HEALTH & WELLBEING BOARD

Minutes of the Meeting held

Wednesday, 28th October, 2015, 2.00 pm

Councillor Vic Pritchard, Chairman	Bath & North East Somerset Council
Dr Ian Orpen	Member of the Clinical Commissioning Group
Ashley Ayre	Bath & North East Somerset Council
Bruce Laurence	Bath & North East Somerset Council
Councillor Michael Evans	Bath & North East Somerset Council
Morgan Daly	Healthwatch Representative
John Holden	Clinical Commissioning Group lay member
Tracey Cox	Clinical Commissioning Group

15 WELCOME AND INTRODUCTIONS

The Chairman welcomed everyone to the meeting and requested that attendees switch their mobiles etc to silent. He stated that the meeting was being webcasted live and the recording stored on the Council's website.

16 EMERGENCY EVACUATION PROCEDURE

The Committee Administrator drew attention to the emergency evacuation procedure

17 APOLOGIES FOR ABSENCE

There were apologies for absence from Councillor Tim Warren (Leader of the Council), Jo Farrar (B&NES Chief Executive), Debra Elliott (NHS England) and Diana Hall Hall (Healthwatch).

18 DECLARATIONS OF INTEREST

The Chairman, Councillor Vic Pritchard declared an other interest as he is a board member of Sirona.

19 TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIR

The Chairman stated that he had allowed an item of urgent business relating to the Better care Fund on the grounds of expediency.

The Deputy Director for Adult Care, Health and Housing Strategy and Commissioning reported that the CCG transfer to the Council for the Better Care Fund (BCF) is £8.9 million in 2015/16. Of this £8.9 million, £540k relates to a payment for performance (P4P) fund for non-elective (i.e. unplanned) admissions, with an associated target for reducing non-elective admissions. BCF monitoring has shown that the 2015/16 non-electives performance to month 5 (end of August 2015) has not reduced from the 2014/15 position. Under BCF guidance, this means that no P4P transfer payment would be made from the CCG to the Council. Locally, the Council and CCG put in place a risk share arrangement that results in the CCG funding the first £250k of the BCF P4P cost pressure and then both Council and CCG funding 50% each.

However, as the targets for the BCF in reducing non-elective admissions have not been achieved as at month 5, activity levels in the Acute (RUH) are showing a corresponding, unplanned, increase. These increased activity levels in the RUH need to be funded by the CCG. This will reduce the value of the P4P fund to the Council as the CCG retains funding in order to pass the necessary funding to the RUH. In this context, the CCG and Council have reviewed the risk share arrangement and agreed that the CCG will retain the full £540k P4P element of the BCF in order to fund, in 2015/16, the increased levels of activity in the RUH related to non-elective admissions.

The retention of the £540k P4P element of the BCF in 2015/16 will not create an unmanageable cost pressure in the Council/adult social care as this can be funded from underspend in the funding in the BCF earmarked for social care cost pressures from the implementation of the Care Act as these are building at a slower rate than anticipated as a result of the announcement to delay aspects of the Act to April 2020.

John Holden asked who had agreed that the CCG would retain the full £540k Payment for Performance element of the Better Care Fund.

The Deputy Director for Adult Care, Health and Housing Strategy and Commissioning replied that she had met with the Strategic Director for People and Communities and that they had taken a delegated decision.

The Board agreed to note the update.

20 PUBLIC QUESTIONS/COMMENTS

Morgan Daly, Healthwatch asked a question on behalf of a member of the public. He asked how the Council would be taking forward the work of the Housing Standards Review from a Health & Wellbeing perspective with regard to Level 2, Lifetime Homes / Suitable Adapted Housing in their development plan documents.

The Chairman replied that the item would be added to the Board's Forward Plan and discussed at the next meeting.

21 **MINUTES 22ND JULY 2015**

The Minutes of the previous meeting held on Wednesday 22nd July 2015 were approved as a correct record and signed by the Chairman.

22 **UPDATE ON YOUR CARE, YOUR WAY**

The Your Care, Your Way Programme Manager gave a presentation to the Board regarding this item. A summary is set out below and a copy of it will be attached to the minutes as an appendix.

- The consultation will close on Friday 30th October.
- 320 respondents so far…
- Good range of cohorts reached

Vision – Key Words

Prevention
Access
Timely Interventions

Vision – Missing Words

Quality
Affordable
Personal

The Models – Pathway or Asset Based?

Positive responses:

Conditions 192 (28%)
Circumstances 171 (25%)
Wellbeing Hub 192 (28%)
Neighbourhood 135 (19%)

Negative responses:

Conditions 107 (22%)
Circumstances 124 (25%)
Wellbeing Hub 100 (21%)
Neighbourhood 157 (32%)

5 Most Important Statements

A single plan 194
A person, not an illness 193
Invest in the workforce 169
Focus on prevention 160
Joining up IT systems 162

5 Least Important Statements

Community capacity 54
Using new technology 54
A personal budget 47
Social prescribing 45
Supporting volunteers 15

The outcomes of the consultation will be discussed in more detail in December.

Bruce Laurence commented that he saw the integration of services as a key theme.

The Chairman asked if they were disappointed with the results of the consultation so far.

The Your Care, Your Way Programme Manager replied that they were not disappointed and that similar themes had been picked up from market provider events.

Morgan Daly said that he supported and was impressed by the consultation process that had taken place.

Dr Ian Orpen commented that he felt that the consultation had been carried out with a great deal of care and attention to detail.

The Board thanked the Your Care, Your Way Programme Manager for the presentation and noted the update given.

23 TRANSFORMATION GROUP UPDATE

The Chief Officer of B&NES CCG introduced this report to the Board. She explained that the Transformation Group had met on 18th September 2015 and discussed the following agenda items:-

- Interoperability of Clinical Systems in B&NES Update
- Prevention & Self Care Update
- Your Care, Your Way: CCG and Council's Consultation Document and Next Phase
- Provider Work on Frequent Admissions – Principle and Benefits of Approach

John Holden asked if there would be an opportunity for the Board to be briefed on the view of providers regarding Your Care, Your Way.

The Chief Officer of B&NES CCG replied that feedback from them would be seen as part of the business case submission and would be received at the Transformation Group at which key local providers attend including Sirona, RUH, AWP, BEMS+ and Dorothy House. This group is a formal subgroup of the HWB.

She stated that the next meeting will take place on 6th November 2015 and include

the following agenda items:

- Progress Report on Musculoskeletal Programme
- Future Savings: Opportunities / Planning assumptions
- Your Care, Your Way Update
- Interoperability: 'Digital Map' Guidance / Business Case / Financial Implications

The Board thanked her for the update report.

24 **PRIMARY CARE CO-COMMISSIONING UPDATE**

The Chief Officer, B&NES CCG gave a presentation to the Board relating to this item. A brief summary is set out below and a copy of it will be available online as an appendix to these minutes.

Context

Challenges facing Primary Care in terms of:
- Contracts, viability & sustainability
- Provision in areas with greatest recruitment problems, resource challenges and health need
- Need for a stronger population focus and an expanded workforce

Context (2) - BMA Survey 2015

More than nine in ten GPs (93%) state their heavy workload had negatively impacted on the quality of patient services.
- Over three in five GPs (62%) support maintaining the model of GPs being able to own their surgery
- Over a third (37%) of GPs say that their practice has joined with a network or federation.
- More than four in five (82%) GPs support maintaining the option of independent contractor status for GPs.

The most mentioned factor essential for general practice was continuity of care.

Context (3) – Patient Survey, July 2015

Overall experience of GP surgery (Good) – 85% (National) / 91% (B&NES CCG)

Ease of getting through to GP surgery on the phone (Easy) – 71% (National) / 86% (B&NES CCG)

The last time you wanted to see or speak to a GP or nurse, were you able to get an appointment / see / speak to someone? (Yes) – 85% (National) / 91% (B&NES CCG)

Overall experience of making an appointment (Good) – 73% (National) / 85% (B&NES CCG)

Key Activities

- Co-Commissioning - Joint working with NHS England on decisions affecting Primary Care (Medical)

- Funding, PMS Reviews - NHS England, LMC and CCG review of existing PMS 'premium' and re-investment into General Practice

- Primary Care Strategy Development

Primary Care Strategy Development

Themes arising:

- Build services around the needs of patients and carers, not organisations
- Benefits for practices working together 'at scale'
- All out of hospital care could be grouped together
- Many practice premises require investment, concerns around housing development and expansion
- GP practice appointments access perceived as variable, often complicated and difficult to book

Primary Care Funding & Investment

PMS Reviews – approx. £1m to be recovered and reinvested into Primary Care system on a recurrent basis (not necessarily to practices on a like for like basis) over next 5 yrs. Process running during 2015/16, with national principles for reinvestment:

- Secures services or outcomes that go beyond core general practice
- Helps reduce health inequalities
- Offers equality of opportunity for GP practices in each locality
- Supports fairer distribution of funding at a locality level

£5 per Head – approx. £1m to be utilised for schemes care of the >75s (Nursing Homes, Urgent Care Escalation, Community Cluster MDT schemes).

Transformation Fund – £200k (non-recurrent in 2015/16) to support practice schemes aligned to national and local priorities, 4 schemes to be selected.

Next Steps

Continue Joint Co-Commissioning approach with NHS England - Consider options for future Primary Care Commissioning in 2016/17

Completion of PMS Review process - Practices required to agree 'indicative' net position of PMS review impact by 31 March 2016

Councillor Michael Evans asked where the money comes from with regard to the PMS funding for primary care.

The Chief Officer, B&NES CCG replied that this would come from NHS England as

part of their baseline for Primary Care Services.

Councillor Michael Evans asked how this would be allocated to differing populations.

The Chief Officer, B&NES CCG replied that some practices have said that their population require special consideration due to inequalities, high levels of students etc.

The Chairman said that he was encouraged by how good our local statistics were.

Dr Ian Orpen commented that a good summary of the general mood of practices would be that they are fragile due to the pressure of workload and increased pressure on services.

The Board agreed to note both the national and local context for Primary Care GP services in B&NES.

25 **B&NES CHILDREN AND YOUNG PEOPLE CAMHS TRANSFORMATION PLAN**

The Director for Children & Young People, Strategy & Commissioning introduced this report to the Board. He explained that local areas were required to submit an initial draft Children and Young People CAMHS Transformation Plan by September 16th 2015 (completed) and a final Children and Young people CAMHS Transformation Plan by October 16th 2015 (completed). He stated that the final transformation Plan was signed-off by Dr Ian Orpen, Co-chair, B&NES Health & Wellbeing Board and Councillor Vic Pritchard Co-chair, B&NES Health & Wellbeing Board; on behalf of the Health & Wellbeing Board.

He added that a decision on whether the plan had been accepted was due at the end of this week.

The Chief Officer, B&NES CCG asked if there were any staffing implications as a result of the plan.

The Project Manager, Children's Health Commissioning replied that there was a delay in recruiting due to the low response in relation to short term contracts. She added that some upskilling of staff would take place instead.

John Holden asked how outcomes of this work would be measured.

Bruce Laurence replied that the SHEU Survey would give a good indication and that could be measured against results from previous years.

The Project Manager, Children's Health Commissioning added that they would look to record children’s feelings at different stages of their involvement in the service, their readiness for school, their attainment and attendance.

Bruce Laurence commented that he was encouraged to see schools and police involved in this area and that eating disorders had been mentioned in the report.

The Chairman said that it was good to read that 25-50% of mental health problems are preventable through interventions in the early years.

The Strategic Director for People and Communities assured the Board that Head Teachers and those involved in other learning settings take this matter very seriously. He added that he supported the innovative work of the plan.

The Board **RESOLVED** to:

i) Note the range of multi-agency partners, including schools and colleges, supporting emotional health and wellbeing in B&NES
ii) Endorse and note the Final Children and Young People's CAMHS Transformation Plan
iii) Support the continued commitment to and funding of current "spend" on emotional health and wellbeing for children and young people in B&NES
iv) Receive a progress report on the implementation of the Plan in 6 months, April 2016

26 CHILD SEXUAL EXPLOITATION

The Strategic Director for People and Communities introduced this item to the Board. He explained that over the past 18 months all Child Care agencies across the B&NES area have engaged to significantly develop services for young people at risk of CSE and "Missing". This has resulted in the adoption of the multi-agency CSE Strategy which was launched last September (2014) and followed up with an agreed multi-agency operational protocol and system of managing referrals where these types of concern have been identified.

He added that the main driver for the development of these initiatives has become the LSCB CSE/Missing Sub-Group. The Sub-Group has also monitored the development of how agencies are utilising Return Home Interviews and the Willow Project to work with young people who are at risk of CSE/Missing.

He said that the CSE/Missing Operational Plan sets out all of the key tasks and challenges for agencies in continuing to develop services in response to the current national and regional challenges.

He stated that the national picture in relation to CSE over the past six months has been fast moving with both national reports and regional developments necessitating continued review and reflection on what constitutes best practice and how to accommodate new initiatives.

He informed the Board that Avon and Somerset Police's bid to secure funding for a regional CSE initiative was successful and the project was launched in June of this year. The project will focus on the disruption of adults suspected of CSE and in offering support to victims of CSE.

He said that the Board may wish to have regular updates on this matter.

The Board noted the report.

27 LSAB ANNUAL REPORT

The Head of Safeguarding and Quality Assurance introduced this report to the Board. She said that safeguarding adults has continued to maintain a high profile during 2014-15 locally, regionally and nationally, both in terms of Government initiatives and in the media.

She informed the Board that Reg Pengelly was now Joint Chair of both the LSAB and LSCB.

She said that the LGA undertook a peer review of the local safeguarding arrangements and was complimentary about the consistent message delivered by all agencies including everyone wanting to do the right thing and having a robust assurance framework in place.

She explained that the *Care Act Statutory Guidance* was published in October 2014 and it contains details of some of the areas that would constitute abuse or neglect (Care Act Guidance 14.17). Many of the areas will be familiar such as physical, financial and sexual abuse. Other areas, such as modern slavery, self-neglect and domestic violence, may not be as familiar in a safeguarding context but have been introduced for the first time. Several publications have been produced this year that support the development of good practice in these areas.

She stated that Robin Cowen, former Chair of the LSAB was keen for the Board to note his quote:

'It is evident from this report that demand for safeguarding support continues to increase. At the same time resources are reducing and are likely to further reduce over the next three to four years. This is bound to affect services and is an area that the LSAB will need to monitor closely.' (September 2015)

The Chairman asked if the Council would be able to cope with the likely increase in demand.

The Head of Safeguarding and Quality Assurance replied that they were aware of the potential impact and they were looking to see how best to prepare.

John Holden commented that if the number of people to be considered for safeguarding increases, if the range of safeguarding to be considered increases, but if resources decrease, then something has to give, presumably the adequacy of what is delivered.

The Head of Safeguarding and Quality Assurance replied that the Council would not want to provide any less of a service to the public.

The Director of Adult Care and Health Commissioning added that they planned to increase the capacity of the Adult Safeguarding team.

The Chief Officer, B&NES CCG asked how we raise awareness of help available.

The Head of Safeguarding and Quality Assurance replied that they publish articles in

Council Connect and the RUH Newsletter, have held an Adult Abuse Awareness Week and staff have visited local libraries to share information.

The Chairman commented that the Head of Safeguarding and Quality Assurance and her team had transformed the service and that he had no doubt in their abilities.

The Board noted the report and business plan.

28 B&NES WIDE ANTI-MICROBIAL RESISTANCE STRATEGIC COLLABORATIVE

Dr Ian Orpen introduced this item to the Board. He explained that Antimicrobial Resistance (AMR) is an increasing global and national problem, predicted to kill an extra 10 million global deaths a year by 2050 – more than cancer. He said there have been very few new antibiotics developed in the past 30 years and very few are in development at the moment. Therefore stewardship of existing antibiotics is essential to allow us to continue to successfully treat infections now and in the future. He stated that the UK Government have included AMR in the National Risk Register of Civil Emergencies and have published a UK 5 Year Antimicrobial Resistance Strategy 2013 to 2018.

He said that a whole economy wide approach is now required to allow us to effectively implement the key objectives within the UK 5 Year Antimicrobial Resistance Strategy. To do this we need to collaborate throughout the whole of Bath and North East Somerset: to improve the prevention of infection, increase peoples understanding of the risks that resistant infections bring, and encourage behaviour change to reduce the inappropriate use of antibiotics. 80% of antibiotic use is in primary care and the community, and half of this is for respiratory infections, many of which are self-limiting and can be managed with supported self-care, for example from community pharmacies. However, there is also a significant amount of 'unknown' antibiotic use in other areas such as dental care; and the large numbers of tourists visiting Bath bring both resistant bacteria and a variety of imported antibiotics.

He proposed the establishment of a Bath and North East Somerset Antimicrobial Resistance Strategic Collaborative, chaired by him, reporting to the Health and Wellbeing Board. He said that membership would include wide representation from NHS and private health care providers, public health, PHE, academic and clinical networks, patient and public representation, and local healthcare professional representation. The purpose of the Collaborative will be to facilitate implementation of the UK 5 Year Antimicrobial Resistance Strategy key objectives at a local level, in particular;

- Improving infection prevention and control practices
- Optimising prescribing practice
- Improving professional education, training and public engagement
- Developing new drugs, treatments and diagnostics
- Better access to and use of surveillance data

He stated a successful collaborative is anticipated to increase appropriate self-care of infections, resulting in a reduction in workload for primary and emergency healthcare services. He added that increased uptake of vaccinations would deliver a

reduction in preventable infections in all parts of the economy, resulting in reduced days lost at work and school, reduced workload for healthcare services, and a reduction in avoidable life lost. Avoidance of healthcare acquired infections will reduce harm and associated costs - each Clostridium difficile infection costs the NHS at least £10,000.

Bruce Laurence said that he strongly supported this initiative and the need to manage our antibiotic use.

The Board **RESOLVED** to:

i) Agree to the establishment of a Bath and North East Somerset Antimicrobial Resistance Strategic Collaborative, chaired by the CCG Clinical Chair, reporting to the Health and Wellbeing Board at 6 monthly intervals
ii) Support European Antibiotic Awareness Day on 18th November and pledge to become an Antibiotic Guardian at https://antibioticguardian.com/ .

29 **TWITTER QUESTIONS / STATEMENTS**

There were none.

The meeting ended at 4.15 pm

Chair ....

Date Confirmed and Signed ....

Prepared by Democratic Services

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Your Care, Your Way

Sue Blackman

28th October 2015

Bath & North East Somerset Council

NHS
Bath and North East Somerset
Clinical Commissioning Group

your care your way

Consultation results so far… 320 respondents

Bath & North East Somerset Council

NHS Bath and North East Somerset Clinical Commissioning Group

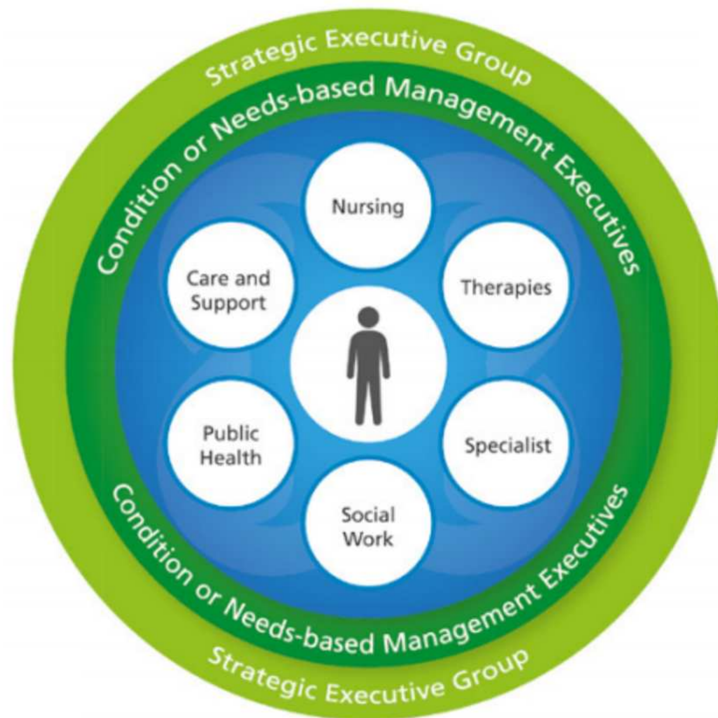
THREE words that you think are most important in our vision

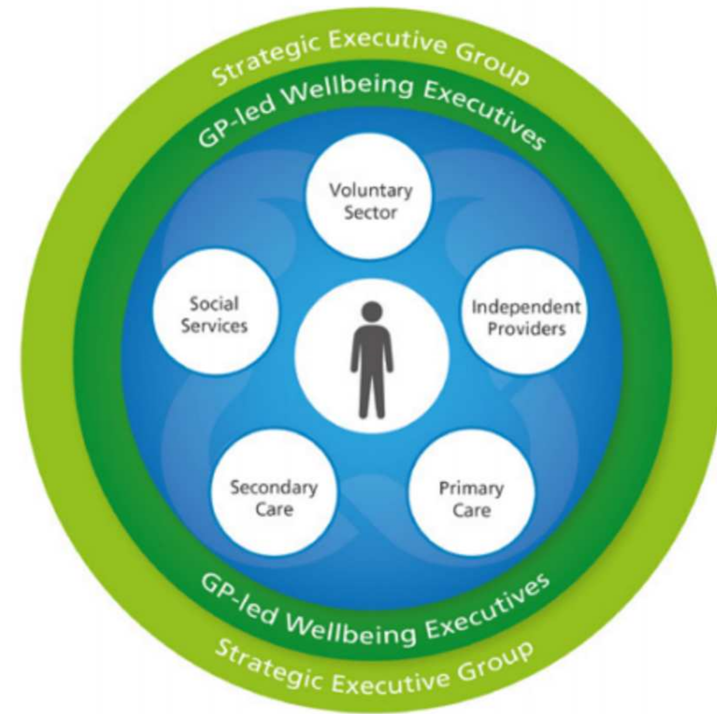
Is there an important word missing from our vision?

things
high
resilience well young
control dignity families housing seemless universal
children coordination dynamic innovative
affordable joined-up providers timely
employees needs
care easy holistic quality
centre good
accountability differently gobbleygook play
adaptable colaboration people partnership walk-in transparent
consistent education integrity personal together
data equity feedback inclusive specialist treatment
sustainable

your care your way

The Models...Pathway or Asset Based?

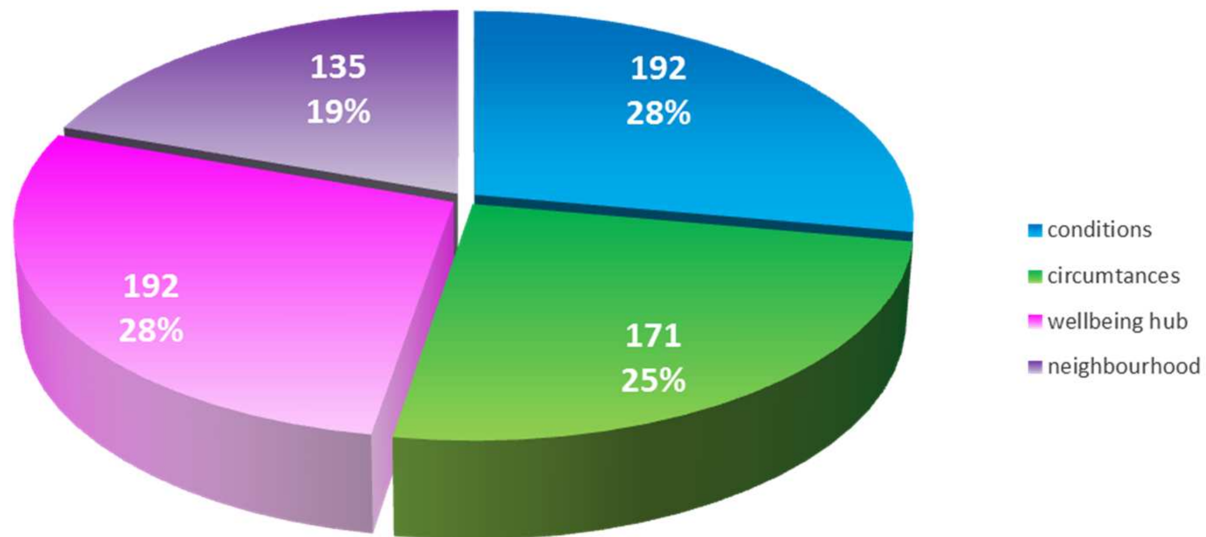




your care your way

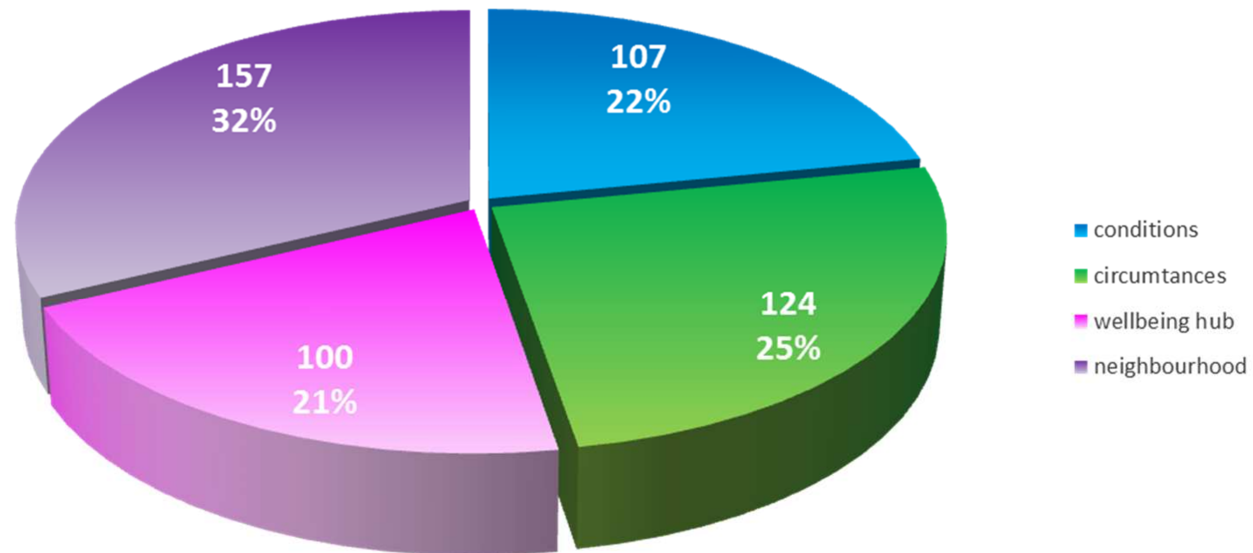
Positives

I really like this model/I think this model is ok



your care your way

Negatives
I'm not sure about this model/ I don't like this model



your care your way

What is our community saying about Condition specific models?

- This is what we have at the moment, where is the innovation?
- This model does not build on the strengths inherent in our communities across B&NES.
- This is a fine model for medical conditions but does not really cater for more social conditions. It would therefore not work as the sole model used.
- Not person-centred enough-medical model-out of date
- Might be confusing to have lots of different professionals and services involved
- It needs to be clear how this type of model would use multi disciplinary teams to ensure support is joined up and there is a 'single view' of each client - so they do not new to repeat their story to each professional
- Many people have more than one problem and this does not address or prioritise social issues is too medical model focussed

- Doctors are trained in specific areas of medicine. This model is aligned with medics' areas of expertise. Alternative models may require a rethink of medical training.

your care your way

What is our Community saying about Circumstances led model?

- This model maintains the status quo and does not build on the strengths available in our communities.
- People struggle with more than one contact.
- I can see patients slipping through the 'gaps' between functions
- There needs to be really clear criteria defining someone's eligibility for each service, and then a seamless transition process if someone moves to a different service.

- Services based around your circumstances will be inclusive to everyone and should include being based around your circumstances if you are a traveller, boater or live itinerantly/ nomadically
- This makes more sense than the conditions model. To have professionals and services involved at the right time

your care your way

What is the community telling us about GP wellbeing hubs?

- This model would involve a considerable shift in working practices to ensure the necessary communication channels were in place. It would also place an additional strain on GP resources.
- From a provider point of view , you need economies of scale to be economically viable - how would this work effectively if the "pot" subdivided to GP clusters
- How will practices fit all these services into their premises?
- If the eligible population is on a resident basis this model would provide two tier services where boundary issues occur
- We need to get people out of GP surgeries and away from always thinking in the medical model
- Needs to be more than GPs - need a broad range of clinicians
- GPs are fine to coordinate medical treatment - but a person's health and social care needs should be looked at together by a heath and social care manager - who has access to all relevant information. GP's are too busy and too expensive to case manage.
- GP's are good at both team working and leadership and are the most senior clinicians in the community
- A more holistic approach should provide an opportunity to deal with root causes due to the knowledge pool gained from a hub model
- Builds on existing and well recognised assets in our community

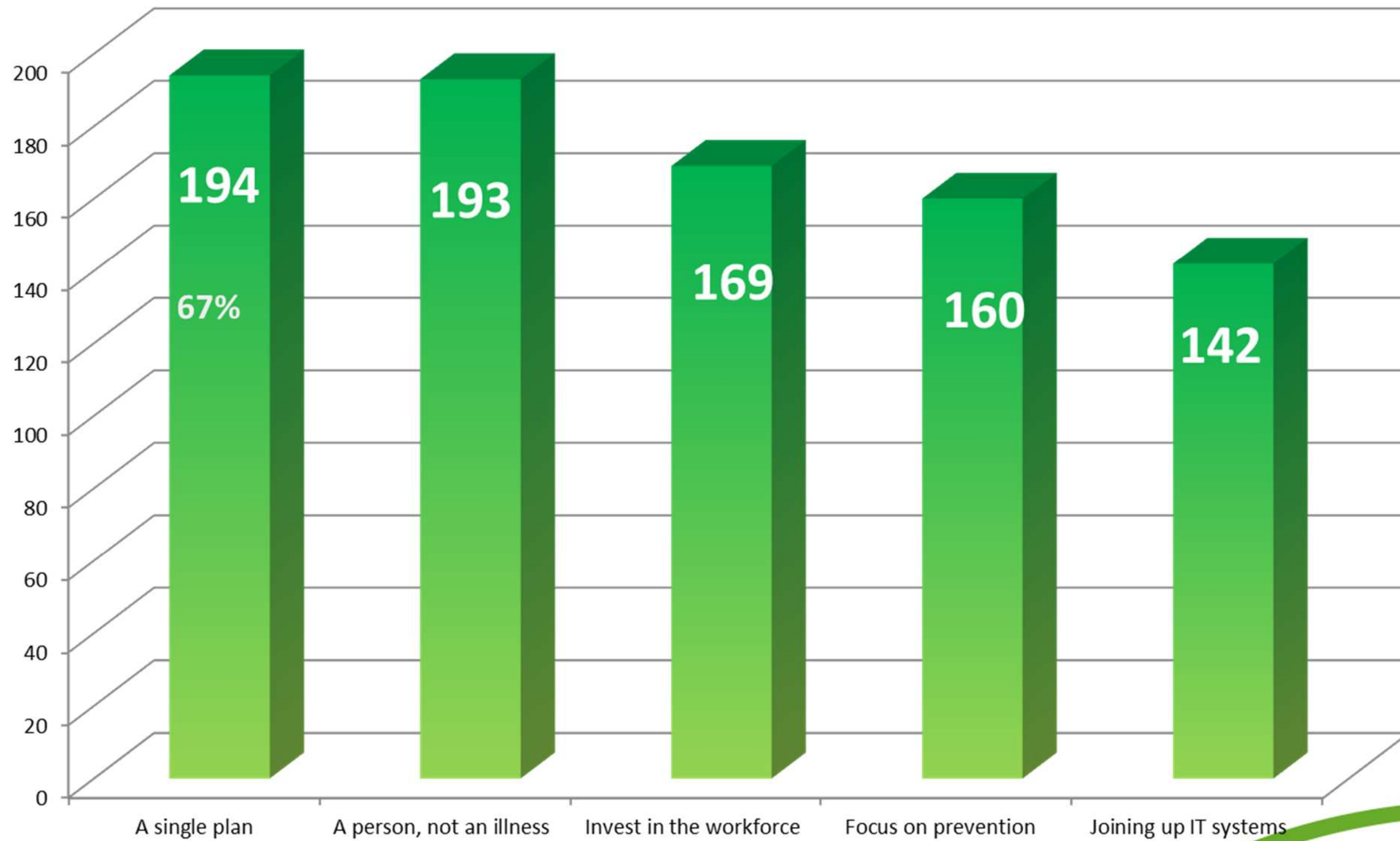
your care
your way

Neighbourhood teams model comments

- I like the idea of more community involvement but worry about the loss of health focus
- Some areas may not be as ambitious as others and so how we ensure that the whole of BaNES moves forward together while maximising local ownership.
- Community led projects sound good but are applying more pressure to communities that are struggling. The community has to be fully supported if given extra responsibilities. Sounds a bit too much like Cameron's 'big society' to me.
- I think in affluent areas with well educated residents this will work very well - in areas of deprivation (which will need the most help) or areas with a large geographic cover this could lead to a poorer model ie inconsistent across B&NES
- This model will struggle in rural areas.
- This would allow for the local ownership of issues which ultimately would create a more sustainable model
- It is very innovative, but how capable is the community of genuinely taking ownership of its most vulnerable.
- Putting people, families and communities central to any model has to be the right way forward.
- Sounds wonderful but I have the feeling this may be too costly and involve too much change.

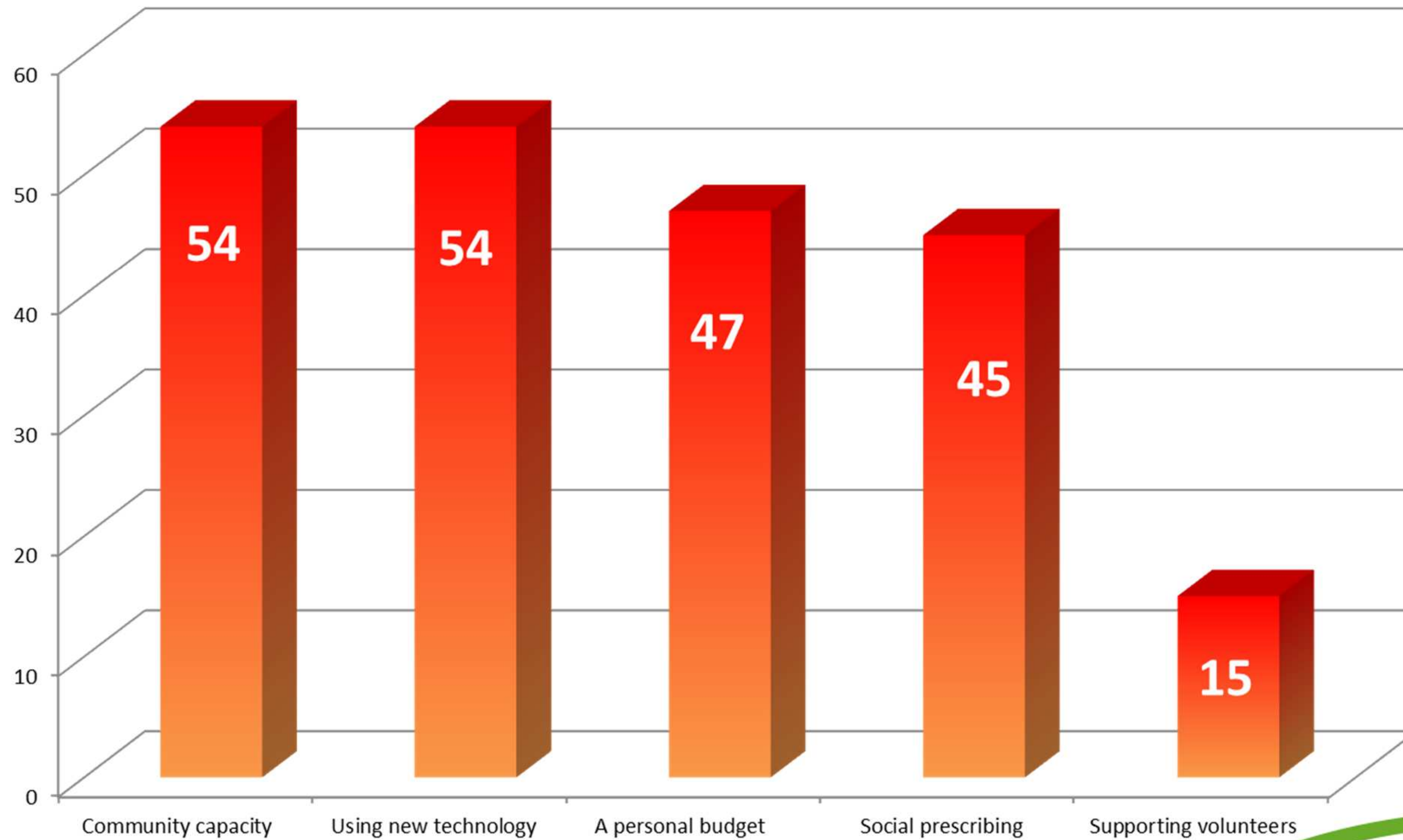
your care your way

5 most important statements



your care your way

5 least important statements



your care your way

your care your way

THANK YOU

Bath & North East Somerset Council

NHS
Bath and North East Somerset Clinical Commissioning Group

NHS England

NHS Bath and North East Somerset Clinical Commissioning Group

Primary Care Update

October 2015

Healthier. Stronger. Together.

Context

Challenges facing Primary Care in terms of:

- *Contracts, viability & sustainability*
- *Provision in areas with greatest recruitment problems, resource challenges and health need*
- *Need for a stronger population focus and an expanded workforce*

Context (2) - BMA Survey 2015

More than nine in ten GPs (93%) state their heavy workload had negatively impacted on the quality of patient services.

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Context (3) – Patient Survey, July 2015

	National	BaNES CCG
Overall experience of GP surgery (Good)	85%	91%
Ease of getting through to GP surgery on the phone (Easy)	71%	86%
The last time you wanted to see or speak to a GP or nurse, were you able to get an appointment / see / speak to someone? (Yes)	85%	91%
Overall experience of making an appointment (Good)	73%	85%
How satisfied are you with the hours that your GP surgery is open? (Satisfied)	75%	81%
Overall, how would you describe your experience of out-of-hours GP services?	69%	63%

Key activities

1. **Co-Commissioning** - *Joint working with NHS England on decisions affecting Primary Care (Medical)*
2. **Funding, PMS Reviews** - *NHS England, LMC and CCG review of existing PMS 'premium' and re-investment into General Practice*
3. **Primary Care Strategy Development** -
   - *NHS Five year forward view, new models of care*
   - *Your Care, Your Way, community services redesign*
   - *CCG transformational workstreams and additional priorities*
   - *BEMS+ (Primary Care Preparing for the Future - PCPF), Understanding potential for collaboration / workforce development, and testing new ways of working*

Context (4) - CCG Strategy

The current CCG 5 year strategy notes in respect of Primary Care:

- Vision: Delivery at scale
- Enablers: Sustainable model of Primary Care, Enhanced services delivered 7 days a week
- Approach: Cluster working / MDT model, out of hospital care

Early stages of developing conversations to refine Primary Care strategy

Primary Care Strategy Development

Initial thinking shared with / feedback received from:

- Your Care, Your Way (Phase 1) - Jan / April 2015
- CCG Team Development Forum / Board seminar sessions May / June 2015
- Your Health, Your Voice meeting June 2015
- Joint Primary Care Co-Commissioning committee July 2015
- CCG Primary Care Strategy Task & Finish Groups June / July 2015

Primary Care Strategy Development (2)

Themes arising:

- Build services around the needs of patients and carers, not organisations
- Benefits for practices working together ‘at scale’
- All out of hospital care could be grouped together
- Many practice premises require investment, concerns around housing development and expansion
- GP practice appointments access perceived as variable, often complicated and difficult to book

Primary Care Funding & Investment

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£5 per Head – approx. £1m to be utilised for schemes care of the >75s

(Nursing Homes, Urgent Care Escalation, Community Cluster MDT schemes)

Transformation Fund – £200k (non recurrent in 2015/16) to support practice schemes aligned to national and local priorities, 4 schemes to be selected

Next steps

1. Continue Joint Co-Commissioning approach with NHS England - *Consider options for future Primary Care Commissioning in 2016/17*

2. Completion of PMS Review process - *Practices required to agree 'indicative' net position of PMS review impact by 31 March 2016*

3. Further development of Primary Care Strategy - outcomes / learning from:

    - *Your Care Your Way Phase 2*
    - *PMS Review process*
    - *BEMS+ PCPF*
    - *Local discussion / engagement*

Any Questions?

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