NHS
Cheshire and Merseyside

Meeting of the Cheshire & Merseyside ICB System Primary Care Committee

Part B – Public Meeting

Thursday 20 February 2025
Venue: Meeting Room 1, No 1 Lakeside,
920 Centre Park Square, Warrington,
WA1 1QY (WA1 1QA for SatNav)

Timing: 10:15-12:30

Agenda

Chair: Erica Morris

AGENDA NO & TIME	ITEM	LEAD	ACTION / PURPOSE	PAGE No
10:15am	**Preliminary Business**			
SPCC 25/02/B01	**Welcome, Introductions and Apologies**	Chair	Verbal	-
SPCC 25/02/B02	**Declarations of Interest**	Chair	Verbal	-
SPCC 25/02/B03	**Questions from the public (TBC)**	Chair	Verbal	-
10:20am	**Committee Business, risk and governance**			
SPCC 25/02/B04	**Minutes of the last meeting (Part B)** 19 December 2024	Chair	Paper To ratify	Page 4 *Click here for link to page*
SPCC 25/02/B05	**Action Log of last meeting (Part B)** 19 December 2024	Chair	Paper For info	Page 14 *Click here for link to page*
SPCC 25/02/B06	**Forward Planner**	Chair	Paper To note	Page 18 *Click here for link to page*
10:30 **SPCC 25/02/B07**	**Risk Register**	Dawn Boyer	Paper To note	Page 20 *Click here for link to page*

AGENDA NO & TIME	ITEM	LEAD	ACTION / PURPOSE	PAGE No
10:40	**BAU and Operations**			
SPCC 25/02/B08	**Contractor Operations Updates** i) **System Pressures**	Jonathan Griffiths / All	Verbal	-
	ii) **Update from LGPN**	Jonathan Griffiths	Verbal	-
	iii) **Update on development of PC Forum**	Jonathan Griffiths / Tom Knight	Verbal	-
10:50 **SPCC 25/02/B09**	**Contracting, Commissioning and Policy Update** - **Optometry and Primary Care Medical** - **Dental and Community Pharmacy**	Chris Leese / Tom Knight	Paper To note	Page 46 *Click here for link to page*
11:00 **SPCC 25/02/B10**	**Finance Update**	John Adams / Lorraine Weekes Bailey	Paper To note	Page 60 *Click here for link to page*
11:15	**Quality and Performance**			
SPCC 25/02/B11	**Healthwatch Update : Access improvement and Patient Experience**	Louise Barry	Tabled For info	-
11:30 **SPCC 25/02/B12**	**Quality Update**	Christine Douglas/ Tom Knight	Paper For info	Page 71 *Click here for link to page*
11:40 **SPCC 25/02/B13**	**Progress on Freedom to Speak Up**	Christine Douglas	Verbal	-
11:50 **SPCC 25/02/B14**	**Performance Indicators**	Chris Leese	Paper For info	Page 82 *Click here for link to page*
12:00	**Transformation**			
SPCC 25/02/B15	**Pharmacy Access**	Tom Knight / Jackie Jasper / Emma Knox	Paper For information/ assurance	Page 88 *Click here for link to page*
12:15 **SPCC 25/02/B16**	**Dental Access Improvement Plan**	Tom Knight	Paper / Presentation For Assurance / Information	Page 97 *Click here for link to page*

AGENDA NO & TIME	ITEM	LEAD	ACTION / PURPOSE	PAGE No
12:30pm	CLOSE OF MEETING			

Date and time of next regular meeting:
Thursday 17 April 2025 (09:00-12:30)

F2F, Lakeside, Warrington

Cheshire and Merseyside ICB
System Primary Care Committee
Part B meeting in Public

Thursday 19th December 2024
10:00-11:30

Karalius Suite, DCBL Stadium Halton,
Lowerhouse Lane, Widnes, Cheshire, WA8 7DZ

Unconfirmed Draft Minutes

ATTENDANCE - Membership		
Name	**Initials**	**Role**
Erica Morriss	EMo	*Chair*, Non-Executive Director
Clare Watson	CWa	Assistant Chief Executive, C&M ICB
Tom Knight	TKo	Head of Primary Care, C&M ICB
Fionnuala Stott	FSt	LOC representative
Mark Woodger	MWo	LDC representative
Naomi Rankin	NRa	Primary Care Member for C&M ICB
Susanne Lynch	SLy	Chief Pharmacist, C&M ICB
Chris Leese	CLe	Associate Director of Primary Care, C&M ICB
Anthony Leo	Ale	Place Director, Halton
Daniel Harle	DHa	LMC representative
Adam Irvine	AIr	Primary Care Partner Member
Christine Douglas	CDo	Director of Nursing & Care, C&M ICB
Jonathan Griffiths	JGr	Associate Medical Director, C&M ICB
Rowan Pritchard-Jones	RPJ	Executive Medical Director, C&M ICB
Mark Bakewell	MBa	Interim Director of Finance, C&M ICB
Matt Harvey	MHa	LPC representative
In attendance		
Sally Thorpe	STh	*Minute taker*, Executive Assistant, C&M ICB
John Adams	JAd	Head of Primary Care Finance, C&M ICB
Loraine Weekes-Bailey	LWB	Senior Primary Care Accountant
Rob Barnett	RBa	Secretary, Liverpool LMC
James Burchell	JBu	Strategic Estates Manager (Cheshire East, Cheshire West & Wirral Place)
David Cooper	DCo	Associate Director of Finance, Warrington Place & Knowsley Place
Cathy Fox	CFo	Associate Director of Digital Operations

Apologies		
Name	**Initials**	**Role**
Louise Barry	LBa	Chief Executive, Healthwatch Cheshire
Tony Foy	TFo	*Vice-Chair*, Non-Executive Director, C&M ICB

Agenda Item, Discussion, Outcomes and Action Points

Preliminary Business

SPCC 24/12/B01 Welcome, Introductions and Apologies

The Chair welcomed everyone to the meeting and respective apologies were noted.

SPCC 24/12/B02 Declarations of Interest

Standard declarations of Interest were noted. There was nothing specific pertaining to any agenda items.

SPCC 24/12/B03 Questions from the public (TBC)

Nil received.

It was noted that the member of the public who attended today had previously been in attendance at a meeting in public and outside of today's meeting enquired as to an update from his previous question raised. **Update requested as to 'has the ICB done anything about it'?**

Committee Business, risk and governance

SPCC 24/12/B04 Minutes of the last meeting (Part B) 17 October 2024

The Committee **approved** the Minutes as a true and accurate reflection of the meeting.

SPCC 24/12/B05 Committee Action Log (Part B) 17 October 2024

The Action Log was **noted** and updated accordingly.

SPCC 24/12/B06 Forward Planner

The Committee **noted** the Forward Planner and agreed to add on the estates reviews will reset following this meeting and would be included on the forward planner to attend every other meeting.

BAU Policy Operations

SPCC 24/12/B07 System Pressures

JGr outlined that general practice were managing the system flow, adding that there were additional pressures to general practice. He gave feedback from the Local GP Network meeting which had been held early November 2024, outlining that the majority of meeting was spent discussing concerns around the SDF for this year. Other issues were discussed and aired, he outlined that a letter had been written to the ICB and a further meeting is being arranged for the new year for a wider discussion between general practice and the ICB.

It was outlined that there is a further challenge in primary care to achieve the Learning Disability and Autism training (known to most as the Oliver McGowan training) advising that this is the only session that meets the necessary training requirement and covers all mandatory elements. Struggles in practice were highlighted for colleagues trying to do their mandatory training as this needs a whole day face-to-face training, and there is a desire to ensure there will be training events far and wide across the patch.

Advised that this training cannot be changed as it is statute, and that hospitals are also grappling with this, there is some current money to assist but do not believe there is any more money once that is spent. It is believed that there is an offer for some free of charge training, but again once the money is spent there may not be other training offered.

<u>Pharmacy</u>
In terms of Community Pharmacy MHa advised this is still looking bleak, advising community pharmacies have been out of contract for the best part of nine months, there have been no contract negotiations following elections and we are now running out of the year and no understanding of what the financial

envelope will be. In autumn 2024, pharmacy owners were balloted on collective action, on the 14th November the results of this showed a huge turnout of 63.5% of independent pharmacies responding. 97.8% of these said they would serve notice on supplementary hours, quantifying that these are the hours worked in addition to the core hours of 40. Members were advised to write to their ICB to confirm what their hours will be as a result of this, this is therefore **noted as a risk** if lots of pharmacies who currently open extra hours will now not take place.

MHa further advised that pharmacies voted to stop providing locally commissioned services. He noted that the cost of delivering these services had spiralled (citing staff costs as the main factor) whilst local remuneration levels had stayed flat for multiple years. Some services were now not viable to operate.

Other balloted action could see the reduction or cessation of non contractual activity, such as the withdrawal of blister packs and other work conducted outside of the core pharmacy contract. It was advised that this has never happened in pharmacy before, and is further compounded by the budget changes to do with the NI increase and the increase to national living wage, this equates to circa £200m and will be for the pharmacies to fund the increase. The funding simply is not there and this causes a huge degree of concern.

It was advised that even if there was a positive negotiation, it is most likely that any injection of money/ budget will be swallowed up to cover this amount, adding that this was not about profit but is just about breaking even.

Pharmacy closures are still taking place and there are lots of local patients having to find other pharmacies to dispense from.

The Committee advised that they had noted the risks around local commissioned services and the contractual hours.

The Committee enquired as to how we are looking after patients in all this and raised the question of 'what is the so what'. **ACTION : TKn to pick up this piece of work**

It was outlined that if pharmacies do stop doing some of the work they are currently doing, then it will have consequences and a knock-on effect to general practice.

It was added that the NI increase was also impacting general practice, outlining that for an average practice of 10k patients this would equate toa cost of circa £20k and this impact will be felt across the whole of primary care.

<u>Optometry</u>
FSt advised that the GOS was running quite nicely and there is an unbalance between private and NHS activity that probably should be looked at sooner rather than later. It was agreed there has to be private work but this has to be funded properly as it is going to get to a point where they will take the private work over the NHS work. It was outlined that there had been great enthusiasm for future work in shared care however just when you start to get the momentum they have been notified that this will stop in April 2025, this is very disappointing and disheartening.

It was confirmed that whilst there is access to small pots of money for care, there is only a small percentage of those funds considered to come into dental and optometry, caution was raised that we do not provide incentives to upskill to provide access for the rural services and there is no estates provision for optometry. Have reached out to the digital team but do not feel optometry is on their agenda and further that optometry are not on the shared care agenda either.

Funding has been reduced for the renewal of service for the most vulnerable, children needing eyesight tests in particular, noting that these are difficult appointments that take time.

In response to this it was advised that this is a nationally contracted service and funding issues for this sight test is a national decision, not an ICB one. The ICB do hear what is being said advising that this is something that we all need to lobby and promote.

In relation to the money bids for the transformation schemes it was advised that there was an exit strategy and not all schemes rolled forward, in fact the majority of schemes did not. It was advised that all contractors were able to apply and the LOC received £200k of non-recurrent funding. Unfortunately we are not in a position to make this money recurrent. There has been no funding for estates for the other three contractor groups. The ICB agree and are sympathetic to the pressures but national discussions agreements out of its control.

It was advised that there was a meeting of the SPCC early in the new year and agreed to put shared care on the agenda – ACTION.

FSt stated that GOS was national yes but that it will become an issue for optometry who are looking to commission outside of the community, this is additional services on the side of the GOS contract and we all just need to be minded to fund correctly. It is not so easy to just shift, there will be a need for funding for workforce. It was noted that other ICBs are providing funding from different money pots and it was asked whether we are able to look at this or change our thinking/ ways of working. In response to this, CWa stated that it would be good to see the business cases and the population for those ICBs and the offers they have, it was asked if there are examples of this so we can see what might be possible.

FSt stated that it does feel there is a postcode lottery across the ICB and we cannot level up across the patch, there is an understanding of the individual CCGs legacies and the ICB inherited these, but advised it would be helpful if we could level up, adding that this was about spending wisely, adding that she would be happy to bring a business case as needed.

It was questioned in relation to the shift-left as to what discretionary funding might be available and that it would be helpful if this could be discussed at a future meeting so we can look to prioritise for oversight. It was agreed that we should not be levelling up or down but that it would be good to have a discussion around the variance.

When the Planning Guidance comes through, we will know more, SPCC is the correct committee to have the discussions and hopefully influence.

It was questioned as to how the ICB was engaging the public to make them aware of the funding issues and the impact of the discussions the contractors have to have with them?

Cheshire and Merseyside ICB is a large one, but it is felt that staff on the ground do not hear hear much about the processes around the steps taken and the influence to change, and that it would be good if they had a greater understanding of the discussions.

In response it was advised that the ICB Board meeting is held in public and there have been transparent discussions regarding funding, the engagement framework has been signed off by the ICB Board. However we do not know what conversations Place are having with contractors and that it would be beneficial to know this. It would be welcomed if this dialogue could improve, Places are closer to the public and would be good to hear how this is happening across the patch.

It was advised that there are lots of conversations with senior clinical leaders and appropriate teams, additionally we have close working with Healthwatch and there is alignment with the recovery work (local authority are in that space also) but that none of this is easy. **ACTION EMo agreed to discuss outside of this meeting around the engagement piece.**

MBa added that we have to try to hang on to the positives and to try to find a way not to be too despondent, to look to move to what are the right things to invest in to really back and support the priorities, adding that it is key to work together to set out the framework as to what we can get behind.

In terms of any influence upwards, RPJ advised there is a Medical Director Forum which involves all 42 ICBs and this is a direct route through, from this, agenda items of repeated significance are escalated upwards. This is about making our money work best, and the Data Into Action (DIA) group is where evidence based / decision based commissioning is worked through. Commissioning is the big leaver to working strategically.

RBa added that what the public want and what the people on the ground want is a simply a degree of honesty, they do not feel that anything is being done; operations are cancelled, medications are had to come by, outpatient appointments are cancelled etc, it is the frontline staff who take on the 'flack' and it is vital staff know that the ICB are fighting their corner. He added that what has got lost with the ICB as opposed to the CCGs is the publicity, in that the engagement teams actually articulated what is being said by staff, it is felt that (we) rely on local authority communication teams rather than the NHS teams, this may not be how it is but it is certainly what is perceived and feels for primary care.

It was stated that the ICB Board meeting in February 2025 has an agenda item focus for Healthwatch regarding access and how it feels. It was questioned whether we wanted to have an additional agenda item on public engagement? If so then we can ask the Comms team for a targeted piece. **ACTION agenda on Board in Feb TBA.**

TKn advised that the National Dental Contract has been highlighted and raised, and that the ICB has lobbied at every opportunity with MPs and local members.

Dental

MWo advised that a big concern is around the Management of Clinical Networks (MCN) locally, in that this has completely stalled, there are some funding challenges also being articulated. Specialised services, hospital services all remaining a challenge, key for a local focus.

In response TKn agreed there had been a hiatus but there is a model on networks being developed, adding that there is a piece of work being worked on currently, pulling together the operating model, assessing costs and budgets and then coming up with a new model. This will be ready in February 2025 with a view to implementing in April 2025. Assurance is a piece of work ongoing and it will be essential and important for pathway redesign and safety concerns via the MCN.

TKn added that in terms of pharmacy, there is regular dialogue with the LDC and the pressures are known. From the very least there are no surprises but agreed would need to work with Healthwatch, he added that this had been done really well with the Dental Improvement Plan and the good news is that we are doing really well on Pharmacy First; managing hypertension and others, the constraint is that that we cannot do more but we must no lose sight of these as achievements.

It is recognised that we do need to work more with Place to understand and gain deeper understanding of the impact locally with colleagues.

The Committee noted the verbal reports and updates.

SPCC 24/12/B08 Contracting, Commissioning and Policy Update

Primary Medical Services; Optometry; Community Pharmacy and Primary Care Dental Services

The Primary Care Policy and Contracting Update provides the Committee with information and assurance in respect of key national policy and related local actions in respect of ;

- GMS/PMS (General Medical Services/Personal Medical Services) and APMS (Alternative Providers of Medical Services) including DES (Directed Enhanced Services)
- General Ophthalmic Services (GOS)
- Community Pharmacy
- Primary Care Dental Services

The Committee;

- ***Noted*** the updates in respect of commissioning, contracting and policy for the 4 contractor groups.
- ***Noted and were assured*** of actions to support any particular issues raised in respect of Cheshire and Merseyside contractors
- This report was noted for ***information*** and ***no decisions*** were required

SPCC 24/12/B09 Finance Update

The Primary Care Committee was asked to: -

1. Note the combined financial summary position outlined in the financial report as at 30th November 2024.
2. Note the Additional Roles spend to date and the anticipated forecast outturn and predicted central drawdown.
3. Note the capital position.

LWB stated that there was not much change since the last committee report. In general practice, local enhanced and enhanced there is a degree of underspend showing. Primary Care SDF was not reported in the last iteration of papers but is now in this report.

Prescribing has a £26.4m overspend, and there is not much difference in the overall position between month 6 and 8. Data received (yesterday) for prescribing looks really good and there are some prescribing schemes to come. SLy advised that spend is as expected which can move into the position as it is. It is noted as a risk but the savings are coming in for the back end of the year. The business case for extra hours has come through, with expressions of interest going out to the Medicines Management Team who are now working extra hours to deliver. Everything is having the impact as intended.

In terms of ARRS, there will be discussions in January around the rest of the drawdown for this with the national team, it is noted that there is a £1.2m gap, not received the GP ARRS as we spend we will start to receive this.

The Primary Care Access programme has £1.2m available from this and we have reached out to spend this, it is important to note that we are unable to put this figure to the *bottom line* but it is based on drawdown. It was questioned as to what sort of things can this money be spent on, it was advised things like the transition to modern general practice (but not digital) and care navigation training/ additional staff, (practice level not PCN level).

It was advised that this needs a degree of common sense, and that providing sensible criteria is used then it is felt the money should be used / transfer of monies and that we must learn from previous mistakes.

JAd advised that in relation to pharmacy, the national contract has been rolled over, costs that come through are above the amount we have seen before. Reporting is done in a way that shows a £3.4m risk for the ICB so unless there is additional funding or some change in the rates that risk will materialise at the end of year. In relation to capital, we are now starting to see this years' schemes coming through.

The GPIT risk still needs sign off by NHSE (as does all governance in this organisation) before we can purchase kit. This is being chased.

It was confirmed that the allocation had been agreed in June 2024 and the PIDS followed soon after. It was advised that this is not a risk as yet, but as we get closer to the end of the year we are hopeful of a positive outcome. It is in three parts, and feels that we have two that reached agreement, the third one has been agreed this morning. Advised that if we feel there is any slippage then it needs to go into estates.

Noted that at this time need to monitor it closely, and will flag / escalate it back to SPCC if it feels like it is heading off track.

For capital there is one grant of £700k and there are conversations as to where this is up to. It was outlined that there is a small risk that some of this might slip (Liverpool) practices says it won't but again this is being monitored closely. As the year end approaches it becomes increasingly harder to spend on estates.

The national team had powers to delegate to the ICB this financial year, and this has not happened, subsequently now heard that it will not be April 2025 so it will still be an issue.

In relation to pharmacy funding it was questioned whether we have outperformed what we should? In general level of everyone is seeing more activity. It was advised that in contract, the national team have amended certain fee rates, and the spend is x if they reduce the fee rates. This is an accepted risk to the service but that the local position might not come into balance.

In terms to whether we are any closer to a decision for enhanced services, LWB advised that this was due to go to Execs or Board next. **ACTION : MBa agreed to look into this and would go back to DHa with the outcome.**

It was advised that we are up to £4m underspend for dental monies, which in effect is split between three ringfenced areas, it was confirmed that all of this funding will go towards the bottom line.

The Committee noted the report as presented and discussed.

Quality and Performance

SPCC 24/12/B10 Quality Update

CDo advised that there was no report in the pack today as the meeting had only been held the day before, but that the minutes would follow for information.

It was reported that there had been a good presentation regarding children and young people receiving services, although some issues with provider assurance, as part of TOR, Lisa Ellis is working on this as a piece on quality in Places. It was advised that the SPCC meeting in February 2025 will see a concise and consolidated report for the last 6-9 months of work. An update on the work for the dashboard and the digital portal was also received adding that assurance has a focus and there is data to back this up.

JGr agreed that it had been a good meeting, and that he had picked up an action that he would raise and escalate to SPCC in terms of the lack of admin support for the meeting. Since this discussion it was advised that Lisa Ellis has suggested and sourced support.

CWa extended thanks to the team, in particular to JGr, CLe, TKn and Lisa Ellis as the work has moved on significantly. She added that, recognising timing, it would be helpful if SPCC could see updates formally please, and that it would be interesting to see it all come together to triangulate this work with performance and the region. Connected to this, JGr advised that at the same time as SPCC (this morning) the PSG (Professional Standards Group) was also meeting, between him and colleagues this can be checked across.

The Committee noted the update as presented.

SPCC 24/12/B11 Freedom to Speak Up (FTSU) Guardian

EMo advised that she was the FTSU NED and that CDo was the Executive lead. Temitayo Roberts is the ICB FTSU Guadian and was reported to be doing a great job in the organisation. As an ICB we do have a responsibility for FTSU for primary care.

It was asked for an understanding of the support mechanism across the four contractor groups, and to identify what gaps there are, but key to note that it not for the ICB to provide the support but that as an organisation we can look to how we can assist and support.

It was questioned whether there is an awareness and a need for skill development and training? Could we look to share best practice?

It was advised that Place have a good understanding of general practice and do link in with the local committees for the contractor groups. Noted that by February 2025 there will be a clearer picture of what it out there and how we can help and support.

ACTION : agreed for a standard item of FTSU for SPCC on progress and resource.

Noted that for our ICB we have an average of 10-12 FTSU matters each quarter, we are in a period of change, especially around recovery, so it is a good and positive thing for the organisation that we are getting these coming through.

CDo stated there is a map of where we have got to, FTSU is everyone's business and we all have a part to play, awareness is key, and there should be a poster of all the FTSU ambassadors displayed in all office buildings as well as the information available on the Staff Hub.

The Committee noted the update as presented.

Transformation

SPCC 24/12/B12 Digital Update

The purpose of this paper is to provide the System Primary Care Committee with an update on current Digital programmes workstreams across all nine places within Cheshire and Merseyside ICB (Integrated Care Board). This includes national and regional commitments, detailing the mandated and local priorities for 2024/25 with associated risks and issues.

The Committee was asked to note:

1. Detailed planning is now underway for delivery of key milestones in the Digital Primary Care sub strategy, progress will be reported to this Committee on an ongoing basis.
2. Work is continuing at pace on the Blinx pilot along with establishing appropriate governance and a robust independent evaluation process which will be led by the Health Innovation network.
3. The TIF project to migrate Wilmslow GP Practice to the new EPR (Medicus) has been delayed because of issues with the incumbent supplier. The indicative go-live date is now first week of April 2025. NHSE have advised of an uplift of funding to support go-live to £130k (from £70k).
4. Ainsdale Practice has commenced Stage 2 of the TIF programme for innovation purposes only with no current plans to implement a product. Discussions are being held with NHSE regarding allocation of funding.

The Committee was asked to note the updates on the Digital workstreams enabling Primary Care services.

CFo gave detail on the progress report which included detail on the Blinx pilot outlining that NHSE are to pilot to a more core patient record from EMIS to a new product on the market to replace EMIS.

Concern was raised that there is always a degree of angst in Q4 around what the ICB are going to 'disinvest' in general practice, and that people want to know about what will continue into the next financial year. It was further outlined that there is 'lots of noise' in general practice around the Blinx project and that it causes angst for practices who have looked at it and do not want it or those who feel it is going to be pushed on them in the future, DHa sought reassurance around this aspect.

In relation to AccuRX, there is ongoing dialogue with the national hub and that the ICB is still awaiting on details of levels of funding and what can be funded with these monies.

CFo and JGr outlined that Blinx was a voluntary programme for those who are interested and that it has been commissioned in parallel, there is an independent body evaluating, and sitting alongside of the ICB to see how it goes and are using the mechanisms that practices already use with their general population.

The way it has been set up and rolled out has deliberately been set up to test it to see if it is beneficial or not and then what the next steps might be following this.

In relation to cyber security the team were praised for doing a fantastic job with recent issues and it was asked if there are any ongoing issues to worry about or any update or risks to be aware of?

CFo outlined that it is taking a bit of time to reflect and learn on the recent issues. Crowdstrike in effect had the same impact as an attack and a number of processes have been/ are being put in place. The Digital team are working with providers who provide to primary care to create and implement a set of standards based on best practice for cyber security against which the IT providers will be monitored. Sadly some cyber incidents occur because best practice processes are not/ have not been followed.

However reassurance was given, and that they are building in good working practices and standards into the contracts to reduce the risks for the wider system and impact therein.

It was noted that primary care contracts (in this instance) is only for General Practice, but if the digital team can assist, help and support other provider groups then please open up the dialogue.

It was reported that a number of practices are changing their practice around the risks to the service for patient experience, and are going for something that looks flash but the outcomes may not match this. Concern was expressed that it may not do what we need it to do. The Patient survey should throw up any issues, and so far Blinx is live across a number of practices already and there are no flags, it was reiterated that we remain open and aware to offer something that is beneficial to the patients we serve.

Noted that as a system we have many moving parts, and we do need to grasp this better, there is always an impact and consequences. It may be more beneficial to move to a smaller use of products and programmes as there is a lack of connectivity between trying to support everything and to multiple suppliers, this is about work streamlining.

Highlights an example of thinking at a more strategic level, variation does lead to a dispersed effort to manage the different approaches, we do need to move towards a more strategic aligned and simplified route.

RBa stated that as a system we have a habit of putting all our eggs in one basket and then fingers get burned. EMIS for example, sounded and looked good and it promised the earth, but then did not deliver. As a system, history tells us we have got it wrong when it did not, so different systems come in because there is not a single one approach that does work, he asked that the ICB did not fall into this trap again.

It was questioned around the shortfall of £180k as noted in the paper, however in response to this LWB outlined that it is not really a shortfall as there is no financial pressure as it is within the £2m.

Another question received was around what was the expectation of being able to book an appointment via a phone, and whether this should be measured. CFo outlined that this was part of the NHS App and Patient Portals projects and will give patients access, however it is dependent on being at the bit of a mercy with suppliers to provide this. CFo outlined that the team could bring something specific on this to a future SPCC meeting if required and will provide more information in the next report regarding the functionality of the fundamental one that is being spoken about.

The Committee noted the report and updates as presented.

SPCC 24/12/B13 Access Improvement Plan

This was presented to update the SPCC on progress of the ICB's Access Improvement Plan at both system and place level(s), following initial approval by the Board in November 2023 and update in March 2024. This paper also reflects updated policy asks for 24/25.

It should be noted that the ask for Boards to be updated during Autumn 2024 was mandated by NHS England. This Plan was submitted to Board in November 2024.

The Committee was asked to ***discuss and note*** the update on the System Level and Place Level Improvement plan(s) including the Board feedback.

It was outlined that this is supported with Place level plans and contains an updated cover sheet with the board feedback. It was noted that we are awaiting the outcomes of the 10 year plan review and the review of the Long Term Workforce Plan, which this plan will need to be mapped against. It was also noted that the report from Healthwatch on the qualitative patient experience of access which is underway, will report to SPCC in February 2025 and then to ICB Board in March 2025.

EMo stated there are some really positive things contained within the report and enquired whether there was a summary *1-pager* with RAG ratings at a glance as to which of these priorities we are tracking against. CLe advised that Appendix 1 showed the national 10 indicators that we ensure to report on and there may be additional things that we wish to add. He added that the ICB were not rated solely red on any of them and some of the work, in particular Self Referrals and Primary Secondary Care Interface, had been highly assured/ were performing above target.

The indicators form part of the regular Contracting Update to SPCC so these indicators will return in February as part of that update. It was noted that as part of the Healthwatch update it would be good to map these indicators against the questions/patient feedback if possible. Following the Healthwatch update the SPCC may wish to review indicators to concentrate on certain elements. EMo raised the issue of appointments via the NHS App and access to them which would be part of additional reporting.

Action : Discuss Access Indicators as part of the Healthwatch update at the next meeting, when the report is presented by Healthwatch colleagues EMo/CLe

The Committee noted the report as presented and assurances within.

CLOSE OF MEETING

Date of Next Meeting: Thursday 20 February 2025 (09:00-12:30)
F2F, Lakeside, Warrington

CHESHIRE MERSEYSIDE
INTEGRATED CARE BOARD

NHS Cheshire and Merseyside

(Public) System Primary Care Committee Action Log 2024-25

Updated: January 2025

	Action Log No.	Original Meeting Date	Description	Action Requirements from the Meetings	By Whom	By When	Comments/ Updates Outside of the Meetings	Status
1	SPCC 23/09/B07	08-Sep-2023	System pressures	a) discussion at a future meeting (summary record access across Dental & GP) b) RPJ agreed to speak to digital teams regarding this	Kevin Highfield /John Llewellyn	22-Jun-2024	*UPDATE Jan 2025 : will now be part of regular update on PC Digital - action closed.* *Update requested from KH/ JL at August 2024* *19.10.23 - RPJ is on the case with this. CWa agreed to liaise with him for update*	COMPLETED
2	SPCC 23/10/B07	19-Oct-2023	Risk Register	"Quality" to be put on both the SPCC and the Quality & Performance Committee so that discussion is being held and recorded	Christine Douglas		*UPDATE Jan 2025 : full risk review undertaken and paper coming to Feb SPCC - action closed.* *Updates on risk to be covered off at August 2024 meeting. Quality placed as a mitigated risk with QSAG etc and the full review of SPCC risks.* *Noted to be on the agenda for todays meeting (Feb 2024)*	COMPLETED
3	SPCC 24/04/B05	18-Apr-2024	Strategic Framework Update	Dental underspend, need to understand why this cannot be spent. Need for a strategic plan and to elevate the strategic approach	Tom Knight	19-Dec-2024	UPDATE Jan 2025: Clarity obtained around dental underspend that will be utilised against ICB deficit - action closed UPDATE : meeting in October - Item closed UPDATE : August 2024 : update to come at end of year Request for TK to update at August 2024 meeting in order to close this action.	COMPLETED
4	SPCC 24/08/B10a	15-Aug-2024	Contracting, Commissioning and Policy update : Community Pharmacy and Dental	Request at the December SPCC meeting for an update, and the view on deprivation	Tom Knight / Chris Leese	April 2025	UPDATE Jan 2025 : View of all 4 contractors across deprived areas and impact of closures - action reset for SPCC in April	ONGOING

(Public) System Primary Care Committee Action Log 2024-25

Updated: January 2025

Action Log No.	Original Meeting Date	Description	Action Requirements from the Meetings	By Whom	By When	Comments/ Updates Outside of the Meetings	Status
SPCC 24/08/B11a	15-Aug-2024	Finance update	Investment piece to come to October SPCC	Lorraine Weekes Bailey /John Adams	19-Dec-2024	UPDATE: Dec 2024 - if this is about dental investments, an update was given to SPCC in Oct 2024 - so can be closed - if this is about SDF monies (which were an issue at the time) then there have been a number of updates and meetings since - therefore can be closed - if this is about estates then need to ask James Burchell - TBC	COMPLETED
SPCC 24/08/B12	15-Aug-2024	Digital Update	Kevin Highfield agreed to ensure that the Digital Leads communicated out to all the Practice Managers / Practices realting to the changes with Accubook	Kevin Highfield	asap	UPDATE Jan 2025 : confirmed by KH and action closed	COMPLETED
SPCC 24/08/B14	15-Aug-2024	Primary Care Update	Noted that the SPCC meeting in October will see a summary of what has been escalted, what are the themes and what needs to be addressed	Tom Knight	17-Oct-2024	UPDATED Jan 2025 : PC Update QSAG now reporting regularly to SPCC and Feb meeting (of SPCC) will have 9 month consolidated view - action closed UPDATED Oct 2024: Please refer to the latest Quality update report submitted for 17.10.24	COMPLETED
SPCC 24/10/B07	17-Oct-2024	Committee Risk Report	CLe, TKn and EMo to have a separate meeting/ discussion regarding the target of 9 for the workforce risk	Dawn Boyer	Feb 2025	UPDATE Jan 2025 - meeting outside of SPCC taken forward and report will come to Feb meeting	ONGOING
SPCC 24/10/B07	17-Oct-2024	Committee Risk Report	DCo to come back to next meeting (December) around next steps following the establishment of a strategic estates board (first meeting in November)	David Cooper	Feb 2025		ONGOING
SPCC 24/10/B08	17-Oct-2024	System Pressures	DHa was asked to share any specific examples to JGr in terms of Primary Care to Secondary Care interface issues	Daniel Harle	asap / as needed	UPDATE Jan 2025 - to be concluded outside of SPCC - action closed	COMPLETED

Cheshire and Merseyside

(Public) System Primary Care Committee Action Log 2024-25

Updated: January 2025

Action Log No.	Original Meeting Date	Description	Action Requirements from the Meetings	By Whom	By When	Comments/ Updates Outside of the Meetings	Status
SPCC 24/10/B13	17-Oct-2024	Local Dental Improvement Plan	JAd and MWo to pick up offline regarding clarity of the quality acess scheme budgeting	John Adams & Mark Woodger	Feb 2025		ONGOING
SPCC 24/10/B13	17-Oct-2024	Local Dental Improvement Plan	Ian Ashworth or the Beyond Team to be invited to a future meeting to give progress on oral health	TBC	TBC		NEW
SPCC 24/10/B15	17-Oct-2024	Performance (Primary Care)	December SPCC to see updates on key indicators, sense of high level and frequencey of seeing those indicators	Chris Leese	19-Dec-2024	UPDATE : will be a regular agenda item to be reflected in the Forward Planner, commencing January 2025	COMPLETED
SPCC 24/10/B15	17-Oct-2024	Performance (Primary Care)	CWa agreed to have a conversation at the next LMC meeting (key indicators / sense of high level)	Clare Watson	TBC	UPDATE Jan 2025 - meetings take place regularly and Committee happy to close action	COMPLETED
SPCC 24/12/B07	19-Dec-2024	System pressures	Committee noted the risks around local commissioned services and the contracted hours. But enquired as to how we are looking after patients in all this and raised the question of 'what is the so what'	Tom Knight	Feb 2025	UPDATE Jan 2025 - ongoing dialogue with TKn to be picked up at next SPCC	ONGOING
SPCC 24/12/B07	19-Dec-2024	System pressures	Shared care to go on Feb SPCC agenda	Cathy Fox	Feb 2025		ONGOING
SPCC 24/12/B07	19-Dec-2024	System pressures	Various conversations within SPCC about possible movements in metrics HW to provide GP client experience information in Feb SPCC	Erica Morriss	Feb 2025	UPDATE Jan 2025 - HW presenting initial report on GP Access and further discussions to follow	ONGOING

(Public) System Primary Care Committee Action Log 2024-25

Cheshire and Merseyside

Updated: January 2025

Action Log No.	Original Meeting Date	Description	Action Requirements from the Meetings	By Whom	By When	Comments/ Updates Outside of the Meetings	Status
SPCC 24/12/B09	19-Dec-2024	Finance update	Whether we are any closer to a decision for enhanced services, was due to go to Execs or Board (not sure of sequencing) - MBa agreed to look into this and would advise DHa acordingly.	Mark Bakewell	Feb 2025		ONGOING
SPCC 24/12/B10	19-Dec-2024	Freedom to Speak Up Guardian	standard item on SPCC agenda for FTSU on progress and resource	Chris Leese	Feb 2025	UPDATE Jan 2025 - standard agenda item within Contracting Comissioning item on agenda - action closed	COMPLETED

Cheshire & Merseyside System Primary Care Committee Forward Planner

Item	Frequency	Who	Part A / B	Feb 24	April 24	June 24	Aug 24	Oct 24	Dec 24	Feb 25	April 25
Committee Management											
Apologies	Every meeting	EM	Both	yes	yes	Yes	Yes	Yes	Yes	Yes	Yes
Declarations of Interest	Every meeting	EM	Both	yes	yes	Yes	Yes	Yes	Yes	Yes	Yes
Minutes of last meeting	Every meeting	EM	Both	yes	yes	Yes	Yes	Yes	Yes	Yes	Yes
Action & Decision Log	Every meeting	EM	Both	yes	yes	Yes	Yes	Yes	Yes	Yes	Yes
Questions from the public (where recv'd)	Every meeting	EM	B	yes	yes	Yes	Yes	Yes	Yes	Yes	Yes
Forward Planner	Every meeting	CL	B	yes	yes	No	Yes	Yes	Yes	Yes	Yes
Review of Terms of Reference	Yearly	EM/MC	n/a	no	no	No	No	No	No	No	Yes
Self-Assessment of Committee Effectiveness	Yearly	EM	n/a	no	no	No	Yes	No	No	No	No
Standing/Recurrent Core Items											
Minutes of any ExtraO Meeting	If held	EM/CL	A	No	No	No	No	No	Yes	No	TBC
Committee Risk Register	Every Other Meeting usually	HS/CL	B	Yes	No	No	Yes note Part A discussion re collective ation	Yes inc quality risk	No	Yes needs breakdown of workforce risk	TBC
Finance Update	Every Meeting	LWB	A	yes	Yes	Yes verbal	Yes inc SDF	Yes	Yes	Yes	Yes
PSRC Minutes/Update Minutes/Update from Pharmacy Operations Group and highlights	Every Meeting	TK	A	yes	Yes	No	Yes	Yes	Yes	Yes	Yes
Policy BAU Update – Primary Care Contracting and Commissioning 2 papers Dental/CP and Primary Medical/Optom	Every Meeting	CL/TK	B	yes	Yes	No	Yes (optom special schools/SDF	Yes	Yes	Yes	Yes
Escalation from Place Primary Care Forums	Where Place indicate	CL	A	yes, where raised	Yes, where raised	Yes, where raised	Yes where raised	Yes **x 2**	Yes where raised	Yes where raised	Yes where raised
Quality	Every Meeting	CD/TK	B	No	Yes general approach paper	No verbal update	Yes – update TOR/notes and dashboard	Yes if escalated	Yes verbal	Yes	Yes
Performance	Every Meeting	CL/BW	B	No	No	No	No	Yes progress and planned dashboard	No	Yes – on agreed indicators	TBC
Primary Care Quality Deep Dives	2 meetings per year	CD/KW		No	No	No	No	TBC	No	TBC	TBC
Update from PC Workforce Steering Group	Quarterly	JG	B	no	No (but is part of PCARP update)	No	No	Yes Summary update	No	No	No (first meeting isn't until March)
Digital Primary Care Update	Quarterly	JL	B	Yes	No	Yes See (1) Below	Yes single side summary of £ capital	Digital strategy	Yes	Yes	TBC
System Pressures and update from local forum(s)	Every Meeting	JG/CL	B	Yes	Yes	Yes	Yes	Yes	Yes	Yes verbal update on development of PC Forum	Yes
Primary Care Estates Update	Quarterly	NA	B	No	Yes inc how we agree extra GMS space	Yes as part of wider updates	No	Yes approval of strategy	Yes but in Part A	Yes Part A	TBC
Non Core Items											
Primary Care Strategic Framework		JG	B	No	Yes	No	No	TBC	TBC	TBC	TBC
Dental Access Improvement Plan		TK	B	Yes	Yes	Yes	No	Yes	No	Yes	No

11.2.2025

Cheshire & Merseyside System Primary Care Committee Forward Planner

Item	Frequency	Who	Part A / B	Feb 24	April 24	June 24	Aug 24	Oct 24	Dec 24	Feb 25	April 25
Primary Care Access Recovery Improvement		CL	B	No	Yes (Board Slide deck updated	Yes/part – digital summary	Part update *part of BAU update?*	Part of BAU primary medical	Yes separate paper with update on patient survey	Part of BAU	Healthwatch Report in full?
Summary – GP Patient Survey (System Level)		CL	B	No	No	No	Yes	No	As part of access improvement paper	No	No
Dental Paper – Part Year performance note		TK	A	No	No	Yes	No	No	Yes	No	No
Capital bids for agreement		KH	B		No	Yes	No	No	No	No	TBC
Improvement Grant Estates Bids		NA	B		No	Yes part of above	No	No	No	No	TBC
ADHD		LM	B		Yes verbal	Yes presentation	No	Verbal update	TBC	TBC	TBC
Digital – alignment of a single system for all four contractor groups		RPJ	B						verbal	TBC	TBC
FTSU		CD/TR	B						Yes -Verbal	Yes - paper	TBC
APMS Procurement		SBS	A							Yes	
Community Pharmacy Access		TK	B							Yes	
Approach to Planning Guidance Primary Care Indicators		CL/TK	B								TBC

Meeting of the System Primary Care Committee of NHS Cheshire and Merseyside

Date: 20 February 2025

Committee Risk Report

Agenda Item No: SPCC A25/02/07

Responsible Director:
Christopher Leese, Associate Director of Primary Care/
Tom Knight, Head of Primary Care

Committee Risk Report

1. Purpose of the Report

1.1 The ICB Risk Management Strategy sets out committee and sub-committee responsibilities for risk and assurance. This is the regular report on principal risks within the remit of this committee and corporate and place risks escalated to the committee.

2. Executive Summary

2.1 There are 16 risks covered by this report including 1 principal risk, 3 corporate risks, 3 place risks in common and 9 unique place risks escalated in accordance with the Risk Management Strategy (scoring high+). Of these, 3 are currently rated as extreme (15+) and 13 as high (8-12). The most significant risks are in relation to:

- Potential GP collective action impacting on patient care and access to services which has been rated as extreme (16) in Sefton, extreme (15) in Wirral and extreme (15) overall.
- Sustainability and resilience of the primary care workforce rated as extreme (16), and as high in relation to the general practice workforce by 5 places. A recommendation to reduce the rating of the corporate risk in respect of the primary care workforce as whole was rejected by the Committee in October pending a review of the primary care risks as a whole.

2.2 Since the October report:

- **6PC: Identified dental provider contract management risk potentially leading to loss of provider and impact on general dental provision** – Primary Care Appeals decision was in the ICB's favour enabling termination of these contracts, and all associated activity has been re-allocated. The residual risk is therefore reduced in line with target and recommended for closure.
- **13DR: There is a risk that the introduction of new core clinical system suppliers through the GP IT Futures Tech Innovation Framework Early Adopter Programme results in a more fragmented infrastructure and has a negative impact on record sharing**, currently rated high (10) has been allocated to the Primary Care Committee.
- Estates risks in relation to general practice meeting the criteria for committee escalation have been identified by 4 places and are therefore deemed to be a risk in common. The extent to which this applies in other places and to other contract groups will be assessed as part of the review of primary care risks.

2.3 The Committee Chair and Lead Officers have met to review the primary care risks, oversight and reporting arrangements as agreed following discussion at the October meeting of the Primary Care Committee. They have agreed on key strategic objectives and risk themes applicable across the 4 contractor groups. A workshop has been arranged to develop these further and allocate ownership

and oversight responsibility and reporting routes. The outcome of this will form the basis of the next quarterly risk report.

3. Ask of the Committee and Recommendations

3.1 **The Committee is asked to:**

3.1.1 **APPROVE** the closure of risk 6PC.
3.1.2 **NOTE** the current position in relation to the risks escalated to this committee, identify any further risks for inclusion, and consider the level of assurance that can be provided to the Board and any further assurances required.
3.1.3 **NOTE** the review of primary care risks, oversight and reporting arrangements currently underway.

4. Reasons for Recommendations

4.1 All committees and sub-committees of the ICB are responsible for:

- providing assurance on key controls where this is identified as a requirement within the Board Assurance Framework
- ensuring that risks associated with their areas of responsibility are identified, reflected in the relevant corporate and / or place risk registers, and effectively managed

4.2 Non-Executive Board members play a critical role in providing scrutiny, challenge, and an independent voice in support of robust and transparent decision-making and management of risk. Committee Chairs are responsible, with the risk owner and the support of committee members, for determining the level of assurance that can be provided to the Board in relation to risks assigned to the committee and overseeing the implementation of actions as agreed by the Committee.

4.3 Risks arise from a range of external and internal factors, and the identification of risks is the responsibility of all ICB staff. This is done proactively, via regular planning and management activities and reactively, in response to inspections, alerts, incidents and complaints. The committee is asked to consider whether any further risks should be included.

5. Background

5.1 The establishment of effective risk management systems is vital to the successful management of the ICB and local NHS system and is recognised as being fundamental in ensuring good governance. The ICB Board needs to receive robust and independent assurances on the soundness and effectiveness of the systems and processes in place for meeting its objectives and delivering appropriate outcomes.

5.2 Risk are escalated to the committee risk register which are rated as high or above. Committees will receive an overview of all relevant risks on first identification and annually, including those not meeting the threshold for escalation, to enable oversight of the full risk profile.

5.3 This committee risk report format follows the standard format and comprises 4 elements which are described in more detail below.

5.3.1 **Committee Risk Register** (appendix one) – which lists the committee's risks, ownership, scoring and proximity. The committee should pay particular attention to those risks where the current score is furthest from target, with a focus on planned action to strengthen controls, and on those where risk proximity indicates the risk is likely to materialise within the next quarter.

5.3.2 **Committee Place Risk Distribution** (appendix two) – which indicates, for risks common across multiple (3 or more) places, how risk is distributed across each of the places and will also feed into place risk reporting. This may indicate that action is required in a particular place/s to strengthen the effectiveness of an existing control or to implement additional controls.

5.3.3 **Risk Assurance Map** (appendix three) – which provides a rating of the adequacy and effectiveness of each group of controls and identifies the sources of assurance available to the committee in relation to each risk. The latter is in the form of reports to the committee and, through their scrutiny and questioning, the committee will be able to form of view of the level of assurance that can be provided to the Board.

5.3.4 **Risk Summaries** (appendix four) – for each risk which describe the risk in more detail and provide scores, trends, controls list, ratings, gaps and actions, planned and actual assurances, ratings, gaps and actions. This enables the committee to dive into the detail of any area of risk which is giving cause for concern.

Implications and Comments

6. Link to delivering on the ICB Strategic Objectives and the Cheshire and Merseyside Priorities

Objective One: **Tackling Health Inequalities in access, outcomes and experience**
Objective Two: **Improving Population Health and Healthcare**
Objective Three: **Enhancing Productivity and Value for Money**
Objective Four: **Helping to support broader social and economic**

6.1 Effective risk management, including the BAF, support the objectives and priorities of the ICB through the identification and effective mitigation of those principal risks which, if realised, will have the most significant impact on delivery.

7. Link to achieving the objectives of the Annual Delivery Plan

7.1 The Annual Delivery Plan sets out linkages between each of the plan's focus areas and one or more of the BAF principal risks. Successful delivery of the relevant actions will support mitigation of these risks.

8. Link to meeting CQC ICS Themes and Quality Statements

Theme One: **Quality and Safety**
Theme Two: **Integration**
Theme Three: **Leadership**

8.1 The establishment of effective risk management systems is vital to the successful management of the ICB and local NHS system and is recognised as being fundamental in ensuring good governance. As such the risk management underpins all themes, but contributes particularly to leadership, specifically QS13 – governance, management and sustainability.

9. Risks

9.1 The report presents 16 primary care risks, including 1 principal risk recorded on the Board Assurance Framework, 3 corporate risks, 3 place risks in common and 9 unique place risks, which are listed in appendix one. Of these 3 are currently rated as extreme and 13 as high. Controls have been identified and further action is planned to mitigate these risks which is expected to have an impact in reducing risk levels. This is summarised below and detailed in the risk summaries at appendix four.

BAF Risks

9.2 **P6: Demand continues to exceed available capacity in primary care, exacerbating health inequalities and equity of access for our population**, currently rated as high (12). This has been mitigated from extreme (16) through the Primary Care Access Recovery Plan and the Dental Improvement Plan.

Corporate Risks

9.3 **1PC: Sustainability and Resilience of Primary Care workforce (General Practice, Community Pharmacy & General Dental Services)**, currently rated as extreme (16). While there remains a general ongoing pressure, there are robust mitigations in place to manage this. It is anticipated that this risk will be retired and replaced with specific workforce risks focussed on each contract group.

9.4 **8PC: Potential Collective Action and GPs working to contract only in response to the 24/25 Contract Offer, impacting on patient care and access to services**, currently rated as extreme (15). This is being managed through EPRR, escalation and reporting and local place responses. In addition, work is underway looking at the potential impact on other healthcare services – in particular our urgent & emergency care services; to determine if there are specific additional risks associated with collective action.

9.5 **13DR: There is a risk that the introduction of new core clinical system suppliers through the GP IT Futures Tech Innovation Framework Early Adopter Programme results in a more fragmented infrastructure and has a negative impact on record sharing**, currently rated high (10). This is managed through the national Early Adopter Programme application and approval process and locally by the digital team working alongside the GP practices to identify any clinical and data risks and ensure that mitigations are built into agreements, implementation and delivery.

Place Risks in common

9.6 Place risks linked to corporate risk 1PC in relation to the sustainability and resilience of the general practice workforce have been identified and assessed as high by 5 places as follows:

Cheshire East	Cheshire West	Halton	Knowsley	Liverpool	Sefton	St Helens	Warrington	Wirral
12	12	N/A	N/A	12	N/A	12	N/A	9

9.7 Place risks linked to the corporate risk 8PC in relation to potential collective action by GPs impacting on patient care and access to services have been identified and assessed as extreme or high by all places as follows:

Cheshire East	Cheshire West	Halton	Knowsley	Liverpool	Sefton	St Helens	Warrington	Wirral
12	12	9	12	12	16	12	12	15

9.8 Place risks in relation to the sustainability of the primary care estate and its ability to support integrated and collaborative models of working have been identified and assessed as high by 4 places as follows:

Cheshire East	Cheshire West	Halton	Knowsley	Liverpool	Sefton	St Helens	Warrington	Wirral
12	12	N/A	N/A	8	N/A	12	N/A	N/A

Unique Place Risks

9.9 Place-level risks, scoring high and above which are unique to only one or two places, and therefore not meeting the criteria for a risk in common, have been identified by 6 places and are listed below. All place-level risks are managed with Place Primary Care forums and escalated to this committee in accordance with the criteria set out in the Risk Management Strategy.

Place	Risk ID	Risk	Inherent Score	Current Score
Cheshire West	CWPC4	Current conflict between contract holders of a practice in Cheshire West potentially resulting in hand back of GMS contract, resulting in no contract	8	8

		holders and CW Place having to procure replacement service – causing cost pressures and disruption to service provision.		
Knowsley	PC4	Changes to access arrangements not effectivity communicated and continue to be deemed not accessible by the local population	**12**	**8**
Knowsley	PC5	Following implementation of the PC Access Recovery Plan demand continues to increase and complexity of need grows impacting on delivery of services.	**8**	**8**
Knowsley	PC7	Individual GP Practices within PCN's remain GP practice focused, failing to develop links to wider and local system partners impacting effective Primary Care Transformation and collaboration.	**8**	**8**
Liverpool	LPCG001	Variation in the development, coordination and maturity of the PCNs will affect the ability of PCNs to deliver at scale and/or with other partners	**12**	**12**
Liverpool	LPCG003	Failure to effectively recover to a sustainable operational model for PC services post Covid, could result in significant levels of unmet demand and exacerbate health inequalities	**12**	**12**
St Helens	PC9	Financial Sustainability of a group of Practices, effects a group of four practices with a collective list size of 28,111 patients. Practices running on Locums, unable to attract sufficient workforce. Recent merger causing excess of admin.	**16**	**12**
Warrington		As a result of potential breach of contract, the contract holder handing the contract back or unable to continue to work / undertake duties for other any other reason, could result in the immediate closure of a single-handed GP practice. This would result in reduced patient experience, possible complaints, business service interruption (permanent loss of facility), adverse publicity and financial loss.	**20**	**9**
Wirral	WiPCG002	Lack of consistency of offer of Mental Health Practitioner roles across PCNs and in most deprived areas	**9**	**12**

10 Finance

10.1 There are no financial implications arising directly from the recommendations of the report.

11 Communication and Engagement

11.1 No patient and public engagement has been undertaken.

12 Equality, Diversity and Inclusion

12.1 There are no equality or health inequalities implications arising directly from the recommendations of the report.

13 Climate Change / Sustainability

13.1 No identified impacts.

14 Next Steps and Responsible Person to take forward

14.1 The Committee Chair and Lead Officers have agreed on key strategic objectives and risk themes applicable across the 4 contractor groups. A workshop has been arranged to develop these further and allocate ownership and oversight responsibility and reporting routes.

14.2 It is anticipated that this will result in greater clarity regarding the specific risks to the delivery of the primary care access and improvements plans and the extent of these risks for each contractor group.

14.3 In line with the Risk Management Strategy and practice in other committees, it is anticipated that the System Primary Care Committee will retain responsibility for providing oversight and assurance to the Board in relation to BAF and Corporate Risk Register risks. Oversight of other risks may be delegated to supporting groups with reporting to the Committee for assurance purposes.

14.4 The outcome of this review will form the basis of proposals in the next quarterly risk report.

15 Officer contact details for more information

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NHS Cheshire and Merseyside ICB
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16 Appendices

Appendix One: Risk Register
Appendix Two: Place Risk Distribution
Appendix Three: Risk Assurance Map
Appendix Four: Risk Summaries

Cheshire and Merseyside ICB
Primary Care Committee Meeting

NHS Cheshire and Merseyside

Appendix One: Primary Care Committee Corporate Risk Register Summary – February 2025

Risk ID	Risk Title	Senior Responsible Owner	Inherent Risk Score	Current Risk Score	Previous Risk Score	Target Score	Risk Proximity
P6	Demand continues to exceed available capacity in primary care, exacerbating health inequalities and equity of access for our population	Clare Watson	**20**	**12**	**12**	12	A – within 3 months
1PC	Sustainability and Resilience of Primary Care workforce (General Practice, Community Pharmacy & General Dental Services)	Chris Lees/ Tom Knight	**16**	**16**	**16**	9	A – within 3 months
8PC	Potential Collective Action and GPs working to contract only in response to the 24/25 Contract Offer, impacting on patient care and access to services.	Chris Lees/ Tom Knight	**15**	**15**	**15**	12	B – within 12 months
6PC	Identified dental provider contract management risk – potentially leading to loss of provider and impact on general dental provision **RECOMMENDED FOR CLOSURE**	Luci Devenport	**9**	**6**	**12**	6	A – within 3 months
13DR	There is a risk that the introduction of new core clinical system suppliers through the GP IT Futures Tech Innovation Framework Early Adopter Programme results in a more fragmented infrastructure and has a negative impact on record sharing	John Llewelyn	**16**	**10**	**12**	2	A – within 3 months

Appendix Two: Place Risk Distribution Summary – February 2025

Risk ID	Risk Title	Current Risk Score									
		ICB Wide	Cheshire East	Cheshire West	Halton	K'sley	L'pool	Sefton	St Helens	W'ton	Wirral
1PC	Sustainability and Resilience of Primary Care workforce (General Practice, Community Pharmacy & General Dental Services)	16	12	12	N/A	N/A	12	N/A	12	N/A	9
8PC	Potential Collective Action and GPs working to contract only in response to the 24/25 Contract Offer, impacting on patient care and access to services.	15	12	12	9	12	12	16	12	12	15
	Risks in common in relation to the sustainability of the primary care estate and its ability to support integrated and collaborative models of working		12	12			8		12		

Cheshire and Merseyside ICB
Primary Care Committee Meeting

NHS Cheshire and Merseyside

Appendix Three: Primary Care Committee Risk Assurance Map – February 2025

Risk ID	Risk Title	Current Risk Score	Controls					Assurance Rating
			Policies	Processes	Plans	Contracts	Reporting	
P6	Demand continues to exceed available capacity in primary care, exacerbating health inequalities and equity of access for our population	12	G	A	A	G	G	Acceptable
1PC	Sustainability and Resilience of Primary Care workforce (General Practice, Community Pharmacy & General Dental Services)	16	G	G	G	G	G	Acceptable
8PC	Potential Collective Action and GPs working to contract only in response to the 24/25 Contract Offer, impacting on patient care and access to services.	15	G	G	G	N/A	G	Partial
13DR	There is a risk that the introduction of new core clinical system suppliers through the GP IT Futures Tech Innovation Framework Early Adopter Programme results in a more fragmented infrastructure and has a negative impact on record sharing	10	R	A	G	G	A	Partial

Cheshire and Merseyside ICB
Primary Care Committee Meeting

NHS Cheshire and Merseyside

Appendix Four: Primary Care Committee Risk Summaries – February 2025

ID No: P6	Risk Title: Demand continues to exceed available capacity in primary care, exacerbating health inequalities and equity of access for our population
Risk Description (max 100 words)	The COVID 19 pandemic generated significant backlogs due to reduced capacity to meet routine healthcare needs and people delaying seeking healthcare interventions, exacerbating existing inequalities in access to care and health outcomes. This risk relates to the potential inability of the ICB to ensure that local plans are effective in delivering against national targets for recovery of primary care access, which may result in poorer outcomes and inequity for patients and loss of stakeholder trust and confidence in the ICB.

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Clare Watson	Chris Leese & Tom Knight	Assistant Chief Executive	Primary Care

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Improving Population Health and Healthcare	Primary Care	A – within the next quarter	Principal	Manage

Date Raised	Last Updated	Next Update Due
10/05/23	10/12/24	15/04/25

	Inherent Score	Q1 Score	Q2 Score	Q3 Score	Q4 Score	Target Score	Target Date	Risk Appetite / Tolerance
Likelihood	5	4	3	3		3	31/03/25	The aim is to reduce to a moderate level of risk over the 2024-26 lifetime of access recovery / improvement plans.
Impact	4	4	4	4		4		
Risk Score	20	16	12	12		12		
Rationale for score & progress in quarter (max 300 words)	There is potential for significant reduction in health outcomes and/or life expectancy, significant increase in health inequality gap in deprived areas or socially excluded groups, adverse public reaction and significant impact on trust and confidence of stakeholders (impact 4). Current controls are effective in reducing the likelihood to possible (3). Ongoing delivery of Primary Care Access Recovery and Dental Improvement Plans is on target and currently achieving the target risk score of 12. From a Primary Medical perspective, the ongoing collective action by GP practices could drive up the score during the remainder of the year if patients are becoming impacted. There will be Place variation with the scoring. In addition, there is also a potential impact on community pharmacies due to the collective action which will also be monitored and could impact the scoreduring the remainder of the year. A new risk for the Collective Action has been drafted and discussed at the System Primary Care Committee who have oversight							

Current Key Controls		Rating
Policies	NHS Long Term Plan, NHS Operational Planning Guidance, National Stocktakes and Guidance in relation to Primary Care, Primary Care Access Recovery Plan, National Dental Recovery Plan 2024	**G**
Processes	System and place level operational planning, performance monitoring, contract management, system oversight framework, place maturity / assurance framework.	**A**
Plans	Primary Care Strategic Framework version 1, Developing Primary Care Access Recovery Plan, System Development Funding Plan, Dental Improvement Plan, ICS Operational Plan, Place Level Access Improvement Plans x 9.	**A**
Contracts	GMS PMS APMS Contracts, Local Enhanced/Quality Contracts, Directed Enhanced Services – Primary Care Networks – Enhanced Access, GDS&PDS Contracts	**G**
Reporting	System Primary Care Committee, NW Regional Transformation Board, Quality & Performance Committee, ICB Board, HCP Board. Place Primary Care forums. Local Dental improvement plan delivery board	**G**

Gaps in control

Primary Care Strategic Framework version 2 to be completed & formally signed off.
Ongoing successful delivery of the access recovery / improvement plans required over a 2-3 year period to close gap, specifically dental workforce and funding for primary medical baselines as reported by contractors.

Actions planned	Expected outcome		Owner	Timescale	Rating
	Likelihood	Impact			
Complete & secure approval to Primary Care Access Recovery Plan Y2			Chris Leese	30/11/24	**Complete**
Delivery of Access Recovery and Improvement Plans			Corporate & Place Primary Care Leads	2024-26	**On Track**
Delivery of Dental Improvement Plan 2024-26			Tom Knight	2024-26	**On Track**
Collective action EPRR process in place			EPRR Team/Chris Leese	2024-26	**On Track**

To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme or critical)

Assurances available to lead committee and ICB Board			
Source	**Planned Date /Frequency**	**Date/s provided**	**Committee Rating**
Reporting on delivery to System Primary Care Committee & ICB Board	Quarterly	18/4/24	**Acceptable**
Performance Reporting to ICB Board	Bi-monthly	30/5/24, 25/7/24, 26/9/24	
ICB Board approval to Primary Care Access Recovery Plan Y2	November 24		
Gaps in assurance			
No Phase 2 of strategic framework			

Actions planned	Owner	Timescale	Rating
Secure approval to Primary Care Access Recovery Plan Y2	Chris Leese	30/11/24	**Complete**

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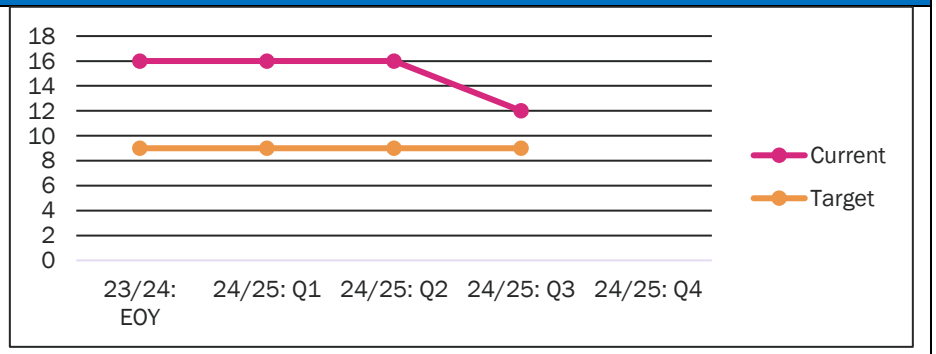
Cheshire and Merseyside

ID No: 1PC	Risk Title: Sustainability and Resilience of Primary Care workforce (General Practice, Community Pharmacy & Dental Services)

	Likelihood	Impact	Risk Score
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	3	3	**9**
Current Risk Score	4	4	**16**
Risk Appetite/Target Risk Score	3	3	**9**

Trend



Cheshire East	Cheshire West	Halton	Knowsley	Liverpool	Sefton	St Helens	Warrington	Wirral
12	**12**	N/A	N/A	**12**	N/A	**12**	N/A	**9**

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Associate Director of Primary Care (CL)/ Head of Primary Care (TK)	Place Primary Care Leads/ ICB PC Manager (JJ)/ Senior Commissioning Mgr (LD)	Assistant Chief Executive/ Place Primary Care Structures	System Primary Care Committee

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Improving Population Health & Healthcare	Quality, performance, transformation, commissioning.	A – within the next quarter	Corporate	Manage

Date Raised	Last Updated	Next Update Due
01/07/2022* *Legacy CCG Risk*	Oct 2024	Dec 2024

Risk Description
Resilience and sustainability of Primary Care in terms of demand, workforce pressure and external factors such as industrial action, peaks in public concern such as (A Strep). Previously a legacy CCG risk across all 9 CCGs; this has been further expanded to include similar pressures across Community Pharmacy and General Dental Service provision. This is a national issue (more than a risk) around contractual performance being reduced as GPs, dental practices and Pharmacies struggle to recruit suitably qualified and experienced staff. Workforce pressures are impacting on opening hours and access to services. Note individual examples of place-based practice resilience and operational concerns are captured on local place risk registers, but the combined issue across C&M is captured on the overall corporate ICB risk register so that there can be assurances in respect of the overall resilience and sustainability of primary care. This cross references with BAF risk P6 and People's Board risk around workforce sustainability. **September 2024**: Although Primary Care workforce remains challenged, across our nine places there is variation in the driving forces behind this risk e.g. some are related to workforce (GP turnover, succession planning etc), others are related to provision of estate e.g. to house the new ARRS roles. Overall controls and mitigations across the places are robust; although there remains an ongoing pressure in general across Community Pharmacy, Dental and General Practice, with a lack of key trained primary professional staff, in particular GPs, Pharmacists and Dentists (in the NHS family). Work continues alongside our primary care partners to respond to national asks/ targets and local demand/ pressures, and all places have robust local oversight & reporting arrangements in place. Urgent care process in place for dental treatment for vulnerable patients; and mitigating wider national issue relating to the dental services contract with some flexible arrangements and negotiation of financial values. Recommend to committee score is **reduced** to 12 (remaining a likely (4) likelihood, but reduced impact to moderate (3) – to reflect mitigations in place and business as usual management across 9 places, and central/ national support/steer. **General Practice:** Overall positive uptake of ARRS across the nine places, helping bolster the primary care workforce with alternative roles; and as at September, salaried GPs have now been added to ARRS roles, with guidance released, due to take effect from 01/10. **Community Pharmacy:** The reported numbers of total workforce have increased 4% from 2022 (using FTE); with the largest increase in trained medicines counter assistants (39%), pre-registration trainee pharmacy technicians (33%) and pharmacy delivery drivers (26%). The number of all pharmacists reported (as headcount) continues to be in the region of 27,000 (27,487). However, despite workforce numbers increasing, Community Pharmacy England has recently released a national report confirming financial pressures are putting community pharmacies at risk of closure, threatening patient care and access to services across England, with increased workload & demand on community pharmacies. Work is underway to scope the risks relating to this. **Dental:** Still awaiting the results of the national dental survey in primary care which is due to be published by NHSE imminently. This survey is completed by practices and the data collected by NHSBA who then report to NHSE for publication.; however, ICB Workforce Steering Group monitors figures and can confirm 4 additional Dental Foundation Trainees (DFTs) have been allocated to dental practices across C&M. As part of the local Dental Improvement Plan providing urgent care and completion of treatment. National work is underway looking at how we incentivise our newly qualified dentists to stay once they complete their training. At a local level we have been encouraging the use

of alternative roles – Dental Nurses, Therapists and Hygienists, and have seen steady growth in activity; although dental nurse uptake, nationally, remains quite low. Dental Improvement Plan has specific workforce focus.

Current Controls		Rating
Policies	• National Stock takes and Guidance in relation to Primary Care • Delivery Plan for recovering access to Primary Care https://www.england.nhs.uk/publication/delivery-plan-for-recovering-access-to-primary-care/ • Dental Improvement Action Plan • Delivering Operational Resilience across the NHS Winter 2023	**G**
Processes	• System Primary Care Committee – escalation to/ from • Managed operationally at place level through place governance (escalation to SPCC as needed). • Working with National Team and DoH on workforce issues and support. • Primary Care Workforce Steering Group reporting • Access Improvement Plan Templates submission 20/10 highlighting what place actions are being undertaken	**G**
Plans	• Primary Care Strategic Framework – ICB level and Place level, place workforce plans • Clinical Strategy • Workforce/ People plans via People Board inc Primary Care Workforce Strategy • ICB engagement with HEE and Liverpool Dental School • Dental Improvement Plan & Dental Foundation Trainee programme • GP retention plan (submitted May 2023) • ICB Access Recovery plan approved by ICB Board (October)	**G**
Contracts	• GMS PMS APMS GDS PDS Contracts updated • Local Enhanced/Quality Contracts/ Directed Enhanced Services • Community Pharmacy Contracts	**G**
Reporting	• Primary Care Workforce Steering Group/ • Community Pharmacy National Workforce Development Group • NHSE National Teams (looking at wider workforce issues across Primary Care) • Place reporting to place primary care structures/ forums - Access Improvement Plan Templates submission • Place reporting to System Primary Care Committee through reporting template already agreed noting a clearer risk principal escalation process is to be developed • System Primary Care Committee reporting through to Northwest Regional Structures • Reporting to PSRC Committee and through community pharmacy commissioning Team	**G**

Gaps in control
• Reporting between People Board and SPCC to be developed • Consistent single set of data to be reported to People Board/ SPCC

Actions planned	Owner	Timescale	Progress Update
Dental Improvement in place agreed and progressing	Tom Knight	Complete	Implementation slowed down due to financial impact. Dental ringfence removed nationally which has resulted in the implementation aspirations

Assurances		
Planned	**Actual**	**Rating**
Closing BI data gaps for Workforce (Ongoing)	Regular updates at SPCC on System Pressures	**Significant**
Dental Improvement Plan in place – however impact on workforce to be determined.	First meeting of PC workforce steering group held May 2023	
Salaried GP Guidance (ARRS role) due to take effect 01/10/24	Primary Care Access Recovery Improvement Plan approved by ICB Board in November	
	Review of Place risks to establish position/ scoring – SPCC risk summary updated to reflect distribution of risk across places and collaborative actions to mitigate	

Gaps in assurance
[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness] • Some BI data gaps remain

Actions planned	Owner	Timescale	Progress Update
Working with National Team and DH on workforce issues and support.	CL/ TK/ JJ	Ongoing	
Working locally with LPCs and contractors to understand & quantify issues and where required managing risk via contractual compliance routes/ local arbitration processes.	CL/ TK/ JJ	Ongoing	
Tracking the C&M risk against national and regional closure rates for comparison.	CL/ TK/ JJ	Ongoing	

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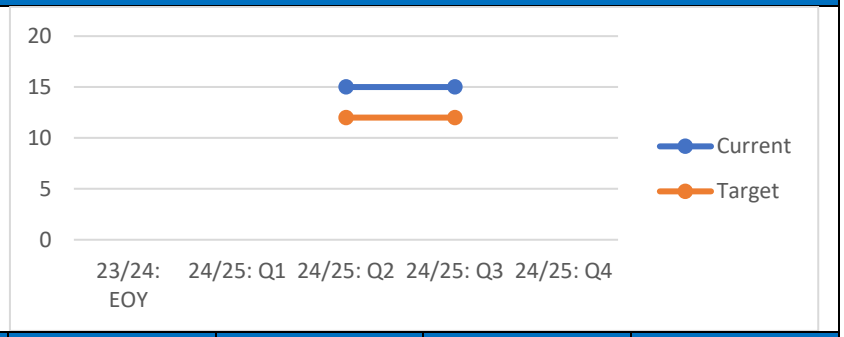
NHS Cheshire and Merseyside

ID No: 8PC	Risk Title: Potential Collective Action and GPs working to contract only in response to the 24/25 Contract Offer, impacting on patient care and access to services.

	Likelihood	Impact	Risk Score
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	3	5	**15**
Current Risk Score	3	5	**15**
Target Risk Score	3	4	**12**

Trend



Cheshire East	Cheshire West	Halton	Knowsley	Liverpool	Sefton	St Helens	Warrington	Wirral
12	12	9	12	12	16	12	12	15

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
System Level – Clare Watson, Assistant Chief Executive	Christopher Leese, Associate Director of Primary Care	Assistant Chief Executive/ Primary Care	System Primary Care Committee

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Enhancing Quality, Productivity and Value for Money	Primary Care/ Quality/ Performance	B – within this financial year	Corporate and Place	Manage/ Mitigate *(removal will depend on factors nationally)*

Date Raised	Last Updated	Next Update Due
June 2024	04/02/25	04/05/25

Risk Description

Following the release of the national contract terms related to finance, there are national and local pressures from some GPs to take collective action in relation to concentrating only on delivering core essential services as per contractual agreements. This would impact on patient care and services to varying degrees depending on the services and scale of the action (e.g. whether localised or spread out across the system). The universality of the action isn't clear at present with responses and feedback being worked through. This may impact on other providers including secondary care and community pharmacists, as well as patients.

September Update: Initial score proposed in August was 15 and **remains** 15 (possible (3) likelihood by a catastrophic (5) impact) on inclusion into SPCC Corporate Risk Register. There are several practices who have indicated that they will be taking a form of this action, and this is currently being managed at place level: with the EPRR team managing the total operational picture of the impact on the system

and providing twice weekly escalation to NHSE of a summary of issues from places. EPRR team can provide further information as required and are currently looking at the potential impact on other healthcare services – in particular our urgent & emergency care services; to determine if there are specific additional risks associated with collective action. As at 30/09 there has been no formal notification of a serious system, or practice, operational impact yet. This is being closely monitored and will be assessed over time. The ICB is in continuous dialogue with NHSE re: any national actions to mitigate this action.

Linked Operational Risks	Sustainability of General Practice Workforce Place related risks

Current Controls		**Rating**
Policies	Region have issued supporting documentation and template for system readiness and assessment	**G**
Processes	Escalation systems in place – place and corporate Escalation and reporting in place ICB to Region Informal temperature check-ins with Region ICB EPRR process in place ICB corporate meetings with all LMCS – regular agenda item	**G**
Plans	A regional temperature check/status template was completed for Region	**G**
Contracts		
Reporting	System Primary Care Committee regular update/Standing agenda item Place Primary Care Forums EPRR / System Control Centre Regional ICB Check-ins now in place	**G**

Gaps in control

- 24/25 Contract offer is a nationally-led process

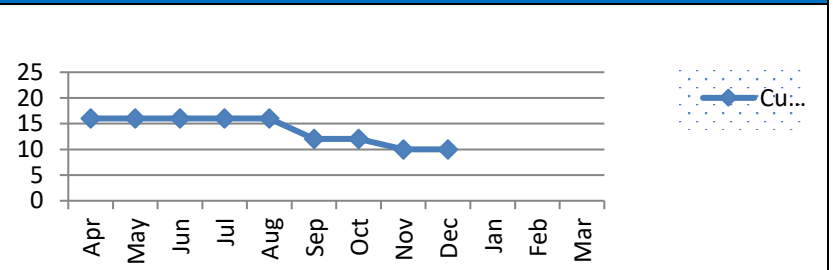
Actions planned	**Owner**	**Timescale**	**Progress Update**
Further ICB / Regional Reporting	JG/CL	In progress	
Place/Corporate regular check ins – initially fortnightly primary care leads	CL	Ongoing	Places developing place-level risk as appropriate – some places have had practices indicate they will be taking some form of action; other places this is still in discussion.
Place individual actions/plans (see Place level risk/plans)	Place PC Leads	Ongoing	Place level risk reporting varies in maturity across the nine places – as above.

Assurances		
Planned	**Actual**	**Rating**
Inter ICB readiness Assurance – more formal EPRR type readiness	Considered but not in place at this stage depending on how things progress	**Partial**

Gaps in assurance
As above

Actions planned	Owner	Timescale	Progress Update
Maintain continuous dialogue with NHSE re: national steer.	EPRR Team/ CL	Ongoing	

ID No:13DR	Risk Title: There is a risk that the introduction of new core clinical system suppliers through the GP IT Futures Tech Innovation Framework Early Adopter Programme results in a more fragmented infrastructure and has a negative impact on record sharing.

	Likelihood	Impact	Risk Score	Trend
Inherent Risk Score *[assess on 5x5 scale, this is the score without any controls applied]*	4	4	16	
Current Risk Score	2	5	10	
Target Risk Score	1	2	2	

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
John Llewellyn	Kevin Highfield	Medical	System Primary Care

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
	Digital	A – within 3 months	Corporate	Manage

Date Raised	Last Updated	Next Update Due
26/1/24	12/12/24	15/04/24

Risk Description (max 100 words)

As part of a national programme GPIT Futures Early Adopter Programme launched in May 2023 primary care organisations interested in changing GP core clinical systems are being supported and funded to work through the process of migrating to a new clinical system.

As early adopters, practices will be able to influence the shape of new systems coming into the market to ensure they meet their need and the evolving primary care space. The majority of practices in C&M use EMIS as a core clinical system with a small number of practices using TPP. Both software's are well embedded within our existing infrastructure, in particular when it comes to record sharing across primary, community and secondary care.
The introduction of new market entrants into this space will introduce variation, additional complexity and data gaps into a system which already has a complex technical infrastructure.

Current Controls		Rating
Policies	National GP IT Futures Tech Innovation Framework Early Adopter Programme	R
Processes	Early Adopter Programme application approval/sign off via System Primary Care Committee	A
Plans	Early Adopter Programme Stages 1, 2, 3, 4 alignments with governance mechanisms and decision point gateways to align with System Primary Care Committee	G
Contracts	Contracts with EMIS and TPP will reside until implementation of new entrant.	G
Reporting	System Primary Care Committee	A

Gaps in control

National TIFF Programme framework and policy does not provide or assess local decision making against risks at practice or ICB level in regard to complexity, variation of gaps in data sharing.

Practice level project management does not allow for the wider architectural footprint to be assessed in regard to minimum viable product and any risks of complexity or variation, therefore the NHSE Programme stages have been aligned with clear project milestones and management which encompass governance products such as clinical safety and data protection/sharing assessment of the wider impacts.

Gateway decision points are being implemented with each practice that align with stages and project methodology to mitigate any decisions being made in silo which pose risks to the complex architecture.

Actions planned	Owner	Timescale	Progress Update
Work alongside 2 GP practices signed up to Early Adopter Programme Stage 1 and 2 to understand plan & output of this stage	CM	Feb – Jun 24	Due to resource issues culminating from sickness and vacancy freeze, stages were not fully understood and risk to variation, complexity and system wide dataflows were apparent. The skills at practice level are not evident and the support required were not in place to mitigate these risks.
Understand the MOU between the Practice, ICB and NHSE and the responsibilities/ expectations of each party regarding decision making and	KH	November to December 2024	20/11/2024 MOU has now been received and stage responsibilities are understood.

strategic risk management of complexity and variation in digital architecture across the footprint within the innovation and deployment stages.			Project methodology has been implemented for 1 practice with key deliverables aligned to the stages and deliverables within the MOU.
Implement safety and protection governance structure which aligns with project methodology to ensure that any clinical and data risks are understood and highlighted when moving through phases.	KH	November to December 2024	20/11/2024 Governance risk and protection assessment strands are in the process of being aligned to the project plan and milestones which aligns with the deliverables of stage 2 deployment phase.
Commission full project support with clear methodology to understand minimum viable product/ interoperability requirements to reduce the risk of increasing infrastructure complexity across the footprint or creating any unaccepted risk	KH	November to December 2024	20/11/2024 Project support has been commissioned for 1 practice which will allow for structured methodology surrounding key deliverables and outputs for stage 2 deployment readiness. More analysis is required for Ainsdale practice regarding the deliverables of Stage 2 and their strategic intent to understand requirements for project support regarding the risk.
Plan Phase timelines that align with Primary Care Committee reporting to ensure coordinated decision making and oversight between all stakeholders.	KH	November to December 2024	20/11/2024 Phase timelines planned for Wilmslow aligning with key PCC dates. Communications plan for alternative stakeholders being delivered as part of project methodology for oversight of other stakeholders within matrix.
Implement Gateway decision points that align with progression through implementation milestones to ensure reduction of risk across the wider infrastructure and patient pathways/flows.	KH	November to December 2024	20/11/2024 Gateway decision points in the process of being planned that align with both PCC and NHSE stages, these gateways encompass clinical safety and data protection of an agreed minimum viable product to reduce the risk of complexity, variation and data exclusion.

To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme or critical)

Assurances		
Planned	**Actual**	**Rating**
Production on a Minimum Viable product documentation via GPIT support to assure that implementation includes necessary elements to withhold current clinical pathways and dataflows. To be signed by practice and ICB as part of gateway decision point	MVP is being produced via GPIT and has been reviewed by practice and ICB, there is currently a potential gap in knowledge regarding the wider footprint and therefore any requirements missing from the MVP will require time to resolve post go-live.	
Inclusion of Connected Care Records team to map the technical architecture and test shared records element of implementation to allow for understanding of any impacts across the footprint.	Resources within the Internal team are less than required due to vacancy control. A summary of required resources has been provided to Lesley Kitchen.	
MOU for Stage 2 and 3 to be signed by the practice to ensure all products of the project that assure relevancy of software and its fit within the current architecture are completed prior to any gateway decision point.	MOU documentation and deliverables will be achieved but any gaps in knowledge will not be understood until impact.	
Staffing for implementation and governance of change needs to be appropriate to monitor the activities of GPIT, Practice and NHSE	The current staffing levels and knowledge within the team are low for such a substantial change. The current resources applied will be reduced in March and the knowledge gap will widen.	
Gaps in assurance		
Though the project endeavors to include the required stakeholders to understand their individual elements of the change, significant migrations in one organisation, whether that be in Primary or Secondary care has an impact on all sectors across the footprint Outside of the shared records agenda, the technical architecture for the wider footprint is not currently mapped and the ICB does not currently have resources to manage or provide an in-depth clinical workflow, patient pathway or dataflow map. There are pockets of knowledge in individual programmes and teams, however, the lack of an overall view is a knowledge gap and impacts which poses a risk to assurance when changing core systems within individual organisations.		

Actions planned	Owner	Timescale	Progress Update
Actions need to be discussed at SMT and the wider executive level to understand actions to mitigate resources for Digital Technical roles outside of shared care records.	JL		

NHS
Cheshire and Merseyside

Meeting of the System Primary Care Committee of NHS Cheshire and Merseyside

February 2025

Primary Care Commissioning, Contracting and Policy Update – Primary Medical Services and Optometry

Agenda Item No: SPCC A25/02/09

Responsible Director: Clare Watson

1. Purpose of the Report

1.1 The Primary Care Policy and Contracting Update provides the Committee with information and assurance in respect of key national policy and related local actions in respect of;

- GMS/PMS (General Medical Services/Personal Medical Services) and APMS (Alternative Providers of Medical Services) including DES (Directed Enhanced Services)
- General Ophthalmic Services (GOS)
- Community Pharmacy
- Primary Care Dental Services

This paper contains ;

- An update on any key areas of policy in the above groups
- Any update on Cheshire and Merseyside issues that the committee need to be aware of for assurance purposes

2. Ask of the Committee and Recommendations

The Committee is asked to ;

- ***Note*** the updates in respect of commissioning, contracting and policy for the primary medical and optometry contractor groups.
- ***Note and be assured*** of actions to support any particular issues raised in respect of Cheshire and Merseyside contractors
- This report is for ***information*** and ***no decisions*** are required

3. Background

3.1 Cheshire and Merseyside ICB is responsible for the management of the national contracts for **General Practice** via a Delegation agreement with NHS England. This delegation agreement commenced following a national assurance process.

3.2 GMS, PMS, APMS (and DES) contracts are managed locally via place through the previously agreed matrix of decision making, through local primary care forums. Place are responsible for implementing any national policy changes locally, with any onward assurance collated by the central corporate team to NHS England.

3.3 Current number of GP Practices and PCNs in Cheshire and Merseyside is given below plus relevant contract statuses ;

	Number of GP Practices by contract	PCNs	GMS	PMS	APMS	Dispensing	Single Handed
Cheshire West	43	9	35	4	4	3	1
East Cheshire	36	9	21	14	1	5	2
Halton	14	2	1	13	0	0	0
Warrington	26	5	8	18	0	1	0
Liverpool	83	8	77	1	5	0	20
Knowsley	23	3	8	15	0	0	6
Sefton	40	2	23	11	6	0	3
St Helens	29	4	21	7	1	0	10
Wirral	45	5	28	14	3	0	3
Total	339	47	222	97	20	9	45

3.4 Oversight of the national general practice contracts are through the **Primary Medical Care Policy and Guidance Manual** https://www.england.nhs.uk/publication/primary-medical-care-policy-and-guidance-manual-pgm/. The ICB must manage the contracts in line with this Policy Book. Further detailed contract documentation can be found here NHS England » GP Contract

3.5 Management of **General Ophthalmic Services contracts** is underpinned via the National Policy Book for Eye Health NHS England » Policy Book for Eye Health . Provision of General Ophthalmic Services (GOS) including sight testing and dispensing is agreed by contract and there are 2 types of contracts: Mandatory Services contracts, which are contracts allowing provision of GOS in a fixed premises and Additional Services (domiciliary) contracts, which allow provision of GOS to a patient in their home address if a patients cannot attend a fixed premises unaccompanied. There are currently 222 mandatory (High Street) services and 60 additional (domiciliary) providers operating within Cheshire and Merseyside ICB. GOS contracting is managed solely at system level via the General Ophthalmic Services Operations Group, which reports to this Committee. Further contract information can be found here https://www.nhsbsa.nhs.uk/provider-assurance-ophthalmic/gos-contract-management

4. Primary Medical Services Update

4.1 The ICB continues to report monthly on key indicators in relation to **improving access to primary medical services** - and the latest NHSE reporting for this is given in **Appendix 1.** Separate meetings in relation to Primary/ Secondary Care interface are continuing and this remains a priority area. The ICB continues to perform well in most of these regional indicators – claims for Modern General

Practice Access payments under the national DES (Directed Enhanced Service) are still not at 100 per cent in all areas and it is anticipated that the rest of the claims will be put forward in the last 2 months of the year. NHS England continue to see further assurances in relation to Prospective Records Access which is a contractual ask and the ICB Digital and Contracting Teams are working with the last few remaining practices to ensure full contract compliance. More information can be found at Prospective record access manually enabling patient access - NHS England Digital. The ICB attended the Joint OSC (Overview and Scrutiny Committee) of Cheshire and Merseyside OSC's on 31.1 to present the ICBs Access Improvement Plan for Primary Medical, including the place level plans.

4.2 The ICB has been supporting the development of **a framework for assessment in respect of primary medical commissioning and primary care development** - and has been part of a small number of test ICBs in this respect. The draft products in relation to this have now been released and we are awaiting next steps for this nationally, as a tool for ICBs to use to self-assess - and support future delivery of - primary care development.

4.3 In 24/25 26 Practices accessed **Practice Level Support through the National General Practice Improvement Programme**, over 4 phases. Within these additional/ extra sessions were also accessed by 6 practices, which was an option under the offer. This programme is commissioned nationally by NHS England and a provider is allocated to the ICB for it's practices - place colleagues have been supporting/facilitating access to the programme via local engagement. The provider of the programme engages regularly with the ICB and the most common areas for support and mutual learning by practices in the 24/25 programme are given below ;

- Frequent Attenders management
- Efficiency in Processes and Workflow
- Use of Technology / NHS App
- Reception and Communication Improvements
- Patient Education and Self-Service
- Care Navigation and Structured Processes
- Administration and Staff Training

The ICB are currently in discussion with NHS England regarding the 25/26 General Practice Improvement Programme.

4.4 Last year the national ARRS (Additional Roles Reimbursement Scheme) was expanded to include GPs, subject to certain criteria - NHS England recently issued a reminder in respect of this to encourage uptake - NHS England » Reminder for primary care networks (PCNs) to use their GP Additional Roles Reimbursement Scheme funding in 2024/25. ICB Place staff continue to encourage and support PCNs with ARRS recruitment – the numbers of GPs recruited for this ICB under the ARRS will be reported at the next meeting.

4.5 NHS England has published its annual Priorities and Operational Planning Guidance for 25/26 NHS England » NHS operational planning and contracting guidance . The headline national priorities for primary medical are to improve patient outcomes for primary medical, contract oversight, commissioning and transformation, to support the delivery of modern general practice, improved access and a support a good overall experience for patients. In addition there is also reference to further work with primary care and trusts to streamline the patient pathway and improving the interface between primary and secondary care, through the 'Red Tape Challenge'. There is also reference to further work in relation to workforce planning, including primary care. **The reporting template with the headlines for Primary Medical is given in Appendix 2**

4.6 Alongside the operational planning guidance, guidelines have been published to help ICBs, local authorities and health and care providers continue to progress **neighbourhood health** in 2025/26 in advance of the publication of the 10 Year Health Plan - NHS England » Neighbourhood health guidelines 2025/26 . All parts of the health and care system – primary care, social care, community health, mental health, acute, and wider system partners – will need to work closely together to support people's needs more systematically. Primary Care are a major part of this and the guidance will build on the work already in place for several years across the ICS in relation to Care Communities.

4.7 The national indicator proposed for elements of 4.5 against which ICBs will be measured, is '**Improve patient experience of access to general practice as measured by the ONS Health Insights Survey'**. The Health Insight Survey is commissioned by NHS England and gives adults the opportunity to offer regular feedback about their experiences of the NHS. The study is a longitudinal survey, which commenced on 23 July 2024. Each participant is asked to complete the survey once every "wave", with each "wave" lasting four weeks. The latest return (December 2024) is given here Experiences of NHS healthcare services in England - Office for National Statistics In the results listed below each question, the response number and percentage for each ICB is given - but unlike the GP Patient Survey, there is no separate bespoke workbook or report for each ICB and the results are headlined as one national position. We have contacted the ONS who have confirmed they are working to try and make it easier to view data for each ICB via filtering mechanisms. In the meantime some work will need to be done to track/analyse the results over time. The primary care medical related questions within the survey are given in **Appendix 3.**

5. General Ophthalmic Services

5.1 **Eye Care in Special Schools programme** update ;

- The intention is for the Eye Care in Special Schools programme to launch through 2025. The offer covers all SES (Special Educational Settings) across Cheshire and Merseyside.
- It will ensure an annual sight test for all pupils (aged 5-25) within a SES setting with School and parent/guardian permission.

- Each pupil within the programme will have an eye health outcome report, there will be support towards glasses in line with GOS. Pupils will be offered a choice of frames.
- Currently no breakdown of total confirmed expressions of interest from schools and providers across C & M and we are still awaiting a final date from the national programme team. The service is not mandated across all schools.
- The fee for the service has been set at £85 per test. This was subject to consultation with OFNC (Optometric Fees Negotiating Committee) and it is not expected to change. Regulations to formalise the service were laid in Parliament in December 2024 and updated Directions published.
- Market engagement should now have been completed nationally and expressions of interest will be collated from providers and schools and the ICB will be notified in due course of lists of details of interested providers and schools for future planning along with a finalised service specification.
- Existing Proof of Concept (POC) providers who wish to, will maintain their contracts until procurement plans are put in place.

5.2 **Local Eye Health Network -**The Local Eye Health Network (LEHN) has been relaunched including key LOC stakeholders, LEHN Chair and meetings have been held in November 2024 and January 2025.

6. Primary Care Dental services

6.1 Dental Operational Group (DOG) meeting on 23/1/25

6.2 Contract Reductions and Hand backs:

X 3 non-recurrent contract reductions for 24/25
X 1 permanent reduction for 25/26. Reason cited by provider was struggling to recruit dentists

Contract variations will be issued and COMPASS updated.

6.3 Change of Location request:

X1 requested move of premises. Short distance proposed but further information requested from provide to assess impact on patients.

6.4 Following patient complaint received and review Dental Advisor will be undertaking a record keeping audit at the practice and reporting back in due course. There are a number of other practice visits that Dental Advisors are undertaking.

6.4 LPN Chair is in the process of contacting orthodontic providers across primary and secondary care with a view to re-establishing the Orthodontic Managed Clinical Network.

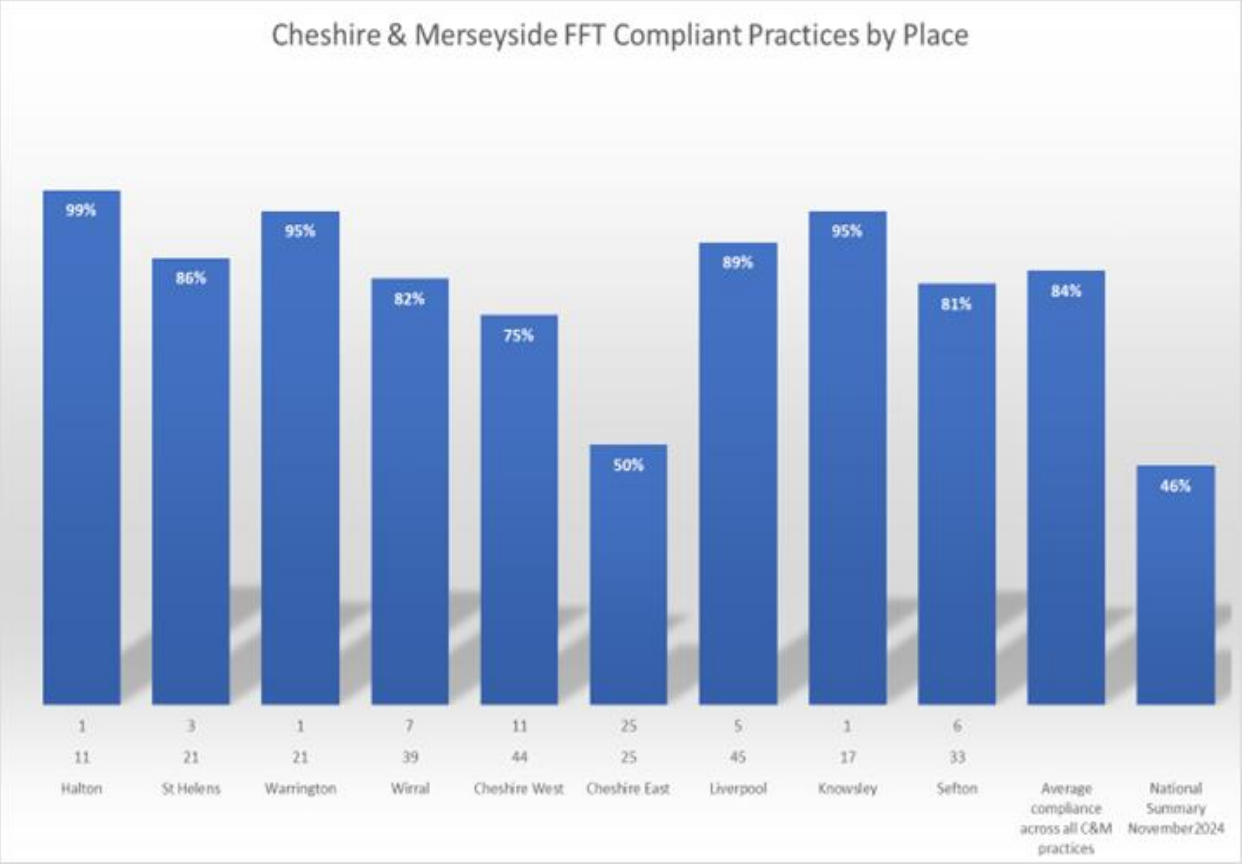
6.5 Friends and Family Test (FFT)

6.6 Dental Advisors have been actively supporting practices to enable FFT to be freely available to patients and then submit monthly response numbers to NHS England. Most NHS dentists have successfully implemented the Friends and Family Test (FFT) and submit monthly data to NHS England. Since it was first introduced in 2013, millions of responses have been collected, making the FFT the largest feedback mechanism to date.

6.7 FFT data is published by the Business Services Authority (BSA) on behalf of the NHS. For over 12 months the team have been supporting practices with their FFT returns and these are analysed with the results published each month.

6.8 As of November 2024, C&M ICB has the highest FFT response rate in England.

6.9 The data also shows that C&M ICB has the highest patient satisfaction rate across all ICB's in England with 98% of patients expressing satisfaction with the NHS dental treatment they receive.



6.10 Quality Assurance

6.11 Robust systems are in place to ensure the practices commissioned to undertake NHS dental services are 'fit for purpose'. This ensures that dental practices are

fully compliant with all current legislation and have robust clinical governance processes in place. These include:

- Clinical governance QA practice visits
- Liaising with CQC practice inspections and sharing information.
- Responding to whistleblowing allegations
- Managing and responding to patient complaints and advising the complaints team on dental issues
- Undertaking investigations and providing reports for serious practice complaints Undertaking investigations for Dental Therapist direct access issues
- Working jointly with Pharmacy Team on prescribing issues
- Working with C&M ICB relating to SMART corporate practice terminations
- Management of patients following practice termination and /or contract hand back
- Liaising with both large and small corporate bodies
- Advising practices on recruitment especially for International Dental Graduates (IDGs)
- Attendance at NHS BSA meetings and resolution of practice performance concerns
- Liaising with Liverpool University Dental Hospital and Community Dental Services
- Attendance at DOG meetings and giving dental input, as required.
- Attendance at NHSE Cheshire & Merseyside Dental Advisor meetings
- Liaising internally with other NHSE Cheshire & Merseyside teams
- Liaising with NHS WT&E on education requirements for IDQs and dental practices
- Monitoring annual statements of decontamination and six-monthly decontamination audits
- Profiling of clinical activity from practices.

6.12 A Bariatric service evaluation has been completed during November and December 2024. The findings with recommendations have been presented to the Special Care Managed Clinical Network and the next step will be to discuss commissioning implications. It is possible that flexible commissioning can be utilised for input from primary care dentists and that any other service changes can be accommodated within existing resources.

7. Community Pharmacy services

7.1 Pharmacy Operational Group summary of meeting held on 29/1/25

7.2 The group reviewed a number of incidents and quality in November and December 2024 and considered any escalation required.

7.3 1 Freedom of Information request had been received regrading consolidations.

7.4 Up to 15 contractors have been identified as requiring visits arising from the latest Community Pharmacy Assurance Framework.

7.5 Temporary suspension of services reporting has flagged a discrepancy between reporting to commissioners and reporting to the BSA. Contractors will be reminded that they must report any unplanned closures to the BSA.

Nov 2024
Pharmacy reported via inbox = 19
BSA - Pharmacy reported in = 5
BSA – Nil returns = 63

December 2024
Pharmacy reported via inbox = 31
BSA – pharmacy reported via MYS portal = 1
BSA – nil returns = 50

7.6 Directed Rota for services during Easter:

7.7 Easter Letter 1 – Good Friday & Easter Sunday has been sent out. Letter 2 for Easter due to be sent out by 13/02/25. May & Aug BH Letter 1 will be sent out shortly.

7.8 The group discussed sending out letters for BH's going forward. SOP's were reviewed & updated.

8. Link to delivering on the ICB Strategic Objectives and the Cheshire and Merseyside Priorities

The paper supports the delivery of the ICBs delegated duties in respect of primary care contracting – effecting and safe contracting supports the wider themes of

- Tackling Health Inequalities in outcomes, experiences and access (our eight Marmot principles).
- Improving population health and healthcare.
- Enhancing productivity and value for money

9. Link to meeting CQC ICS Themes and Quality Statements

QS4 Equity in access
QS5 Equity in experience and outcomes
QS7 Safe systems, pathways and transitions
QS8 Care provision, integration and continuity
QS9 How staff, teams and services work together
QS13 Governance, management and sustainability

10. Risks

Supports the mitigation following BAF risks - P1, P4, P5, P6, P8,

11. Finance

Will be covered in the separate Finance update to the Committee.

12. Communication and Engagement

No external formal consultation or further engagement is required in respect of this paper. Duties for engagement are accounted for accounted for in each of the aforementioned Policy Book's for the contractor groups. Nationally negotiated contract terms in respect of engagement are already agreed. National guidance in these areas is followed as detailed in the technical guidance for commissioning decisions in respect of these contractor groups.

13. Equality, Diversity and Inclusion

Duties for these are accounted for in each of the aforementioned Policy Book's for the contractor groups. Nationally negotiated contract terms in respect of this area are already agreed. National guidance in these areas is followed as detailed in the technical guidance for commissioning decisions in respect of the contractor groups.

14. Next Steps and Responsible Person to take forward

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Tom Knight, Associate Director of Primary Care (Dental and Community Pharmacy.
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15. Officer contact details for more information

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Appendix 1 – Access Improvement – Regional Indicators

Copy of CM PCARP Highlight Reporting 2

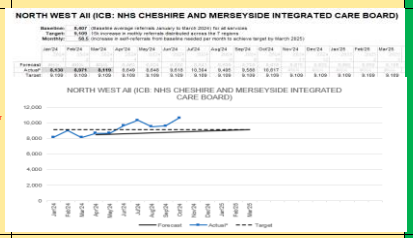
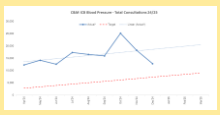
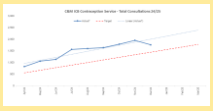
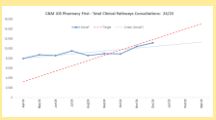
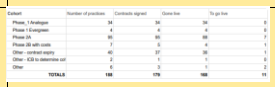
Appendix 2 Planning Guidance Primary Medical Template *for submission by 11.2 unless stated – it should be noted that these areas are not all contractual for providers*

Put in place action plans to **improve general practice contract oversight, commissioning and transformation** and tackle unwarranted variation in 25/26. [Draft action plans in place in line with PG timelines; finalised plans June 25]
Support delivery of **modern general practice and target support to practices to deliver access and a good overall experience for patients**, ensuring financial support is in place for practices for MGP digital tools and that use of other services to improve access (including Pharmacy First) is optimised.
Identify those practices (no.) requiring **targeted support to improve access and move to modern general practice**; secure/ provide high quality evidence based support to those practices from the national GPIP contract or through local arrangements, put in place engagement and improvement trajectories
Implement Primary Care Contracts including the **2025/2026 GP contract** *[End March submission]*
[Implement the **red tape challenge recommendations** and focus on the PC/SC interface taking action to improve and ensuring Trust contract levers are maximised] *[End March submission]*

Appendix 3 ONS Health Insights Survey - Primary Care (Medical) Questions

Percentage who attempted to contact their GP practice for themselves or someone else in their household in the last 28 days
Percentage who contacted a GP practice for either themselves or someone else in their household in the last 28 days
Percentage who were successful or unsuccessful in making contact with their GP in the last 28 days, by time frame
Percentage who were successful or unsuccessful in making contact with their GP in the last 28 days, by time frame
Method used to make contact with GP practice, for those who were successful in contacting their practice in the last 28 days
Perceived ease of contacting GP practice by method of contact, for those who were successful in contacting their practice in the last 28 days
Perceived ease of contacting GP practice by method of contact, for those who were successful in contacting their practice in the last 28 days [Time series]
Actions of those who were unable to make contact with their GP in the last 28 days
Percentage who knew how soon their request would be managed after making contact with their GP practice, by method of contact, in the last 28 days
Actions of those who successfully made contact with their GP practice in the last 28 days
Percentage who were either given a face-to-face appointment or asked if they wanted one, of those who were given a face-to-face appointment or callback in the last 28 days
Timescales for face-to-face appointments, for those offered a face-to-face appointment in the last 28 days
Timescales for call back appointments, for those offered a call back appointment in the last 28 days
Percentage who have a preferred healthcare professional, of those who were given a face-to-face appointment in the last 28 days
Percentage asked if they wanted to see a preferred healthcare professional, of those who were given a face-to-face appointment in the last 28 days
Percentage asked if they wanted to see a preferred healthcare professional, of those who have a preferred healthcare professional and who were given a face-to-face appointment in the last 28 days
Percentage who were able to see their preferred healthcare professional, of those who have a preferred healthcare professional and who were given a face-to-face appointment in the last 28 days
Reasons for being unable to see their preferred healthcare professional, of those who have a preferred healthcare professional and who were given a face-to-face appointment in the last 28 days
Percentage who were offered appointments with their preferred healthcare professional which were not convenient, of those who have a preferred healthcare professional and who were given a face-to-face appointment in the last 28 days
Perceptions of how reasonable the time between requesting an appointment and when a face-to-face or call back or appointment was booked for, in the last 28 days
Perception of overall experience of GP practice, for those who tried to contact their GP practice in the last 28 days
Perception of overall experience of GP practice, for those who tried to contact their GP practice in the last 28 days
Perception of overall experience of GP practice by level of confidence managing a long-term condition or illness, for those who tried to contact their GP practice in the last 28 days

Perceptions of how the service provided by an individual's GP practice has changed over the last 12 months
Percentage who were on a hospital waiting list
Percentage who knew when to expect their next hospital appointment or treatment, for those who were on a hospital waiting list
Satisfaction with the communication of waiting times for NHS treatments, for those who were on a hospital waiting list
Satisfaction with the communication of waiting times for NHS treatments, for those who were on a hospital waiting list
Percentage who had been referred to a specialist by their GP practice in the last 28 days
Percentage offered a choice of hospital when referred by their GP practice to see a specalist, in the last 28 days
Percentage offered a choice of hospital when referred by their GP practice to see a specalist, in the last 28 days
Percentage who have a long term health condition or illness and how they are impacted
Percentage with a long term health condition or illness and their confidence in managing their condition

	PCARP Programme Priority	National Programme Commitment	Metric	National Target	ICB Latest Position	Delivery Confidence	ICB Latest Position	POINTS TO CONSIDER
Empowering the Patient	Increase the use of **NHS App** and other digital channels to enable more patients to access to their prospective medical records (including test results) and manage their repeat prescriptions	Enable patients in over 90% of practices to −see their records and practice messages −book appointments −order repeat prescriptions using the NHS App by March 2024. *Data relating to repeat prescriptions will be shared with PCNs alongside working with General Practice teams and PPG to understand how barriers can be overcome and increase adoption can be obtained*	Percentage of practices with prospective record access enabled	>90%	**74% of C&M practices are compliant** with GMS/PMS/APMS Contract requirements for this metric whilst **98% of practices** have organisational settings set to allow prospective record access ***Data reflective of 12th January 2025 dashboard.***	green	C&M Digital team working with contracting to look at step 1 'non compliant'. We are currently believe that there is just 1 practice who has has not yet enabled record access, however there are 6 others that we are querying due to a discrepancy in the compliant/non compliant stsus at stage 1. We will be supporting IT service delivery teams working with practices identified as high users of the 104 code to work through solutions to ensure patients are able to view their detail coded records where is it considered safe for them to do so.	*How your ICB worked with its PCNs/practices to ensure:* ** application of system changes or manual updating of patient settings to provide prospective record access to all patients* ** ensured directly bookable appointments are available* ** offering secure NHS App messaging to patients where practices have the technology to do so in one place* ** encourage patients to order repeat medications via the app*
			Increase NHS App records views from 9.9m to 15m per month by 03/25	National: 15m per month	**No data currently available**	amber/green	We will be looking at practices who are high users of the 104 code - their reasons and support needed to bring this percentage down. IT Delivery Services across Cheshire & Merseyside are also working with practices to promote the use of the NHS App. This is a challenge in some areas of Cheshire & Merseyside where other online services apps have been embedded for a number of years. follow up with Warrington PCNs who showed particular interest in promoting the use of volunteers/work experience to support patients to use the available functionality of the NHS App and will include accessing records in the future. At this moment in time, the data for record access is not available on the NHS App reporting dashboard however this has been escalated to NHSE and we	
			Increase NHS APP repeat prescription numbers from 2.7m to 3.5m per month by 03/25	National: 3.5m per month	275,534 repeat prescriptions - December 2024 **+5.37% change on prior month**	green	IT Delivery Services across Cheshire & Merseyside are working with practices to support the transition to paperless prescription ordering along side the continued promotion of the NHS App. C&M comms team promoted use of NHS App over the christmas period - in particular for repeat prescriptions (repeat of the campaign from last year). Unfortunately the plan for an NHS APP campaign nationally has been put on hold so we will be looking at using existing materials that previously had a positive impact on the use of the NHS app and in particular repeat prescriptions. This will be discussed with the C&M comms team.	
	Continue to expand **Self-Referrals** to appropriate services	Ensure integrated care boards (ICBs) expand self-referral pathways by September 2023	Increase the number of self-referrals across a wider range of pathways by at least 15,000 patients per month by March 2025	additional 15,000 per month		green		
	Expand pharmacy oral contraception (OC) and blood pressure (BP) services this year, to increase access and convenience for millions of patients, subject to consultation.		Increase number of community pharmacy blood pressure check appointments per month by at least 71,000 by 03/25	additional 2.5m by 03/25	*i) Data source* ***Pharmacy First Regional Analysis Report*** *(NHSE) - Sept 24* **15,827 consultations** delivered during **September 2024** **282.1% of ICB target** *ii) Data Source* ***NHSE Monthly 'Unverified' Pharmacy First Reports*** *- Dec 24* 1. **12,757 BP consultations in Dec 24** compared to 18,228 in Nov – 30.0% reduction. National growth was -31.8% 2. ABPM made up 9.6% of total consultations (1,220) a reduction of 22.8% on Nov. National figure was -26.7% 3. Clinic BP consultations made up 90.4% (11,537) of total consultations, a reduction of 30.7% compared to Nov. National growth was -32.2% 4.C&M have delivered a **total of 213,248 BP consultations since Sept 23** (available data) or **6.5% of the national delivery.** C&M ICB has a **4.7% target** of National delivery in PCARP metrics based population size 5. **510 (94.4%) C&M Pharmacies** have **opted in** to provide the BP service. National opt in % is 93.0%	green	Data source ii) C&M ICB are performing well above the national expectation in this metric. **Dec 24** performance shows **C&M ICB are 1st out of 42 ICBs. C&M ICB are expected to achieve this target.** 	*How your ICB has supported the expansion of pharmacy oral contraception (OC) and blood pressure (BP) services and coordinated local communications:*
	Expand uptake of **Pharmacy First services** ***The trajectory for these commitments will be reviewed in September 2025 using data from the first 9 months of service delivery.***	Increase the number of oral contraception prescriptions coming directly from a community pharmacy without GP by at least 25,800 by 03/25	Increase the number of oral contraception prescriptions coming directly from a community pharmacy without GP by at least 25,800 by 03/25	additional 25800 by 03/25	*i) Data source* ***Pharmacy First Regional Analysis Report (NHSE)*** *- Sept 24* **1,625 consultations** delivered during **September 2024** **146.4% of ICB target** *ii) Data Source* ***NHSE Monthly 'Unverified' Pharmacy First Reports*** *- Dec 24* 1. **1,761 Oral contraceptive consultations** delivered in **Dec 24** compared to 1,952 in Nov 24 – (9.8% reduction). National growth was 4.5% 2. 15.2% (267) of Dec 24 OC cons are initiation of supply. National figure is 12.6% 3. C&M have delivered a total of 15,857 since Sept 23 (available data), or **5.1% of National delivery.** C&M ICB has a **4.7%** target of National delivery in PCARP metrics based population size 4. **438 (81.1%)** C&M Pharmacies have **opted in** to provide OC service. National opt in is 80.4%	green	Data source ii) C&M ICB are performing above the national expectation in this metric. **Dec 24** performance shows C&M ICB are **9th out of 42 ICBs. C&M ICB are expected to achieve this target.** 	
		Launch Pharmacy First so that by end of 2023 community pharmacies can supply prescription-only medicines for seven common conditions.	Increase number of PF pathway consultation appointments per month by at least 320,000 by 03/25	additional 320,000 by 03/25	*i) Data source* ***Pharmacy First Regional Analysis Report (NHSE)*** *- Sept 24* **8,883 consultations** delivered during **September 2024** **103.4% of ICB target** *ii) Data Source* ***NHSE Monthly 'Unverified' Pharmacy First Reports*** *- Dec 24* 1. **11,175 clinical pathways** delivered in **Dec 24**, **an increase of 7.2%** on Nov. National growth was 9.2%. 2. Since the launch of Pharmacy first C&M have delivered **99,932** clinical pathway consultations or **5.5% of National delivery.** C&M ICB has a 4.7% target of National delivery in PCARP metrics based population size 3. 525 (97.2%) C&M Pharmacies have opted in to provide Pharmacy First Service. National opt in is 97.1%	green	Data source ii) Compared to regional Neighbours per 100k population the North West is currently the highest performing region in this metric and C&M sit in 2nd place in the North West. C&M are ranked **11th out of 42 ICBs in England**. 	*How the ICB has supported the delivery of Pharmacy First?*
Implementing Modern General Practice Access	Complete implementation of **better digital telephony**	Support all practices on analogue lines to move to digital telephony, including call back functionality, if they sign up by July 2023.	% of practices on Cloud Based Telephony (CBT)			amber/green	Remaining go live dates for those in funded programme are scheduled for Jan/Feb 25 . For those outstanding there have been issues with landlords and also BT with broadband issues. Progress has been made on these issues, with IT Provider and Place Digital leads working closely with key contacts of landlords. The situation is being monitored by the ICB and with relevant IT Providers. The ICB will continue to monitor practices outside of the programme who are working with the Hub directly as contracts expire.	
	Complete implementation of **better digital telephony**		Percentage of practices meeting CAIP payment criteria	>90%	50%	amber/green	anticipating remaining claims feb march	*How the ICBs coordinated access to specialist procurement support through NHS England's commercial hub, achieving and tracking the transition of the majority of practices from analogue to CBT by 31 December 2023, and supported the remainder by 31 March 2024?*
	Complete implementation of highly usable and accessible **online journeys for patients**	Provide all practices with the digital tools and care navigation training for Modern General Practice Access and fund transition cover for those that commit to adopt this approach before March 2025.	Percentage of practices meeting CAIP payment criteria	>90%	41.00%	amber/green	as above	*How the ICB has ensured that all practices have nominated one member of staff to access care navigation and digital and transformation lead training* *How Transition Cover Support has, and will be made available for those practices transitioning to Modern General Practice Access.*
	Complete implementation of **faster care navigation**, assessment, and response		Percentage of practices meeting CAIP payment criteria	>90%	38.00%	amber/green	as above	
	National transformation/improvement support for general practice and systems	To scale the learning from GPIP and strengthen locally owned delivery of transformation support in partnership with ICBs. To provide an online support offer alongside flexible, hands-on support to a proportion of practices as part of the transition to a system-owned delivery model.	Programme milestone inc. shared evidence, standards, best practice and support tools, which in turn enhance system-led targetted support to practices and PCNs	None given		green	see last return - we continue to liase with the provider and shared learning is ongoing via them - awaiting details of 25/26 offer	*How the ICB identifies and nominates practices and PCNs likely to benefit from transformation support and encourages uptake and participation?* *Including all training and transformation support, capacity backfill support (for transition cover and transformation support funding), bather quality online consultation tool, etc.*
Cutting Bureaucracy	Make further progress on the four **Primary Care Secondary Care Interface AoRMC** recommendations	Reduce time spent liaising with hospitals – by requiring ICBs to report progress on improving the interface with primary care, especially the four areas we highlight from the Academy of Medical Royal Colleges report, in a public board update this autumn.	Baseline in 04/24 using assessment tool and monitoring ICB progress based on provider returns every 6/12	None given		green	progressing as per plans outlined	*How the ICBs has set out actions to improve interface, including on the four key areas set out in the recovery plan with clear leadership responsibility in the ICB Board i.e. onward referrals, complete care (fit notes and discharge letters), call and recall and clear points of contact?*
	Make **online registration** available in all practices by October 2024	The commitment for 2,000 practices to be using this service was met in November 2023, one month ahead of schedule. More than 1 million patients have used a national online service to register with a GP since its launch 18 months ago. In 2024/25, we will roll this out to all practices by 31 December 2024	More than 90% of practices using the on-line registration system by 31st December 2024	>90%	97.1% of Cheshire & Merseysde Practices are enrolled in the service. There are 4 practices exempt leaving 6 practices outstanding across 2 localities.	amber/green	Work is ongoing The next step is focusing on increasing digital uptake across the enrolled estate from now until the end of March, focusing on practices with less than 40% uptake.	

NHS
Cheshire and Merseyside

Primary Care Finance Update

NHS Cheshire and Merseyside Primary Care Committee (System Level)

Agenda item : SPCC A25/02/10

Date: 20th February 2025

NHS Cheshire and Merseyside
Primary Care Committee (System Level)

NHS Cheshire and Merseyside

Date of meeting:	20th February 2025
Agenda Item No:	SPCC A25/02/10
Report title:	**24/25 Primary Care Finance Update**
Report Author & Contact Details:	Lorraine Weekes-Bailey, Senior Finance Manager - Primary Care John Adams, Head of Primary Care Finance
Report approved by:	Mark Bakewell-Director of Finance

Purpose and any action required	**Decision/ Approve →**		**Discussion/ Gain feedback →**		**Assurance →**	x	**Information/ To Note →**	x

Route to this meeting / Committee/Advisory Group previously presented to (if applicable)

N/A

Executive Summary and key points for discussion

The report provides the Primary Care Commissioning Committee of the Cheshire and Merseyside Integrated Care Board (ICB), with a detailed overview of the financial position related to primary care expenditure as at the end of January 2025 (M10).

The report covers seven areas of spend: -

- Local Place Primary Care
- Primary Care Delegated Medical
- Prescribing
- Primary Care Delegated -Pharmacy
- Primary Care Delegated -Dental
- Primary Care Delegated -Optometry
- Primary Care Delegated Other Services

The paper will highlight any key variances within the financial position, in respect of the forecast outturn, compared to the allocated budgets.

Also provided is an overview of any reserves and flexibilities available.

It also provides the most up to date breakdown of the Additional Roles Reimbursement Scheme (ARRS) allocation, and Place level spend and projected forecast.

NHS Cheshire and Merseyside
Primary Care Committee (System Level)

NHS Cheshire and Merseyside

Recommendation/ Action need:	**The Committee is asked to:** The Primary Care Committee is asked to: - 1. Note the combined financial summary position outlined in the financial report as at 31st January 2025. 2. Note the Additional Roles spend to date and the anticipated forecast outturn and predicted central drawdown. 3. Note the capital position.

Which purpose(s) of an Integrated Care System does this report align with?	
Please insert **'x'** as appropriate:	
1. Improve population health and healthcare	**x**
2. Tackle health inequality, improving outcome and access to services	**x**
3. Enhancing quality, productivity and value for money	**x**
4. Helping the NHS to support broader social and economic development	**x**

C&M ICB Priority report aligns with:	
Please insert **'x'** as appropriate:	
1. Delivering today	**x**
2. Recovery	**x**
3. Getting Upstream	**x**
4. Building systems for integration and collaboration	**x**

Place Priority(s) report aligns with:	
Please insert **'x'** as appropriate:	

Governance and Risk					
Does this report provide assurance against any of the risks identified in the ICB Board Assurance Framework or any other corporate or Place risk? **No**					
What level of assurance does it provide?					
Limited		**Reasonable**	**x**	**Significant**	
Any other risks? **Yes** If **yes,** please identify within the main body of the report.					
Is this report required under NHS guidance or for a statutory purpose? (*Please specify*) **Yes**					
Any **Conflicts of Interest** associated with this paper? If **yes,** please state what they are and any mitigations undertaken. **None**					
Any current services or roles that may be affected by issues as outlined within this paper? **No**					

Primary Care Finance Update

1. Introduction and Background

1.1. The report provides the Primary Care Commissioning Committee of the Cheshire and Merseyside Integrated Care Board (ICB) with a detailed overview of the financial position in relation to primary care expenditure anticipated for 2023/24 as at 31st January 2025.

1.2. As of the 1st April 2023, the ICB took on the delegated responsibility for all Ophthalmic services and Dental services across Cheshire and Merseyside.

1.3. The financial positions for January 2025 (M10) are based on the historical recurrent expenditure at each Place plus in-year amendments, including any uplifts for national assumptions.

2. Financial Position

2.1. Table 1, as shown overleaf, illustrates the detailed financial position of the Primary Care and Prescribing services across Cheshire and Merseyside ICB

Table 1

Primary Care Position Summary - Month 10 ICB TOTAL	Year To Date			Forecast Outturn		
	Budget (£000's)	Actual (£000's)	Variance (£000's)	Annual Budget (£000's)	FOT (£000's)	Variance (£000's)
Delegated Medical Primary Care						
Core Contract	275,678	274,516	1,162	330,781	329,789	992
QOF	32,768	33,069	(301)	39,322	39,656	(334)
Premises Reimbursements	45,313	45,555	(242)	54,375	54,810	(436)
Other Premises	619	583	36	743	707	35
Direct Enhanced Schemes	3,822	3,804	17	4,586	4,565	21
Primary Care Network	45,468	46,380	(911)	54,562	55,479	(917)
Additional Roles Reimbursement Scheme	56,505	56,490	14	53,686	53,686	0
Fees	8,893	8,796	97	10,671	10,513	158
Other - GP Services	1,139	1,161	(22)	1,367	1,386	(19)
DELEGATED PRIMARY CARE TOTAL	**470,205**	**470,355**	**(150)**	**550,092**	**550,593**	**(501)**
Local Primary Care						
GP Local Enhanced Service Specification	27,096	26,466	629	32,487	31,729	758
Local Enhanced Services	13,904	13,161	743	16,885	16,087	798
Commissioning Schemes	1,785	1,640	144	2,132	1,999	133
Out Of Hours	24,340	23,858	482	29,262	28,626	636
GP IT	16,383	15,507	876	19,838	18,857	981
GP Investment	225	205	20	303	281	22
Primary Care SDF	8,364	4,684	3,681	10,079	5,818	4,262
Primary Care Other	1,936	1,753	183	2,290	2,072	218
QIPP	(1,341)	0	(1,341)	(1,609)	0	(1,609)
PC Local Pay Costs	511	424	86	613	412	200
LOCAL PRIMARY CARE TOTAL	**93,202**	**87,698**	**5,503**	**112,280**	**105,881**	**6,398**
Prescribing						
Central Drugs	15,001	14,977	24	18,001	17,909	92
Medicines Management - Clinical	1,127	917	209	1,352	1,403	(51)
Oxygen	2,236	2,279	(43)	3,239	3,267	(28)
Pay Costs Prescribing	9,402	8,190	1,211	11,277	10,004	1,273
Prescribing BSA	406,334	418,941	(12,608)	486,475	507,435	(20,960)
Prescribing Other	9,277	14,112	(4,835)	10,895	10,878	16
PRESCRIBING TOTAL	**443,376**	**459,417**	**(16,041)**	**531,239**	**550,897**	**(19,658)**
Delegated Pharmacy Optoms Dental and Other						
Delegated Community Dental	10,819	10,819	(0)	12,983	12,983	0
Delegated Ophthalmic	22,310	22,351	(41)	26,772	27,189	(417)
Delegated Pharmacy	63,064	64,082	(1,019)	74,043	74,043	0
Delegated Primary Dental	112,403	112,403	(0)	144,596	144,596	0
Delegated Property Costs	1,218	469	749	1,512	625	886
Delegated Secondary Dental	36,047	35,885	161	45,166	45,166	0
PHARMACY, OPTOMS, DENTAL & OTHER TOTAL	**245,861**	**246,010**	**(149)**	**305,071**	**304,601**	**470**
TOTAL	**1,252,644**	**1,263,480**	**(10,837)**	**1,498,682**	**1,511,973**	**(13,291)**

3. Delegated Primary Care - Medical

3.1. The Delegated Primary Care Medical financial forecast as at Month 10, is approximately projected to overspend by £0.501m based on the current data and payments.

3.2. **Core Contracts-** The core contracts are currently forecast to underspend by £0.992m. The list size was considerably lower than planned. The quarter 4 list size has been accounted for within the financial forecast and we do not anticipate any further changes to the forecast.

3.3. **Quality Outcomes Framework- (QOF)**- The Delegated Medical Primary Care budget shows an overspend of £0.334m within the QOF service line. This is due to year-end achievement costs of 2023/24 being higher than anticipated. There is a deterioration in the forecast since

the last report. This is due to NHSE England advising that there had been a validation error in four of the QoF indicators. When this data has been re-validated, this has produced a cost pressure of £0.167m.

3.4. **Primary Care Networks-**The forecast outturn is projected to be an overspend of £0.917m. This is due to the actual achievement costs incurred at year end being much higher than projected.

3.5. **Fees-** The forecast within "Fees" is anticipated to be approximately £0.158m underspent. This is mainly due to the "Dispensing Professional Fees" that were incurred being lower than anticipated, based on our year end projections.

4. Local Primary Care

4.1. **Local Primary Care**- The forecast overall is currently projected to underspend by £6.398m.

4.2. **GP Local Enhanced Service GP Specification-** There is a projected underspend of £0.758m against the GP Service Specifications. There are two main reasons for this:

In Sefton place, the budget was based on 100% delivery of this specification. However, the forecast is based on the current estimated achievement of 93.05% this equates to an underspend of £0.394m.

Cheshire East place is projecting a £0.268m underspend. This is due to a duplication of budget for some services, this has now been released.

4.3. **Local Enhanced Services-** There are large variations in Local enhanced services across Cheshire and Merseyside. However, the majority are paid on an activity basis, we are now in receipt of Quarter 1 to 3 data and this is indicating a projected forecast underspend of £0.798m.

4.4. **GP Out of Hours-** There is a projected underspend of £0.636m against the GP Out of Hours Service. This is due to the planned budget being higher than the projected cost of the services.

4.5. **GP IT**-There is a projected forecast underspend of £0.981m. This is due to costs incurred being lower than budgeted for some software licenses and VAT that has been able to be recovered.

4.6. **Primary Care SDF-** The Primary Care SDF allocation is £10.08m. The Senior Leadership team made a collective decision around this funding process and the amount to be allocated to general practice. This equated to £2m to be allocated directly to Place General Practice, a further £3.35m has been allocated to support Digital projects, a GP Fellowship programme, GP Training and other transition and retention initiatives. The remaining £4.2m SDF funding has been used to support negate other system pressures.

4.7. **QIPP**- The QIPP target Local PC was £1.609m, and is on target and expected to be achieved.

5. Prescribing

5.1. The Prescribing drugs financial forecast shows an overspend of £20.960m including a prior year pressure of £1.2m. There a number of drivers for the overspend position including cost pressures and growth in activity above the national planning assumptions

5.2. An additional months prescribing data has now been received covering the period from April through to November. A review has been undertaken to understand likely costs for the rest of the financial year based on updated average costs per prescribing day, QIPP schemes and other initiatives(such as the waste management scheme launched in the autumn)

5.3. As a result, the projected forecast has improved since the last financial reporting paper by £5.5m and will continue to be monitored closely as further information becomes available.

5.4. The finance team will continue to work closely with the Medicines Management team and the Business Intelligence team.

6. Delegated Pharmacy

6.1. The year-to-date position shows a pressure of £1.019m, the current forecast is to break even in 2024/25 but the ICB recognises a risk of £1.227m. NHSE has requested that ICBs show forecasts in this way. NHSE has asked ICBs to show a break-even position in anticipation of either: (1) a reduction to current fee rates later in the year to bring total remuneration within the current national contract cap; or (2) increases to the contract remuneration cap and ICB allocations. The risk has reduced in month 10 as NHSE has confirmed that there will be no prescribing quality scheme in 2024/25 and ICBs are no longer required to accrue costs. Risk has therefore reduced by £2.5m to £1.227m.
In addition to an increase in the number of prescriptions being issued each prescribing day, take-up of New Advanced Services such as Hypertension Finding, Contraception and the New Medicines Service is also rising.
NHSE is discussing current fee rates, the £2.5bn national contract remuneration cap, and proposals for new contract rates with representatives of the profession.

The new “Pharmacy First” contract started on 31st January. All costs of this scheme are expected to be funded, but funding is provided in arrears (six months has been received to date). Therefore, the forecast shows a balanced position, whilst the year-to-date shows the correct cumulative spend but the variance has been adjusted to show a balanced position in accordance with NHSE’s funding arrangement.

7. Delegated Optometry

7.1. Activity in Optometry services has risen steadily over the last year and payments for spectacle vouchers have increased by 7%. The current 24/25 forecast is an overspend of £0.42m. The ICB is expecting to receive an allocation for optometry in special educational settings which could reduce the pressure to £0.27m.

8. Delegated Other Costs

For information:-
The budget line "Delegated Other" consists of budgets for Transformation Team staff, NHS Mail and Remote Access costs for POD contractors, Sterile Product costs and an unallocated reserve of £0.9m.

8.1. The unallocated reserve is forecast to underspend by £0.9m. The underspend was identified by the ICB as a mitigation of pressures in the wider ICB plan and supports the overall ICB financial position.

9. Delegated Dental

9.1. Performance to date suggests that there will be an underspend on core contracts as contractors appear to be targeting their available staff resources towards the delivery of the dental improvement plan, resulting in slippage on core contracted activity. Final agreed contract performance from the mid-year contract reviews will be used to update future forecasts.

9.2. The £15m Dental Investment Plan (the largest ever undertaken in Cheshire & Merseyside) targets those patients most in need of treatment and expenditure to date is broadly in line with plan.

9.3. Secondary care dental services are forecast to underspend by £2m. Other national allocations have fully funded the cost of 24/5 contract uplifts and £0.5m remains following the withdrawal by Southport & Ormskirk Hospitals from the delivery of orthodontic services.

9.4. The outcome of the appeal lodged by the contractor for the primary care dental contracts which were issued with termination notices in 2023, itself the culmination of action begun by NHSE prior to delegation, has concluded. The appeal found in favour of the ICB. The care of patients in mid-treatment is now being arranged while the contracts close. On-going care for displaced patients is being managed by commissioning additional UDAs from other local providers.

9.5. Dental funding is ringfenced in 2024/25 and cannot be used to support other services, any underspends will be clawed back by NHSE. Expenditure on the dental investment plan will reduce the value to be clawed back.

10. Additional Roles Reimbursement Scheme

10.1 The PCN entitlement for the Additional Roles Reimbursement Scheme for 2024/25 is £68,361,348. However, the allocation available to the ICB is £67,100,068.

10.2 As previously highlighted, due to the allocation methodology used by NHS England, the ICB currently has a shortfall in allocation available of £1,261,281. This is recognised by NHS England recognises and nationally there is a methodology to mitigate the risk.

10.3 Based on current projections and the revised PCN DES criteria, the current forecast outturn as at Month 10 is £67.842m.

10.4 Table 3 illustrates the budget and forecast at Place level. We are working with PCN's to ensure the forecasting is as accurate as possible.

10.5 Please note this allocation does not include the GP ARRS funding, that will be allocated later in the financial year.

Table 3

Place	ICB Held Budget	Available Drawdown	Funding Gap in ICB Allocation	Total	FOT	%age Utilisation
Cheshire East	£7,570,994	£2,071,306	£181,246	£9,823,546	£9,823,546	100%
Cheshire West	£7,220,270	£1,975,353	£172,850	£9,368,473	£9,368,473	100%
Halton	£2,634,499	£720,758	£63,069	£3,418,325	£3,418,325	100%
Knowsley	£3,451,445	£944,261	£82,626	£4,478,332	£4,478,332	100%
Liverpool	£11,382,619	£3,114,107	£272,495	£14,769,221	£14,769,221	100%
Sefton	£5,471,669	£1,496,963	£130,989	£7,099,622	£6,897,693	97%
St Helens	£4,067,424	£1,112,784	£97,372	£5,277,580	£5,225,265	99%
Warrington	£4,092,076	£1,119,528	£97,963	£5,309,567	£5,165,082	97%
Wirral	£6,795,006	£1,859,007	£162,670	£8,816,682	£8,695,819	99%
Total	**£52,686,002**	**£14,414,066**	**£1,261,281**	**£68,361,348**	**£67,841,756**	**99%**

11. Capital

11.1 Table 4 shows the latest primary care capital expenditure position.

Table 4

Cheshire & Merseyside ICB Primary Care Capital Position - Month 10 2024/25

Description	Cheshire & Mersey Planned £'000s	Cheshire & Mersey Received £'000s	Comments
Capital Resources			
BAU allocation	4,698	4,698	
Redemption of Legal Charge	474	474	Knutsford War Memorial Hospital
IFRS 16 - schemes funded centrally	1,516	1,266	Drawn down when cost incurred. Nat team to provide funds. Ringfenced for IFRS16.
Total Expected Capital Resource	**6,688**	**6,438**	

Description	Cheshire & Mersey Approved /Planned £'000s	Cheshire & Mersey Spent £'000s	Comments
Approved Expenditure			
GP Premises Improvement Grants			
Multi-year schemes approved in 2023/24	79	79	Approved 23/24
Schemes approved in 2024/25	1,702	150	Approved by Regional Director of Finance, July 2024
Subtotal Improvement Grants	**1,781**	**228**	
GPIT			
Approved NW Region	2,630	0	All Places except Liverpool and Sefton
Subtotal GPIT	**2,630**	**0**	
IFRS 16 - Schemes funded Centrally			
Disposal of The Department, Lewis's (Liverpool)	-343	-343	
New Lease, Old Mkt Hse (Wirral)	250	0	Expected March 2025. National team has agreed to provide funding
New Lease, Wyvern Hse, Winsford (CW)	0	0	National team has agreed to provide funding
Lease extension 5yrs, Ellis Centre	79	79	National team has agreed to provide funding
New Lease, Lakeside (Warrington)	1,530	1,530	National team has agreed to provide funding
Subtotal IFRS 16 - centrally funded	**1,516**	**1,266**	
Total Approved Expenditure	**5,927**	**1,494**	
Planned Expenditure Under Development			
GP Premises Improvement Grants	3		PIDs pending
GPIT	758		Liverpool & Sefton Place PIDs in progress
IFRS 16 - Schemes not funded Centrally	0		
Subtotal Planned Additional Expenditure	**761**	**0**	
Total Approved and Planned Expenditure	**6,688**	**1,494**	
Capital Resource (Surplus)/Deficit	**0**	**-4,943**	

11.2 £0.800m of GP Premises Improvement Grant (IG) projects that were approved by this committee in June and a further £0.902m approved in August are under way. £0.150m has been completed and paid to date.

11.3 £3.388m of GPIT Projects were approved in principle by this committee in June. PIDs for £2.630m, covering all places except Liverpool and Sefton, have been signed off by NHSE and the ICB's digital delivery partners are now procuring the equipment. The Liverpool and Sefton PIDs are being reviewed by the NW Regional Director of Digital Transformation, they will then proceed for final approval from the ICB and NW Regional Directors of Finance, after which the ICB Digital team will secure delivery of the equipment.

11.4 IFRS16 schemes are accounting adjustments for leases. This is managed locally by the ICB Corporate team, and nationally by NHS England. The national team has confirmed that funding is available for the schemes listed in Table 4.

12. Recommendations

The Primary Care Committee is asked to:

12.1 Note the combined financial summary position outlined in the financial report as at 31st January 2025.

12.2 Note the Additional Roles spend to date and the anticipated forecast outturn and predicted central drawdown.

12.3 Note the Capital position.

13. Officer contact details for more information

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Meeting of the System Primary Care Committee of NHS Cheshire and Merseyside

Date: 20 February 2025

Primary Care Quality Group Update

Agenda Item No: SPCC A25/02/12

Responsible Director: Clare Watson

Primary Care Quality Group

1. Purpose of the Report

1.1 The purpose of this report is to provide an update and a summary of the latest meeting held on 18 December 2024.

2. Executive Summary

2.1 The Primary Care Quality Group meets bimonthly reporting to the System Primary Care Committee with a line of site to the Quality and Performance Committee.

2.2 The group will routinely and systematically review primary care quality through the Cheshire and Merseyside Quality Dashboard. It will recommend quality reviews and identify quality improvements where necessary.

2.3 The group will work closely with the ICB Nursing and Care Team and the ICB Primary Care Team to promote and establish a culture of quality improvement and assurance across primary care providers and triangulating feedback from place arrangements in respect of quality performance and improvement.

2.4 The group will receive assurance on the quality of primary care services contracted by NHS Cheshire and Merseyside at a system level, demarking the management of primary medical quality services managed at place level

3. Ask of the Committee and Recommendations

3.1 **The Committee is asked to:**

Note this update.

4. Reasons for Recommendations

4.1 The establishment of the Primary Care Group is an essential function of the ICB and will routinely and systematically review primary care quality.

4.2 The group will work closely with the ICB Nursing and Care Team and the ICB Primary Care Team to promote and establish a culture of quality improvement and assurance across primary care providers and triangulating feedback from place arrangements in respect of quality performance and improvement.

4.3 The group will seek to reduce unwarranted variation across all primary care services.

4.4 Escalations will come to Part A of SPCC to be agreed/discussed.

5. Update

5.1 The group met on 18 December 2024 and the following items for escalation were discussed:

- Update received for General Practice regarding Employee Assistance Programme. A service delivery issue had been identified and subsequent assurances had been requested and received. The issue had occurred prior to the ICB taking on commissioning responsibility for the service.
- No items noted for Community Pharmacy
- No items noted for Optometry
- Update regarding dental provider and termination of contracts. Commissiong team have been working on contract variations to allow completions of treatments. 2 practices have also recently been declared bankrupt and commissioners are working on reallocation of UDA's.

5.2 Lisa Ellis reported that Place level Task and Finish Groups have been established and including Place Primary Care leads. A process has been agreed on data reporting and work is progressing.

5.3 A full report will be submitted to the next Primary Care Quality Group in February.

5.4 A consolidated dashboard is under development. The first version of this is being made available to Place leads and will be available from the Business Intelligence Portal (BIP). Some work has been undertaken to incorporate existing Place dashboards where applicable.

5.5 It was agreed that the indicator set would be shared with the group and 96 indicators are currently available in the BIP.

5.6 Patient Complaints and Enquiries Report - Quarters 1 and 2 (2024-25) sourced from various data information systems utilised by Patient Advice and Complaints Team (PACT) including Ulysses, Datix, CRM and excel spreadsheets is detailed below:

5.7 Complaints, MP and Councillor enquiries is detailed below:

Table 1 – Primary Care Formal Complaints

Contact Type	April 2024	May 2024	June 2024	Jul 2024	Aug 2024	September 2024	Total
Pharmacy	0	0	1	0	0	0	1
Ophthalmology	0	0	0	0	0	0	0
Dental	2	4	8	3	2	1	20
GP	9	23	28	23	13	10	106

Totals	11	27	37	26	15	11	127

5.8 The number of primary care formal complaints received in Q1 2024/25 (75) is a 45% decrease when compared to Q4 (2023/24), when 136 complaints were received.

5.9 The number of primary care formal complaints received in Q2 2024/25 (52) is a 31% decrease when compared to Q1 (2024/25), when 75 complaints were received.

5.10 The themes and trends relating to the primary care complaints received during the two quarters are as follows in Chart 1:

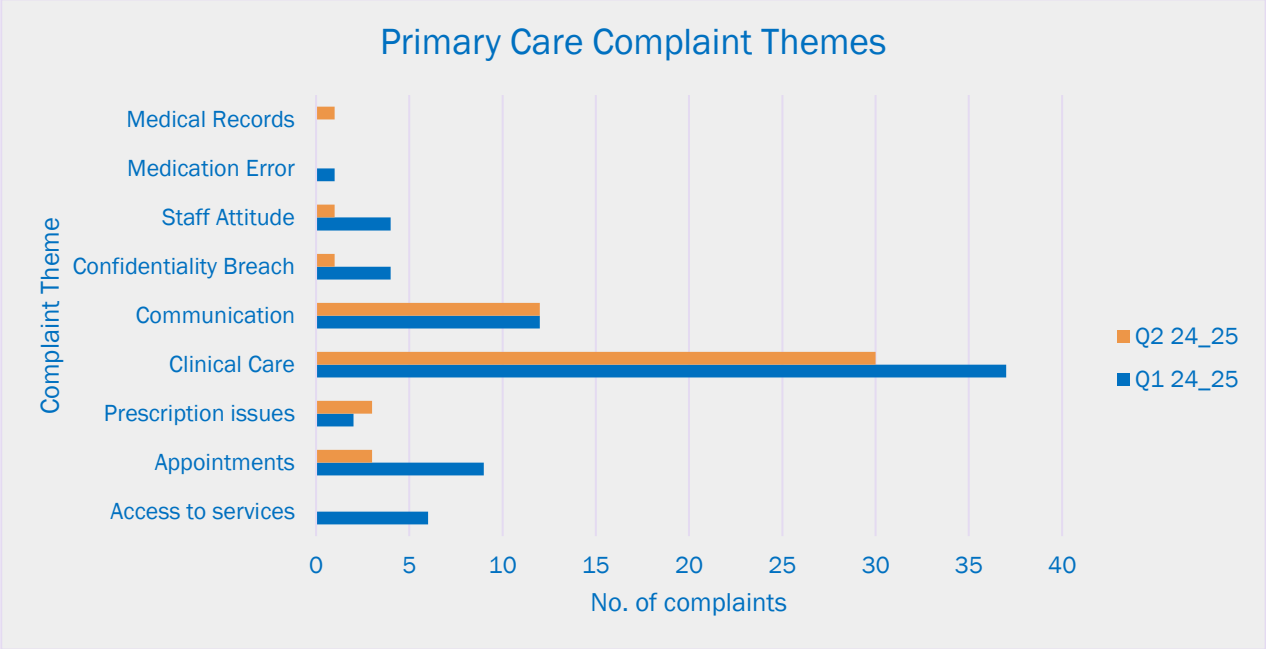

Chart 1 – Primary Care Complaint Themes (Q1+Q2)

5.11 Enquiries raised by Members of Parliament are reported below.

5.12 During the reporting periods, 28 primary care related enquiries were raised by MP's on behalf of their constituents during Q1 and 27 during Q2. The most common themes raised were as follows:

- 26 GP (access to appointments, registration, removal, referral, care issues, premises, staffing).
- 29 Access to NHS Dental services.

5.13 The Patient Advice and Liaison Service (PALS) offers confidential advice, support, and information on health-related matters. The service provides a point of contact for patients, their families, and their carers.

5.14 During Q1, the PACT assisted with 1,412 enquiries / concerns. Note: This number includes primary care and non-primary care enquiries.

5.15 During Q2, the PACT assisted with 791 enquiries/concerns. Note: This number includes primary care and non-primary care enquiries.

5.16 Primary Care enquiries and concerns are listed below:

- Access to NHS Dental services – 412 enquiries were received by the PACT during Q1 and 126 enquiries during Q2. The large number in Q1 can be predominantly attributed to patient concerns regarding dental access in response to the issuing of a contract termination notice by the ICB to a dental provider group.
- Patient covid vaccination requests – 382 enquiries were handled by the PACT in Q1 and 76 in Q2, with the majority of the contacts being housebound patients who had been signposted from their GP Practice to the NHS119 covid booking service, who in turn directed the patient to the ICB PACT. Actions were taken by the PACT to liaise with vaccination leads in Place and housebound vaccination providers, to ensure that housebound patients received their vaccinations. This caused poor patient experience in being signposted between different providers and the ICB. As a result, additional communications were released by the ICB vaccination team for the Autumn campaign 2024, to clarify with GP Practices which providers are arranging housebound patient covid vaccinations and the correct contact information to use. Despite this, the same issues remained and continued in the Liverpool Place area.
- GP (access, registration, referral, specially face to face appointments, care) – 105 patient enquiries were received by the PACT in Q1 and 114 in Q2 and included difficulties with registration/ /deregistration, access to appointments, and referral concerns.

5.17 Current and Future Plans:

5.18 The PACT meets weekly to discuss current and future improvement methods to assure the delivery and effectiveness of the service provided in the handling of enquiries and complaints received into NHS Cheshire and Merseyside. The development and implementation of the following product is in train:

5.19 Since September 2024, the PACT has successfully transitioned onto a single I.T. system for the management of PALS, Complaints and MP enquiries. The I.T. system is Ulysses which is supported by the Insight Team at Midlands and Lancashire Commissioning Service Unit. Additional development of the system reporting functionality is taking place to offer Place specific reports. This is expected to be available for roll-out by April 2025.

6. Link to delivering on the ICB Strategic Objectives and the Cheshire and Merseyside Priorities

Objective One: **Tackling Health Inequalities in access, outcomes and experience**

Objective Two: **Improving Population Health and Healthcare**

7. Link to achieving the objectives of the Annual Delivery Plan

This reports links to:

- Tackling Health Inequalities in Outcomes, Access, and Experience
- Improving Population Health and Healthcare
- Enhancing Quality, Productivity and Value for Money

8. Link to meeting CQC ICS Themes and Quality Statements

Theme One: **Quality and Safety**

Clear linkages to the requirements under statements QS1/2/3/5/6

Theme Three: **Leadership**

Clear linkages to the requirements under statements QS 12/13/14/15

9. Risks

9.1 Without a focus on quality in primary care and the establishment of a Primary Care Quality Group the ICB cannot be assured that it will be provided with assurance in delivering its functions in a way that secures continuous improvement in the quality of services, against each of the dimensions of quality (safe, effective, person-centered, well-led, sustainable and equitable), set out in the Shared Commitment to Quality and enshrined in the Health and Care Bill 2021.

9.2 This includes reducing inequalities in the quality of care, coupled with a focus on performance.

10. Finance

10.1 There are no known financial implications resulting from this paper.

11. Communication and Engagement

11.1 N/A

12. Equality, Diversity and Inclusion

12.1 The group must demonstrably consider the equality, diversity and inclusion implications of decisions or issues that are brought to its attention.

13. Climate Change / Sustainability

13.1 N/A

14. Next Steps and Responsible Person to take forward

14.1 The group meets on a bimonthly basis and reports to SPCC as and when required.

15. Officer contact details for more information

15.1 Tom Knight
Associate Director Primary Care (Dental and Pharmacy)
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16. Appendices

Appendix One: Primary Care Quality Meeting Minutes and Action Log 18/12/24

Primary Care Quality Meeting Minutes

Wednesday 18th December 2024 10:00-11:30
Via MS Teams

Name	Initials	Role / Organisation	In Attendance (Y/N)
Jonathan Griffiths	JG	Associate Medical Director (Primary Care / Chair)	Y
Chris Leese	CL	Associate Director of Primary Care, Cheshire and Merseyside ICB (System Level).	Y
Tom Knight	TK	Associate Director of Primary Care (Dental and Pharmacy), Cheshire and Merseyside ICB	Y
Lisa Ellis	LE	Associate Director of Quality and Safety Improvement, St Helens Place, Cheshire and Merseyside ICB	Y
Janet Charnock	JC	Head of Policy and Contracting for Primary Care, Cheshire and Merseyside ICB	N
Maxine Dickinson	MD	Head of Quality and Safety Improvement, Warrington Place	Y
Susanne Lynch	SL	Chief Pharmacist, Cheshire and Merseyside ICB	Y
Paul Sedgwick	PS	Deputy Medical Director, System Improvement and Professional Standards, NHSE in NW	Y
Katie Mills	KM	Head of Quality and Safety Improvement, Cheshire East Place, Cheshire and Merseyside ICB	Y
Becky Williams	BW	Associate Director of Business Intelligence, Planning and Performance Directorate, ICB	For item 9.
David Knowles	DK	Deputy Head of Business Intelligence, Cheshire and Merseyside ICB	Apols Sent
Gary Shenton	GS	Senior Patient Experience Manager, Cheshire and Merseyside ICB	Y
Julie-Ann Bowden	JAB	Head of Professional Standards, NHSE in NW	Apols Sent
Richard Crockford	RC	Associate Director of Nursing and Care (Patient Safety) Nursing and Care Directorate	Y
Donna Gillespie-Greene	DGG	Head of Patient Safety and Quality, Medicines Optimisation, Cheshire and Merseyside ICB	Y
Catherine Brown	CB	Primary Care Administrator, Cheshire and Merseyside ICB	Y
Melanie Pilling	MP	Project Manager, Beyond CYP Transformation Programme	For item 4

1	**Welcome, introductions and apologies** JG welcomed the Group to the last Quality Group meeting of 2024. JG encouraged everyone to use the chat for any introductions.
2	**Minutes of previous meeting** The Group agreed that no amendments were to be made to the minutes of the previous meeting dated 23rd October 2024.
3	**Action Log** Please take note of the action log for updates.
4	**Beyond Board** Melanie Pilling, Project Manager, Beyond CYP Transformation Programme attended the meeting to present to the Group. The Beyond Programme is a Cheshire and Merseyside Transformation Programme and there is a campaign on the horizon backed by the Beyond Board and the C&M Children and Young People's Committee. Please find attached the presentation with the draft minutes of this meeting. **ACTION - Meet with MP to discuss the link between the Programme and the Paediatric or Special Care Dental Managed Clinical Network - TK** **ACTION – Meet with MP to discuss the Beyond Transformation Programme and GP Engagement – JG** **ACTION – Meet with MP to discuss the Beyond Transformation Programme and Pharmacy Engagement – SL**
5	**Face to Face Sign Language** An issue has arisen in relation to General Opthalmic Services. The ICB inherited from NHSE an arrangement where they provided and funded deafness support through video link and that has always been the arrangement for all contractor groups. We have started to receive challenge from a national campaign led by Patients around why we don't fund face to face translation appointments. CL wanted to raise awareness to the Group because a piece of work will need to be done on this and investigate what we should be providing. **ACTION – Share Signing Solutions Report with the Group after the meeting – CB**
6	**Primary Care Medical – Employee Assistance Programme** This Programme is a commissioned service by NHSE since 2020 which General Practice Staff can access to help them with a range of health and wellbeing issues such as accessing online information about mental health and wellbeing and there is a portal where they can access counselling via telephone or face to face if necessary. The uptake has always been poor and NHSE collaborated with the CCGs to raise awareness in the past. Before May '24 NHSE commissioned the contract but has since said that the ICB should now commission it, if they continued to fund it. A conversation took place with the Place Leads and it was agreed it was something we wanted to carry on. In Oct/Nov '24 a Place Lead shared newspaper article links with CL about the Provider. CL, LE and Suzanne the Commissioning Support Information Governance Lead formed an Instant Group and picked up these issues with Health Assured. Please see the papers which includes the correspondence between the Instant Group and Health Assured. CL also had a conversation with NHSE because the incidents took place before the ICB took on the contract and they had no knowledge of this. At the end of the Paper there is a series of recommendations from the Instant Group which require the Quality group to decide on.

	JG summarised the proposal and asked the Group if they required any elaboration on the actions. No further discussion was needed, and the recommendations were accepted.
7	**Quality Quarterly Report** Task and Finish Groups have been formed across the 9 places including the Primary Care Leads and a process has been established on how to report the data going forward. LE did go through this at the last meeting but it has since been refined. At the next meeting in February '25, LE will bring a Succinct Report to the Group. LE asks the Group to look at Pg 54 of the pack and to give any comments at their earliest convenience. It was noted that some Places are doing nothing in regard to any overview of Primary Care and LE noted that going forward this will need to be looked at. This is currently going through the reporting process. **ACTION – Look through the paper and send comments to LE – CL/ALL** KM shared with the Group a draft report using the template including detail from Cheshire East Place. LE would like to combine all 9 templates into 1 report. This will need a further discussion.
8	**Contractor Issues for Escalation** • **General Practice** • **Dental – SMART Dental** TK updated the Group on SMART Dental. As previously reported, all contracts were terminated however there are Patients who were receiving care at this time and the Commissioning Team are working on the contract variations to allow completion of treatment. All of the units of dental activity from those Practices which were terminated have been reallocated. There were two bankruptcies in Knowsley where the units were not able to be reallocated due to the financial position. • **Pharmacy** • **Optom**
9	**Dashboard Updates** BW explained that it was previously reported that moving forward there was going to be one consolidated dashboard for Cheshire and Merseyside. The first version is ready and being made available to the Primary Care Place Leads. This will be put onto the Business Intelligence Portal so that it is always accessible. Some Places have an extensive dashboard in place and have come forward as they don't want to lose it. BI are looking to incorporate those areas of the dashboard. This has gone from 96 metrics to 250 metrics. **ACTION - Share list of Indicators with Group – BW** The current version with the 96 metrics is live now and in use. **ACTION – Add KM to the Dashboard distribution list – BW**
10	**AOB** No other business.
Next Meeting **Wednesday 19th February 2025 09:00-10:30**	

Primary Care Quality Group - Action & Decision Log					
Wednesday 18th December 2024					
Action Number	**Meeting Date**	**Action/Decision Requirements from Meeting**	**By Whom**	**By When**	**Comments/Updates/COI**
2404-10	25.04.24	For POD template works and is clear.	TK	Next meeting	19/06 - TK to make amendments - Ongoing. 23/10 - TK to check final template. Ongoing. **18/12 - Template not being used. Needs sending out to Teams for us which will be done between Xmas and NY. Ongoing.**
2408-03	21.08.24	Follow up with Comms and Engagement Team/Contact and Healthwatch about Patient insight and involvement in this Group.	TK	Next meeting	23/10 - TK has a call with Liverpool HW next week. Ongoing. **18/12 - Has had discussions with HW and Comms and is currently pulling together a proposal. Agenda item for next meeting in Feb. Ongoing.**
2408-04	21.08.24	Link together to discuss sending out communications RE LFPSE (Learning from Patient Safety Events).	LE & RC	Next meeting	23/10 - LE to get update from RC. Ongoing **18/12 - Not yet sent. Will send narrative to Group first. Ongoing**
2410-04	23.10.24	**AOB:** The Group to agree who else could input from the ICB RE the NW Professional Standards Teams' Lessons Learn Framework.	ALL/JAB	Next meeting	**18/12 - Ongoing.**
2412-01	18.12.24	**Action Log:** When updating on the K041B Report, GS to distinguise in new data rec'd from NHSE which Practices did not submit information on complaints.	GS	Next meeting	
2412-02	18.12.24	**Beyond Board:** Meet with MP to discuss the link between the Programme and the Paediatric or Special Care Dental Managed Clinical Network.	TK	Next meeting	
2412-03	18.12.24	**Beyond Board:** Meet with MP to discuss the Beyond Transformation Programme and GP Engagement.	TK	Next meeting	
2412-04	18.12.24	**Beyond Board:** Meet with MP to discuss the Beyond Transformation Programme and Pharmacy Engagement.	SL	Next meeting	
2412-05	18.12.24	**F2F Sign Language:** Share Signing Solutions Report with the Group after the meeting.	CB	Next meeting	**18/12 - CLOSED.**
2412-06	18.12.24	**Quality Quarterly Report:** Look through the paper and send comments to LE.	CL/ALL	Next meeting	
2412-07	18.12.24	**Dashboard Updates:** Share list of Indicators with Group.	BW	Next meeting	**19/12 - CLOSED.**
2412-08	18.12.24	**Dashboard Updates:** Add KM to the Dashboard distribution list.	BW	Next meeting	

NHS
Cheshire and Merseyside

Meeting of the System Primary Care Committee of NHS Cheshire and Merseyside

February 2025

Primary Care (Medical) Performance Indicators

Agenda Item No: SPCC A25/02/14

Responsible Director: Clare Watson

1. Purpose of the Report

1.1 To update the Committee on the common ICB performance indicators agreed for primary medical (general practice) with some performance analysis – and to discuss next steps in terms of these indicators.

2. Ask of the Committee and Recommendations

The Committee is asked to ;

- ***Note and discuss*** the update in respect of ICB performance indicators for primary medical and ***consider*** future reporting asks to avoid duplication with work being reported under performance routes.

3. Background

3.1 Last year the Committee received an Audit Committee report which highlighted as an action, the need for a common set of ICB primary care (medical) performance indicators to be agreed across the ICB. Unlike the other three contractor groups there is not a single contractual framework for performance for primary medical although there are some core contract asks/areas which are specifically reported.

3.2 Following this, discussions with each place resulted in common areas being agreed for performance, with support from the BI team, who produced the key insights, data and analysis for this paper. It was noted that outside of these agreed areas each place will look at additional indicators as part of their local commissioned services/local need. In addition, the ICB measures and reports on other primary medical indicators such as those for Access Improvement (given in the Contracting Update) and those in the ICB Performance Report.

4. Performance and Analysis

4.1 The table in **Appendix 1** gives the headlines for each place on the agreed indicators (noting the reporting split for Sefton) - data is also available per practice as part of this set.

4.2 **Some key observations** are given below (noting the **full sets** of data have been looked at to support this narrative) ;

Access:

- Appointment Rate per 1,000 Population: Southport & Formby shows the highest appointment rate (888.40), while Halton has the lowest (421.36), suggesting that access to appointments varies widely with the appointment rate in Southport and Formby more than twice that of Halton.

- Face-to-Face Appointments: The percentage of face-to-face appointments ranges from 54% in Southport & Formby to 77% in Warrington, indicating some variability in access to in-person care.
- Same-Day Appointments: The availability of same-day appointments is highest in Liverpool (54%) and lowest in Knowsley (36%).
- GP-Led Appointments: Liverpool reported 52%, while Knowsley and South Sefton have the lowest percentages (42% and 44%, respectively).

Patient Experience:

- Friends and Family Recommendation: Southport & Formby has the highest percentage of patients recommending their GP practice (95%), while St Helens has the lowest (85%).
- Good Experience When Contacting GP (based on last year's survey): Cheshire East (74.2%) and Wirral (74.2%) have the highest percentages, while Halton (59.1%) and South Sefton (60.3%) are lower.

Workforce:

- GP WTE Rate: Cheshire East and Wirral have the highest GP WTE (0.8 per 1,000), while Halton and South Sefton have the lowest (0.5 per 1,000).
- Nurse WTE Rate: Cheshire East and Southport & Formby have the highest nurse WTE rates (0.3 per 1,000), while Cheshire West and Wirral have the lowest (0.1 per 1,000).
- Admin WTE Rate: Most areas are similar, with rates between 1.2 and 1.5 per 1,000, but South Sefton has the lowest at 1.2 per 1,000.
- DPC (direct patient care staff) WTE Rate: Cheshire East and Cheshire West have the highest DPC (0.3 per 1,000), while Halton and South Sefton have the lowest (0.1 per 1,000).

4.3 **Insight and Triangulation -** The indicators in the scorecard can also be viewed in combination to offer more valuable insight. A summary of some key insights are given below:

- **Access and Patient Experience: Access (Appointment rate per 1,000 population) vs. Patient Experience (Good Experience when contacting GP Practice %).** A higher appointment rate often correlates with improved access to care, but it's important to also consider patient experience. For example, Southport & Formby has the highest appointment rate and also a high percentage (95%) of patients recommending their service. This could indicate that higher appointment availability contributes to better patient satisfaction. In contrast Knowsley has a lower appointment rate and a significantly lower patient experience (65.7%).

- **Workforce and Access: Workforce (GP WTE rate per 1,000) vs. Access (Same-Day Appointments).**Higher workforce availability in terms of GPs may contribute to improved access for urgent care. For example, Cheshire East (0.8 GP WTE per 1,000) has 44% of appointments being offered on the same day, while Knowsley (0.6 GP WTE per 1,000) has only 36% of

appointments available on the same day. In contrast to Knowsley, South Sefton has a similar GP WTE rate (0.5) as Knowsley, but offers a slightly better same-day appointment rate (47%)

- **Demographics and Screening Rates:IMD Score vs. Prevention and Screening (Cervical Screening).** Deprivation levels, indicated by the IMD score, often correlate with lower engagement in screening programmes. For example, Liverpool and Knowsley (IMD Scores = 44.65, 43.45) have lower cervical screening rates (64.0% and 70.9% for 25-49 age group).In contrast, Cheshire East (IMD Score = 14.23) has a higher cervical screening rate (75.7% for 25-49 age group)

- Workforce levels (GP, nurse, admin, and DPC) may play a role in determining both access to appointments and the overall patient experience. Areas with higher workforce density tend to have better access and, in some cases, better patient satisfaction.

- Deprivation (IMD score) tends to correlate with lower engagement in prevention and screening, particularly in more deprived areas like Liverpool and Knowsley.

- Patient experience and access to appointments are not always directly correlated, as seen in Knowsley and South Sefton, where lower access rates did not necessarily correlate with low patient satisfaction, suggesting other factors may play a role.

- Linking these metrics can provide a more nuanced picture of where interventions might be needed, such as improving workforce resources in areas with high emergency admission rates or addressing socio-economic barriers to increase screening uptake in deprived regions.

5. Further considerations/Next Steps

5.1 The current primary care data set has an agreed list of 30 core indicators. The release of the 2025/26 NHS Operational Planning guidance means that the current list of metrics should be reviewed in line with the guidance to determine whether any new metrics need to be added to the scorecard and others retired. The ICB Business Intelligence team update the scorecard on a monthly basis and circulate via email as a Microsoft Excel based report. To move in line with more efficient automated reporting that the BI team are embedding across the ICB, preparations are being made to present the report on the ICB Business Intelligence Portal (BIP). This Microsoft power BI platform allows users to access information securely with the ability to look at metric performance both over time and in comparison between areas (Place, PCN and Practice level).

5.2 The Committee should consider what elements it requires reporting on in future, and ensuring resources within the ICB are not duplicating reporting (for example with Board Performance Report) – and maybe focus on some key areas within

the agreed scorecard for deep dives including a further discussion on a framework to reduce variation across the places.

5 Link to delivering on the ICB Strategic Objectives and the Cheshire and Merseyside Priorities

The paper supports the delivery of the ICBs delegated duties in respect of primary care contracting – effecting and safe contracting supports the wider themes of ;

- Tackling Health Inequalities in outcomes, experiences and access (our eight Marmot principles).
- Improving population health and healthcare.

6 Link to meeting CQC ICS Themes and Quality Statements

QS4 Equity in access
QS5 Equity in experience and outcomes
QS7 Safe systems, pathways and transitions
QS8 Care provision, integration and continuity
QS9 How staff, teams and services work together
QS13 Governance, management and sustainability

7 Risks

Supports the mitigation following BAF risks - P1, P4, P5, P6, P8,

8 Finance

No finance considerations for this paper

9 Communication and Engagement

No external formal consultation or further engagement is required in respect of this paper.

10 Equality, Diversity and Inclusion

The performance measures consider deprivation as part of the overall analysis.

11 Next Steps and Responsible Person to take forward

Christopher Leese, Associate Director Of Primary Care
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Becky Williams Associate Director of Business Intelligence
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12 Officer contact details for more information

Christopher Leese, Associate Director Of Primary Care
Chris.leese@cheshireandmerseyside.nhs.uk

Appendix 1

Ref	Domain	Metrics	Reporting Period	Ches & Mersey Average	Cheshire East	Cheshire West	Halton	Knowsley	Liverpool	Southport & Formby	South Sefton	St Helens	Warrington	Wirral
		Links to PCN/Practice Level Information			Cheshire E. Metrics	Cheshire W. Metrics	Halton Metrics	Knowsley Metrics	Liverpool Metrics	Southport Formby Metrics	South Sefton Metrics	St Helens Metrics	Warrington Metrics	Wirral Metrics
1	Demographics	List Size	Dec-24	290520	468,849	432,147	136,772	178,627	597,309	129,943	168,294	211,264	230,885	351,109
2	Demographics	IMD Score (Average)	2019	31.28	14.23	19.47	33.10	43.45	44.65	19.07	35.01	30.83	20.67	32.79
3	Demographics	Female Life Expectancy (Average)	2016-20	81.47	84.08	83.28	81.61	80.41	80.02	83.86	81.20	81.29	82.38	81.62
4	Demographics	Male Life Expectancy (Average)	2016-20	76.49	77.92	78.08	77.31	73.47	74.27	79.56	77.13	75.55	78.39	77.55
5	Improving Quality	CQC (Inspection) Rating	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good
6	Access	Appointment rate per 1,000 population	Nov-24	515.52	554.35	567.56	421.36	476.69	449.51	888.40	359.68	436.70	446.92	554.05
7	Access	% Face to Face apppointments	Nov-24	64.89%	64%	64%	71%	68%	58%	54%	66%	63%	77%	63%
8	Access	% Same Day appointments	Nov-24	44.12%	44%	44%	44%	36%	54%	50%	47%	44%	47%	42%
9	Access	% GP Led appointments	Nov-24	47.99%	45%	45%	44%	42%	52%	52%	60%	45%	47%	47%
10	Patient experience	Friends and Family - No submissions last 3 months	Nov-24											
11	Patient experience	Friends and Family - % recommended	Nov-24	86.49%	94%	91%	92%	92%	92%	95%	89%	85%	90%	88%
12	Patient experience	GP Survey Response Rate	2024	30.68%	37%	33%	28%	26%	24%	36%	28%	32%	33%	30%
13	Patient experience	Good Experience when contacting GP Practice %	2024	68.58%	74.2%	75.5%	59.1%	65.7%	65.3%	72.0%	60.3%	71.7%	68.0%	74.2%
14	Workforce	GP WTE rate per 1,000	Nov-24	0.65	0.8	0.5	0.5	0.6	0.7	0.6	0.5	0.5	0.5	0.8
15	Workforce	Nurse WTE rate per 1,000	Nov-24	0.26	0.1	0.1	0.3	0.2	0.2	0.3	0.2	0.2	0.2	0.3
16	Workforce	Admin WTE rate per 1,000	Nov-24	1.25	1.4	1.2	1.5	1.3	1.2	1.3	1.2	1.2	1.2	1.5
17	Workforce	DPC WTE rate per 1,000	Nov-24	0.20	0.3	0.3	0.3	0.2	0.1	0.2	0.1	0.2	0.2	0.2
18	Effective use of resources	(All) AE Rate per 1,000 - (Yearly)	Nov-24	429.66	331.9	409.1	694.0	647.0	560.8	435.1	400.9	523.6	445.0	373.9
19	Effective use of resources	Emergency Admission rate per 1,000 - (Yearly)	Nov-24	105.05	107.6	123.1	124.1	112.7	117.1	81.8	113.0	139.5	80.3	101.4
20	Effective use of resources	Emergency Admissions ACS Chronic rate per 1,000 - (Yearly)	Nov-24	8.75	7.6	10.9	9.6	9.5	10.8	7.1	10.6	9.8	7.2	8.5
21	Effective use of resources	Emergency Admissions ACS Acute rate per 1,000 - (Yearly)	Nov-24	11.20	13.0	12.9	13.6	9.2	13.0	7.2	12.8	12.5	10.2	10.9
22	Effective use of resources	GP Referred 1st OP rate per 1,000 - (Yearly)	Nov-24	221.12	212.0	245.9	280.8	78.9	231.4	212.6	277.8	249.3	209.2	213.2
23	Prevention and Screening	Cervical Screening Coverage (Age Group 25 To 49)	2023/24	69.37%	75.7%	73.0%	69.3%	70.9%	64.0%	74.0%	66.5%	71.0%	72.9%	71.6%
24	Prevention and Screening	Cervical Screening Coverage (Age Group 50 To 64)	2023/24	74.05%	79.3%	77.4%	72.3%	72.5%	67.9%	76.3%	69.4%	73.7%	75.8%	74.0%
25	Prevention and Screening	Breast Screening Rate	2023/24	72.00%	73.8%	70.9%	71.3%	65.5%	64.4%	74.2%	66.4%	70.7%	74.6%	69.4%
26	Prevention and Screening	Bowel Screening Rate	2023/24	70.72%	73.4%	70.5%	67.0%	63.7%	62.8%	74.2%	67.1%	67.1%	72.7%	67.4%
27	Prevention and Screening	% MMR 1 @ 2 Years	Q2 24/25	89.40%	95.1%	94.7%	88.8%	78.2%	79.6%	95.5%	85.6%	91.6%	94.3%	90.7%
28	Prevention and Screening	% MMR 1 @ 5 Years	Q2 24/25	93.92%	97.4%	95.7%	94.9%	88.0%	88.0%	95.8%	92.8%	95.8%	96.4%	94.4%
29	Prevention and Screening	% MMR 2 @ 5 Years	Q2 24/25	87.21%	94.2%	91.4%	89.1%	76.0%	74.8%	93.4%	82.2%	90.3%	91.3%	89.3%
30	Quality Outcome Framework	QOF PCA Rate (All Domains)	2023/24	9.63%	9.4%	13.8%	11.8%	6.8%	10.1%	8.0%	10.5%	10.3%	10.5%	8.7%

NHS
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Meeting of the System Primary Care Committee of NHS Cheshire and Merseyside

COMMUNITY PHARMACY ACCESS REVIEW

Date: 20 February 2025

Agenda Item No: SPCC A25/02/15

Responsible Director: Clare Watson

Primary Care Quality Group

1. Purpose of the Report

1.1 To update the committee on the current issues and concerns regarding access to pharmacy services, particularly during evenings and weekends.

2. Executive Summary

2.1 Increasingly the ICB is having to manage concerns and complaints regarding reduced number of pharmacies and accessibility of services during evenings and weekends. These issues are due to several different factors. This paper lays out the individual factors and explains the differences between those issues that are and are not within the gift of the ICB to resolve.

3. Ask of the Committee and Recommendations

3.1 **The Committee is asked to:**

- Consider seeking an agreement to review the current Rota fee.
- Note the information relating to the current pharmacy contract settlement negotiations.
- Note the current position regarding community pharmacy access and mitigations.

4. Reasons for Recommendations

4.1 To reduce the potential for further reduction in pharmacy access during bank holidays.

4.2 To understand the current position regarding pharmacy access and agree any mitigations.

5. Update

5.1 The ICB is having to regularly manage concerns raised about the impact of pharmacy closures on access. This is due in part to the current drive to conduct an ever-increasing number of national NHS services through pharmacy. The Pharmacy First service which has now been in place for 12 months allows patients to access urgent repeat medication, treatment for minor illness 7 common clinical pathways, without the need to attend either a GP practice or walk in centre. This is in addition to other new services such as contraception, hypertension and flu vaccination.

5.2 Pharmacy contracts are commissioned via a set of Regulations, The National Health Service (Pharmaceutical and Local Pharmaceutical Services). This

makes them different to a standard NHS contract and the powers that the ICB have to award a contract and influence the opening hours are governed by what is stated in the regulations as well as the Pharmaceutical Needs Assessment. The Pharmaceutical Needs Assessment (PNA) is a statutory document that assesses the pharmacy needs of the local population and is a crucial part of the market entry system and supports commissioning decisions based on patient needs.

5.3 All pharmacy opening hours are captured in the PNA for the relevant Health & Wellbeing Board (HWB). The HWBs are responsible for approving the content and conclusions of each PNA. The PNAs must draw a conclusion that pharmaceutical services and access are either sufficient or insufficient to meet the needs of their population. At present, all the PNAs declare there to be no gaps in provision. If this situation changes then the HWB are obliged to issue a PNA supplementary statement that reflects the change.

5.4 The HWBs and public health teams are class as 'interested parties' and are informed via the ICB pharmacy team of all changes to the pharmaceutical list including, permanent closures and changes in hours.

Current Issues

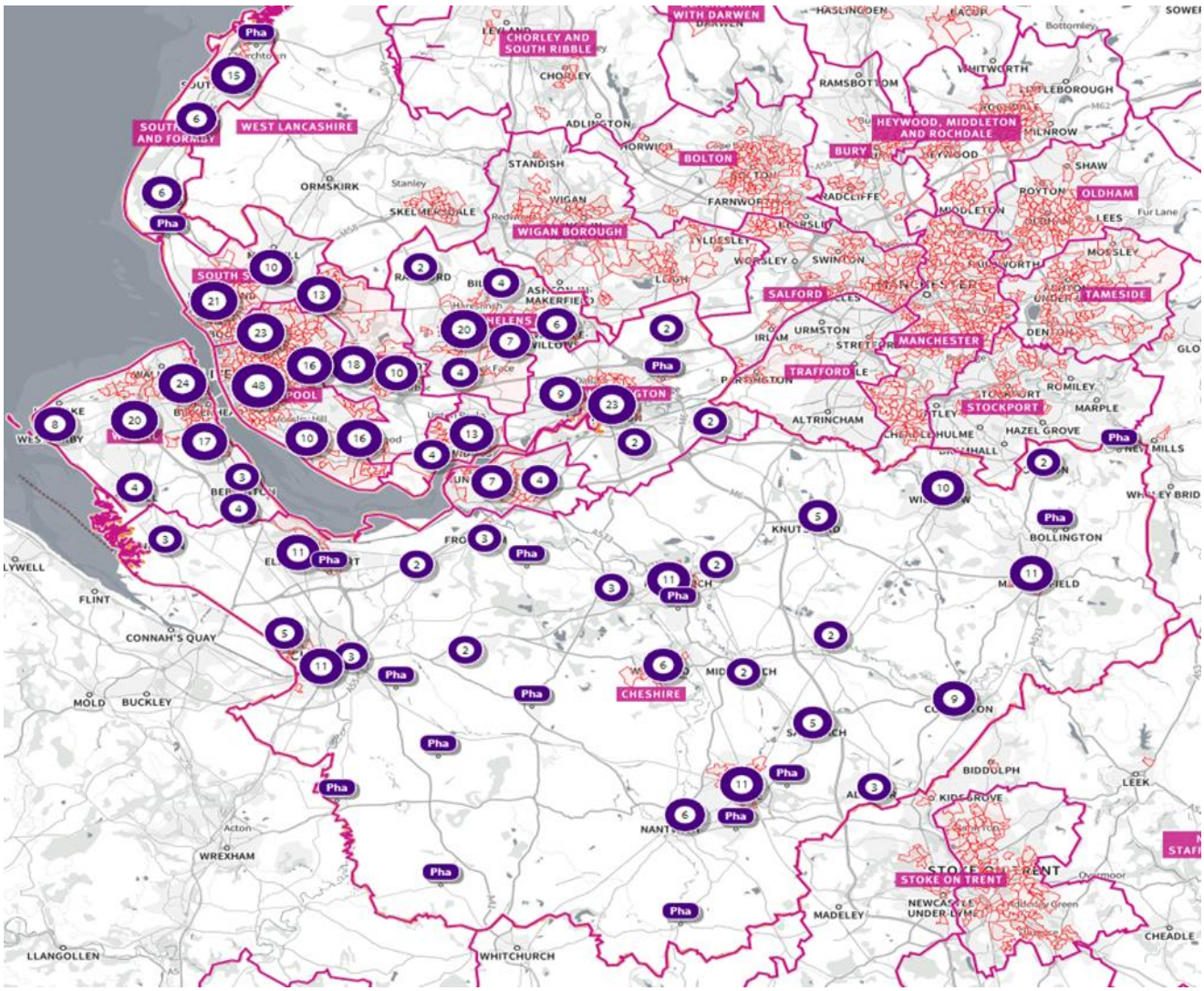
5.5 Permanent Closures:

5.6 The current issue of pharmacy closures is a national one. Pharmacies have been subjected to ongoing financial, operational and workforce pressures for some time and some have been left with no option but to close permanently. In January, the National Pharmacy Association, using figures from NHS Business Services Authority, reported that 700 pharmacies across England closed in the last 4 years, 222 of which closed in 2024.

Current provision across C&M is:

Place	**Number of Pharmacies**
Halton	31
St Helens	41
Knowsley	34
Sefton	68
Liverpool	112
Wirral	77
Warrington	41
Cheshire East	72
Cheshire West and Chester City	72

5.7 Current provision mapped across C&M – source SHAPE tool.



5.8 Reduction in opening hours:

5.9 In the last 2 years, there has been a reduction in pharmacy opening hours. This is primarily due to the Regulatory change that came into force in May 2023 that allowed 100-hour contracts to apply to reduce their core opening hours to not less than 72. These regulations are permissive and the ICB is unable to refuse applications that fall under this regulation

5.10 There were conditions attached to these reductions, designed to ensure that pharmaceutical provision during the early evenings and at weekends was not adversely affected. This required these contracts to continue to deliver their existing core hours between 5pm & 9pm Monday to Saturday and 11am & 4pm on a Sunday.

5.11 In addition to the change in 100-hour regulations the notification period for change to supplementary hours is now only 5 weeks where previously it was 3 months.

5.12 The tables below shows a breakdown of the current hours across C&M:

	Open during day					OPEN After 18:30					
	CORE HRS		SUPP HRS		Total	CORE HRS		SUPP HRS		Total	
	Number of branches	%	Number of branches	%	Number of branches	Number of branches	%	Number of branches	%	Number of branches	%
Mon	478	**88%**	63	**12%**	541	47	**9%**	49	**9%**	96	**18%**
Tues	478	**88%**	63	**12%**	541	48	**9%**	48	**9%**	96	**18%**
Weds	472	**87%**	69	**13%**	541	47	**9%**	48	**9%**	95	**18%**
Thurs	476	**88%**	65	**12%**	541	47	**9%**	48	**9%**	95	**18%**
Fri	478	**88%**	63	**12%**	541	48	**9%**	47	**9%**	95	**18%**
Sat	301	**56%**	240	**44%**	541	40	**7%**	26	**5%**	66	**12%**
Sun	330	**61%**	211	**39%**	541	8	**1%**	1	**0.18%**	9	**2%**

	OPEN UNTIL 21:00					
	CORE HRS		SUPP HRS		Total	
	Number of branches	%	Number of branches	%	Number of branches	%
Mon	42	**8%**	1	**0.18%**	43	**8%**
Tues	42	**8%**	1	**0.18%**	43	**8%**
Weds	42	**8%**	1	**0.18%**	43	**8%**
Thurs	42	**8%**	1	**0.18%**	43	**8%**
Fri	42	**8%**	1	**0.18%**	43	**8%**
Sat	37	**7%**	2	**0.37%**	39	**7%**
Sun	2	**0.37%**	2	**0.37%**	4	**1%**

Late opening By Place	OPEN UNTIL 21:00		
PLACE	**Mon -Fri**	**Sat**	**Sun**
Cheshire East	7	7	0
Cheshire West and Chester	3	4	1
Halton	3	3	0
Knowsley	5	3	0
Liverpool	8	6	2
Sefton	3	3	0
St Helens	4	3	0
Warrington	4	4	1
Wirral	6	6	0
	43	**39**	**4**

5.13 What the data shows is that during the week, just under 20% of pharmacies across C&M are open after 6.30pm, of these 45 (just under 10%) are open until 9pm.

5.14 It should be noted however that half of these opening hours are supplementary and not core which means they could be removed with 5 weeks' notice.

5.15 At the weekend this number drops off with only 66 (12%) of sites being open after 6.30pm on a Saturday, 40 of which are open until 9pm. On a Sunday 9 pharmacies (2%) are open after 6.30pm of which only 4 remain open until 9pm. However, it is known from the PNAs and local intelligence that, apart from those seeking to have an Out of Hours prescription dispensed, footfall after 7pm is low.

5.16 A recent public survey that was conducted as part of the current cycle of PNAs, due for publication in October, shows overall that on average 82% of respondents are happy with the opening times of their chosen pharmacy. Of the 31% of respondents that had tried to access a pharmacy when it was closed, 43% of these stated this occurred on a Saturday and 25% after 5pm.

5.17 Rota Provision:

5.18 Pharmacies are not required to open their contracted hours on Bank Holidays. To ensure adequate provision the ICB utilises a combination of Rota volunteers and pharmacies directed to open by way of the regulations.

5.19 Recent feedback from Primary Care leads at Place level did not demonstrate any issues with Rota or access over the Christmas & New Year Period.

5.20 There are currently 29 sites across C&M signed up to a voluntary SLA to open bank holidays. In addition to this the ICB directs between 30 – 55 sites to open each Bank holiday. These sites are agreed in collaboration with the LPCs. Both arrangements attract an hourly fee.

5.21 Much of current situation is linked to the need for central government to renegotiate the pharmacy funding settlement. However, there are actions that the ICB can take minimise the risk to the local system and manage expectations:

- Continued close collaboration with Public Health Teams to ensure that pharmacy access at any given point is accurately reflected by means of the PNA and supplementary statements.
- Consider the requirement to increase the hourly rate for rota to avoid the risk of reduced numbers of volunteers and potential non-compliance with ICB direction.
- Continued liaison with HWBs and elected members by way of guidance and face to face information sessions to help manage the expectation of what can and cannot be achieved via the Regulations.

5.22 The Committee should note that that the Department of Health & Social Care announced on 27th January that it has entered consultation with Community Pharmacy England (CPE) regarding the 2024 to 2025 and 2025 to 2026 funding contractual framework. An agreement on a package that reflects the increased role of pharmacies should alleviate some of the pressures that have driven both closures and reduction in hours.

6. Link to delivering on the ICB Strategic Objectives and the Cheshire and Merseyside Priorities

Objective One: Tackling Health Inequalities in access, outcomes and experience

Reduced pharmacy access directly impacts the ability of the population to access NHS services particularly in areas with known health inequalities and areas of deprivation with low car ownership.

Objective Two: Improving Population Health and Healthcare

Pharmacies allows improved access to NHS services without the need to attend GP practices or urgent care centres

7. Link to achieving the objectives of the Annual Delivery Plan

This reports links to:

- Tackling Health Inequalities in Outcomes, Access, and Experience
- Improving Population Health and Healthcare
- Enhancing Quality, Productivity and Value for Money

8. Link to meeting CQC ICS Themes and Quality Statements

Theme One: Quality and Safety

Clear linkages to the requirements under statements QS1/2/3/5/6

Theme Three: Leadership

Clear linkages to the requirements under statements QS 12/13/14/15

9. Risks

9.1 Further permanent closures and reduction in supplementary hours due to the current underfunding at a time when more is being asked of community pharmacy with regards to Primary Care Access Recovery and the NHS 10 Year Plan.

9.2 Further notifications to remove supplementary hours due to lack of profitability will further reduce access during the out of hours period.

9.3 Inadequate levels of funding for Rota will reduce the numbers of pharmacies volunteering for Rota. This will increase the number of sites needing to be formally directed to open.

9.4 If the Rota fee remains such that the Contractors operating costs are not being met then there is the risk that pharmacies will ignore the ICB, accept a contractual breach against them, and not open in line with their direction. It is unlikely that the Contractor would inform the ICB of this in advance which would result in the ICB not being sighted on gaps in provision at peak times, and, potentially, failed referrals from NHS111.

10. Finance

10.1 There are financial implications resulting from this paper with regard to the funding of Rota arrangements. Funding for community pharmacy generally is nationally set with the ICB receiving its share of national allocations.

11. Communication and Engagement

11.1 N/A

12. Equality, Diversity and Inclusion

12.1 NHS Cheshire and Merseyside must consider the equality, diversity and inclusion implications of decisions or issues that are brought to its attention.

13. Climate Change / Sustainability

13.1 N/A

14. Next Steps and Responsible Person to take forward

14.1 Continue to monitor community pharmacy access and implement any recommendations regarding Rota payments.

15. Officer contact details for more information

15.1 Jackie Jasper, Primary Care Manager
Jacqueline.jasper@cheshireandmerseyside.nhs.uk

16. Appendices

NHS
Cheshire and Merseyside

PRIMARY CARE DENTAL IMPROVEMENT PLAN Review of 2024/2025 and proposals for 2025-2026

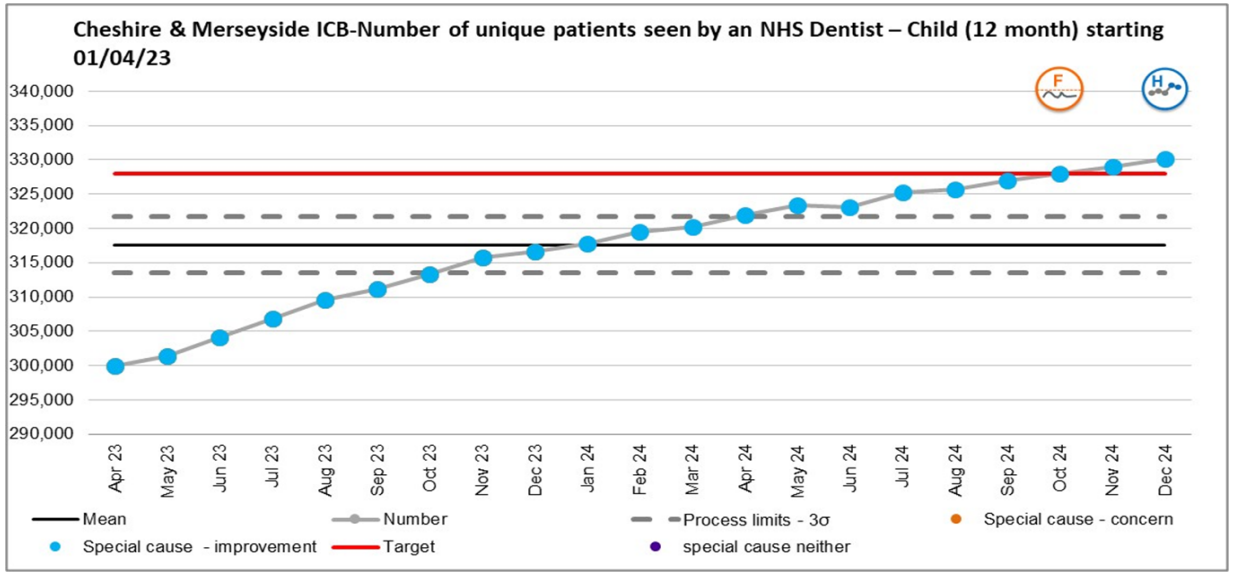
SYSTEM PRIMARY CARE COMMISSIONING COMMITTEE FEBRUARY 2025

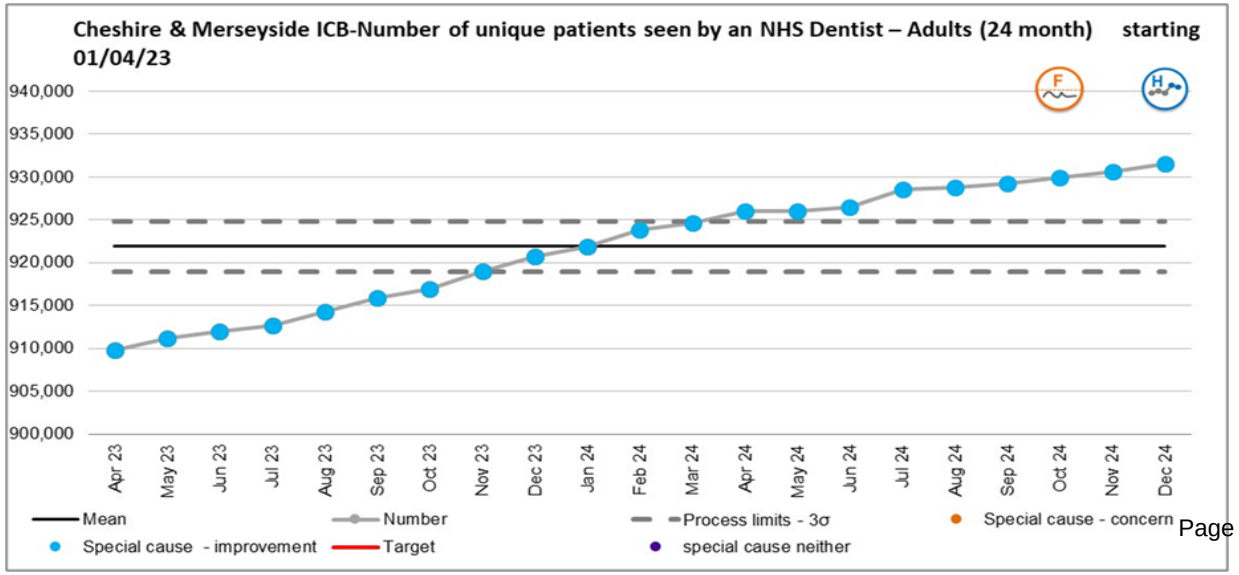
(*updated version*)

Increasing capacity, improving access and addressing oral health inequalities

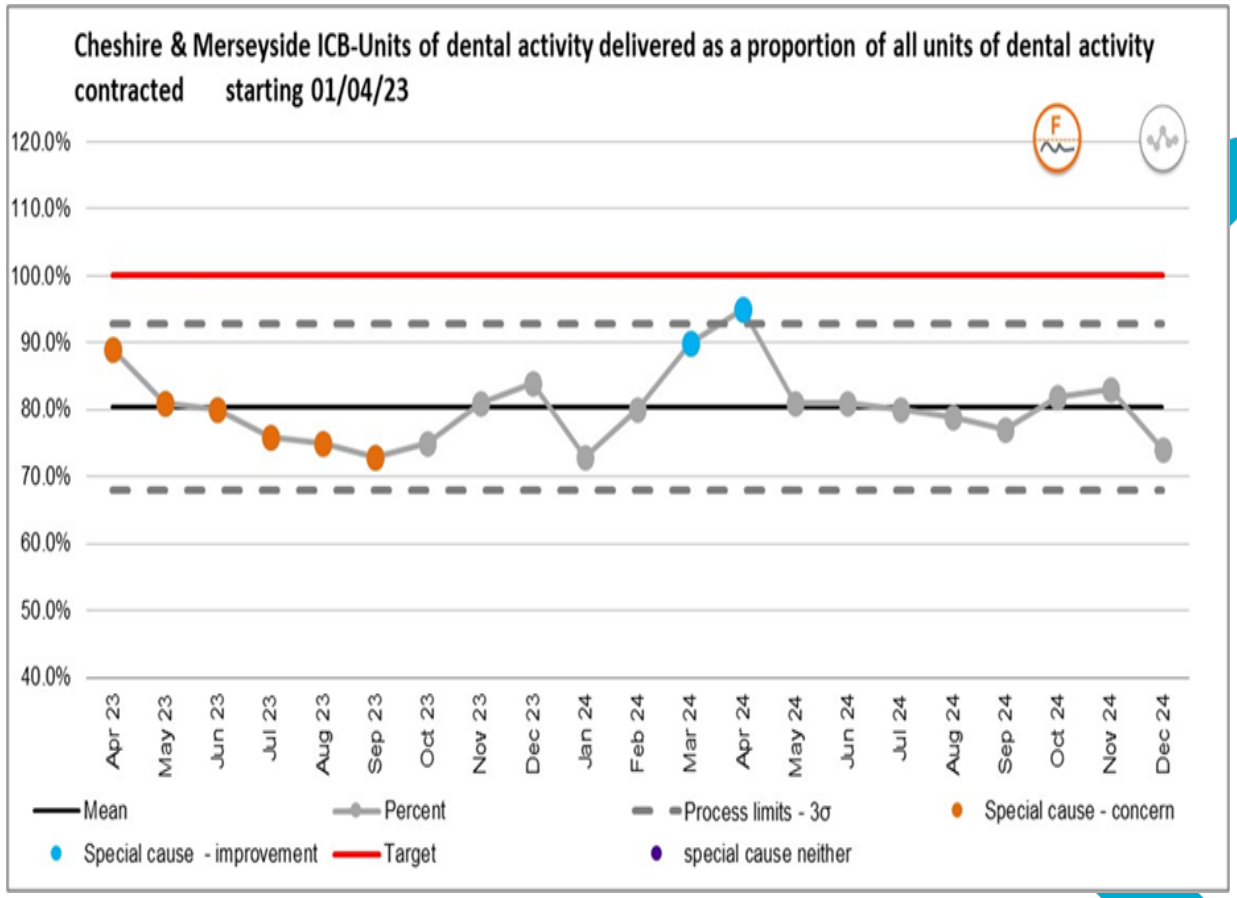
PERFORMANCE OVERVIEW 2024/2025

NHS
Cheshire and Merseyside





National Ranking	23/42	ICB Trend (Dec-24)	Improved



Local Dental Delivery Plan 2024/2025
Delivery April 24-Dec 24

NHS
Cheshire and Merseyside

PLACE	NUMBER OF URGENT CARE PATIENTS SEEN PATHWAY 1	NUMBER OF URGENT CARE PATIENTS SEEN PATHWAY 2 (COMPLETION OF TREATMENT)	NUMBER OF NEW ROUTINE ACCESS PATIENTS BOOKED PATHWAY 3
	April 2024 – Dec 2024	**April 2024 - Dec 2024**	**April 2024 - Dec 2024**
	Adults and Children	**Adults and Children**	**Adults and Children**
East Cheshire	1500	281	2578
Cheshire West and Chester City	3000	305	3626
Halton	750	0	744
Knowsley	1500	222	TBC
Liverpool	3000	120	2158
Sefton	2250	179	1703
St Helens	1500	0	2713
Warrington	750	514	1253
Wirral	2250	542	6175
TOTAL	**16,500**	**2,163 (SEE NOTE 2)**	**20,950**

NOTES

Note 1 Pathway 1 includes provision for vulnerable Adults and Children including LAC and patients undergoing cancer treatment
Note 2 Pathway 2 An additional **7,516** patients are to be allocated awaiting split by PLACE.
Note 3 An additional 7 practices data will be included in final figures
Note 4 NHSBSA data evidences over 50000 new patients seen by practices undertaking the schemes

Pathway 4 Children was merged into existing pathway

Pathway 5 Delivery to date - Expressions of Interest received to link dental practices with care homes to support/facilitate oral health plans, signpost to training for care home staff, facilitate appointment at a practice where required and support end of life care has been undertaken

NB:URGENT CARE APTS TO DEC 24 12,375

Local Dental Delivery Plan 2024/2025

NHS
Cheshire and Merseyside

Proof of Concept

Provider using vacant premises following a relocation and agreed to undertake the project as a 'Proof of Concept' providing an attractive contract that looks to recruit and retain NHS dentists and related professional staff – so dental nurses/therapists etc.

Features:

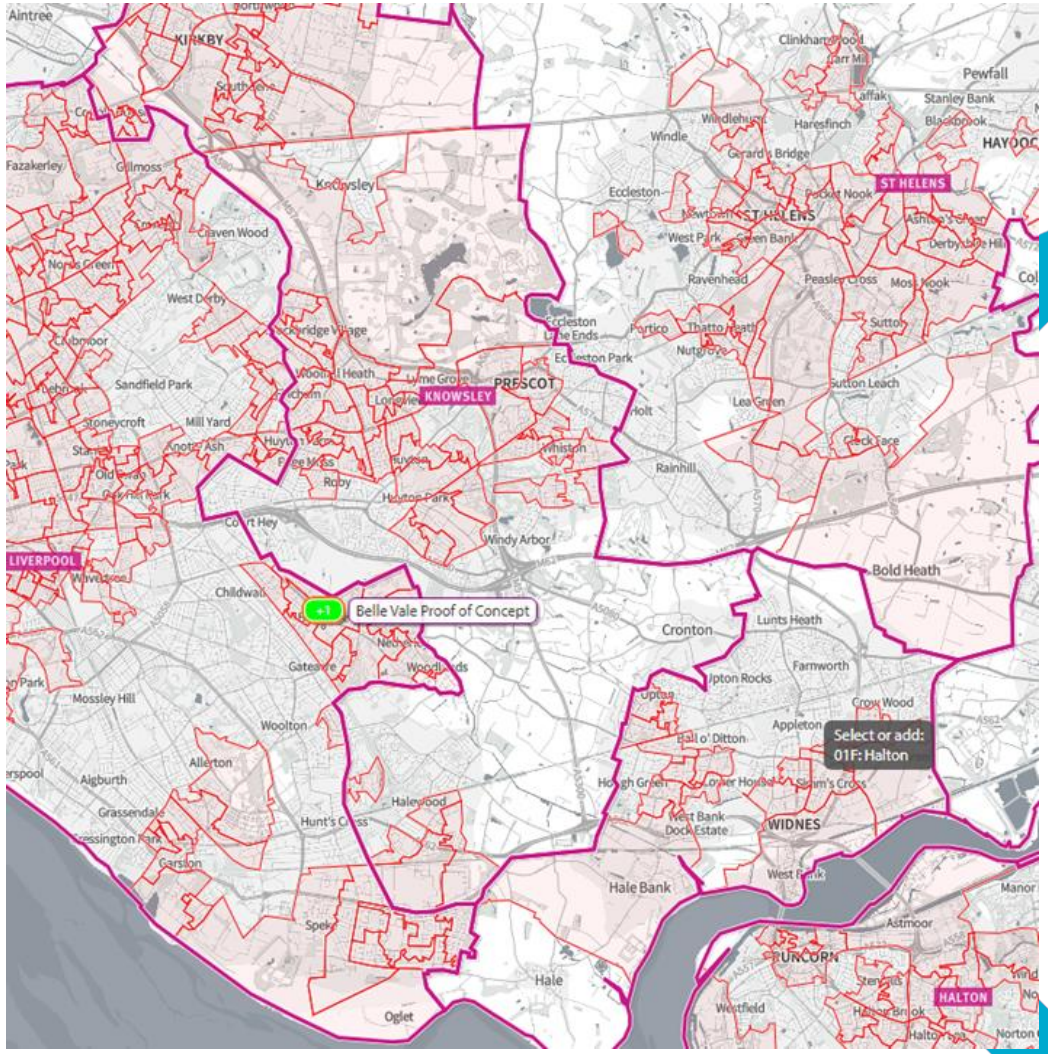
- Specific pathways in place for access up to a maximum of 20 per week
- Based on outcomes not UDA activity
- Fail to attends reflective of patient groups, mostly brought to appointments
- Offer career development opportunities by way of post graduate skills development across a multi-disciplinary team.
- Train nurses locally to complete Oral Health Education course
- Will provide Urgent Care/Urgent Care Plus
- Act as a proof of concept and will inform our future model for PDS

Vulnerable patients offered substantive care and ongoing routine care, delivered using skill mix, including:

- Children
- Nursing & Expectant mothers
- Referrals from Social Care/hospital
- Provider works primarily with Liverpool Beyond Team Midwifery Team. Recently linked with 3 care homes,
- Refugee referrals and Knowsley Drug and Alcohol Team for new mothers.

Performance headlines: Over 304 sessions delivered. Over 2,621 patients referred in total since April.

Number of patients booked into sessions	Number of new patients booked in	Number of children seen 0-3yrs	Number of children seen 4-10 yrs	Number of children seen 11-16 yrs	Number of nursing mothers seen	Number of expectant mothers seen	Number of failed to attend or late cancellation	Number of patients referred from social care, hospital
2028	1975	817	870	795	514	319	637	53



National Dental Recovery Plan – local implementation to date

NHS Cheshire and Merseyside

- NEW PATIENT PREMIUM AND NUMBER OF PRACTICES BY PLACE

Cheshire West	17
Cheshire East	30
Halton	4
Knowsley	14
Liverpool	23
Sefton	17
St Helens	10
Warrington	13
Wirral	20
Total	**148**

New Patient Premium BSA Data March – Sep 2024
Performance to date

Adults/Children	Number of FP17s Processed with NPP Tariff (number of patients seen where NPP credits were awarded)
Adults	25,776
Children	16,615

- DENTAL RECRUITMENT INCENTIVE SCHEME APPROVED PRACTICES

Practice	Place
Arrowe Park Dental Practice	Wirral
Belle Vale	Liverpool
Hoghton Street	Sefton
Little Sutton	Cheshire West
Western Avenue	Cheshire West
Newtown Dental Practice	St Helens
Smile Dental Clinic	Halton

OUR AMBITION FOR 2025/2026

NHS
Cheshire and Merseyside

- Will continue to build upon the current programmes in place and aligns to the delivery of the national dental recovery plan Our plan to recover and reform NHS dentistry - GOV.UK (www.gov.uk)(Published Feb 24).
- **£4.8 million** was previously approved by SPPC in June 2023. Utilisation of a further **£9.985m** of anticipated under-performance was requested for the expansion of the plan in 2024 giving a total investment of **£15.420m**.
- SPCC had already agreed funding of **£550k for 3 years** for the oral health programme and this is included in the overall total to date.
- The plan for 2025/26 is to seek approval to utilise an additional £8 million of ring-fenced dental funding.
- Maintain and create workforce development opportunities within existing practices and wider within health and social care. Maximise the opportunity of flexing contracts to take into account the altered contracting mechanisms outlined in the dental recovery plan and previous contract reforms.
- Increase access to primary care dental services and review any “knock on” impact to specialist primary care, community and secondary care services.
- Include preventative advice for all patients and in specific defined areas support a collaborative approach for preventative treatment.
- Focus on ensuring our most vulnerable populations are able to access NHS dental services as an integral element of the ICB ambitions regarding population health management.
- Addressing our health inequalities agenda by focussing activity on areas of highest need and linking to the oral health strategic partnership.
- Develop our proof of concept model to areas of high priority such as Halton and Knowsley with a focus on vulnerable patients including children and frail elderly.

ACCESS AS A PRIORITY

NHS
Cheshire and Merseyside

Our plan will continue to be focussed on:

- Three **General Access** pathways:

Urgent Care : Access to urgent dental care for those in immediate need of support, such as dental pain, or specific medical/statutory requirement with definitive treatment following urgent care, if required/requested.

Routine care: routine and ongoing access for patients not seen by a dentist in the previous 24 months with a focus on vulnerable patients. Incorporating children, with additional preventative/treatment needs/“cared for” frail vulnerable adults.

Proof of Concept: access for vulnerable patient including pathways for children and frail elderly. Working with LA dental public health.

PLANS PROPOSED FOR CONTRACT REFORM

NHS
Cheshire and Merseyside

- No indication yet that National Patient Premium will continue for year 25/26.
- Focus on provision of urgent care, extending pathway to 7 day presentations (broken crowns, lost filings). Limited guidance to ICBs available for additional urgent care - 37,492 appointments required in C&M for 25/26. Awaiting final details.
- Longer term plans for enhancement for substantive treatment following urgent care intervention with revised UDA allocations for urgent care dependent on treatment provision.
- Move towards standard payments for high need patients rather than UDAs.
- Allocation of UDAs for preventative measures delivered by Dental Care Practitioners
- No new funding

SCHEMES AND ALIGNMENT TO CONTRACT REFORM

NHS
Cheshire and Merseyside

LOCAL SCHEME	DESCRIPTION	ALIGNMENT TO NATIONAL PLAN
Urgent Care	URGENT CARE • Requires adequately funded fully functioning helpline • Network of commissioned urgent care practices	An interim proposal from national to increase urgent care activity across England and offer an additional 700k apts. The schemes in place support this and ideally further roll out will support local target of 37,500 for 24/25.
	URGENT CARE PLUS • Follow up DEFINITIVE care for patients without a dentist.	Offering just urgent care creates issues with patients having received temporary care and likely will repeatedly attend the urgent care pathway. This scheme supports the proposal from national and more importantly patients as they receive substantive care following their initial urgent care apt. Ideally further roll out of this scheme will support both patients and any local targets
Routine Care	ROUTINE CARE FOR ALL (termed quality access scheme) Routine and ongoing access for new patients defined as having not seen a dentist in the previous 24 months	This scheme uses a flexible commissioning approach to incentivise practices to take new and high need patients including vulnerable patients.
Proof of Concept Scheme	ACCESS for Vulnerable patient groups children and frail elderly.	TBC.
The last changes as part of national contract were announced in 2022. A recent strategic meeting held on 13 January 2025 identified a proposal for plans and next steps with a focus on urgent care, clinical/non-clinical changes and prevention. Formal announcement expected Quarter 3 of 2025/26. Difficult to say how the local plans will align given the delays with any contract reform however the schemes in C&M mirror the national direction of travel.		

PLANNING ASSUMPTIONS AND PRIORITISATION

NHS
Cheshire and Merseyside

ASSUMPTIONS

- The affordability of the plan depends on:

a) continued take-up of the schemes within the local improvement plan;

b) the ability of ICBs to permanently and unilaterally reduce the contracts of practices which persistently under-perform (action indicated in the national recovery plan);

c) The future redistribution of ICB dental allocations based on need, as identified in the national recovery plan;

d) National contract reform timescales (yet to be determined)

e) relies on dentists delivering to similar levels of under-performance in 2024/2025 and not recovering to pre-COVID levels.

PRIORITISATION

- Stepping down one element of Urgent care centres which is not currently cost effective, this will free up funding for alternative schemes
- Continuation of urgent care and extended pathway
- Continuation and development of Access & Quality Scheme to include vulnerable individuals (i.e LAC/Care leavers/Patients on cancer pathways and other medical priorities with support from Local Professional Network and by NHSE NW Dental Public Health

INVESTMENT AND FINANCE

NHS
Cheshire and Merseyside

1.CONTINUATION OF FUNDING FOR ADVICE TRIAGE HELPLINE

- Feedback from stakeholders and service provider is that this service is much needed and an integral part of the primary care dental system

- Service is based on national service specification. Service covers C+M and operates 7 days per week providing access to urgent care/urgent care and advice help to patients

- Review of funding post April 2025 to ensure resilience and capacity to respond to need

The funding for this service is £1.5 million.

INVESTMENT AND FINANCE

NHS
Cheshire and Merseyside

2. URGENT CARE PATHWAY

- Continuation of network of practices formerly referred to as Urgent Care Centres was agreed up to March 2026. These practices will continue to provide urgent care appointments, in addition to the commissioned service, which are available via the local dental helpline.
- 12,375 additional urgent care appointments were delivered from April to December 2024/25.
- This network will no longer provide support to defined vulnerable patient pathways including ‘looked after children’ and priority breast cancer patients. These patients will be incorporated into the agreement for the Access & Quality Scheme – Pathway 3.
- Continuation of funded additional sessions extending the urgent care pathway, allowing patients who have attended an urgent care appointment to attend a separately commissioned session where they are offered a full examination and any substantive treatment to get them dentally fit. Approx 10000 patients have been seen and treated in the sessions
- 74 practices (53 delivered by performers/21 delivered by DFTs) currently deliver the urgent care plus scheme.
- Potential to expand specifically to Knowsley/Halton

TOTAL REQUESTED FOR THIS PATHWAY IS UP TO FOR 2025/26: £6,191 MILLION AND UP TO £3,75 MILLION FOR THE NATIONAL SCHEME

INVESTMENT AND FINANCE

NHS
Cheshire and Merseyside

3. ROUTINE CARE

QUALITY ACCESS SCHEME PATHWAY

Funded from 10% reduction in contract activity

Continuation of the scheme where participating practices have a reduction in the annual contractual target by 10% at the start of the year. Access to new patients and liaison with a local vulnerable group

- Pathway will be include vulnerable patient pathways including ‘looked after children’ priority cancer patients, veterans
- Work will continue with Clatterbridge to extend the cancer pathway to other priority cancer patients and also to cardiac patients. This will include the pathways being added to the e-referral management system
- Data evidences over 20,000* new patients have been seen under this scheme (April 24 to Dec 24) including those from vulnerable patient groups and those with a high clinical need.
- 53 practices currently undertaking the scheme
- Potential to expand particularly to areas of high need (Halton/Knowsley)

* 7 practices are not included in the data set so figure will be higher.

Total requested for this Pathway is UP TO: £9.37 MILLION

INVESTMENT AND FINANCE

NHS
Cheshire and Merseyside

DENTAL ACCESS - PROOF OF CONCEPT PATHWAY

- One centre currently operating plan to expand to identified areas of highest need.
- Specific pathways for vulnerable groups
- Based on outcomes not UDA activity
- Offer career development opportunities by way of post graduate skills development across a multi-disciplinary team.
- Train nurses locally to complete Oral Health Education course /Extended duties (fluoride varnish application)
- Provide Urgent Care/Urgent Care Plus access
- Vulnerable patients offered substantive care and ongoing routine care, delivered using skill mix, including:

    Children

    Nursing & Expectant mothers

    Referrals from Social Care/hospital

Existing proof of concept site has been working with Liverpool Beyond Team, Midwifery Team, links with care homes, refugee referrals and Knowsley Drug and Alcohol Team for new mothers.

- Up to 2 more sites to be developed - priority will be Knowsley & Halton

TOTAL REQUESTED FOR THIS PATHWAY IS UP TO: £3 MILLION

SUMMARY - INVESTMENT PLAN 2025/26

NHS
Cheshire and Merseyside

	Plan 2025/26 (£'000s)	
Pathway 1 - Urgent Care	6,191	
Pathway 1 - National Urgent Care Appointments	3,750	Estimated at £100 per appointment
PATHWAY 2 - Routine Access	9,370	Local Access Scheme needs to expand to replace activity delivered by the National Patient Pathway
PATHWAY 3 - Proof of Concept x 3	3,000	Expand to three sites
Advice Triage Helpline	468	
Oral Health Promotion	600	
Total	23,379	

NEXT STEPS

NHS
Cheshire and Merseyside

- COMPLETE REVIEW OF 2024/25 PLAN.
- SUBMIT 2025/26 PLAN FOR APPROVAL ON FEBRUARY 20 2025.
- MAINTAIN FOCUS ON ACCESS – URGENT CARE AND ROUTINE ACCESS INLCUDING CHILDREN AND ADULTS.
- IMPLEMENT NATIONAL INITIATIVES AS REQUIRED.
- SEEK TO EMBED PRIMARY CARE DENTISTRY IN FUTURE MODELS FOR INTEGRATED NEIGHBOURHOOD DELIVERY
- MAINTAIN FOCUS ON VULNERABLE GROUPS AND ADDRESSING HEALTH INEQUALITIES
- CONTINUE TO WORK WITH HEALTHWATCH AND OTHER KEY STAKEHOLDERS