



**NHS LEWISHAM CLINICAL COMMISSIONING GROUP
COMMISSIONING STRATEGY 2013-18**

**A LOCAL HEALTH PLAN
FOR LEWISHAM**

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Originator/Author	Head of Strategy & Organisational Development
Responsible Committee	Strategy & Development

INTRODUCTION

NHS Lewisham Clinical Commissioning Group was established on 1 April 2013 and is responsible for commissioning (planning, buying and monitoring) the majority of health services in Lewisham. We are a membership organisation made up of all the GP practices in Lewisham.

This is our five year commissioning strategy for 2014/15 to 2018/19. It is a framework for how we will work over the next five years and has been developed in the context of national requirements to improve health outcomes, significant service and financial challenges facing the NHS and the rising expectations of patients and the public. As a new organisation, clinically led and formed from the membership of all our GP practices it sets out our commitment to the people of Lewisham.

The strategy sets out our purpose, vision, our understanding of the health needs of Lewisham residents and our ambitious plans to improve their health and wellbeing. It explains how we will use our available resources to ensure they receive high quality, safe health services which are good value for money.

The strategy will shape our commissioning priorities and service improvement plans; help us develop our commissioning intentions and annual operating plans over the next five years. It is informed by the experiences and views of our patients and the public, the Lewisham Joint Strategic Needs Assessment and the Lewisham Health and Wellbeing Strategy.

We have a good record of partnership working and the strong relationships with the local authority, health care providers, Healthwatch Lewisham, and voluntary and community organisations will continue to be critical to our success as we deliver these plans.

We will focus on local transformational plans to enable us to develop a sustainable local health service which meets local health needs and which will help us deliver our vision for the best health and best care for Lewisham residents

Dr Marc Rowland



CCG Chair

Martin Wilkinson



Chief Officer

WHO WE ARE

Lewisham CCG took over full responsibility for planning and buying most of the healthcare services for Lewisham residents on 1st April 2013. These services include:

- Hospital care
- Rehabilitation care
- Urgent and emergency care
- Most community health services
- Mental health and learning disability services

Primary care services such as GPs, pharmacists, dentists and opticians and some other specialist services are commissioned by NHS England¹.

Our aim is to secure the best possible health and care services for Lewisham residents in order to reduce health inequalities and improve health outcomes. We will do this by using findings about the health needs of our population² to identify priorities and to make plans for how healthcare can be provided. We have contracts with a range of health service providers that includes NHS and private hospitals and voluntary sector organisations. We monitor how well the services are being delivered to ensure that they are meeting the needs of our patients, that they are safe and of high quality, and that they are providing value for money.

We are overseen by NHS England which makes sure that we have the capacity and capability to commission services successfully and to meet our financial responsibilities.

As a membership organisation, our GP member practices work closely in local or neighbourhood groupings, to discuss common problems that are arising, and to see how local services can be improved and co-ordinated better.

¹ Visit www.england.nhs.uk for more information

² JSNA <http://www.lewishamsna.org.uk/>

GP Practices in Lewisham

● Neighbourhood 1 Practices

- 1 Mornington
- 2 Queens Road
- 3 Kingfisher MC
- 4 Clifton Rise
- 5 New Cross Health Centre
- 6 Grove Medical Centre
- 7 Vesta Road
- 8 Amersham Vale Training Practice
- 9 Deptford Surgery
- 10 Dr Batra Surgery
- 11 Deptford Medical Centre

● Neighbourhood 2 Practices

- 12 Belmont Hill
- 13 Lewisham Medical Centre
- 14 Lee Health Centre
- 15 Morden Hill
- 16 St Johns Medical Centre
- 17 Lee Road
- 18 Brockley Road
- 19 Hilly Fields Medical Centre
- 20 Honor Oak
- 21 Triangle
- 22 Rushey Green
- 23 Woodlands Health Centre
- 24 Nightingale
- 25 Hurley Group Practice

● Neighbourhood 3 Practices

- 26 South Lewisham
- 27 Torridon Road
- 28 Baring Road
- 29 ICO Moorside Clinic
- 30 Downham Family Practice
- 31 Winlaton
- 32 ICO Chinbrook
- 33 Parkview
- 34 ICO Marvels Lane Health Centre
- 35 Muirkirk Road
- 36 ICO Boundfield Road Medical Centre
- 37 Oakview

● Neighbourhood 4 Practices

- 38 Jenner
- 39 Sydenham Green
- 40 Woolstone Medical Centre
- 41 Sydenham Surgery
- 42 Wells Park
- 43 Bellingham Green
- 44 Vale Medical Centre



The GPs in Lewisham have elected seven representatives, including the CCG Chair Dr Marc Rowland, to lead clinical commissioning in Lewisham. As well as spending time

on commissioning, these GPs are still practising clinicians and they work closely with other doctors to share information about the services that people need.

They are members of the CCG's Governing Body, along with two lay members, a nurse and a hospital doctor as well as two senior managers (the CCG's Chief Officer and Finance Director). The Governing Body has responsibility for agreeing commissioning plans, ensuring public funds are spent correctly and for assuring the quality and safety of services the CCG commissions.

1.1 Partnership Working

We work in partnership with other commissioners to meet our goals and to ensure efficient and effective working.

1.1.1 Lewisham Health & Wellbeing Board

The Health & Wellbeing Board is a statutory committee of the London Borough of Lewisham (LBL). Its functions include encouraging integrated working to advance health and wellbeing of the area, and to prepare a joint strategic needs assessment (JSNA) so that the Council and CCG can develop strategies to meet identified needs. The CCG Chair is a member and vice chair of the Health and Wellbeing Board.

1.1.2 Borough Joint Commissioning

The CCG works closely with Lewisham council to jointly commission services for children and young people, learning disability, mental health, physical disabilities and emerging client groups, and older adults services. The unit also includes a team for commissioning, contracting and brokerage for the borough. These arrangements have been established under Section 75 agreements. All of these joint commissioning arrangements sit within the management structures of LBL. The LBL Executive Director of Community Services is a co-opted advisory member of our Governing Body.

1.1.3 Public Health

Lewisham Public Health functions and staff transferred to LBL in April 2013. The CCG's strong working relationship with Public Health has continued with the Director of Public Health also a co-opted advisory member of our Governing Body.

1.1.4 South East London Clinical Commissioning Groups

The six CCGs in South-East London, Lewisham, Lambeth, Southwark, Greenwich, Bexley and Bromley, have established collaborative arrangements to meet their shared and interdependent commissioning responsibilities. These arrangements include lead commissioning arrangements, joint clinical strategy committees, and programme boards

to support implementation of the Trust Special Administrator (TSA) recommendations for the South London Healthcare Trust (SLHT) and Community Based Care (CBC) strategy. These arrangements are supported by a South East London CCG Programme Management Office hosted by Southwark CCG.

2. OUR VISION – BETTER HEALTH, BEST CARE, BEST VALUE

This section describes the difference we aim to make through commissioning to meet the challenges we describe in section 3.

Our mission is visually represented as:



Working together with Lewisham people is at the centre of everything we do.

2.1 OUR AMBITION

Better Health - the Five Year Vision

To reduce the gap in key health outcomes between Lewisham and England by 10% over the five year period

We will determine our success in improving the health of Lewisham people through measures of life expectancy, rates of premature mortality from the three biggest causes of death in Lewisham (cancer, respiratory diseases and cardiovascular disease), infant mortality, patient experience and end of life care.

Using National Health & Social Care Information Centre data, Lewisham Public Health have identified target levels for these key measures through which we will monitor progress towards achieving our vision.

Outcomes	Measures	Current Level	Target 2018
Life Expectancy	Potential years of life lost from causes amenable to healthcare	Females 2110.5 Males 2415.3	Females 2091.1 Males 2409.0
	Life expectancy at birth	Females 81.3 Males 76.7	Females 83.8 Males 79.8
	Disability free life expectancy at age 65	Females 9.01 Males 8.99	Females 9.20 Males 9.11
Causes of death	Under 75 mortality rate from cancer	125.4 deaths per 100,000	104 deaths per 100,000
	Under 75 mortality rate from cardiovascular disease	84.8 deaths per 100,000	54 deaths per 100,000
	Under 75 mortality rate from respiratory disease (bronchitis, emphysema and other COPD)	36.4 deaths per 100,000	31.5 deaths per 100,000
Infant mortality	Neonatal mortality	3.6 per 1000	<i>To be confirmed</i>
	Stillbirths	6.1 per 1000	<i>To be confirmed</i>
Patient experience	People feeling supported to manage their condition	Not yet available ³	Not yet available
End of life care	Proportion who die hospital	58.3%	55.1%
	Proportion who die at home ⁴	20.4%	23.1%

³ This measure is not yet available from the Health & Social Care Information Centre

⁴ Proxy measures pending development of a single measure for preferred place of death

Best Care – the Commissioning Vision

High quality care for everyone

We will determine our success by commissioning services differently, in partnership with other commissioners, to deliver high quality support and care which is:

- Proactive and planned, with a focus on early detection, diagnosis and intervention
- Patient centred, personalised to the individual's preferences and choices and considers the whole person rather than specific health conditions
- Empowering to the individual to be confident in their management and decision making about their own care, as far as they want and are able to
- Developing local neighbourhoods and communities to help people and communities to manage their health and wellbeing by finding local solutions:

Best Value – the Financial Vision

To commissioning more effectively with the most efficient use of resources

We will measure our success by operating within our commissioning budget and demonstrating that we have used the budget effectively, delivering value for money.

The Quality, Innovation, Productivity and Prevention (QIPP) programme is the national initiative that aims to make the NHS work more efficiently so that there are more funds available for treating patients. Delivering a successful QIPP programme in Lewisham will be crucial to ensuring we are using our resources in the most efficient way to enable us to meet our vision for better health and best care.

3. COMMISSIONING DIFFERENTLY – ‘THE CASE FOR CHANGE’

This section explains why we need to work differently with you: the public, other commissioners and providers of care. The challenges outlined provide the ‘case for change’: why we need a new strategic vision to improve the way we commission services. No change will not deliver our vision for better health, best care and best value.

3.1 THE HEALTH NEEDS OF LEWISHAM’S POPULATION

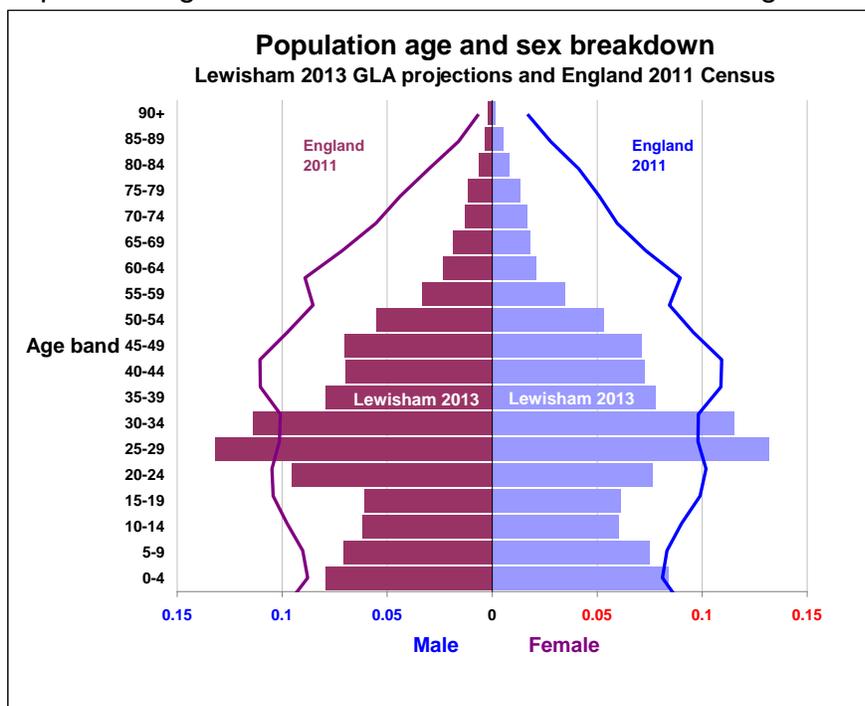
In order to obtain information on the health and wellbeing of the people of Lewisham, we have referred to Lewisham’s Joint Strategic Needs Assessment (JSNA) (<http://www.lewishamjsna.org.uk/>) The JSNA brings together in one place a wealth of information on the health and social care needs of Lewisham’s citizens, complemented by information on the social, environmental and population trends that are likely to impact on people’s health and well-being. The JSNA also includes the community and patient view on local health and social care services.

3.1.1 Population Profile

- **Demography**

The Census in 2011 reported the actual population in Lewisham was 275,900. In 2013 it is estimated to be 284,325. Lewisham has a young population - 25.4% of the population of Lewisham is under the age of twenty.

Population age and sex breakdown Lewisham and England



Source: Census 2011

- **Living alone**

In 2011 census Lewisham had a higher proportion of one person households 34% compared to 30% in England. Nearly nine percent of one person household are aged 65 and over.

- **Lone parent household**

In 2011 Lewisham had a higher proportion of lone parent household (11%) compared to London (9%) and England (7%).

- **The projected population for Lewisham**

Over the next 15 years 2013 -2028 it is estimated that the total population will rise by 13%. The greatest percentage increase will be in those aged 65 and over.

There has been a sustained rise in the birth rate in Lewisham for several years, reflecting a similar rise in London and the country as a whole. Much of the rise in births has been in births to mothers who were not born in the UK, the Commonwealth or the EU. Over 50% of all births in Lewisham now occur to women from minority groups.

Lewisham population projected counts by broad age band

Age band	2013	2018	2023	2028	% Change (2013-2028)
0 to 4	22388	23341	23048	22887	2.2%
5 to 19	48795	50606	53780	55418	13.6%
20 to 64	186334	198192	203616	208041	11.6%
65 to 90+	26808	27482	29878	34288	27.9%
Total	284325	299621	310321	320635	12.8%

Source: GLA Population Projections 2012 Round, SHLAA, Borough SYA

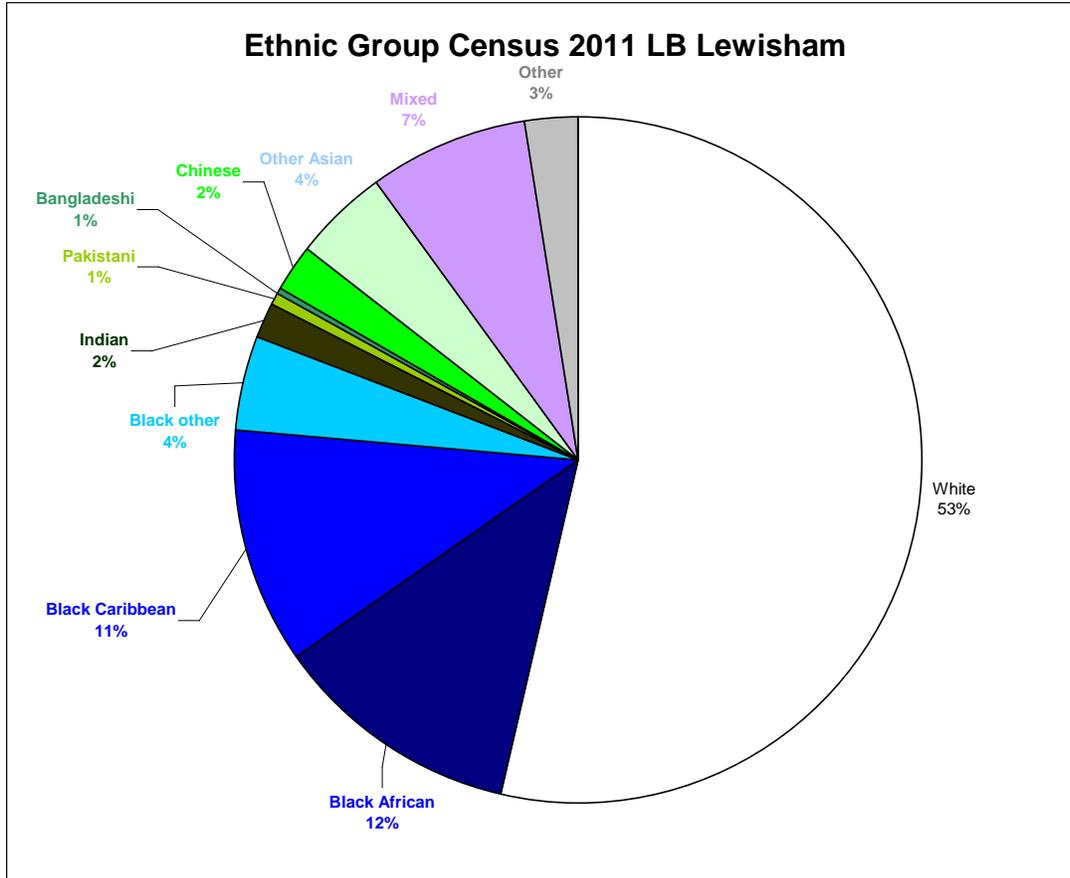
Though the birth rate in Lewisham is expected to plateau and decline towards the latter half of this decade, the population of children, in particular those aged 5 to 14 will continue to rise for the foreseeable future because of the previous rise in births.

In Lewisham the number of residents aged over 65years has been stable or even falling slightly over the last decade, despite an overall growth in the population between 2001 and 2011 of about 11%. However population projections suggest that from about 2015 the number of Lewisham residents over 65 years old will begin to rise. This projected growth is not simply as a result of overall population growth as the proportion of over 65s in the population is also expected to increase. In Lewisham as a whole the proportion of over 65s in the population in 2013 was 9% and is expected to be 11% by 2028. This is because the population is living longer. Nationally the chance of surviving from birth to the age of 85 has more than doubled for men over the last thirty years, from 14% in 1980-1982 to 38% in 2009-11. In Lewisham the life expectancy at birth was 76.7 years for women and 72.3 years for men in 1991-93; in 2008-10 it had increased to 81.3 years and 78.8 years respectively. Similarly life expectancy aged 65 years was 15 years for men and 16.6 years for women in 2000-2002 and increased to 18.4 years and 19.9 years respectively in 2008-10.

- **Ethnicity**

Lewisham is a very ethnically diverse borough, 46.5 % of the population are from Black and Minority Groups (BAME) compared to 40.2% London and 12.5% in England. In 2011 the two largest BAME group were Black African (12%) and Black Caribbean (11%). In the school population the proportion from BAME rises to 77% and over 170 different languages are spoken.

Census 2011 Ethnic Group Breakdown



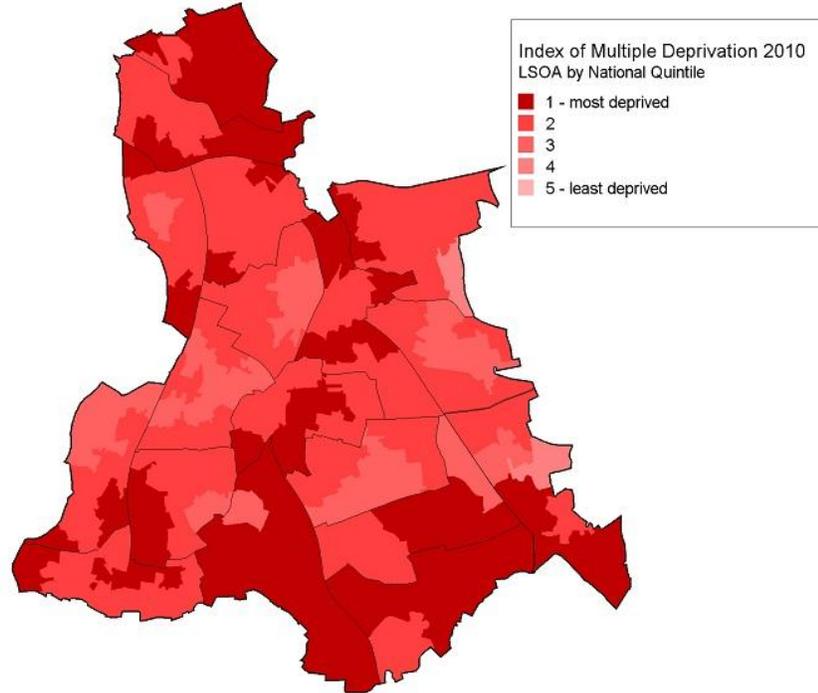
The rates of growth in various ethnic groups means that by 2028 the proportion of population from each group will have changed. This change is most significant in the over 65 age group, where the White population will reduce from 71% in 2013 to 53% in 2028. There is also a projected decline in the proportion of the population from the Black Caribbean group.

- **Deprivation**

Deprivation has increased in Lewisham. The 2010 Index of multiple deprivation (IMD) ranked Lewisham 31st out of the 354 local authorities in England compared to a rank of 39 in 2007. Relative to the rest of the country Lewisham is becoming more deprived.

Evelyn ward in the North of Lewisham is the most deprived ward followed by Bellingham, Downham and Whitefoot (5th) in the South of the borough. Rushey Green in the centre of Lewisham borough ranks as the 4th most deprived borough.

Map of IMD by quintile across Lewisham

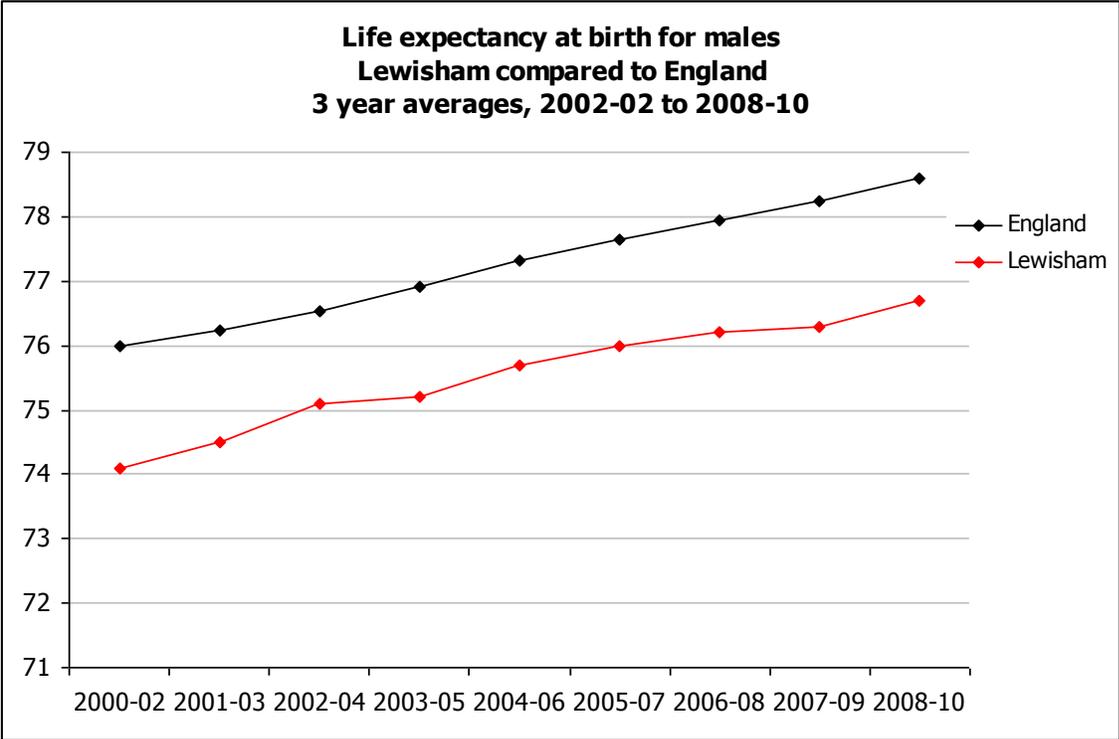


3.1.2 Life Expectancy & Mortality

- **Life Expectancy**

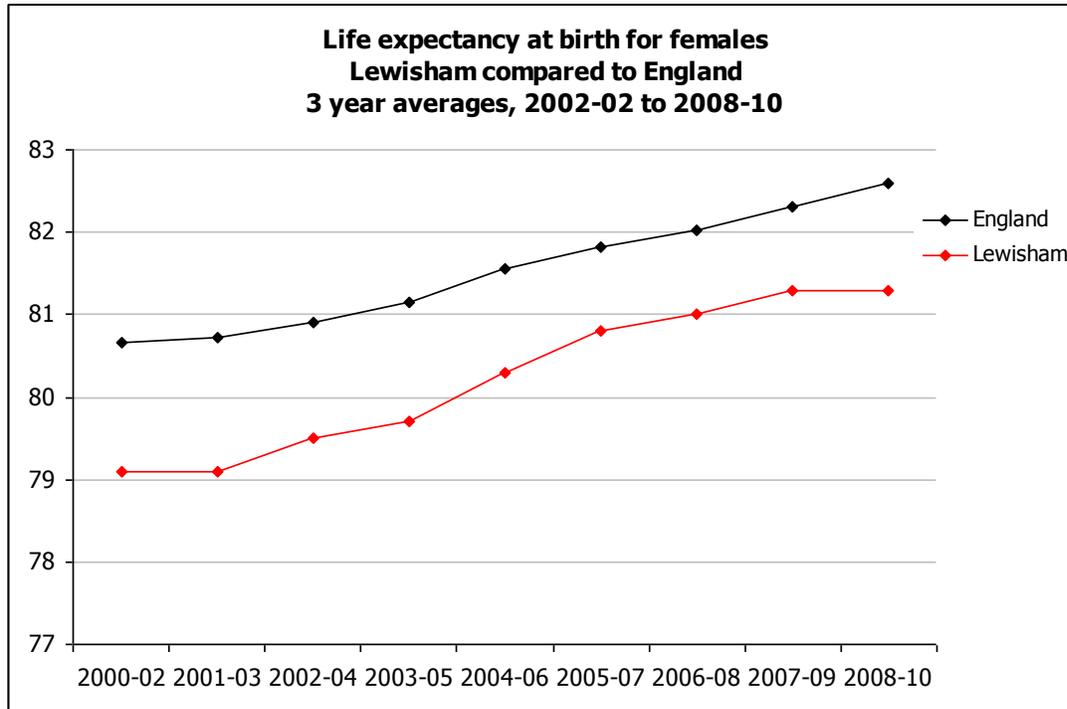
For males, life expectancy rose 2.6 years in England and 2.5 years in Lewisham in this ten year period. However there is a two year difference in the life expectancy for males between England and the Lewisham average.

Life Expectancy at Birth for Males



For males, Lewisham has significantly lower Life Expectancy than England, London and South East Sector. Males in Lewisham Central ward have significantly lower life expectancy than the Lewisham average.

Life Expectancy at birth females



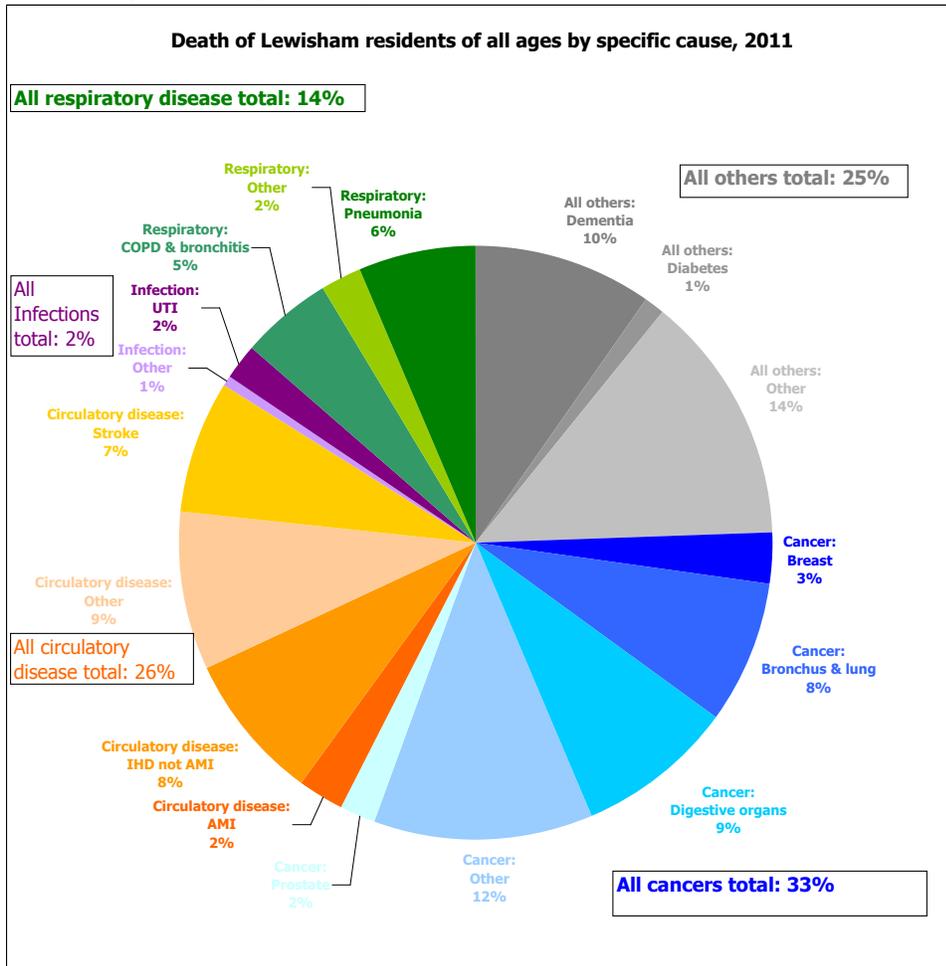
Source: HSCIC Indicator Portal (<https://indicators.ic.uk/webview>)

For females, life expectancy rose 1.9 years in England and 2.2 years in Lewisham in this ten year period. However there is a 1.9 year difference in the life expectancy for females between England and the Lewisham average.

- **Mortality**

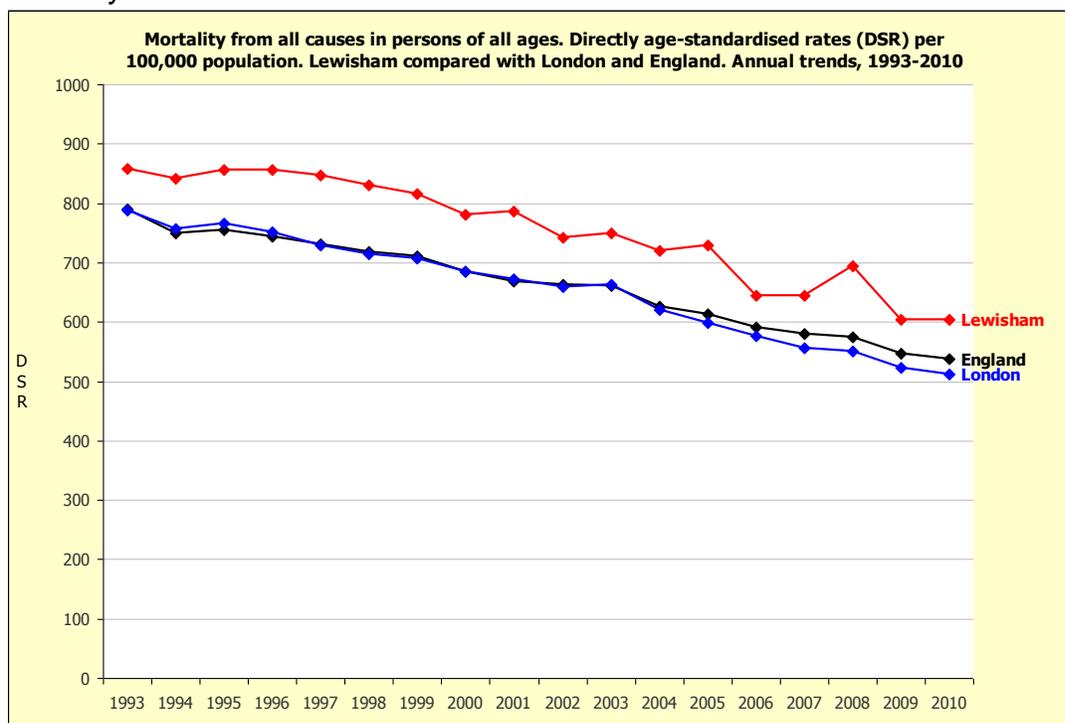
In 2011 there were 1,561 deaths in Lewisham. The main causes of death were cancer (518) 33%, circulatory disease (412) 26% and respiratory (212) 7.4% followed by dementia (152). Over the last couple of years cancer has overtaken cardiovascular disease as the main a cause of death, and cancer deaths are now 33% of all deaths. Deaths from cancer, circulatory disease and respiratory disease are the major contributors to the gap in life expectancy between Lewisham and England for both men and women.

Deaths by cause (percent)



Since 2000 overall the rates of All Cause, all age mortality have been falling in England, London and Lewisham. However rates in Lewisham remain higher than those of England and London.

Mortality from all causes trend 1993-2010



Source: HSCIC Indicator Portal (<https://indicators.ic.nhs.uk/webview/>)

3.1.3 Morbidity

Prevalence models provide estimates of underlying prevalence derived from population statistics and research on the risk factors for different conditions. At any time there will be a significant number of people with undiagnosed disease who are not benefitting from treatment.

A 'long term condition' is a health problem that cannot be cured but can be controlled by medicines or other treatments. Examples include diabetes, heart disease, chronic obstructive pulmonary disease (COPD), dementia, depression, and there are many more.

Research indicates that nearly 20% of people have more than two long-term conditions and this proportion increases steeply with age. In addition for Lewisham there are inequalities in long-term conditions with their prevalence of being 60% higher in social class V versus those in social class I and the prevalence of those with two or more long-term conditions is also higher in more deprived populations.

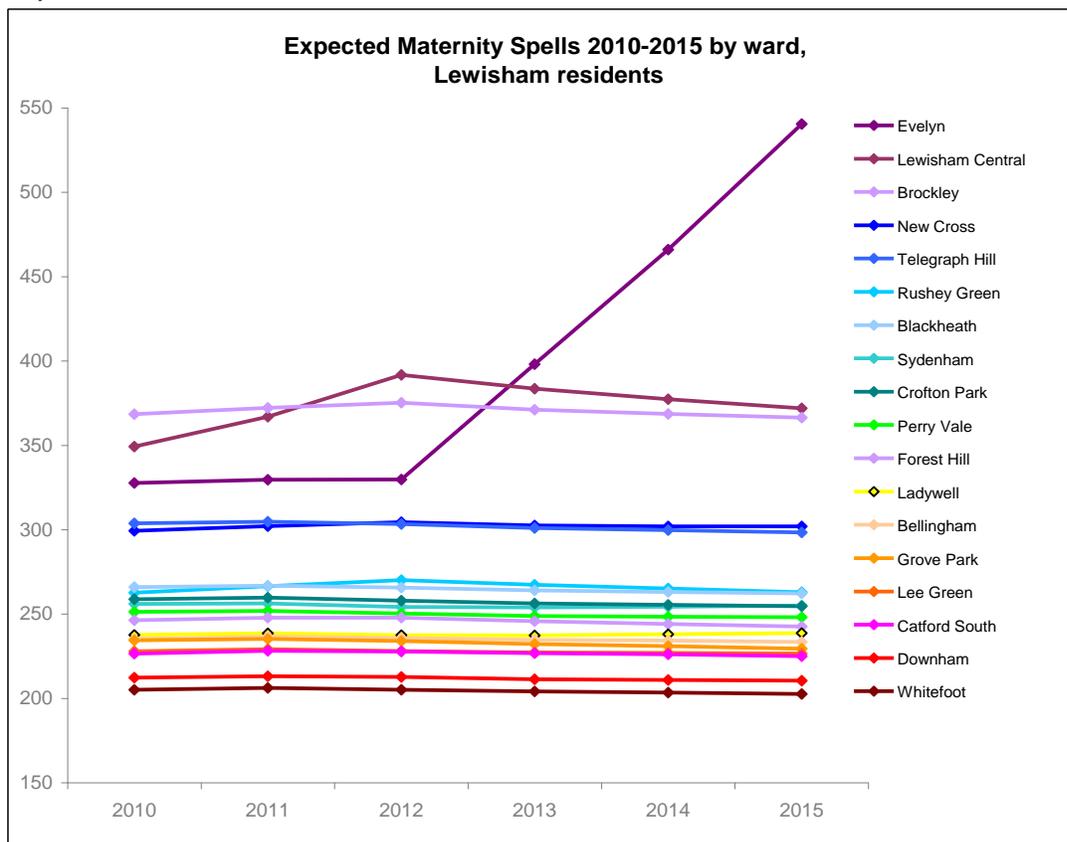
In addition in 2010 there were 1,360 people in Lewisham known to be living with HIV with 30-40% undiagnosed estimated to be approximately 500 people.

People with long-term physical health conditions – the most frequent users of health care services – commonly experience mental health problems such as depression and anxiety, or dementia in the case of older people.

3.1.4 The Health of Children and Young People in Lewisham

The population of children in Lewisham has been increasing due to an increase in the number of births. This is expected to plateau towards the end of decade but new housing developments planned for Lewisham Central mean that there is expected to be an increase in births in that particular ward.

Expected Births to Lewisham Residents

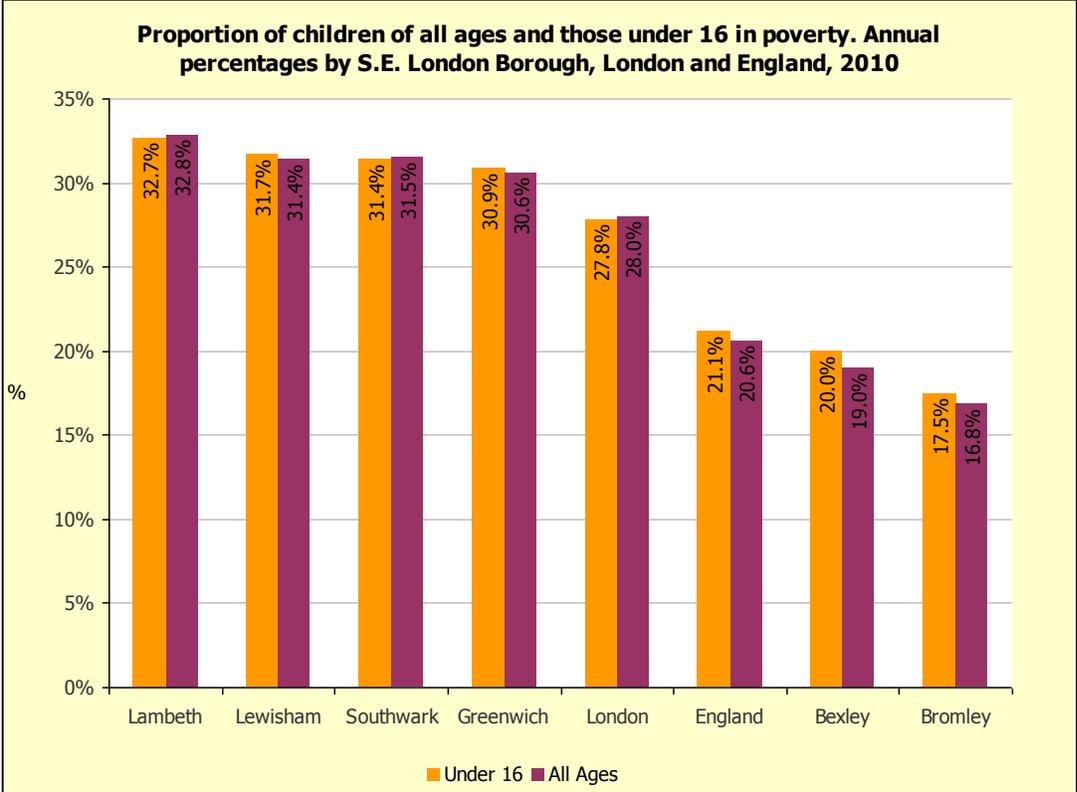


Source: GLA

The huge number of languages spoken in Lewisham and the numbers of adults who do not have English as a first language are well documented. The extent of the impact of this, is however, unclear, particularly in relation to the health of children where the impact may be greater because of the increasing proportion of children born to mothers who themselves were born abroad which may create barriers to accessing health services or expose the children themselves to a different range of health risk factors.

The impact of deprivation on the health and particular mental health of parents has an adverse impact on children. The level of child poverty is significantly worse than the England average. The rate of family homelessness is also worse than the England average.

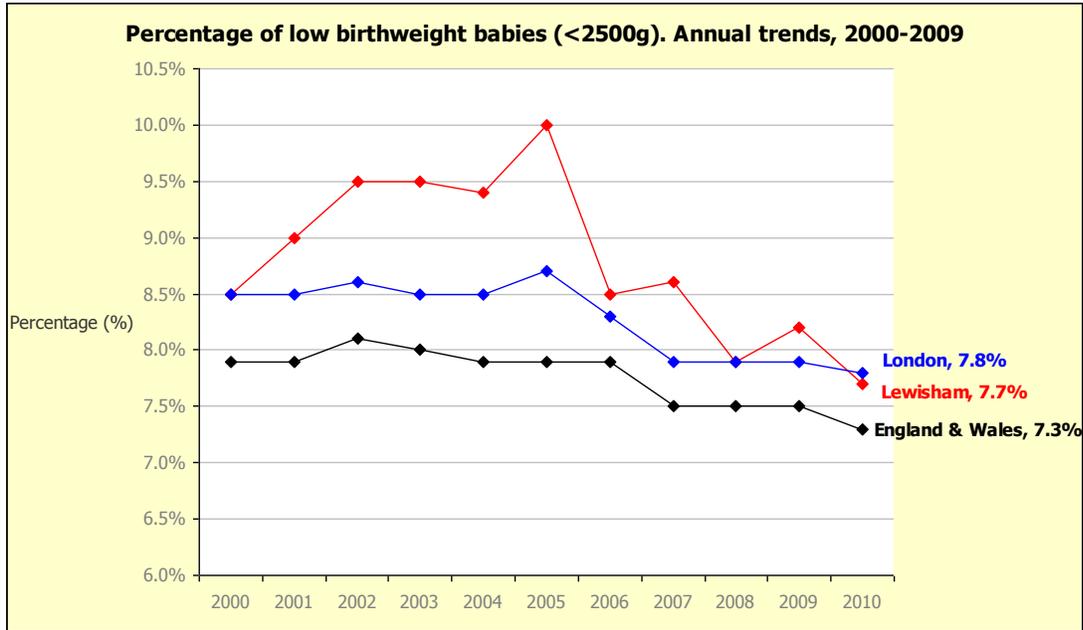
Proportion of children living in Poverty



- **Low Birthweight**

A low birthweight baby is defined as a baby who weighs less than 2.500kg (5 lbs 8oz). Low birthweight is a major determinant of perinatal illness, disability and death and adversely affects babies born into families from a lower socio-economic background. Smoking is the major modifiable risk factor contributing to low birth weight. A concerted programme to reduce low birthweight rates in Lewisham, focussing on increasing the proportion of women seeing a midwife early in pregnancy and on smoking cessation in pregnancy, seems to have had some effect with a change in the local picture and Lewisham’s position in relation to England and London as a whole, however low birthweight remains a problem.

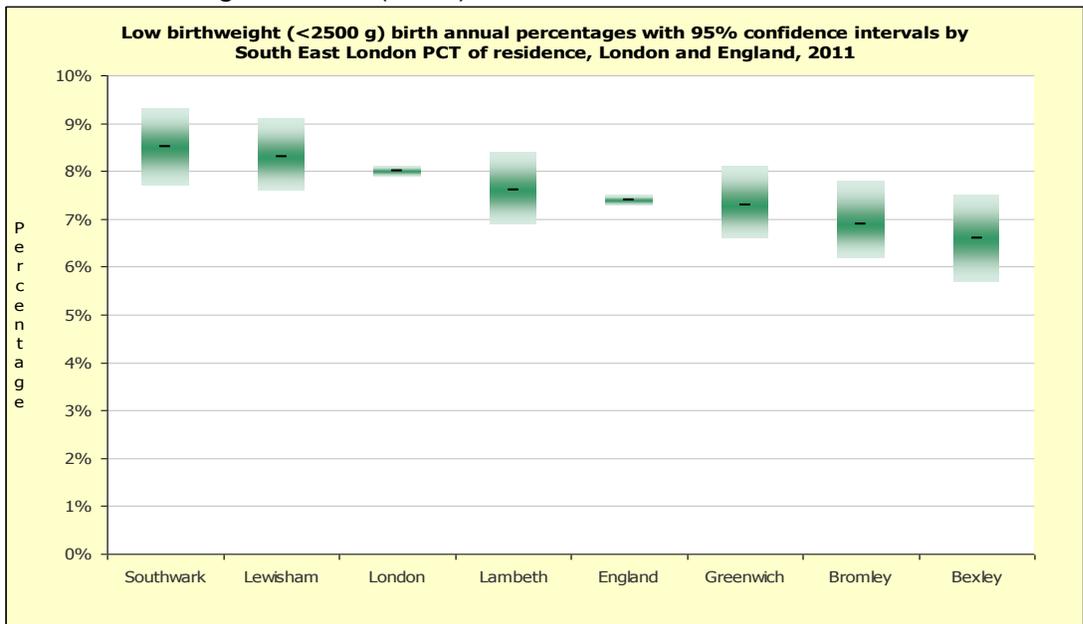
Percentage of Low Birthweight Babies(2000 - 2009)



Source: ONS

Most recent information suggests that the local rate is significantly higher than that of England, though comparable to that of London as a whole.

% Low Birthweight Babies (2011)



Source: ONS

- **Stillbirth rates, Infant and Child Mortality**

In the past, perinatal mortality, and in particular stillbirth rates have been significantly higher in Lewisham than in England and London as a whole. This is no longer the case; the most recent data suggest that local Infant and child mortality rates are similar to the England average. Efforts continue to keep these rates low but continued scrutiny of these important indicators of child health is necessary.

3.1.5 Mental health

Poor mental health has a great social and economic impact. In 2011, 1.1% of the population registered with a Lewisham GP was on an Severe Mental Illness (SMI) register. This equates to 3,423 people. In London the figure is 1% and England 0.8%. The number of people on a Care Programme Approach (CPA) which is a way of coordinating care for those with severe and enduring mental health problems is higher than London at a rate of 9.07 per 1,000 population compared to 7.43 per 1,000 in London.

Most mental disorder begins before adulthood with 50% of lifetime cases of diagnosable mental illnesses beginning by age 14 and 75% of disorders starting by the mid-20s This highlights that interventions for children and adolescents can offer the greatest opportunities for prevention of mental disorder.

Within Lewisham there is variable need, with the southern wards of the borough (Downham, Bellingham and Whitefoot) estimated to have a 25 – 40% higher need for services, in contrast to less deprived wards such as Forest Hill and Catford South that have lower need than the national average.

3.1.6 Health risks

- **Smoking**

Smoking remains the biggest single cause of preventable mortality and morbidity. Tobacco use remains one of our most significant public health challenges and smoking is the single biggest cause of inequalities in death rates between the richest and poorest in our communities. Lewisham is significantly worse than England in smoking attributable mortality, smoking attributable deaths due to heart disease, deaths from lung cancer and COPD, lung cancer registrations and smoking related admissions.

- **Alcohol**

Alcohol related harm is significant and increasing in Lewisham. Alcohol use has a major impact on health, anti-social behaviour, crime and other important social issues, including the well-being and development of children.

Lewisham men are more than twice as likely to die from alcohol related causes compared with women, however the death rate is decreasing for men and increasing for women. Lewisham men have twice the rate of alcohol attributable hospital admissions compared with women, however the rate for women has almost doubled in the past five years, and the rate for men is beginning to level off. Lewisham young women have twice the alcohol specific admission rate compared with young men, whereas in over 18s it is three times as high for men compared with women.

- **Obesity**

Local data sources indicate the prevalence of adult obesity is around 33% in Lewisham compared to 24.2% in England. Lewisham has a high prevalence of childhood obesity: 11.4% of reception children were obese as were 25.0% of children in year 6, significantly higher than the England average for the past three years. Over 40% of 10-11 year olds and nearly a quarter of 4-5 year olds were overweight or obese in 2011/12.

- **Physical Activity**

In 2009 the percentage of the total adult participation in at least 3 days sport and active recreation for at least 30 minutes, was 18.7% in Lewisham compared to 20.3% in London and 22.1% in England

- **Cancer screening uptake 2010-2011**

Uptake of cancer screening in Lewisham is significantly worse than London. This has implications for cancer survival as many women particularly are missing the opportunity for early diagnosis of cancers which may result in better treatment outcomes.

SUMMARY – OUR POPULATION HEALTH CHALLENGES

1. Inequalities	While there are improvements in population health, there are still differences between different part of the borough, for instance life expectancy at birth is rising (now on average 76.6 years for men and 81.3 years for women) but for men in Lewisham Central and for women in Telegraph Hill it is significantly lower than the average. The same is true for all cause mortality rates which have been falling in Lewisham but in Lewisham Central is significantly higher than the Lewisham average.
2. Population	The Lewisham population is projected to grow across all age groups over the next five years. For this period the largest percentage growth rate is in the 20-64 year old age group, and for the period 2013-28 the largest growth will be in the 65-90+ age group. The increasing number of births expected to plateau towards the end of the decade.
3. Cause of Death	Cancer is now the main cause of death (33% of deaths), followed by circulatory disease (26%), respiratory disease (13%) and dementia (10%).
4. Health Promotion	More people smoke than the national average and reducing the number of people in Lewisham who smoke would make a major impact on the key causes of premature death.
5. Long-Term Conditions	There will be increasing numbers of people who have long-term conditions and this will further increase with the ageing population, particularly the likelihood of having more than two conditions. Lewisham's black and minority ethnic communities are also at greater risk from health conditions such as diabetes, hypertension and stroke. Dementia - with the increasing age of the population the number of dementia cases will rise; prevalence increases particularly in the population older than 65.
6. Mental health	Prevalence of mental illness is high in Lewisham and there are inequalities within the borough: southern wards which are also deprived (such as Downham, Bellingham and Whitefoot) have higher needs for services than some other areas.
7. Birth weight	The percentage of low birthweight babies falling but is still a significantly higher rate than the England average, though it is now comparable to London as a whole.

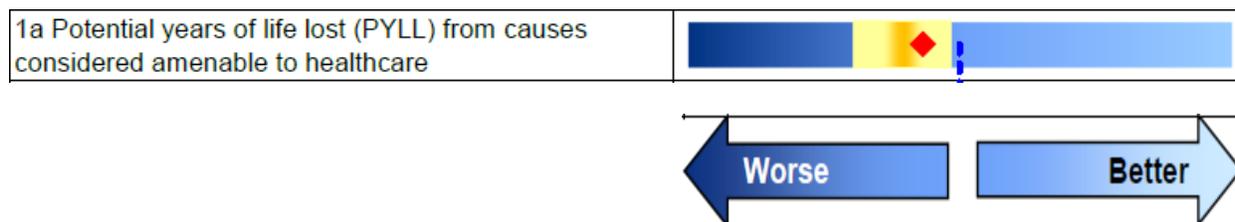
3.2 HEALTH OUTCOMES

Our aim is to improve health outcomes for all of the Lewisham population. Over the last 10 years health outcomes have got better for Lewisham people however compared to other similar London boroughs we have further room to improve. The NHS Health Outcomes Framework provides the mechanism to assess improvements, and these indicators in particular will reflect the priorities of the CCG's strategy:

3.2.1 Potential Years of Life Lost

To ensure that the NHS is held to account for doing all that it can to prevent amenable deaths. Deaths from causes considered 'amenable' to health care are premature deaths that should not occur in the presence of timely and effective health care.

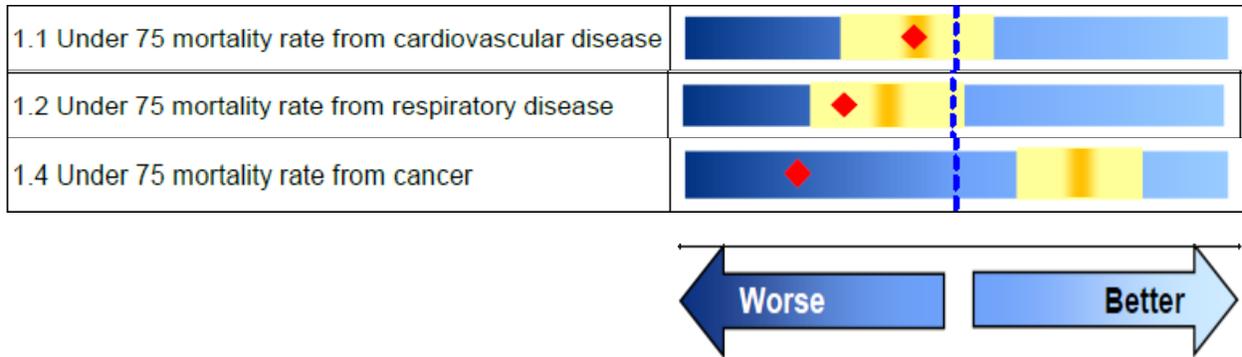
The figures below illustrates Lewisham's current position (red square) in comparison to the England average (blue dotted line), and its ONS cluster (yellow segment).⁵



3.2.2 Premature (under 75) mortality rates

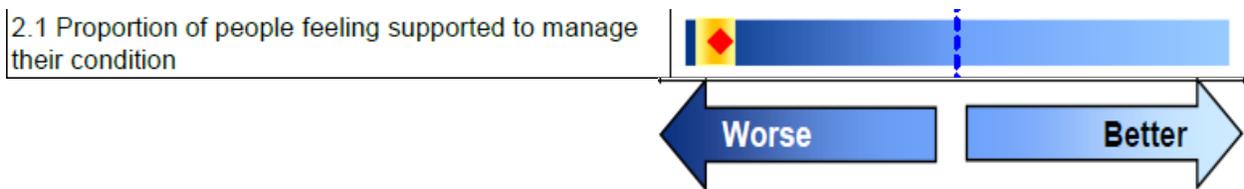
- Cardiovascular disease - To ensure that the NHS is held to account for doing all that it can to prevent deaths in people under 75 suffering from cardiovascular disease.
- Respiratory - To ensure that the NHS is held to account for doing all that it can to prevent deaths in people under 75 suffering from respiratory disease.
- Cancer - To demonstrate that the NHS can make a contribution to improving preventable as well as amenable cancer mortality.

⁵ NHS Commissioning Board Outcomes Benchmarking Support Packs: CCG Level 2012



3.2.3 Long Term Conditions

An assessment of the extent to which those with long-term conditions are able to manage their condition through the quality of the support offered by healthcare providers. The outcome will be proportion of people feeling supported to manage their condition. Lewisham’s current position is:



3.2.4 Infant Mortality

The outcome framework will include an indicator that measures how neonatal mortality and stillbirths relates to the outcomes of NHS care during pre-pregnancy, pregnancy, birth and immediately after birth.

Currently available is a measure of infant deaths per 1,000 births. This shows Lewisham comparison with England as follows (the yellow circle being Lewisham and the vertical line the England average)⁶:



⁶ Lewisham Health Profile 2012 English Public Health Observatories

3.3 PUBLIC FEEDBACK

We have collected patient and public feedback from a number of sources, including questionnaires, the PALS service and complaints, and outreach events. A summary of the main messages is:

- The birthing unit at Lewisham is highly praised
- It is important to include patients and carers in care plans
- People have told us that they are not given enough information about medication and other aspects of their care
- Older people can feel disengaged as they are seldom involved in decisions
- Access to primary care varies
- There are positive views of community pharmacy services
- Patients value A&E Service
- People would like to see care joined up

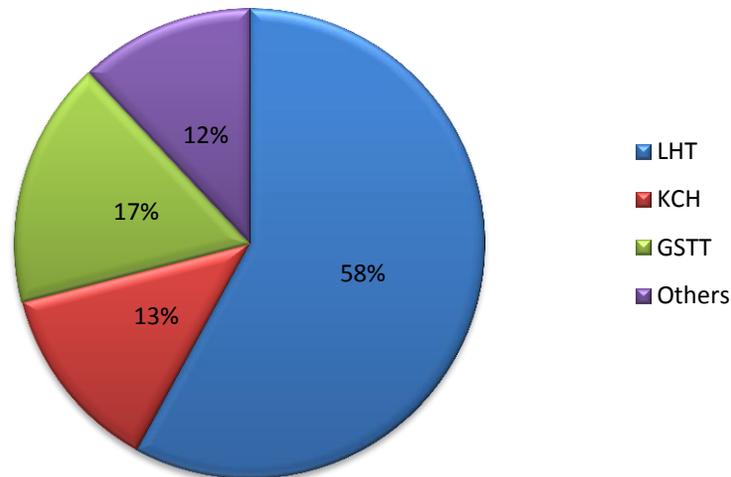
The phases of public engagement activity are described in Appendix 1, including the activities in 2012 and January and July 2013 to comment on the strategic priorities.

From September 2013 a further engagement programme has focused on the delivery of the strategic priority areas which will inform their implementation and QIPP plans following a complete engagement activity and outcomes analysis.

3.4 PROVIDER LANDSCAPE

Our main providers of secondary care services are Lewisham Healthcare NHS Trust (LHT), King's College Hospital NHS Foundation Trust (KCH), and Guy's and St Thomas's NHS Foundation Trust (GSTT). Their approximate share of activity is as follows:

Secondary Care Providers % Activity 2013-14



Our community services provider is also Lewisham Healthcare, and mental health services are provided by the South London and Maudsley NHS Foundation Trust (SLAM).

All our health service providers, public, voluntary and privately owned organisations, are facing challenges to secure sustainable primary, community and acute services.

Health service providers face increasing demand because:

- Health demand overall is increasing – rising rate of people with one or more long-term conditions and an ageing population
- Public expectations - patients using services 24/7 and seeking treatment for minor conditions rather than healthy living and self management
- Medical advances are helping people to live longer but, in line with this, more people can expect to live for some time with a care and support need. The NHS can now treat conditions that previously went undiagnosed or were simply untreatable.

Health services providers face increasing difficulty in providing/supplying services:

- Increasing costs - the cost of providing care is getting more expensive. The NHS now provides a much more extensive and sophisticated range of treatments and procedures

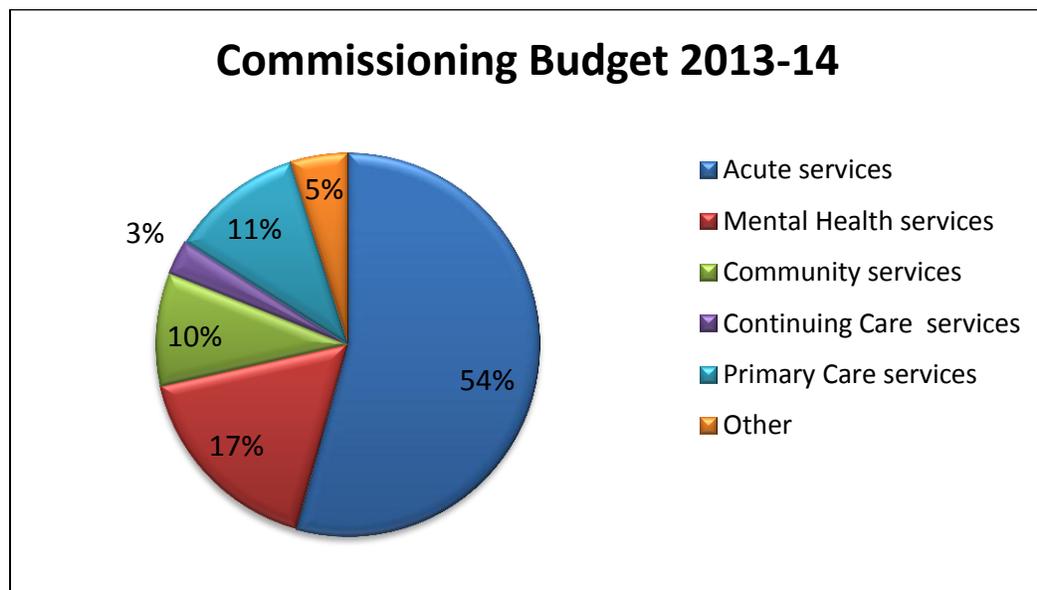
- Greater scrutiny and higher expectations of quality and governance standards. For example workforce standards - the impact of the European Working Time Directive (EWTD) on the hours doctors work and staffing levels.
- Limited financial resources to buy health services - the broad consensus is that for the next decade, the NHS can expect its budget to remain flat in real terms, or to increase with overall GDP growth at best. This represents a dramatic slow-down in spending growth for the NHS.

Locally primary care, community care and hospital providers are considering how they can work together differently to make their services more sustainable.

The outcomes of the Trust Special Administrator (TSA) review of the South London Healthcare NHS Trust will have a further impact on the organisation of local NHS organisations with the planned merger of Lewisham Hospital and the Queen Elizabeth Hospital in Greenwich. We are committed to working together with all local health providers, other commissioners and you, to identify and implement the best configuration of local hospital services which will deliver our strategic aims of 'better health, best care and best value' for Lewisham people.

3.5 FINANCIAL CONTEXT

We currently receive (2013/14) around £365m to commission most of the healthcare services in Lewisham which we allocate as follows:

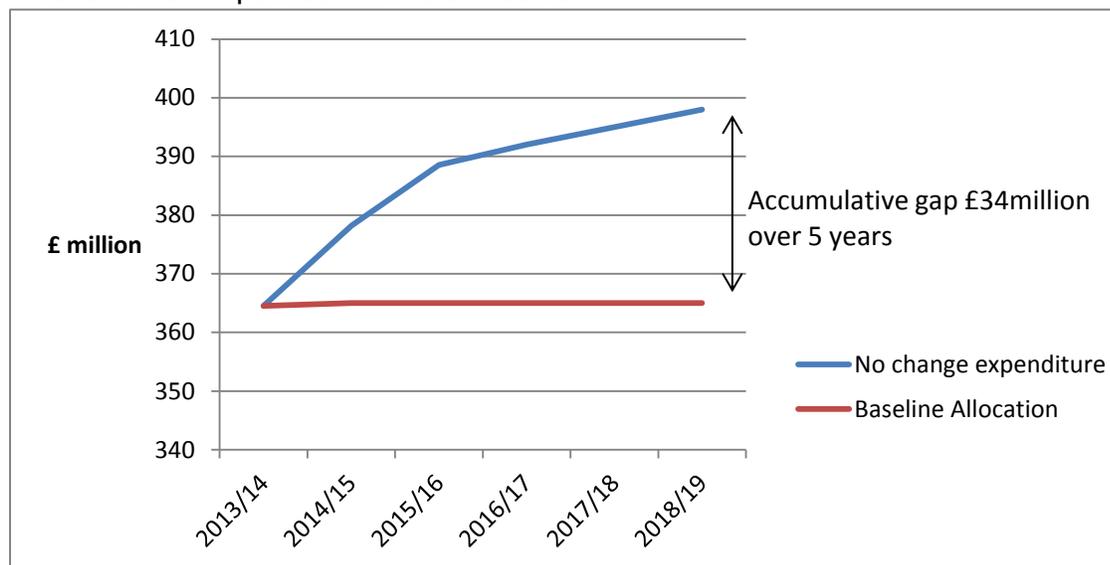


If Lewisham CCG continues to commission in the same way as today it will result in the CCG facing a funding gap between projected spending requirements and resources

available of around £34 million between 2014/15 and 2018/19 (approximately 9% of projected costs in 2018/19). This estimate is made taking into account current expected productivity improvements and the expected annual out-turn expenditure in line with contracts, and assumes that the health budget will remain protected in real terms.

Based on the above assumptions, the expected financial position for the CCG would be an accumulative financial gap of £34m over 5 years. We will be doing further work during autumn 2013 to test and update our current financial assumptions, so that we can be more certain about our future financial position.

Illustration of Expected Financial Position



3.6 NATIONAL REQUIREMENTS

3.6.1 The NHS Constitution

The NHS Constitution requires Government to provide a statement of NHS accountability, describing the principles, values, rights and responsibilities that underpin the NHS:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170656/NHS_Constitution.pdf

3.6.2 The NHS Mandate

The NHS Mandate sets out the Government’s vision for the NHS and the funding available to achieve this. The first and current mandate to NHS England, sets out objectives based on five priority areas identified by Government following a wide consultation held in 2012 which aims to deliver the ‘*best possible care and treatment for all*’:

NHS Mandate: Priority Areas

- i) Improving standards of care and not just treatment, especially for older people and at the end of people's lives;
- ii) The diagnosis, treatment and care of people with dementia;
- iii) Supporting people with multiple long-term physical and mental health conditions, particularly by embracing opportunities created by technology, and delivering a service that values mental and physical health equally;
- iv) Preventing premature deaths from the biggest killers;
- v) Furthering economic growth, including supporting people with health conditions to remain in or find work

Source: NHS Mandate 2012

The current mandate sets out the strategic direction and objectives for NHS England and other organisations across health and social care for 2013 to 2015. To ensure that the mandate reflects the ongoing developments and scale of the challenges ahead, the mandate is refreshed on an annual basis.

The Government plans to carry forward all the existing objectives of the current mandate and while the impact of a public consultation on the existing mandate is not yet clear, recent challenges and evidence which has emerged over the last 12 months is expected to influence the changes proposed:

- **Patient Care and Safety** – The recommendations proposed following the Francis Inquiry on Mid-Staffordshire NHS Foundation Trust, and the cases of abuse which emerged at Winterbourne View both demonstrate the failings which have occurred within the health and social care system which organisations must learn from. It is anticipated that the revised mandate will aim to transform patient care and safety becoming one of its key priorities.
- **Integrated Care** – The NHS faces significant challenges ahead. The scale of the financial challenge and limited resources available increases this pressure even further. Integrated Care is seen as a key enabler to address these challenges, by bringing health, social care and other organisations to work more closely together so that resources are use more efficiently and effectively. It is anticipated that the Mandate will set the expectation for NHS England to leading the way for better integration of health and social care.
- **Accident and Emergency (A&E) services** – This year has seen the significant pressures placed on A & E services. The increasing demand on these services are symptomatic on longer term pressures on the NHS such as the support

available to stay healthy which creates additional pressures on existing services. NHS England are currently working to develop a plan for vulnerable older people which aims to address this and how to improve out of hospital care. The Government aims to use the refreshed Mandate to outline its ambitions to support this plan.

Conclusion – the case for change

- The changing health needs of the Lewisham population will increase demand on services
- We need to improve our health outcomes
- We need to improve quality and accessibility of local services to all
- The current configuration of health services is not likely to be sustainable
- There will be gap in finances, between resources available and expenditure

More of the same will not address this challenge

This means working with our partners to do things differently

4. TRANSFORMING LOCAL SERVICES

This section describes the changes we plan to make to our commissioning to achieve our vision.

Our commissioning strategy does not sit alone, and we will be working in partnership with other South East London clinical commissioning groups and in particular as members of the Lewisham Health & Wellbeing Board to meet the health needs identified in the JSNA.

4.1 PRIORITIES

We have identified eight strategic priorities that we will focus on to transform services:

Strategic Themes	Strategic Priorities
Healthy Lifestyles and Choice	1. Health and wellbeing – smoking cessation, alcohol abuse, obesity and cancer
	2. Maternity and children’s care in hospital
Frail and Vulnerable People	3. Frail older people (including end of life care)
Long Term Conditions	4. Long Term Conditions – eg COPD, diabetes, CVD, dementia
	5. Mental Health
Deliver Services Differently	6. Primary care development and planned care
	7. Urgent Care
	8. Greater integration of health and social care commissioning

Over the past eighteen months we have asked Lewisham people “what’s important about your health services”, and we have listened to what you told us. Your feedback helped us to set the priorities that will help us to meet our challenges that we have described in our case for change. We call this linkage our ‘golden thread’.

Strategic Priorities	Case for Change Summary
Health promotion – smoking cessation, alcohol abuse, obesity and cancer	<p>This provides long-term benefits in helping to address our health needs challenges such as the main causes of death (cancer, circulatory diseases, respiratory disease) and inequalities between different areas of Lewisham.</p> <p>The NHS Mandate’s objective of <i>‘Preventing people from dying early’</i> includes supporting the earlier diagnosis of illness, particularly through appropriate use of primary care, and tackling risk factors such as high blood pressure and cholesterol. Also focusing on preventing illness, to help people stay in good health – by not smoking, eating healthily, drinking less alcohol, and exercising more.</p>
Maternity and children’s care in hospital	<p>We want to build on the positive public feedback about the maternity unit at Lewisham Hospital and to support the long-term sustainability of our local maternity providers. We also need to address the rates of low birthweight babies.</p> <p>The Mandate’s ambitions for Maternity and Children’s services particularly feature in its objective for <i>‘Ensuring that people have a positive experience of care’</i>. This includes helping to give Children the best start in life and promoting their health and resilience as they grow up through a more joined-up approach to addressing their needs.</p>
Frail older people (including end of life care)	<p>Our health needs analysis has highlighted the increasing numbers of frail elderly people, while public feedback has identified that older people feel disengaged in their care.</p> <p>The Mandate has as one its priority areas <i>‘Improving standards of care and not just treatment, especially for older people and at the end of people’s lives’</i>.</p>
Long Term Conditions – eg COPD, diabetes, CVD, dementia	<p>Long term conditions and dementia rates are increasing and we need to ensure that our local services are able to manage this demand efficiently while providing high quality care which is inclusive of patients and carers in care planning</p> <p>The Mandate’s objective <i>‘Enhancing quality of life for people with long-term conditions’</i> and supporting people with ongoing health problems to live healthily and independently with better control over the care they receive. This includes better involvement of patients and their carers and to manage and make decisions about their own care and treatment and developing the knowledge skills and confidence to manage their own health.</p>

<p>Mental Health</p>	<p>There is a high prevalence of mental health need in Lewisham, and in this area too we have heard feedback about how important it is to include patients and carers in plans</p> <p>Mental health appears in across several of the Mandate’s objectives which our strategic priority for Mental Health will aim to address. This includes treating mental and physical health in a coordinated way to support recovery and improving access to services for people with Mental health so that to be on par with physical health.</p>
<p>Primary care development and planned care</p>	<p>The demands on these sectors are increasing with the increasing prevalence of long term conditions and dementia. Public feedback has highlighted that access to primary care varies and with a positive view of the contribution of pharmacies.</p>
<p>Urgent Care</p>	<p>Patients value A&E services but we need to work with the public and providers to develop a local configuration of emergency services that is affordable.</p>
<p>Greater integration of health and social care commissioning</p>	<p>People would like to see care joined up. This will also be essential as our population develops more complex health needs and there is increasing pressure on our services.</p>

4.2 STRATEGIC AIMS

For each of our priorities we have identified the changes we will aim to implement, our key objectives and changes that will be introduced in the next two years. As we progress towards our goals in subsequent years we will refine and add to our plans and the changes we have to introduce.

4.2.1 Health and Wellbeing

Strategic Aims

To contribute to the delivery of the Health and Wellbeing Board's nine priorities with a particular focus on reducing smoking, alcohol abuse, obesity and to increase cancer awareness, screening and early diagnosis.⁷

4.2.2 Maternity and Children's Care in Hospital

Strategic Aims

- To normalise and improve the quality of maternity care to women in Lewisham across the care pathway
- To develop children's integrated care pathways to ensure that children receive excellent care in the appropriate setting.

4.2.3 Frail Older People (Including End of Life Care)

Strategic Aims

- To improve the advice, support and care provided to frail older people so they can continue to live independently;
- As needs change to ensure that there is responsive and appropriate high quality care and support available in a variety of settings including community, extra care and care homes

4.2.4 Long-Term Conditions

Strategic Aims

- To develop integrated care pathways, building on COPD, Heart Failure and Diabetes service redesign work.

⁷ For more information on the Health & Wellbeing Board and strategy priorities see <http://councilmeetings.lewisham.gov.uk/mgCommitteeDetails.aspx?ID=315>

- To provide personalised care, using risk stratification tools to systematically identify people earlier with health issues.
- To provide comprehensive integrated services for people with dementia.
- To improve the patient's and carer's experience by changing culture and behaviours so that the patient is at the centre.
- To enable patients to be better supported to take greater responsibilities, with the opportunity for a healthcare personalised budget.

4.2.5 Mental Health

Strategic Aims

To ensure a mental health service system within which all providers, whether statutory, independent or third sector, through outcome based commissioning focused on seven success criteria:

- I. Health outcomes
- II. Social outcomes
- III. Community safety outcomes
- IV. Treatment choice and service relationship outcomes
- V. Physical health outcomes
- VI. Fair and straightforward access
- VII. Value for money

4.2.6 Primary Care Development and Planned Care

Strategic Aims

- Working with primary care to ensure high quality of care for all by levelling up standards and reducing variations between practices and care for specific communities.
- Working with local providers to ensure optimisation of planned care services by commissioning effectively

4.2.7 Urgent Care

Strategic Aims

- To ensure that the right care is delivered in the right place, at the right time to reduce the requirement for unplanned care, working with providers of urgent care.
- To review, with stakeholders, the current number of different ways Lewisham people access urgent care to enabling us to develop and implement the most appropriate model(s) and configuration of urgent care services

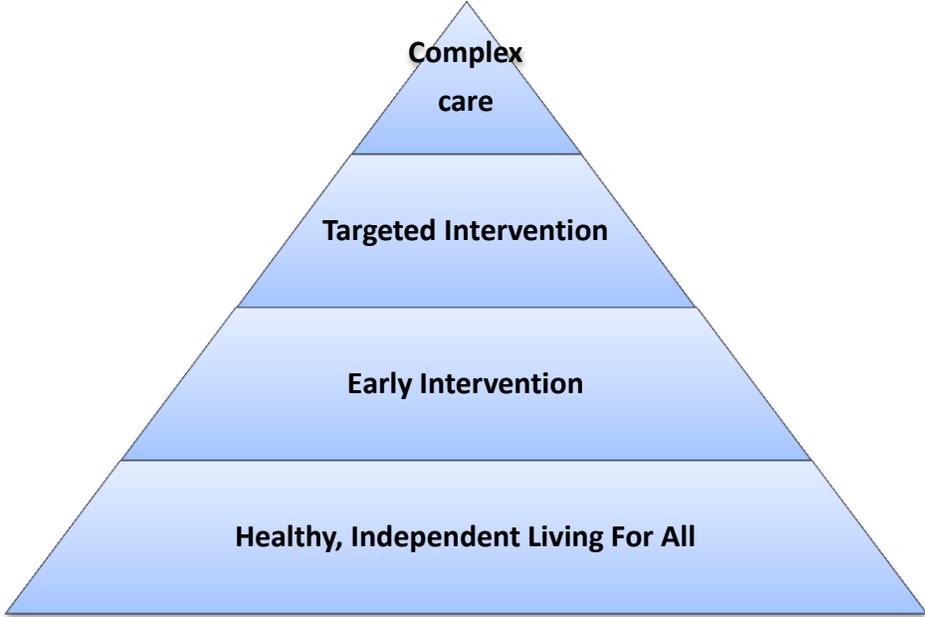
4.2.8 Greater Integration of Health and Social Care Commissioning

Strategic Aims

Greater Integration of health (primary, community and secondary care) and adult social care commissioning - by implementing the Lewisham's integrated delivery model which is based on providing advice, support and care to an individual, recognising that each person's health is unique and dynamic, so will need different levels of advice, support and care from a variety of services during their life time. The delivery of this priority is represented by four levels of advice, support and care:

- Healthy Choices for All – empowering and supporting individuals, families and communities to take action to make healthy lifestyle choices
- Early Intervention - identifying at an early stage when more support is required and providing fast and convenient access to high quality support and advice.
- Targeted Intervention – identifying those specific high risk individuals who would benefit from active intervention to avoid a potential crisis such as an inappropriate admission and re-admissions to hospital.
- Complex Care – coordinating and managing a complex health and social care package in a single care plan which is tailored around the needs of the individual, carer and the family with them at the heart and still in control - 'nothing about me, without me'.

DELIVERY MODEL



CCG PRIORITIES

Long Term Care:

- Long-term conditions (COPD, diabetes, CVD)
- Mental health
- Frail older people

Healthy Choices:

- Maternity
- Health promotion

Integration of health and social care commissioning

Social Care

Primary & Community Care

Hospital Care

Urgent Care

Provision

5. EQUALITIES ANALYSIS

An equalities analysis of the draft strategic aims and priorities has been undertaken by Lewisham Public Health and is included in Appendix 2. It examined the eight strategic priorities and for each one identified potential positive, negative and neutral outcomes. It concludes that overall the strategy will contribute to reducing inequalities, and highlights potential positive outcomes for disadvantaged groups and for those that share protected characteristics. Further work on equality impact assessment will be undertaken as part of the development of the CCG's QIPP plans.

Appendix 1: Phases of Engagement 2012-13

Engaging on our priorities	
2012	<p>Our outreach programme in 2012 utilised the <i>'Have Your Say'</i> patient survey – presenting outcomes across the borough; asking patients about what they do and don't value in their health service. We attended a series of local meetings and engaged with GP Practice Patient Groups.</p>
January 2013	<p><i>Shaping Your Health Services</i></p> <p>On the 31st January 2013 over 50 Lewisham patients, members of the public, carers and local councillors filled the Lewisham Town Hall Civic Suite. The engagement event was to enable discussions on the Lewisham Clinical Commissioning Groups (LCCG) Strategic Priorities to improve services and patients health.</p> <ul style="list-style-type: none"> • Complete the engagement cycle by ensuring that the CCG feedback to patients: <i>'You Said We Did'</i> • Confirmed that patients were happy with the priorities • Considering good practice, expectations and barriers what patients thought of our plans
Developing a local strategy for Lewisham	
July	<p><i>Lewisham Peoples Day Launch</i></p> <p>Our strategy was launched at Lewisham Peoples Day on Saturday 13th July. Local people were encouraged to comment on the strategy and priorities using questionnaires. LCCG engaged with 120 residents and 73 completed the questionnaires.</p>
September /October	<p>An engagement programme on the draft strategic priorities <i>'We are up for the challenge'</i> was launched on 16th September, incorporating the NHS England <i>'A call to action'</i> national programme launched on 11th July 2013. This has involved:</p> <ul style="list-style-type: none"> • Distributed information on the Strategic Plan to over 4000 individuals utilising partner networks via (Voluntary Action Lewisham, SLAM, Healthwatch, Lewisham Ethnic Minority Partnership) • Created a webpage dedicated to the plan – with an online survey • Provided updates and alerts on Twitter and Face Book • Included 2 updates on GPi • Informed all Practice Participation Groups via Healthwatch • Targeted 12 practices (across the Borough) – using face to face attendance at these practices

To ensure we involved marginalised groups specific face to face activity has taken place with:

- Lewisham Health and Social Care Forum
 - Carers Lewisham
 - St Mungo's Housing
 - Lewisham Park Housing Association
 - 999 Club (homeless/rough sleepers support group)
 - Lewisham Pensioners Day
 - BME Older People's Group
 - Stroke Association
 - Foodbank Lewisham
- **CCG membership:** Engaging with our members at the Membership Forum meetings and on-line
 - **Talking to our stakeholders:** Healthier Communities Select Committee, LCCG Public Engagement Group, Health & Well Being Board, and Local Medical Council.

The survey and stakeholder engagement and face to face activity have used six core questions:

- I. Are we getting the basics right in local health services at the moment?
- II. Do we need to include anything else in order to get these basics right?
- III. How can we support you to stay well?
- IV. What makes it difficult for you to stay well and what can we do differently?
- V. How can health and social care services work better together?
- VI. What do we need to do differently so that people receive joined up care?

Appendix 2: Equality Impact Assessment Scoping Paper

October 2013

Lewisham Public health Team

Introduction

The document is an Equality Impact Assessment of the Lewisham Clinical Commissioning Group (CCG) strategic plan for 2013-18. It is based on the information available at the time of writing, mostly a strategic view of intended changes. Because of the timing of this paper, a detailed review of the evidence and background work underpinning the proposed changes was not possible. Further work in this area may be warranted.

A full assessment of the Lewisham population in relation to the nine statutory protected characteristics (age, disability, sex and gender, pregnancy and maternity, race, religion or belief, gender reassignment, sexual orientation, marriage and civil partnership), plus deprivation was carried out in August 2013 by the Lewisham Public Health team. This assessment formed part of an Equality Impact Assessment of the Lewisham Health and Wellbeing Board's Strategy for the next decade.

This population assessment has been used as the principal source of information on Lewisham's population for this paper and is given in full in annex 1, along with the primary data sources used. Additional information has been taken from CCG papers relating to this strategy. These are listed in annex 2. Statements of fact about the characteristics of various populations are drawn from the above sources but are not individually referenced for ease of reading.

The CCG strategy highlights eight strategic priority areas (listed below). An Equality Impact Assessment of each of these areas is given below.

- Health Promotion
- Maternity and Acute Children
- Frail Older People (including End of Life Care)
- Primary Care Development and Planned Care
- Long-Term Conditions
- Urgent Care
- Mental Health
- Greater Integration of health and Social Care Commissioning

Impact Assessment

Health Promotion

The Health Promotion priority encompasses how Lewisham CCG will support the delivery of the Lewisham Health and Wellbeing Strategy.

As mentioned above, a full Equality Impact Assessment of the Lewisham Health and Wellbeing Strategy for the next decade has already been carried out. Please see this document for more details.

Maternity and Acute Children

Potential Positive Outcomes

1. Lewisham has high rates of low birth weight babies and infant mortality, although both are falling. Changes to maternity services are expected to improve quality of delivery and care across a range of outcomes. These improvements should be of benefit to all those who access these services, regardless of their race, age, sexuality, marital status etc.
2. However there are a number of high risk populations in Lewisham with high rates of complications in pregnancy due to obesity, diabetes, mental health and deprivation. The highest risk of low birth weight is in babies born to mothers of Black African and Black Caribbean ethnicity, to mothers of any Asian ethnic group, and to mothers from deprived areas. High rates of maternal obesity are associated with deprivation and being of Black African Black Caribbean and Pakistani ethnicity. Planned changes to move to an integrated model of service should improve service quality and benefit these groups.

Potential Negative Outcomes

1. Service reconfigurations can often result in higher staff turnover and disruption while changes are being implemented. The proposed changes might therefore reduce service quality as organisational knowledge is lost and (possibly) staff morale is affected in the short term. If services are temporarily disrupted, the high-risk groups identified above are likely to be disproportionately affected by this disruption.
2. Lewisham's birth rate is rising and is expected to continue at a high level for several years before starting to fall. Planned service reconfigurations are to be made within the existing budget even though this includes a national annual growth assumption. This may not be possible and the service might then experience disruption but without the positive outcomes hoped for in the longer term.

Neutral Outcomes

1. The Cochrane review of midwife-led maternity services – the model upon which this service reconfiguration is broadly based – anticipates improvements across the board. Those who are not high-risk in terms of age, ethnicity, deprivation, obesity etc may notice less of a change than those with greater needs.

Frail Older People (including End of Life Care)

Potential Positive Outcomes

1. Although the proposed changes were only defined in broad terms at the time of writing, improvements to services for frail older people are likely to benefit women, since they live longer, have more long term conditions on average than men, are more at risk of common mental illnesses and make greater use of social services.
2. The older population in Lewisham is less ethnically diverse than the younger demographic. Improvements in services for frail elderly people are therefore likely to benefit those of white ethnicity, who make up three quarters of the older population. Over time the proportion of the older population from BME groups will increase as these populations age.
3. Disability increases with age, so improvements to services for frail elderly should be of particular benefit to disabled people.
4. There is a larger older population in the south of the borough compared to the north. The south of Lewisham is also generally deprived. Improvements to services for frail elderly people should therefore benefit these deprived areas.
5. Greater consistency of provision to care homes should benefit older people who are no longer fully independent, especially women, who make greater use of health services.

Potential Negative Outcomes

1. At present Lewisham's elderly population is mostly white. The ethnic diversity of older people in Lewisham will increase as the current population ages. This change in the demographic profile needs to be borne in mind in future service plans, ensuring sensitivity to ethnicity and religion in particular.

Anticipated Neutral Outcomes

1. As long as the proposed changes are delivered sensitively to individual's needs - in terms of the nine protected characteristics plus deprivation - it is difficult to assess (based on outline information on commissioning plans available at the time of writing) how they might disadvantage certain groups.

Primary Care Development and Planned Care

Potential Positive Outcomes

1. Improving standards in primary care across the board, by reducing variation in performance, should most benefit those with significant health needs. These are likely to be older people, those living in deprived areas, those with disabling long term conditions, mothers of young children and young children themselves.
2. Women might benefit from improvements to primary care, given their greater risk of common mental illness, which is commonly identified in a primary care setting. Also women might benefit if improvements led to better management of CVD as the 40% of life expectancy gap in women is due to CVD compared with 32% for men.
3. Where poor primary care performance is associated with deprivation, improvements to primary care should be of particular benefit to those who live with poor health in deprived areas.
4. A desire to maintain local provision of primary care by sustaining local practices should be particularly benefit those with restricted mobility and/or low incomes, such as those living with disabilities, those living in deprived areas, older people and perhaps mothers with young families.
5. A planned move to self management technology might also be of particular benefit to those with restricted mobility. Familiarity with technology might also benefit younger people with long term conditions.
6. Some ethnicities are at greater risk of certain diseases commonly treated in primary care. For example diabetes is more common in Asian and Black populations and obesity is strongly linked to deprivation among those from ethnic minorities. Improvements to primary care should therefore benefit those from ethnic minorities.
7. Improvements to primary care should benefit those who are divorced, separated or widowed, since they tend to have poorer physical and mental health than single people.

Potential Negative Outcomes

1. A planned move to self management through technology might disadvantage those with learning disabilities, people who are less familiar with technology (e.g. some older people) or those with lower levels of education. Careful screening and appropriate alternative methods of care will be needed for those for whom self-care technology is not appropriate.

Potential Neutral Outcomes

1. As long as services are delivered sensitively and appropriately, the proposed changes should not have an impact on people because of their religion or belief, those from the Lesbian, Gay, Bisexual and Transgender (LGBT) community and those in marriages or civil partnerships.

Long-Term Conditions (LTCs)

Potential Positive Outcomes

1. LTCs increase with age, are often disabling, are more prevalent among deprived communities and are in some cases associated with certain ethnicities (e.g. diabetes). A focus on improving integration and quality of care, along with earlier identification should benefit all these groups through delaying/reducing the impact of disease and reducing emergency admissions.
2. A proposed integration with the 3rd sector for dementia care should benefit older people.
3. Women with LTCs are at greater risk of complications in pregnancy. A focus on improved management of LTCs should benefit women and their children.

Potential Negative Outcomes

1. HIV is not considered explicitly in the CCG strategy, however it is a long term condition with a high prevalence in Lewisham. Whilst HIV treatment is commissioned by NHSE rather than the CCG, HIV care and support including specialist nursing and specialist mental health provision is commissioned by the CCG. The burden of HIV falls disproportionately on men who have sex with men (MSM), and Black African communities, where heterosexual men are likely to be diagnosed late. HIV is also a particularly sensitive topic for certain religions. HIV therefore cuts across many of the protected characteristics, most importantly race, sexuality, maternity, gender and religion. The explicit inclusion of HIV among other listed LTCs would help address inequalities in these areas.
2. Obesity is linked to a number of LTCs and associated with deprivation in women and is more common among certain ethnic minorities in Lewisham, such as those of Black African and Black Caribbean descent. This should be considered in the LTC workstream.
3. A planned move to possible personal budgets for care of people with LTCs might, if inappropriately applied, disadvantage those lacking the skills to appropriately manage this. Those with learning difficulties and those with lower educational attainment (linked to deprivation) would be particularly at risk.

Potential Neutral Outcomes

1. Those who do not suffer from long term conditions - regardless of their age, ethnicity, religion, sexuality, etc - are unlikely to be affected by these changes.

Urgent Care

Possible Positive Outcomes

1. If the proposed changes do deliver savings, as anticipated, this should free resources for other areas of healthcare provision or contribute to required savings. In general terms this could benefit those who make use of these services, as discussed in this paper.
2. Although homeless people and people with drug and alcohol problems are not explicitly covered by the 9 protected characteristics, planned pathways for these groups should help ensure they are not disadvantaged by changes to reduced urgent care provision.

Possible Negative Outcomes

1. The implication of specific pathways for homeless people and people with drug and alcohol problems is that these are heavy users of Urgent Care. If these pathways are unsuccessful then these groups could be disadvantaged by proposed changes.
2. An increased use of telephone triage and other non face-to-face forms of contact may disadvantage people with disabilities (for example those with learning disabilities or who are hearing impaired). Those on low incomes may be unable to afford phone calls, for example if they have run out of credit. Internet access is not universal and some groups, such as some older people, may find remote ways of working more challenging.
3. Similarly, while an increased focus on self-care may be appropriate for many people, this will be more challenging for those with low levels of education (associated with deprivation) and those with learning disabilities.

Possible Neutral Outcomes

1. It is not expected that the proposed changes to urgent care will significantly affect people with regards to religion or belief, the LGBT community and those in marriages or civil partnerships.

Mental Health

Potential Positive Outcomes

1. Mental ill health is more prevalent in certain BME groups, those who identify as Lesbian, Gay or Bisexual, those who are divorced/widowed/separated and those living in deprived areas. There are also very high levels of mental illness amongst those known to the criminal justice system. Expecting providers to demonstrate how they meet the needs of diverse communities will help ensure that those at highest risk of mental illness will be supported to access services.
3. Community based services delivered near to home help support people with poor mental health to recover without requiring initial or further hospital admission.
4. Certain ethnic groups are over-represented in local inpatient services (principally White other and Black Other). Improving the community offer to patients may

prevent escalation of mental illness and reduce over representation in inpatient services.

Potential Negative Outcomes

1. Those with the poorest mental health are most likely to need access to inpatient services. A reduction in inpatient beds may mean that those with the worst mental health wait longer for treatment in an inpatient setting or need to travel further to access inpatient care.

Neutral Outcomes

1. Those who identify as Lesbian, Gay, Bisexual and Transgender (LGBT) are at increased risk of mental illness. It is not clear if the commissioning intentions have any specific impacts for this group over those highlighted above.

Greater Integration of Health and Social Care Commissioning

Possible Positive Outcomes

1. A move towards closer integration of health and social care commissioning, with four proposed levels of support (Healthy Choices for All, Early Intervention, Targeted Intervention and Complex Care) should particularly benefit those whose needs cut across health and social care. For example, older people with LTCs often require social support in addition to health services. Those from deprived communities, certain ethnic minorities, and women (who use more social care) should all benefit.
2. Those of all ages with disabilities also often require health and social care on an ongoing basis. They should benefit from closer integration of commissioning.

Possible Negative Outcomes

1. Targeted intervention will only benefit those who have been identified. The process of identifying those at risk requires careful scrutiny from an inequalities perspective to ensure certain groups are not missed, disadvantaged or marginalised. It would be worth giving consideration to groups not covered by the nine protected characteristics plus deprivation considered here, for example those without recourse to public funds, homeless people and people with drug and alcohol problems. This is a potential area for more detailed work in the future.

Possible Neutral Outcomes

1. People who are not big users of health or social care are unlikely to be much affected by the proposed changes. This applies to healthy people of all ages, ethnicities, sexual orientation and so on.

Conclusion

The conclusion of this study is that, at the strategic level considered here, the proposed changes to services would, on the whole, prove more beneficial than harmful. The changes have clearly been designed with the aim of reducing inequalities.

In broad terms, there are however two areas that give cause for concern.

Firstly, the move towards increased self-management and remote care, either through the use of technology or non face-to-face contact may disadvantage those with certain disabilities, learning disabilities, older people, those with low levels of education and those with low incomes. Alternatives need to be considered for these groups.

Secondly, the interface with HIV care commissioned by NHS England should be reconsidered, particularly because HIV affects several vulnerable groups such as men who have sex with men and those from Black African communities as part of the mental health work.

Because of the timing of this paper, the detailed evidence and background work which has informed the proposed changes has not been considered. In addition, the commissioning intentions are at an early stage and have not yet been translated into service specifications. It would be worth considering how to involve assessment of the impact of proposed changes on inequalities through each stage of the commissioning cycle.

This paper has only considered the impact on the nine protected characteristics plus deprivation. There are other non-statutory characteristics that might be considered on a service-by-service basis, for example the impact of planned changes to Urgent Care on homeless people and people with drug and alcohol problems.

Annex 1: Assessment of Lewisham Population in Relation to the nine protected characteristics plus deprivation

Data Sources

General

Census 2011 (various elements)

Greater London Authority (2012) Population Projections 2012 Round, SHLAA

Office of National Statistics (2011) General Lifestyle Survey

Age

APHO (2012) Health and Wellbeing of Older People's Atlas

Lewisham Joint Strategic Needs Assessment (alcohol, tobacco control, sexual health, mental health, long term support, cancer, immunisations and healthy weight chapters)

Health Equity Audit of the Stop Smoking Service in Lewisham, May 2013

Health Survey for England 2009

Department of Health (2012) Long Term Conditions Compendium of Information

Purdy S, King's Fund (2010) Avoiding hospital admissions What does the research evidence say?

Department of Health (2011) The likely impact of earlier diagnosis of cancer on costs and benefits to the NHS.

NHS Lewisham Health Equity Audit of Breast Cancer Screening 2010

K Robb, S Stubbings, A Ramirez, U Macleod, J Austoker, J Waller, S Hiom and J Wardle (2009) Public awareness of cancer in Britain: a population-based survey of adults (British Journal of Cancer 2009 101(Suppl 2): S18–S23)

Lewisham Public Health Performance Dashboards: Immunisations

Disability

Lewisham Joint Strategic Needs Assessment (alcohol, adults with learning disabilities and healthy weight chapters)

NHS Yorkshire and the Humber (2010) Healthy Ambitions for People with Learning Disabilities

Department of Health (2012) Long Term Conditions Compendium of Information

Child and Maternal Health Observatory (2011) Disability and obesity: The prevalence of obesity in disabled children

Gender

Lewisham Joint Strategic Needs Assessment (alcohol, tobacco control, sexual health, mental health, long term support, cancer, immunisations and healthy weight chapters)

Health and Social Care Information Centre (2013) Statistics on Obesity, Physical Activity and Diet, England.

Department of Health (2012) Long Term Conditions Compendium of Information

Health Equity Audit of the Stop Smoking Service in Lewisham, May 2013

London Health Improvement Board (2011) Alcohol

Hospital Episode Statistics (various years)

Pregnancy/Maternity

Lewisham Joint Strategic Needs Assessment (tobacco control, sexual health, immunisations and healthy weight chapters)

NHS Information Centre (2012) Statistics on Smoking in England

Lewisham Public Health Performance Dashboards: Immunisations

Kelly y et al (2009) Why does birthweight vary among ethnic groups in the UK? Findings from the Millennium Cohort Study

(*J Public Health (2009) 31 (1): 131-137*)

Race

Lewisham Joint Strategic Needs Assessment (alcohol, tobacco control, sexual health, mental health, long term support, cancer and healthy weight chapters)

Health Survey England (2004) (special focus on ethnic minority health)

Hospital Episodes Data (2011)

Selten, J-P, Cantor-Graae, E & Kahn, René S (2007) Migration and Schizophrenia

(*Current Opinion in Psychiatry: March 2007 - Volume 20 - Issue 2 - p 111-115*)

Kelly y et al (2009) Why does birthweight vary among ethnic groups in the UK? Findings from the Millennium Cohort Study

(J Public Health (2009) 31 (1): 131-137)

British Heart Foundation Health Promotion Research Group (2010) Ethnic Differences in Cardiovascular Disease

Diabetes UK (2010) Diabetes in the UK 2010: Key statistics on diabetes

Health Equity Audit of the Stop Smoking Service in Lewisham, May 2013

NHS Lewisham Health Equity Audit of Breast Cancer Screening 2010

K Robb, S Stubbings, A Ramirez, U Macleod, J Austoker, J Waller, S Hiom and J Wardle (2009) Public awareness of cancer in Britain: a population-based survey of adults

(British Journal of Cancer 2009 101(Suppl 2): S18–S23)

Public Health England (2013) HIV Epidemiology in London: 2011 Data

Religion/Belief

Department of Health (2009) Religion or Belief: a practical guide for the NHS

Gender Re-assignment

Department of Health (2007) Reducing health inequalities for lesbian, gay, bisexual and trans people

Gender Identity Research and Education Centre (2011) The Number of Gender Variant People in the UK - Update 2011

Sexual Orientation

Lewisham Joint Strategic Needs Assessment (demography, sexual health and mental health chapters)

Public Health England (2013) HIV Epidemiology in London: 2011 Data

Marriage/Civil Partnership

Derbyshire County Council (2013) Equality Impact Analysis of Health and Wellbeing Strategy

Deprivation

Lewisham Joint Strategic Needs Assessment (alcohol, tobacco control, sexual health, mental health, long term support, cancer and Lewisham profile chapters)

Health Equity Audit of the Stop Smoking Service in Lewisham, May 2013

Characteristics of Lewisham Population

Age

- Lewisham has a relatively young population:
- 25.4% of residents are under 19 (compared to an England average of 25%)
- Children under 5 make up 8% of the population, compared to 6.3% in England
- Only 10.5% of the population are over 65 (compared to an average of 11% for London and 16% for England)
- There is a higher proportion of older residents in the south of the borough (7% of residents of the northern wards of the borough (Evelyn, New Cross and Brockley) are aged 65 years and over compared to 14% in the southern wards of Grove Park, Downham, Sydenham and Catford South). (There is not a similar geographical pattern for younger residents.)
- Lewisham's younger population is more ethnically diverse; 73% of residents aged 65 and over are white, compared to 61% of those aged 16-64 years.

Older People

- Both healthy and disability adjusted life expectancy at age 65 are significantly lower in Lewisham than both the England and London averages.
- The rates of all and emergency admissions for those aged 65 and older are significantly higher in Lewisham than England.
- Lewisham has a directly standardised all cause mortality rate for the over 65s that is significantly worse than England as a whole.
- Health declines with age; 16% of Lewisham residents aged 35-49 report not being in good health compared to 71% of over 85s.
- England-wide figures show that long term conditions become more common with increasing age. Three times as many over 75 year olds report having at least one long term condition compared to those aged 16-44.
- The prevalence and hospital admission rates for COPD (Chronic Obstructive Pulmonary Disease) are higher in Lewisham than in England as a whole. 88% of admissions for COPD are amongst people aged 60 years or over. Similarly rates of admissions for heart failure are higher in Lewisham than England as a whole.
- Emergency readmission rates within 28 days of discharge for residents aged over 75 are significantly worse than England.
- The rates of admission of over 65s to residential and nursing homes in Lewisham was 560 per 100,000 in 2011/12; this is lower than the England average, though

higher than the London average. The rates of over 65s returning home to their usual place of residence following a hospital admission for hip fractures is worse for Lewisham residents than the England average.

- 89% of those aged 65+ in Lewisham discharged to rehabilitation services are still at home 91 days after admission.
- Standardised cancer mortality rates amongst the over 65s are significantly higher in Lewisham than England. However, those for 35-64 year olds are lower than England.
- In 2011/12 70% of over 65s year olds were vaccinated against influenza. This is below both the London and England rates.

Children and Young People

- Obesity amongst children in Lewisham is a significant problem. The prevalence of obesity amongst both 4-5 year old and 10-11 year olds is higher in Lewisham than the England average; 37% of 10-11 year olds are either overweight or obese.
- Lewisham has a high proportion of children and young people from ethnic minorities; national data has shown a higher prevalence of overweight (including obesity) in Black African and Caribbean children.
- England has one of the highest death rates from chronic liver disease, used as a marker for alcohol-related harm, in Western Europe. And importantly for young people it is the only disease in which deaths amongst the under 65s are increasing. Hospital admissions related to alcohol are high and increasing in Lewisham. Binge drinking is more common amongst young people, and there is evidence of a rise in alcohol harm amongst young women in particular (see gender section for further details)
- The earlier children or young people start smoking the greater their risk of developing lung cancer and heart disease later in life. Children who live with parents or siblings who smoke are two to three times more likely to take up smoking. There is evidence that smokers who started at an early age smoke more and are less likely to be able to quit. In Lewisham smokers aged 15-19 using the Stop Smoking Service were less likely to successfully quit than older smokers.
- Rates of mental illness are higher in Lewisham than England and London. Most mental disorder begins before adulthood with 50% of lifetime cases of diagnosable mental illnesses beginning by age 14 and 75% of disorders starting by the mid-20s.
- The under-18 conception rate in Lewisham is significantly higher than rates in both London and England. In Lewisham abortion rates are highest amongst 18 and 19 year old women, and overall the abortion rates in the borough are higher than both London and England.
- Uptake rates of MMR2 and pre school booster vaccination for Lewisham children are amongst the lowest in London. There was an outbreak of Measles in Lewisham in 2008.

Disability

- In 2011 14% of individuals in Lewisham reported having a long-standing health condition or disability that limited their day to day activities. Half of those reported that it limited them “a lot”.
- Individuals with a long standing disability or health condition may be more vulnerable to minor illnesses or accidents. These may also have a greater impact on their wellbeing and ability to live independently in the short or long term.
- Similarly those with a long standing disability or health condition are more likely to require long term care and support.
- The rates of admission for people with COPD and heart failure are higher in Lewisham than the England average.
- Individuals with learning disabilities are more likely to be admitted to hospital than the general population (26% per year and 14% per year respectively). They are also four times more likely to die of preventable causes and are significantly more likely to die under the age of 50.
- Lewisham is currently a pathfinder in a national programme for children with disabilities and special educational needs.
- People with long term conditions are 2 to 3 times more likely to suffer from depression than those in good health. Amongst those with two or more chronic physical conditions, the risk of depression is seven times higher.
- The proportion of people achieving recommended levels of physical activity is lower amongst those with disabilities than the able-bodied. The prevalence of obesity is higher in children with long-term health conditions or disabilities.
- In Lewisham 17% of people accessing alcohol treatment services have a disability.

Sex and Gender

- 15.5% of males living in Lewisham of all ages reported not being in good health, compared to 17.7% of women.
- Emergency admissions for Lewisham residents vary across the borough. Rushey Green and Ladywell have the highest standardised rates for men and Rushey Green and Evelyn for women.
- Men are twice as likely to die from alcohol related harm as women.
- Alcohol harm is an increasing problem amongst women and in particular young women; although alcohol-specific admissions are higher for men than women, over the past few years rates have levelled off in men but continue to rise in women. In the case of under 18s the alcohol-specific admission rates for women are twice those of young men (though in the over 18s the rates for men are three times higher)
- The premature mortality rate for all cancers for men (under 75) in Lewisham was 24% higher than the England-wide rate, the same rate for women in Lewisham was 10% higher than the rate for England.

- Physical activity is higher amongst men than women at all ages. A higher proportion of women than men in England have a healthy⁸ body mass index (BMI) (34% and 39% respectively), but more women are obese than men (26% and 24% respectively) In the case of women (in England) rates of obesity increase with increasing levels of deprivation; this relationship with deprivation is weaker for men.
- In the UK smoking prevalence is slightly higher in men than women and smoking-related mortality is higher amongst men. In Lewisham more women than men seek support to quit smoking through the Stop Smoking Service, but men are more successful in quitting using the service than women.
- Women are more likely to suffer from common mental illnesses than men, though men are twice as likely to suffer from schizophrenia.
- Women have more long term conditions on average than men, particularly with increasing age.
- On the average, women receive more social care services (8.2%) than men (3.6%) in Lewisham, though this is presumably because on average women live longer than men.

Pregnancy and Maternity

- The general fertility rate (number of live births per 1000 women aged 15-44) in Lewisham is higher than the London and England averages. In 2011 the wards with the highest rates were Crofton Park and Rushey Green; Brockley and Telegraph hill had the lowest.
- Abortion rates in Lewisham are higher than the England average and almost half of abortions are performed on women who have had at least one previous abortion. The highest rates of abortion in the borough are for women aged 18-19 years old.
- The low birth weight rate for Lewisham births is higher than the England average, though not significantly different to London. Low birth weight can be associated with some ethnicities, including black Caribbean and black African, alcohol use, smoking and deprivation.
- Smoking by mothers at time of delivery is lower in Lewisham than the UK average.
- Local maternal obesity data show there are more women overweight (31%) or obese (24%) in Lewisham compared with England as a whole (28% and 17%).
- Influenza vaccine rates amongst pregnant women in Lewisham are below the London average.

Race

- Lewisham is an ethnically diverse borough, with only 41.5% of the population describing themselves as white British. The largest BME groups in the borough are black Caribbean and black African.

⁸ BMI between 18.5 and 25

- In Lewisham self reported health at the 2011 Census was worse in white British and black Caribbean residents than other ethnic groups. However, this may simply reflect the age profiles of these ethnic groups.
- Obesity prevalence varies between ethnic groups. In England the prevalence of obesity is higher in women of Black Caribbean, Black African and Pakistani groups compared to the general population.
- In Lewisham the majority of people accessing alcohol treatment services are white British; the Health Survey England in 2004 found that harmful drinking was less prevalent among ethnic minorities, including black Caribbean and Africans.
- There is evidence nationally that some ethnic minorities have a higher prevalence of some mental illnesses, most notably black African and Caribbean men and schizophrenia; it is thought migration and other factors play a part in this association. In Lewisham there are high numbers of admissions amongst people whose ethnicity is reported as black other.
- Smoking prevalence varies between ethnic groups. Taking this into account proportionately fewer black African smokers are using the local Stop Smoking Service.
- Some long term conditions are more prevalent amongst ethnic minority communities, including diabetes and cardiovascular disease.
- There is evidence nationally to suggest that emergency admissions are higher amongst ethnic minority groups.
- Cancer incidence in general is lower amongst ethnic minority groups, although there are some important exceptions. For example, prostate cancer incidence is greater amongst Black African and Black African-Caribbean men.
- Levels of public awareness of early symptoms and signs of cancer have been found to be lower amongst ethnic minority groups. In Lewisham breast cancer screening attendance was lower amongst BME women than white British women.
- Pregnancy rates are 74% higher amongst black ethnic groups than white ones; similarly, abortion rates are higher.
- New diagnoses of HIV are higher amongst black Africans in Lewisham, and Lewisham as a whole has one of the highest prevalences of HIV in England. About a third of new diagnoses of HIV in South East London are in Black Africans.

Religion or Belief

- Christianity is the most widely reported religion in the borough, with 53% of residents identifying themselves as Christian, 6% identify as Muslim and 27% have no religion.
- At the last census rates of self reported poor health were significantly lower than average amongst those with no religion and Hindus and higher than average amongst Christians, Buddhists, and those of “Other Religions⁹.
- Religious and cultural views can influence attitudes towards reproductive medicine, abortion, contraception, neonatal care and death. They may also determine the

⁹ Excluding Hinduism, Christianity, Buddhism, Islam, Judaism and Sikhism

types of treatment and drugs used, for example blood transfusions, porcine or alcohol-based drugs.

- In Lewisham there are a number of successful health projects run alongside religious groups. For example, the Community Health Improvement Service conduct health drop in sessions in a variety of faith centres, including the Hindu temple. Similarly, services have worked alongside religious groups at key times, such as the Stop Smoking Service at Ramadan.

Gender Reassignment

- There is very limited information on the prevalence of gender reassignment. The most recent estimate suggests that 25 per 100,000 individuals have received treatment for gender variance; 60% of those have undergone transition surgery. The majority (80%) of those undergoing surgery were born male and transitioning to female.
- A national survey of transgender people found that a third of adults had attempted suicide.
- Rates of substance misuse have been found to be higher amongst transgender communities.
- 30% of transgender people have experienced discrimination from healthcare professionals, including with regard to cancer screening.

Sexual Orientation

- There are no accurate statistics available regarding the profile of the lesbian, gay, bisexual and transgender (LGBT) population either in Lewisham, London or Britain as a whole.
- The Greater London Authority based its Sexual Orientation Equality Scheme on an estimate that the lesbian and gay population comprises roughly 10% of the total population.
- At the 2011 census 2% of over 16 year olds were cohabiting with someone of the same sex or were in a civil partnership, this is higher than both the England and London averages (0.9 % and 1.4% respectively).
- There are higher rates of mental illness amongst individuals who describe themselves as lesbian, gay, or bisexual. Young gay men have been found to have a 5 fold increase in the risk of depression compared to heterosexual men. Suicide risk is 12 times higher.
- Men who have sex with men (MSM) are at increased risk of acquiring HIV; just over half of new diagnoses of HIV in 2011 in South East London were in MSM. In London as a whole rates of new HIV infection amongst the MSM community are increasing, despite falling amongst other groups.

Marriage and Civil Partnership

- About half of Lewisham residents over 16 have never been married or in a civil partnership. This is higher than England as a whole.
- A third of over 16s in Lewisham are currently married or in a civil partnership (0.5% in civil partnership)
- 17% of residents (aged 16 and over) have been married or in a civil partnership but are now separated, divorced¹⁰ or widowed¹¹.
- Married people's physical and mental health tends to be better than that of single people. However the health of single people is usually better than that of people who are widowed, separated or divorced.

Deprivation

- Lewisham is the 31st most deprived local authority in England and deprivation is increasing in the borough relative to the rest of the country.
- The highest levels of deprivation are found in Evelyn ward, in the north of the borough and Downham ward, in the south of the borough.
- Deprivation is quantified using the Index of Multiple Deprivation, which takes into account the following components: income, employment, health and disability, education, skills and training, housing and services, crime and the living environment.
- Increased deprivation is associated with worse health and wellbeing outcomes across many domains:
 - In Lewisham alcohol specific admissions are higher amongst residents of more deprived wards. The admission rates in Lewisham central for the period from 2005 to 2011 were three times higher than the ward with the lowest rates of alcohol specific admissions.
 - Obesity is higher amongst those from more deprived areas. National figures have shown obesity levels amongst 4-5 year olds in the most deprived areas to be double that of the least deprived.
 - It has been estimated that the need for mental health services is 25-40% higher amongst residents of the least affluent wards in the borough compared to the most affluent.
 - Cancer incidence and mortality are generally higher in deprived groups compared with affluent groups. Although breast cancer has higher incidence in more affluent groups, its mortality is higher in less affluent women.
 - Smoking prevalence is higher amongst those from lower socio-economic groups.

¹⁰ Or were in a civil partnership that has now been legally dissolved

¹¹ Or are the sole surviving partner of a civil partnership

- Additionally, smokers from lower socio-economic groups are more likely to have started earlier, smoke more and find it harder to quit than smokers from higher socio-economic groups.

Annex 2: Additional Data Sources

CCG Papers

Commissioning Intentions, Strategic Priorities [undated]: Powerpoint presentation, supplied on 9/9/13 by Charles Malcolm-Smith

Lewisham CCG Strategy Development Update 6th June 2013

Lewisham CCG Strategy Summary Version 0.4 August 13

Appendix 3: Glossary of Terms

AAS Admission Avoidance Service

A&E Accident and Emergency

AHSN Academic Health Science Network

APMS Alternative Provider Medical Services

AQP Any Qualified Provider

BMA British Medical Association

BME Black and Minority Ethnic

BNF British National Formulary

CAMHS Child and Adolescent Mental Health Services

CAS Central Alert System

C&B Choose & Book

CBT Cognitive Behavioural Therapy

CCG Clinical Commissioning Group

CEMACH Confidential Enquiry into Maternal and Child Health

CIO Chief Information Officer

CIP Cost Improvement Programme

CNST Clinical Negligence Scheme for Trusts

COPD Chronic Obstructive Pulmonary Disease

CRL Capital Resource Limit

CPA Care Programme Approach

CPD Continuing Professional Development

CPR Child Protection Register

CQC Care Quality Commission

CQUIN Commissioning for Quality and Innovation

CRB Criminal Records Bureau

CSU Commissioning Support Unit

CSS Commissioning Support Service

CYPPB Children and Young people Partnership Board

DAT Drug Action Team

DGH District General Hospital

DH or **DoH** Department of Health

E&D Equality and Diversity

EDS (NHS) Equality Delivery System

EI Early Intervention

EIA Equality Impact Assessment

EMIS Practice Information System

ENT Ear, Nose and Throat

EPP Expert Patient Programme

EPR Electronic Patient Record

EPS Electronic Prescription Service

EWTD European Working-Time Directive

FCE Finished Consultant Episode

FHS Family Health Services

FIMS Financial Information Management System

FOI Freedom of Information

FOT Forecast Outturn

FT Foundation Trust

GP General Practitioner

GPI General Practitioner Interactive

GPSI or **GPwSI** General Practitioner with a special interest

GSTT Guy's & St. Thomas's NHS Foundation Trust

HCA Health Care Assistant

HCAIs Healthcare Acquired Infections

HIA Health Impact Assessment

HRG4 Healthcare Resource Group version 4

HTA Health Technology Assessment

HV Health Visitors
HWB Health and Wellbeing Board

Staphylococcus Aureus
MSK Musculoskeletal

IAPT Improving Access to Psychological Therapies (programme)
ICO Integrated Care Organisation
ICP Integrated Care Pathway
ICT Information and Communication Technology
ICU Intensive Care Unit
I&E Income and Expenditure
IG Information Governance
IM&T Information Management and Technology
IST Intensive Support Team

NCAS National Clinical Assessment Service Programme
NCB National commissioning Board
NTDA National Trust Development Authority
NHS National Health Service
NHS SBS NHS Shared Business Services
NHS CB NHS Commissioning Board
NHSLA NHS Litigation Authority

JHWS Joint Health and Wellbeing Strategy
JSNA Joint Strategic Needs Assessment

OD Organisational Development
ONS Office for National Statistics
OOH Out of Hours
OP Outpatient Assessment
OSC (local authority) Overview and Scrutiny Committee

KPI key Performance Indicator

PALS Patient Advice and Liaison Service
PBMA Programme Budgeting and Marginal Analysis
PbR Payment by Results
PHE Public Health England
PHO Public Health Observatory
PI Performance Indicator
PMS Personal Medical Services
PNA Pharmaceutical Needs Assessment
POD Point of Access
PPA Prescription Pricing Authority
PPE Patient and Public Engagement
PPG Patient Participation Group
PPI Patient and Public Involvement
PROM Patient-Reported Outcome Measure

LA Local Authority
LES Local Enhanced Services
LHNT Lewisham Healthcare NHS Trust
LIFT Local Improvement Finance Trust
LINKs Local Involvement Networks
LMC Local Medical Committee
LSP Local Strategic Partnership
LTC Long-Term Conditions

MCATS Musculoskeletal Community Assessment and Treatment Service
MFF Market Forces Factor
MMR Measles, Mumps, Rubella (vaccination)
MRI Magnetic Resonance Imaging
MRSA Methicillin-Resistant

QA Quality Assurance
QALY Quality-Adjusted Life Year
QIPP Quality Innovation Productivity
and Prevention
QMAS Quality Management and
Analysis System
QOF Quality and Outcomes Framework

RO Responsible Officer
RRL Revenue Resource Limited
RTT Referral to Treatment

SBS (NHS) Shared Business Services
SFI Standing Financial Instructions
SLA Service Level Agreement
SLaM South London and Maudsley
Mental Health Foundation Trust
SMR Standardised Mortality Ratio

SO Standing Order
SUS Secondary User Services

TIA Trans Ischaemic Attack- Stroke
Indicator
TDA – Trust Development Authority
TSA – Trust Special Administrator

UCC Urgent Care Centre

VFM Value for Money
VPR Virtual Patient Record

WIC Walk in Centre
WTD Working-Time Directive
WTR Working Time Regulations