NHS
Cheshire and Merseyside

Meeting of the Cheshire & Merseyside ICB System Primary Care Committee

Part B – Public Meeting

Thursday 19 June 2025
Venue: Meeting Room 1, No 1 Lakeside,
920 Centre Park Square, Warrington,
WA1 1QY (WA1 1QA for SatNav)

Timing: 12:00-13:30

Agenda (V2)

Chair: Erica Morris

AGENDA NO & TIME	ITEM	LEAD	ACTION / PURPOSE	PAGE No
12:00am	**Preliminary Business**			
SPCC 25/06/B01	**Welcome, Introductions and Apologies**	Chair	Verbal	-
SPCC 25/06/B02	**Declarations of Interest**	Chair	Verbal	-
SPCC 25/06/B03	**Questions from the public (TBC)**	Chair	Verbal	-
12:05am	**Committee Management**			
SPCC 25/06/B04	**Draft Minutes of the last meeting (Part B) -** 17 April 2025	Chair	Paper To note	Page 3 *Click here for link to page*
SPCC 25/06/B05	**Action Log of last meeting (Part B)** 17 April 2025	Chair	Paper For info	Page 13 *Click here for link to page*
SPCC 25/06/B06	**Forward Planner**	Chris Leese	Paper To note	Page 16 *Click here for link to page*
(12:15) **SPCC 25/06/B07**	**Contractor Forums Updates** i) **Issues for awareness**	Jonathan Griffiths / All	Verbal	-

AGENDA NO & TIME	ITEM	LEAD	ACTION / PURPOSE	PAGE No
12:25am	**Contracting, Commissioning and Policy Update(s)**			
SPCC 25/06/B08	**Dental and Community Pharmacy Optometry and Primary Care Medical**	Tom Knight & Chris Leese	Paper To note	Page 17 *Click here for link to page*
12:35am	**Finance**			
SPCC 25/06/B09	**Finance Update**	John Adams / Lorraine Weekes-Bailey	Paper To note	Page 29 *Click here for link to page*
12:45am	**Quality and Performance**			
SPCC 25/06/B10	**Quality Update**	Lisa Ellis (via Teams) / Tom Knight & Chris Leese	Paper To note	Page 39 *Click here for link to page*
(12:55) **SPCC 25/06/B11**	**Evidence based oral health improvement programme (All Together Smiling) – progress update**	Ian Ashworth (via Teams)	Paper To note	Page 49 *Click here for link to page*
(13:05) **SPCC 25/06/B12**	**Advice and Guidance**	Chris Leese	Paper To note	Page 61 *Click here for link to page*
13:15pm	**Transformation**			
SPCC 25/06/B13	**Estates Programme Update**	James Burchell & Lucy Andrews	Presentation To note	Page 88 *Click here for link to page*
13:30pm	**CLOSE OF MEETING**			

Date and time of next regular meeting:
Thursday 14 August 2025 (09:00-12:30)

F2F, Lakeside, Warrington

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

Thursday 17th April 2025
09:30-12:30
Meeting Room 1, No 1Lakeside, 920 Centre Park Square, Warrington, WA1 1QY

Unconfirmed Draft Minutes

ATTENDANCE - Membership		
Name	**Initials**	**Role**
Erica Morriss	EMo	*Chair*, Non-Executive Director
Clare Watson	CWa	Assistant Chief Executive, C&M ICB
Louise Barry	LBa	Chief Executive, Healthwatch Cheshire
Fionnuala Stott	FSt	LOC representative
Naomi Rankin	NRa	Primary Care Member for C&M ICB
Chris Leese	CLe	Associate Director of Primary Care, C&M ICB
Christine Douglas	CDo	Director of Nursing & Care, C&M ICB
Matt Harvey	MHa	LPC representative
Loraine Weekes-Bailey *(Representing Mark Bakewell)*	LWB	Senior Primary Care Accountant
Rob Barnett	RBa	LMC representative, Secretary, Liverpool LMC
In attendance		
Sally Thorpe	STh	Minute taker, Executive Assistant, C&M ICB
Kevin Highfield	KHi	Interim Head of ICB Primary Care Digital Services
Chris Haigh *(via Teams)*	CHa	Deputy Chief Pharmacist, C&M ICB
Cathy Fox	CFo	Associate Director of Digital Operations, C&M ICB
Lesley Kitchen	LKi	Associate Director of Digital and Data platforms, C&M ICB
Lisa Ellis *(via Teams – Meeting in part – agenda item SPCC 24/04/A06)*	LEl	Associate Director Quality & Safety Improvement, St Helens Place, C&M ICB

Apologies		
Name	**Initials**	**Role**
Adam Irvine	AIr	Primary Care Partner Member
Rowan Pritchard-Jones	RPJ	Executive Medical Director, C&M ICB
Jonathan Griffiths	JGr	Associate Medical Director, C&M ICB
Mark Woodger	MWo	LDC representative
Anthony Leo	Ale	Place Director, Halton, C&M ICB
Tom Knight	TKo	Head of Primary Care, C&M ICB
Mark Bakewell	MBa	Interim Director of Finance, C&M ICB
Susanne Lynch	SLy	Chief Pharmacist, C&M ICB
Daniel Harle	DHa	LMC representative

John Adams	JAd	Head of Primary Care Finance, C&M ICB
John Llewellyn	JLl	Chief Digital and Information Officer, C&M ICB

Agenda Item, Discussion, Outcomes and Action Points

Preliminary Business

SPCC 25/04/B01 Welcome, Introductions and Apologies

EMo welcomed everyone to the meeting.

SPCC 25/04/B02 Declarations of Interest

There were no declarations of interest pertinent to the meeting today.

SPCC 25/04/B03 Questions from the public (TBC)

None received.

Committee Business, risk and governance

SPCC 25/04/B04 Primary Care Risk Report

DBa outlined the highlights of the report, which identified 22 new corporate risks, comprising of 9 risks applying across some or all of the four contractor groups. The inherent scores were noted, which reflects the position before the ICB takes action to control the risk.

The Committee were asked to consider the 22 new corporate risks and ascertain whether the judgements regarding the applicable contractor groups were correct.

There are two existing risks, 1PC and 8PC, which are subsumed into the new risks and therefore were requested to be closed. Additionally the report showed 3 place risks in common and 9 unique place risks that have been escalated to SPCC, further noting that those in common, and potentially some of the unique risks, are covered by one of the new risks. DBa stated that, subject to approval of the new risks, a meeting would be arranged with Primary Care leads to seek a consistent approach to describing and managing these risks. Outlined that subject to Committee agreement this detail would be available for the next meeting of SPCC in June.

The Risk Management Strategy requires that this Committee (SPCC) provide direct oversight and assurance of any BAF or Corporate Risk Register risks. Any risks scoring below this may be delegated to sub-committees for oversight and assurance with highlight / assurance reporting and escalation up to SPCC.

In terms of the workforce risk, it was requested to close, the Committee **AGREED**.

It was asked that the collective action narrative in the report be reworded to apply to pharmacy as well as general practice primary care – **ACTION : DBa noted this and agreed to amend**. It was also noted that whilst collective action may have been paused in general practice, safe working practices have not, RBa stated that this is a risk to the system in terms of the link to funding or lack of funding coming into a practice.

Noted that for Primary Care, PG6, it is felt that perhaps this should be ~~a~~ split between estates and digital in order to be able to score it accurately. In addition to this CWa stated that it did depend on how we want to manage this as the same could be said for 'finance' and then split off into 'branches'.

The Committee requested whether PG7 could be revised in terms of the specifics try to capture this better.
ACTION : DBa to look to reword this risk to capture better

For risk PD4, it was noted that there is not any capital for dental therefore this needs to be removed, as does community pharmacy PP4 – **ACTION : DBa to update accordingly**

MHa advised that a funding allowance had now come through in relation to PP2, however the threat has not gone away, in that none of the items that pharmacy would take collective action on potentially is not anything that NHSE or the ICB commission (or have any 'interest' in) as it is private work. Having said this, potentially the reduction in opening hours is still a risk in terms of risk to patients for access possibly.

CHa added that in relation to local services there were ongoing discussions for locally commissioned services in terms of whether they can/ cannot break even on providing that service.

Additionally the Committee were asked to acknowledge there is a finance perspective in terms of the palliative care service or anything within the local authority, such as contraception, or is a collective local service for health and public health commissioned services.

Agreed that for the next meeting, the report would show the inherent risks and take a view from the service leads. Noting that the Committee could look to note the impact where it scores less than 3 for example, it would tolerate but continue to review. Noting the effort and resource behind monitoring something with little impact.

Highlighted for accuracy the difference between Opthalmology (being secondary care) and Optometry is Primary Care, it was requested that the report be clear as to which it was referring to – **NOTED.**

Concern was raised regarding the unrest in the sector, in terms of workforce at lots of levels. Practices are planning for services, however there is concern regarding the longevity of those services (investment comes through but if locally commissioned services are only given 12 months for example then are practices able to provide those local services at the price they are funded at – this is a risk.

ACTION : For the next SPCC meeting it was requested to have a discussion around 'what are all the risks' and 'what can the ICB do'. To then look to decide which are our priorities; what can we live with and mitigate and what can we directly affect.

In meeting actions noted:

- **Optom to group, what is correct – Chris Leese to take back**
- **POD – can go through operational group next time**
- **Primary Medical, pick up with Lisa (partly managed at place and partly at system)**

Nothing on Community Pharmacy around workforce, query capacity in C&M?

Recommendations
The Committee agreed to note and approve the recommendations as listed, although it was noted that PD4 (within dental services) and PP6 (within community pharmacy) were both regarding capital, and were requested to be removed – **ACTION : DBa to amend**

SPCC 25/04/B05 Minutes of last meeting (Part B) 20 February 2025

The minutes of the meeting were **APPROVED** as a true and accurate reflection of the meeting.

SPCC 25/04/B06 Action Log of last meeting (Part B) 20 February 2025

EMo noted that the Action Log template has changed to give a more streamlined format, it was noted that actions have been carried over from previous versions and would be reviewed outside of the meeting so that going forwards the Action Log was up to date. It was agreed that following this review the updated Action Log would be circulated to all (next week) for information.

Post meeting note, review of Action Log has been completed and an updated version has been shared with members (22nd April 2025), noted that any actions captured at the meeting of 17th April 2025 will feature on the next iteration.

SPCC 25/04/B07 Forward Planner

EMo noted that the Forward Planner template had changed to give a more streamlined format. The Planner would be reviewed outside of the meeting and will be available at the next meeting.

BAU Policy Operations

SPCC 25/04/B08 Contractor Operations Updates

i) Issues for awareness

Covered within other areas of the agenda discussions.

ii) Update from LGPN

Carried forward to next meeting.

iii) Feedback from Primary Care Forum

Carried forward to next meeting.

Contracting, Commissioning and Policy Update(s)

SPCC 25/04/B09

i) Dental and Community Pharmacy

The paper was presented as an update in respect of key national policy and related local actions.

In relation to the national contract settlement for CP (Community Pharmacy) MHa noted that there was a degree of cautious optimism within the system and that the next few years will be crucial. A lot will ride on the spending review to see if community pharmacy becomes more sustainable, we will need to read this in conjunction with the economic review.

It was noted that CP are private businesses and with this comes a significant risk in the sector if they solely rely on NHS service funding against those who have a mix of NHS and non-nhs work.

Acknowledgment was given for the amount of work that comes down centrally and how much the team deal with, also noted that each contractor deals with a lot of work on a day-to-day basis – there was thanks expressed for the work of our CP colleagues and commissioning staff.

The Committee

- **NOTED the updates in respect of commissioning, contracting and policy for the two contractor groups**
- **NOTED and were ASSURED of actions to support any particular issues raised in respect of &M contractors**

ii) Optometry and Primary Care Medical

The Committee noted the paper as presented including the details of GP Contract for 25/26 and Learning Disability Educational Settings programme for Optometry.

The Committee

- **NOTED the updates in respect of commissioning, contracting and policy for the primary medical and optometry contractor groups**
- **NOTED and were ASSURED of actions to support any particular issues raised in respect of C&M contractors**

Access Improvement

SPCC 25/04/B10 Healthwatch – General Practice Access survey results

The Committee thanked and acknowledged all the work undertaken regarding this, and the impact of the nine Healthwatch's coming together to deliver this as both place and system level reporting.

LBa presented the initial summary findings of the survey. LBa outlined that Cheshire Healthwatch had produced the overview report from a consistency point of view, but that it was on behalf of all nine Healthwatch organisations. There will be a full report and there will be nine individual reports that sit behind it, in the final version.

It was noted that the report captured a spread of views and feedback from across all nine places and aimed to present a balanced but accurate representation of the views of our patients.

There is a raft of information and everything should link back to what was asked of in terms of the initial recovery programme asks and headings. It was noted that uptake in each Place varied but overall there was a significant number of responses for the ICB.

It was agreed that the report should support the ICB in awareness of how our public feel about accessing primary medical services and how that is measured against the original plan asks/aims and to see what the gaps are – and is part of a suite of information that can in turn support our planning for access improvement for 25/26

There was a feeling that public perception has not changed in some areas – and there was still some frustration for patients in experiencing improvements in making an appointment, particularly by telephone.

LBa advised that the report hopefully showed balance, in that it was not just to highlight complaints, however it is important to recognise for that for some people, perception is their reality, and we need to be mindful of this. Positive feedback was included in the report.

CWa stated that it would be useful to look at this as part of the conversation on the Access Plan and the noted variation, she gave enormous thanks to all Healthwatch involved. Adding that the survey was a temperature check, and we have a lot of relative money which has been invested in general practice and in June we would be submitting a further plan around access - it is helpful that this will be a foundation to that report and to enable feedback to places.

Issue were also raised about patient education and understanding behaviours and usage of services from a practice perspective and not all feedback would reflect the actual individual experience for example when patients are seen multiple times within a short space of time. Assurance was given that clearly this would not be the only 'commissioner' information used when supporting/working with individual practices.

LBa agreed in that there is something about where and when people are choosing to self-refer for care because it is inherent to go to GP. A copy of the questions will be available alongside of the report to see the context of this.

Another consideration is how can we fit the data into a PCN level and the additional work that would require.

Regarding care navigation, it was noted that there is work to do around some of the differing language/approaches used and understanding all roles within practices – CWA would flag this area as part of the execs discussion on SDF spend (System Development Funding).

ACTIONS :

- **LBa on behalf of the Healthwatch's would formally send the final report to the ICB/ CWa inviting a response as part of the official release.**

- **EMo to include an update on this survey in the Chair's report to Board in May with the full report , actions agreed and the earlier mentioned 'June' plan returning to Board in July via CWa / EM/ CL**
- **A further discussion around the investment made by the ICB via SDF/PCARP would be picked up by CWa as part of future Exec funding discussion with Place.**
- **CLe would share this presentation with Place Primary Care leads in advance of the final report**

The Committee thanks LBa and the nine Healthwatch for the work and **NOTED** the presentation and supporting discussion.

SPCC 25/04/B11 Operational Planning Guidance – Access Improvement Oversight (Primary Medical)

CLe outlined to the Committee the update to the ICB's response to the Operational Planning Guidance for primary medical services for 25/26 as well as outlining the initial actions agreed within the ICB and the expected approach to this commissioned area for 25/26 to meet the asks within the Planning Guidance. A further nationally mandated plan will need to be completed by June and agreed within the ICB, final details currently awaited.

It was noted that the final submitted response was given in appendix 1 and one final piece of financial information had been requested but there had been no additional changes requested nationally to the submission.

It was noted that the emphasis had to be on reducing variation, a more single consistent offer for patients using a single set of 'baseline' indicators, with a heavy emphasis on patient experience. This was expected to be managed as a single commissioned approach as outlined in the paper/return to further support and improve access for patients.

It was noted that the June plan fitted into the timeline for the Healthwatch survey and onward reporting to Board in July.

The Committee noted that there are a list of actions already being put in place as outlined in the paper and more would follow as part of the review of the operating model.

It was discussed that there needed to be a balance between using data to identify practices that are doing all they can but understanding that their demand is consistently high, and this did not mean it was necessarily a performance 'issue'. The ICB needed to look to target and support those practices that are having issues, using the range of measures available to commissioners and acknowledge where practices were doing as much as possible as well as those that further support or involvement. As part of this continued sharing of best practice across all places was important.

It was acknowledged that this paper and operational planning guidance response outlined the approach that would frame commissioning for primary medical for 25/26 and would be further detailed in the 'June' plan.

It was also noted that these asks are national and not decided/ developed by the ICB in isolation.

ACTIONS:

- **CLe to continue to hold the ring on this work and bring the June plan to the next Committee meeting (subject to any national agreement re timelines)**
- **CWa to pick up further the framework discussions as part of Exec work on the future operating model**
- **that the June plan be presented to the July ICB Board as noted in earlier actions, as part of an overall Access Improvement paper**

The Committee gave thanks for the update and work involved and NOTED the report

Finance

SPCC 25/04/B12 Finance Update

LWB presented the report which was to update the Committee with a detailed overview of the preliminary financial position related to primary care expenditure as at the end of March 2025 (M12).

It was advised that the Delegated Medical Primary Care financial forecast for M12 was stated in the paper as an overspend of £0.171m **however this is incorrect and should read as an underspend.**

In terms of the QOF outcomes for this year, data has been received and can see a slight pressure against the budget for this year, it is great for practices but we will need to note this in terms of funding.

There was a reported underspend of £2.4m for IT, and that for last year there was funding through digital tools, this was realised as a benefit in 2024/25. However, NHSE will not fund this for this year, so the ICB will need to fund this ourselves in 2025/26.

April 29th will be when the data is submitted.

Prescribing has a £30m overspend and the December dispensing days was noted as being high but this has come down in January 2025.

In relation to Additional Roles, this was over the allocation received and we are still working through the gap however there is an assurance of 100% of the drawdown, but there will still be a gap and are awaiting the finalised figures.

£10m removed for dental and was returned back to NHSE, funding will be included again this year.

CWa stated that in good faith we slowed down pathways at the end of 2023-24 and we were allowed to keep 100% of our dental underspend, however the consequence of doing this is that NHSE have subsequently taken it back. It was noted this was correct and in M11, they took back £10m.

It was asked that as a Committee, what are the concerns, what are the unknowns and what is under pressure. In response, LWB advised that it is always prescribing as we cannot control the costs, the medicines management team works hard on programmes around QIPP. The other concern is around rent valuations and premises. Local primary care and discretionary funding tends to be budgeted in full and costs are incorporated, so it is usually the estates side of things that causes a pressure.

It was advised that QIPP has extended this year but work is ongoing for risks around new drugs, this will increase significant pressure.

It was asked whether the waste programme would continue, as it had for the last quarter? However it was noted that the focus for this was around winter time. Data evaluation is taking place and work is being done to adapt the 'Dorset work' they did around the impact of that campaign. It is felt that in general, and with the caveat of the operating model, we know the risks we have and we have as much control and ability to manage as best we can

ACTION : Laura Marsh to be invited to update on ADHD update around any possible cap – RBa / EMo to look to correspond with

In response to the question of variance, in that whether it was the same things having the same issues, LWB advised that by June we might be in a position, along with the submission of plan at end of month, to be able to give a timeline of this.

CWa expressed concern around the % uplift and also how much, and how we allocate SDF funding, noting that this will need to be reviewed in light of the financial position and that we will need to manage the consequence of this.

Clinical colleagues felt that if the ICB was open and honest about the situation and gave information at an early opportunity then yes it would be a difficult conversation but would understand the financial situation. Frustration comes in when they believe funding will come but are told last minute that it is not.

The Committee gave thanks for the update and;

- **NOTED the preliminary combined financial summary position**
- **NOTED the Additional Roles spend and central drawdown**
- **NOTED the Capital position**

SPCC 25/04/B13 General Practice Capital Allocation 2025/26 – Estates and Digital

PUn presented this item for discussion and consideration of approval.

It was advised the PUn was now working very closely with Finance to ensure accuracy and completeness.

For clarity, it was outlined that any sign-off to budget was from within this Committee and that when approving we are signing to the allocated budget.

It was advised that all bids had been prioritised and that the budget received from national is capital, and we do not go over this. Although it is noted there is a degree of slippage due to withdrawals etc and then bids are reprioritised. The ask of the Committee therefore, is the endorsement of the top budget line, nothing above this.

It was therefore noted that the recommendation / ask of the Committee was to approve the budget in the knowledge there are more bids submitted, and the approval is for the allocation of £5.027m. Assurance was given that no money would be awarded until there was a signed lease.

It was further noted that the total of submitted bids had a value of £8,197,372 into the Utilisation and Modernisation Fund.

These bids may be able to be supported if additional funding becomes available if not fully utilised across the system.

It was agreed in principle and will be clarified and discussed further at the next meeting of SPCC in June on the actual allocations for Estates, U&M and digital costs.

Quality and Performance

SPCC 25/04/B14 Freedom To Speak Up

CDo presented this paper which was noted to be lengthy but gave a detailed update on the development of FTSU, additionally it noted the scoping work commenced in primary care and the contractor groups.

It was noted that there have been many conversations held across many areas and the discussion around potential models for delivery, including the risk and delivery of those models. It was questioned whether there were resources able to do this, and that there are no finance available.

CDo noted that she had had conversations with a colleague in the central Cheshire Federation and this has been useful.

Noted that there is Ambassador training within the ICB and access to independent Guardians within individual practices.

However it was noted that in light of recent news, the role and function of the ICB may will impact this work, however it is felt that potentially FTSU would still be very much needed and we do not see this changing.

The Committee gave thanks for a really good report.

It was questioned why, in terms of Community Pharmacy, were PCN pharmacists being used or maybe confused with community pharmacists, it was asked whether we were asking PCNs to train up a pharmacist to be an FTSU Ambassador / Guardian. It was noted that the ICB had received a very small amount of funding for a community pharmacy based community pharmacist, employed on a fixed year contract so it felt unreal to expect that person to do the community pharmacist role as well as the FTSU Guardian aspect.

Additionally many pharmacies will not have a FTSU Guardian, there are so many conflicts associated with this and it would be challenging to unpick this for community pharmacy. Noted that as it currently stands the LPC would also be conflicted if there was an issue raised to the professionally responsible person (who is usually a member of the LPC) then they are also conflicted.

ACTION : It was confirmed that the wording of this would be changed to reflect more accurately for clarity, to confirm this was not a PCN pharmacist.

EMo stated that, as NED lead, if we know who the Ambassadors are, we can get them trained, then ensure those who are the Guardians are also trained, but also registered with the NGO. Going forwards it is likely that this will be some form of partnership model, and is a much bigger issue that can be covered today.

It was asked that it would be good to understand as to how many people were at each level of the 'tree'.

Additionally it was questioned whether it might be better to have fewer people doing the role on behalf of more people, and asked how many in this role do we actually need across an area? It was confirmed that it is helpful to have more Ambassadors to then have fewer Guardians who can then act upon the issues raised.

The Committee were asked to:

- Note the overall progress in relation to developments of FTSU – **NOTED – to also assist people with registering**
- Consider the options for the delivery of FTSU in primary care – **CONSIDERED / NOTED and work ongoing, also to check in terms of the Partnership model; what comes out as ICB responsibility**
- Support and advise on how we can make the most impact with very limited resources – **NOTED**
- Endorse a model that works – it was felt this could not be completed today due to the discussions and comments raised – to look to reconsider this as part of a future paper to the Committee

Transformation

SPCC 25/04/B15 Digital – shared Care (Connected Care records)

Lesley Kitchen gave an informative presentation and it was requested for the presentation to be shared with the committee.

It was assumed that the FIRC Committee have also seen this and it was questioned whether this was as 'fast' as we can go?

Noted that there was something about the speed of this work, and if we can move some of this forwards then we absolutely will do. Additionally it was questioned as to what it would take to share this across all four contractor groups and whether this was an option to be looked at?

It was outlined that the first step for the contractor groups was that they were connected to it, to look at whether there is information held in local areas that would benefit others and that is contributed to. Suggestion that it would be good to look to a pilot into other contractor groups, and yes this is about being open to the art of the possible. Noted that if we try to quick fix at the beginning it is likely to trip us up further down the line. It was advised that Pharmacy should hopefully be looked at this year and maybe some discovery work with Optometry and dental will follow.

General Practice connect has lots of parts to it and there are others connecting into Pharmacy, LKi stated that she would be very happy to be link with CLe on this.

It was noted that getting the foundations was absolutely right, and for example knowing where the sovereign record of the patient is held.

Local Healthwatch were keen and interested in this work, and requested to be considered part of this, to work 'within' it rather than hearing 'of' it.

In conclusion it was noted that there needed to be more time given to this agenda item, there are great opportunities to be had. The committee asked how LKi would like to continue and update the committee. It was requested for a follow up with a representative from each of the contractor groups and in terms of update to the Committee, a suggestion of 6 monthly was proposed.

ACTION : a representative from each of the four contractor groups to liaise and link in with LKi
ACTION : regular 6 monthly update to SPCC Committee

The Committee gave thanks for the presentation and subsequent discussion.

SPCC 25/04/B16 Update from Primary Care Workforce Steering Group

The report was presented to provide an update from the Steering Group which met in March 2025.

Concerns were raised regarding the lack of available data for the three contractor groups in comparison to lots for Primary Care.

Workforce is noted to continue as an issue and it was advised that when we know as much information we can around the accountability of the ICB then there will be a wider conversation around Primary Care workforce.

The Committee NOTED the update as presented.

CLOSE OF MEETING

Date of Next Meeting: Thursday 19 June 2025 (09:00-12:30)
F2F, Lakeside, Warrington

Action Log 2025/26 *updated June 2025*

SPCC (B - Public) Action Log - Live Actions

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/B10a	15-Aug-24	Contracting, Commissioning and Policy update : Community Pharmacy and Dental	Request at the December SPCC meeting for a view of progress of PC Strategies on Inequalities/ deprivation . Discussion held at April SPCC and further conversation to be held between Clare Watson and Ian Ashworth around availability of Inequality data for future meeting	Clare Watson	June 2025	*Verbal update expected from Clare in June following her conversation with Ian on the art of the possible with a future date proposed for a detailed presentation.*	ONGOING
SPCC 24/10/B13	17-Oct-24	Local Dental Improvement Plan	Ian Ashworth or the Beyond Team to be invited to a future meeting to give progress on oral health - to come as part of the improvement plan	Ian Ashworth & Team	June/August 2025	*scheduled on June 2025 agenda*	ONGOING
SPCC 24/12/B07	19-Dec-24	System pressures	Various conversations within SPCC about progress of PCARP and the movement of metrics against the patient experience, brief verbal update from survey from Healthwatch in Feb and full review in April SPCC with actions for Board in July 25.	Clare Watson/ Chris Leese	June 2025	*Thorough research document presented by Healthwatch to April SPCC - response will be required to HW plus action plan to Board in July* *merged with Action Log #SPCC 25/02/B13ii with the narrative 'Subject to fitting into national timescales, the June action plan (mandated by NHSE) will be an item for June's SPCC, this will outline expected actions and key metrics to deliver the operational planning guidance / access improvement for 25/26, including relevant patient experience measures'.*	ONGOING
SPCC 25/02/B14i	20-Feb-25	Performance Indicators	Discuss at next meeting under revised planning guidance asks	Chris Leese	April & June 2025	*Chris Leese delivered a detailed update on the "asks' with a final report to be completed in June. This will be included within the agenda for June SPCC.*	ONGOING
SPCC 25/02/B15	20-Feb-25	Community Pharmacy Access Review	looking to seek to acknowledge and review the rota fee	Tom Knight	Aug 2025		ONGOING

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/B10a	15-Aug-24	Contracting, Commissioning and Policy update : Community Pharmacy and Dental	Request at the December SPCC meeting for a view of progress of PC Strategies on Inequalities/ deprivation . Discussion held at April SPCC and further conversation to be held between Clare Watson and Ian Ashworth around availability of Inequality data for future meeting	Clare Watson	June 2025	*Verbal update expected from Clare in June following her conversation with Ian on the art of the possible with a future date proposed for a detailed presentation.*	ONGOING
SPCC 25/04/B04	17-Apr-25	Primary Care Risk Report	For a future SPCC meeting to have a discussion around 'what are all the risks' and 'what can the ICB do'. To then look to decide which are our priorities, what can we live with and mitigate and what can we directly affect	Dawn Boyer / Gavin Wraige	Aug 2025		ONGOING
SPCC 25/04/B10	17-Apr-25	Healthwatch - General Practice Access survey results	i) on behalf of the Healthwatch's would formally send the final report to the IDB. CWa inviting a response as part of the official release	Louise Barry / Clare Watson	May 2025	*Formal report received by ICB and acknowledged. Response will include July Board Plan.*	COMPLETED
SPCC 25/04/B10	17-Apr-25	Healthwatch - General Practice Access survey results	ii) to include an update on this survey in the Chair's report to Board in Many with the full report, actions agreed and the earlier mentioned 'June' plan returning to Board in July	Clare Watson / Erica Morriss / Chris Leese	May Board	*Included in report and verbal update given to Board with thanks to Healthwatch*	COMPLETED
SPCC 25/04/B10	17-Apr-25	Healthwatch - General Practice Access survey results	iii) A further discussion around around the investment made by the ICB via SDF / PCARP would be picked up by CWa as part of future Exec funding discussion with Place	Clare Watson	May - Executive conversations		COMPLETED
SPCC 25/04/B10	17-Apr-25	Healthwatch - General Practice Access survey results	iv) share this presentation with Place Primary Care leads in advance of the final report	Chris Leese			ONGOING
SPCC 25/04/B11	17-Apr-25	Operational Planning Guidance - Access Improvement Oversight (Primary Medical)	i) to continue to hold the ring on this work and to bring the June plan to the next committee meeting (subject to any national agreement re timelines)	Chris Leese	June - TBC		ONGOING
SPCC 25/04/B11	17-Apr-25	Operational Planning Guidance - Access Improvement Oversight (Primary Medical)	ii) to pick up further the framework discussions as part of Exec work on the future operating model	Clare Watson	May - Executive conversations	*Included within current operating model review*	COMPLETED
SPCC 25/04/B11	17-Apr-25	Operational Planning Guidance - Access Improvement Oversight (Primary Medical)	iii) that the June plan be presented to the July ICB Board as noted in earlier actions, as part of an overall Access Improvemen paper	Clare Watson	July Board	*Presentation to Board scheduled for July to incorporate Healthwatch survey results and ICB Plan.*	ONGOING

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/B10a	15-Aug-24	Contracting, Commissioning and Policy update : Community Pharmacy and Dental	Request at the December SPCC meeting for a view of progress of PC Strategies on Inequalities/ deprivation . Discussion held at April SPCC and further conversation to be held between Clare Watson and Ian Ashworth around availability of Inequality data for future meeting	Clare Watson	June 2025	*Verbal update expected from Clare in June following her conversation with Ian on the art of the possible with a future date proposed for a detailed presentation.*	ONGOING
SPCC 25/04/B12	17-Apr-25	Finance Update	Update on ADHD dropped from action logged and SRO to be contacted and diary date agreed for next presentation.	Chris Leese/Clare Watson	August	*Laura Marsh to present update to SPCC in Aug 025*	ONGOING
SPCC 25/04/B14	17-Apr-25	Freedom to Speak Up	that the narrative be reworded to give clarity around the PCN pharmacist	Chris Douglas & Temitayo Roberts	May	*Actioned through conversation between Chris/Temitayo*	COMPLETED
SPCC 25/04/B15	17-Apr-25	Digital - Shared Care (Connected Care records)	i) a representative from each of the four contractor groups to liaise and link in with Lesley Kitchen	May/June	outside of SPCC	*No further action*	COMPLETED
SPCC 25/04/B15	17-Apr-25	Digital - Shared Care (Connected Care records)	ii) regular 6 monthly update to SPCC Committee	Kevin Highfield / Cathy Fox	October 2025		ONGOING

Forward Planner 2025/26 : System Primary Care Committee

updated June 2025

Item	Who	Frequency	Part A/B	Apr-25	Jun-25	Aug-25	Oct-25	Dec-25	Feb-26
Standing items									
Apologies	EM	Every meeting	Both	Yes	Yes	Yes			
Declarations of Interest	EM	Every meeting	Both	Yes	Yes	Yes			
Minutes of last meeting	EM	Every meeting	Both	Yes	Yes	Yes			
Action Log & Decision Log	EM	Every meeting	B	Yes	Yes	Yes			
Questions from the public (where received)	EM	Every meeting	B	Yes	Yes	Yes			
Forward Planner (pre meeting)	CL	Every meeting	B	Yes	Yes	Yes			
Governance & Performance of Committee									
Review of Terms of Reference	EM / MC	Yearly	n/a	Yes	No	No			
Self-Assessment of Committee Effectiveness	EM	Yearly	n/a	No	No	No			
Forward Planner Annual Plan Review	EM / CL	Yearly		No	Yes	No			
Key Business Items									
Minutes of any ExtraOrd SPCC Meetings	EM/CL	If held	A	No	No	TBC			
Committee Risk Register for 4 contractor groups	HS/CL	Every Other Meeting usually	B	Yes	No	Yes			
Finance Update including Capital position	LWB	Every Meeting	A	Yes	Yes	Yes			
PSRC Minutes/Update Minutes/Update from Pharmacy Operations Group and highlights	TK	Every Meeting	A	Yes	Yes	Yes			
Patient Experience									
Deep Dive (s)				Yes - HW Survey (initial)	No	Yes - HW survey (Final)			
Assurance of progress of Primary Care Strategic Plans									
Primary Care 'Plan' response to 10 year plan TBC				No	No	TBC			
Estates Update		Quarterly	B	No	Yes	No			
Digital Strategy	JL	Quarterly	B	Yes	No	Yes			
Workforce Strategy	JG	Quarterly	B	Yes	No	No			
FTSU support across Primary Care	CD/TR		B	Yes	No	Yes			
(Strategic) Commissioning and performance									
Policy BAU Update – Primary Care Contracting and Commissioning (All 4 contractor groups)	CL/TK	Every Meeting	B	Yes	Yes	Yes			
Priority Commissioning Area - Improving Access (Primary Medical)	CL	Quarterly	B	Yes	Yes - june plan	Yes			
Priority Commissioing Area - Improving Access (Dental)	TK	Quarterly	B	Yes	No	Yes			
Performance Issues (escalated from Place)	TBC	As required	A	No	Yes	TBC			
Quality - Report from QSAG plus key performance metrics	LE/TK/CL	Every Meeting	B	Yes	Yes	Yes			
Committee Budget SORD Delegations									
Capital bids for agreement across Estates and Digital	CF/LA/JB/KH	As required	A/B	Yes	Yes	No			
Improvement Grant Estates Bids	JA	As required	B	Yes	No	No			
Primary Care Business cases / approvals required from Place	TBC	As required	A/B	Yes	Yes	tbc			
Ad Hoc Items									
Connecting care	LK			Yes	No	No			
Beyond/Oral health	IA			No	Yes	No			
PCN/Neighbourhood Development/Health	TBC			No	No	Yes			
Deep Dives on Quality areas	LE/TK/CL	2 meetings per year		No	No	TBC			
Dental Paper – Operational/Contract Part Year performance note	TK		A	No	No	TBC			

NHS
Cheshire and Merseyside

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

Primary Care Commissioning, Contracting and Policy Update

Agenda Item No: SPCC 25/06/B08

Date : 19 June 2025

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)
- General Dental Services (GDS)
- Community Pharmacy

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 four 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 support from the central team of contract managers who each lean out to place. All other contracts are managed centrally.

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	9	77	1	5	0	18
Knowsley	23	3	8	15	0	0	6
Sefton	40	2	23	11	6	0	3
St Helens	29	4	22	6	1	0	10
Wirral	45	6	27	15	3	0	2
Total	339	49	222	97	20	9	42

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 undertaken by a small central team, 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 220 mandatory (High Street) services and 68 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

3.6 The current number of dental practices (GDS) by contract and community pharmacy contracts is listed below:

Local Authority	Community Pharmacies	Dental Practices
Cheshire East	70	55
Cheshire West & Chester	71	42

Local Authority	Community Pharmacies	Dental Practices
Halton	31	11
Knowsley	34	17
Liverpool	108	42
Sefton	67	30
St Helens	41	20
Warrington	40	19
Wirral	77	32
Total	**539**	**268**

4. Primary Medical Services Update

4.1 **Access –** The Committee is aware of the ongoing work to address variation in access and improve patient experience across the ICB - which is to be consolidated into a plan submission in June. This work is ongoing and will be consolidated into a regular future agenda item to the Committee, supported by ongoing data and patient insight information. To support this commissioning staff across the ICB are accessing the new GP Dashboard - and we are currently awaiting further information in relation accessing CBT (cloud based telephony) data. The aim of this work is to ensure a consistent approach to the commissioning of access as a contractual element across all ICBs, with access to appropriate support such as Practice Level Support (PLS) see 4.3 below.

4.2 **General Practice Contract implementation 25/26** – As part of the 'June plan' expectations ICBs are expected to monitor oversight of implementation of this years contract arrangement – noting some areas are not contractual until October 2025. Work in relation to GP Connect to support continuation of care between providers, is ongoing and we are currently awaiting more information in relation to the patient charter which will set out the standards a patient can expect from their practice. A separate paper on the new Advice and Guidance Enhanced Service is included within the committee papers but sign up with practices is progressing. An update on contract implementation will be included as part of the 'June plan'. Details on the GP Contract for 25/26 can be linked here NHS England » Changes to the GP Contract in 2025/26

4.3 In April the ICB were advised of an additional draw down of funding for **Practice Level Support** from a nationally held pot, the ICB's share being £0.397m. The drawn down was applicable to only a certain level of offers for support and the deadline for the first two levels, closed in early May. The next level offer window closes at the end of June, and we are currently working with practices to scope interest in this. The scheme is voluntary, although practices with particular challenges in respect of access and implementation of 'modern general practice' are particularly encouraged to be targeted initially for support, working with commissioners.

4.4 **SDF (Service Development Funding) Guidance** - NHS England published guidance that supports the ICB in making decisions with regards to prioritising spend areas and key considerations for SDF -NHS England » Primary care service development funding and general practice IT funding guidance 2025/26. The approach agreed by the Executive team at the ICB with regards to the split of this funding allocation was to target a proportion at reducing variation in access and improving patient experience, based on need and the 'June' plan – and a proportion for transformation and neighbourhood health.

4 General Ophthalmic Services

4.1 **Service Provision** - Current eyecare provision is steady across the ICB with growth in domiciliary (additional) services, current provision is 220 mandatory - (high street/community) providers and 68 domiciliary providers.

4.2 **Eye Care in special education settings (SES) programme update** Cheshire and Merseyside ICB in conjunction with Greater Manchester and Lancashire and South Cumbria ICB are currently initially working with a North of England Community Support (NECS) Procurement Lead and are finalising an initial pre- procurement Request for Information (RFI) questionnaire which will be sent to interested providers. There will be further engagement with special schools through 2025/2026 to help scope the service, in the interim the current Proof of Concept (POC) programme will be maintained across our existing schools and providers through the year until the new programme can be launched through 2026/2027

4.3 **Local Eye Health Network –** The Local Eye Health Network (LEHN) met in April, key points discussed were a workforce report for 2024/2025 including training updated and spend, consistency of enhanced service pathways across the ICB and utilisation of qualified Independent Prescribing (IP) opticians to support urgent eyecare pathways

4.4 **Eyecare for patients with Learning disabilities/autism -** Primary Eyecare Services (PES) have shared their Easy Eyecare 2024/2025 report on provision of eyecare for patients with LD/Autism. 214 sight tests were completed across the region through the year with 100% patient satisfaction with the service reported.

4.5 **Programme of Blood Pressure case finding in optical practices (AF/CVD) –** Expressions of Interest in the Blood Pressure (BP) checks in eyecare pilot have been received by the CVD programme team with a significant and encouraging level of interest across the profession. Around 100 providers expressed an interest, the mobilisation of the service is underway based on the intention of 1500 BP checks being completed by up to 50 providers.

4.6 **Local Optometry (enhanced) services –** a review of these is ongoing and will link into the overall review of non-core primary care contracts across the ICB.

5 Dental

5.1 **Contract Discussions -** Members reviewed a Provider Sub-Contracting Request from a provider to subcontract 4,000 UDAs from two sites to an alternative site in the same locality. Members noted that the Dental Policy book explains that a contract variation is not required for such a request, but if agreed, Compass will need to be updated with the relevant locations on a contract, with an agreed end date for the sub-contracting arrangement.

5.2 Request from Dental Practice to Award Overperformance over 110% for 24/25 UDA target 19,145. Achieved (activity actuals 24/25) = 21,792.40 (113.83%) The provider is not eligible for any offsets for local schemes for 24/25. The provider has stated: “The demand for service is so high at the minute that we were unable to stay just under the 10% as patients needed to be seen however the dentist do want to be paid for the work that they have done so the practice would appreciate if we could be paid for these additional UDA’s so that we can pay our dentist for the work they have done.” It was agreed that the request must be refused, as all providers were advised that the maximum overperformance permitted was 10%. Providers were also afforded the opportunity to request some non-recurrent activity toward the end of 24/25 and no request was received from this provider.

5.3 Provider in Liverpool have received a breach notice for no performer being available on site to deliver NHS activity. This is the provider’s second breach notice for the same offence. The first breach was issued in 2022.

5.4 Dental Practice, Crosby – Recurrent Reduction. A meeting has taken place with the provider to discuss recurrent underperformance and accumulated debt. A further recurrent reduction was agreed with the provider, taking the contract target to 1,150 UDAs per annum from 25/26.

5.5 **Friends and Family Test –** national website has stopped publishing data. The last data submitted for Cheshire and Merseyside was hugely positive. Enquiries made to national team as to when the data will resume.

5.6 **Local Dental Professional Network** – At the last meeting of the group in February an update was provided regarding Liverpool Dental Hospital. A new dental school is in the early stages of development and NHS facilities could be available early 2030.

5.7 **Paediatric Managed Clinical Network** - updating the Paediatric Dentistry referral form and adding this to work plan for the year. The aim is to make it similar to the Orthodontic referral form, so it is clear which patients should end up in CDS, to try to stem the volume of inappropriate referrals to Alder Hey. Also investigating support onward referrals to AHH from CDS, so that children who are referred to CDS and end up being unsuitable are not disadvantaged. Work is underway to gather GA waiting times and service acceptance criteria /capabilities for all services providing Paeds Dental GAs and this is nearly complete. Also rolling out a C+M GA utilization audit in the next 2-3 months, so there is more comparable data going forward.

5.8 **National Urgent Care Appts –** Current performance reported as mainly on track with minor issues. Overall AMBER for April. Sessions have been increased from 143 to 250 per week for the delivery of urgent care (and then appt for stabilisation) whilst the figures are disappointing commissioners are in the process of reaching out to providers to understand the position. Providers have 60 days to submit and it is envisaged that delivery will increase in next months report.

5.9 **Dental Recruitment Incentive Scheme** – 2 dentists appointed. Remaining practices have adverts out and support has been offered to practices struggling to recruit under the scheme.

6 Community Pharmacy

6.1 **Implementation of Pharmacy First** - continues for 25/26 with new cumulative consultation target having been agreed as part of the operational planning process.

6.2 An increase of 11.5% was agreed based on average monthly performance from the last 6 months of 24/25. This data was used to account for lower numbers in the 1st quarter of 24/25 due to the programme being newly introduced and to deter underreporting in the 25/26 forecast.

6.3 The annualised figure was then applied to the months of 25/26 utilising the percentage number of dispensing days for each month. This created an increase of 11.5% on the previous years performance or an additional 38,829 consultations.

6.4 As of March 2025 Pharmacy First had delivered 336,701 consultations and the new target for 25/25 has been set at 375,529.

6.5 Progress is monitored via an ICB oversight programme group with reporting into the Modern GP workstream and led by ICB Clinical Lead for Community Pharmacy integration and working alongside the community pharmacy commissioning team.

6.6 **Pharmacy Operational Group -** No update available for this report as the May meeting has been rescheduled for 25 June.

6.7 **Community Pharmacy Funding settlement** – as reported previously discussions have continued to look at the implications of the national settlement and the identified risks relating to financial sustainability. Commissioners are also looking at funding issues relating to ROTA arrangements and are aware that LPCs are frustrated by a lack of confirmation of future funding arrangements and subsequent uplifts. The ICB is awaiting confirmation of allocations in order to understand what scope there will be to cover any subsequently approved contractual uplifts. Rota will be included in this process.

6.8 A meeting is being scheduled with LPC colleagues to discuss financial issues and significant concerns raised in a recent communication from Liverpool LPC. Commissioners are in the process of responding to these concerns at the time of writing this report.

7 Self Declaration for Primary Care Delegated Functions

7.1 The Primary Care Commissioning Assurance Framework (PCAF) is intended to provide clarity on NHS England's expectations on how ICBs will provide assurance to NHS England that they are exercising the delegated functions safely, effectively, and consistently within legislation, regulations and statutory guidance. The Framework also describes the need for ICBs to complete an annual self-declaration. The purpose of the self-declaration is to provide assurance that ICBs have the necessary processes and mechanisms in place to meet core commissioning and contracting standards, as set out in the delegation agreement, and is based around the **four commissioning domains for each of the delegated functions**. The self- declaration for 24/25 is given in Appendix 1 and is included for information, for the committee.

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

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

15 Officer contact details for more information

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

Appendix 1

Annex 2. Annual self-declaration form

ICB Assurance Framework

Delegated Primary Care Functions - Self-certification

For each question, please rate your response following the key provided below. Full details of what assurance is required for each domain is set out in Table 1 of the Framework.

Red	Non-compliant
Amber	Compliant but some risks identified
Green	Fully compliant

ICB Name	NHS Cheshire and Merseyside
Year to which certification applies	24/25

General		
	R/A/G Rating	Comments
Compliance with the Delegation Agreement Has the ICB complied with the terms and associated responsibilities and measures required to ensure the effective and efficient exercise of the Delegated Functions?		If Red or Amber, please provide further details
Governance structures Does the ICB have the appropriate governance structures for the delegated functions in place to enable the commissioning and delivery of high quality care		If Red or Amber, please provide further details
Pharmaceutical Services		
	R/A/G Rating	Comments
Compliance with mandated Guidance issued by NHS England		
Has the ICB understood and complied with all nationally set operating procedures and policies (e.g. the Pharmacy Manual)?		If Red or Amber, please provide further details
Service provision and planning		
Has the ICB been actively involved with all Pharmaceutical Needs Assessments (PNA) in their area, as undertaken by HWBs in year?		If Red or Amber, please provide further details
Has the ICB assured itself that there are no material gaps (as defined by the PNA) in pharmaceutical provision and has it taken action to address any gaps identified?		If Red or Amber, please provide further details
Can the ICB confirm that all payments made to community pharmacy contractors, dispensing appliance contractors and dispensing doctors are as outlined in the Drug Tariff, in line with usual NHSBSA custom and practice or are made within other formal contractual routes (e.g. LPS contracts or NHS Standard Contract)?		If Red or Amber, please provide further details
Can the ICB confirm that all contracts put in place for local enhanced services are in line with The Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2013?		If Red or Amber, please provide further details
Has the ICB obtained written consent of NHS England prior to making any new LPS schemes?		If Red or Amber, please provide further details
Can the ICB confirm that all applications for the Pharmaceutical List received by the ICB		If Red or Amber, please provide further details

related to community pharmacy contractors, dispensing appliance contractors and dispensing doctors have been decided within their regulatory timescales? Reasons should be provided where this is not the case.		
Contractor/ Provider compliance and performance		
Can the ICB confirm that it has the necessary processes in place to comply with all guidance/regulations for contractor compliance and has taken appropriate action where necessary.		If Red or Amber, please provide further details
Can the ICB confirm that contractors have completed the Community Pharmacy Assurance Framework (CPAF) and it has taken appropriate action where this is not the case?		If Red or Amber, please provide further details
Primary Ophthalmic Services		
	R/A/G Rating	**Comments**
Compliance with mandated Guidance issued by NHS England		
Has the ICB understood and complied with all nationally set operating procedures and policies (e.g. the Eye Health Policy Book)?		If Red or Amber, please provide further details
Service provision and planning		
Can the ICB confirm that it has the necessary processes in place to plan and manage service provision.		If Red or Amber, please provide further details
Contracting		
Can the ICB confirm that it is managing the processes involved for new, varied and terminated contracts effectively and efficiently.		If Red or Amber, please provide further details
Contractor/ Provider compliance and performance		
Can the ICB confirm that it has the necessary processes in place to comply with all guidance/regulations for contractor compliance and has taken appropriate action where necessary.		If Red or Amber, please provide further details
Dental Services		
	R/A/G Rating	**Comments**
Compliance with mandated Guidance issued by NHS England		
Has the ICB understood and complied with all nationally set operating procedures and policies (e.g. the Policy Book for Primary Dental Services)?		If Red or Amber, please provide further details
Service provision and planning		
Can the ICB confirm that it has the necessary processes in place to plan and manage service provision.		If Red or Amber, please provide further details
Contracting		

Can the ICB confirm that it is managing the processes involved for new, varied and terminated contracts effectively and efficiently.		If Red or Amber, please provide further details
Does the ICB have local process mechanisms in place for the collection of data relating to decisions on Discretionary Payments or Support?		If Red or Amber, please provide further details
Contractor/ Provider compliance and performance		
Can the ICB confirm that it has the necessary processes in place to comply with all guidance/regulations for contractor compliance and has taken appropriate action where necessary.		If Red or Amber, please provide further details
Primary Medical Services		
	R/A/G Rating	
Compliance with mandated Guidance issued by NHS England		
Has the ICB understood and complied with all nationally set operating procedures and policies (e.g. the Primary Medical Care Policy and Guidance Manual?		If Red or Amber, please provide further details
Service provision and planning		
Can the ICB confirm that it has the necessary processes in place to plan and manage service provision		If Red or Amber, please provide further details
Contracting		
Does the ICB have local process mechanisms in place for the collection of data relating to decisions on Discretionary Payments or Support?		If Red or Amber, please provide further details
Does the ICB have processes to implement Premises Costs Directions Functions?		If Red or Amber, please provide further details
Contractor/ Provider compliance and performance		
Has the ICB got the appropriate systems and processes in place to manage quality and performance of providers? Has the ICB taken appropriate action where necessary.		If Red or Amber, please provide further details

NHS
Cheshire and Merseyside

Primary Care Finance Update

NHS Cheshire and Merseyside Primary Care Committee (System Level)

Date: 19th June 2025

Date of meeting:	19th June 2025
Agenda Item No:	SPCC 25/06/B09
Report title:	**2025/26 Primary Care Finance Update**
Report Author & Contact Details:	Lorraine Weekes-Bailey, Senior Finance Manager - Primary Care John Adams, Assistant Director of Finance (Primary Care)
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 preliminary financial position related to primary care expenditure as at the end of May 2025 (M02).

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.

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 preliminary combined financial summary position outlined in the financial report as at 31st May 2025. 2. Note the Additional Roles allocation 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 2025/26 as at 31st May 2025.

1.2. The financial positions for May 2025 (M02) 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 below, illustrates the detailed financial position of the Primary Care and Prescribing services across Cheshire and Merseyside ICB.

Table 1

Primary Care Position Summary - Month 02 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	60,273	59,152	1,121	361,639	356,992	4,647
QOF	5,973	5,973	(0)	35,838	35,838	0
Premises Reimbursements	9,314	9,315	(0)	55,888	55,888	0
Other Premises	124	124	(0)	744	744	0
Direct Enhanced Schemes	792	792	0	4,753	4,753	0
Primary Care Network	9,387	9,387	(0)	56,323	56,323	0
Additional Roles Reimbursement Scheme	13,372	13,372	0	80,232	80,232	0
Fees	1,992	1,992	0	11,950	11,950	0
Other - GP Services	146	144	2	875	875	0
DELEGATED PRIMARY CARE TOTAL	**101,372**	**100,250**	**1,122**	**608,243**	**603,596**	**4,647**
Local Primary Care						
GP Local Enhanced Service Specification	5,434	6,209	(774)	32,607	37,253	(4,647)
Local Enhanced Services	3,127	3,124	2	18,762	18,762	0
Commissioning Schemes	303	303	0	1,821	1,821	0
Out Of Hours	4,987	4,987	(0)	29,920	29,920	0
GP IT	3,247	3,248	(1)	20,623	20,628	(5)
GP Investment	19	(32)	51	112	112	0
Primary Care SDF	0	3	(3)	0	0	0
Primary Care Other	391	426	(35)	3,075	3,075	0
QIPP	0	0	0	0	0	0
PC Local Pay Costs	70	80	(10)	422	422	0
LOCAL PRIMARY CARE TOTAL	**17,578**	**18,347**	**(768)**	**107,342**	**111,994**	**(4,651)**
Prescribing						
Central Drugs	3,070	3,124	(54)	18,421	18,475	(54)
Medicines Management - Clinical	167	186	(18)	1,230	1,192	38
Oxygen	958	958	0	5,746	5,746	0
Pay Costs Prescribing	1,955	1,626	328	11,728	10,746	983
Prescribing	84,226	84,294	(68)	511,811	511,811	0
Prescribing Other	0	0	0	0	0	0
PRESCRIBING TOTAL	**90,376**	**90,187**	**189**	**548,937**	**547,970**	**967**
Delegated Pharmacy Optoms Dental and Other						
Delegated Community Dental	2,239	2,239	0	13,433	13,433	0
Delegated Ophthalmic	4,846	4,846	0	29,079	29,079	0
Delegated Pharmacy	11,735	11,735	0	72,342	72,342	0
Delegated Primary Dental	25,026	25,026	(0)	150,154	150,154	0
Delegated Property Costs	136	136	0	818	818	0
Delegated Secondary Dental	7,462	7,229	233	45,344	45,344	0
PHARMACY, OPTOMS, DENTAL & OTHER TOTAL	**51,445**	**51,212**	**233**	**311,170**	**311,170**	**0**
TOTAL	**260,771**	**259,996**	**775**	**1,575,692**	**1,574,730**	**962**

3. Delegated Primary Care - Medical

3.1. The Month 2 financial forecast for Delegated Medical Primary Care indicates a projected overspend of £4.647 million, based on current data and payment trends

3.2. **Core Contracts**- This overspend is primarily due to a technical budget adjustment for Knowsley Place. Historically, Knowsley has funded its Local Quality Incentive Scheme from its Delegated allocation. To align funding approaches across all Places, this expenditure will now be identified through discretionary funding.

3.3. As the Delegated allocation is ringfenced, funds cannot be reallocated. Consequently, the Delegated budget now reflects an underspend of £4.647 million, with a corresponding overspend of £4.647 million recorded against the Local Primary Care budgets.

3.4. **Primary Care Networks-** Components of the PCN DES (Support payments, Enhanced Access and Capacity & Access) are funded using the January 2025 PCN Adjusted Population list size. NHSE has made the ICB aware that the data originally published to calculate the DES payments was incorrect. This has resulted in some PCN payments in April and May containing an error.

3.5. This was due to a change in the data source which mainly impacted PCNs with practices that had merged during 2024/25. The correct list sizes have now been shared with the ICB. The financial impact is expected to be minimal, but all PCN payments will be reviewed and corrected retrospectively in July.

3.6. **Quality Outcomes Framework (QoF) -** The QoF budget currently shows that we are anticipating that expenditure will match our budget plan. However, practices are currently submitting final declarations for their 2024/25 achievement payment. Although not yet finalised, based on the data received to date there may be an overspend against this budget as 2024/25 achievement claims are slightly higher than anticipated.

3.7. **Premises Reimbursements-** Similarly for Premises, despite the expenditure also showing to plan, although the finance team has accounted for all known financial pressures relating to rent revaluations, there may be risks not accounted for with some revaluations being higher than anticipated.

4. Local Primary Care

4.1. **Local Primary Care**- The Local Medical Primary Care forecast for month 2 is an expected overspend of £4.651m.

4.2. **GP Local Enhanced Service GP Specification-** The projected overspend is due to the change in presentation of the Knowlsey Place Local Quality Incentive Scheme as noted in 3.3 of this paper.

4.3. **Primary Care SDF-** At the time this report was finalised, the allocation of the Service Development Fund (SDF) was still to be confirmed. As a result, budgetary values have not yet been formally assigned to Primary Care.

4.4. The Integrated Care Board (ICB) has engaged with both the Local Medical Committee (LMC) and the GP Network meeting to communicate the recommendations from the ICB Executive Team. It has been advised that £2.7 million of the total £6.628 million SDF allocation for Primary Care will be redirected to address other financial pressures across the ICB.

5. Prescribing

5.1. Due to a standard two-month time lag in the availability of prescribing data, the most up-to-date information relating to the 2024/25 financial year-end was not available at the time this report was finalised.

5.2. Preliminary analysis suggests there is likely to be a financial pressure associated with prescribing for 2024/25, with March costs being higher than initially anticipated.

5.3. The Prescribing budget allocated for 2025/26 assumes delivery of Cash Releasing Efficiency Savings (CRES) of £22.187m

5.4. In order to ensure clear visibility on Prescribing spend and CRES, the finance team have profiled the budget and CRES delivery on dispensing days. Forecasting and monitoring will be more precise, allowing for better financial oversight.

6. Delegated Pharmacy

6.1. The 24/25 out-turn position on the Pharmacy contract was an underspend of £3m. This was based on a recurrent allocation of £70m and non-recurrent allocations of £10m (incl Pharmacy first). For 25/26 we are showing a balanced position as the funding allocation for pharmacy has not yet been confirmed.

6.2. Pharmacy fee rates have been increased by approximately 15% for 25/26 and patient charges have been held at the 24/25 rate. The fee increase follows a five year agreement with the profession where total Pharmacy Contract remuneration remained static.

6.3. The ICB requires further funding of approximately £25.3m (in addition to its recurrent allocation) to maintain the 24/25 surplus, fund the 25/26 fee rate increases and the cap on patient charges in 25/26. Roughly, £10.5m reinstatement of non-rec allocations, £13.5m fee rate increases that exceed growth uplift, £1.3m foregone by cancelling increases on patient charges.

7. Delegated Optometry

7.1. Following receipt of a £182k allocation for Optometry in Special Educational Settings, the Optometry budget ended the year with a small surplus of £51k. Activity in Optometry services rose steadily over the last year with total costs increasing by £1.5m (6%). Expectations are for a balanced position in 25/26.

8. Delegated Other Costs

For information:-
The budget line “Delegated Property Costs” consists of budgets for Transformation Team staff, NHS Mail and Remote Access costs for POD contractors and Sterile Product costs.

9. Delegated Dental

9.1. The utilisation of Pharmacy, Optometry & Dental (POD) allocation is subject to the rules set out in the ICB and system finance business rules – namely the duty to break even within the resource use limit. It is also subject to the additional rule that dental budgets are ringfenced and NHS England reserves the right to direct that any unused resources are used to improve dental access. Exceptionally, the unspent allocation may be returned to NHS England. A separate schedule will be issued setting out the ringfenced dental budget included in 2025/26 POD allocations.

9.2. For 2025/26 NHS England may agree to relax the dental ringfence (so that any underspends are retained locally) for ICBs which (i) deliver additional urgent care in line with the manifesto commitment, and (ii) improve dental access more broadly. Additional guidance will be issued on the opportunity to have the ringfence relaxed in 2025/26contract.

9.3. Expenditure on the local dental investment plan utilises funds from anticipated dental contract under-performance to improve dental access, reducing the likelihood of funds being returned to NHSE.

9.4. The Dental Investment Plan targets those patients most in need of treatment and expenditure has broadly been in line with plan. The ICB’s share of the government’s manifesto commitment to provide 700,000 additional urgent appointments needs to be funded from dental under-performance.

9.5. Workforce capacity limitations may affect the ability of dentists to deliver the level of additional service envisioned in the Dental Investment Plan in addition to the national increase in urgent appointments.

9.6. The BSA is currently assessing the total level of activity delivered by dental contractors in 24/25 and will notify ICB commissioners of the result. Commissioners will discuss the outcome with contractors and agree repayment plans for those who have under-performed against their contract.

10. Additional Roles Reimbursement Scheme

10.1 For the 2025/26 financial year, the total ARRS allocation is £80.232 million. Unlike in previous years, this funding is no longer split between GP-specific roles and traditional ARRS roles. Instead, it is provided as a single unified allocation to support all eligible roles under the scheme.

10.2 The allocation is calculated based on £26.631 per weighted population unit. A key change for 2025/26 is that the ICB will no longer be required to draw down funds from NHS England (NHSE); the full ARRS allocation is now included within the ICB's delegated base allocation.

10.3 Table 3 illustrates the ARRS allocation at Place level for 2025/26

Table 3

Additional Roles Reimbursement Scheme 2025/26	
Place	**£**
Cheshire East	£11,524,348
Cheshire West	£10,982,522
Halton	£4,005,309
Knowsley	£5,264,445
Liverpool	£17,371,596
Sefton	£8,328,997
St Helens	£6,186,991
Warrington	£6,231,871
Wirral	£10,336,061
Total	**£80,232,141**

11. Capital

11.1 There are two capital funding streams available to Primary Care in 2025/26. £5.027m is available for GP premises improvement grants through the Utilisation and Modernisation Fund (U&M). £6.012m is available from the Business-as-Usual Primary Care capital fund (BAU).

11.2 Separate reports have been brought to this committee describing the requirements for premises improvement grants and GPIT equipment & systems. IFRS16 cover for ICB lease costs also needs to be funded from BAU capital.

11.3 It is anticipated that the U&M fund will be fully utilised, NHSE has already endorsed a full list of projects plus reserve schemes (to replace any projects that are withdrawn); £4.6m of BAU is required for investment in GPIT for network upgrades, kit replacement and cyber security; the balance should initially be reserved for IFRS16. When IFRS16 requirements are confirmed, the balance will be released for investment in either premises grants or GPIT.

11.4 A separate paper and associated PIDs will be brought to SPCC. The paper will provide details of individual capital schemes and seek SPCC approval to proceed. Once approved, progress will be monitored and reported to SPCC.

12. Recommendations

The Primary Care Committee is asked to:

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

12.2 Note the Additional Roles allocation at Place.

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: 19th June 2025

Primary Care Services - Quality Report

Agenda Item No: SPCC 25/06/B10

Report Author: *Lisa Ellis – Associate Director Quality & Safety Improvement (St Helens) – SRO Primary Care Quality (C & M)*

Primary Care Services - Quality Report

1. Purpose of the Report

1.1 This paper provides the Committee with assurance and information to effectively deliver Quality in Primary Care Services contracted by NHS Cheshire and Merseyside at a system level relating to:

- General Practice
- Dental Services
- General Ophthalmic Services
- Community Pharmacy Services

1.2 This paper includes an update on quality assurance across Cheshire and Merseyside by highlighting:

- ALERT – matters of concern, non-compliance or matters requiring response.
- ADVISE – general updates of ongoing monitoring.
- ASSURE – where assurance has been received.

2. Ask of the Committee and Recommendations

2.1 The Committee is asked to:

- **Note** the updates relating to Quality in Primary Care Services for the four contractor groups listed above.
- **Note and be assured** of actions raised to support any quality issues.
- This report is for **information** and **no decisions** are required.

3. Quality Issues for Alerting (matters of concern, non-compliance)

3.1 **General Practice**

- Liverpool Place - Potential for scan results not being returned to GP surgeries involving CDC, Liverpool Women's and LUHFT Trusts. Following a patient incident regarding scan results not being actioned and patient subsequent 2 week wait referral, there could be multiple GP practices not receiving scan results. Investigation and SBAR in progress:

1. x 18 patients with alert/unusual findings have been identified, LUHFT has contacted GP practices and harm review in progress.

2. x 900+ normal scan results and unclear if these have been sent to GP Practices; currently looking at whether these results will be manually pushed out to practices; Awaiting confirmation as to whether PCMG team to support comms to practices.

3.2 Dental Services

- Record card audits – The Dental Practice Advisor is auditing 6 performers who have flagged in BSA reports as delivering more than 12,000 Units of Dental Activity (UDAs) a year. An experienced dentist would generally deliver around 5000/6000 UDAs per annum. In some cases, this may be exceeded but this is normally due to some FP17 submissions being made by a dental therapist under a dentist's performer number. The audits undertaken identify if the performer is working with dental therapists and will also highlight any clinical concerns including recording keeping. A practice has been recently audited for inappropriate claiming by a Dental Therapist which was identified because of a patient complaint and the standard investigations carried out as a result of this.

- The visits often take the form of a support approach to educate providers on the regulations and appropriate claiming. To date for 25/26, the audits have not resulted in the need to issue a breach notice.

3.3 General Ophthalmic Services

- No formal items for *alert* to the Committee – attached with this paper is a summary of the Optometry processes/systems for quality assurance, managed through the Optometry Operations Group (appendix 2).

3.4 Community Pharmacy Services

- One Contractor which operates 2 sites within Cheshire East is currently subject to A GPHC enforcement notice. This relates to:

- Standard 1.1 - The risks associated with providing pharmacy services are identified and managed

- Standard 4.2 - Pharmacy services are managed and delivered safely and effectively

- An unannounced re-inspection of the pharmacy was carried out on 19 February 2025. Multiple issues were found with the pharmacy's stock management processes which resulted in people not receiving their medicines in a timely manner. This had also been identified at a previous inspection which had not been addressed. The concerns identified fall below the standards expected and increase the risk to patient safety.

- In addition to GPHC, the ICB clinical advisor has conducted on site visits and local arbitration meetings, required under the regulations. These have included input from the local practice to help highlight operational issues.

- The deadline for compliance was 24/5/25.

4. Quality Issues for Advising (ongoing monitoring)

4.1 General Practice

- Learning from Patient Safety Events

  Roll out of system reporting across Primary Care in 6/9 places. Issues highlighted in relation to:

  1. The system does not support the entry of patient identifiable information.

  2. The absence of the national system having the functionality to provide thematic reports.

  3. Delays in reporting patient safety events ranging from 2-7 months.

- Safeguarding Assurance using eDEC (May 2025) – Agreement to use eDec as baseline for safeguarding assurance within Cheshire and Merseyside from April 2023.

  1. A Place-specific template and report have been created this year to support evidence and assurance for other agencies (such as Safeguarding Children's Partnerships)

  2. Outliers have been flagged with the GP Practices concerned and is being followed up by safeguarding teams in the relevant Places.

  Questions and Responses taken from eDec 2024/2025 submissions:

	ChW	ChE	Hal	Kno	Liv	Sef	StH	Warr	Wir
2b. Professional registration for staff	100	100	100	100	100	100	100	100	100
2c. DBS checks for staff	100	100	100	100	100	100	100	100	100
2l. Clinicians have had PREVENT training	96	100	92	100	89	92	96	100	95
2m. Policies include DA, FGM, MCA, FTSU	100	100	100	100	100	100	100	100	100
4u. Access to interpreters	100	100	100	100	100	100	100	100	100
5u. Update of Whistleblowing Policy	100	100	100	100	100	100	96	100	100
5v. Identification of Whistleblowing person	97	100	100	100	89	100	96	100	89
5w. Chaperone Policy	100	100	100	100	100	100	100	100	100
6g. Practice has a lead for vulnerable adults	99	100	100	100	100	100	96	96	100
6l. Procedures and agreements for multi-agency information sharing	100	100	100	100	100	100	100	100	100
6m. Safeguarding training records	100	100	100	100	100	100	100	100	100

100% in green
95-99% in amber
<94% in red

4.2 **Dental Services**

- Access to urgent dental care – 102 dental practices are undertaking the urgent care plus scheme in 25/26 to support the national initiative to provide 700k more urgent care appointments across England. The scheme in C&M provides patients accessing urgent dental care with an opportunity for a full examination and any treatment requirements identified completed (not just for the urgent care presentation. Commissioners are monitoring the number of urgent FP17s being transmitted across C&M, to meet the local target of circa 46k extra urgent care appointments in 25/26. Practices have been reminded of the need to submit an urgent FP17 for every patient seen as part of the UDC Plus scheme.

- Clinical governance visits and record card audits – Since January 2025, 13 clinical governance visits have taken place. A routine programme of visits to practices by the Dental Practice Advisor is ongoing as part of routine contract monitoring and compliance.

4.3 **General Ophthalmic Services**

The Committee is advised that there are plans to undertake contract assurance visits as outlined in this document appendix 2, noting the limited resources within the small central contracts team to undertake these.

4.4 **Community Pharmacy Services**

- Annual Contract Monitoring - All pharmacies are subjected to an annual monitoring cycle, the Community Pharmacy Assurance Framework. This is a combination of online reporting and face to face visits based on the pharmacy's RAG rating. This is a national process overseen by NHSBSA. To date, for 24-25 cycle, 13 visits have been conducted this year and reported to NHSBSA. Action plans for all have been generated. The actions required will be subject to individual deadlines based on the levels of seriousness.

- Incident Reporting

  Q4 reporting:
  59 incidents reported
  32 incidents closed
  17 remain open –RAG rating: 5 Red, 5 Amber,7 Green

- <u>Pharmacy Quality Scheme</u>

  The Pharmacy Quality Scheme (PQS) is a component of the Community Pharmacy Contractual Framework (CPCF) that rewards community pharmacies

for delivering quality criteria. It focuses on three key areas: clinical effectiveness, patient safety, and patient experience.

The PQS provides financial incentives to community pharmacies that demonstrate excellence in their services.

The scheme has 2 domains, each containing separate quality criteria:

1. Medicines Optimisation
2. Patient Safety

The detail of the PQS is contained within Part VIA of the drug tariff. (attached as appendix 4)

- PCARP/Pharmacy 1st

Quality Intervention	Enabler	Report Type	Owner
DOS reports	System Compliance reports	Monitoring of Contractual obligation to secure a Compliant IT System to support	CPCL
	Closure report (RAG Changes) Service declined report	Monitoring of Contractual Compliance	Clin Gov Pharmacist
Incidents	Incident reporting log and Investigation Process	Monitoring of incident reporting and investigation	CP Contracts Team and Clin Gov Pharmacist
Data Analysis on Power BI	Gap Analysis report	Analysis of "opted In" pharmacies and levels of service delivery Monitoring of impact on National Cap for pharmacy 1st Service levels	CPCL and PCARP Stakeholder Group
	Referral Report	Monitoring of levels of GP Referrals into service to support PCARP agenda.Referral Report	CPCL and PCARP Stakeholder Group
	Pharmacy 1st Report	Monitoring of levels of service delivery with service breakdown at ICB/Place/PCN/Pharmacy level	CPCL and PCARP Stakeholder Group

PCARP Community Pharmacy stakeholder Group	PCARP action plan	Support for PACRP agenda and delivery. ICB/LPC/national and regional stakeholders actions to support service delivery and promotion	SRO - T Knight

5. Quality Issues for Assurance (assurance received)

5.1 General Practice

- Patient Experience

1. 5/9 Places are green on BIP in relation to Friend and Family (% who would recommend). Sefton has the highest recommendation rate of 94.4% and Warrington the lowest at 84.9%

2. 6/9 Places are green in relation to GP Survey Response Rate. Cheshire East has the highest response rate with 36.8% and Liverpool the lowest at 22.8%.

- Prevention/ Screening Reviews

1. LD Annual Health Checks 14+ - Overall compliance achieved across all Cheshire and Merseyside Places at 80% against NHSE target of 75%

5.2 Dental Services

- Patient experience - Results of the Friends and Family Test show an improvement in submission rates as contact is routinely made with those practices who do not submit the data for two months or more.

- Access – Data collection on local schemes including UDC Plus and the Access & Quality scheme show an increase in appointments being offered to new and vulnerable patient groups. For 24/25 BSA data shows that around 60k new patients access NHS care across C&M as a direct result of local schemes.

5.3 General Ophthalmic Services

The Committee is advised that there is a piece of work ongoing in relation to *local eye care contracts* to understand further the contracting/quality framework around these.

5.4 Community Pharmacy Services

- All CPAF action plans for 23-24 were completed. No outstanding actions

6. Complaints

6.1 Primary Care Services - Formal Complaints

The information in this report covers quarters 3 and 4 from 1st October to 31st December 2024 and 1st January to 31st March 2025 and is sourced from the Ulysses system which the PACT utilises for the management of complaints, patient and MP enquiries.

Contract Type	Q3	Q4	Total
Pharmacy	7	5	12
Ophthalmic	0	0	0
Dental	11	16	27
GP	54	38	92
Totals	**72**	**59**	**131**

The number of primary care formal complaints managed by the Patient Advice and Complaints Team (PACT) in Q3 2024/25 (72) is a 38% increase when compared to Q2 (52 complaints).

6.2 General Practice

- The number of general practice formal complaints fluctuate each quarter. The mean average for general practice complaints is 50 for the financial year 2024/25.
- Enquiries raised by Members of Parliament on behalf of their constituents during Q3/Q4 – 30 GP (access to appointments, registration, removal, referral, care issues**,** premises, staffing).

6.3 Dental Services

- The number of dental formal complaints fluctuate each quarter. The mean average for dental complaints is 12 for the financial year 2024/25.
- Enquiries raised by Members of Parliament on behalf of their constituents during Q3/Q4 – 28 access to NHS Dental Services

6.4 General Ophthalmic Services

- The PACT has not received any formal complaints for optometry services during 2024/25, tho complaints are part of the cycle reporting outlined in the appendix.

6.5 Community Pharmacy Services

- No information

The PACT has not received any formal complaints for ophthalmology services during 2024/25.

6.6 Primary Care Services Complaint Themes (Q3 and Q4)

The main themes and trends relating to the primary care complaints (GP & Dental) received during the two quarters are as follows:

- Access to services
- Referral issues
- Prescription issues
- Clinical Care
- Communication
- Removal from list
- Staff Attitude

7 Reasons for Recommendations

7.1 The System Primary Care Committee is asked to be alerted, advised and assured by the detail contained within this report and more detailed description of the key issues affecting general practice quality in the subsequent nine place-based reports

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

8.1 The paper supports the delivery of the ICBs duties in respect of Quality Primary Care Services and supports the wider themes of:-

- Tackling Health Inequalities in access, outcomes and experience
- Improving Population Health and Healthcare
- Enhancing Productivity and Value for Money
- Helping to support broader social and economic development

9 Link to meeting CQC ICS Themes and Quality Statements

9.1 Quality & Safety - QS2, QS3, QS5
9.2 Integration – QS7, QS8
9.3 Leadership – QS10, QS13, QS15

10 Risks

10.1 Supports the mitigation following BAF risks – P1, P4, P5, P8

11 Finance

11.1 Will be covered in separate Finance update.

12 Communication and Engagement

12.1 Not required in respect of this paper.

13 Equality, Diversity and Inclusion

13.1 Nationally negotiated terms in respect of this area are already agreed.

14 Next Steps and Responsible Person to take forward

14.1 Lisa Ellis, Associate Director of Quality & Safety Improvement (St Helens Place) (SRO for Primary Care Quality C & M)

15 Appendices

Appendix One: *General Practice Quality Indicators & Process*

General Practice - Quality Indicators &

Appendix Two: *Optometry Quality Oversight Process*

OPTOMETRY QUALITY OVERSIGHT

Appendix Three: *Dental National Assurance Process*

NHS England » Policy book for primary dental services

Appendix Four: *Community Pharmacy Quality Scheme*

Pharmacy Quality Scheme.pdf

Meeting of the Cheshire & Merseyside ICB System Primary Care Committee

Date: **19th June 2024**

Evidence-based oral health improvement programme (All Together Smiling) progress update

Agenda Item No: SPCC 25/06/B11

Paper Prepared by:
Jordan Brown, Oral Health Programme Manager, Beyond CYP Transformation Programme

Responsible Directors:
Prof. Ian Ashworth, Director of Population Health, NHS Cheshire and Merseyside
Dr Elizabeth Crabtree, Programme Director, Beyond CYP Transformation Programme

Specialist Adviser:
Dr Yvonne Dailey, Lead Consultant Dental Public Health, NHS England - North West

Evidence-based oral health improvement programme (All Together Smiling) progress update

1. Purpose of the Report

1.1. The report provides assurance to the Primary Care Committee regarding the progress of All Together Smiling (ATS) – Cheshire & Merseyside's (C&M) supervised toothbrushing programme (STP) hosted by Beyond, Cheshire and Merseyside's Children's Transformation Programme on behalf of NHS Cheshire and Merseyside. The paper describes work undertaken to address dental decay in children, with a focus on areas of highest deprivation.

2. Executive Summary

2.1. On the 19th of October 2023, the Primary Care Committee approved a proposal to establish a three-year, evidence based, oral health STP across C&M.

2.2. Since April 2024, Beyond have mobilised 'All Together Smiling', working closely with Oral Health Public Health leads within each Place to operationalise delivery, enhancing existing programmes where applicable. ATS is targeted at supporting children aged 2-7 living in CORE20 communities.

2.3. Mobilisation of the programme is complete with initial scoping undertaken, governance agreed, procurement of suppliers (training and consumables) completed, trailblazers delivered, and a local evidence-based toolkit developed.

2.4. In 2023/24, £250,000 was allocated from Primary Care dental underspend. Data stratification enabled target population groups to receive oral health packs (toothbrush, toothpaste, key message leaflet). This funding, as well as programme roll out to date, has resulted in 246,735 oral health packs distributed across C&M, with distribution supported through key partners such as Health Visitors, Foodbanks and Holiday Activities and Food (HAF) programmes.

2.5. Programme recruitment and mobilisation was undertaken in 2024/25 with roll out of STPs across all 9 Places by Q4 (2024/25). Currently, 157/ 520 eligible settings (30%) are participating in delivery of daily programmes. This is in line with the expected delivery at this stage of roll out. STPs are delivered alongside communications and engagement activities which are a key function to raise awareness of the offer and provide oral health support, education, and signposting. A culturally sensitive communications plan has been developed which includes key calendar and cultural events.

2.6. The programme will actively build on the initial roll out and aims to reach a minimum 50% of eligible settings participating (as recommended within the

evidence-base) by Q2 (2025/26) end, with the longer-term aim of working with local areas to maximise programme reach.

2.7. Delivery will be enhanced further through the Department of Health and Social Care (DHSC) allocation of resources and funding through a national STP targeting three- to five-year-olds in the most deprived areas of England. In C&M, an options appraisal process is underway to discuss how local funding, and resources can be best utilised to maximise the impact of the programme, while continually enhancing and aligning to existing delivery.

3. Ask of the Committee and Recommendations

3.1. The Primary Care Committee is asked to note the content of the report.

4. Reasons for Recommendations

4.1. To provide assurance to the Primary Care Committee regarding the progress of All Together Smiling while considering key areas of improvement / escalation.

5. Background

5.1. The 2019 National Dental Epidemiology Programme (NDEP) oral health survey showed that:

- 5-year-olds living in the most deprived areas in the country were almost 3 times more likely to have experienced dental caries (37%) than children living in the least deprived areas (13%).
- Nearly 67,000 (42%) of 2-7 years olds in Cheshire and Merseyside live in the 20% most deprived areas of the country, with 8 of our 9 Places worse than the England average for dental decay in 5-year-olds.

5.2. The 2024 NDEP survey recently showed that:

- 31.2% of children in Cheshire and Merseyside who participated in the survey had experience of tooth decay in the deciduous dentition (primary teeth or baby teeth) (North West 28.7%, England 22.4%).
- The prevalence of the severity of decay (enamel caries and / or dentinal decay experienced (36.6%)) was the third highest of any ICB (North West 36.8%, England 26.9%).

5.3. On the 19th of October 2023, the Primary Care Committee approved a proposal to establish a three-year, evidence based, oral health improvement programme across C&M (appendix one). The programme would be funded through the Primary Care Dental underspend and focused on CORE 20+ populations across all 9 Places. The proposal outlined an aim to:

> *"Improve the oral health of the child population of C&M by implementing a co-ordinated, evidence-based oral health improvement programme across both community and clinical settings. The majority of the programme will be targeted to support*

children residing in the most deprived areas within each C&M Local Authority."

5.4. Since April 2024, Beyond have mobilised ATS. The programme team have worked closely with Oral Health Public Health leads within each Place to operationalise delivery, enhancing existing programmes where applicable. ATS is targeted at supporting children aged 2-7 living in CORE20 communities.

5.5. Evidence shows that establishing STPs across a region results in a 45.7%-52.7% reduction in tooth decay for the most deprived quintile within 12-24 months and a return on investment of £3.06 at 5 years for every £1 spent[1].

6. Programme updates / key functions

6.1. Initial distribution of dental packs

6.1.1. In 2023/24, £250,000 was allocated from Primary Care dental underspend. Data stratification, focused on children living in areas of IMD 1&2, enabled target population groups to receive oral health packs (toothbrush, toothpaste, key message leaflet). This data was used to allocate funding and as a result, 210,836 oral health packs were delivered as described in Table 1

Table 1: Oral Health Pack Distribution

Place	Regular oral health packs	SEND oral health packs
Cheshire East	8,696	141
Cheshire West	13,537	220
Halton	15,061	245
Knowsley	24,064	391
Liverpool	70,856	1,154
Sefton	19,011	309
St Helens	18,413	300
Warrington	9,801	159
Wirral	28,022	456
Total	**207,461**	**3,375**

6.1.2. Including programme roll out to date, an overall total of 246,735 packs have been distributed across C&M through Early Years, Primary School and Family Hub settings as well as key partners such as foodbanks, Holiday Activities and Food (HAF) programmes, Health Visitors, Special Schools, HENRY (Health, Exercise and Nutrition for the Really Young) programmes, Secondary Care Trusts, General Dental Practices and more. Feedback relating to oral health pack distribution has re-iterated their need, particularly for families who are struggling on a low budget:

[1] Public Health England (2016), A rapid review of evidence on the cost-effectiveness of interventions to improve the oral health of children aged 0-5 years.

*"…so that children in each household can receive a brand-new toothbrush, **something that has become unaffordable and a 'luxury' item for many** who are struggling on a small budget."*

*"…parents have shared that their **children haven't currently got a toothbrush**, so having the toothbrush pack has meant that they can start to get their child back into the*

6.2. Initial distribution of dental packs

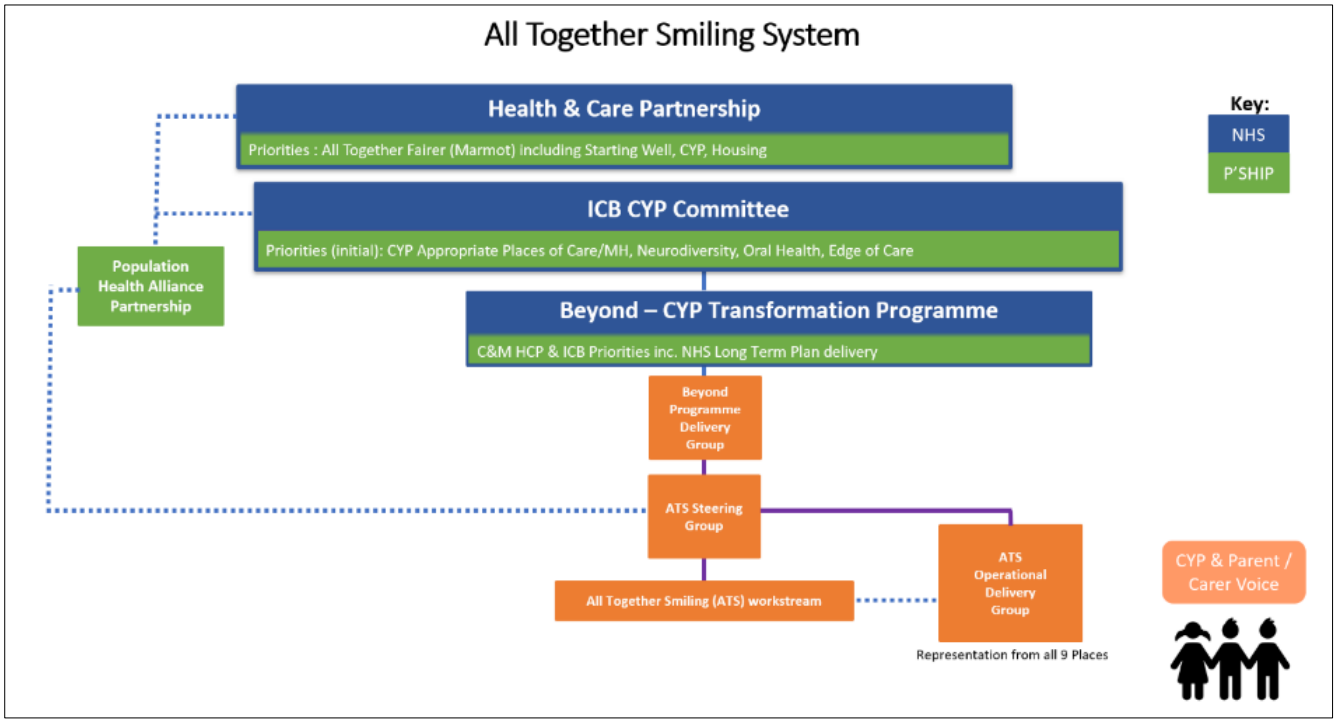
6.2.1. Initial scoping was undertaken by NHSE NW Dental Public Health and Beyond to understand existing provision of Local Authority funded oral health initiatives and STPs across C&M. The review identified one Place with an established STB programme, another with a smaller scale offer (self-funded by settings), and another who had secured funding to deliver but were experiencing delays due to procurement.

6.2.2. Scoping has identified 520 eligible (early years, primary school and childminder) settings across C&M within CORE20 populations. Place-based delivery models have been agreed in each Local Authority with:

- Alignment and enhancement of existing STP delivery in five Places (Halton, Knowsley, Liverpool, St Helens, Warrington).
- Alignment and enhancement of existing oral health related initiatives in two Places (Cheshire West & Chester, Wirral).
- Establishment of new STPs in two Places (Cheshire East, Sefton).

6.3. Governance

6.3.1 The following governance structure has been developed:



6.2. Procurement

6.2.1. Beyond, supported by Health Procurement Liverpool, has procured a consumables supplier, and a training and quality assurance provider:

6.2.2. Consumables (tender): An Invitation to Tender (ITT) was issued in December 2024. Five applications were received and evaluated with The Brush Bus identified as the preferred supplier. The contract was formally awarded on the 25th of February 2025.

6.2.3. Training and quality assurance (expressions of interest):An Expressions of Interest (EOI) was issued in December 2024. Two applications were received and Healthbox CIC was identified as the preferred provider with a hybrid delivery model (face to face, virtual and digital training) agreed including in-house expertise from a Registered Dental Therapist.

6.3. Trailblazer delivery

6.3.1. Trailblazers were mobilised to test the approach and understand local learning, challenges and opportunities in November 2024:

- Halton Borough Council – area of highest dental decay for CYP (second only to Liverpool[2]) with 5,256 eligible children in IMDs 1&2.
- Knowsley Council – third highest percentage of children living in IMDs 1&2 (8,397) across C&M.

6.3.2. Fifty-one settings were involved in trailblazer delivery across the two areas. Useful learning related to recruitment of settings, overcoming capacity challenges / anxieties, and key enablers / facilitators to delivery. Regular sharing of good practice is taking place via the programmes Operational Delivery Group, with a trailblazer learning paper to be produced, and shared. Trailblazer delivery built upon existing learning from established programmes in C&M.

6.4. Programme manual

6.4.1. ATS has developed a local toolkit[3] to support staff to implement safe and effective STPs focusing on infection, prevention and control (IPC) protocols and quality standards. The programme has adopted a positive ‘opt in’ consent process (in line with national guidance). Tools for gathering informed consent are embedded within the toolkit. The ATS information and consent form has been translated into the five most spoken languages across C&M.

[2] Liverpool was not chosen due to the existing delivery of the ‘Tiny Teeth’ project (NHS England Early Years Intervention pilot) that includes supervised toothbrushing delivery and oral health pack distribution.
[3] based on Office of Health Improvement & Disparities (OHID), 2025: Commissioning and delivering supervised toothbrushing schemes in early years and school settings (updated Public Health England toolkit, 2014).

7. Impact update

7.1. Roll out of STPs across all 9 Places commenced in Q4 2024/25 summarised in Table 2.

Table 2; Summary of Reach and Delivery across Cheshire and Merseyside

Cheshire & Merseyside	Total (Q4 24/25 end)
Number of Local Authorities participating	**9**
Number of oral health packs distributed	**246,735**
Number of eligible settings identified	**520**
Number of eligible settings taking part	**157***
Percentage of eligible settings taking part	**30%**
Number of eligible settings declined to participate	**2****

*Including existing STP delivery across C&M aligned / enhanced through ATS.
**Due to staff capacity challenges.

7.2. Feedback from delivery to date has re-iterated the impact of STPs:

"My child **has always been reluctant to brush their teeth at home** but since doing the supervised toothbrushing at nursery, **it has become much easier and is no longer a battle to get him to brush at home**".

"Children taking part in supervised toothbrushing in the nursery **reinforces the importance of oral health and how to brush teeth properly**... doing this with their peers **encouraged children** who are more reluctant".

"We can already see a difference in the **children's attitudes to dental health**. All children taking part are enjoying the process, and we have had parents say they are doing this **at home, with ease** too".

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

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

Children within the most deprived areas are at highest risk of dental decay due to factors such as lack of awareness of dental access pathways, poor diet, and low awareness/ education of the importance of good oral health resulting in missed school days due to dental pain/ general anaesthesia for tooth extractions. ATS is targeting children living in CORE20 communities while providing evidence-based initiatives that have shown to significantly reduce dental decay while improving both immediate health, and long-term outcomes.

8.2. Objective Two: Improving Population Health and Healthcare

STPs improve population health when implemented at scale and targeted towards deprived areas e.g.,

- reducing the prevalence of dental decay.
- enabling long-term habits.
- reducing dental extractions.
- reducing health service use and associated costs.
- empowering and educating communities.

8.3. Objective Three: Enhancing Productivity and Value for Money

Dental decay is a major cause of preventable hospital admissions amongst children, often requiring costly treatment under general anaesthetic. Hospital admissions for tooth extractions cost the NHS £74.8 million in financial year ending 2024, with the cost of decay-related extractions accounting for £45.8 million (an increase from 2023 - £40.7 million)[4]. STPs have shown to return £3.06 for every £1 spent (after five years) and £3.66 for every £1 spent (after 10 years)[5].

8.4. Objective Four: Helping to support broader social and economic development

STPs support this objective by addressing health inequalities at their root while breaking the cycle of poverty and poor oral health. This includes ensuring all children, regardless of background, receive daily preventative care while enabling wider outcomes such as enhancing school readiness, educational attendance, educational outcomes, supporting parental and community engagement, and strengthening the economy through prevention.

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

9.1. ATS links to the priority area (2025/26) of 'Neighbourhood and Population Health' while also supporting in the long-term 'Financial Stability' and 'Urgent Care Improvement' through addressing inequalities and a shift towards prevention. The programme is closely aligned to the All Together Fairer strategy while taking a population health targeted approach, utilising data to inform delivery, standardising STPs at scale, integrating with neighbourhood and muti-disciplinary teams and in the long-term will help to address the current demand for urgent/ emergency dental services. Beyond are identified as one of the key strategic and enabling programmes for delivery.

[4] Office for Health Improvement & Disparities (2016), hospital extractions in 0-to-19-year-olds.
[5] Public Health England (2016), A rapid review of evidence on the cost-effectiveness of interventions to improve the oral health of children aged 0-5 years.

10. Link to meeting CQC ICS Themes and Quality Statements

10.1. Theme One: Quality and Safety

The evidence-base of STPs outline the benefits of reducing decay, improving oral hygiene habits and encouraging long-term dental health as well as clear return on investment. ATS provides a learning culture through teaching the importance of using fluoride toothpaste when brushing teeth, while creating positive oral hygiene habits. ATS receives clinical advice through the NHSE NW Dental Public Health team and training is provided (aligned to clear quality standards) through a Registered Dental Therapist. The targeted approach focuses on children residing in the most deprived communities with high-quality support offered to all participants regardless of background, including additional support for children with SEND.

10.2. Theme Two: Integration

ATS takes an approach across Health, Population Health and Public Health within Local Authorities. This enables close partnership working across teams / services across Place building on local expertise to ensure the diverse needs of local communities are met, while taking a flexible approach to support choice and continuity.

10.3. Theme Three: Leadership

ATS embeds a shared direction through clearly defined goals relating to oral health and equity while providing consistent training / support alongside open communication and collaboration. Through its governance, the programme benefits from inclusive and supportive leaders at all levels while building on the strength in partnerships. Continuous learning is embedded through a continued quality improvement approach that includes co-production and feedback with both children / families and professionals. A commitment to environmental sustainability and workforce equality, diversity and inclusion was key in the procurement ITT process.

11. Risks

Risk Description	Overall Risk	Mitigations
Engagement in the programme by providers is impacted due to the number of similar interventions and in turn alternative suppliers of consumables.	9	• Supplier contract awarded through a formal tender process. • Options appraisal process underway in consideration of national funding and Colgate consumables.

12. Finance

12.1. Programme funding allocated will enable approx. 128,000 children to participate in daily STPs across C&M.

12.2. The initial paper allocated circa. £503,530 per annum for delivery of ATS (2024-2027). Details of allocations can be seen in appendix two for information. This included staffing, consumables, training, printing and other costs.

12.3. Since inception, additional funds have been received to reflect pay uplifts and inflation, resulting in £514,152 received in 2024/25. Allocation against these funds is detailed below. It should be noted that recruitment processes during mobilisation resulted in underspend against staffing. This underspend was re-directed to purchase consumables (hence overspend in this line).

Table 3: Budget Summary 2024/25

Category	Description	2024/25 budget	2024/25 spend
Staffing	B8a Programme Manager	£71,879	£52,412
	B5 Project Support Officer	£41,113	£27,713
	B5 Project Support Officer	£41,113	£24,643
	B4 Project Administrator	£34,255	£12,970
Consumables	STP delivery consumables	£287,800	£360,010
Training	Training provider	£26,000	£30,000
Printing	Brand development	£2,000	£1,344
Other	Miscellaneous	£9,992	£5,060
	Total	**£514,152**	**£514,152**

12.4. An additional epidemiology oral health survey of 5-year-olds (NDEP) will be undertaken in 2025/26 to help monitor and target the programme impact. This will be carried out by Bridgewater Community Healthcare NHS Foundation Trust with funds allocated directly from NHS Cheshire and Merseyside.

13. Communication and Engagement

13.1. Communications and engagement activities are a key function to raise awareness of the offer and provide oral health support, education, and signposting. A culturally sensitive communications plan is developed which includes key calendar events (e.g. National Smile Month) and cultural events (e.g. Eid, Easter and Lunar New Year) across each year. Regular social

media and setting-based communications are developed and shared across the system to reach CYP and families.

13.2. During National Smile Month (12th May-12th June), the programme delivered a roadshow of engagement events across all nine places to distribute fluoride toothpaste oral health packs, information, and resources. Communications and engagement are ongoing with CYP, families and all key stakeholders across C&M.

14. Equality, Diversity and Inclusion

14.1. ATS is playing a valuable role in promoting equality, diversity, and inclusion (EDI) and key examples include:

- Targeting health inequalities – focusing on areas of highest deprivation and providing equal access to preventative care.
- Children with SEND – an inclusive offer of consumables including the provision of flavour free and non-foaming toothpaste and 3-way (adapted) toothbrushes with supplementary training support on how to adapt STP delivery for children with sensory, physical, or learning needs.
- Cultural and religious – such as consultation with parents/ communities to respect beliefs (e.g., fasting periods like Ramadan) while having access to products (i.e., toothpaste) that are halal, kosher or free-from animal products.
- Inclusive communication – family facing materials such as the key message leaflet and information and consent form available in multiple languages with family facing resources/ communications reviewed to lower reading age before distribution with health literacy in mind.

15. Climate Change / Sustainability

15.1. Details regarding a 'commitment to sustainability in the context of sourcing and production of consumables' was requested within the ITT. The programme supplier, The Brush Bus, outlined a strong commitment including the sourcing of bio-degradable and recyclable materials, processes to minimise carbon footprint, as well as being a plastic neutral company.

16. Next Steps and Responsible Person to take forward

16.1. The programme will actively build on the initial roll out and aims to reach a minimum 50% of eligible settings participating (as recommended within the evidence-base) by Q2 (2025/26) end, with the longer-term aim of working with local areas to maximise programme reach.

16.2. Since the development of ATS, the Department of Health and Social Care (DHSC) has allocated funding for national STPs targeted at three- to five-year-olds in the most deprived areas of England. This includes a partnership with Colgate-Palmolive to provide toothbrushes and pastes in each area. Where existing schemes are already in place, the funding can be used flexibly

to provide additional provision. This might include older or younger children, children in IMDs 3, 4, and 5, those with SEND or those from "PLUS" groups, aligned with the CORE20PLUS5 framework and oral health needs assessments.

16.3. In C&M, an options appraisal process is underway to discuss how local funding, and resources can be best utilised to maximise the impact of the programme, while continually enhancing and aligning to existing delivery.

16.4. The committee is asked to note the content of the paper for assurance and consider areas of improvement/ escalation.

17. Officer contact details for more information

Jordan.brown2@alderhey.nhs.uk - Oral Health Programme Manager (Beyond)

18. Appendices

Appendix One (23/10/B14: page 154-172)

SPCC - Agenda & Papers - Part B (Publ

Appendix Two

Committee paper profile		**Spend 2024/25**
Staffing • B8a Programme Manager • Two B5 Project Support Officers • B4 Project Administrator	£165,420	£117,738
Consumables	£287,110	£360,010
Training	£24,000	£30,000
Printing	£25,000	£1,344
Other	£2,000	£5,060
Total	**£503,530**	**£514,152**

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

Advice and Guidance

Agenda Item No: B25/06/12

19 June 2025

Responsible Director: Clare Watson

1. Purpose of the Report

1.1 The purpose of the paper is to provide the Committee with ;

- An update in respect of the ICB's response to the release of Advice and Guidance including key contractual, operational and financial information – including any risks.
- An outline of key initial actions that the ICB needs to put in place to support delivery of this and meet national asks.
- Outline any key decisions required by this Committee to move this work forward and respond to these national asks.

2. Ask of the Committee and Recommendations

The Committee is asked to ;

a. ***Note*** the updates in respect of Advice and Guidance
b. ***Agree the key actions*** as outlined in 4.2 below.

3 Background

3.1 NHSE previously announced a national Enhanced Service for General Practice Advice and Guidance - NHS England » General Practice Requests for Advice and Guidance Enhanced Service 2025/26 which is commissioned at local level by the ICB. This service will pay £20 to the practice for each Advice and Guidance (A&G) request made to secondary care. Advice and Guidance is designed for GPs to raise clinical queries with consultant colleagues and receive prompt advice in return. This is hoped to reduce the need for out - patient appointments thus reducing costs and waiting times.

3.2 NHSE guidance was also released for ICB's NHS England » Advice and guidance – operational delivery framework for integrated care boards for 2025/26 which asks us to monitor the Advice and Guidance programme through a Primary Secondary Care Interface Group (PSCI Group). The ICB have one overarching system level PSCI group and then local groups typically arranged around the local trust(s). The ICB plan for the local PSCI groups to operationally manage the A&G programme with oversight form the C&M wide group moving forward.

3.3 There is a ongoing/ reporting ask from NHSE with a template as part of the above Guidance. We are asked to undertake self-assessment of our ability to undertake A&G across the system and the latest version of this assessment is given in **Appendix 1.**

3.4 The expectation for Advice and Guidance is that fewer patients will be referred for out patient appointments, with GPs retaining responsibility and potentially undertaking further investigation and/or treatment on the advice from specialist consultant colleagues. The ICB are not expecting all A&G requests to be dealt with as advice alone and there will be a proportion who 'convert' to out-patient referral.

3.5 The ICB have established an initial steering group chaired by Dr Sinead Clarke (Clinical Lead) with membership from the C&M Provider Collaborative, primary care and finance. This group will report to the System Primary Care Committee and may be in place for a limited period whilst this work is embedded across the ICB and the urgent asks/decisions are addressed.

4.0 Ask of the Committee

4.1 The ICB has received a fixed resource to support this work. Funding primary care above and beyond this fixed resource is currently unaffordable. Therefore, we propose a cap on the number of A&G requests that we will fund, the potential for a cap is referenced in the enhanced service specification. The proposal is that each practice is provided with a cap based on weighted capitation numbers which gives a figure of £1.23 pp, and the table below shows the breakdown of this cost **by place**.
The tariff for Primary Care is identified as £20 per A&G request and we're proposing that this is paid as an activity based payment within the caps identified below.
The A&G Steering Group will review the performance of each practice to feedback into current contracting reporting routes against the cap.
A tariff rate for secondary care has been agreed and set at £100 per advice given. This is an interim solution while year one 'beds in'. This value may change in future years.

Advice and Guidance		
Place	AG capped activity	££
Cheshire East	26,786	£535,720
Cheshire West	25,503	£510,060
Halton	9,291	£185,820
Knowsley	12,223	£244,460
Liverpool	40,297	£805,940
Sefton	19,399	£387,980
St Helens	14,355	£287,100
Warrington	14,461	£289,220
Wirral	23,989	£479,780
Total	**186,304**	**£3,726,080**

4.2 The Committee is asked to agree:

- The value of the cap as outlined in the table above with a recommendation that weighted population numbers are used utilising the entirety of the budget available.
- That we monitor progress/activity through the local PSCI groups with oversight at the C&M PSCI group -but managed by exception through the steering group whilst this embeds across the ICB to ensure the national asks are met.
- That a report returns to this committee in 6 months
- That the ICB review any underspend in the final quarter with any funding recommendations in relation to the Enhanced Service returning to this Committee for decision.

5.0 Risks

- Inappropriate use of A&G (using A&G when a direct OPA referral should have been sent)
- Quality of A&G requests / clinical advice in return
- Overperformance

Mitigation for these risks will be managed by the Steering Group, with escalation to the SPCC as part of the update – these risks are currently being worked through

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.
- Enhancing productivity and value for money

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

Outlined in the paper.

9 Communication and Engagement

No external formal consultation or further engagement is required in respect of this paper. But communications and engagement with stakeholder, providers and our patients is key to understand and take forward the actions and recommendations..

10 Equality, Diversity and Inclusion

EQHIA (Equalities Health Impact Assessment) considerations are contained within the national commissioning/action plan responses – any further work required will be managed through the A&G Steering group.

11 Next Steps and Responsible Person to take forward

Clinical
Dr Sinead Clarke, Clinical Lead
Sinead.clarke@cheshireandmerseyside.nhs.uk

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

12 Officer contact details for more information

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

Advice and Guidance operational delivery framework for integrated care boards for 2025/26

Following the publication of the plan for Reforming elective care for patients (Jan 2025), NHS England is implementing a national operational delivery framework for Advice and Guidance (A&G) to support ICBs and system partners to deliver timely care in the right place using high quality, effective specialist advice in 2025/26. The objectives of the framework are:- to optimise use of high quality Advice and Guidance through reducing unwarranted variation, service improvement and innovation;- to enable ICBs to assess and mature progress against delivery plans through 2025/26; and - to support the planning, commissioning, and delivery of Advice and Guidance services.

The framework includes:
• 7 sections for effective A&G, each with indicators and a set of minimum standards;
• guiding principles for accountability;
• an ICB action plan template and useful resources.

National Baselining Phase - for completion by close of play on Thursday 17 April 2025. This baselining phase undertaken will support ICBs to identify areas for improvement during 2025/26 and will allow a position from which to measure that improvement with quarterly data submissions.

Integrated care boards are required to complete this ICB self-assessment survey by Thursday 17 April 2025.

Most of the questions require an answer on a scale (0-3) that indicates the level of implementation within your system. For these questions please select one option between 0-3 and use the "other" option to add narrative you think would be helpful.

Please also download a PDF of your responses when you have completed the survey for your records.

Please contact england.electivepmo@nhs.net if you need any support or have any questions about this, citing "Advice and Guidance" in the subject.

Your details

1. Name *

   April Tuley / Sinead Clarke

2. Email address *

   april.tuley@cheshireandmerseyside.nhs.uk / sinead.clarke@cheshireandmerseyside

3. Role *

   Senior Programme Manager / Associate Medical Director

4. Integrated Care Board *

   Cheshire and Merseyside ICS

Domain 1: Leadership and Governance

5. A primary and secondary care **interface group** – or an equivalent forum with both primary and secondary care representation (hereafter referred to as the 'interface group') – is established to oversee performance of Advice and Guidance with agreed roles and responsibilities, reporting lines, terms of reference and membership.

   Minimum standards:
   • establish a primary secondary care interface group to assess, plan and improve service delivery
   • establish clear terms of reference
   • ensure named Advice and Guidance clinical leads from primary and secondary care provide joint leadership to the interface group, with agreed roles and

responsibilities
• implement a clear action plan to deliver high quality advice and guidance, for which progress is regularly monitored
• follow the guiding principles for accountability for Advice and Guidance
• articulate the legal liability associated with Advice and Guidance in accordance with the national Specialist Advice: Clinical Responsibility and Medicolegal FAQs

Please select one option between 0-3 to indicate the current level of implementation within your system:
*

- ○ **0 - Not yet started** - little or no evidence of progress is available or can be provided against the minimum standards
- ◉ **1 - Early Progress** - evidence that some of the minimum standards being met or evidence against all indicators, but it is limited in some places (< 50% achievement)
- ○ **2 - Firm Progress** - evidence that the majority of the minimum standards are being met, with no major omissions (> 50% achievement)
- ○ **3 - Mature** - all minimum standards are being met, with evidence of how this is leading to improvement (100% in place)

6. Optional - please add any comments or information relating to the above answer:

   Primary secondary care interface group established along with A&G steering grou

7. The interface group routinely **reviews agreed elective care and Advice and Guidance performance data** (including utilisation ratio per 100 outpatient first attendances, diversion rate, turnaround rate and unprocessed rate) and patient choice - with an established process to manage exceptions and data quality issues.

   Minimum standards:
   • regularly utilise data and insights using Model Health System: Outpatients compartment/specialist advice, Opportunities dashboard for systems and 4 metric overview by organisation, supplemented with local data and insights to inform planning and improvement
   • agree approval processes for maintaining ICB policy and guidance relating to Advice and Guidance (for example, access policy)
   • establish processes to manage local data quality issues

Please select one option between 0-3 to indicate the current level of implementation within your system:
*

- ○ **0 - Not yet started** - little or no evidence of progress is available or can be provided against the minimum standards
- ○ **1 - Early Progress** - evidence that some of the minimum standards being met or evidence against all indicators, but it is limited in some places (< 50% achievement)
- ◉ **2 - Firm Progress** - evidence that the majority of the minimum standards are being met, with no major omissions (> 50% achievement)
- ○ **3 - Mature** - all minimum standards are being met, with evidence of how this is leading to improvement (100% in place)

8. Optional - please add any comments or information relating to the above answer:

   Already happening within elective recovery programme - requirement is to now m

9. The interface group (or equivalent forum) provides regular **assurance reports** to the relevant ICB performance board, as part of regular elective performance reporting, including action plans to increase warranted use of Advice and Guidance.

   Minimum standards:
   • deliver regular assurance reports to the relevant ICB performance board on Advice and Guidance including monthly performance of pre-referral Advice and Guidance metrics: utilisation ratio per 100 outpatient first attendances, diversion rate (%), turnaround rate (%) and unprocessed rate (%)
   • implement actions to improve performance, address gaps and mitigate identified risks

   Please select one option between 0-3 to indicate the current level of implementation within your system:
   *

   - ○ **0 - Not yet started** - little or no evidence of progress is available or can be provided against the minimum standards

- ○ **1 - Early Progress** - evidence that some of the minimum standards being met or evidence against all indicators, but it is limited in some places (< 50% achievement)
- ◉ **2 - Firm Progress** - evidence that the majority of the minimum standards are being met, with no major omissions (> 50% achievement)
- ○ **3 - Mature** - all minimum standards are being met, with evidence of how this is leading to improvement (100% in place)

10. Optional - please add any comments or information relating to the above answer:

    Already happening within elective recovery programme - requirement is to now m

11. Within the ICB, **clear and accessible pathway referral criteria** (including for pre-referral investigations carried out in diagnostic settings) are developed and visible to referrers; and **standard operating procedures for triage** outlining referral criteria, investigation requirements and sub-specialty booking criteria are developed for high-volume specialties.

    Minimum standards
    • develop clear and accessible pathway referral criteria, including for pre-referral investigations carried out in diagnostic settings, and make visible to referrers by July 2025
    • implement a plan to develop triage standard operating procedures for high-volume specialties, outlining referral criteria, investigation requirements and sub-specialty booking criteria by December 2026
    • develop standard operating procedures for triage outlining referral criteria, investigation requirements and sub-specialty booking criteria for high-volume specialties
    • periodically review and update of pathway referral criteria and triage standard operating procedures through clinical governance processes
    • ensure the specialty GIRFT A&G Toolkits and Templates are embedded in secondary care

    Please indicate **per specialty** where **pathway referral criteria** and **SOPs for triage** are agreed and in place:

	Pathway referral criteria are agreed and in place	Standard operating procedures for triage are agreed and in place
Cardiology	◉	○
Dermatology	◉	○
Gastroenterology	◉	○
Gynaecology	◉	○
Neurology	◉	○
Urology	◉	○
Clinical Haematology	◉	○
ENT	◉	○
Endocrinology	◉	○
Paediatrics	◉	○
Respiratory Medicine	◉	○
Rheumatology	◉	○

12. Optional - please add any comments or information relating to the above answer:

Please enter at most 200 characters

Domain 2: Use of digital platforms to support Advice and Guidance

13. **Specialty referral guidelines** are available via a web-based platform, digital system or built into digital workflows.

    Minimum standards:• ensure the interface group (or relevant group) has access to a named lead for improving the digital interface for Advice and Guidance, aligned with the ICB digital strategy
    • implement actions to address gaps in digital accessibility of pathway referral criteria and guidelines (including for pre-referral investigations carried out in diagnostic settings) and ensure the resources are visible for referrers
    • implement processes to evaluate utilisation and application of referral guidelines

    Please indicate whether **specialty referral guidelines are in place (per specialty):**
    *

	Yes	In Progress
Cardiology	○	◉
Dermatology	○	◉
Gastroenterology	○	◉
Gynaecology	○	◉
Neurology	○	○
Urology	○	◉
Clinical Haematology	○	○
ENT	○	◉
Endocrinology	○	◉
Paediatrics	○	◉

	Yes	In Progress
Respiratory Medicine	○	◉
Rheumatology	○	◉

14. Optional - please add any comments or information relating to the above answer:

    The ICB operates across 9 Places and there is variation across specialties.

15. There is a plan in place at system level for **digitising Advice and Guidance and referral channels** - and clearly defined **interim processes** for email and paper-based requests.

    Minimum standards:
    • establish a baseline of maturity of digitised use of Advice and Guidance channels
    • develop and implement a plan to digitise the use of Advice and Guidance channels which may include interim processes for managing emails and paper-based requests

    Please select <u>one option</u> between 0-3 to indicate the current level of implementation within your system:
    *

    ○ **0 - Not yet started** - little or no evidence of progress is available or can be provided against the minimum standards

    ○ **1 - Early Progress** - evidence that some of the minimum standards being met or evidence against all indicators, but it is limited in some places (< 50% achievement)

    ◉ **2 - Firm Progress** - evidence that the majority of the minimum standards are being met, with no major omissions (> 50% achievement)

    ○ **3 - Mature -** all minimum standards are being met, with evidence of how this is leading to improvement (100% in place)

16. Optional - please add any comments or information relating to the above answer:

    Majority on eRS

17. **All acute NHS providers have open digital channels** to support Advice and Guidance in specialties reporting on consultant-led referral to treatment (RTT) waiting times, starting with high volume specialties.

    Minimum standards:
    • establish a baseline understanding of open digital channels for specialties with Advice and Guidance
    • implement a plan to open digital channels to support Advice and Guidance channels for all relevant specialties, starting with high volume specialities

    Please indicate whether all acute NHS providers have **open digital channels** to support advice and guidance **for each specialty** listed below:
    *

	Yes	Partial
Cardiology	◉	○
Dermatology	◉	○
Gastroenterology	◉	○
Gynaecology	◉	○
Neurology	○	◉
Urology	○	◉
Clinical Haematology	○	◉
ENT	○	◉
Endocrinology	○	◉

	Yes	Partial
Paediatrics	◉	○
Respiratory Medicine	◉	○
Rheumatology	○	◉

18. Optional - please add any comments or information relating to the above answer:

    Varies across acute providers

Domain 3: Improving the quality of advice and guidance

19. Referral assessment services and clinical assessment services **offer patient choice**, in line with the Choice Framework and NHSE Choice Guidance.

    Minimum standards:
    • provide GPs with patient choice guidance and training, to help patients make informed, meaningful choices about how and where they receive treatment (resource: Choice Framework and NHSE Choice Guidance)
    • where there is a mechanism to convert Advice and Guidance to an elective referral, patients are given the opportunity to discuss their choices prior to the Advice and Guidance request or elective referral
    • where Advice and Guidance leads to an elective referral being made, processes are in place for patients to choose a clinically appropriate provider

    Please select one option between 0-3 to indicate the current level of implementation within your system:
    *

    ○ **0 - Not yet started** - little or no evidence of progress is available or can be provided against the minimum standards

    ○ **1 - Early Progress** - evidence that some of the minimum standards being met or evidence against all indicators, but it is limited in some places (< 50% achievement)

- **2 - Firm Progress** - evidence that the majority of the minimum standards are being met, with no major omissions (> 50% achievement)
- **3 - Mature** - all minimum standards are being met, with evidence of how this is leading to improvement (100% in place)

20. Optional - please add any comments or information relating to the above answer:

    Please enter at most 200 characters

21. **Standards for urgent and routine turnaround times** for Advice and Guidance requests are locally determined at specialty level and are supported by protocols and escalation processes for open and outstanding requests.

    Minimum standards:
    • determine turnaround time locally by specialty (ranging from 24-48 hours for urgent Advice and Guidance requests, and not exceeding 10 days for routine requests), in accordance with the national Specialist Advice: Clinical Responsibility and Medicolegal FAQs
    • implement protocols and processes to ensure open and outstanding requests are addressed in a timely manner and requests that have been responded to are closed

    Please select one option between 0-3 to indicate the current level of implementation within your system:
    *

    - **0 - Not yet started -** little or no evidence of progress is available or can be provided against the minimum standards
    - **1 - Early Progress** - evidence that some of the minimum standards being met or evidence against all indicators, but it is limited in some places (< 50% achievement)
    - **2 - Firm Progress** - evidence that the majority of the minimum standards are being met, with no major omissions (> 50% achievement)
    - **3 - Mature** - all minimum standards are being met, with evidence of how this is leading to improvement (100% in place)

22. Optional - please add any comments or information relating to the above answer:

Please enter at most 200 characters

23. **Clinically led audits** are in place at specialty level to assess the quality of Advice and Guidance requests and responses, and to assess local diversion rates in comparison to national benchmarking.

Minimum standards:
• develop an audit plan for 2025/26
• establish parameters that trigger an exception audit including specialty level diversion rates exceeding the national average diversion rate of 45%
• complete clinically led audits quarterly at specialty level
• utilise national specialist advice benchmarking data and insights in Model Health System for opportunities to reduce unwarranted variation
• review outcomes with the interface group (or equivalent forum) and plan actions to reduce unwarranted variation
• establish a forum for primary and secondary care clinicians to lead improvement in areas such as:
- peer to peer learning
- service commissioning
- demand and capacity planning including job planning
- the quality of Advice and Guidance requests and/or responses
- service improvement opportunities including primary and secondary care led joint MDTs, in-reach service models, and pathway redesign
• ensure referrers have access to national and local guidelines and Frequently Asked Questions tools such as GIRFT A&G Toolkits and Templates and NHS Impact and GIRFT - Outpatient services: A clinical and productivity improvement guide

Please select one option between 0-3 to indicate the current level of implementation within your system:
*

- ○ **0 - Not yet started** - little or no evidence of progress is available or can be provided against the minimum standards
- ◉ **1 - Early Progress** - evidence that some of the minimum standards being met or evidence against all indicators, but it is limited in some places (< 50% achievement)
- ○ **2 - Firm Progress** - evidence that the majority of the minimum standards are being met, with no major omissions (> 50% achievement)

- **3 - Mature** - all minimum standards are being met, with evidence of how this is leading to improvement (100% in place)

24. Optional - please add any comments or information relating to the above answer:

Please enter at most 200 characters

Domain 4: Reducing health inequalities

25. An **equality and health inequality impact assessment** (EHIA) has been completed covering Advice and Guidance with agreed actions implemented and monitored.

Minimum standards:
• develop local equality and health inequality impact assessments (EHIA) with respect to Advice and Guidance (resource: national EHIA template for specialist advice)
• regularly review the EHIA and implement and monitor interventions to reduce disparities for groups who face additional waiting list challenges

Please select one option:
*

- Not yet started
- Early progress
- Yes

26. Optional - please add any comments or information relating to the above answer:

Please enter at most 200 characters

27. **Health inequalities reporting** is embedded in elective performance, with actions taken to address the most relevant local issues for patients in relation to Advice and Guidance.

Minimum standards:
• regularly review local data by protected characteristics (including Waiting List Minimum Data Set by deprivation, age, ethnicity, gender and by specialty) for insights into health inequalities
• regularly review data quality and completeness regarding health inequalities in Advice and Guidance data
• identify any variation and/or issues relating to Advice and Guidance of most relevance to patients locally using key strategic indicators for health disparities and health inequalities (resource: Gov UK: Health disparities and health inequalities: applying All Our Health
• implement actions to tackle issues of most relevance to patients locally including accessibility and communication

Please select one option between 0-3 to indicate the current level of implementation within your system:
*

- ◉ **0 - Not yet started** - little or no evidence of progress is available or can be provided against the minimum standards
- ○ **1 - Early Progress** - evidence that some of the minimum standards being met or evidence against all indicators, but it is limited in some places (< 50% achievement)
- ○ **2 - Firm Progress** - evidence that the majority of the minimum standards are being met, with no major omissions (> 50% achievement)
- ○ **3 - Mature** - all minimum standards are being met, with evidence of how this is leading to improvement (100% in place)

28. Optional - please add any comments or information relating to the above answer:

Please enter at most 200 characters

Domain 5: Patient and staff engagement

29. Communication tools are used to **improve patient awareness and understanding** of Advice and Guidance, how they can participate and raise follow-on queries or concerns.

Minimum standards:
• use national and local patient communication tools to improve patient awareness of Advice and Guidance, how they can participate, and how to raise follow on queries or concerns (supporting resource: Specialist Advice Communications Toolkit
• design user-centred communication tools to provide and maintain non-digital healthcare support, alongside an inclusive digital health approach (supporting resource: Inclusive digital healthcare: a framework for NHS action on digital inclusion)
• ensure processes are embedded to convey Advice and Guidance communication tools to patients

Please select one option between 0-3 to indicate the current level of implementation within your system:
*

- ○ **0 - Not yet started** - little or no evidence of progress is available or can be provided against the minimum standards
- ◉ **1 - Early Progress** - evidence that some of the minimum standards being met or evidence against all indicators, but it is limited in some places (< 50% achievement)
- ○ **2 - Firm Progress** - evidence that the majority of the minimum standards are being met, with no major omissions (> 50% achievement)
- ○ **3 - Mature** - all minimum standards are being met, with evidence of how this is leading to improvement (100% in place)

30. Optional - please add any comments or information relating to the above answer:

Please enter at most 200 characters

31. **Regular feedback on patients' experience** of Advice and Guidance is gathered through a questionnaire, supplemented by other mechanisms and

forums. This feeds into an improvement action plan with clear delivery timelines.

Minimum standards:
• establish processes to understand patients' experience of Advice and Guidance
• establish opportunities for the 'voice' of people with lived experience to shape and influence how Advice and Guidance services are improved
• provide questionnaire results to the named director responsible for improving patients' experience of care, and improving experience for patients and their carers while they wait for elective care, and include the named director in improvement planning
• review any feedback received on advice and guidance through other forms or patient engagement forums to inform planning (for example, NHS Family and Friends Test comments)

Please select one option between 0-3 to indicate the current level of implementation within your system:
*

- (●) **0 - Not yet started** - little or no evidence of progress is available or can be provided against the minimum standards
- ( ) **1 - Early Progress** - evidence that some of the minimum standards being met or evidence against all indicators, but it is limited in some places (< 50% achievement)
- ( ) **2 - Firm Progress** - evidence that the majority of the minimum standards are being met, with no major omissions (> 50% achievement)
- ( ) **3 - Mature -** all minimum standards are being met, with evidence of how this is leading to improvement (100% in place)

32. Optional - please add any comments or information relating to the above answer:

Please enter at most 200 characters

33. **Regular feedback is gathered from NHS staff** involved in commissioning, administering and delivering Advice and Guidance through a questionnaire, supported by other feedback mechanisms or forums and feeding into an an improvement action plan with clear timelines.

Minimum standards:
• develop a localised questionnaire for NHS staff involved in commissioning, administering and delivery of Advice and Guidance in primary, secondary and community care to better understand challenges, barriers and opportunities for improvement
• conduct and analyse the questionnaire annually, as a minimum
• review any feedback received on advice and guidance through other existing forms or forums relating to NHS staff engagement to inform planning
• review outcomes with the interface group (or equivalent forum), applying a continuous improvement approach to improving service delivery and experience
• implement an improvement action plan with clear delivery timelines

Please select one option between 0-3 to indicate the current level of implementation within your system:
*

- (●) **0 - Not yet started**
- ( ) **1 - Early Progress** - evidence that some of the minimum standards being met or evidence against all indicators, but it is limited in some places (< 50% achievement)
- ( ) **2 - Firm Progress** - evidence that the majority of the minimum standards are being met, with no major omissions (> 50% achievement)
- ( ) **3 - Mature** - all minimum standards are being met, with evidence of how this is leading to improvement (100% in place)

34. Optional - please add any comments or information relating to the above answer:

Please enter at most 200 characters

Domain 6: Workforce, training and development

35. **Workforce plans reflect requirements for resourcing Advice and Guidance** within primary and secondary care.

Minimum standards:

• ensure resource allocation for Advice and Guidance is included within job planning and clinical workforce plans within primary and secondary care
• ensure resource allocation for the administration of Advice and Guidance is included in workforce plans within primary and secondary care
• review and adjust workforce plans at least annually
• establish processes to escalate and mitigate risks when capacity levels are unable to meet service demand for Advice and Guidance
• adjust workforce plans and resourcing to respond to in-year or immediate fluctuations in demand and capacity of advice and guidance requests

Please select one option between 0-3 to indicate the current level of implementation within your system:
*

- ○ **0 - Not yet started** - little or no evidence of progress is available or can be provided against the minimum standards
- ◉ **1 - Early Progress** - evidence that some of the minimum standards being met or evidence against all indicators, but it is limited in some places (< 50% achievement)
- ○ **2 - Firm Progress** - evidence that the majority of the minimum standards are being met, with no major omissions (> 50% achievement)
- ○ **3 - Mature** - all minimum standards are being met, with evidence of how this is leading to improvement (100% in place)

36. Optional - please add any comments or information relating to the above answer:

Multiple providers in C&M - differs across these.

37. Users of Advice and Guidance services have **access to e-learning resources and/or training.**

Minimum standards:
• promote and/or provide e-learning resources, toolkits and/or training to users of Advice and Guidance services in areas such as:
- maximising Advice and Guidance e-RS use (supporting resource: Advice and Guidance toolkit for the e-Referral Service (e-RS) and/or alternative digital systems use
- System EROC technical guidance (including how we use the e-RS data extracts)

- Advice and Guidance within pathway redesign
- referral criteria
- relevant policies and guidance

Please select one option between 0-3 to indicate the current level of implementation within your system:
*

- ( ) **0 - Not yet started** - little or no evidence of progress is available or can be provided against the minimum standards
- (•) **1 - Early Progress** - evidence that some of the minimum standards being met or evidence against all indicators, but it is limited in some places (< 50% achievement)
- ( ) **2 - Firm Progress** - evidence that the majority of the minimum standards are being met, with no major omissions (> 50% achievement)
- ( ) **3 - Mature** - all minimum standards are being met, with evidence of how this is leading to improvement (100% in place)

38. Optional - please add any comments or information relating to the above answer:

Please enter at most 200 characters

39. A **peer learning programme** is in place between primary and secondary care, focusing on the use and service delivery of Advice and Guidance.

Minimum standards:
• identify peer learning needs and establish requirements for targeted education
• agree and develop a peer learning programme to address identified learning needs
• evaluate the benefit of the peer learning programme on the delivery of high-quality Advice and Guidance

Please select one option between 0-3 to indicate the current level of implementation within your system:
*

- ( ) **0 - Not yet started** - little or no evidence of progress is available or can be provided against the minimum standards

- (●) **1 - Early Progress** - evidence that some of the minimum standards being met or evidence against all indicators, but it is limited in some places (< 50% achievement)
- ( ) **2 - Firm Progress** - evidence that the majority of the minimum standards are being met, with no major omissions (> 50% achievement)
- ( ) **3 - Mature** - all minimum standards are being met, with evidence of how this is leading to improvement (100% in place)

40. Optional - please add any comments or information relating to the above answer:

    Where RMS are in place peer review is established.

Domain 7: Local commissioning and payment mechanisms

41. Advice and Guidance services are **commissioned based on a thorough assessment**, with arrangements implemented and reviewed annually using data and insights.

    Minimum standards:
    • reflect and monitor elective activity targets and funding allocations for Advice and Guidance in local commissioning arrangements
    • embed processes to support the funding approach for the payment of the £20 Item of Service fee (IoS) per 'pre-referral' Advice and Guidance request
    • consistently optimise referrals using Advice and Guidance and effective triage to increase the proportion of patients being treated in the most appropriate care setting
    • establish processes to better understand categorisation of Advice and Guidance requests:
    - categorise requests into:
    1) referral and/or advice – the requesting clinician believes a referral is needed but could be diverted;
    2) advice and/or referral – the requesting clinician is unsure if a referral is needed and could lead to a diversion;
    3) advice only – the requesting clinician is seeking advice only with no intention to refer; or
    4) Advice and Guidance ongoing care coordination – the requesting clinician knows a referral is not needed as the patient is already on a referral to

treatment pathway and/or active monitoring
- the proportion of diversions that lead to an avoided RTT clock start
- the proportion of Advice and Guidance requests that are administrative or low value (for example, a request to expedite an outpatient appointment)
• incorporate a range of evidence, data and insights including the above when reviewing commissioning arrangements for Advice and Guidance services. This should be done at least annually and consideration given for multi-year funding

Please select one option between 0-3 to indicate the current level of implementation within your system:
*

- ( ) **0 - Not yet started** - little or no evidence of progress is available or can be provided against the minimum standards
- (•) **1 - Early Progress** - evidence that some of the minimum standards being met or evidence against all indicators, but it is limited in some places (< 50% achievement)
- ( ) **2 - Firm Progress** - evidence that the majority of the minimum standards are being met, with no major omissions (> 50% achievement)
- ( ) **3 - Mature** - all minimum standards are being met, with evidence of how this is leading to improvement (100% in place)

42. Optional - please add any comments or information relating to the above answer:

Working on secondary care payment and modelling of GP funding

43. Advice and Guidance services are **evaluated to inform priorities for commissioning and care optimisation** at the interface between primary and secondary care.

Minimum standards:
• regularly evaluate Advice and Guidance services (for example, annually) using quantitative and qualitative data and insights including feedback gathered from patients and NHS staff
• identify key enablers and barriers in the uptake, sustainability and reducing unwarranted variation
• agree priorities for commissioning and care optimisation at the interface between primary and secondary care

Please select one option between 0-3 to indicate the current level of implementation within your system:
*

- ○ **0 - Not yet started** - little or no evidence of progress is available or can be provided against the minimum standards
- ◉ **1 - Early Progress** - evidence that some of the minimum standards being met or evidence against all indicators, but it is limited in some places (< 50% achievement)
- ○ **2 - Firm Progress** - evidence that the majority of the minimum standards are being met, with no major omissions (> 50% achievement)
- ○ **3 - Mature** - all minimum standards are being met, with evidence of how this is leading to improvement (100% in place)

44. Optional - please add any comments or information relating to the above answer:

Please enter at most 200 characters

45. **Commissioning decisions and service designs** are based upon outcomes from the evaluation of Advice and Guidance.

Minimum standards:
• design specialty pathways and referral guidelines based upon advice and guidance qualitative and quantitative data and insights
• new services are commissioned in response to local patient needs and value for money

Please select one option between 0-3 to indicate the current level of implementation within your system:
*

- ○ **0 - Not yet started** - little or no evidence of progress is available or can be provided against the minimum standards
- ◉ **1 - Early Progress** - evidence that some of the minimum standards being met or evidence against all indicators, but it is limited in some places (< 50% achievement)
- ○ **2 - Firm Progress** - evidence that the majority of the minimum standards are being met, with no major omissions (> 50% achievement)

- ◯ **3 - Mature** - all minimum standards are being met, with evidence of how this is leading to improvement (100% in place)

46. Optional - please add any comments or information relating to the above answer:

    Please enter at most 200 characters

Any other feedback

47. Please leave any final comments or additional information here:

    Enter your answer

NHS
Cheshire and Merseyside

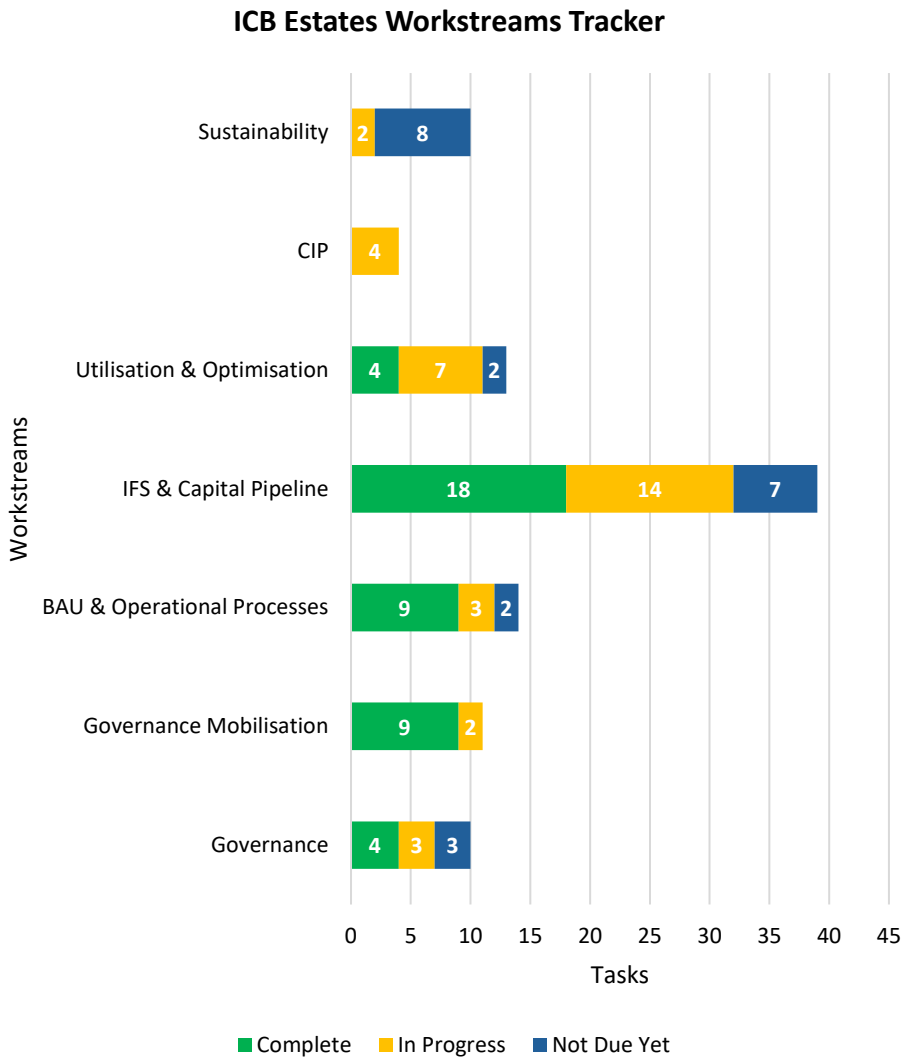
Estates Programme Update– System Primary Care Committee

June 2025

James Burchell

ICB Estates Programme Update

NHS
Cheshire and Merseyside



Workstream	Key Focus
Sustainability	• How to plan estate adaptations for climate resilience and potential to pilot a digital twin model • Reviewing energy spend and emissions to develop league tables. • Considering how to embed sustainability into leases and explore funding opportunities.
CIP	• Designing a system-wide estates cost improvement plan with a focus on HQ buildings and void space. • Linking estate utilisation to financial performance and reviewing FM contracts. • Exploring internal efficiencies and use of Section 106 funding. • Reviewing service charge subsidies across Primary Care
Utilisation & Optimisation	• Developing an asset management plan and identifying disposal opportunities. • Drafting minimum building specifications and addressing data quality issues. • Adoption of S106 policy • Reclassification of Core, Flex and Tail for Primary Care and wider NHS assets
IFS & Capital Pipeline	• Finalising the infrastructure strategy and testing a capital prioritisation tool. • Conducting core/flex/tail assessments and integrating pipelines across all sectors. • Developing long-term investment strategies and a delivery framework.
BAU & Operational Processes	• Creating standard templates and automating grants and leasing processes. • Enhancing asset management practices and improving estate data quality. • Bi-Monthly NHSPS and CHP debt meetings established
Governance Mobilisation	• Establishing SEB, PEGs, and operational groups with agreed terms of reference. • Standardising reporting formats and supporting Place-level group development. • Ensuring strategic alignment and integration with wider system workstreams.
Governance	• Redesigning governance structures • Developing risk escalation mechanisms and improving utilisation reporting. • Preparing KPIs, SOPs, and a refreshed approvals process for consistency • Adopting of Risk Management Strategy at Strategic Estates Board

ICS Infrastructure Strategy – Progress Update

NHS Cheshire and Merseyside

Theme	NHSE Feedback	Progress	Key Next Steps	Timescales
Capital Pipeline	• The capital pipeline outlines a £6.3bn investment needed but there was a £258.4m capital envelope for 2024/25 – will need careful planning and prioritisation • Potential to explore alternative funding sources and partnerships to sustain long-term investment	• All 9 PEGs are responsible for gathering and reporting feedback to ensure accurate updates to the capital pipeline • Each place is in the process of approving their capital pipeline, confirming alignment with proposed plans • Developed a place level prioritisation tool (tested with ICB Central Estates team and with Warrington PEG in May)	• Test system-wide prioritisation tool at June SEB • Agree plan for roll out across places, through PEG governance • Update quarterly	Ongoing
Estates Classification (Core/Flex/ Tail)	• The Core, Flex, and Tail concept has been applied to primary care, but a full estate-wide assessment is needed • Integrate the classification with the ICS Disposal List • Explain how categorisation improves efficiency and strategic resource management	• PEGs are tasked with updating the system-wide estates baseline for an accurate reflection of assets • PEGs are tasked with reporting planned or potential acquisitions and disposals ahead of Core, Flex, and Tail workshops • Expanded the Core, Flex, and Tail methodology to include all areas of the system • Obtained any existing classifications from Trusts, NHS PS etc • Carried out a gap analysis and full assessment of remaining estate using agreed desktop methodology to classify sites • Held x3 engagement sessions to confirm or challenge classifications throughout May	• Provide feedback and agree next steps at June SEB	End May 2025
Disposals	• A disposals pipeline document is needed as part of the strategy to align with the CFT categorisation of estates • This should identify potential revenue opportunities from disposals to support future strategic reinvestment plans	• This is sequential to the work around core, flex and tail • Drafted a potential disposals list which includes the tail assets as identified above	• Finalise the disposals list through PEG governance • Identify potential revenue from disposals • Update quarterly	End May 2025
Delivery Plan	• The delivery plan needs to include SMART (Specific, Measurable, Actionable, Realistic, Timely) objectives and should encompass key priorities, a unified programme and change management approach, and regular progress monitoring.	• The delivery plan is a key part of the system roadmap, structured around five essential pillars – by embedding the five pillars, the plan aims to drive progress, enhance system-wide collaboration, and ensure effective implementation of key initiatives.	• Once the capital pipeline, Core/Flex/Tail assessment, and disposals plan are finalised, create a SMART objectives framework to be approved by each place	End June 2025

Capital Pipeline Prioritisation

NHS
Cheshire and Merseyside

- Requirement from ICS Infrastructure Strategy
- Capital pipeline prioritisation – proposed system wide criteria launched at Strategic Estates Board in April
- Testing a Warrington Place Estates Group for principles and structure
- Testing of criteria toolkit undertaken with existing Primary Care new builds identified
- Pro-forma for toolkit launched at Strategic Estates Board in June Place Estates Groups asked to feedback and test through up coming meetings

Next Steps

Place Estates Group (PEGs) workshop (or time used at existing PEG meeting) to:

- Collaboratively appraise the pipeline of projects
- Identify gaps in project information
- Identify initial draft list of 'high', 'medium' and 'low' priority projects

Place	Next PEG meeting
Cheshire East	11th June
Cheshire West	9th July
Wirral	3rd July
Liverpool	5th June
Knowsley	July – Date tbc
Sefton	7th July
St Helens	tbc
Halton	tbc
Warrington	15th July

Core, Flex and Tail Classification and Estates Programme Update

NHS
Cheshire and Merseyside

NHSE/DSHE Definitions:

- **Core:** Good quality, fit-for purpose and future proof estate that aligns with the ITP and the ICS's clinical strategy.
- **Flex:** Estate that is of an acceptable quality, or provides unique access to services, but does not fully enable the ambitions of the LTP
- **Tail:** Poor quality estate that is not fit-for purpose or for patient-facing services and should be phased out when alternative estate is available.

Cheshire & Merseyside ICB Proposed Definitions:

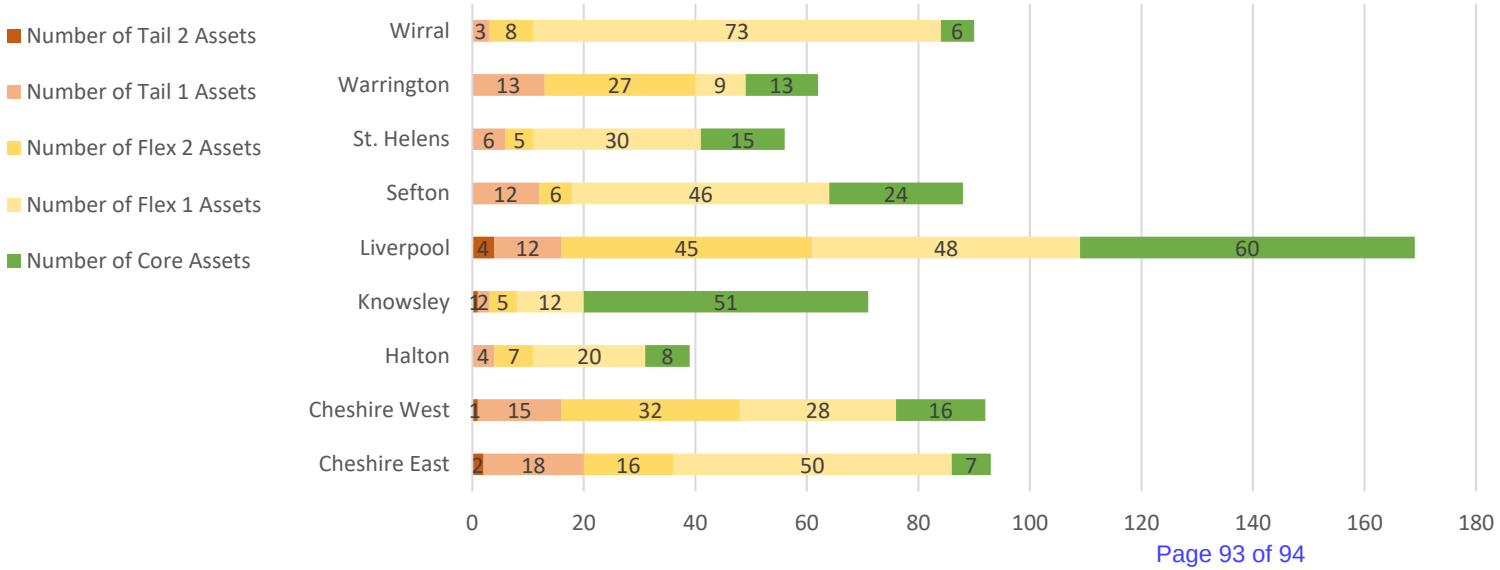
- **Core:**
  - Good quality, fit for purpose and future-proofed
  - Aim to eliminate voids and maximise use, including for other health care/local authority services.
  - Investment would i) support more patients, including mixed delivery model (telephone/digital pods/etc), ii) support PCNs, iii) support integration of services iv) deliver on Net Zero Carbon delivery targets
- **Flex 1**
  - Investment would enable the site to become 'core'
  - Investment would i) support more patients, including in mixed delivery model (telephone/ digital pods/ etc), ii) support PCNs, iii) supports integration of services- likely to be more limited than core and iv) deliver on Net Zero Carbon delivery targets
- **Flex 2**
  - Investment would not enable the site to become 'core'
  - Limited investment in short/medium term i.e. maximising space from exiting patient records, where is no alternate estate options
  - Could consider disinvestment if sufficient capacity in the area
- **Tail 1**
  - Patient facing site - poor quality and not fit for services
  - Significant and major investment required to raise to 'Flex'
  - Only invest in core IT (wi-fi) and compliance works for patient safety
  - Look to disinvest and relocate services to 'Core or 'Flex 1' facilities
- **Tail 2**
  - Non patient facing site - poor quality and not fit for purpose
  - Significant and major investment required to raise to 'Flex '
  - Only invest in core IT (wi-fi) and compliance works for staff safety
  - Look to disinvest and relocate services to 'Core or 'Flex 1' facilities

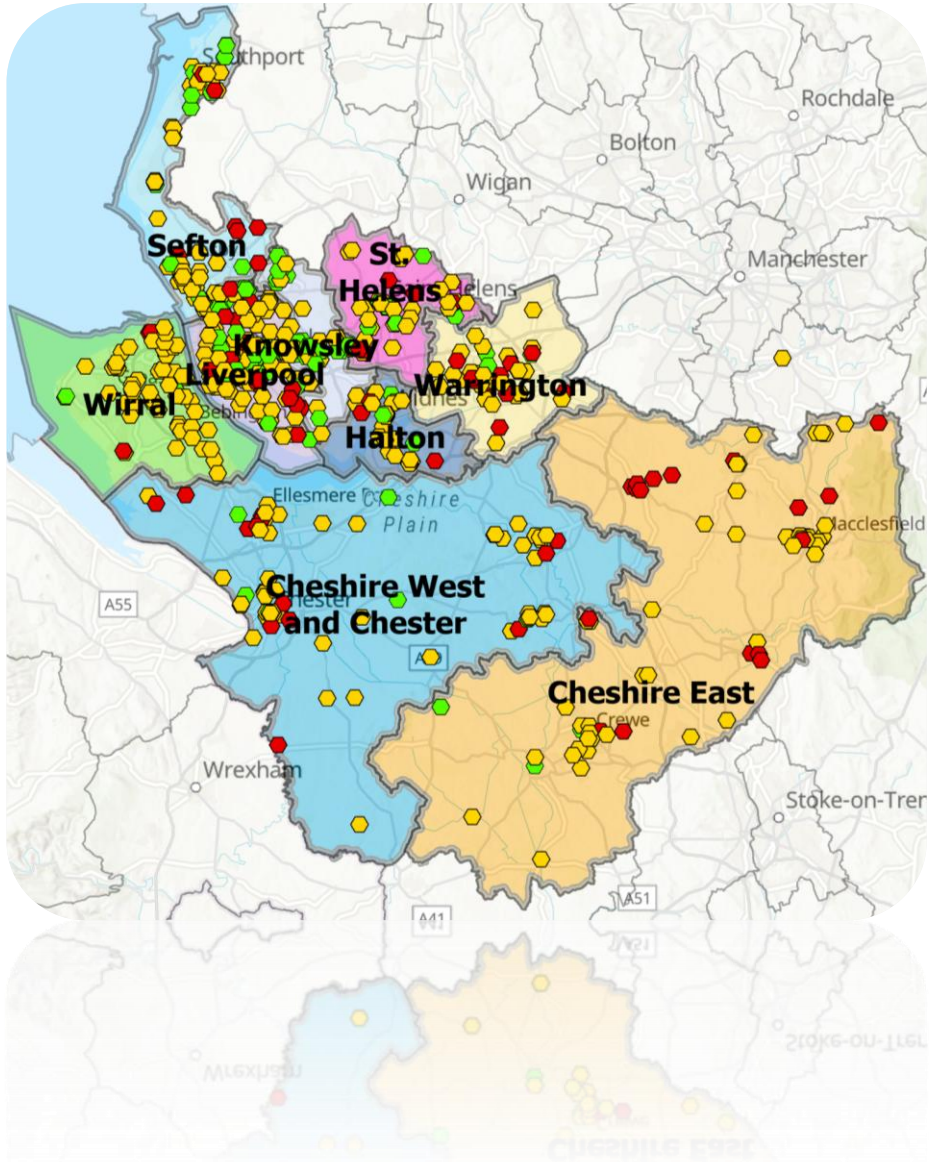
Core, Flex and Tail Classification and Estates Programme Update

NHS Cheshire and Merseyside

Places	Number of Tail Assets	Number of Flex Assets	Number of Core Assets	Total
Cheshire East	20	66	7	**93**
Cheshire West	16	60	16	**92**
Halton	4	27	8	**39**
Knowsley	3	17	51	**71**
Liverpool	16	93	60	**169**
Sefton	12	52	24	**88**
St. Helens	6	35	15	**56**
Warrington	13	36	13	**62**
Wirral	3	81	6	**90**
Total	**93**	**467**	**200**	**760**

Places	Number of Tail 2 Assets	Number of Tail 1 Assets	Number of Flex 2 Assets	Number of Flex 1 Assets
Cheshire East	2	18	16	50
Cheshire West	1	15	32	28
Halton	0	4	7	20
Knowsley	1	2	5	12
Liverpool	4	12	45	48
Sefton	0	12	6	46
St. Helens	0	6	5	30
Warrington	0	13	27	9
Wirral	0	3	8	73
Total	**8**	**85**	**151**	**316**





Example – not finalised position

Core, Flex and Tail Classification and Estates Programme Update

NHS Cheshire and Merseyside

Next Steps

- Task and finish groups / 121s for closing out any categorisations that were challenged at the workshops
- Seek endorsement of categorisations with place via PEGs (standing agenda item)
- Provide progress update to NHSE in June 2025
- Develop a potential disposals list/plan aligned with tail estate including potential revenue/savings
- Agree frequency of refreshes of categorisations and disposals lists
- Creation of forward tracker for regular updating of Classifications via PEGs

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