delivered within financial plans.

  A summary of QIPP initiatives and their impact by programme over 2012/13 to 2014/15 is set out below:

  *Table 5: QIPP Savings by Programme 2012/13 – 2014/15*
### QIPP Programme

<table>
<thead>
<tr>
<th>QIPP Programme</th>
<th>2012/13 Planned Savings (£000s)</th>
<th>2013/14 Planned Savings (£000s)</th>
<th>2014/15 Planned Savings (£000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Care</td>
<td>5,234</td>
<td>2,273</td>
<td>2,273</td>
</tr>
<tr>
<td>Unplanned Care</td>
<td>1,966</td>
<td>2,936</td>
<td>2,593</td>
</tr>
<tr>
<td>Mental Health</td>
<td>3,826</td>
<td>3,857</td>
<td>1,500</td>
</tr>
<tr>
<td>Community</td>
<td>1,750</td>
<td>1,250</td>
<td>100</td>
</tr>
<tr>
<td>Primary Care</td>
<td>3,727</td>
<td>250</td>
<td>220</td>
</tr>
<tr>
<td>Other</td>
<td>1,081</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>17,584</strong></td>
<td><strong>10,566</strong></td>
<td><strong>6,686</strong></td>
</tr>
<tr>
<td><strong>Risk Assessment</strong></td>
<td>(5,611)</td>
<td>(3,004)</td>
<td>(2,051)</td>
</tr>
<tr>
<td><strong>Total after Risk Assessment</strong></td>
<td><strong>11,974</strong></td>
<td><strong>7,562</strong></td>
<td><strong>4,635</strong></td>
</tr>
</tbody>
</table>

- **2% Non-Recipient Investment Funds**

Plans assume and include use of the 2% Non-Recipient Investment funds in full as an enabler for QIPP delivery and to effectively manage the transition to the new commissioning environment. These will build on schemes undertaken during 2011/12 to accelerate of reduce slippage in these areas.

### Ensuring Financial Delivery

Financial balance and the delivery of our planned financial position is a core priority and a statutory requirement for NHS Lambeth. Clinical Commissioning Groups (CCGs) play a vital leadership role in this.

The financial position is reviewed regularly by the CCG, the NHS SE London Joint PCT Board and the Joint Integrated Governance Committee. Joint Cluster and NHS Lambeth stocktake meetings provide executive assurance of financial and service performance including QIPP delivery, and review progress against the achievement of full authorisation. Internal and external audit review the PCT’s financial management, reporting and controls. Further external assurance is also put in place where this is needed.

The achievement of in-year and underlying financial balance is supported by the delivery of Recovery Plans. These plans are kept under CCG review as part of the agreed overall financial reporting arrangements. Savings proposals are developed through a process of budget challenge across all areas of activity.
Lambeth CCG is developing and implementing its Organisational Development plan based on the NHS London Roadmap which is recognised by the Department of Health as a means of achieving full authorization as a CCG. The Roadmap’s eight domains include finance and governance and development programmes are being implemented to strengthen the CCG’s skills in these areas.

It is recognised that there is risk attached to the significant programme of organisational change arising from the implementation of the Health Bill. The emerging structures including the delegation of budgets to the CCG bring changes in governance arrangements, responsibilities of individual staff members, different reporting lines and potential changes in personnel with the risk of loss of organisational memory. This is however mitigated in part by the continuity of the NHS Lambeth workforce in particular. The NHS Lambeth Finance team continues to work closely with Cluster Directors and Finance staff to minimise risk and ensure that changes to the budgetary framework and governance arrangements are embedded including:

i. Refreshed overall scheme of delegation for CCG
ii. Refreshed budgetary delegation to budget holders
iii. Refreshed authorised signatory lists
iv. Enhanced reporting arrangements
v. Budget holder guidance and training.
vi. Robust handover arrangements.

The Cluster finance team is actively pursuing debtor management to recover all income owing to the PCT. Processes are in place to ensure that creditors are paid efficiently and on time so that the Better Payment Practice Code (BPPC) can be met and outstanding creditor balances are, wherever possible, minimised. This involves regular reporting of outstanding invoices supported by staff training in the use of electronic workflow systems.

12. Enabling strategies

We are reviewing the following areas to support the development and implementation of our key priorities:

Clinical leadership and network

A key component of our bid to become a pathfinder Clinical Commissioning Group is the development of our Clinical Network. This is formed from commissioning clinicians and providers leading on service redesign and transformation work. This will include GPs, Practice Nurses and the wider primary care team including community pharmacists, dentists and opticians. As part of the development programme for clinical commissioning we are reviewing skills and expertise of GPs and practice staff including Practice
Managers at practice, locality and Clinical Board level.

We are working on education and development of the primary care workforce through the pathway redesign work on long terms conditions and mental health. Examples have included the development of ‘virtual clinics’ for diabetes and promoting the ‘co-creating’ philosophy for long term conditions services working with patients to promote a collaborative approach to consultations.

A pilot programme to support acute nurses to convert to practice nursing has been developed by the South East Cluster of PCTs, subject to further evaluation.

**Patients, carers and public engagement**
The LCCCB is keen to using the skills, knowledge and expertise of patients, carers and the public to guide the change and development of services. We will further develop co-production methodologies to ensure that patients and clinicians work effectively together. This will learn from Lambeth Living Well Collaborative in mental health and developments in diabetes care. We will work with patients, carers and the public to support them to better manage and maintain their own health. We are committed to explaining to the public about the changes in the health service and extending choice of healthcare provision. Each programme of work has its own patient engagement plan reviewed as part of the reporting of the programme. As part of our measurement of quality of services we have a number of methods for identifying patient experience. Our contracts for commissioned services include patient experience measures. We utilise national survey information such as the national NHS survey programme and GP patient survey to identify local issues for services. We review patient views submitted to websites such as NHS Choices and Patient Opinion. We discuss and review complaints, compliments and feedback from patient advice and liaison services, we review and look at lessons learned from serious incidents and LINk and CQC inspection reports and feedback. We currently report public and patient engagement activity on an annual basis but it forms a thread through all our commissioning activities.

Our specific priorities are:

**Planned care**
- Developing co-production across long terms conditions starting with diabetes through the Diabetes Modernisation Initiative
- Patient experience evaluation of new services put in place
- Engagement with sickle cell anaemia patients and their carers
- Reviewing patient and carer experience of paediatric outpatient services
• Patient involvement in the procurement of musculo-skeletal clinical assessment and treatment services
• HIV testing user engagement
• HIV as a long term condition
• User engagement in re-procurement of services

Unplanned care
• Working as part of the Integrated Care Programme to identify patient experience of services for frail older people
• Patient and carer experience of new services being put in place
• Patient involvement in the procurement of the urgent care centres at st Thomas’ and King’s
• Patient experience of patient advice and liaison service and diversion schemes from St Thomas’
• Working with frequent A&E attenders to identify how to support people into prevention and early support services

Mental Health
• Development of co-production/culture change across the whole service delivery system with users, carers, providers and clinicians
• Development of the collaborative co-production commissioning framework
• Involving service users and carers in the redesign of services for older adults

Staying Healthy
• Public engagement infrastructure for wellbeing and happiness programme
• Improving co-production of wellbeing and happiness programme
• User experience evaluation of childhood healthy weight programme

Infrastructure

Premises
In 2004/5 as part of our Strategic Services Development Plan we published our proposals for a pattern of Neighbourhood Resource Centres (NRCs) based on local geographies and covering the whole borough. We proposed NRCs to be the heart of local services networks bringing together into closer integration GP and other family health services, community health services, council services (including social care) and mental health and acute services where possible.

NHS Lambeth has continued to follow this neighbourhood strategy to support the development of improving primary care and enabling shift
of resource and services from acute to primary and community health services. In 2009 we opened Gracefield Gardens in Streatham a purpose built centre encompassing primary, community and acute health services and partnership with London Borough of Lambeth. In 2011 we secured financial close for the development of Akerman Road in Brixton due to open August 2012. Our Clapham One development in partnership with LBL opened March 2012. We are have received approval for exciting new development in Norwood to the south east of Lambeth which will see health services as part of a campus incorporating leisure services and a primary school. This is due to open in 2013.

We will continue to work with Kings and Guys’ & St Thomas to develop the future use of the St Thomas’ and Kings sites. This first phase will be re-commissioning of urgent care centres which will form part of A&E configuration on both sites.

**Information management and technology**

NHS Lambeth, NHS Southwark and NHS Bromley are working with United Health on the implementation of the Population Health Management and Clinical Checking Tool. This draws information from the acute Secondary User Services and primary care to risk stratify the population and identify those at risk of admission to hospital and support better case management in primary and community services. This tool also enables practices to check coding and raise queries with acute trusts on activity reporting.

We are developing a case for the roll out of EMIS Web to GP practices to improve usage of primary care systems, this will also enable more comprehensive data extracting to support research and performance management of general practice.

Over the period of the CSP we will be driving and promoting the use of Choose and Book to support better real time information on referrals and to support patient choice of hospital treatment and use of alternatives to hospital. We are working with practices to benchmark activity information within localities, across Lambeth and compared with London. As part of our current development programme we will be working with United Health and KPMG partners to improve use of information to support change in practise.

We have developed the usage of ADASTRA in emergency care through GP out of hours services and will be reviewing It systems and information across urgent care services. As 111 develops we will be looking at appropriate systems to support single point of access to services.

We have rolled out the community RiO system across Lambeth and Southwark and are currently planning to upgrade the systems in partnership
with GSTT. This will support the implementation of patients based data for community services, improving data down to practice level. It will also enable us to develop the PHMCC system to include data from community services refining the risk stratification process.

In partnership with South Bank University we have developed the DataNet system which enables GPs to review and collate clinical data and compare with peers in Lambeth. This has supported public health research and health inequalities work at practice level. We are seeking to further develop this tool across Lambeth.

Lambeth is part of wider local and regional clinical networks, particularly Cardiac & Stroke and Cancer. The networks are working on key outcome measures across the health system which we will incorporate into contract and monitor as part of our performance management frameworks. At local level we are developing pathway based information and finance on our key priority areas of long terms conditions and elective care.

In partnership with South London and the Maudsley we are launching a programme to give mental health service users secure access to their care records.

As part of work with the Integrated Care Pilot we are looking at options for shared patient care records across primary and secondary care, reviewing systems in place elsewhere in the country and internationally. Another project workstream within the ICP is telecare and telehealth looking at the opportunities for improving productivity through better use of patient monitoring. This project is being undertaken jointly with London Boroughs of Lambeth & Southwark.

Organisational development
The LCCCB will have delegated responsibility for all eligible commissioning budgets from 1st April 2012. A locality structure has been established which supports the decision making of the Board and the engagement of constituent practices through a range of activities, meetings, practice visits and communications. The LCCCB have agreed an Organisational Development programme which will take the Board, and constituent practices, through to CCG authorisation during 2012/13 utilising London- wide and national development and learning resources. Lambeth will work with partners in the South East London Cluster to ensure there is the capacity and capability to commissioning a full range of healthcare services in line with the strategic priorities.

Partnership
We currently work as part of the South East London Cluster of PCTs sharing
good practice, expertise and support services across the area. We have identified a range of key partners with whom we have developed strong and supportive relationships, building on those effective and strengthening partnerships that already exist in Lambeth. These are crucial to the deliver of the CSP.

**Commissioning Partners**

The development of commissioning will increasingly be a collaborative approach with:

- London Borough of Lambeth, through a shared Integrated Commissioning Team for specific commissioned services including mental health and substance misuse, learning disability, adults with physical disabilities, older adults, carers and children services
- Other Clinical Commissioners; including Southwark through our joint Planned and Unplanned Care programmes and more widely across the SE London Cluster and Wandsworth for services at St George’s and in the south west of Lambeth. We have further partnerships in place to commission community services and mental health services across Lambeth, Southwark and Lewisham (and Croydon for mental health)
- South London and South East London Clinical Networks through shared acute contract management and certain commissioning support functions.

**Health and Wellbeing (and Lambeth First)**

Lambeth has been designated as an Early Implementer Health and Wellbeing site and with local partners we have the H&WBB has held a series of workshops, facilitated by the Kings Fund, to discuss the priority areas for joint working. LCCCB members are taking a leading and very active role in the development of our health and wellbeing arrangements in Lambeth. The Health & Wellbeing Board H&WBB will develop the Joint Strategic Needs Assessment (JSNA), a borough-wide Health and Wellbeing Strategy and for overseeing health improvement in our local community. All partners are committed to ensuring that the work of the Board has practical benefits for the people who live in Lambeth. Two further areas of importance have been identified as enhancing the involvement of our communities and the role of Public Health.

**Integrated Care Programme**

The Integrated Care Programme is a designed to deliver sustainable integrated health and social care services to people in Lambeth and Southwark. This will involve the redesign of services and the system and will redefine the way professionals engage with each other. It will fundamentally change the way in which people are supported in taking charge of their own care and conditions.
It is a partnership of NHS Lambeth, NHS Southwark, London Boroughs of Lambeth and Southwark, Kings Health Partners Academic Health Sciences Centre and GP practices.

The programme’s initial focus will be on care of older people, broadening its scope systematically during the course of three years (2012-15). From its third year onwards the initial changes made to the systems and to services for older people will become self financing and the transformation seen will mean that every year in Lambeth & Southwark:

- 15,900 unnecessary bed days currently spent in hospital are avoided for older people ((a reduction of 14%)
- 118 older people are supported in a way that means they do not have to go into care homes (18% fewer care home packages)
- Savings of £13.9m per annum are released across the system.

This will be achieved by integrating care and re-incentivising the system – driving up the quality and doing so at lower cost, improving the value of care we provide to people in Lambeth & Southwark by:

- Joining up care around people, across providers
- Identifying and managing people’s care needs better and intervening earlier
- Ensuring care is provided in the most appropriate setting, particularly at times of acute crisis

The system will be led by a Federation of health and social care providers with an overarching Integrated Board Structure, working in partnership with commissioners and responsible for the shared delivery of care along agreed pathways.

The process of service change will be evolutionary – during 2011/12 we have established programme structures and plans and commissioned new admissions avoidance schemes such as the Virtual Ward, community based Rapid Response, enhanced Reablement services. During 2012/13 we will be developing risk registers and reporting in GP practices, holistic health assessment (including mental health) and case management for older people through GP practices, urgent access ‘hot’ geriatric outpatient clinics for rapid diagnosis of older people.

We succeeded in securing significant resources from Guy’s & St Thomas’ Charity to pump prime the programme, but are also working together on use of emergency admissions and readmissions funding, community care and mental health contract resources and primary care. In particular we are seeking the charity’s support to deliver information technology that would allow a sophisticated single view of real time information related to the care of individuals and take the findings of the department of Health’s whole systems demonstrator pilots of telehealth and telecare and deliver them at scale.
• Care provider partners
The QIPP challenge we face will only be achieved through close and collaborative working with the organisations that deliver care to people in Lambeth.
• King’s Health Partners (KHP) – we are actively engaged with King’s Health Partners and its member bodies Guy’s & St Thomas’ Foundation Trust, King’s College Hospital Foundation Trusts and South London & the Maudsley Foundation Trust at a range of different levels:
  - LCCCB members as members of the three FTs Members Councils
  - working together on system redesign, in particular through the Integrated Care Pilot co-chaired by the LCCCB Chair and South London and Maudsley (SLAM) Chief Executive
  - working through programmes of pathway redesign in mental health, planned and unplanned care and in public health
  - engagement with Clinical Academic Groups and across the KHP leadership
  - driving up quality in secondary care through programme of quality review
  - The Director of Clinical Strategy for KHP sits on the LCCCB Board.
• Statutory bodies representing primary care - We are seeking to maintain and improve engagement with the statutory practitioners committees representing all areas of primary care. The Local Medical Committee (LMC) is represented at our Board meetings and LCCCB members attend LMC meetings. We have good links and communications to the other practitioner committees, in particular the Local Pharmaceutical Committee. We will work with the primary care contracting team now at SEL cluster and in the future as part of the National Commissioning Board to ensure we are clear and aligned approaches to commissioning primary care.

Patient and Public and Voluntary Sector Partnerships
Lambeth Local Involvement Network (LINk) (and HealthWatch in the future) – We are developing a close and positive working relationship with the LINk, including attending LINk meetings and having a LINk representative on the LCCCB. We are keen to support the process of transition into HealthWatch locally.
• Voluntary sector partners – we see voluntary sector organisations as key local providers of care and important patient advocates. We will work with the emerging representative structures for the voluntary sector in Lambeth as well as engaging voluntary sector organizations in pathway work such as the Lambeth Living Well Collaborative and the Integrated Care Programme.
• Guy’s & St Thomas’ Charity – The charity provides considerable local support in fostering innovation and partnership working across Lambeth and
Southwark. We are keen to maintain our close working relationship to make the best use of this fantastic local resource for the people of Lambeth.

**To find out more**

To find out more about the health of Lambeth people and commissioning in Lambeth visit our website
www.selondon.nhs.uk/your_local_nhs/lambeth

For information on Lambeth Clinical Commissioning Network visit
www.lpbcc.wordpress.com/lambeth-clinical-network

We welcome comments on all aspects of our work. In conjunction with our Health & Wellbeing Board partners we will be refreshing our CSP and developing our Health & Wellbeing Strategy over 2012/13. We welcome your views
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