NHS
Brighton and Hove
Clinical Commissioning Group

2018/19 Commissioning Intentions

Delivering Caring Together

Version 3 (13th September 2017)

Contents

Background and Context

1. Purpose of this document

This document sets out the CCGs initial plans for the coming year (2018/19). This should be read alongside Brighton and Hove Caring Together which sets the strategic direction for the local health and care system. The proposals contained here will form the basis of further engagement with our local community and stakeholders as part of the Big Conversation.

2. Developing our plans

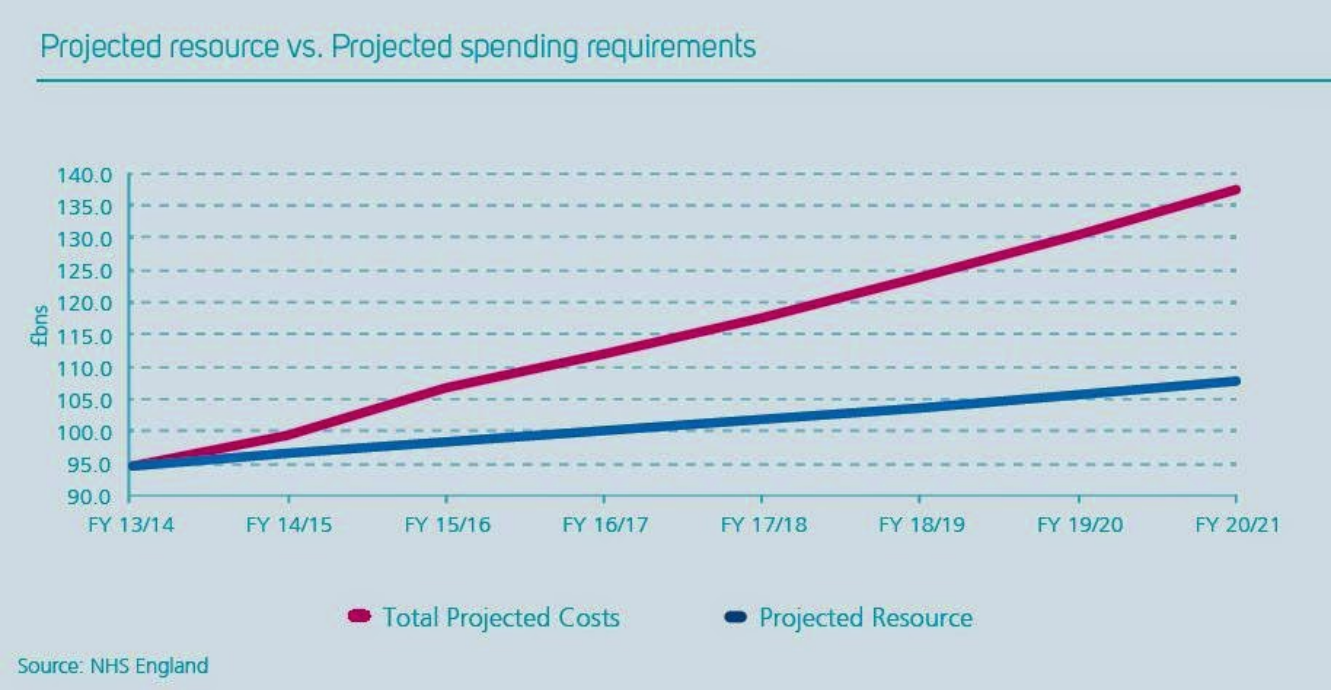
Our draft commissioning intentions have been informed by our ongoing engagement with local people, particularly through our “Big Health and Care Conversation” in 2017.

A summary of our draft commissioning intentions will be sent to patients, carers, key Community and Voluntary Sector partners and other stakeholders as widely as possible across the city. We will seek feedback on, and active involvement in, these plans and the resulting activity, and ensure that in all areas there is appropriate and proportional patient, carer and public involvement.

3. National Financial context

There is little doubt that the health and social care environment that we face is extremely challenging. Demand for services is rising faster than funding can keep pace and the complexity of patient and service user conditions increases as communities are challenged, and people live longer and require more integrated support in older age.

NHS England and independent analysts have calculated that a combination of growing demand and flat real terms funding would produce a mismatch between resources and patient needs of nearly £30 billion a year by 2020/21. The graph below illustrates the scale the challenge:



4. Local Financial and planning context

The CCG has a legal duty to live within its means and will need to deliver the efficiency savings within its commissioning plan in order to achieve its financial control total.

The current levels of national NHS funding, coupled with the continued rising demand on services, means many local CCGs and others across the country are struggling to manage a balanced financial plan and there is now a real risk that BHCCG will experience similar problems in the future.

To mitigate this risk, the CCG has started a Financial Sustainability Programme that aims to change the culture and way of working within the organisation to ensure the commissioning plans are delivered and the size of the financial challenges is not increased.
The programme is a formal way in which we will scrutinise budgets and the delivery of our financial plan. The programme will involve:

- All budget holders being expected to manage all costs pressures within their existing funding allocation
- The Quality, Innovation, Prevention and Productivity (QIPP) process being strengthened with enhanced Executive Director oversight to include a full reconciliation of QIPP delivery against activity modelling
- A weekly Financial Sustainability meeting

In terms of planning for 18/19 this means that we must focus our plans on the areas of highest need and proven effectiveness. To ensure that our plans are delivering best value for money we must also look at areas of low priority and low effectiveness and potentially decommission in those areas.

As a result all budget areas within the CCG have been looked to ensure we have the ability save 5% to create headroom and to provide an investment profile for out of hospital care.

5. Priority Areas

The Brighton and Hove Joint Strategic Needs Assessment (JSNA) and the Annual Report of the Director of Public Health provide an overview of the needs of the city and have been used to identify where we best allocate our funding.

The JSNA highlights the following areas:

- Brighton & Hove is one of the most deprived areas in the South East and has a population with significant health needs and inequalities
- The city's population is predicted to get older with the greatest projected increase (37%, 9,300 extra people) will be seen in the 55-64 year age group. The population of people aged over 70 is also predicted to increase by 21% (5,500 people) including those aged 90 or older (500 people, 21%). People aged 20 to 29 are predicted to fall by 3% (1,600 people).
- There is a larger difference in healthy life expectancy in the city between the most and least deprived individuals – 14.0 years for males and 12.5 years for females
- The commonest causes of death in the city are cancers, circulatory diseases, respiratory diseases and digestive diseases. The under 75s age-standardised mortality rate from cancer is higher than for England and the South East at 146.4 deaths per 100,000 people for 2013-15 compared to 138.8 and 129.4 respectively.
- We also have a higher suicide rate. The rate of deaths by suicide and injury undetermined for Brighton & Hove residents for 2013-15 was 15.2 deaths per 100,000 people (age standardised), approximately 50% higher than the rate for England (10.1 deaths per 100,000).
- We have some of the worst rates of lifestyles behaviours at age 15 in the country, which impact upon young people's current and future health and wellbeing.
- Smoking, alcohol and drug misuse in particular are significant issues in Brighton & Hove.
- Brighton & Hove has a relatively large proportion of older people living alone and potentially isolated who are more dependent upon public services, but also more active older people than England.

Commissioning Intentions

The development of the Caring Together Programmes, which form the basis of these commissioning intentions, has been clinically led, based on need and jointly developed with partners. They have been further refined based on the feedback received as part of the Big Conversation.

The six programmes are:

- Prevention and Community Care.
- Planned Care services
- Access to Primary Care and Urgent Care.
- Equality of Access to Mental Health services.
- Medicines Optimisation.
- Future Models for Acute Care.

In the following sections we set out by programme the commissioning intentions required to deliver transformation and ensure financial sustainability.

In addition we recognize that there are a number of enabling programmes which require articulating and inclusion in contracts. In this respect we have included an additional section on Digital Delivery.

6. Prevention and Community

This care programme represents the implementation of the six components of the CCG's Operating Plan and includes the greatest areas of working with Brighton & Hove City Council, Public Health and with community and acute providers. This is a significant programme both in terms of delivery commitment and of priority.

The Programme is divided into the below six projects. Within each project there are a number of workstreams that are detailed.

- Project 1A: Prevention
- Project 1B: Community Short Term Services
- Project 1C: Continuing Health Care
- Project 1D: Frailty
- Project 1E: Dementia
- Project 1F: End of Life

During the development and implementation of each project, the following elements will be considered. Progress for each project will be measured against indicators relating these elements.

- Addressing the needs and assets of carers.
- Strengthening self-care and self-management.
- Addressing health inequalities.

Commissioning Intention	Description	Delivery Date
Project 1A: Prevention	Historic structures of funding and service delivery and recent challenges around rising demand, complexity and falling budgets have all contributed to a health and social care system that spends money on illness and long-term care instead of keeping people well and independent. An approach to prevention that is informed by local needs, particularly as identified in the Joint Strategic Needs Assessment (JSNA), will form the core of Brighton & Hove's specific project that will aim to commission locally-relevant and effective preventative services. This project will be formally constituted and commence activity in Q3 of 2017/18. Consequently, it has been identified as a PRIORITY project within the programme. The project is led by Public Health and uses locally-evidenced approaches. The key workstreams are: • Ageing well • social prescribing including community navigation,	End of Q1, 2018/19

Commissioning Intention	Description	Delivery Date
	• Befriending to reduce social isolation	
Project 1B: Community Short Term Services	The JSNA predicts that the city's population will get older with the population of people aged over 70 increasing by 21% (5,500 people), by 2026. As people live longer the size of the older population will increase leading to a growing number of people living with multiple long-term conditions. Plans will need to be put in place to manage their future health and care needs set against a challenging economic climate. The Community Short Term Services Project is likely to comprise the most significant and intensive of any activity within the overall CaTo Programme. It seeks to redesign the community pathways activity around admission avoidance; supported, timely discharge, intermediate care services (step-up and step-down), reablement, and new ways of working, and single access arrangements. This project has been identified as a PRIORITY project within the CaTo programme and its overall purpose is to create genuinely aligned and, where practicable, integrated community health and social care functions that support admission avoidance and timely discharges from acute care, thereby reducing acute activity and increasing positive patient and service user experience. This project will be formally constituted and commence activity in Q2 of 2017/18. Led by Brighton and Hove CCG and Brighton and Hove City Council this project will deliver the following workstreams: • Discharge to assess / Home First pathway incl. community partners. • Social prescribing to support hospital discharge. • Community short term services around step up and step down beds. • Review and rationalisation of short term domiciliary provision and pathways. • Hospital at Home.	End of Q4, 2018/19
Project 1C: Continuing Health Care	To develop a service model that achieves the 'NHS Next Steps on the NHS Five Year Forward View' requirement of less than 15% of all full NHS Continuing Healthcare (CHC) assessments take place in an acute hospital setting by March 2018. The project will focus on the following outcomes: • To ensure that fewer than 15% of full NHS CHC assessments take place in an acute hospital setting by the end of March 2018. • To continue to maintain national standards with regard to continuing healthcare assessments and reviews. • To complete assessments within 28 days. • To review patients within 3 months and annually thereafter.	End of Q4, 2017/18
Project 1D: Frailty	To ensure that all older people are assessed for the presence of frailty during all encounters with health and social care personnel. The project focuses on all older people identified as living with frailty to have a comprehensive review of medical, functional, psychological and social needs, based on the principles of comprehensive geriatric	End of Q2, 2018/19

Commissioning Intention	Description	Delivery Date
	assessment (CGA). The project will ensure use of a common measurement tool across the health and social care pathway following a CGA (i.e. Rockwood) and establish shared care and support plans that involve families and carers. The purpose of this project is to develop a community response in partnership with primary care, adult social care, and the local acute sector (incorporating outputs from the national acute frailty network programme), to support wellbeing and independence, avoid inappropriate admissions and to improve delayed transfers of care for those who are frail. The project will focus on the following outcomes: • To define frailty and use this definition across the city for example agreed use of the Rockwood Measure. • To share patient and organisational information across providers, including STP partners to deliver seamless care. • To agree a single patient care pathway embedding the right care, right time, right place principles. • To achieve a reduction of inappropriate and unplanned admissions.	
Project 1E: Dementia	In Brighton and Hove, in June 2017, the prevalence of people aged 65 and over with dementia was estimated as 2,767 and approximately 61 with early onset dementia. However only 64.3% of these people have been formally diagnosed with dementia, against the national target for dementia diagnosis rate of 67%.Of those diagnosed with dementia, only 71% have had a dementia care plan completed as part of a review in the preceding 12 months. As a result, Brighton and Hove are ranked in the bottom 15% of CCGs for dementia diagnosis and the bottom 2% for annual care plans. Dementia has been prioritised for partnership working by the Joint Health and Well Being Board and progress has been made on the key action areas set out in the Brighton & Hove Dementia Joint Strategic Delivery Plan 2014-17. However, this now needs to be refreshed and new key areas for action identified. The overarching aim of the dementia work stream is to ensure that the services we commission for dementia are framed in line with The Well Pathway for Dementia developed by NHS England (2016) and The Prime Ministers 20:20 Challenge (2015) and meet the needs of the population and the carers who support them. The Well Pathway provides a transformation framework that will help us provide services that ensure that: • The risk of people developing dementia is minimised. • Timely accurate diagnosis ,care plan and review within the first year. • Access to high quality health and social care for people with dementia and their carers. • People with dementia can live normally in safe accepting communities. • People living with dementia die with dignity in the place of their choosing.	End of Q2, 2018/19

Commissioning Intention	Description	Delivery Date
Project 1F: End of Life	In 2015 there were 2,123 deaths (all ages) in Brighton & Hove. Of these, 41% occurred in hospital, whilst 23% occurred in the usual place of residence and 22% in care homes. Brighton & Hove performs better than England for deaths in hospital (47% of deaths in England were in hospital) and has the third lowest percentage of deaths in hospital of the 17 comparator Clinical Commissioning Groups. Brighton & Hove is similar to England for the percentage of deaths in usual place of residence and has the 2nd lowest percentage of people dying in hospitals of its comparator group of 17 CCGs. We are looking to ensure that the services we commission meet the needs of the population including the person at end of life and the carers and families who support them and as a consequence benefit the wider health and social care system. End of life care (EOLC) services support those with advanced, progressive, incurable illness to live as well as possible until they die. They also enable people to choose their preferred place of care and death. The provision of end of life care services has become increasingly complex as people are living longer with multiple conditions. Surveys of the public have shown that the first preference for most people in the UK (56-74 %) would be to die at home, although as people become sicker and approach death this proportion may decline, as they want access to more extensive support, such as hospice care. NHS England's Ambitions for Palliative and EOLC: The project will focus on delivering the following: • To develop an End of Life strategy. • To work with STP partners to establish and adopt EOLC best practice models to ensure local provision of an equitable, high quality, integrated, value for money end of life care services for people and their carers . • To relaunch the Advance Care plan (ACP) by education and implementation of ReSPECT with support from Academinc Health Science Network. These are likely to be included in anticipated ATP plans. This will include training for care homes, ambulance GPs and other providers • To improve support to care homes including residential homes to improve EOLC • To support electronic information sharing by use of Summary Care Record additional information and the local contingency plan, as well as sharing & coordination between health & social care. • To support carers to access relevant services pre and post bereavement. • To implement robust equalities monitoring across EOLC pathway.	End of Q4, 2018/19
Palace Place Premises	The Ardingly Court practice is due to move into new premises in Palace Place in the town centre in the aututmn of 2018. The commissioner would like to explore with our providers what other services could be co-located there, to improve service integration and patient access.	

7. Planned Care and Cancer

The NHS Constitutional Referral to Treatment (RTT) standards have not been met locally for the past two years because the available capacity at the local acute trust has not been sufficient to meet demand and a significant waiting list has therefore developed. In addition, data quality issues have hampered the CCG's ability to accurately quantify the issues.

The NHS sets out a number of standards for cancer diagnosis and treatment. The 62-day urgent referral to treatment standard has not been met for a significant period of time. In addition, Brighton and Hove has lower rates of early detection of cancer; uptake of cancer screening and survival rates following a diagnosis of cancer than other areas of the country.

The CCG's Operating Plan 2017/19 is clear that the development of the system-wide recovery plan in 2016/17 marked a turning point in our approach to planned care. The plan is based on significantly improved data and focused on plurality of provision, patient choice and managing demand. The development of a Brighton and Hove Cancer Strategy and a programme of work focused solely on cancer aims to support the improvement in cancer outcomes, experience and care for our population. Using the RightCare Methodology, the CCG has set out in the Operating Plan how it will address the failure to meet its constitutional standards for referral to treatment times and cancer diagnosis and treatment times, and the Caring Together Programme refines these ambitions further into a series of project-based deliverables.

Commissioning Intention	Description	Delivery Date
Project 2A: Cardio-Vascular Programme	This project is made up of a number of components that will deliver a system-wide response to cardiovascular disease within the city, bringing care close to home and maximising opportunities to diagnose risk factors early, delivering city wide primary prevention schemes and delivering care within acute settings that offers the best clinical outcomes for patients. The project will focus on the following outcomes: • To reduce mortality rates caused by cardiovascular disease. • To reduce non-elective admissions for heart failure. • To reduce acute care procedures considered of limited clinical benefit.	End of Q1, 2018/19
Project 2B: Demand Management	The demand management project will incorporate a number of areas of focus including GP peer to peer review, the use of advice and guidance, the development of robust clinical guidelines and review of referral management processes. The project will focus on the following outcomes: • To meet NHS Constitutional Standards by ensuring patients have access to the right elective service at the right time and reducing RTT times for clinically appropriate referrals. • To ensure GPs are supported to make referral decisions based on robust clinical guidelines and processes. • To provide GP access to consultant advice and guidance to ensure more patients are seen in a primary care setting. • To provide the highest quality and value clinical care by using capacity within local acute Trusts. • To deliver savings by preventing clinically inappropriate referrals to secondary care when appropriate alternatives are	End of Q4, 2017/18

Commissioning Intention	Description	Delivery Date
	available.	
Project 2C: Digestive Diseases Straight to Test (STT) Pathway	This project is based on the outcome of piloting the delivery of a straight to test pathway for Two-Week Wait (2WW) colorectal referrals with the intention to roll out the pathway fully within digestive diseases. Best practice evidence has shown that the use of telephone triage to assess patients requiring endoscopy can lead to reductions of up to 80% in first outpatient appointments and up to 50% in follow up appointments. We will also work with our main acute provider, BSUH, to scale up straight to test pathways across a number of other digestive disease pathways. The project will focus on the following outcomes: • To deliver NHS Constitutional Standards for patient access to the right diagnostic and the right treatment at the right time following triage. • To free up capacity in the system to improve the pathway for patients. • To ensure clinical digestive disease pathways are current and correct to enable GPs to make the right decisions for patients. • To deliver savings by supporting clinically appropriate decision-making.	End of Q1, 2018/19
Project 2D: Intermediate Tier Headache Service (ITHS)	Brighton and Hove CCG will launch a 12 month Intermediate Tier Headache Service (ITHS) to include Direct Access MRI. The ITHS will be commissioned as a pilot for a period of one year. Evaluation of the pilot will determine whether the CCG will commission this service for the long term. The project will focus on the following outcomes: • To reduce first outpatient neurology referrals by offering patients a dedicated clinical session with sufficient time for a full assessment and consultation. • To reduce referrals for routine MRI brain scans by ensuring referrals are only requested once a full GP assessment has been undertaken. To improve patient experience and patient outcomes with patients seen in a community setting for chronic headache/migraine. • To determine the future of the services through an evaluation of the ITHS service in Q3 17/18. • To deliver savings by supporting clinically appropriate decision-making.	End of Q4, 2017/18
Project 2E: Stable PSA Monitoring in the Community	This project focuses on the implementation of a primary care PSA service will positively impact upon demand management by providing an alternative to secondary care pathways releasing capacity to support the increasing demand. Stable PSA monitoring in the community is happening in neighbouring CCGs and supported the movement towards stratified pathways. The project will focus on the following outcomes: • To reduce secondary care follow-up outpatient appointments. • To improve patient experience by bringing care closer to home. • To deliver savings by supporting clinically appropriate decision-	End of Q1, 2018/19

Commissioning Intention	Description	Delivery Date
	making.	
Project 2F: Cancer Care	This project aims to achieve the above national requirements through the implementation of a locally commissioned service for cancer, implementation of NG12, development of the recover package and working with the Cancer Alliance to develop rapid diagnostic centres and pathway redesign. The project will focus on the following outcomes: • To increase one-year survival rates from the current 69% to 75% by 2020 for all cancers combined. • To ensure that 95% of patients given definitive cancer diagnosis, or all clear, within 28 days of being referred by a GP, and 50% within 14 days. • To increase uptake of the national screening programmes for breast, bowel and cervical Increase in the number of cancer staged at 1 and 2 in Brighton and Hove • Compliance with the constitutional access standards • 70% of cancer patients have access to all elements of the recovery package. • To ensure GPs are supported to make referral decisions based on robust clinical guidelines and processes. • To deliver savings by supporting clinically appropriate decision-making.	End of Q1, 2018/19
Project 2G: Ophthalmology Service Re-design	To set out a whole system service re-design for Ophthalmology in order to move demand away from secondary care and into a community setting. This will be delivered by using the skills of consultants, community Optometrists and other eye health professionals within the community for diagnosis and treatment. There will also be opportunities to develop nurse led clinics to deliver post-operative and follow up care, and using eye health technology to provide for virtual clinics. The project will focus on the following outcomes: • To increase in ophthalmology activity provided within a community setting. • To improve patient experience by providing care in a community setting, closer to home. • To provide care in the right setting, using the skills of community optometrists, nurses and other eye health professionals. • Using technology to provide for virtual clinics to aid diagnosis • To reduce waiting times for patients by accessing care in the community. • To deliver savings by supporting clinically appropriate decision-making.	End of Q4, 2017/18
Project 2H: Ear, Nose and Throat (ENT) Service	This project will launch a suite of ENT pathways to support GPs to manage ENT conditions within primary care. Use of Advice and Guidance via the NHS e-Referral System, ENT is not currently included within the Advice and Guidance service.	End of Q4, 2017/18

Commissioning Intention	Description	Delivery Date
Re-design	• To scope a comprehensive community ENT service, this will include children from the age of two years old. The service provides for an extended scope of conditions that can be treated in a community setting. The service would be staffed by; GPs, GPwSI, ENT Specialist Nurses, Audiologists and ENT Consultant. The project will focus on the following outcomes: • To increase ENT activity provided within a community setting. • To improve patient experience by providing care in a community setting, closer to home and reducing waiting times. • To deliver savings by supporting clinically appropriate decision-making.	
Project 2J: Strategic review of the Central Sussex Integrated MSK Service	Musculoskeletal (MSK) services are currently commissioned on an integrated pathway basis by Brighton and Hove, Horsham and Mid Sussex and Crawley CCGs. The current contract is let on a 5 year term and will come to an end, pending any extension agreement, in September 2019. As a CCG, we need to develop the future commission and delivery model for MSK services from this date. The project will focus on the following outcomes: • To evaluate the current service model and develop an appraisal of options for future service delivery. • To develop a commissioning model for MSK services. • To reduce acute MSK related activity through the use of pathways with a high clinical value. • To deliver savings by supporting clinically appropriate decision-making.	End of Q4, 2018/19

8. Access to Primary Care and Urgent Care.

This care programme provides the foundations for collaborative working, including with Brighton & Hove City Council Adult Social Care, Public Health, and community, primary care and acute providers. This is a significant programme both in terms of delivery commitment and of priority which is why the access to services requires individual attention and focus.

The principal objective of this care programme, therefore, is to deliver an effective, efficient urgent care system, integrated across all relevant providers, including A&E, primary care out-of-hours services, NHS 111, the ambulance service (SECAmb) and the walk-in centre. Primary care is not a purely urgent care provider but has an important role to play in urgent care, both as a provider and as a gatekeeper to other service provision.

The principles are to review, overhaul and recommission a primary urgent care system that uses the resources of various providers and facilities to deliver an integrated, 24/7 environment to respond to the care needs of the population.

The overall outcomes will align components of primary care delivery in a revised delivery model, including the non-practice delivery mechanisms such as the current walk-in centre at Brighton Station and the primary care presence at A&E to support improvement in the four-hour target at BSUH.

This programme confirms the commitment of the local system to meeting the challenges set by the General Practice and Urgent Care Five Year Forward Views; in particular the national targets for Enhanced Access (which are attached at the end of this document).

To achieve this, the CCG will be increasing investment into General Practice in 2017/18 to support practices in the timing of appointments and commissioning additional consultation capacity. This is funded via national funding (£3.34 per patient rising to £6 per patient, which is summarised at the end of this document. In addition, there will be an increase in advertisements regarding services to patients including publicity of practice, pharmacy and dental service opening hours so that it is clear to patients when they are able to access these services. Practice receptionists will also be trained to signpost patients to alternative services as appropriate.

This Care Programme is divided into five principal deliverable outcomes, each with its own delivery project supporting transformation of services. These are:

- Primary Care at the Front Door of BSUH.
- GP Out-of-Hours Services.
- Roving GP Services.
- Clinical Navigation Hubs.
- NHS 111.
- Achievement of Enhanced Access targets

Commissioning Intention	Description	Delivery Date
Project 3A: Primary Care at the Front Door of BSUH.	The purpose of this project is to improve use of Accident and Emergency Services by streaming primary care presentations to general practice. The project will focus on the following outcomes: • To implement Front Door Clinical Streaming that will support patients and clinicians to make appropriate decisions. • To manage patient flow effectively by supporting hospital wards to divert inappropriate admissions from the front door of A&E. • To implement more coordinated processes for diverting patients to community and social care services and therefore reducing admissions from A&E. • To reduce the number of mental health referrals from A&E to physical health wards by increasing appropriate referrals to mental health services and commissioning specialist mental health care in A&Es. • To reduce the number of inappropriate presentations to A&E through enhanced NHS 111 by increasing the proportion of calls dealt with by a clinician from 22% to 50%.	End of Q4, 2018/19
Project 3B: GP Out-of-Hours (OOH) Services	Locally, there has been a shortage of GPs willing to work in the OOH environment. A key reason for this is the rising costs of indemnity year on year, which has been partially addressed by a national winter indemnity scheme, supported by the Department of Health and NHSE. Nevertheless, although the current OOH provider, IC24, increased GP pay by 3% in 2014, there was little to no consequent impact on GP rota fill. The project will deliver the work needed to strengthen IC24's proactive role as a system partner with respect to the local escalation system and transparency of its arrangements and processes. The system as a whole would benefit from full SHREWD 'automated' feeds from IC24 and more frequent engagement in system calls. Recent work has identified weakness in notifications to the system when a change in status occurs. This will be followed up by the CCG and NHS 111 to identify a more straightforward process for IC24 to alert escalation	End of Q1, 2018/19

Commissioning Intention	Description	Delivery Date
	status. The project will focus on delivering the following outcomes: • To redesign the GP OOH service to ensure that a there is a full rota between 19.00 and 08.00. • To redesign the GP OOH service to ensure a full rota in A&E between 19.00 and 00.00. • To implement a revised SHREWD process that delivers automated feeds.	
Project 3C: Roving GP (RGP) Services	The Roving GP service has two primary objectives: • To visit and assess/review patients that have an urgent medical need and are at risk of hospital admission but where the patient's main GP cannot visit. • To undertake medical reviews of Community Short Term Services (CSTS) patients in bedded units and at home. For the bed units they provide dedicated hours for each bed unit and at home they visit patients where their primary care GP cannot visit. The key aim is to avoid hospital admission and ensure patients receive the medical care they require in the appropriate environment. There are times when multiple referrals come in from primary care and the service cannot respond within target or at all. Performance and CCG satisfaction levels with the service is variable. The following points summarise key performance issues: • 75% of referrals from primary care GPs responded to within 1 hour. IC24 RGP service generally meets or just comes under this target due to multiple referrals at the same time that they cannot respond to in time as there is only one GP on duty at any time. • 75% urgent referrals from CSTS bed units responded to within 1 hours – this is a new one that we are starting to capture so no data yet. • 60% of contacts result in admission avoided – IC24 RGP service meets this target consistently. • 90% positive responses in patient feedback – we receive very little info on this because patient returns are very low. The project will focus on the following outcomes: • To review the Roving GP referral criteria and communication support plan. • To review the Service specification including a value-for-money evaluation. • To review Service capacity and hours. • To review Key Performance Measures and performance monitoring data to support better evaluation of system impact and benefits. • To review future service scope against key domains identified in the 5YFV.	End of Q4, 2018/19

Commissioning Intention	Description	Delivery Date
Project 3D: Clinical Navigation Hubs	To improve the number of patients seeing the right clinician at the right time, first time, every time. The development of an Integrated Clinical Assessment Service (ICAS) is seen as pivotal to bring urgent care services together with an Integrated Urgent Care model. The ICAS will provide clinical advice to patients contacting NHS 111 or 999, GP speak to services as well as providing clinical support to clinicians, such as ambulance staff and emergency technicians so no decision is made in isolation, as detailed within the Integrated Urgent and Emergency Care Commissioning Standards. The current contract for NHS 111 covers the geographical area of Kent, Medway, Sussex and Surrey (KMSS) as a regional contract, historically 21 CCGs. This system will be supported by being functionally integrated with all the local urgent care models that are in development with further support of the model to be achieved by the technical integration of IT systems enabling the sharing of single patient records and the warm transfer of calls to available services to avoid re-triage at each step. The procurement will include the telephone triage aspects of the current Out of Hours service. The face to face OOH will be delivered locally but will be informed by the outputs from this model. The model will be developed in order to support navigation of patients away from ED, when attending with symptoms appropriate for primary care intervention. It should be noted that although emergency services within the A&E departments are not part of this review, they should be positively affected by the programme, as patients attending these departments that do not require this level of expertise should be directed and treated elsewhere within the urgent care system.	End of Q4, 2018/19
Project 3E: NHS111	The NHS 111 KMSS service is provided by South East Coast Ambulance service (SECAmb), which subcontracts some parts of the service to Care UK. This contract expired on March 31st 2016 with 17 remaining CCGs under taking a two year extension, included in the original contract. Sussex CCGs are currently in a two year service extension until 31st March 2018 with all CCGs recently approving an additional 12 months extension to the current contract until March 2019 at the latest. This 111 re-procurement is a pan-Sussex Programme, requiring collaboration across 7 CCGs which will need to reflect local requirements spanning the clinical model at the front door of Accident and Emergency (A&E), Urgent Care and other services that require access on the same day. NHS Coastal West Sussex CCG took on the lead for the pan Sussex re-procurement in July 2016. The project will focus on the following outcomes: • To re-procure NHS 111 supported by an Integrated Clinical Advice Service (ICAS) with all seven pan-Sussex CCGs. • To detail the options for the design and locations of face to face urgent and emergency care services and procure services as part of the wider urgent care model in line with the national recommendations, best practice and local need • To ensure that our patients and public, providers, voluntary sector and social care partners are co-designers and formally	End of Q4, 2018/19

Commissioning Intention	Description	Delivery Date
	consulted (as required) on the service model options • To agree and seek the relevant approval to the chosen service model • To recommission current services as appropriate • To procure and implement the new service model • To ensure the CCGs and local health economy remains on a sound financial footing in the future • To ensure that the urgent and emergency care model compliments and aligns with the aspirations for the Sustainability and Transformation Plan (STP).	
Project 3F: Enhanced Primary Care Access	CCGs have a responsibility to commission Enhanced Access to General Practice. This is distinct from Extended Access, which comes under a Directed Enhanced Service (now delegated from NHS England to the CCG). This project responds to the core requirements of the General Practice Forward View (GPFV) for delivery of Enhanced Access to General Practice are as follows: **Timing of Appointments:** • Commission weekday provision of access to pre-bookable and same day appointments to general practice services in evenings (after 6:30pm) – to provide an additional 1.5 hours a day. • Commission weekend provision of access to pre-bookable and same day appointments on both Saturdays and Sundays to meet local population needs. • Provide robust evidence, based on rates of use, for the proposed disposition of services throughout the week. • Appointments can be provided on a hub basis with practices working at scale. **Capacity:** Commission a minimum additional 30 minutes consultation capacity per 1000 population, rising to 45 minutes per 1000 population. **Measurement:** Ensure usage of a nationally commissioned new tool to automatically measure appointment activity by all participating practices, both in-hours and in extended hours **Advertising and Ease of Access:** • Ensure services are advertised to patients, including notification on practice websites, notices in local urgent care services and publicity that into the community, so that it is clear to patients how they can access these appointments and associated service. • Ensure ease of access for patients including all practice receptionists able to direct patients to the service and offer appointments to extended hours service on the same basis as appointments to non-extended hours services. Patients should be offered a choice of evening or weekend appointments on an equal	End of Q1, 2018/19

Commissioning Intention	Description	Delivery Date
	footing to core hours appointments. **Digital:** Use of digital approaches to support new models of care in general practice. **Inequalities:** Issues of inequalities in patients' experience of accessing general practice identified by local evidence and actions to resolve these put in place. When the project is completed, we will have achieved consistent availability of urgent and routine primary care appointments Monday – Friday until 20.00 and at weekends in line with assessed patient need across our total population in a way that integrates with the other components of our strategies for urgent and primary care.	

9. Equality of Access to Mental Health services

This care programme recognises the complex interdependencies of mental health care across health, social care and voluntary sector services. There are a significant number of national priorities relating to mental health, including:

- Increased access to additional psychological therapies and increased high-quality mental health services for children and young people.
- Delivery of mental health access and quality standards e.g. through 7 day access to the commissioned Crisis Resolution Home Treatment (CRHT) Service.
- Maintenance of the dementia diagnosis rate.
- Elimination of Out of Area Placements for non-specialist acute care by 2020/21.
- In addition to primary adult mental health, the programme will oversee a significant programme of development in respect of children's and young people's mental health services, perinatal care, reduction in suicide rates and community and voluntary sector procurements.
- In respect of learning disability, the programme focuses on the national 'Transforming Care' agenda, particularly in respect of autism diagnosis and treatment pathways.

The programme additionally focuses on implementing the maternity five year forward view, 'Better Births', the delivery of enhanced services for homeless people and is scheduled to establish a pilot consultant paediatric clinic and a Community Nursing Team. This care programme comprises five projects:

- Project 4A: Transforming Maternity Care
- Project 4B: Development of Children & Young People Integrated Care Hubs
- Project 4C: Transforming Care for People with Learning Disabilities and Autism
- Project 4D: Transforming Mental Health
- Project 4E: Development of Integrated Model of Care for Homeless.

Within each project, there is a range of workstreams each with existing multi-agency delivery structures. These are the foundations for collaborative working with principal partners, including Brighton & Hove City Council, Adult Social Care, Public Health, Children's services and community, primary care, mental health and acute providers. Each of the five programmes are significant in their own right and involve multiple stakeholders from across the system.

Commissioning Intention	Description	Delivery Date
Project 4A: Transforming Maternity Care	The purpose of this project is to improve the local maternity care system based on the recommendations from Better Births – the 5 Year Forward View for Maternity. The vision for Maternity Services in Brighton & Hove is the same as that set out in 'Better Births': • For them to become safer, more personalised, kinder, professional and more family friendly. • Where every woman has access to information to enable her to make decisions about her care. • Where she and her baby can access support that is centred around their individual needs and circumstances. It is also important for all staff to be supported to deliver care which is woman-centred, working in high performing teams, in organisations which are well led and in cultures which promote innovation, continuous learning, and break down organisational and professional boundaries. The project will deliver the following outcomes: • To ensure that maternity services deliver personalised care, centred on the woman, her baby and her family, based around their needs and their decisions, where they have genuine choice, informed by unbiased information. • To ensure continuity of carer and safe care based on a relationship of mutual trust and respect in line with the woman's decisions. • To commission a maternity system where professionals work together across boundaries to ensure rapid referral, and access to the right care in the right place; leadership for a safety culture within and across organisations; and investigation, honesty and learning when things go wrong. • To improve postnatal and perinatal mental health care, which can have a significant impact on the life chances and wellbeing of the woman, baby and family. • To ensure multi-professional working, breaking down barriers between midwives, obstetricians and other professionals to deliver safe and personalised care for women and their babies. • To commission maternity services to support personalisation, safety and choice, with access to specialist care whenever needed. • To design a payment system that fairly and adequately compensates providers for delivering high quality care to all women efficiently, while supporting commissioners to commission for personalisation, safety and choice.	End of Q4, 2018/19
Project 4B: Development of Children & Young People Integrated Care	The majority of health care for children and young people is provided by GPs in primary care and is in the context of looking after the family unit. Primary care services in the city are commissioned to have the capacity and capability to offer high quality and holistic health care to children and young people through the Locally Commissioned Service	End of Q4, 2018/19

Commissioning Intention	Description	Delivery Date
Hubs	(LCS) outcomes contract. This project will develop children's health hubs around GP clusters providing more integrated and multi-disciplinary approaches, in particular by sharing skills across secondary and primary care. A hospital paediatrician will work with GPs in a cluster to provide joint clinics, enabling more care to be provided in primary care and therefore avoiding the need for hospital attendances. This will rotate between surgeries each month and be followed by multi professional case discussions, allowing children's professionals to bring cases for wider discussion and learning. The CCG is committed to bringing care for children and young people, particularly those with the most complex needs, closer to home and away from hospital based settings. This is also reflected in the work we do with the Local Authority to support services in schools and to jointly commission a range of services promoting positive mental health. The project will deliver the following outcomes: • To implement children's health hubs around GP clusters. • To commission integrated and multi-disciplinary teams across primary care and secondary care.	
Project 4C: Transforming Care for People with Learning Disabilities and Autism	There are an estimated 4,746 adults aged 18-64 years with a learning disability living in Brighton & Hove in 2015, approximately 6% of whom have a severe learning disability. The CCG and the City Council are working together to improve and transform the access to, provision of and quality of health, social care and community services for this cohort of our population through The Brighton & Hove Joint Strategic Plan: Transforming Care, 2014 – 2019. This will be achieved by ensuring they have equitable access to the same level of health, social and community services as others, that they are proactively supported when they are in crisis and ensuring they are cared for in the most appropriate place with high quality care when required. The joint plan will also deliver improved access to health care to reduce the higher rate of premature mortality in this group and to ensure the quality of this care through the education and training of staff and ensuring access and equipment are matched to their needs. The project will deliver the following outcomes: • To ensure all hospital placements are good quality, appropriate and reviewed regularly, with a focus on effective intervention & timely discharge. • To review and enhance local resources for crisis intervention and prevention of admission. • To ensure all local services provide good quality, safe services. • To review and improve how children and young people considered to be in the at risk group are identified, assessed and planned for. • To achieve a 75% annual health check target. • To improve health outcomes and reduce inequalities by increasing take up of screening and immunisation in this cohort	End of Q4, 2018/19

Commissioning Intention	Description	Delivery Date
	of the population. • To reduce premature mortality within this population.	
Project 4D: Transforming Mental Health	The NHS England Five Year Forward View for Mental Health (2016) sets out a clear direction for the NHS to improve mental health and wellbeing, showing why change is needed and what it will look like. Some of what is needed can be brought about by the NHS itself. Other actions require partnerships with local organisations including local government, housing, education, employment and the voluntary sector. The evidence is clear that improving outcomes for people with mental health problems supports them to achieve greater wellbeing, build resilience and independence and optimise life chances, as well as reducing premature mortality. The evidence is equally clear on the potential gain for the NHS and wider public sector from intervening earlier, investing in effective evidence-based care and integrating the care of people's mental and physical health. This programme recognises that the successful local implementation of the Five Year Forward View for Mental Health is dependent upon establishing services which are sustainable for the long-term. The principles on which the Implementation Plan is based include: Co-production with people with lived experience of services, their families and carers. • Working in partnership with local public, private and voluntary sector organisations, recognising the contributions of each to improving mental health and wellbeing • Identifying needs and intervening at the earliest appropriate opportunity to reduce the likelihood of escalation and distress and support recovery • Designing and delivering person-centred care, underpinned by evidence, which supports people to lead fuller, happier lives • Underpinning the commitments through outcome-focused, intelligent and data-driven commissioning Brighton and Hove CCG plans to increase its expenditure on Mental Health in 2017-18 by at least 2% in order to meet our obligations under the Mental Health Investment Standard. • To ensure that 30% of mental health need for children and young people is met by 31 March 2018. • To increase access to perinatal care. • To increase access to IAPT to meet 25% of need by 2020/21. • To increase access to mental health liaison teams ensuing it meets CORE 24 standards by 2018/19 • To develop 24/7 Crisis Resolution Home Treatment Teams as an alternative to hospital admissions. • To eliminate all out of area placements by 2020/21. • To reduce suicide rates by 10% by 2020/21. • To reduce out of area specialist placements	End of Q4, 2018/19

Commissioning Intention	Description	Delivery Date
	• To improve the physical health of people with serious mental illness	
Project 4E: Development of Integrated Model of Care for Homeless.	Homeless people have multiple health needs and suffer from poorer health outcomes. The project sets out to improve the health and wellbeing of homeless people by providing integrated and responsive services that place people at the centre of their own care, promote independence and support them to fulfil their potential.	End of Q4, 2018/19
Palace Place Premises	The Ardingly Court practice is due to move into new premises in Palace Place in the town centre in the aututmn of 2018. The commissioner would like to explore with our providers what other services could be co-located there, to improve service integration and patient access.	

10. Medicines Optimisation.

This care programme represents the implementation of the six components of the CCG's Operating Plan and includes the greatest areas of working with Brighton & Hove City Council, Public Health and with community and acute providers. This is a significant programme both in terms of delivery commitment and of priority.

The Programme is divided into seven principal deliverable outcomes, each with its own delivery project supporting transformation of services. These are:

- Project 5A: Better Care Pharmacists (BCP)
- Project 5B: Pharmacy Support to Discharge
- Project 5C: Non-Medical Prescribers
- Project 5D: Community Education
- Project 5E: Support to Practice Support Staff
- Project 5F: Education within General Practice
- Project 5G: Paediatric Formulary

Commissioning Intention	Description	Delivery Date
Project 5A: Better Care Pharmacists (BCP)	To improve pharmacy support to general practice and improve outcomes for patients by formalising the BCP Pharmacy Process. The project will focus on the following outcomes: • To achieve the seamless employment transfer of the BCP team to CCG. • To prevent admissions and reduce falls by extending community pharmacy services to care home residents as well as domiciliary patients. • To expand access to BCP to those who need it most by creating referral routes from appropriate agencies (e.g. Age UK) following learning from AHSN polypharmacy project. • To prevent readmission and improve quality of life by targeting patients newly discharged from hospital or intermediate care. Developing a risk stratification to identify high risk patients and	End of Q4, 2018/19

Commissioning Intention	Description	Delivery Date
	avoid medication related admissions and re-admissions • To implement cluster-based, and city wide non-medical prescribing clinics in cluster priority areas e.g. cardiovascular, substance misuse, pain management. • To empower patients to manage their own conditions by providing education about their medication and their condition Collectively this will enable delivery of medicines optimisation medication reviews aimed at improving patient outcomes, reducing problematic polypharmacy and associated cost savings from de-prescribing. In addition to reducing/preventing hospital admissions. To help address the high demand in primary care from complex patients as part of the wider 'releasing time to care programme' which is aimed at supporting the GP workforce.	
Project 5B: Pharmacy Support to Discharge	To reduce delayed discharges especially to residential and nursing homes caused by medicines issues. These issues include; incomplete medication lists, unresolved medication queries, unclear information with regards to which medication are continued and stopped. All these issues are safety risks for the transfer of care of patients and complications for residential and nursing home staff. The project will focus on the following outcomes: • To establish integrated pharmacy pathways and communication between acute and community providers. • To establish the roles of BCPs, community and acute sector pharmacists within hospital discharge processes. • To implement a new model of nursing home reviews and care home medication reviews to ensure consistency across the pharmacy pathways • To implement streamlined and transparent access to medicines reviews.	End of Q1, 2018/19
Project 5C: Non-Medical Prescribers	There is evidence of multiple national project using pharmacists as prescribers in GP practices to reduce the burden on GP time and support the management of chronic long term conditions through pharmacist led clinics and services. Training the members of the CCG medicines management team to become non-medical prescribers, e.g. BCPs, dietician which will free time in general practice Using BCPs to help address the high demand in primary care from complex patients as part of the wider 'releasing time to care programme' which is aimed at supporting the GP workforce. The project will focus on the following outcomes: • To increase efficiency, the BCPs medication reviews and associated recommendations by auctioning recommendations without requiring access to GPs. • To reduce the burden on GPs by implementing and promoting non-medical prescribing within general practice. • To streamline the process will improve overall patient experience and reduces waiting times for actions of necessary	End of Q3, 2017/18

Commissioning Intention	Description	Delivery Date
	changes to medication. • To deliver overall better patient outcomes through timely changes following medication reviews. • To support primary care pharmacists delivering a greater range of services by operating as non-medical prescribers within general practice.	
Project 5.4: Community Education	To reduce wastage and cost of prescribing practice that can be improved. The project will focus on the following outcomes • Evaluation and review of the effectiveness and impact of 'paracetamol and ibuprofen' campaign 1. • Rolling out the #HelpmyNHS campaign to include other items that can be purchased OTC eg anti-histamines, vitamins. • Work with the Prevention and Community Care Programme and voluntary sector commissioned activity and engagement campaigns to increase public awareness through 'HelpMyNHS'.	End of Q1, 2018/19
Project 5E: Support to Practice Support Staff and Project 5F: Education within General Practice	To reduce wastage and cost of prescribing practice that can be improved via a more efficient model of prescription management. Up skilling of practice support staff and review of the prescription management systems will ensure appropriate processes for medication requests exist and reduce over ordering/ inappropriate ordering of prescriptions and wastage. These robust processes will contribute to improving patient outcomes. The project will focus on the following outcomes • To educate practice staff via a programme of support, training and guidance to practice support staff , specifically around repeat prescriptions that are processed by front-office staff • To support practice staff via cluster technician and pharmacist model to complete training on prescription ordering systems, • To provide face to face support and also incentivised support via the Prescribing Incentive Scheme domain prescription management to identify where further training and supported is needed in order to deliver improvements in prescription ordering and cost reduction' • To complete repeat prescribing audits completed as part of 17/18 prescribing incentive schemes • To complete PresQipp training modules (minimum of two reception staff to complete training per practice).	End of Q1, 2018/19
Project 5G: Paediatric Formulary	The scope of this project is to define the list of medicines that should be available for routine prescribing within primary and secondary care for paediatric patients in Brighton and Hove. The established adult joint formulary is a joint venture between the CCGs (Brighton and Hove and High Weald Lewes Havens) and BSUH. This web based document is a list of medicines which are routinely commissioned. Each chapter defines the medicines to be prescribed and recommended based on their efficacy and cost effectiveness. The list also provides supporting information and documentation necessary to reduce prescribing errors and therefore improve patient outcome e.g. the provision of shared	End of Q1, 2018/19

Commissioning Intention	Description	Delivery Date
	care documentation to enable patients to receive appropriate medicines from their GP rather than needing to attend the acute provider. The governance for the adult joint formulary is provided by the Brighton Area Prescribing Committee. This project aims to bring the patient benefits realised from the use of the adult joint formulary to the paediatric setting, working primarily with the Royal Alexandra Hospital, BSUH. **Better provision of appropriate medicines for paediatric patients** A common list of medicines with information on where they can be used (primary or secondary care) increases patient access to the best possible cost effective medicines. **An increase in the quality of shared care for paediatric medicines** Hosting shared care documentation for paediatric medicines in one single place, with appropriate governance provided by the APC will increase the quality of shared care to paediatric patients. This will increase the availability of these medicines being available from the paediatric patient's GP, reducing the need for patients (and parents) to attend a secondary or tertiary care centre. **A reduction in GP prescribing issues in relation to paediatric medicines** GPs will have a single point of access detailing the paediatric medicines routinely commissioned. This will reduce the number of prescribing queries resulting in a delay to patients receiving their medicines, whilst also reducing the number of prescribing errors associated with paediatric medicines, thereby improving patient outcome. **A reduction in transfer of care issues between primary and secondary care** Having a common set of paediatric medicines between BSUH and the CCGs will improve the quality of transfer of care between these settings. A common paediatric joint formulary will allow admission and discharge to happen without the need to query and change medication, reducing patient waiting times and improving the patient experience. In addition, less frequent medication changes on transfer leads to a lower rate of prescribing error and therefore a better patient outcome.	
BSUH/SMSK Biosimilar program	Continue to implement the biosimilar switching strategy to enable the use of more cost effective high cost excluded medicines, especially important when biosimilar adalimumab becomes available.	Ongoing
Statutory NICE implementation	Continue to use the APC as evidence of our governance for implementing NICE technology appraisals and updating our medicine related commissioning intentions contain within NICE clinical guidelines.	Ongoing
SCT - Dressings	Monitor the use of the non-prescription procurement method for dressings and investigate a better way to provide dressing packs.	18/19
BSUH - Joint formulary	To continue the review cycle of the joint formulary and to incorporate paediatric medicines to ensure the most cost effective, clinically appropriate medicines are made available to the population.	18/19

11. Digital Delivery

The Brighton and Hove Digital Delivery plan explains how we will support the CCG's Vision, 'to improve the health and wellbeing of Brighton and Hove through the commissioning of health services which are high quality, effective and clinically led', through the commitment to maximise the use of existing technologies and to accelerate the delivery of new technologies to enable more efficient working and improved patient experience.

For our citizens, digital transformation will support patient centred care by providing immediate access to relevant information for practitioners involved in care, whilst enabling individuals to view and contribute to their own record and care plan.

The plan is comprised of 7 domains; 5 of which are aligned to the Local Digital Roadmap (LDR), one to General Practice Information Technology (GPIT) and the last to CCG Corporate Information Technology (IT).

Commissioning Intention	Description	Delivery Date
Project 12A – E-Referral	E-referral – ensure every referral is created and transferred electronically, every patient will be presented with information to support their choice of provide, every initial outpatient appointment will be booked for a date and time of the patients choosing.	October 2018
Project 12B - Electronic prescriptions *(EPS)*	Electronic prescriptions *(EPS)* – ensure all permitted prescriptions are electronic, all prescriptions for patients with or without nominations and repeat dispensing will be done electronically for all appropriate patients. EPS brings many benefits to GP practices, pharmacies and patients. Electronic prescriptions cannot be lost, reducing the risk of duplicates being generated. The process for dealing with repeat prescriptions is more efficient as there is no need to issue, sort and file paper prescriptions or prepare for prescriptions to be collected, instead the electronic prescription can be signed electronically and sent to the dispenser of the patients choice.	March 2018
Project 12C – Summary Care Record	Ensure information is accessed for every patient present in an Accident & Emergency, ambulance or 111 setting where is information may inform clinical decisions (including out of area patients) and information will be accessed in community pharmacies and acute pharmacies where is could inform clinical decisions. The SCR is available across England and is being used in a wide number of care settings. Clinicians in unscheduled care settings can access GP information and professionals across care settings can access GP information Summary Care Record (SCR) Professionals made aware of End of Life preferences information Summary Care Record – Additional Information (SCR-AI) Professionals made aware of End of Life preferences information (SCR-AI)	March 2018
Project 12D – Patients Online	Patients can book appointments and repeat prescriptions from GP practice Patient on Line (POL) Patients can access their GP record online (POL) Empowering Patients, Carers and Families to use Technology: Several citizen portals are in place across different care and health settings, however these are often in isolation by organisation, care	March 2018

Commissioning Intention	Description	Delivery Date
	type or clinical need. Increasing evidence shows that people living with long term needs of conditions find such a tool very useful as it supports their desire to control their own care. To make some of the changes required for delivery, this will also need to be closely aligned with change management to enable new ways of working and be closely associated with the development of a Shared Health & Care Record. Electronic consultations will provide the ability for practitioners to hold consultations and assessments remotely with citizens. We will be identifying a number of practices to run online consultations in order to test the system across the city. This will enable us to share learning with other organisations with the STP footprint and to consider joint procurement of the online consultation tool. During 2017 learning Telehealth and Telecare activities across areas within the STP footprint will be shared and a common approach will be agreed. It is anticipated that this initiative will require support from third parties as well as the community and the decision may be taken to build a solution, join with another footprint or seek private sector support.	
Project 12E - GPIT	In order to support the best possible delivery of Primary Care and guided by the latest version of the GPIT Operating Model, the following recommendations are made: IT infrastructure – we will continue with plans to move practices to off-site data storage and hosting and implement wireless connectivity to all sites We will provide on line access to primary care services (appointment booking, e-consultations, access to patient records) Develop an e-consultation strategy for implementation in 2017 / 2018 onwards incorporating self-care strategy recommendations from commissioners Electronic transfer of clinical correspondence via between GPs and other providers Order communications using the Integrated Clinical Environment system (ICE) Planning and implementing a Virtual Desktop Infrastructure / Cloud Solution Roll out the Document Management Solution (DOCMAN 10) to General Practice to enable documents to be shared between primary and secondary care and to support federated working Implementation of GP Connect to open up information and data held within GP Practice IT systems for use across health and social care Electronic Prescribing Service – Phase 4 Improving General Practice connectivity, data sharing and bandwidth through procurement and implementation of a new virtual Community of Interest Network (COIN)	March 2019 March 2019 March 2018 March 2018 March 2018 March 2019 March 2019

12. Estate

As can be seen from the above intentions, the health and social care estate will play a key part in achieving the necessary changes we will commission. At this stage, we are not able to state detailed intentions but would wish to use this opportunity to signal to providers our intention to work jointly with them to ensure the best possible use of our estate. The key drivers for this will be:

- The urgent care hub and spoke model
- Co-location of community and mental health services with primary care
- Potential shift of services from the acute sector into community settings
- The impact of technology

The CCG will invite providers to be part of the early strategic and operational planning processes for this work.

Appendix 1 – Planning timetable