NHS
Cheshire and Merseyside

Meeting of the Cheshire & Merseyside ICB System Primary Care Committee

Part B – Meeting held in Public

Thursday 18 December 2025
Venue: Meeting Room 1, No 1 Lakeside,
920 Centre Park Square, Warrington,
WA1 1QY (WA1 1QA for SatNav)

Timing: 10:15-12:30

Agenda (V2)

Chair: Tony Foy

AGENDA NO & TIME	ITEM	LEAD	ACTION / PURPOSE	PAGE No
10:15am	**Preliminary Business**			
SPCC 25/12/B01	**Welcome, Introductions and Apologies**	Chair	Verbal	-
SPCC 25/12/B02	**Declarations of Interest**	Chair	Verbal	-
SPCC 25/12/B03	**Questions from the public (TBC)**	Chair	Verbal	-
10:20am	**Committee Management**			
SPCC 25/12/B04	**Draft Minutes of the last meeting (Part B) –** 16 October 2025	Chair	Paper To approve	Page 3 *Click here for link to page*
SPCC 25/12/B05	**Action Log of last meeting (Part B)** 16 October 2025	Chair	Paper To note	Page 9 *Click here for link to page*
SPCC 25/12/B06	**Forward Planner**	Chris Leese	Paper To note	Page 11 *Click here for link to page*
(10:35) **SPCC 25/12/B07**	**Primary Care Risks - Update**	Stephen Hendry	Paper To Note	Page 13 *Click here for link to page*

AGENDA NO & TIME	ITEM	LEAD	ACTION / PURPOSE	PAGE No
10:45am	**Finance Assurance**			
SPCC 25/12/B08	**Finance Update**	John Adams / Lorraine Weekes-Bailey	Paper To Note	Page 22 *Click here for link to page*
(10:55) **SPCC 25/12/B09**	**Prescribing Position – risk and mitigations**	Chris Haigh	Paper To Note	Page 34 *Click here for link to page*
11:05am	**Policy and Commissioning**			
SPCC 25/12/B10	**Policy and Commissioning Update: Dental, Community Pharmacy, Optemetry and General Practice**	Chris Leese / Tom Knight	Paper To note	Page 41 *Click here for link to page*
(11:15) **SPCC 25/12/B11**	**Advice and Guidance Update**	Jonathan Griffiths	Paper For update / Decision	Page 51 *Click here for link to page*
(11:30) **SPCC 25/12/B12**	**National Community Pharmacy Independent Prescribing (CPIP) Pathfinder Programme**	Pam Soo	Paper For update / Note	Page 69 *Click here for link to page*
11:40am	**Key Strategic Delivery Areas**			
SPCC 25/12/B13	**Access to General Practice – Patient Experience update**	Louise Barry	Presentation	Tabled
(11:55) **SPCC 25/12/B14**	**Access to General Practice / June 2025 Plan update**	Chris Leese	Paper For Info	Page 106 *Click here for link to page*
(12:10) **SPCC 25/12/B15**	**Neighbourhood Health**	Clare Watson	Verbal	-
12:20pm	**Quality**			
SPCC 25/12/B16	**Primary Care Quality Update**	Chris Leese/ Jonathan Griffiths/ Tom Knight	Paper To note	Page 122 *Click here for link to page*
12:30pm	**CLOSE OF MEETING**			

Date and time of next regular meeting:
Thursday 19 February 2026 (09:00-12:30)

F2F, Lakeside, Warrington, room tba

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

Thursday 16 October 2025
08:30-10:15
Teams Only

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
Jonathan Griffiths	JGr	Associate Medical Director, C&M ICB
Mark Woodger	MWo	LDC representative
Naomi Rankin	NRa	Primary Care Member for C&M ICB
Chris Leese	CLe	Associate Director of Primary Care, C&M ICB
Anthony Leo	Ale	Place Director, Halton
Rowan Pritchard-Jones	RPJ	Executive Medical Director, C&M ICB
Adam Irvine	AIr	Primary Care Partner Member
Daniel Harle	DHa	LMC representative
Tom Knight	TKo	Head of Primary Care, C&M ICB
Matt Harvey	MHa	LPC representative
Christine Douglas	CDo	Director of Nursing & Care, C&M ICB
In attendance		
Sally Thorpe	STh	*Minute taker*, Executive Assistant, C&M ICB
Loraine Weekes-Bailey	LWB	Senior Primary Care Accountant
John Adams	JAd	Head of Primary Care Finance, C&M ICB
Kevin Highfield	KHi	Head of Digital Operations, C&M ICB
Cathy Fox	CFo	Associate Director of Digital Operations, C&M ICB
Chris Haigh	CHa	Deputy Chief Pharmacist, C&M ICB
James Burchell	JBu	Strategic Estates Manager (Cheshire East, Cheshire West & Wirral Places), C&M ICB

Apologies		
Name	**Initials**	**Role**
Tony Foy	TFo	*Vice-Chair*, Non-Executive Director, C&M ICB
Susanne Lynch	SLy	Chief Pharmacist, C&M ICB

Agenda Item, Discussion, Outcomes and Action Points

Preliminary Business

SPCC 25/10/B01 Welcome, Introductions and Apologies

The Chair opened the meeting and welcomed everyone, confirmed attendance and apologies were noted as received.

SPCC 25/10/B02 Declarations of Interest

Standing DoI were noted and there were no new declarations pertinent to the meeting.

SPCC 25/10/B03 Questions from the public (TBC)

There were no questions raised.

Committee Management

SPCC 25/10/B04 DRAFT Minutes of the last meeting (Part B) 14 August 2025

Minutes from the previous meeting (14 August) were reviewed and approved with no amendments.

The Minutes were **approved** as a true and accurate record of the meeting.

SPCC 25/10/B05 Committee Action Log (Part B) 14 August 2025

Action log: Two outstanding actions discussed.

- Prescribing action was marked as completed.
- Healthwatch/GP access comms action : CWa proposed integrating this with winter comms to avoid multiple campaigns; will coordinate with colleagues as appropriate.

The Action Log was updated accordingly.

SPCC 25/10/B06 Forward Planner

The forward planner was reviewed. The Chair encouraged members to suggest additional items, noting the planner is dynamic and subject to frequent change.

The Forward Planner was **noted** for information.

Contractor Forums Updates

SPCC 25/10/B07 Issues for awareness/ updates

JGr highlighted a significant emerging risk: contract variation for general practice, specifically the requirement for online consultations to be available 08:00–18:30 without capping routine requests. Noted that the position from NHSE and the DoH is that patients should be able to contact the practice between these hours, but up to now practices have capped the number of appointments for capacity, now they are unable to do this.

- Risks include: patient safety (urgent requests may be missed), increased workload, system limitations, and impact on ICB capacity (e.g., rapid audits of 330 practice websites).
- NHS England and Department of Health expect practices to offer access via surgery, phone, or online consultation during these hours.
- ICB is required to monitor compliance and potential contract breaches, with a preference for supportive intervention before escalation.
- GPC is in formal dispute with government over contract changes.

DHa added that there are risks of increased waiting lists, safety concerns with digital systems, financial sustainability (need to pay staff for extended hours), and broader pressures from IT cuts, service charge changes, and funding shortfalls.

It was questioned whether there should be a process for escalation and that it needs to be fair to everyone, it was questioned whether there was a process of support to drive consistency, in response it was outlined that it would be for the place teams to fully support this.

Escalation processes were discussed and it was confirmed that national guidance applies and is supportive, consistent approaches are preferred. It was suggested to review standardisation across Cheshire and Merseyside.

Contractor Group Updates

Dentistry: discussed urgent care contract changes, including proposals for reserved urgent care slots at £10/hour, which is financially unsustainable. Risks include mass contract breaches or hand-backs. Contingency planning underway, including financial modelling for 2026/27.

Optometry: reported ongoing uncertainty about CPD payments and pre-registration supervisor funding, causing unrest. Single point of access for optometry referrals to be relaunched, expected to impact GP referrals. It was noted that there was an outstanding action to follow up from a previous SPCC meeting around the placements for independent prescribing students and the request for support from the trusts and cost considerations. **Look back on minutes and pick this up for the Action Log.**
(post meeting note, action picked back up and added to the Action Log – item number SPCC 25/02/B08 – marked as 'ongoing')

Pharmacy: described October pressures (flu/COVID vaccines), staff abuse due to eligibility confusion and wasted time. National contract changes include Pharmacy First service criteria updates and a new national emergency contraception service. Liverpool pharmacy piloting contraceptive implants. Matt raised concerns about lack of pharmacy involvement in Neighbourhood Health models and called for more integrated primary care representation.

It was outlined that for clarity there were not bids for funding, it was around pioneer sites (Sefton and St Helens) and not just General Practice.

Contracting, Commissioning and Policy Update(s)

SPCC 25/10/B08 Contracting, Commissioning and Policy Update

Updates were presented and included:

- Monthly reporting templates for all four contractor groups now required by NHS England; additional indicators for dental and medical.
- Audit report on self-assessment was green.
- Medical and optometry contract changes have led to multiple rapid assurance returns.
- Optometry: Special education setting project ongoing, with resource pressures.
- Dental: Team reduced due to sickness, now recovering. Year-end financial management letter issued to contractors. Recent contract variation issued per NHSE policy book, with LDC support. Oliver McGowan training implementation for primary care flagged as a challenge.
- Pharmacy: Operational group update to be provided at next meeting. COVID vaccine confusion and contract changes noted.

Concerns were raised about the national urgent care dental target (700,000 appointments), stating the allocation is arbitrary and not reflective of local need. Suggested repurposing capacity for medical need referrals.

SPCC 25/10/B09 Governance Changes

CWa outlined the governance review following Mersey Internal Audit recommendations:

- Reduction in committees reporting to board.
- Move from nine place primary care committees to a devolution/strategic authority footprint.
- Changes to primary care groups and decision-making framework.
- No change to this meeting, but changes to underlying architecture and reporting.

- Drafts to be shared for comment; feedback to be provided in December. Estates, digital, and finance colleagues to be engaged. Noting there will be changes underneath in terms of the architecture and the reporting underneath this meeting. Hoping to take something back to Board in November, so will share some drafts with the group for comment.

ACTION : to share drafts with SPCC for comment and feedback at the December meeting

Key Strategic Delivery Areas

SPCC 25/10/B10 Neighbourhood Health

CWa described the Neighbourhood Health framework, approved at July board, and its alignment with national planning guidance and ICB priorities (10-year plan, shift left).

- Emphasis on integrated services, prevention, and local tailoring.
- Reference group membership to be reviewed for wider representation.
- Place directors to be asked to engage with wider primary care and local representative committees.
  Naomi Rankin and Adam Irvine stressed the need for local tailoring, engagement of all primary care contractors, and funding for participation. Mark Woodger noted challenges for dentistry (activity-based funding, estate ownership, co-location difficulties). Adam noted that it would be useful for members to listen back to the Board agenda item on this aspect, adding that this was such a complex area and that the PCN boundaries do not always make a lot of sense.

- The need for systematic engagement and capacity/resilience across the system was highlighted.
- Update to be brought to December or February meeting.

ACTION : Admin to share the July Board Neighbourhood Health papers with the Committee members following Alr's recommendation
ACTION : to ask Place and the SPOC about appropriate engagement with this committee on Neighbourhood Health.

SPCC 25/08/B11 Improving Access to Dentistry

TKn presented detailed data:

- Urgent care and urgent care plus schemes: patient numbers, DNA rates, practice sign-ups.
- Quality and access scheme: focus on vulnerable groups, new patient registrations, links to family hubs.
- Rapid evaluation of Liverpool proof-of-concept pilot; full year-end review planned.
- NHS operational plan: UDA delivery at 73%, 33rd nationally, with monthly fluctuations. Unique patient numbers rising, but UDA metric misaligned with population health outcomes.
- National urgent care dental scheme: 11,000 under target, trajectories reset to higher levels, all regions underperforming. Second incentive scheme launched, but uptake low due to poor financial attractiveness.
- Delivery issues: disincentivisation for complex patients, short-term focus on numbers, demotivation for providers.
- Commissioning considerations: contract reform for 2026/27, strategic intentions and planning cycle, need for flexible commissioning and alignment with Neighbourhood Health.

It was reiterated around contract metrics being outdated and counterintuitive to prevention and population health.

Finance

SPCC 25/08/B12 Finance Update

LWB and JAd reported:

- Delegated budgets: half-million underspend due to Cheshire West development delay; property services invoices show underspends.

- Prescribing: £10.8m year-to-date overspend, forecast £14.7m. Key drivers: Tirzepetide, Lidocaine patches, diabetes drugs. Remedial plan in place, including clinical leadership, protocols, and system-wide engagement.
- Data shows growth below national trend, but financial pressures remain.
- Dental delegated budget: ring-fenced allocation, guidance now suggests underspend cannot be repurposed. Awaiting official confirmation; exec team to decide on spend once clarified.
- Capital: Utilisation Modernisation Fund (£5m) fully allocated, additional funds received. GPIT (£4.6m) projects to commence. BAU allocation (£1.3m) available for estates/digital, pending IFRS 16 lease cost confirmation. Estates and digital teams to prepare proposals for December meeting; expedited process if required.
- Naomi Rankin requested clear communication to practices about digital funding and decommissioning decisions, especially regarding standardisation vs. levelling down.
- Jonathan Griffiths cautioned against piecemeal defunding, advocating for holistic resource review.
- James Burchell noted challenges in spending capital within tight timeframes due to NHS England approval processes.
- John Adams added that on delegated dental the allocation was ringfenced, and that the ICBs will not be able to keep any underspend, but this needs to be clarified with the national finance leads and would then go to the ICB Exec Committee when we know more.

ACTION : request for a detailed financial and contractor input paper between Estates and Digital to come to the Public meeting of SPCC in December (unless anything changes or there are any concerns to do quicker).

Noted that there needs to be really clear and robust comms out to Practices, exactly what is being defunded and why, the term 'levelling down' is used too often rather than saying a 'standardised approach'.

In terms of IT kit and infrastructure it was noted that there may be different criteria, and that it would be helpful to understand this criteria and why it is applied. **ACTION for the next meeting** please.

It was questioned as to how quickly could estates and digital work on the additional availability of £1.2m and whether we are sure it will be available. **ACTION : CWa and EMo to look at this for expediency and possible ExO meeting.**

Quality

SPCC 25/08/B13 Quality update

Clinical Waste Procurement

- The procurement process for clinical waste contracts (covering general practice and community pharmacy) is delayed, with no SRO assigned and insufficient project traction.
- There is a risk that the project will not meet its timeline, potentially resulting in lost cost savings and a possible 25% cost increase if not resolved by April.
- Contingency plans are being considered, but escalation to the executive team was requested to assign an SRO and ensure delivery.
- The quality group, including Chris Leese and Rowan Pritchard Jones, emphasized the clinical and contractual risks of service interruption and the need for executive oversight.

ACTION : Clare Watson agreed to escalate this to execs for SRO assignment.

Occupational Health Service Transfer

- Occupational health services for primary care (medical and dental) are currently managed by NHS England and need to transfer to the ICB.
- Further work is needed to clarify the scope and ensure the necessary finances are transferred to support the service.

- The quality group stressed the importance of oversight and a safe transition, with Chris Leese noting the need for accountability and the group's role in raising awareness

Complaints and Compliments

- There has been a 24% increase in complaints compared to previous quarters, though the themes remain consistent.
- The rest of the quality report contained routine updates and no significant new risks.
- LBa requested a breakdown of complaints by Place

Assurance and Actions

- The quality group's role is to ensure that these issues are escalated and assigned appropriate oversight within the ICB.
- Actions include escalating both the clinical waste procurement and occupational health service transfer to the executive team for SRO assignment and oversight, and providing further detail on complaints as requested

AOB

CWa noted that this was EMo's last meeting as Chair of the Committee noting that she was standing down from the ICB at the end of November. Thanks were given and that she had worked really hard for the Committee and with everyone in the Primary Care Team – thank you!

CLOSE OF MEETING

Date of Next Meeting: Thursday 18 December 2025 (09:00-12:30)
Lakeside, Warrington

CHESHIRE MERSEYSIDE
INTEGRATED CARE BOARD

Action Log 2025/26 *updated post Oct 2025 meeting*

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 25/02/B08		Contractor Operations Updates	Optometry : qualification of FP10 starting in Jan 2026, placement requirement within a Trust - requesting support from the Trusts and the ICB for their commitment to this programme - has been agreed in principle but ideally would like a formal agreement	Clare Watson & Rowan Pritchard Jones & Fionnuala Scott	ASAP	*suggestion for RPJ to write out to Trust MDs asking for commitment to support*	ONGOING
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	December 2025		ONGOING
SPCC 25/06/B12	19-Jun-25	Advice and Guidance	Pilot in place, for a period of 6 months to allow for review, to come back to SPCC with a report and update (sooner than 6 months if necessary)	Jonathan Griffiths	December 2025		NEW
SPCC 25/10/B10	16 Oct 2025	Governance changes	To share the July Board NH papers with the SPCC members for comment and feedback in December	Committee Admin	December 2025	*Governance items now on pause following announcements re organisational restructure*	ONGOING
SPCC 25/10/B10	16 Oct 2025	Neighbourhood Health	To ask Place and the SPOC about appropriate engagement with this SPCC Committee on NH	TBC	December 2025		ONGOING
SPCC 25/10/B12	16 Oct 2025	Finance Update	Request for a detailed financial and contractor input paper between Estates and Digital to come to the Public meeting of SPCC in December *(unless anything changes or there are any concerns to do quicker)*	Estates & Digital	December 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 25/10/B12	16 Oct 2025	Finance Update	Understanding of criteria and its application towards IT kit and infrastructure	Estates & Digital	December 2025		ONGOING
SPCC 25/10/B12	16 Oct 2025	Finance Update	question as to how quickly Estates and Digital can work on the £1.2m and whether we are sure it will be available.	Clare Watson & Erica Morriss	December 2025		ONGOING
SPCC 25/10/B12	16 Oct 2025	Qualty Update	to escalate to Execs for SRO assignment (clinical waste contracts, covering general practice and community pharmacy)	Clare Watson	ASAP		ONGOING

Forward Planner 2025/26 : System Primary Care Committee Updated 11/11/2025

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	Yes	Yes	Yes
Declarations of Interest	EM	Every meeting	Both	Yes	Yes	Yes	Yes	Yes	Yes
Minutes of last meeting	EM	Every meeting	Both	Yes	Yes	Yes	Yes	Yes	Yes
Action Log & Decision Log	EM	Every meeting	B	Yes	Yes	Yes	Yes	Yes	Yes
Questions from the public (where received)	EM	Every meeting	B	Yes	Yes	Yes	Yes	Yes	Yes
Forward Planner (pre meeting)	CL	Every meeting	B	Yes	Yes	Yes	Yes	Yes	Yes
Governance & Performance of Committee									
Review of Terms of Reference	EM / MC	Yearly	n/a	Yes	No	No	No	No	No
Self-Assessment of Committee Effectiveness	EM	Yearly	n/a	No	No	No	No	No	No
Forward Planner Annual Plan Review	EM / CL	Yearly		No	Yes	No	No	No	No
Key Business Items									
Minutes of any ExtraOrd SPCC Meetings	EM/CL	If held	A	No	No	Yes	Yes	Yes	Yes
Committee Risk Register for 4 contractor groups	SH	Every Other Meeting usually	B	Yes	No	Yes	No	Yes	Yes
Finance Update including Capital position	LWB	Every Meeting	A	Yes	Yes	Yes	Yes	Yes	Yes
PSRC Minutes/Update Minutes/Update from Pharmacy Operations Group and highlights	TK	Every Meeting	A	Yes	Yes	Yes	Yes	Yes	Yes
Prescribing position and risk	SL/CH	Every Meeting					Yes	Yes	Yes
Patient Experience									
Deep Dive (s)				Yes - HW Survey (initial)	No	Yes - HW survey (Final) and GPPS	Dental	General Practice via Healthwatch	tbc
Assurance of progress of Primary Care Strategic Plans									
Estates Update	Estates	Alt	B	No	Yes	No	Yes	No	Yes
Digital Strategy	JL	Alt	B	Yes	No	Yes	No	Yes	No
Workforce Strategy	JG	Alt	B	Yes	No	No	No	No	tbc
FTSU support across Primary Care	CD/TR	TBC	B	Yes	No	No	No	No	tbc
Priority Commissioning Area - Improving Access (Primary Medical)	CL	Alt	B	Yes	Yes - june plan	Yes	No	Yes	No
Priority Commissioing Area - Improving Access (Dental)	TK	Alt	B	Yes	No	No	Yes	No	Yes
Priority Commissioning Area - Neighbourhood Health/Primary Care	CWA	Every meeting TBC	B	No	Yes	Yes	Yes	Yes	Yes
Commissioning , Quality and Performance									
Policy BAU Update – Primary Care Contracting and Commissioning (All 4 contractor groups)	CL/TK	Every Meeting	B	Yes	Yes	Yes	Yes	Yes	tbc
Performance Issues (escalated from Place)	TBC	As required	A	No	Yes	No	Yes	no	tbc
Quality - Report from PCQ plus any key performance metrics	LE/TK/CL	Every Meeting	B	Yes	Yes	Yes	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	Yes	Yes	tbc
Improvement Grant Estates Bids	JA	As required	B	Yes	No	No	No	No	tbc
Primary Care Business cases / approvals required from Place	TBC	As required	A/B	Yes	Yes	Yes	Yes x 1	No	tbc
Ad Hoc Items for tracking/follow up									
Connecting care	LK		B	Yes	No	No	No	No	tbc
Beyond/Oral health	IA		B	No	Yes	No	No	No	tbc
ADHD update	LM		A	No	No	Yes	No	tbc	tbc
Advice and Guidance -Update	JG		B					Yes	As part of BAU update
Digital - BP discussion	CF/JL		B					Yes	tbc
Protected Learning Time	CL/JG		B					No	Yes/tbc

Governance Arrangements - Primary Care inc revised decision making matrix	CWA/CL		B					No	Yes/tbc
Enhanced Services Review (sep paper)	JG/CL/LWB		B						Yes
Dental Paper – Operational/Contract Part Year performance note	TK		A	No	No	No	Yes	No	Yes

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

Date: 18th December 2025

Committee Risk Report

Agenda Item No: SPCC 25/12/B07

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

Committee Risk Report

1. Purpose of the Report

1.1 The ICB Risk Management Strategy sets out committee and sub-committee responsibilities for risk and assurance. The purpose of this report is to detail those principal (BAF) risks which fall within the remit of this committee and relevant corporate and place risks escalated to the committee during the relevant reporting cycle.

2. Executive Summary

2.1 At the August 2025 meeting, the Committee agreed to the inclusion of 15 new primary care related risks on its risk register. These risks were applied across all four contractor groups and included key strategic themes of improving access, national and regional financial constraints, workforce capacity and estates planning;

- **GP primary care** – 8 risks including access & demand, financial constraints at national and local level, workforce, estates and neighbourhood development
- **Dental services** – 3 risks including access & demand and financial constraints at both national and local level
- **Community pharmacy** – 3 risks including access & demand and financial constraints at a national and local level
- **Ophthalmology** – 1 risk relating to workforce

One principal risk from the ICB's 2024/25 Board Assurance framework (P6) was delegated to committee level for management and oversight, although the Committee determined that the risk would essentially duplicate the new 'access and demand' themed risk which was more aligned with the ICB's current organisational context, objectives and the NHS 'Ten Year Plan'. The Committee therefore recommended that risk P6 be stood down given that the newer risk was more reflective of the current context and environment that the ICB was operating in.

2.2 Following the August 2025 Committee meeting, work began to develop more detailed risk summaries with the nominated risk leads. In parallel to this process, engagement with place primary care leads / business support colleagues took place during September and October 2025 to identify any similar 'themed' risks at place level which could be either aligned with (or superseded by) the new suite of risks approved by the Committee. At the time of writing, this work is still ongoing and is also intrinsically linked to the wider effort at corporate level to review the ICB's risk profile following the approval of the 2025-2028 Board Assurance Framework and the response to the NHSE 'Enforcement Undertakings' letter issued to the ICB's board in November 2025.

Discussions continue with colleagues in other directorates to support the assessment of the new risks relating to national and local financial challenges

and estates planning, and it is expected that these risk summaries will be completed by January 2026. A schedule of updates for 2026/27 will also be agreed with risk leads in line with the reporting schedule of the Committee.

2.5 A desktop review of risks at place level has confirmed a total of 19 risks currently active across all nine places. Except for some place-specific risks, most risks currently reported at place level can be linked thematically to the new risks approved by the Committee in August 2025;

Risk Theme	Total (across places)
Access & Demand (GP primary care)	**4**
GP workforce resilience	**3**
Estates sustainability / planning (General Practice)	**2**
Collective Action (GPs)	**2**
Sub-optimal practice engagement	**2**
Contract risk (single handed practice	**2**

Only three risks reported by place are scored at 15+, as summarised in the table below:

Risk	Score	Place
Increased demand, funding and workforce pressures preventing delivery of high quality Primary Care Services resulting in poor care and potential provider failure	16	St Helens
ADHD (Adults) waiting times	20	Wirral
Impact of increased employer national insurance costs on independent contractors	20	Wirral

Engagement will continue with place primary care leads and business support colleagues to ensure a more streamlined, coordinated and consistent approach to the reporting and management of risks relating to primary care for 2026/27.

3. Ask of the Committee and Recommendations

3.1 **The Committee is asked to:**

3.1.1 **NOTE** the contents of report in regard to progress and proposed actions / arrangements for the continued reporting of risks and assurance to the Committee.

4. Reasons for Recommendations

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

- providing assurance on key controls where this is identified as a requirement within the Board Assurance Framework

- ensuring that risks associated with their areas of responsibility are identified, reflected in the relevant corporate and / or place risk registers, and effectively managed

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

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

4.4 A review of the primary care risks, oversight and reporting arrangements was agreed following discussion at the August 2025 meeting of the Primary Care Committee. The Committee Chair and Lead Officers agreed on key strategic objectives and risk themes applicable across the 4 contractor groups.

5. Background

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

5.2 Risk are escalated to the committee risk register which are scored as 15 or above. Committees will receive an overview of all relevant risks on first identification and annually, including those not meeting the threshold for escalation, to enable oversight of the full risk profile.

5.3 This committee risk report sets out proposals following a review of the primary care risks and includes a proposed Committee Risk Register at appendix one reflecting the outcome of this work.

Implications and Comments

6. Link to delivering on the ICB Strategic Objectives and the national ICB Core Purposes / Priorities

- **Improve population health outcomes**
- **Tackle health inequalities**
- **Enhancing Productivity and Value for Money**

- **Helping to support broader social and economic development within the local area**

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

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

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

8. Link to meeting CQC ICS Themes and Quality Statements

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

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

9. Risk Overview

9.1 The primary care related risks have been reviewed within the context of the key strategic objectives of the ICB and risk themes agreed by the Committee Chair and Lead Officers. The risks have been applied to each of the 4 contractor groups as appropriate based on the ICB's responsibilities in relation to each group and the current operating environment.

9.2 All risks have been reviewed in the period with no reportable changes to current risk scores. There are five risks with a current score of 15+ (but none currently scored at 20+).

Risk ID	Risk Description	Current Score
PG6	Reduction in capital development funding for estates may curtail or delay GP primary care access improvement plans, impacting on quality and trust and confidence in the ICB	15
PG7b	ICB financial constraints / pressures may limit funding available to deliver strategic aims for GP primary care impacting on quality and trust and confidence in the ICB	16
PG8	GP primary care estates capacity constraints may curtail or delay access improvement plans, impacting on quality and trust and confidence in the ICB	15

Risk ID	Risk Desription	Current Score
PD5b	ICB financial constraints may limit funding available to deliver strategic aims for dental services, impacting upon quality and trust and confidence in the ICB	16
PP5b	ICB financial constraints / pressures may limit funding available to deliver strategic aims for GP primary care impacting on quality and trust and confidence in the ICB	16

A summary table of all risks attached to the Committee (and their application to each contractor group) can be found in Appendix 1 of this report.

9.3 Further work is required in relation to developing an Optometry risk and engagement will continue with colleagues in this contractor group to establish risks, threats and issues to this important element of primary care services.

9.4 Responsibility for dental services, community pharmacy and ophthalmology continue to align with the corporate Primary Care Team. Responsibilities for GP primary care are split between corporate and place teams.

9.5 Given the rapidly changing internal and external environment in which the ICB operates, it is essential that a more consistent approach to describing and managing risks (including 'risks in common') across places is achieved. At the time of writing, it is still expected that for the short-term, ownership of such risks and mitigating actions will be divided between the corporate and place teams based on the nature of the risk and respective responsibilities.

9.6 The Committee will continue to be supported in its oversight and assurance role by the sub-groups reporting to the Committee (e.g. Primary Care Workforce Group, Primary Care Estates Group). The ICB's *current* Risk Management Strategy and process require that the Committee retains direct oversight and responsibility for providing assurance to the Board in relation to all BAF and Corporate Risk Register (Extreme+) risks but allows oversight of other risks to be delegated with appropriate reporting arrangements.

9.7 The approved BAF risks for 2025-2028 include a strategic risk relating to the ICB's delivery and implementation of a neighbourhood / community health service. This risk has initially been delegated to the ICB's Executive Committee for oversight and management but may transfer ownership to the System Primary Care Committee in the near future. The Committee will, of course be kept informed of any plans to transfer ownership of risks in which it has an interest in.

10 Finance

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

11 Communication and Engagement

11.1 No patient and public engagement has been undertaken.

12 Equality, Diversity and Inclusion

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

13 Climate Change / Sustainability

13.1 No identified impacts.

14 Next Steps and Responsible Person to take forward

14.1 The nominated operational lead for each risk will be asked to complete a risk assessment using a new format of the ICB's risk summary template. Support will be made available to leads from the Corporate Affairs and Governance team.

14.2 The completed risk assessments (in the new corporate format), together with proposals for a reporting schedule of oversight, assurance and reporting arrangements will be brought to the June meeting of the Committee for approval. Reporting to Committee Sub-Groups will commence following approval, supported by a briefing on Sub-Groups responsibilities at the initial meeting.

15 Officer contact details for more information

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16 Appendices

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

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

Risk ID	Risk Title	Senior Responsible Owner	Inherent Risk Score	Current Risk Score	Previous Risk Score	Target Score	Risk Proximity
All Contractor Groups							
P6	Demand continues to exceed available capacity in primary care, exacerbating health inequalities and equity of access for our population **Stepped down from 2025/26 BAF for management / oversight at Committee level [Subsumed by new risks]**	Clare Watson	**20**	**12**	**12**	**12**	B – within financial year
GP Primary Care							
PG1	Access to general practice services will not meet demand, impacting negatively on patient experience and outcomes and delivery of the access improvement plan.	Chris Leese	**4x4=16**	**12**	**12**	**8**	B – within financial year
PG4	Inability to recruit and retain GP primary care workforce may curtail or delay access improvement plan success, impacting on quality and increasing pressure on remaining staff	Chris Leese	**4x4 = 16**	**12**	**12**	**8**	B – within financial year
PG6	Reduction in capital development funding for estates may curtail or delay GP primary care access improvement plans, impacting on quality and trust and confidence in the ICB	James Burchell	**3x5=15**	**15**	**15**	**10**	B – within financial year
PG7a	National financial constraints / pressures may limit funding available to deliver strategic aims for GP primary care impacting on quality and trust and confidence in the ICB	John Adams	**4x4 = 16**	**12**	**12**	**8**	B – within financial year
PG7b	ICB financial constraints / pressures may limit funding available to deliver strategic aims for GP primary care impacting on quality and trust and confidence in the ICB	John Adams	**5x4=20**	**16**	**16**	**8**	B – within financial year
PG8	GP primary care estates capacity constraints may curtail or delay access improvement plans, impacting on quality and trust and confidence in the ICB	David Cooper/Chris Leese	**3x5=15**	**15**	**15**	**10**	B – within financial year
13DR	There is a risk that the introduction of new core clinical system suppliers through the GP IT Futures Tech Innovation Framework Early Adopter Programme results in a more fragmented infrastructure and has a negative impact on record sharing	John Llewelyn	**4x4 = 16**	**12**	**12**	**4**	A – within Quarter

Dental Services							
PD1	Access to dental services will not meet demand, impacting negatively on patient experience and outcomes	Tom Knight	**4x4 = 16**	**12**	**12**	**8**	B – within financial year
PD2	Inability to recruit and retain dental primary care workforce may curtail or delay access improvement plan success, impacting on quality and increasing pressure on remaining staff	Tom Knight	**4x4=16**	**12**	**12**	**8**	B – within financial year
PD5a	National financial constraints may limit funding available to deliver strategic aims for dental services impacting upon quality and trust and confidence in the ICB	John Adams	**4x4 = 16**	**12**	**12**	**8**	B – within financial year
PD5b	ICB financial constraints may limit funding available to deliver strategic aims for dental services, impacting upon quality and trust and confidence in the ICB	John Adams	**5x4=20**	**16**	**16**	**8**	B – within financial year
Community Pharmacy							
PP1	Access to community pharmacy services will not meet demand, impacting negatively on patient experience and outcomes	Tom Knight	**4x4=16**	**12**	**12**	**8**	B – within financial year
PP5a	National financial constraints may limit funding available to deliver strategic aims for dental services, impacting upon quality and trust and confidence in the ICB	John Adams	**4x4=16**	**12**	**12**	**8**	B – within financial year
PP5b	ICB financial constraints may limit funding available to deliver strategic aims for community pharmacy, impacting on quality and trust and confidence in the ICB	John Adams	**5x4=20**	**16**	**16**	**8**	B – within financial year
Optometry							
Discussion at Operations Group re national funding and related risks							
Neighbourhood Health							
To be discussed further cross ICB - including reporting and assurance							

NHS
Cheshire and Merseyside

Primary Care Finance Update

NHS Cheshire and Merseyside Primary Care Committee (System Level)

Date: 18th December 2025

Date of meeting:	18th December 2025
Agenda Item No:	SPCC 25/12/B08
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:	Andrea McGee, 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 November 2025 (M08).

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.

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 30th November 2025. 2. Note the Additional Roles spend by Place 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 30th November 2025.

1.2. The financial positions for November 2025 (M08) 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 08 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	239,238	238,825	413	359,399	358,861	538
QOF	25,144	25,144	0	37,401	37,401	0
Premises Reimbursements	37,805	37,491	314	56,618	55,209	1,409
Other Premises	496	516	(20)	744	775	(31)
Direct Enhanced Schemes	4,171	4,261	(90)	5,755	5,864	(109)
Primary Care Network	37,544	37,539	4	56,421	56,427	(6)
Additional Roles Reimbursement Scheme	53,850	53,850	0	80,812	80,812	0
Fees	8,246	7,431	815	12,305	11,112	1,193
Other - GP Services	586	525	60	878	830	49
DELEGATED PRIMARY CARE TOTAL	**407,079**	**405,582**	**1,496**	**610,334**	**607,291**	**3,042**
Local Primary Care						
GP Local Enhanced Service Specification	24,836	24,336	499	37,253	36,754	500
Local Enhanced Services	12,626	12,733	(107)	18,880	19,019	(139)
Commissioning Schemes	1,393	1,345	48	2,000	1,926	74
Out Of Hours	20,016	20,197	(180)	30,024	30,296	(272)
GP IT	13,214	13,329	(115)	19,035	19,133	(98)
GP Investment	75	65	11	113	93	20
Primary Care SDF	2,027	2,033	(7)	3,702	3,709	(7)
Primary Care Other	708	785	(77)	2,221	1,579	642
QIPP	0	0	0	0	0	0
PC Local Pay Costs	294	312	(18)	441	482	(42)
Medicines Management - Clinical and Pay Costs	8,377	8,151	225	12,623	12,051	572
LOCAL PRIMARY CARE TOTAL	**83,565**	**83,286**	**280**	**126,292**	**125,042**	**679**
Prescribing						
Central Drugs	12,334	13,356	(1,021)	18,475	19,887	(1,413)
Oxygen	3,649	3,316	333	5,564	5,009	556
Prescribing BSA	344,228	356,273	(12,045)	513,949	527,460	(13,511)
Prescribing Local Schemes	2,768	3,295	(527)	4,153	4,943	(790)
PRESCRIBING TOTAL	**362,980**	**376,240**	**(13,260)**	**542,140**	**557,299**	**(15,158)**
Delegated Pharmacy Optoms Dental and Other						
Delegated Community Dental	8,895	8,603	292	13,343	12,903	440
Delegated Ophthalmic	19,386	19,067	319	29,079	29,043	36
Delegated Pharmacy	64,872	61,726	3,146	96,907	94,395	2,512
Delegated Primary Dental	95,825	90,092	5,734	151,626	145,774	5,852
Delegated Property Costs	545	489	56	818	826	(8)
Delegated Secondary Dental	28,987	27,958	1,029	40,964	40,957	7
PHARMACY, OPTOMS, DENTAL & OTHER TOTAL	**218,511**	**207,934**	**10,577**	**332,737**	**323,898**	**8,839**
TOTAL	**1,072,135**	**1,073,042**	**(908)**	**1,611,503**	**1,613,530**	**(2,599)**

3. Delegated Primary Care - Medical

3.1. The Month 8 financial forecast for Delegated Medical Primary Care indicates a projected underspend of £3.042m, based on current data and payment trends.

3.2. **Core Contracts**- The current underspend of £0.538m within the core contracts budget is primarily attributable to a prior-year benefit. This variance arose because the forecasted costs exceeded the actual expenditure incurred. Additionally, the projected list size growth has been lower than anticipated, contributing to a positive variance.

3.3. **Premises Reimbursements-** The Premises Reimbursement budget is currently reporting an underspend of £1,4m. Of this, £0.330m specifically relates to the delay in moving to the new Great Sutton premises within Cheshire West Place.

3.4. The remaining underspend is attributed to adjustments in Business Rates and NHS Property Services and Community Health Partnership buildings invoices now forecast in line with billing schedules.

4. Local Primary Care

4.1. **Local Primary Care**- The Local Medical Primary Care forecast for Month 8 is an expected underspend of £0.679m.

4.2. **GP Local Enhanced Service Specification-** This budget line reflects an underspend of £0.5m. It primarily relates to Wirral Place, where the 2024/25 achievement data has now been finalised. The confirmed figures are significantly lower than anticipated, resulting in a substantial variance from the original projections of £0.5m.

4.3. **Local Enhanced Services-** The Local Enhanced Services budget is currently showing an overspend of £0.139m. This is attributable due to the Asylum Seeker/Refugee Health Checks, which have increased due to additional hotels being stood up. As a result, the budgets set during the planning stage have proven insufficient in light of the current cost levels being incurred.

4.4. **GP Out of Hours-** The GP Out of Hours service line is currently showing an overspend of £0.272m. This pressure has arisen due to a discrepancy between the budget planning assumptions and the actual contract uplift. During planning, a 2.15% increase was applied to certain GP Out of Hours contracts based on 2024/25 values. However, the actual uplift payable is 4.15%, resulting in a significant variance and contributing to the current overspend.

4.5. **Primary Care Other-** There is currently an underspend of £0.642m against this service line. This is primarily due to a timing issue between budget planning and actual expenditure requirements when budgets were allocated in April 2025. The funding is no longer expected to be utilised. Budget planning is typically based on Month 8 financial forecasts; however, by Month 12, the forecast had reduced, resulting in the additional budget being unnecessary.

4.6. **Pay Costs Prescribing-** There is currently a projected underspend of £0.572m against the Pay Cost Prescribing budget. This variance is primarily due to unfilled vacancies within the team.

5. Prescribing

5.1. **Central Drugs-** This expenditure relates to costs that cannot be directly attributed to a specific ICB or cost center. These costs, often relate to unidentified prescribing or VAT, that are accumulated nationally by the NHS Business Services Authority (BSA) and then shared out fairly among all ICB's based on their respective prescribing percentages, as well as some cross border prescribing.

5.2. This also includes Dental Prescribing; this is not allocated to the dental patient's own ICB as this is not recorded in BSA data, so the cost is allocated on a Prescribing spend %. For Cheshire and Merseyside ICB, this is approximately 5.7%, thus meaning we receive 5.7% of all Dental Prescribing across England.

5.3. The ICB cannot control the costs incurred within the Central Drugs budget. Recent data for April through to September 2025 indicates a notable increase in daily expenditure.

5.4. Our current financial position reflects the cost pressures of £1.021m in our year-to-date expenditure and have been incorporated into our financial forecast with a projection of £1.4m.

5.5. **Prescribing BSA-** Prescribing budgets were set for 2025/26 based on available information and using agreed assumptions (2024/25 financial outturn as the baseline, growth / price uplifts to reflect anticipated price / demand increases, followed by a reduction in line with the agreed CRES targets.

5.6. **Prescribing BSA**- **GP Prescribing Data –**The average daily cost per dispensing day from April through to July has been used to inform the year to date / forecast position including CRES achievements to date, with the assumption that current performance levels will be sustained throughout the year**.**

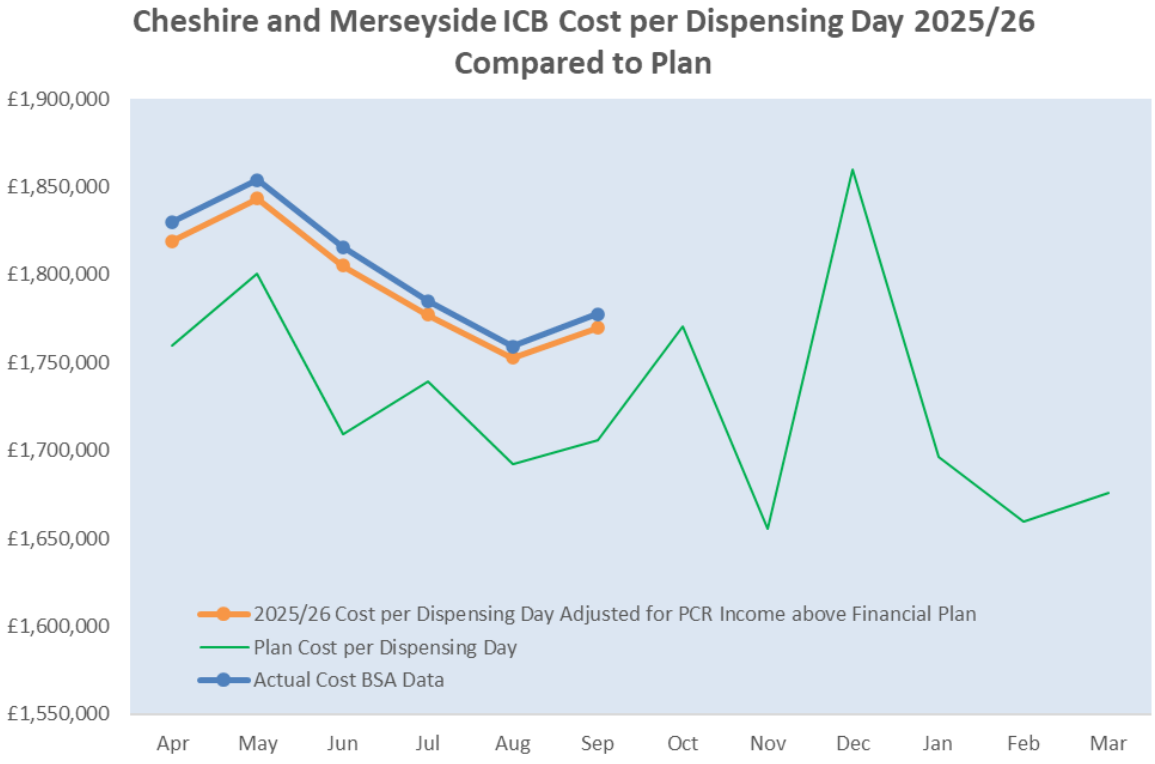
5.7. Analysis indicates that, whilst the 2025/26 prescribing budget was set using recognised assumptions, current data suggests a projected financial pressure of approximately £13.5m for GP prescribing using April to September data.

5.8. As shown in Table 2 below, in the latest data the cost per dispensing day is significantly higher than planned. While part of this variance can be attributed to known cost pressures particularly from Tirzepatide and Lidocaine, there is also a marked increase in prescribing activity.

Prescribing Cost per Dispensing Day Comparison

Table 2-This table comparison highlights current cost pressures relative to both 2025/26 planned expectations and the 2024/25 monthly trends.

Table 2



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).

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. In month 4 the ICB received an allocation increase of £17.4m for services covered by the Community Pharmacy Contractual Framework (CPCF), together with confirmation that services within the Pharmacy First programme will be funded in-year at 100% of cost incurred. Based on current activity growth, it is likely that the pharmacy budget will underspend by £2.5m in 25/26.

7. Delegated Optometry

7.1. In December, the ICB was notified of an increase in sight test fees of 2.55% and Domiciliary fees of roughly 1%, the increase to be backdated to April 2025. The service is now expected to deliver a balanced position at the end of the year. The current surplus reflects the benefit of 2024/25 accrual balances.

8. Delegated Other Costs

8.1. 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. This budget is expected to break even.

9. Delegated Dental

9.1. The utilisation of Pharmacy, Optometry & Dental (POD) allocation is subject to the principles set out in the ICB and system finance business rules – namely the duty to break even within the resource 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 resource is used to improve dental access, or exceptionally, the unspent allocation may be returned to NHS England.

9.2. Published guidance for 2025/26 says that 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 is expected to be issued on the opportunities for the ringfence to be relaxed in 2025/26.

9.3. Narrative received in early October describing the funding of the new national incentive payment for dentists (subsequently amended at the end of November) reaching a target level of additional urgent activity, contradicts the published guidance and suggests that there will be no flexibility to earn the right to re-direct unused dental funding. The ICB is seeking clarification from NHSE on the future of the dental ringfence. If the ringfence is not to be lifted the ICB could review the cap applied to payments for over-performance against contracted UDAs.

9.4. Expenditure on the local dental investment plan utilises funds from anticipated primary care dental contract under-performance to improve dental access, improving population health whilst reducing the likelihood of funds being returned to NHSE.

9.5. 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, and the new Urgent Care initiative announced at the beginning of October also need to be funded from dental under-performance.

9.6. 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 required national increase in urgent appointments.

9.7. Early assessment of the likely cost of 24/25 superannuation payments and debt recovery suggested that there could be a benefit of £6.1m in 25/26.

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 £26.848 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, the year to date spend, forecast outturn and utlisation rate.

Table 3

Place	Total	Monthly Allocation	Forecast	YTD Allocation	YTD Spend from Portal	YTD Utilisation	Annual Utilisation
Cheshire East Total	11,618,253	968,188	11,618,253	7,745,502	6,875,815	89%	59%
Cheshire West Total	11,072,012	922,668	11,072,012	7,381,341	7,103,975	96%	64%
Halton Total	4,037,946	336,495	4,037,946	2,691,964	2,607,550	97%	65%
Knowsley Total	5,307,342	442,279	5,307,342	3,538,228	3,122,844	88%	59%
Liverpool Total	17,513,147	1,459,429	17,513,147	11,675,431	11,029,797	94%	63%
Sefton Total	8,396,865	699,739	8,396,865	5,597,910	4,315,878	77%	51%
St Helens Total	6,237,405	519,784	6,237,405	4,158,270	3,593,160	86%	58%
Warrington Total	6,282,651	523,554	6,282,651	4,188,434	3,418,273	82%	54%
Wirral Total	10,420,283	868,357	10,420,283	6,946,855	6,033,854	87%	58%
Total	**80,885,904**	**6,740,492**	**80,885,904**	**53,923,936**	**48,101,144**		

11. Capital

11.1 There are two capital funding streams available to Primary Care in 2025/26. £5.027m was made 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). NHSE also provided an additional £0.700m for the purchase of IT kit for ARRS staff.

11.2 It is anticipated that the ICB will fully utilise its U&M funding. NHSE has already endorsed a full list of projects plus reserve schemes (to replace any projects that are withdrawn), so C&M can benefit from the redistribution of U&M funds. The Estates team is managing the collection of documentation to enable the latest U&M schemes to begin. The main risk to completion is the time taken by NHSE's legal team to produce the grant agreements which need to be in place before larger schemes can start.

11.3 As other ICBs have been unable to spend their U&M fund in full, a further £2.1m has been made available to Cheshire and Merseyside (C&M) for U&M schemes that were being held in reserve.

11.4 Separate reports have been brought to this committee describing the requirements for premises improvement grants (both BAU and U&M) and BAU GPIT equipment & systems.

11.5 In June, SPCC gave in principal approval for £4.7m of BAU funding to be utilised as follows:-

General Practice BAU Capital				
BAU Capital Projects	**Allocation**	**Digital**	**Estates**	**Expenditure to be approved by Committee**
Allocation	£ 4,700,000			£ 4,700,000
Estates C&M schemes		£ 80,000		
Digital costs associated with U&M (P1+P2)		£ 576,000		
ICB Corporate office re-alignment			£ 100,000	
Informatics Merseyside - Priority 1 C&M Investment		£ 1,371,843		
Mid Mersey Digital Alliance - Priority 1 C&M Investment		£ 844,932		
Midlands and Lancashire CSU - Priority 1 C&M Investment		£ 1,700,000		
C&M pool of Digital kit for break/fix		£ 27,225		
Totals	**£ 4,700,000**	**£ 4,600,000**	**£ 100,000**	**£ 4,700,000**

PIDs for the GPIT projects have now been signed off by NHSE (North West) and the ICB can proceed with the purchase of equipment.

11.6 IFRS16 cover for ICB lease costs also needs to be funded from BAU capital, but there will be no costs in 25/26. Instead, disposal of administration buildings will generate an

additional capital resource in 25/26. This additional resource can be spent on premises improvement grants or GPIT - a separate paper is being brought 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 30th November 2025.

12.2 Note the Additional Roles spend 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

18th December 2025

Primary Care Prescribing

Agenda Item No: SPCC 25/12/B09

Responsible Director: Professor Rowan Pritchard Jones

Primary Care Prescribing

1. Purpose of the Report

1.1 The report provides the committee with an update on primary care prescribing based on month 6 NHS Business Service Authority (BSA) data and delivery of Cash Releasing Efficiency Savings (CRES) up to the end of November 2025.

2. Executive Summary

2.1 Summary of Month 6 position:

- Month 6 BSA data for primary care prescribing shows an actual spend greater than planned spend. This equates to around £1.9m higher planned in month 6 (+4.2%) and £10.5m higher than planned year to date (+3.9%).
- Items per dispensing day have increased by 2.5% and BSA cost per dispensing day by 2.9% compared to the same point in the previous year. Weighted population has increased by 4.6% and registered population by 2.4%. This is a greater increase than seen nationally (+2.73%) and the Northwest has the largest Weighted population increase in England.
- BSA Cost per weighted person has reduced by £1.42 (-1.65%), meaning that despite cost increases, the population's rising health needs (as measured by the index) are being met with better cost efficiency.

The spend above plan is due to several factors including:

- Non delivery/step down of CRES programmes of work in August plan (mitigation plan due to deliver from October).
- The weighted population has grown faster than the registered population, indicating greater relative healthcare needs in the ICB.
- Local Tirzepatide spend higher than financial planning assumption, £4.9M increase on previous year.
- Local SGLT-2 Inhibitors (Dapagliflozin/Empagiflozin) usage and associated costs have increased by £2.3M, however a price reduction began in September for Dapagliflozin.
- Local Lidocaine spend has increased by £894K on the previous year
- Local ADHD prescribing has increased in items and costs - an additional £672k.
- National drug shortages with associated national advice on alternatives to use - Hydrocortisone has cost an additional £243k, Creon has cost an additional £227K compared to this time last year.

  CRES plans span across a wide range of medicines prescribed. There is targeted word underway on the review and deprescribing of Tirzepatide and Lidocaine patch prescribing outside of guidance. Monitoring via GP practice system data across C&M is undertaken every 2 weeks.

The latest data indicates that there has been a reduction in use outside of guidance of both medicines. There remains variance within places and between places within NHS C&M. The month 7 BSA data will be critical to confirm the outcomes of the work to date and the associated financial benefit.

3. Ask of the Committee and Recommendations

3.1 **The Committee is asked to n**ote the report and endorse the actions being undertaken to manage the primary care prescribing spend.

4. Reasons for Recommendations

4.1 Previously the ICS Chief Pharmacist has shared the extensive analysis of prescribing data that is undertaken to interpret the primary care prescribing spend, trends and pressures. The ICS Chief Pharmacist works closely with experienced BI colleagues and finance colleagues to agree a monthly prescribing forecast position as detailed in the System Primary Care Committee finance paper.

4.2 Analysis of multiple data sources along with knowledge and understanding of national and local influences on prescribing inform the monthly analysis undertaken by the ICB.

4.3 A subsequent summary for the overall position of the ICB, as well consistent analysis at place level informs actions, escalations (local and national) and ensures medicines management colleagues, clinical directors and place directors can work with and support primary care colleagues to optimise the use of the primary care prescribing budget.

4.4 Information and required actions are communicated at a place level and from the ICB centrally. The ICB is running its second general practice webinar on the 10th of December to provide key updates relating to prescribing spend and quality.

4.5 Monthly reporting of CRES by the ICB medicines management team ensures the ICS Chief Pharmacist and ICB have oversight and assurance relating to the delivery of CRES plans and can manage/mitigate any potential under delivery.

4.6 Additional oversight of CRES and prescribing spend is provided to the ICB Financial Oversight and Control Group (FCOG) by the ICS Chief Pharmacist.

4.7 The oversight of CRES and understanding of the primary care prescribing spend ensures the ICB and Chief Pharmacist can proactively manage and forecast this significant area of spend.

4.8 Work is nearly finalised for the horizon scanning of the predicted spend in primary care prescribing for 2026/27 and associated CRES plan. The information will be utilised to inform NHS C&M financial planning.

5. Background

5.1 The 2025/26 primary care prescribing budget for NHS Cheshire and Merseyside is £526.8m. The budget assumes delivery of CRES of £21.8m within the primary care prescribing spend.

5.2 Including November delivery, the forecast of CRES for primary care prescribing is £18.7m with a further £8.2m in planned spend mitigation.

5.3 The main driver for the under delivery of the original CRES plan relates to a decision to pause a programme of work planned to review oral nutritional supplements (ONS) prescribed.

5.4 NHS C&M is a national outlier for ONS spend and therefore plans will be reconsidered for 2026/27 delivery.

5.5 Prescribing spend is affected by many factors including changing population, clinical need, change in clinical guidance, prescriber behaviours/engagement, national price changes, medicines shortages and management of profit margins into community pharmacy (which is managed via national changes to medicines reimbursements).

5.6 The size and volatility of the primary care prescribing spend means the budget is a significant risk to the ICB. It does however offer opportunities for significant cash releasing cost savings.

5.7 Appendix One details the primary care spend against plan for NHS C&M based on BSA data.

5.8 Appendix Two details the spend by place compared to their statistical neighbours across England.

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

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

Optimised prescribing including management of resources consistently across NHS C&M supports tackling health inequalities in access, outcomes and experience.

Objective Two: Improving Population Health and Healthcare

Optimised prescribing including best use of resources across NHS C&M supports the improvement of population health and outcomes.

Objective Three: Enhancing Productivity and Value for Money

The primary care prescribing spend offers significant opportunities for increasing value for money.

Objective Four: Helping to support broader social and economic development

Consideration of primary care prescribing spend in relation to patient outcomes and impact on relevant stakeholders e.g. community pharmacy supports broader social and economic development.

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

Prescribing is the most common intervention in healthcare. Optimised prescribing and appropriate use of resources is therefore essential to the delivery of the annual plan.

8. Link to meeting CQC ICS Themes and Quality Statements

Theme One: Quality and Safety

Optimised primary care prescribing and spend supports quality and safety.

Theme Two: Integration

Optimised prescribing including use of resources is most likely to be achieved if there is an integrated approach across C&M via providers and local authorities.

Theme Three: Leadership

Leadership within pharmacy and across prescribers is essential to the delivery of optimised prescribing and management of resources.

9. Risks

9.1 The size and volatility of the primary care prescribing spend means the budget is a significant risk to the ICB. It does however offer opportunities for significant cash releasing cost savings.

9.2 ICB medicines management team and general practice capacity and stability are essential for the optimised spend of the primary care prescribing budget. Capacity and stability in both are challenged at present which represents a risk.

10. Finance

10.1 The agreed month 8 financial position (based on month 6 BSA data) is detailed in the SPCC finance paper.

11. Communication and Engagement

11.1 ICB colleagues at place including Heads of Medicines Management, Place Directors, Clinical Directors and finance colleagues are fully sighted on the in-year position relating to spend and CRES delivery via monthly communication and regular meetings.

11.2 The ICB communications team has recently rerun the Only Order What You Need campaign with the public to reduce medicines waste. A campaign relating to switching to cost effective medicines is currently being planned.

Like the waste reduction campaign, the switching campaign will support work in primary care and secondary care.

11.3 All work within the primary care prescribing CRES plans is supported by parallel work in our trusts to ensure a system approach is taken. The ICS Chief Pharmacist has monthly meetings with all provider Chief Pharmacists and is a member of the C&M Provider Collaborative Efficiency at Scale Programme Board.

12. Equality, Diversity and Inclusion

12.1 Weighted population growth indicates higher healthcare need among specific communities; optimisation actions will be implemented with due regard to health inequalities and access, ensuring clinically appropriate prescribing and support across Places.

13. Climate Change / Sustainability

13.1 No direct environmental impact identified; optimisation programmes will seek to minimise waste and unnecessary prescribing in line with the Green Plan.

14. Next Steps and Responsible Person to take forward

14.1 The ICS Chief Pharmacist will update the committee on the targeted work around Tirzepatide and Lidocaine at the next committee meeting as well as providing further context of system prescribing spend influencing primary care prescribing spend.

15. Officer contact details for more information

Mrs Susanne Lynch MBE, ICS Chief Pharmacist
Susanne.lynch@cheshireandmersyside.nhs.uk

16. Appendices

Appendix One: Primary Care in Year Spend against Plan

In-Year Actual Vs Plan 2025/26 Month 6

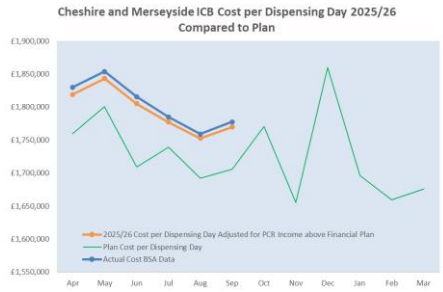
(Actual – including Flus/Pneumos)

NHS
Cheshire and Merseyside

As of Month 6, Cheshire and Merseyside is £10.4M above plan, based on BSA Actual Cost.

BSA Actual Cost has been adjusted to include income received for Primary Care Rebates (PCR) which are additional to the Financial Plan assumptions to enable tracking of delivery of place level plans.

A further adjustment has been made for Tirzepatide costs from Sept-25 onwards due to the list price increase and nationally handled rebate price adjustment



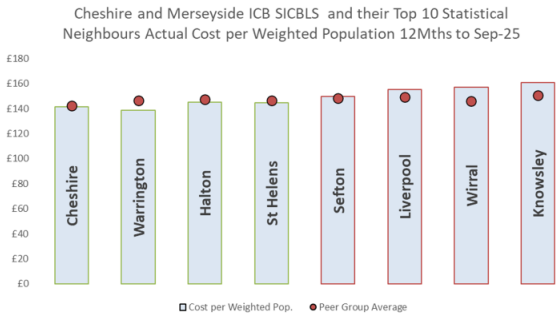
	Actual Cost BSA Data Inc. Tirzepatide Adjustment	Actual Cost Adjusted for PCR Income Above Financial Plan	Planned Cost	Cost per Dispensing Day BSA Data: Actual	Plan	Variance	%	Variance to Planned Cost	Cost per Dispensing Day (Adjusted for PCR Income above Financial Plan): Actual	Plan	Variance	%	Variance to Planned Cost
Apr-25	£43,917,160	£43,661,249	£42,237,464	£1,829,882	£1,759,894	£69,987	4.0%	£1,679,696	£1,819,219	£1,759,894	£59,324	3.4%	£1,423,785
May-25	£46,343,328	£46,082,760	£45,006,810	£1,853,733	£1,800,272	£53,461	3.0%	£1,336,518	£1,843,310	£1,800,272	£43,038	2.4%	£1,075,949
Jun-25	£45,389,583	£45,130,885	£42,733,701	£1,815,583	£1,709,348	£106,235	6.2%	£2,655,882	£1,805,235	£1,709,348	£95,887	5.6%	£2,397,184
Jul-25	£48,197,904	£47,981,449	£46,955,329	£1,785,108	£1,739,086	£46,021	2.6%	£1,242,575	£1,777,091	£1,739,086	£38,004	2.2%	£1,026,119
Aug-25	£43,983,684	£43,815,042	£42,305,347	£1,759,347	£1,692,214	£67,133	4.0%	£1,678,337	£1,752,602	£1,692,214	£60,388	3.6%	£1,509,695
Sep-25	£46,216,852	£46,011,795	£44,358,763	£1,777,571	£1,706,106	£71,465	4.2%	£1,858,089	£1,769,684	£1,706,106	£63,578	3.7%	£1,653,032
Oct-25			£47,805,670		£1,770,580					£1,770,580			
Nov-25			£41,389,385		£1,655,575					£1,655,575			
Dec-25			£46,487,654		£1,859,506					£1,859,506			
Jan-26			£44,101,393		£1,696,207					£1,696,207			
Feb-26			£39,825,539		£1,659,397					£1,659,397			
Mar-26			£43,575,093		£1,675,965					£1,675,965			
	£274,048,511	£272,683,179	£526,782,149	£1,812,526	£1,727,155	£85,371	4.9%	£10,451,096	£1,793,968	£1,751,815	£42,153	2.4%	£9,085,764

Appendix Two: Spend by C&M Place Compared to Statistical Neighbours

SICBLs Primary Care Stat Neighbours

GP Practices Only (Exc. Flus/Pneumos, Stoma, Catheters, Dressings and *Tirzepatide*)

NHS
Cheshire and Merseyside



	SICBL	Cost	Weighted Pop	Cost per Weighted Pop.	Peer Group Average	Variance from Average	Saving if at Group Average	% Saving	75th percentile	Saving if at 75th Percentile	% Saving
27D00	Cheshire	£127,233,932	898,908	£141.54	£142.36	-0.6%			£138.12	£3,076,648	2.4%
02E00	Warrington	£35,840,743	258,557	£138.62	£146.36	-5.6%					
01F00	Halton	£25,007,290	172,434	£145.03	£147.62	-1.8%			£141.97	£527,381	2.1%
01X00	St Helens	£37,552,950	259,340	£144.80	£146.43	-1.1%			£141.97	£735,280	2.0%
	Sefton	£54,153,661	361,688	£149.72	£148.32	0.9%	£506,937	0.9%	£146.62	£1,121,957	2.1%
99A00	Liverpool	£97,069,128	625,286	£155.24	£149.20	3.9%	£3,778,000	3.9%	£143.38	£7,418,698	7.6%
12F00	Wirral	£70,021,510	445,801	£157.07	£146.05	7.0%	£4,910,850	7.0%	£141.00	£7,161,724	10.2%
01J00	Knowsley	£34,359,021	213,965	£160.58	£150.70	6.2%	£2,114,089	6.2%	£145.27	£3,276,363	9.5%
Cheshire and Merseyside		**£481,238,236**	**3,235,979**	**£148.71**			**£11,309,876**			**£23,318,050**	

NHS
Cheshire and Merseyside

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

Primary Care Policy and Commissioning Update

Agenda Item No: SPCC 25/12/B10

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 commissioning 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

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. Overall Delegated Assurance

3.1 The ICB is now reporting monthly to NHS England on key areas in relation to all four contractor groups – that latest delivery plan has been updated and summarised and can be found in **Appendix 1**.

Key areas highlighted in the return

- Special education settings for dental and optometry - the return also sought additional assurances and narratives in this respect at the request of NHS England.
- Primary/Secondary care interface – the return rate for trusts is highlighted, as this is not a compulsory return – this has been flagged with NHS England and supporting work for the next return remains a priority.
- Where there are gaps in data or not up to date – a manual narrative is given.
- In respect of primary medical there are still areas of non compliance for prospective records access which is an historic contractual requirement – a narrative is given in the return and these are being followed up with the relevant practices individually to assure NHS England further.

3.2 The Committee previously received the primary care assurance framework annual declaration for 24/25. This is intended to provide clarity on NHS

England's expectations on how ICBs will provide assurance that they are exercising the delegated functions safely, effectively, and consistently within legislation, regulations and statutory guidance. Following consideration by NHS England who reviewed the self-assessment provided by the ICB, alongside any supporting intelligence and evidence, we received written confirmation that the ICB is fully compliant with the delegation agreement and relevant legislation.

4. Primary Medical Services Update

4.1 Current contract provision is given below

	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	28	4	21	6	1	0	9
Wirral	45	6	27	15	3	0	2
Total	338	49	221	97	20	9	41

4.2 The 2025 **e-declaration** for general practice closed on the 21st November - this is a mandatory annual declaration whereby practices have several weeks to respond to a series of contractual questions to confirm contract compliance in key areas such as opening times. Levels of completed declarations per practice were shared with the ICB during this process so we could remind practices to complete. We are currently awaiting the final data drop in respect of this for further analysis and follow up. More information is given here General Practice Annual Electronic Self-Declaration (eDEC) - NHS England Digital

4.3 There remains a continued national focus on **areas of the national contract implemented from 1.10**, covered here https://www.england.nhs.uk/long-read/changes-to-the-gp-contract-in-2025-26/

- In relation to 'On Line Consultations' the ICB is reporting 99 per cent compliance and this is being followed up with the respective practice – a new on line consultation analysis dashboard has recently become live, so further work will be undertaken by commissioners in relation to this. During October follow on assurance in these areas has continued. An FAQ was released in September to support this NHS England » Online consultations – frequently asked questions and support resources
- 'You and Your GP' is reporting at full compliance and this will be verified as part of the national edec contractual follow up

- Some areas of non- compliance have been reported in relation to GP Connect and those are referenced in the delivery assurance return in Appendix 1 – and are being followed up.

4.4 Protected Learning Time (PLTs) and On Line Consultations (OLCS) – Current arrangements for OLC's during PLTs are continuing, including for those arranged in February 2026 (noting there are no PLTs in December or January) - The OLC approach for PLTs will be reviewed and any decisions made after this, once we have received any further FAQs or information from NHS England. Concurrently, a review of existing PLT arrangements is underway across the ICB– an update will be given at the next Committee meeting.

4.5 Access by telephone/in person – as part of the assurance outlined in 4.3 for on line access, NHS England asked for confirmation of access by telephone and in person between core hours of 8 and 6.30. An issue with one building and door access is being followed up with the practices concerned. No other areas of non- compliance in this area were reported. The national contract e-declaration (4.2 above) also asks for confirmation of opening hours and modes of access and responses will be followed up once that data is released.

4.6 Actions to support delivery of improved access and associated areas, in line with the 'June' plan asks are given as a separate agenda item. ICBs are routinely asked for updates in respect of variation where flagged nationally though there has been no recent additional specific national asks of this ICB in this respect.

4.7 The Enhanced Services review is continuing - deep dives are in progress on the current locally commissioned services including any unbundling where there are several specifications and asks contained in one overall contract. A further detailed update will be presented at the committee in February. LMCs are represented on the review group. This area is particularly key in the development of the emerging commissioning intentions.

4.8 The commissioning oversight group which has met monthly since July has covered a range of areas at recent meetings, including

- Agreement to set up a small panel to review targeted SDF (service development funding)
- Reviews and updates on variation lists
- Updates on contract areas (1.10 implementation)
- Advice and guidance uptake/ referrals and follow on actions
- Sharing of approaches for PCN DES (Primary Care Network Directed Enhanced Service) issues
- Enhanced Access over the Christmas period

5.0 General Ophthalmic Services

5.1 There are currently 218 mandatory and 70 domiciliary (additional) contracts in place with service provision remaining as expected.

5.2 There are a number of live issues that the optometry operations group are working through including ;

- post payment verification
- contracts with no activity
- a quality and contractual issue escalated for further legal advice
- non submission of annual complaints data by some contractors.

Contractual action that may fall out of this will be agreed by the Assistant Chief Executive and reported to the next Committee meeting.

5.3 A QIO (Quality in Optometry) follow up contract assurance programme of visits has commenced to randomly selected Cheshire and Merseyside opticians with one visit undertaken in Liverpool and one in Tarporley, Cheshire, to date. A third visit be scheduled in due course, noting future visits are dependent on capacity within the small central team.

5.4 The 2022/2024 Homeless Project report outlining eyecare for hard to reach groups will be complete shortly - and the service is still being received well, with women's shelters and traveller sites being added to the programme. A further report looking at these new areas will be completed during 26/27

5.5 Special Education Settings – work is progressing subject to further discussion and agreement at the Executive Committee.

6.0 Dental

6.1 The Dental Operational Group met on 22/10/25 and discussed the following items:

- Continued contact with a provider who had been previously issued with a Breach Notice
- Contacting a provider who had incorrect information on their website
- Processing a change in partnership arrangements
- Working with a provider regarding underperformance and position next year
- Recieving notification from a provider that due to recruitment issues they would be requesting to reduce their NHS contract
- Reviewing a practice relocation request from one site to another more improved location
- Supporting a provider who is struggling with staffing and premises and the request to temporarily relocate UDAs to another site.
- Mid-Year Review 25/26 letters issued to a number of providers. All providers under 30% performance will be required to submit actions plans for approval by commissioners.

- Managed Clinical Networks for Orthodontics and Special Care have both recently met.
- Warning issued to all practices, including the LDC, to warn of practices being contacted by bogus CQC inspectors and what practices should do to verify the identity of an inspector.
- The LDCs have requested an overview on the ICB's position regarding underspend for YE 24/25 and MY 25/26. This is being processed by finance colleagues.
- Work is ongoing to understand the requirements for dental practices around the Oliver McGowan training, which must be face-to-face training for clinical staff. It was noted that work is also ongoing nationally and NHSE's WT&E Team are also linked in.
- The team recognised the years of service and support given to patients, commissioners and providers by Gill Shea – Dental Advisor, who recently retired after many years of service.
- Confirmation of winter planning arrangements for urgent dental care access and communications to all stakeholder/ NHSE assurance

7.0 Community Pharmacy

7.1 The Pharmacy Operational Group met on 7/10/25 and discussed the following items:

- Temporary Suspension of Services - 11 pharmacy returns / 55 pharmacy returns via MYS Portal
- Meetings with LPCs and amendments to Enhanced Service Specifications
- Working with national team and the issues regarding Jhoots pharmacies
- Responding to issues of concern raised regarding a temporary pharmacy re-location
- Working with LPC on ROTA arrangements, communications to stakeholders and assurance to NHSE under delegation requirement for winter planning.
- Commissiong team members attended Oral Appeal Hearing regarding a contractor and inappropriate claims.
- Work commenced with LPCs on the redesign of ROTA arrangement for 26/27 as recently agreed by SPCC.

8.0 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

9.0 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 national Policy Book's for the contractor groups and duties on contractors nationally set. Any additional commissioner requirements would be outlined in this update.

13 Equality, Diversity and Inclusion

Duties for these are accounted for in each of the national Policy Book's for the contractor groups and nationally negotiated contract terms. Any additional commissioner requirements would be outlined in this update.

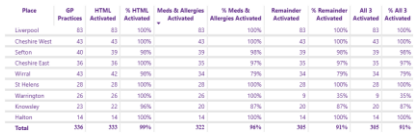
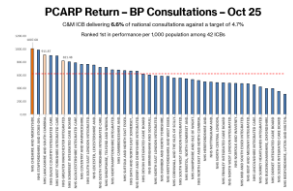
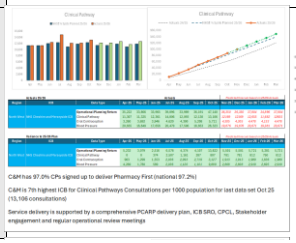
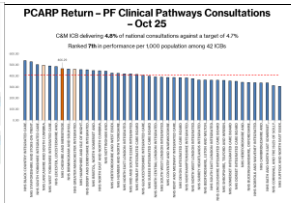
14 Officer contact details for more information

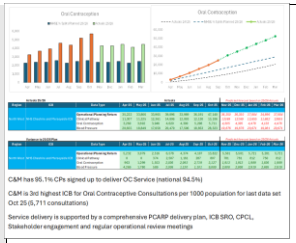
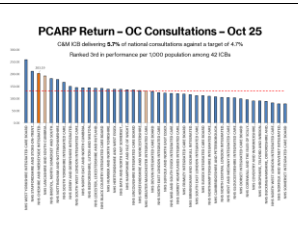
Christopher Leese, Associate Director Of Primary Care
Chris.leese@cheshireandmerseyside.nhs.uk

Cheshire & Merseyside Highlight Report Template - November 2025

Please Select Region	North West	

Deliverable	Metrics			Due Date	Delivery Update	Delivery Confidence
	Title	Target/Ambition	Latest Data			
Empower Patients						
All practices to link to Patient Charter 'You and Your GP' and ICBs to implement process to manage patient concerns	Practices with link to Patient Charter on practice website	100%	to check after edec but assuming 100 per cent compliance	From Sep 25 (contractual requirement 2 weeks after practices receive contract variations) timescale for practices to implement TBC	needs to be re-confirmed after Edec declarations	HIGH
	ICBs to have process and inbox in operation	100%	100%			
Online consultation switched on for at least the duration of core hours for non-urgent appointment requests	Practices with tool open during core hours	100%	1 practice not compliant per 'manual' checks - data checks ongoing as per column G	From 1 Oct 25	**Note further work is required on the data side -and access to the OLC tool is pending/ongoing so for now we are working on the manual assurance of 1 practice non compliant but post data review we will follow up with practices with the confirmed data set in train and the OLC tool**	MEDIUM-HIGH
	Capacity and Access Improvement Payments (CAIP)	90%	see below MGPA figure			
Support practices to move to full modern general practice, including ensuring practices have access to digital tools (as per Operational Planning Guidance)	Capacity and Access Improvement Payments (CAIP)	90%	44 practices have declared	May-25	expecting majority of claims in last quarter	HIGH
Establish new Enhanced Service (ES) to incentivise use of appropriate pre-referral Advice and Guidance in General Practice	Advice and Guidance funding used	90%	14.4 per cent of allocation	On going	as at October 2025 536,340 claimed/spent under the E/S which 14.4% of allocation (forecast to spend all) noting some claims are not yet showing as waiting to be approved	MEDIUM-HIGH
Ensure all practices are fully contractually compliant for Prospective Records Access	Practices fully compliant	100%	75%	Mar-26	the ICB has an individual breakdown of each practice and supporting actions. Of the 83 practices showing as non compliant, 59 of those praactices are above 80% of patients having access. The target set is 90%. 3 practices are showing as low and not compliant due to them holding the SAS patient contracts, registered patients cannot have access to the patient records so causing them to be highlighted as an outlier. Only 4 practices across C&M are of a concern and place are liasing with each of these practices directly.	MEDIUM-HIGH
Bring Back the Family Doctor						
PCNs stratify their patients including to identify those that would benefit most from continuity of care	Capacity and Access Improvement Payments (CAIP)	90%	57 practices declared	Mar-26	Expected majority of claims in last quarter	HIGH
Maximise utilisation of ARRS funding and track staffing trends, including number of GPs in post	Number of GPs employed through ARRS	See table tracker	See table	Mar-26	Figures for ARRS WTE shows that there has been growth since June 2022, with current WTE numbers at 2,146 WTE 	MEDIUM

Reduce Bureaucracy						
All practices to enable functionality in GP Connect to allow read only access to patient records for all NHS providers; and provide 'update record' functionality for community pharmacy providers to enable them to send consultation summaries to the GP practice workflow	Practices with functionality configured and enabled	100%	October 2025 Figures: HTML Activated: 333/336 (99%) Meds & Allergies Activated: 322/336 (96%) Remainder Activated: 305/336 (91%) All 3 Activated: 305/336 (91%)	Mar-26	Place level breakdown for this indicator at October is as follows note follow on work is ongoing:  Liverpool 83 83 100% 83 100% 83 100% 83 100% Cheshire West 43 43 100% 43 100% 43 100% 43 100% Sefton 40 39 98% 39 98% 39 98% 39 98% Cheshire East 36 36 100% 35 97% 35 97% 35 97% Wirral 43 42 98% 34 79% 34 79% 34 79% St Helens 28 28 100% 28 100% 28 100% 28 100% Warrington 26 26 100% 26 100% 9 35% 9 35% Knowsley 23 22 96% 20 87% 20 87% 20 87% Halton 14 14 100% 14 100% 14 100% 14 100% Total 336 333 99% 322 96% 305 91% 305 91%	MEDIUM-HIGH
Ensure all practices are using the online registration system and integrate online registration into GPIT	Registrations through national online system	TBC	99%	Mar-26	all practices using system apart from issue re exempt lists.	HIGH
All providers of secondary, community and mental health to submit six-monthly self-assessments on primary/secondary care interface	Providers submitting	100%	36% - 5 trusts (of 14)	Mar-26	Work is ongoing to support future delivery of returns but remains optional for trusts to complete. place and system governance in place via PCSI to support completion/ongoing work	MEDIUM-LOW
Strengthen ICB Capability						
Provide ICBs with access to Practice Level Support aspect of the General Practice Improvement Programme and funded places	Funding utilised	TBC	88% - 34 practices	Mar-26	All interested practices able to be accomodated are in the programme using the national funding. Any learning from these will be shared across the ICB. The ICB remains in ongoing contact with each provider and practices in the programme	HIGH
Pharmacy						
Implement and build on the delivery of Pharmacy First to increase referrals	Pharmacy First referrals: Blood Pressure	103,096	113,991	Mar-26	 C&M has 95.7% CPs signed up to deliver Hypertension Case finding (national 85.4%) C&M is 1st highest ICB for Hypertension Case Finding Consultations in performance per 1,000 population for last data set Oct 25 (28,323 consultations) Service delivery is supported by a comprehensive PCARP delivery plan, ICB SRO, CPCL, Stakeholder engagement and regular operational review meetings  PCARP Return – BP Consultations – Oct 25 C&M ICB delivering 6.6% of national consultations against a target of 4.7% Ranked 1st in performance per 1,000 population among 42 ICBs	HIGH
Implement and build on the delivery of Pharmacy First to increase referrals	Pharmacy First referrals: Clinical Consultations	86,706	74,022	Mar-26	 C&M has 97.0% CPs signed up to deliver Pharmacy First (national 97.2%) C&M is 7th highest ICB for Clinical Pathways Consultations per 1000 population for last data set Oct 25 (10,106 consultations) Service delivery is supported by a comprehensive PCARP delivery plan, ICB SRO, CPCL, Stakeholder engagement and regular operational review meetings  PCARP Return – PF Clinical Pathways Consultations – Oct 25 C&M ICB delivering 4.8% of national consultations against a target of 4.7% Ranked 7th in performance per 1,000 population among 42 ICBs	HIGH

Implement and build on the delivery of Pharmacy First to increase referrals	Pharmacy First referrals: Oral Contraception	14,453	25,116	Mar-26	 	HIGH
Dental						
Design, implement and assure delivery of 700,000 additional urgent dental appointments	Additional Urgent Dental Appointments	337164		Mar-26	reported seperately	Select Delivery Confidence >>
Assure delivery of 240 dentists through the Golden Hello incentive scheme	Dentists recruited	21	2	Mar-26	reported seperately	Select Delivery Confidence >>
ICBs establish services for dental checks for children in special schools	ICBs confirm services are in place	N/A	To be populated from SES returns	Mar-26	We have reviewed the ask with DPH colleagues and intend to follow the Most Suitable Provider element of PSR. Commissioners attended the national SES dop in session on 25 November and the view of colleagues in other ICBs was that CDS would be best placed to deliver. NHSE NW Dental Public Health colleagues have drafted a C&M strategy for this piece of work which is currently under review. A query has been raised re the £650 per session and what the expectation would be in regard to number of patients/dental checks to be carried out in a session and whether it includes travel expenses. An expression of interest has been distributed to CDS Trusts and engagement with local residential schools will be undertaken as from the national engagement/EOI - only one school has expressed an interest in the service to date.	LOW
	% of funding utilised	100%	To be populated from SES returns	Apr-26		
Return of Units of Dental Activity to pre-pandemic levels	UDAs delivered	89%	77% Sept 2025	Jan-00	Contract performance continues to be monitored for 25/26. The mid-year process is currently underway. Various local schemes remain in place for 25/26 across 147 practices and these have been expanded to support the delivery of our local allocation of 700k urgent dental care appointments, as well as supporting routine access for vulnerable patients. The national urgent care incentive scheme has also been rolled out with 27 practices in C&M signed up. However, the limitations of the current dental contract remain challenging and in conjunction with Finance colleagues, we are reviewing the potential impact of the proposed contract reform measures and how these could impact on activity levels from 26/27 onwards.	MEDIUM
Optometry						
ICBs establish services for sight checks for children in special schools	ICBs confirm services are in place	100%	To be populated from SES returns	Mar-26	C&M currently operate a proof of concept for the ses but the new service spec is not in place yet. There are 98 schools across C&M of which 13 schools are currently covered which is 16%, under the existing scheme. re the new specification, prelimimary work has commenced for procurement in conjunction with other two NW ICBs but needs confirmation from the ICB . Resourcing the work has been previously highlighted.	MEDIUM
	% of funding utilised	100%	To be populated from SES returns	Mar-26	30 per cent of existing funding used for the above so far	

Meeting of System Primary Care Committee of NHS Cheshire and Merseyside

18/12/2025

Advice and Guidance - Update

Agenda Item No: SPCC 25/12/B11

Responsible Director:

1. Purpose of the Report

a. The purpose of the paper is to provide the Committee with ;

- An update on advice and guidance including general assurance, current reporting and governance.
- An update on activity and finance.
- Note and discuss *revised national funding arrangements* outlined in 2.8 below which impacts on the original capping decision made by the committee - and may require a revised decision/approach
- Seeks *approval* of the TORs for the Cheshire and Merseyside Primary Secondary Care Interface Group

2. Executive Summary

2.1 In June the committee were updated on the new national Enhanced Service for General Practice Advice and Guidance. This paper provides an update and asks for approval with regard to funding arrangements that will need to be in place for year end.

2.2 NHS England 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.

2.3 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 is for the local PSCI groups to operationally manage the A&G programme with oversight from the C&M wide group moving forward. The TORs for the system-wide C&M PSCI Group are attached and require approval by this Committee (**Appendix 1)**

2.4 The expectation for Advice and Guidance is that fewer patients will be referred for outpatient 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.

2.5 An ongoing/reporting ask from is 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 2.** For the current quarter a smaller summary assurance report is required and this will be reported to the next committee meeting

2.6 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. The NHSE ask was that this programme is overseen by a system level PSCI group but due to the size and complexity of the C&M system we also made a decision to have a system level steering group in place to manage the many asks and assurances, at least for an initial period.

2.7 As outlined above, resources have been made available by NHSE to fund the £20 per A&G to General Practice via the national enhanced service NHS England » General Practice Requests for Advice and Guidance Enhanced Service 2025/26 . In June the SPCC agreed that we would cap these payments according to the fair share allocation per practice. **Table 1** below shows claims to date against the overall monies made available at Place level noting there is some variation also at practice level.

Place	Advice and Guidance Cap	£ Paid	Number of claims approved and paid	Balance to claim	% Claimed	% Remaining
Cheshire East	26,786	111,240	5,562	21,224	21%	79%
Cheshire West	25,503	134,060	6,703	18,800	26%	74%
Halton	9,291	34,280	1,714	7,577	18%	82%
Knowsley	12,223	25,020	1,251	10,972	10%	90%
Liverpool	40,297	240,860	12,043	28,254	30%	70%
Sefton	19,399	47,900	2,395	17,004	12%	88%
St Helens	14,355	59,360	2,968	11,387	21%	79%
Warrington	14,461	96,540	4,827	9,634	33%	67%
Wirral	23,989	62,240	3,112	20,877	13%	87%

Total	**186,304**	**811,500**	**40,575**	**145,729**	**22%**	**78%**

2.8 The ICB understands that indicative allocation thresholds may be removed and ICBs will be funded for the total number of pre–referral requests made within their system across the whole of 25/26. The understanding is that there will be no clawback of funding given to ICBs in the first half of the year and funding for the second half, will be based on actual activity levels and validated forecasts.This will potentially impact on the original cap decision made by the committee and requires further discussion to agree a way forward, once absolute confirmation of this decision is received.

2.9 **For further context, Tables 2(a) and (b)** below shows specialist advice given by month comparing 2024-2025 – noting that A/G is advice and guidance requested by the GP and given by the provider, that attracts the current agreed fees. RAS is post referral advice for which the GP does not receive the payment. This information is useful as it gives the overall advice given rather than just the fee-paying activity.

Table 2 (a)

	24/25		24/25 Total	25/26		25/26 Total	Var		Var Total
Month	**A&G**	**RAS**		**A&G**	**RAS**		**A&G**	**RAS**	
Apr	7,463	33,812	41,275	7,175	33,546	40,721	-288	-266	-554
May	8,151	36,513	44,664	7,885	35,590	43,475	-266	-923	-1,189
Jun	7,798	33,553	41,351	7,949	36,508	44,457	151	2,955	3,106
Jul	8,090	35,711	43,801	9,209	38,977	48,186	1,119	3,266	4,385
Aug	7,059	33,408	40,467	7,488	31,649	39,137	429	-1,759	-1,330
Sep	7,309	34,247	41,556	8,919	37,067	45,986	1,610	2,820	4,430
Oct	7,474	35,062	42,536	9,422	34,949	44,371	1,948	-113	1,835
Total	**53,344**	**242,306**	**295,650**	**58,047**	**248,286**	**306,333**	**4,703**	**5,980**	**10,683**

Place level (b)

	24/25		24/25 Total	25/26		25/26 Total	Var		Var Total
Place	**A&G**	**RAS**		**A&G**	**RAS**		**A&G**	**RAS**	
Cheshire East	5,342	22,168	27,510	7,922	22,281	30,203	2,580	113	2,693
Cheshire Unknown	228	0	228	180	0	180	-48	0	-48
Cheshire West	8,250	40,629	48,879	8,110	40,320	48,430	-140	-309	-449
Halton	1,982	3,880	5,862	2,300	4,740	7,040	318	860	1,178
Knowsley	1,185	16,871	18,056	1,970	18,251	20,221	785	1,380	2,165
Liverpool	14,609	61,894	76,503	15,431	63,458	78,889	822	1,564	2,386
Sefton	5,942	32,695	38,637	6,572	35,107	41,679	630	2,412	3,042

St Helens	4,450	18,668	23,118	3,377	18,310	21,687	-1,073	-358	-1,431
Warrington	2,467	7,119	9,586	2,688	8,376	11,064	221	1,257	1,478
Wirral	8,889	38,382	47,271	9,497	37,443	46,940	608	-939	-331
Total	**53,344**	**242,306**	**295,650**	**58,047**	**248,286**	**306,333**	**4,703**	**5,980**	**10,683**

2.10 NHSE are increasing their oversight of this programme. The North West as a whole is underperforming against expectations with regard to A&G activity, and Cheshire and Merseyside cited as not increasing A&G activity compared to previous years. The ICB had already agreed an outline improvement plan but now an overall 'recovery' plan has been requested from ICBs, which is in train. The ICB have also put in place a monitoring and assurance template to be completed at place and system level to outline actions in relation to, for example, variation in E/S referrals. Ongoing areas of risk will be developed and managed as part of the recovery plan and escalated to this Committee if required.

2.11 The ICB have also produced a document of principles to support Primary and Secondary Care in their use of A&G. This outlines the contractual and funding framework and describes the behaviours we would expect from clinicians. The link to this document is given here cheshire-and-merseyside-advice-and-guidance-principles.pdf. This has been well received by colleagues within C&M and shared with neighbouring systems.

3.0 Ask of the Committee

3.1 The Committee is asked to:

a. Note the updates in respect of Advice and Guidance
b. Note and discuss the changed financial arrangements outlined in 2.8 above which may impact on the need for the original capped approach, once confirmed.
c. Agree the terms of reference in Appendix one for the system level primary/secondary care interface group.

4.0 Officer contact details for more information

Dr Jonathan Griffiths jonathan.griffiths@cheshireandmerseyside@nhs.uk

5.0 Appendices

Appendix One: **Terms of Reference**
Appendix Two: **Self Assessment**

6.0 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

7.0 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

8.0 Risks

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

9.0 Finance

Outlined in the paper.

10.0 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.

11.0 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

NHS Cheshire & Merseyside ICB

Primary Secondary Care Interface Group

Terms of Reference

Document revision history

Date	Version	Revision	Comment	Author / Editor
27.6.25	V1.1			JG
24/7/25	V1.2	Clarified reporting arrangements and lack of secretariate function		JG
8/8/25	V1.3	Amends to reporting arrangements following review by A&G steering group		jg
29/8/25	V1.4	Changes to membership	Following discussion at CMPC Med Directors Group	JG
21/11/25	V1.5 Final	Agreed by C&M PSCI Group 15th October 25		JG

Review due: October 2026

V1.5 approved by the System Primary Care Committee of NHS Cheshire and Merseyside on Date to be added when approved

NHS Cheshire and Merseyside Primary Secondary Care Interface Group

Terms of Reference

1. Introduction and Purpose

The NHS Cheshire and Merseyside Primary Secondary Care Interface Group (PSCI Group) is established by NHS Cheshire and Merseyside Integrated Care Board ('NHS Cheshire and Merseyside').

These terms of reference set out the membership, the remit, responsibilities, and reporting arrangements of the PSCI Group.

The PSCI Group members, including those who are not staff of the ICB or members of the Board, are bound by the Standing Orders and other policies of NHS Cheshire and Merseyside.

The PSCI Group's main purpose is to:

- Develop the relationship between primary and secondary care clinicians to enable clinicians from both groups to better understand each other's working practices and pressures, and how these impacts on patients.
- Aim to discuss issues that arise at the interface between primary and secondary care and, where consensus opinion can be reached, provide recommendations to member organisations.
- Learn from and share good practice.
- Oversee the delivery of Advice and Guidance services

2. Role and Responsibilities

- Identify and work to resolve issues that arise at the interface between primary and secondary care that impact on the quality or services, the outcomes for patients and the overall patient experience.
- Promote effective communication between both sectors.
- Promote a collaborative approach between primary and secondary care.
- Develop understanding of the pressures facing colleagues across our system from both a primary care and secondary care perspective.
- Ensure reducing health inequalities are taken into account in discussions.
- Capitalise on changes that encourage innovation, research and development, and drive improvements in clinical services.
- Identify challenges and potential improvements in clinical pathways and escalate to appropriate colleagues.
- Escalate any matters of concern or emergent risk that cannot be readily dealt with by the forum to the relevant governance structures within member's organisations and/or the ICB.
- Share and support implementation of national priorities and requirements where appropriate to the PSCI.
- assess, plan and improve the delivery of high quality Advice and Guidance services using the Advice and Guidance operational delivery framework for integrated care boards in 2025/26 [PRN01910]

3. Authority

- The PSCI Group is authorised by the NHS Cheshire and Merseyside System Primary Care Committee to deliver on the above purpose and responsibilities.

4. Membership & Attendance

Membership

The PSCI Group membership shall be confirmed by the System Primary Care Committee of NHS Cheshire and Merseyside.

Membership of the PSCI Group may be drawn from individuals employed by or appointed by NHS Cheshire and Merseyside: individuals drawn from partners within the wider health and social care system; and other individuals / representatives as deemed appropriate for the delivery of the PSCI Group's remit.

The PSCI Group Membership will be composed of:

- Associate Medical Director for Primary Care – Chair
- Associate Medical Director for Quality and Improvement
- Associate Director for Primary Care
- Representatives from:

Committee/Group/Organisation	Required Representative
Local PSCI Groups*	Clinical representative from: • North Mersey PSCI Group • Mid Mersey PSCI Group • Wirral PSCI Group • Warrington PSCI Group • Cheshire East PSCI Group • Cheshire West PSCI Group
***There is an expectation that there will be a mix of professionals attending from the local PSCI groups to ensure we have adequate representation from primary, secondary, community and mental health clinicians.**	

Cheshire and Merseyside Provider Collaborative	• Senior Programme Manager • Rep from Chief Operating Officer Group
Association of Cheshire and Merseyside LMC	Clinical Rep

Attendees

Only members of the PSCI Group have the right to meetings, but the Chair may invite relevant staff and individuals to the meeting as necessary in accordance with the business of the Group.

The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of matters.

5. Meetings

5.1Leadership

The PSCI Group shall be chaired by the Associate Medical Director for Primary Care. PSCI Group members may appoint a Deputy Chair from amongst its standing members.

If the Chair, or Deputy Chair, is unable to attend a meeting, they may designate an alternative member of the PSCI Group to act as Chair.

If the Chair is unable to chair an item of business due to a conflict of interest, the Deputy Chair will be asked to Chair the meeting. On the occasion where both the Chair and Deputy Chair are unable to Chair an item due to a conflict of interest, then another member of the PSCI Group, without any conflicts, will be asked to chair the Meeting for that item. Where these requirements are unable to be met the meeting item will need to be deferred.

The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these Terms of Reference.

5.2 Quorum

A meeting of the PSCI Group is quorate if 50% of the membership are present.

If any member of the PSCI Group has been disqualified from participating on an item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

5.3 Decision-making and voting

Decisions will be taken in accordance with the Standing Orders and Operational Standing Orders of NHS Cheshire and Merseyside and within the authority as delegated to the PSCI Group and its members. The PSCI Group will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

Only members of the PSCI Group may vote. Each member is allowed one vote, and a majority will be conclusive on any matter.

Where there is a split vote, with no clear majority, the Chair of the PSCI Group will hold the casting vote.

If a decision is needed which cannot wait for the next schedule meeting, the Chair may conduct business on a 'virtual basis through the use of telephone, email or other electronic communication'. Decisions will be recorded and formally minuted and ratified at a subsequent formal meeting of the PSCI Group.

5.4 Frequency and meeting arrangements

The PSCI Group will meet in private.

The PSCI Group will meet every other month.

Additional meetings may take place as required.

Members may call for a special meeting of the PSCI Group outside of the Schedule as they see fit, by giving notice of their request to the Chair. The Chair may, following consultation with the members, confirm the date on which the special meeting is to be held and then issue a notice giving not less than one weeks' notice of the special meeting.

The PSCI Group may meet virtually and members attending using electronic means will be counted towards the quorum.

6. Accountability and Reporting

The PSCI Group is accountable to the System Primary Care Committee and shall report on how it discharges its responsibilities.

The PSCI Group will also submit copies of its confirmed minutes to the System Primary Care Committee following each of its meetings.

The PSCI Group will also report to the C&M Advice and Guidance Steering Group for the purposes of the Advice and Guidance programme.

The PSCI Group will escalate issues as needed to the C&M Provider Collaborative Medical Directors.

7. Behaviours and Conduct

Members will be expected to conduct business in line with the NHS Cheshire and Merseyside values and objectives and the principles.

Members of, and those attending, the PSCI Group shall behave in accordance with NHS Cheshire and Merseyside constitution, Standing Orders, and Standards of Business Conduct Policy.

All members shall comply with the NHS Cheshire and Merseyside Managing Conflicts of Interest Policy at all times. In accordance with the NHS Cheshire and Merseyside policy on managing conflicts of interest, PSCI Group members should:

- Inform the chair of any interests they hold which relate to the business of the PSCI Group.
- Inform the chair of any previously agreed treatment of the potential conflict / conflict of interest.
- Abide by the chair's ruling on the treatment of conflicts / potential conflicts of interest in relation to ongoing involvement in the work of the PSCI Group.
- Inform the chair of any conflicts / potential conflicts of interest in any item of business to be discussed at a meeting. This should be done in advance of the meeting wherever possible.
- Declare conflicts / potential conflicts of interest in any item of business to be discussed at a meeting under the standing "declaration of interest" item.
- Abide by the chair's decision on appropriate treatment of a conflicts / potential conflict of interest in any business to be discussed at a meeting.

As well as complying with requirements around declaring and managing potential conflicts of interest, PSCI Group members should:

- Comply with NHS Cheshire and Merseyside policies on standards of business conduct which include upholding the Nolan Principles of Public Life
- Attend meetings, having read all papers beforehand
- Arrange an appropriate deputy to attend on their behalf, if necessary
- Act as 'champions', disseminating information and good practice as appropriate

- Comply with the NHS Cheshire and Merseyside administrative arrangements to support the PSCI Group around identifying agenda items for discussion, the submission of reports etc.

Equality diversity and inclusion
Members must demonstrably consider the equality, diversity, and inclusion implications of decisions they make.

8. Review

The PSCI Group will review its effectiveness at least annually

These terms of reference will be reviewed at least annually and earlier if required. Any proposed amendments to the terms of reference will be submitted to the System Primary Care Committee for approval.

ICB:	Cheshire and Merseyside ICS	Name:
		Email:
		Role

ICB impact assessment of the Enhanced Service Specification - GP Requests for A&G 2025/26

1

Assessing the impact of the Enhanced Service Specification – ICB Requests for A&G 2025/26

- NHS England is seeking early feedback from ICBS who have signed up for the Enhanced Service Specification.
- We value your participation as the information will help to understand how the scheme is impacting the use and delivery of Advice and Guidance locally and what changes may improve any future schemes for general practice.

2

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

Q2 2025/26 - Submission

Instructions:

The Advice and guidance – operational delivery framework for integrated care boards for 2025/26 (link in cell above) was published on 1 April 2025. Following this, ICBs completed a baselining exercise via Microsoft Forms to support them to identify areas for improvement during 2025/26 and to allow a position from which to measure that improvement with quarterly data submissions.

Your ICB's baseline submission data and if provided your voluntary Qtr1 submission has been included in column E and F below. Please review this and use column F to update your response for Qtr2 if the maturity has changed since the baseline exercise.

Key:

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.

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)

Domain	Statement No.	Statement	ICB's response from April 2025 Self Assessment	Q2 July - Sept 2025
Leadership and Governance	1.1	**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.**	1	2
		Optional - please add any comments or information relating to the above answer:	Primary secondary care interface group established along with A&G steering group to support. Clinical leads from Primary and Secondary care identified. ToR and action plan to be developed.	Central PSCI Group established - system wide membership from both primary and secondary care with A&G performance monitoring included in ToR. First meeting to be held on 15th October. Local PSCI groups also now have A&G within their ToR to support with issues at a local level. Escalation route to centra group if required. C&M A&G principles document created to support primary and secondary care with understanding roles and responsibilties - to be shared in October 25.
	1.2	**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.**	2	2
		Optional - please add any comments or information relating to the above answer:	Already happening within elective recovery programme - requirement is to now move into new reporting arrangements.	The central PSCI group will start reviewing this data on a monthly basis from launch (October). Currently this data is reviewed by the C&M A&G steering group and within the Elective Reform programme (CMPC).
	1.3	**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.**	2	2
		Optional - please add any comments or information relating to the above answer:	Already happening within elective recovery programme - requirement is to now move into new reporting arrangements.	Further work required to establish governance route within the ICB.
	1.4	**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.**		2
		Cardiology	Pathway referral criteria are agreed and in place	
		Dermatology	Pathway referral criteria are agreed and in place	
		Gastroenterology	Pathway referral criteria are agreed and in place	
		Gynaecology	Pathway referral criteria are agreed and in place	
		Neurology	Pathway referral criteria are agreed and in place	
		Urology	Pathway referral criteria are agreed and in place	
		Clinical Haematology	Pathway referral criteria are agreed and in place	
		ENT	Pathway referral criteria are agreed and in place	
		Endocrinology	Pathway referral criteria are agreed and in place	
		Paediatrics	Pathway referral criteria are agreed and in place	
		Respiratory Medicine	Pathway referral criteria are agreed and in place	
		Rheumatology	Pathway referral criteria are agreed and in place	
		Optional - please add any comments or information relating to the above answer:		Pathway referral criteria agreed and in place for all specialties. This is currently being refined as part of the implementation of a digital RMS across all C&M.
Use of digital platforms to support Advice and Guidance	2.1	**Specialty referral guidelines are available via a web-based platform, digital system or built into digital workflows.**		
		Cardiology	In Progress	
		Dermatology	In Progress	
		Gastroenterology	In Progress	
		Gynaecology	In Progress	
		Neurology	No	
		Urology	In Progress	
		Clinical Haematology	No	
		ENT	In Progress	
		Endocrinology	In Progress	
		Paediatrics	In Progress	
		Respiratory Medicine	In Progress	
		Rheumatology	In Progress	
		Optional - please add any comments or information relating to the above answer:	The ICB operates across 9 Places and there is variation across specialties.	This currently being refined as part of the implementation of a digital RMS across all C&M.
	2.2	**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.**	2	3
		Optional - please add any comments or information relating to the above answer:	Majority on eRS	Secondary care provison mapped across C&M. 95% of provison on eRS with one service operated via telephone service at the Walton Centre. Plan in place at system level - focus for CMPC project is to support Trusts to open A&G channels for all specialties and ensuring all via eRS.
	2.3	**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.**		2
		Cardiology	Partial	Partial - ECHT outstanding
		Dermatology	Yes	Yes
		Gastroenterology	Partial	Partial - ECHT and WUTH outstanding
		Gynaecology	Partial	Partial - ECHT outstanding
		Neurology	Partial	Yes
		Urology	Partial	Yes
		Clinical Haematology	Partial	Partial - MCHT outstanding
		ENT	Partial	Partial - ECHT outstanding
		Endocrinology	Partial	Partial - WUTH outstanding
		Paediatrics	Yes	Yes
		Respiratory Medicine	Yes	Yes
		Rheumatology	Partial	Yes
		Optional - please add any comments or information relating to the above answer:	Varies across acute providers	Secondary care provison mapped across C&M. Variation across providers. Forward focus will be on those providers with specialties outstanding.
uality of Advice idance	3.1	**Referral assessment services and clinical assessment services offer patient choice, in line with the Choice Framework and NHSE Choice Guidance.**	3	3
		Optional - please add any comments or information relating to the above answer:		Patient choice offered in line with Choice Guidance.
	3.2	**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.**	1	2

Improving the q and Gu		**Optional - please add any comments or information relating to the above answer:**		Local turnaround standards set within the C&M principles document. Awaiting final approval of document to formalise.
	3.3	**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.** **Optional - please add any comments or information relating to the above answer:**	1	2 Urology to pilot a clinically led audit over next quarter. Exploring opportunities to utilise AI to draw out themes from A&G requests to support with assessment and education.
Reducing health inequalities	4.1	**An equality and health inequality impact assessment (EHIA) has been completed covering Advice and Guidance with agreed actions implemented and monitored.** **Optional - please add any comments or information relating to the above answer:**	0	1 Currently in draft.
	4.2	**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.** **Optional - please add any comments or information relating to the above answer:**	0	1 Elective Care Inequalities Dashbaord is in development - as part of this there will be an A&G component. This will be reviewed by the A&G steering group.
Patient and staff engagement	5.1	**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.** **Optional - please add any comments or information relating to the above answer:**	1	2 C&M principles document has been drafted to support conversations between GP and patients. Patient communications are currently in draft which will further support this.
	5.2	**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.** **Optional - please add any comments or information relating to the above answer:**	0	1 Reviewed nationally provided information and plan to share questionnaire in next quarter.
	5.3	**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 an...** **Optional - please add any comments or information relating to the above answer:**	0	1 Reviewed nationally provided information and plan to share questionnaire in next quarter. Utilising local PSCI groups for feedback in addition, with escalation opportunities to central PSCI group.
Workforce planning, training and development	6.1	**Workforce plans reflect requirements for resourcing Advice and Guidance within primary and secondary care.** **Optional - please add any comments or information relating to the above answer:**	1 Multiple providers in C&M - differs across these.	2 Secondary care mapping demonstrates majority of A&G is job planned across Trusts.
	6.2	**Users of Advice and Guidance services have access to e-learning resources and/or training.** **Optional - please add any comments or information relating to the above answer:**	1	2 C&M principles document developed which includes links to e-learning and resources. Further work to continue to develop this offer required.
	6.3	**A peer learning programme is in place between primary and secondary care, focusing on the use and service delivery of Advice and Guidance.** **Optional - please add any comments or information relating to the above answer:**	1 Where RMS are in place peer review is established.	2 Local PSCI groups utilised for peer learning. Identifying themes for future education sessions. Further work to continue to develop this is required.
Local commissioning and payment mechanisms	7.1	**Advice and Guidance services are commissioned based on a thorough assessment, with arrangements implemented and reviewed annually using data and insights.** **Optional - please add any comments or information relating to the above answer:**	1 Working on secondary care payment and modelling of GP funding	2 Primary and secondary care funding models for 25/26 have been agreed across C&M - separate secondary care tariff and practice level caps applied to GPs. Task and finish group established to review 26/27 commissioning arrangements.
	7.2	**Advice and Guidance services are evaluated to inform priorities for commissioning and care optimisation at the interface between primary and secondary care.** **Optional - please add any comments or information relating to the above answer:**	1	2 Primary and secondary care funding models for 25/26 have been agreed across C&M - separate secondary care tariff and practice level caps applied to GPs. Task and finish group established to review 26/27 commissioning arrangements.
	7.3	**Commissioning decisions and service designs are based upon outcomes from the evaluation of Advice and Guidance.** **Optional - please add any comments or information relating to the above answer:**	1	2 Primary and secondary care funding models for 25/26 have been agreed across C&M - separate secondary care tariff and practice level caps applied to GPs. Task and finish group established to review 26/27 commissioning arrangements.
		Please leave any final comments or additional information here:		

3 **ODF Evaluation**: **ICBs to complete** to share the impact of 'The Advice and guidance – operational delivery framework for integrated care boards for 2025/26'

System-Level Change					
1	To what extent has the ICB A&G Operational Delivery Framework improved the operational delivery of Advice and Guidance in high volume specialties in your service or setting? If you have answered significantly or slightly please provide feedback/ example in the comments box.	**Significantly**	**Slightly**	**Not at all**	**Comments**
		☐	☑	☐	Greater focus on A&G within specialities.
2	To what extent has the framework influenced clinical decision-making and referral behaviours across your system? If you have answered significantly or slightly please provide feedback/ example in the comments box.	**Significantly**	**Slightly**	**Not at all**	**Comments**
		☐	☑	☐	Small increase in GP requests
3	Has the framework supported more effective collaboration between primary, secondary, and community care? If you have answered yes or partially please provide feedback/ example in the comments box.	**Yes**	**Partially**	**No**	**Comments**
		☐	☑	☐	Strong collaboration already existed across C&M but the framework has highlighted the need for a central PSCI group to be formally established.
Leadership & Governance					
4	How has the framework influenced leadership engagement and governance structures around A&G delivery? If you have answered significantly or slightly please provide feedback/ example in the comments box.	**Significantly**	**Slightly**	**Not at all**	**Comments**
		☑	☐	☐	Formal governance has been introduced to support the delivery of the framework.
5	Is there evidence of stronger accountability or clearer ownership of A&G performance at system level since the introduction of the ICB A&G ODF? If you have answered yes or partially please provide feedback/ example in the comments box.	**Yes**	**Partially**	**No**	**Comments**
		☐	☑	☐	Formal governance has been introduced to support the delivery of the framework. Given the national focus on this, stronger accountability has been required.
Framework Structure & Relevance					
6	Do you feel the seven sections of the framework include all relevant and essential areas of focus to support the uptake of high-quality Advice and Guidance? If you think there are areas that need to be included please state/ provide in the comment box	**Yes**	**Partially**	**No**	**Comments**
		☑	☐	☐	The framework is very comprehensive and looks at all aspects. Further work to prioritise the 7 sections would be benefical.
7	What, if anything, do you think is needed to further improve the framework to make it a sustainable tool for long-term delivery of A&G across systems?	*Examples or feedback:*			
		Needs to be more easily adaptable to local system requirements and based on quality outcomes rather than purely and increase in utilisation and diversion rates.			
Sharing of improvements					
8	Are there examples of innovation or best practice that have emerged as a result of implementing the framework? (e.g. reduced variation within specialty regarding referral and or triage)	*Examples or feedback:*			
		Still in the early stages of implementation - this is likely to come in future months as progress.			

NHS
Cheshire and Merseyside

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

15 December 2025

National Community Pharmacy Independent Prescribing (CPIP) Pathfinder Programme

Agenda Item No: SPCC 25/12/B12

National Community Pharmacy Independent Prescribing (CPIP) Pathfinder Programme

1. Purpose of the Report

1.1 To provide an update regarding the delivery of the National Community Pharmacy Independent Prescribing Pathfinder (CPIP) programme in Cheshire & Merseyside. The programme will conclude on 31st March 2026.

2. Executive Summary

2.1 C&M currently commission 7 CPIP sites as part of the National Community Pharmacy Independent Prescribing (CPIP) Pathfinder Programme. The aim of the community pharmacy independent prescribing (IP) pathfinder programme was to establish a framework for the future commissioning of NHS community pharmacy clinical services incorporating independent prescribing for patients in primary care.

3. Background

3.1 C&M currently commission 7 CPIP sites as part of the National Community Pharmacy Independent Prescribing (CPIP) Pathfinder Programme.

3.2 The aim of the community pharmacy independent prescribing (IP) pathfinder programme was to establish a framework for the future commissioning of NHS community pharmacy clinical services incorporating independent prescribing for patients in primary care.

3.3 The NHS 10 Year Plan clearly describes future commissioning, development and integration of CPIP services within the NHS Primary Care offer. Further mandated by the recently published Medium Term Planning Guidance.

3.4 The seven sites below have provided CPIP services from April 2025.

Pharmacy ODS Code	Pharmacy Name	ICB Place
FKJ00	Kensington Health Centre Pharmacy, 155 Edge lane, Liverpool L7 2PF	Liverpool
FTW03	Allied pharmacy (Upton Rocks), Fir Park Health Centre, Lanark Gardens, Widnes, Cheshire, WA89DT	Halton
FRG94	Daveys Chemist, 99 Holt Road, Liverpool, L7 2PN	Liverpool
FK172	Daveys Chemist, 253 Kensington, Liverpool, L7 2RG	Liverpool
FFW97	Allied Pharmacy (Crosby Road), 77a Crosby Road North, Waterloo, Liverpool L22 4QD	**Sefton**
FVK97	West Bank Pharmacy, 8a Mersey Road, West Bank, Widnes, Cheshire, WA8 0DG	Halton
FHH35	Allied Pharmacy (Knowsley Road), 290 Knowsley Road, Bootle L20 5DQ	**Sefton**

3.5 The sites deliver CPIP clinical modules and prescribe to patients over two specific clinical models:

- Minor Illness Service
- Respiratory Review Service

3.6 A “Transitional Period” has been agreed between 1st January 2026 and 31st March 2026 where ICBs have been asked to support the existing sites (where possible) with national underspend budget and, where agreed locally, ICB allocated funding.

3.7 ICBs were asked by NHS England to consider the following requests:

NHS England request	C&M Programme action taken
Agree locally which Pathfinder sites they wish to continue after 31 December 2025, as well as which clinical models will be maintained; active pharmacy sites with patient consultation activity should be prioritised.	After review of residual budget and programme activity from the seven CPIP sites it has been established that all seven sites can continue to deliver activity under the CPIP programme during the transition phase 1st January 2026 to 31st March 2026
Consider extending local commissioning arrangements to any existing service arrangements to cover the interim period until 31 March 2026 (where possible)	The existing programme SLA has been supplemented with a contract variation detailing the transitional arrangements, Transitional Phase dates and programme contractual end date of 31st March 2026.
Prepare for the closure of Pathfinder sites that won’t continue after December 2025, including closing down cost centres, Cleo profiles and deactivating NHS smartcard roles.	Existing sites will continue to deliver patient-facing activity including prescribing services during the transitional period 1st January 2026 to 31st March 2026 with preparation being made to manage closure of this service from 1st April 2026. Appropriate closedown processes and arrangements are being developed to ensure a safe management of withdrawal from this service in line with this timeline.

3.8 To support this a review of programme underspend and residual budget available (as confirmed via C&M Finance Team) has been undertaken.

3.9 Funding has been identified from this resource adequate to finance continued CPIP services, under the current terms and conditions (24 sessions per month per site), across the Transitional Period – 1st January 2026 to 31st March 2026.

3.10 All CPIP clinical activity, service operational support, and programme costs within this period, will be fully financed via NHS England underspend and residual budget. This will have no requirement for local allocation of ICB funding. During this period NHS England have agreed to support by continuing to fund the Cleo license, enabling community pharmacies to prescribe via NHS EPS. NHS England are also providing additional funding of £1500 per participating pharmacy to support service delivery during the Transitional Period.

3.11 The NHS 10 Year plan and Medium-Term Planning Framework mandates that ICBs must commission CPIP services from 2026.

3.12 Currently the NHS England, the DHSC and Community Pharmacy England are in national negotiations regarding plans for commissioning and funding of the National Community Pharmacy Framework (National Contract) for 2026/27. This framework agreement is anticipated to describe and inform the commissioning of CPIP services by ICBs from 2026 onwards.

3.13 National agreement and arrangements, including operational deliverables and service design, is not anticipated to be in place and available to start operational commissioning or service roll out and delivery from 1st April 2026.

3.14 The C&M CPIP Pathfinder Programme will cease form 31st March 2026.

4. Ask of the Committee and Recommendations

4.1 **The Committee is asked to:**

- Note the programme end date of 31st March 2026 and use of residual funding.
- Note paper will be submitted for Committee in January 2026 to consider:
    - The impact of the discontinuation of the existing CPIP service provision and access in the period from 1st April 2026 to such time as national arrangements are in place to further support local commissioning.
    - Options for local commissioning of CPIP services in this interim period during 2026/27.
    - Funding potential arrangements and impact on ICB budgets to support any local arrangements for commissioning CPIP service in the interim period
    - The development of clear risk-based plans to commission future CPIP services in C&M to support access to clinical services as a part of the ICB integrated Primary Care arrangements and offer to patients.

5. Reasons for Recommendations

5.1 Further work is required to confirm the ICB approach prior to any nationally agreed way forward post April 2026.

Implications and Comments

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

Objective One: **Tackling Health Inequalities in access, outcomes and experience**
Objective Two: **Improving Population Health and Healthcare**

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

The national delivery plan for recovering access to primary care has a focus on improving access and reducing demand on GP appointments. Every CPIP appointment represents an additional GP practice appointment capacity. Equivalent to almost 1000 additional GP practice appointments between April and October 2025.

8. Link to meeting CQC ICS Themes and Quality Statements

Theme One: **Quality and Safety**

Theme Two: **Integration**

Theme Three: **Leadership**

9. Communication and Engagement

There are no communication or engagement requirements at this stage.

10. Equality, Diversity and Inclusion

At this stage health inequalities related impacts to ensure the ICB has given regard to the need to reduce / tackle inequalities (ICB Priority One) have not been considered.

11. Climate Change / Sustainability

No issues to consider at this stage.

12. Next Steps and Responsible Person to take forward

12.1 Consider the commissioning requirements post April 1, 2026, and align with national policy and negotiations regarding plans for commissioning and funding of the National Community Pharmacy Framework (National Contract) for 2026/27.

13. Officer contact details for more information

13.1 Pam Soo – Clinical Lead for Community Pharmacy

14. Appendices

Appendix One: National Community Pharmacy Independent Prescribing (CPIP) Pathfinder Programme: Cheshire and Merseyside Programme Review 20026.

NHS
Cheshire and Merseyside

National Community Pharmacy Independent Prescribing (CPIP) Pathfinder Programme

Cheshire and Merseyside Programme Review 2026

1. Executive Summary

1.1. The aim of the community pharmacy independent prescribing (IP) pathfinder programme is to establish a framework for the future commissioning of NHS community pharmacy clinical services incorporating independent prescribing for patients in primary care.

1.2. From September 2026 newly qualified pharmacists will be joining community pharmacy ready to work as independent prescribers. The development of IP as part of clinical services in community pharmacy is expected to have key benefits including:

1.2.1. Improved patient access to healthcare across the system

1.2.2. Ensuring community pharmacists are working to their full potential

1.2.3. Supporting General Practice

1.2.4. Enabling better Integrated Care System (ICS)/Integrated Care Board (ICB)1 service delivery planning

1.2.5. Creating the opportunity for placed based training for Foundation pharmacists and newly registered pharmacists to expand their clinical practice and create career pathways for a sustainable workforce in primary care.

1.3. Enabling community pharmacy clinical services to offer IP needs to be robustly tested and developed. In order to do this ICBs are being asked to establish Pathfinder sites to identify and test the delivery of IP across all NHSE regions.

1.4. Pathfinder sites will be nationally coordinated with core requirements whilst allowing local variation in clinical design responding to local need and availability of competent IP community pharmacists.

1.4.1. ICBs are asked to design service delivery models that will align with the following objectives for the programme:

1.4.2. Identify the optimum processes including governance, reimbursement and IT requirements required to enable independent prescribing in community pharmacy.

1.4.3. Help address the risks and identify the benefits for the NHS and patients:

1.4.4. Inform the development of assurance processes for professional and clinical service standards that support IP activities in the context of NHS community pharmacy services.

1.4.5. Inform the professional development needs of community pharmacists and wider workforce strategy for pharmacy professionals in primary care.

1.4.6. Inform the post 2019- 2024 community pharmacy contractual framework clinical strategy.

2. Introduction / Background

2.1. The Pharmacist Independent Prescriber (PIP) pathfinder model proposed by NHS Cheshire and Merseyside Integrated Care has been determined following extensive local and regional consultation with stakeholders. The model is designed to fully utilise the existing competencies of the PIPs working within our constituent pharmacies and enhance the clinical services provided to meet the present-day needs of our citizens.

2.2. The commissioned service delivers CPIP supported clinical sessions from pharmacy contractors. The service allows a clinical service offer via a flexible hybrid solution, stratified to the local needs via three key care components.

2.3. A primary care core component with a minimum number of weekly appointments dedicated to minor ailments from 111, general practices and urgent care, linked to the NHS Community Pharmacy Consultation Service (CPCS).

2.4. Contractors can supplement this core offer with extra appointments for a second-tier component, which is prescriber competency dependent. :

2.4.1. Respiratory Disease, to take referrals from Primary Care to initiate or manage inhaler therapy, supporting the green agenda and managing over/under usage of inhalers.

2.5. Originally, a third clinical model was proposed which was anticipated to deliver Antidepressant Therapy Review to support patients who have not had their Antidepressant therapy reviewed in the last year and who may wish to step down therapy or address concerns relating to this therapy.

2.6. This module was withdrawn from consideration and development due to delays in the National rollout of this pilot. The delays would have resulted in the length of the national pilot not being appropriate to deliver the timelines required for patients to effectively be recruited on to these pathways and adequate time for the CPIPs to support and manage these patients to an appropriate clinical resolution and outcome. As such, it was deemed inappropriate to commission a service that patients could start on via one service delivery model, however would have to transition to another provider to conclude their episode of care.

3. Programme development and initiation –

3.1. In conjunction with the Cheshire and Merseyside LPCs, Independent prescriber resource employed in Community Pharmacies in Cheshire and Merseyside was mapped to describe capacity and opportunity within this sector of workforce. An

EOI was submitted, based on this, as part of the national process detailing a plans to undertake a comprehensive and ambitious scheme to deliver a consistent service across 20 pharmacies over the Cheshire and Merseyside footprint. The financial allocation resulting from that EOI was equivalent to delivery of 7 pathfinder sites across Cheshire and Merseyside.

3.2. C&M CPIP Worforce Survey - 148 responses were received from a PharmOutcomes CPIP survey;
- 23 CPs employ pharmacists who have a prescribing qualification,
- 10 have pharmacists who are currently in training and
- 10 have pharmacists who are about the begin training
- (these responses represent 37 unique pharmacies).

3.3. We engaged with the CP multiples who also have declared that they have CPIPs employed in Cheshire and Merseyside and mapped (where possible) this resource.

3.4. The CPIP Pathfinder service Specification was developed to utilise and comply with locally approved formularies and guidelines for the specific conditions within scope of the pathfinder initiative, initially; minor illness, respiratory care and antidepressant prescribing. The ICB ensured that this programme complied with Cheshire and Merseyside Area prescribing Group (APG) Formulary in line with all Cheshire and Merseyside prescribers and utilises national guidance/resources (including but not exclusive to):
- ICB Self Care Policy
- British National Formulary (BNF)
- Summary of Product Characteristics (SPC)
- ICB Prescribing Guidance
- NICE Clinical Knowledge Summaries (CKS)

3.5. The Cheshire and Merseyside PIP pathfinder service model is based on each community pharmacy contractor providing a PIP led primary service (minor ailments) for a minimum of 16 hours per week. They can increase sessions beyond this and also offer a secondary service; focused on respiratory disease or SSRI deprescribing.

3.6. These areas have been chosen in order to maximise existing areas of primary care and prioritise areas where there is demand form patients for access to service.

3.7. The Minor Ailments aspect was designed to capitalise on referrals in to the nationally commissioned Community Pharmacy Consultation Service (CPCS) and enhance the existing offer to patients with regard to the treatment and management of Minor Ailments and minimise instances where referral to a secondary service is required in order to access a POM medication to resolve the patient's therapeutic journey.

3.8. Respiratory Review was been selected as an additional clinical service module as we understood from the local workforce survey that this was a clinical area where a number of Community Pharmacy IPs had clinical specialism. We were aware of a range of respiratory review models currently delivered across Cheshire and Merseyside, managed via a range of IPs in different roles and professional background including Nursing Staff and PCN Pharmacists.

3.9. The deprescribing of Antidepressant Therapy, originally considered, was led by current work in Sefton due to patent demand identified locally. This work is currently being developed for and delivered by Sefton PCN pharmacists. This programme of clinical work has also been supported by professional input from the Maudsley Hospital, London whose expertise in this area is nationally recognised.

3.10. All three selected cli9nical areas were identified as contributing to the Recovery and Access agenda.

3.11. The national funding allows each commissioned site to claim up to 24 sessions per month. An allowance is given to consider activities post consultation, e.g. record keeping, participation in peer support activities, review with clinical leads, training and PCN engagement etc.

3.12. The commissioned pathfinder service model was based on a combination of both referrals and a walk-in service to maximise PIP sessional utilisation. This model allows CPIP services to prioritise primary care and urgent care referrals.

3.13. Sites also explored and will evaluate the use of appointment booking and referral systems

3.14. The service model was based on face to face however the option of remote access could be delivered as part of the providers service model in line with the restrictions and guidance for national commissioned CP clinical services. Remote access would be via NHS approved care processes with the PIP

situated at the pharmacy premises. Arrangements for remote consultations included a requirement for recall if a face-to-face assessment was required.

3.15. As NHS Virtual Wards develop we may in future explore how home / offsite PIP visits could be developed within the scope of the initial pathfinder.

3.16. Effective working partnership working between pharmacists and general practice/PCNs was identified from the offset as key to the success of the initiative. This requires clear communication, inter-professional collaboration on the design and ongoing development of the service model via joint working and stakeholder groups, and PIP participation in PCN meetings and other relevant forums.

3.17. The following were also incorporated into the service model;

- Our service models were based on the best use of clinical systems and designed to help PIPs fully consider existing patient medication.

- IT provision was designed to create a digital pathway for communication between PIPs and general practices regarding the care provided, including integration of care provision into practice medical record systems.

- Within the sessions commissioned time will be allocated so that PIPs can participate in PCN forums to aid collaboration, peer networking and information sharing on the pathfinder initiative. This will involve regular audit to identify model enhancements and opportunities and improve patient care.

- Governance pathways were established through the ICB with oversight of this programme by the ICB NMP group.

3.18. Programme development established a model for ICB clinical support via a set up of a programme steering group to both establish this programme and ongoing to ensure clinical governance

3.19. Processes and data flow mapping were established to ensure there is sufficient the clinical governance oversight, supporting quality improvement risk and incident management.

3.20. Development of and implementation of comprehensive clinical governance policies and procedures were undertaken to ensure that the service model operates in a safe, effective, and appropriate manner. These policiesl covered the management of risks and incidents within the service model and the development of mitigation strategies to address identified risks. This involved

incorporation of the PIPs and CPIPs into existing governance and oversight processes and policies regarding management of NMPs in the ICB

3.21. Resources were allocated to allow PIPs to undertake and share regular clinical audits to monitor the quality of care provided and to identify areas for improvement.

3.22. Implementation of a robust incident reporting and management system to ensure that incidents are reported, investigated, and acted upon in a timely manner. This included processes for the prompt reporting of incidents, investigation and analysis of root causes, and the implementation of corrective actions to prevent similar incidents from occurring in the future.

3.23. Work with regional colleagues to provide regular performance reporting. This included the reporting of key performance indicators (KPIs) and the results of service provider self-assessed clinical audits and risk assessments.

3.24. Full consideration was given to the possible commercial conflicts of interest faced by PIPs to mitigate against potential financial incentives, sponsorship or funding, industry relationships, and dispensing arrangements that may impact on prescribing in line with ICB policies.

3.25. CPIPs were required to comply with the ICB policy in relation to Working with the Pharmaceutical Industry (PI), Dispensing Appliance Contractors (DACs) and Prescribing Associated Product Suppliers Policy.

3.26. Place Clinical Leads were engaged with to support the IPs with clinical mentorship and ensure that they are incorporated in to existing clinical support systems e.g. peer mentorship groups for IPs in PCNs, communities of practice, PCN training programmes for existing PCN pharmacists

3.27. The ICB worked via a prescribing monitoring process to provide oversight of, and ensure that this programme's prescribing complies with the Cheshire and Merseyside Area prescribing Group (APG) Formulary in line with all Cheshire and Merseyside prescribers. Programme governance processes including EPACT data review was established monitor prescribing patters and formulary compliance.

3.28. Regional experience of clinical oversight with dispensing doctors to regularly review individual prescribing and item volumes against local formularies and

comparisons with other contractors was used to mitigate against on site dispensing influencing service outputs.

3.29. In collaboration with other pathfinder ICBs, development of clear ethical and clinical guidelines was undertaken to allow CPIPs demonstrate that their professional judgement was not compromised and that all dispensing arrangements were transparent in relation to ensuring;

- There was no prescription direction or restricting a person's choice of dispenser.
- Any prescribing errors detected at dispensing were reported through an agreed ICB process in line with other IPs

3.30. Contractors and CPIPs delivered assurance process in line with the current ICB NMP processes before they were registered as a pathfinder site or as a CPIP practicing within the ICB. This covered:

- Site appropriateness and readiness
- Processes and policies to support CPIPs and the process of prescribing
- Risk assessment specific to service
- Risk assessment specific to prescribing and dispensing on same site
- CPIP professional assurance and documentation re training and current competence
- CPIP areas of clinical competence

3.31. The service model was designed to ensure that a second Pharmacist was involved in carrying out the final accuracy check and the check for clinical appropriateness where any CPIP prescription was dispensed "in house". The assurance process was designed to ensure that the service provided declared that they there were robust procedures and arrangements in place to ensure this, and to consider any risks of supplying against not supplying any prescribed medication. Processes and documentation (IT modules) were designed to ensure and record that Patients were always given the choice to take their prescription to another pharmacy for supply.

3.32. The PIP service model was developed to offer the greatest support to our population. It has a primary, core component dedicated to minor illnesses. Contractors can supplement this with extra appointments for a second tier service of respiratory disease. Service design ensured that the initiative

delivered a model for high-quality care that was inclusive and accessible to all sections of the local population.

3.33. Pathfinder sites ensured, and gave assurance, that the initiative was inclusive and accessible to all sections of the local population, including marginalized and disadvantaged groups.

3.34. The pathfinder sites worked to establish provision that met the recommendations of the Fuller Stocktake report, “Next steps in integrating primary care” by using PIPs to;

- Streamline access to care and advice for people, where and when they need it.
- Provide more proactive, personalised care.
- Help people to stay well for longer as part of a more ambitious and joined-up approach to prevention.
- Improve the health of children and young people.
- Support people to stay well and independent, acting sooner to help those with preventable conditions.
- Support those with long-term conditions and those with multiple needs as populations age get the best care as quickly as possible.

3.35. To do this within the PIP initiative;

- Collaborated with local stakeholders, including general practices, PCNs, community organisations, and patient groups, to ensure that the initiative was tailored to meet the specific needs of the local population and to ensure that it was delivered in a way that is accessible and acceptable to patients.
- Monitored and evaluated the progress of the initiative regularly to ensure that it was achieving its intended outcomes and to identify areas for improvement.
- The final evaluation will involve collecting data on patient outcomes, patient satisfaction, and health inequalities, and using this data to make informed decisions about the future direction of national and local commissioning.

3.36. Future work will be required to resolve the requirements of the digital agenda for this programme. Work was undertaken with digital partners and regional colleagues to procure an IT platform that provided pharmacists with the clinical access to data required to safely prescribe e.g. patient histories, previous test results and care plans.

3.37. This system allowed access to IT provision to facilitate prescriptions via the NHS Electronic Prescription Service and ensured that CPIP prescribing, advice and interventions were communicated to GP Partners to allow incorporated into medical records for safe and effective prescribing and collaboration among healthcare providers.

3.38. The programme was developed to ensure that providers had access to IT resources such as remote consultations, electronic prescribing, and prescribing support systems, to improve prescribing safety and effectiveness, and support better and safer patient pathways. The National IT Team provided access for Pathfinder sites to GP Connect, Cleo and supporting Pharmacy System providers to provide referral system compliant with the Booking and referral standards.

3.39. IT resources such as decision support tools, drug information databases, and drug interaction checkers were linked where possible to support CPIPs to prescribe based on informed decisions, avoid errors, and provide the best possible care.

3.40. The key project management elements required in this initiative included:

- Project planning to define project goals, objectives, scope, timeline, budget, and resources required to achieve the desired outcomes.
- Stakeholder engagement to understand their needs and expectations to ensure the project is aligned with their interests.
- Risk and quality management to Identify potential risks to patient safety, regulatory compliance, privacy and security of patient data and implement measures to manage these, ensuring the project remains on track and achieve programme goals.
- Quality assurance processes to ensure quality aspects were paramount and included all relevant elements of clinical governance and guidance e.g. Infection Control policies
- Communication processes and mechanisms, ensuring regular and effective communication between project team members, stakeholders, and relevant parties.
- Continuous monitoring of progress, identifying issues, and making necessary adjustments to keep the project on track.

- Evaluation and review to assess the performance of the programme including regular evaluations to identify areas for improvement, and making necessary changes to ensure programme outcomes and inform future developments or commissioning intentions and patient pathways.

3.41. Budget was pooled Regionally to ensure adequate programme support.

3.42. This has been Provided via a contract funded via shared costs by each of the three NW Region ICBs pro rata based on site numbers

3.43. This contract is held by CPMG and delivers support for programme set up and development support, development , maintenance and management of Pharmoutcomes clinical and operational modules to support the programme, support to manage and facilitate national reporting for the programme as per national audit and evaluation requirements and employment and management of an operational programme manager (shared cost across the NW Region three ICBs).

3.44. The input of our PIPs in the planned evaluation process was crucial to develop the programme and will inform the final review of the service model, outcomes and delivery, key governance requirements and standards, the digital and clinical system functionality and considerations, assurance framework development and the core KPIs of the programme.

3.45. The following steps have been taken as part of established national evaluation processes to create a supportive environment for participants in the evaluation process;

- Clearly communicate the purpose and benefits of the evaluation to explain why the evaluation is being conducted and what benefits it will bring as a whole.

- Provide training and resources to participants with the necessary training and resources to help them understand the evaluation process, and how they can contribute effectively.

- Ensure confidentiality and anonymity and reassure participants that their responses will be confidential and anonymous, to encourage honest and open feedback.

- Foster open communication and actively listen to participants' feedback, concerns, and suggestions. Respond to their questions and provide clarification as needed so that they can see the impact of their contributions and feel valued.

3.46. In order to prioritise the EOIs received by the ICB in relation to this programme we have considered the following aspects:

- Clinical governance including clinical mentorship and integration in to communities of practice and peer review groups
- Premises specifications
- Infection Control and adherence to IC policy
- Assurances regarding processes and policies in relation to Independent prescribers
- Geography – including potential impact on access to services and areas of multiple depravation
- Feedback form Interested Parties e.g. LPC, GPhC, Community Pharmacy Commissioning Teams, Place Based Heads of Medicines Optimisation, Regional CDAO Team
- Community Pharmacy provider history of service provision including provision of COVID services and other Innovative or Transformational services
- Place bases historic collaboration and levels of innovative and transformational working with Community Pharmacy and Community Pharmacy Stakeholders e.g. LPC

3.47. As a result of this analysis we identified the Following Places where EOIs would be actively considered and have been working with providers in these areas to identify potential priority providers:

- Liverpool
- Halton
- Sefton

3.48. This would allow each place between 2-3 Pathfinder sites to work with across their system

3.49. Based on the available funding allocation from NHS England we commissioned seven CPIP Pathfinder sites as following:

Pharmacy ODS Code	Pharmacy Name	ICB Place
FKJ00	Kensington Health Centre Pharmacy 155 Edge lane Liverpool L7 2PF	Liverpool
FTW03	Allied pharmacy (Upton Rocks) Fir Park Health centre, Lanark gardens, Widnes, Cheshire, WA89DT	Halton
FRG94	Daveys Chemist, 99 holt road, Liverpool, l7 2PN	Liverpool
FK172	Daveys Chemist, 253 Kensington, Liverpool, L7 2RG	Liverpool

FFW97	Allied Pharmacy Crosby Road 77a Crosby Road North Waterloo Liverpool L22 4QD	**Sefton**
FVK97	West Bank Pharmacy, 8a Mersey Road, West Bank, Widnes, Cheshire, WA8 0DG	Halton
FHH35	North Park HC 290 Knowsley Road Bootle L20 5DQ	**Sefton**

3.50. For context - NHS Lancashire and South Cumbria ICB have been allocated 7 Sites and NHS Greater Manchester ICB 10 sites.

3.51. The selection of the sites and providers ensured that, for programme evaluation purposes, we had considered the following

- Local support from Place / key clinical leads within place
- Local relationships between CP sites and local surgeries
- Patient demographics
- Areas of deprivation and defined need
- Pharmacy set up and site in relation to GP Practice – some co-located with GP Practices, others not including High St locations, proximity to residential areas and local communities etc
- Size and throughput of pharmacy provision and dispensing
- Participation in and delivery of National and Local commissioned services
- Pharmacies were in “good standing” with commissioners and professional regulatory bodies
- Support from stakeholders including LPCs

4 Engagement

4.1 Initial engagement was facilitated during weekly briefing meetings with a Range of stakeholders including LPC, GPhC Regional Colleagues including regional Pharmacy and Clinical Leads

4.2 The Medicines Optimisation Leads were briefed at monthly MOP meetings to ensure that they are informed and can inform the programme development.

4.2 Programme initiation meetings with Leads from Place including Place Directors, Place Clinical Leads, Heads of Medicines Optimisation and any other interested party identified by Place to introduce the specifics of the programme to Sefton Place, Halton Place and Liverpool Place as the three geographies initially identified via the EOI process to as having potential viable sites for development into pathfinder status.

4.3 Clinical leads from ICB Places and Medicines Optimisation Leads from Place along with other interested parties including ICB Primary Care leads and external Stakeholders formed an ICB Steering Group to shape and develop this programme. This group had a mandate to ensure key deliverables were optimised including patient pathways, quality and safety governance arrangements, clinical supervision and mentorship, IT arrangements, AMR agendas delivered, IP policies were delivered and supported.

4.4 Under this steering group each place had arrangements in place to ensure this programme reported to and had oversight by an appropriate local operational group with Key Place representation and Stakeholders local to Place. This was supported by the ICB Steering group to ensure that the Place has an opportunity to, where appropriate, localise these services, patient pathways, referral arrangements and to facilitate cross professional working between the pathfinder sites and local PCNs and other clinicians

.

4.6 The SLA was subject to a consultation process within Cheshire and Merseyside ICB. The initial SLA included the minor Ailments / Low Acuity Conditions service with a further appendices for the Respiratory Service being added as this service was developed and clinically launched.

5 Quality and Safety

5.1 Work was undertaken to begin to work with Quality and Care team and the Community Pharmacy Commissioning Team to ensure that suitable arrangements are in place for both contract management and clinical and quality support for the Pathfinder sites.

5.2 This work mapped and agreed appropriate pathways to facilitate the reporting, Clinical management and support for any concerns, complaints or issues raised concerning this programme or the delivery thereof.

5.3 This work covered any concerns, complaints or issues raised by the sites themselves, clinicians, or the public.

5.4 This work supported and underpinned the nationally agreed and supported Evaluation process for this programme.

5.5 A Clinical Mentor has been appointed @one session per week to provide additional senior clinical oversight to this programme. The clinical Mentor delivers one clinical session per week to support the CPIPs, has over sight of prescribing and any feedback concerns or incidents.

5.6 All prescribing (in an anonymised format) is detailed in a report for the Stakeholder Group on a monthly basis. This allows transparency of the programme and allows professional review by the programme clinical lead, and at Place via the Heads of Medicines Optimisation (and their teams) for local review and intelligence. Review and feedback is provided back to the programme and shared with all CPIPs regarding quality including formulary and AMR adherence, clinical feedback and insight which is shared across the programme CPIPs.

5.7 Personal prescribing data is shared with each individual CPIP monthly to allow personal review and audit of prescribing. This supports the CPIPs personal development , programme quality and facilitates their prescribing development programme with their personal Clinical Supervisor.

5.8 Prescribing data is accessed via the PharmOutcomes Modules that have been developed to support the programme and is available in “real-time” in comparison with the NHSBSA Epact data that is available to the programme, however has a time lag in the data provision.

6 Equality, Diversity and Inclusion

6.1 Any change in provision that impacts on access must be reviewed in the context of health inequalities and more vulnerable population in C+M.

6.2 Completed programme QIA

CM%20ICB%20QIA%20Template%20-%20(

6.3 Completed programme EIA

EIA%20CP%20Pharmacy%20independent%

6.4

7 Health Inequalities

7.1 The development of IP as part of clinical services in community pharmacy is expected to have key benefits including:

- Improved patient access to healthcare across the system
- Ensuring community pharmacists are working to their full potential
- Supporting General Practice
- Enabling Integrated patient pathways

7.2 Capitalising on these benefits and ensuring that the Pathfinder Sites are integrated fully in to Place and PCN systems would enable the m to deliver services out with that already commissioned including (though not exclusively) late night and weekends. This increased access to services will support delivery of services generally however would support addressing inequality of access.

7.3 The addition of prescribing to support GPCPCS and CPCS would also support inequality by supporting patients who may not be able to pay for self-care OTC medications and would at the point of counselling leave the CPCS service to access their GP for a “free” prescription. This created an additional step in a patient pathway and a barrier to them accessing self-care support or accessing self-care support in a timely manner. As such the CPIP pathfinder sites could support such vulnerable patients.

7.4 Independent prescribing in Community pharmacy would enhance the clinical offer of Community pharmacy services building on national prioritisation of clinical services e.g the Common Conditions Service (commissioned as part of the Recovery and Access agenda) to deliver seamless point of access clinical care to patients.

7.5 The pathfinder can be a key component towards meeting the recommendations of the Fuller Stocktake report, “Next steps in integrating primary care” by using PIPs to;

- Streamline access to care and advice for people, where and when they need it.
- Provide more proactive, personalised care.
- Help people to stay well for longer as part of a more ambitious and joined-up approach to prevention.
- Improve the health of children and young people.
- Support people to stay well and independent, acting sooner to help those with preventable conditions.
- Support those with long-term conditions and those with multiple needs as populations age get the best care as quickly as possible.

8 Climate Change / Sustainability

8.1 The overall programme supports the Climate Change and Sustainability agenda in line with existing primary care services and arrangements e.g. arrangements for waste management and provision for patient education programmes with regard to waste and sustainability.

8.2 The commissioned clinical model for Respiratory Review includes specific commissioned content regarding the “green agenda” with regard to inhaler supply, choice and use and a focus on sustainability.

9 Digital

9.1 Work with the ICB Digital Leads to ensure that the National digital plans for this programme were visible to the ICB Digital leads. This also allows feedback to the National programme and local influence for the programme digital arrangements and inclusion in local digital strategic plans where appropriate.

9.2 The National Digital implementation plan included provision of GP Connect to allow access to clinical information and the national commissioning of Cleo to allow production of EPS prescriptions.

9.3 The Cleo System to facilitate access for EPS prescribing for CPs was procured nationally to support this programme with associated support for ICBs to adopt use of this system as part of the CPIP programme. This support included Guidance documents for DPIA development etc.

9.4 Nationally there is no programme to support CPs with IT infrastructure of clinical systems or Digital Programmes. All existing nationally commissioned services are designed and commissioned nationally using a “Provider Pays” model. This is restrictive for commissioners in terms to access to both service provision detailed data and clinical data. This arrangement is also not in line with standing equivalent funding arrangements for other parts of primary care including GP contractual arrangements.

9.3 Pharmacy System providers are working with NHS England and NHS Digital to develop solutions for recording clinical sessions and supporting reporting of CP Prescribing intervention outcomes to GP Clinical Systems in an integrated manner. These solutions were not yet available to support the go live, or current programme of ongoing development, of this programme.

9.4 To address the gap in availability of digital solutions and clinical systems to support the CPIP programme, the North West regional ICB programme leads collaborated to commission a provider to develop and support a Pharmoutcomes solution to provide a -

- clinical record recording and reporting model for the commissioned clinical modules and
- service delivery recording and reporting module.

These modules included-

- Clinical consultation recording
- Collation of and recording of QOF data
- Collation of and recording of clinical and diagnostic records and data sets - Including clinical test results
- Links to appropriate diagnostic tools

- Collation and recording of clinical intervention outcomes including prescribing, amendment to existing mediation, advice, safety netting, escalation or future follow up
- Communication of consultation outcome and follow up including any prescribing QOF data sets, and relevant clinical findings and outcomes to the Patients GP for inclusion in Patient Clinical Records.
- Collation of and recording of data sets required to inform national and local evaluation
- Collation of sessional provision data sets and remuneration claims
- Recording and reporting of Prescribing data sets to inform prescribing analysis and clinical evaluation and oversight

10 Finance

10.1 This programme did not require any financial input from the ICB in that all funding was provided via the National Allocation.
The ICB provided support to the programme via staff and clinical oversight as part of their day-to-day roles and responsibilities. Any additional programme or clinical support, e.g. ICB Clinical mentorship was funded by the national allocation.

10.2 Nationally, an overall budget of up to £12m was allocated to the Pathfinder programme. Funding was provided to ICBs to support the operational delivery and provide support for the Pathfinder sites including:

• Project management, including the local commissioning of the Pathfinder sites using a Local Enhanced Service contractual agreement.

• Clinical mentoring, peer networks, supporting prescribing pharmacists.

• Evaluation. A portion of the funding was made available to ICBs will be available to
pharmacies involved in delivery of the programme.

Sites were able to claim for:
• Set up costs, including support to enable IT for prescribing activity, participation in evaluation and operational readiness.

• Sessional time for prescribing pharmacist(s); up to six sessions per week.
No additional funding was be made available for medicines costs, which continued to be attributed to ICBs and funded from existing allocations as usual.

10.3 For NHS Cheshire and Merseyside ICB the following finances have been allocated

National Programme Allocation for C&M 25/26= £63,804	
ICB Funding for C&M 25/26- National allocation via SDF	**Allocated Funding**
General Programme	50,952.00
Non Pharmacy Evaluation @426/site	1,750.00
Clinical Support @£1,586/site	11,102.00
TOTAL (from original 25/26 funding)	**£63,804.00**
Additional nationally agreed allocation – payable for "Transition Period" commissioning = 500/site/month for 7 sites Jan -Mar- Transition Period)	10,500.00
Residual Budget from2024/25)	83,345.00
Total Current balance available 25/26	**£157,649.00**

Cost pressure (cost incurred 25/26	**Cost(£)**
Project Manager (CHL) (21695.2 + 1810.8 = 23506)	14,380.60
CPPE clinical training for URTI 30th April / 9th May 2025	2,232.00
Printing (apt.creative) Patient survey/evaluation	419.00
Evaluation Work	1,750.00
Clinical Mentor £320 (+20% on costs) = £384.00	
• AW April-June 25 (13 weeks)	4,992.00
• RR July 25 -March 26 (40 weeks)	15,360.00
Total programme costs incurred 25/26 to date -	£39,133.60
Current balance available to facilitate programme extension over "transition Period" 1st Jan 2026 to 31st March 2026	**£118,515.40**
Current Balance equated to clinical sessions (@£197.60 per session)	560 sessions = **28.5** sessions per month per site (Jan-March 2026)

10.5 There is also additional complex service funding is to support models that may require additional support and greater level of clinical mentorship or additional set up support. This additional £500.00 can be claimed by sites as appropriate.

10.6 6 sessions a week is the maximum that sites can deliver. The pharmacies claim monthly for sessional fees as undertaken. Claims are reviewed by the Programme and submitted for payment via existing "local payment scheme"

national funding payment mechanisms by NHS BSA and are charged to the ICB. The ICB recharges NHS England for the cost of the sessional fees monthly as part of the programme operational processes to recover this cost.

10.8 Annual Programme costs were transferred to the ICB the SDF funding route.
The finance team were able to give assurance that this funding was received.

10.9 This programme funding has been actively managed and reviewed to ensure that
this has fully cover the costs associated with this programme.

10.10 Any residual allocations unused by the ICB at the close of this programme can be recovered by NHS England. This funding may, where appropriate, be redistributed to ICBs where extension of their programme has been agreed.

10.11 It was anticipated that any prescribing undertaken in this programme would not be
over and above prescribing that would happen under current primary care arrangements and would seek to instead provide the same prescribing provision in an alternative location. Monthly review of prescribing has given additional assurance that this is the case.

10.12 Future arrangements within the agreed “Transition Period” will ensure that costs remain within the current allocated budget.

10.13 The C&M Programme continuance for the nationally proposed “Transition Period” 1st Jan – 31st March 2026 @24 sessions per site per month for all seven sites will result in a Maximum Spend of £99,590.40

10,14 Note that this will leave a residual funding of £18,925.00 (minimum residual budge based on all 7 sites claiming and delivering maximum allocation of 24 clinical sessions per month for 3 months Transitional Period activity)

10.15 This residual budget will ensure that any unforeseen additional programme closedown costs or evaluation costs will be funded from existing national programme allocation and will not result in any cost pressures to the ICB.

10.18 Future commissioning (post 1st April2026) is anticipated to cost-

- £197.60 per clinical session (in line with existing arrangements)
- Equates to £4,742.40 per site per month for 24 clinical sessions per month (in line with existing arrangements)
- IT costs – to facilitate access to EPS arrangements – if commissioned via Cleo (existing provider) this is anticipated to be £160.00 per site per month (TBC)

- Total cost per site /month = £4,902.4 per month
- Total cost for all seven sites / month = £34,316.8 per month

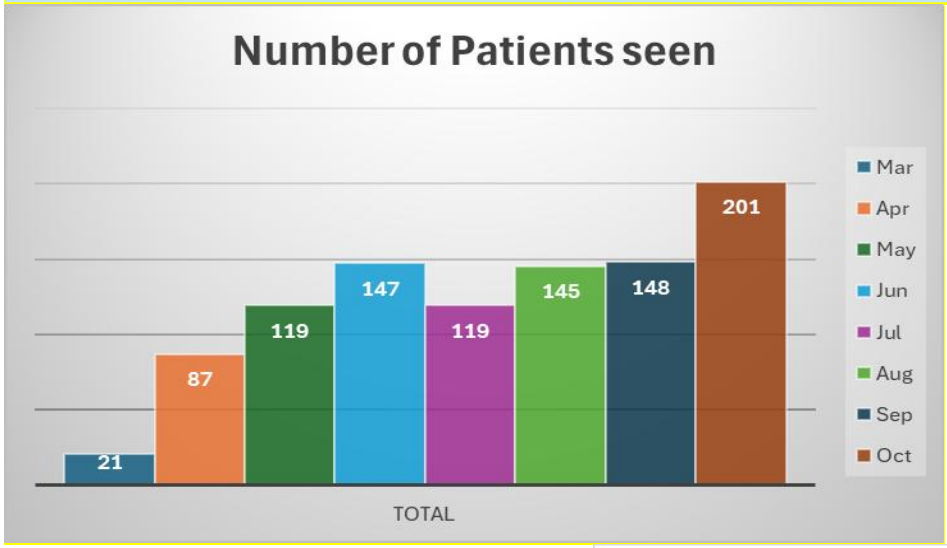
9.19 10 Any further future commissioned services will require identification of ICB funding.

11 Service Outcomes to Date

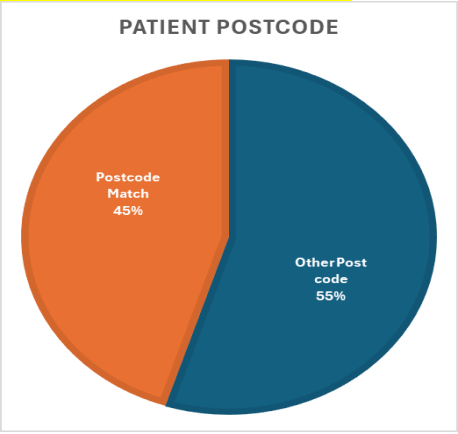
Total Number of Patients seen within C&M service – April – October 2026 = 987

Numbers of Patients seen across all C&M sites October -

Column Labels									
	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Grar
Count of PatientLinkID	21	87	119	147	119	145	148	201	987

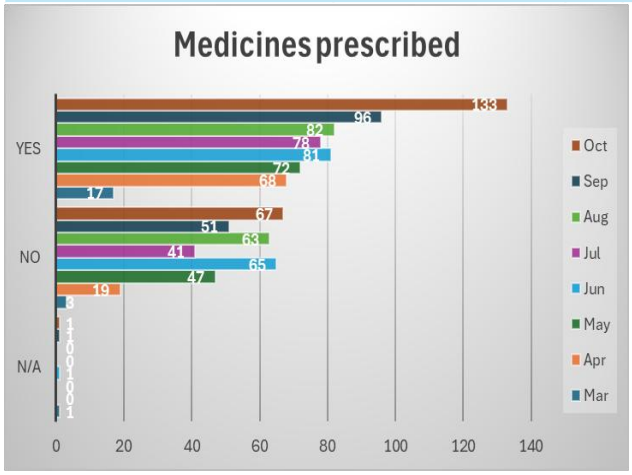


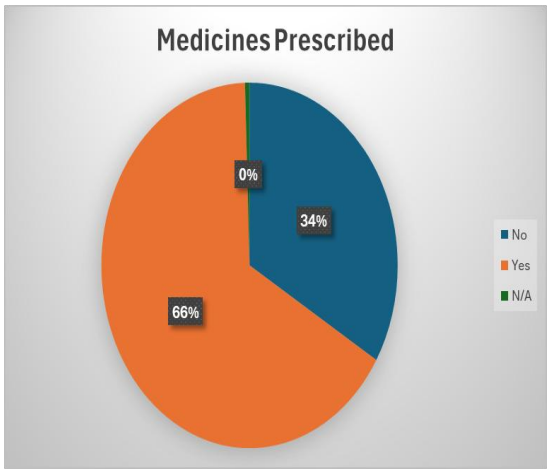
Pharmacy	IMD Decile	Number of Patients seen
Kensington Pharmacy	1	9
Upton Rocks Pharmacy	9	0
Daveys Chemist (Holt Road)	1	16
Daveys Chemists (Kensington)	1	22
Allied Pharmacy Crosby Road	4	34
West Bank Pharmacy	1	7
Allied Pharmacy North Park	1	85



Patient outcome – prescribing frequency –

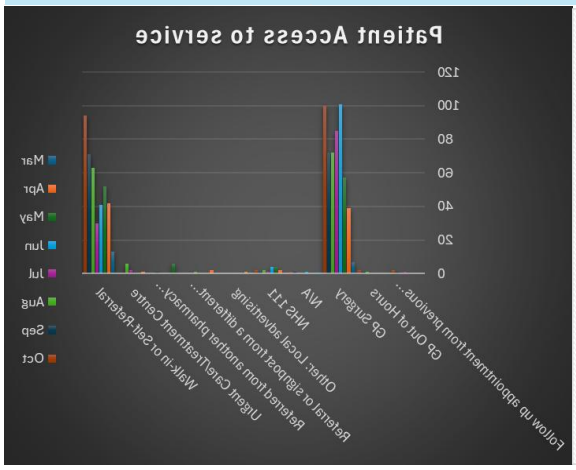
Count of Did you prescribe	Column Labels								
Row Labels	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Grar**
N/A	1			1			1	1	4
No	3	19	47	65	41	63	51	67	356
Yes	17	68	72	81	78	82	96	133	627
Grand Total	**21**	**87**	**119**	**147**	**119**	**145**	**148**	**201**	**987**

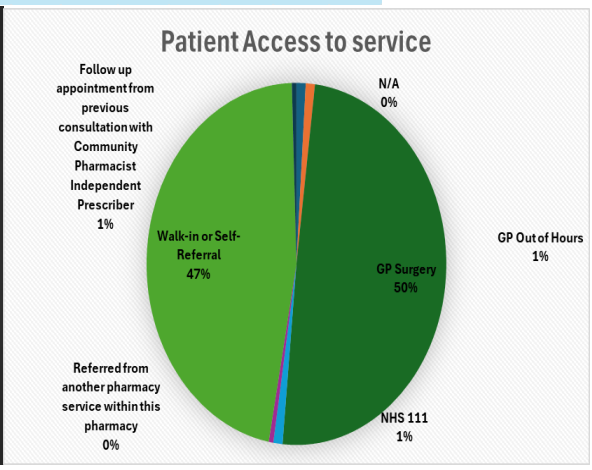




Access Routes into service -

Count of How did the patie	Column Labels								
Row Labels	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Grar**
Follow up appointment from previous consultation with Commu					1		1	2	4
GP Out of Hours						1	1	2	4
GP Surgery	7	39	57	101	85	72	72	100	533
N/A	1			1			1	1	4
NHS 111		2	4	4	1	2	1	2	16
Other: Local advertising		1							1
Referral or signpost from a different community		2				1			3
Referred from another pharmacy service within this p		6					1		7
Urgent Care/Treatment Centre		1			2	6			9
Walk-in or Self-Referral	13	42	52	41	30	63	71	94	406
Grand Total	**21**	**87**	**119**	**147**	**119**	**145**	**148**	**201**	**987**





11. Next Steps

11.1 National programme funding and Sessional funding will cease 31st December 2025.

11.2 ICBs have been asked to review and consider available residual budget from 25/26 programme underspend and any additional ICB funding to support delivery post 31st December 2026 for a "Transitional period" 1st January 2026 to 31st March 2026.

NHS England request for ICB action	C&M Programme response
Agree locally which Pathfinder sites they wish to continue after 31 December 2025, as well as which clinical models will be maintained; active pharmacy sites with patient consultation activity should be prioritised	Subsequent to review of residual budget and programme activity from the seven CPIP sites it has been established that all seven sites can continue to deliver activity under the CPIP programme during the transition phase 1st January 2026 to 31st March 2026
Consider extending local commissioning arrangements to any existing service arrangements to cover the interim period until 31 March 2026 (where possible)	The existing programme SLA has been supplemented with a contract variation detailing the transitional arrangements,Transitional phase dates and programme contractual end date of 31st March 2026.
prepare for the closure of Pathfinder sites that won't continue after December 2025, including closing down cost centres, Cleo profiles and deactivating NHS smartcard roles	Existing sites will continue to deliver patient facing activity including prescribing services during the transitional period 1st January 2026 to 31st March 2026 with preparation being made to manage closure of this service from 1st April 2026. Appropriate closedown processes and arrangements are being developed to ensure a safe management of withdrawal form this service in line with this timeline

11.3 A review has been undertaken and established that the ICB would not be in a financial position to commit any further funding to this programme to support further commissioned activity during this Transition Period.

11.4 A review has been undertaken to establish residual underspend and available budget to support delivery of clinical sessions in the Transition Period 1st January to 31st March 2026.

11.4.1 Identified budget for the nationally proposed "Transition Period" 1st Jan – 31st March 2026 = £118,515.40

11.4.2 Continuing the existing terms and conditions of the existing SLA (maximum 24 clinical sessions per month per site) will result in a Maximum Spend of £99,590.40

11.4.3 This will leave a residual funding of £18,925.00 (minimum residual budge based on all 7 sites claiming and delivering maximum allocation of 24 clinical sessions per month for 3 months Transitional Period activity)

11.4.4 This residual budget will ensure that any unforeseen additional programme closedown costs will be funded from programme Allocation and will not result in any cost pressures to the ICB.

11.4.5 During this Transition Period the existing 7 C&M will work towards site and programme closedown and clinical services will be no longer delivered after 31st March 2026.

11.5 Post Transition Period propositions and arrangements –

11.5.1 The existing Pathfinder Programme will be closed down from 31st March 2026

11.5.2 It is anticipated that options for a further National CPIP programme will be in place, subject to National negotiations, as part of the National Community Contractual Framework consultation for 2026 /27 as part of the NHS England 10 Year Plan.

11.5.3 There is no assurance (and it is not generally anticipated) that a contractual agreement will be in place to start 1st April 2026.

11.5.4 Any future commissioning in 2026/27 will be on a phased roll out (yet to be established)

11.5.5 This will result in the requirement, for any delivery of CPIP prescribing services post 31st March 2026, to be locally commissioned by ICBs as part of their primary care delivery strategic commissioning intentions.

11.5.6 National Guidance and support documents will be made available to ICBs to support any commissioning intensions in this arena as part of learnings developed from this programme.

11.6 The ICB will be required to consider further commissioning intensions regarding Community Pharmacy Independent prescribing as part of the 10 year plan and the indication that these services must be commissioned by ICBs in 2026 as outlined in the Medium Term Planning Framework Medium term planning framework - delivering change together 2026/27 to 2028/29

11.7 Consideration should be made as to potential for future any collaboration and integration opportunities for this programme with existing Transformation Programmes e.g. Neighbourhood Pioneer Sites – Specifically relevant to the two Sefton CPIP Sites which sit within the Sefton Neighbourhood Model for Neighbourhood Health

11.8 Consideration should be taken as to any Risks which may be identified due to the closure of this Programme –

11.8.1 Impact of withdrawal of this additional prescribing capacity and access within local systems.

11.8.2 Potential negative impact on perception of public and local professions for discontinuation of this service

11.8.3 Potential negative impact on engagement of local professional with CPIP services in the future – discontinuation and then "restarting" of services may give an appearance of short term commissioning intensions/ transient programme delivery for CPIP future programmes

11.8.4 Potential loss of engagement from Local Pharmacy Providers / Local Pharmacy stakeholders regarding CPIP future programmes.

11.8.5 Potential loss of local resources – e.g. CPIPs lost from local workforce system as IP employed positions are lost as part of programme discontinuation and IPs move elsewhere for employed positions. CPIPs lost to CP workforce and / or from C&M workforce

11.9 The ICB should consider options for any commissioning intensions for Cheshire and Merseyside ICB for period following "Transition Period" – i.e. Financial year 2026/27

11.9.1 Options appraisal -

Option appraisal	Description of option	Risk/ Benefit	Potential finding requirement
Option 1	Full C&M CPIP programme discontinuation post 31st March 2026	Risks as described above regarding full close down of programme	No further funding
Option 2 (recommended option if preferred Option (Option	Partial continued commissioning of existing programme (selected sites). Priority given for	Some risks as described above – limited to specific Place where service is discontinued.	Sessional funding required IT provision funding based on number of sites continuing delivery. (current approximation of cost = £160/site/month). To

4) is deemed non viable)	sites within existing commissioning of transformative services e.g. Neighbourhood Pioneers	Risks lessened due to less active sites being subject to discontinuation hence less impact on local services and patient population however same existing reputational and workforce risks.	be negotiated /confirmed with supplier. Proposed monthly funding of - 24 sessions per site - £4,747.40 - £160 IT costs - Total £4902.40/site/ month Dependent on number of sites to continue
Option 3	Partial continued commissioning of existing programme (all sites commissioned under agreement re reduced numbers of clinical sessions). Priority given for allocation of available funding based on individual site activity / patient workload Sites within existing commissioning of transformative services e.g. Neighbourhood Pioneers given priority for funding allocation	Some risks as described above – limited to specific Place where level of commissioned service is reduced. Risks lessened due to less active sites being subject to reduced offer of commissioning hence less impact on local services and patient population. Lessened risk to reputational impact and workforce risk	Sessional funding required IT provision funding based on number of sites continuing delivery. (current approximation of cost = £160/site/month). To be negotiated /confirmed with supplier. Proposed monthly funding of - Up to 24 sessions per site - £4,747.40 - £160 IT costs - Total up to £4902.40/site/ month Dependent on number of clinical sessions agreed per site
Option 4 (recommended Option)	Full commissioning of existing programme (7 existing sites(until such time that a national commissioning framework / solution is available to inform CPIP future provision withing CP	No immediate risks as service continues as is	Sessional funding required IT provision funding based on number of sites continuing delivery. (current approximation of cost = £160/site/month). To be negotiated /confirmed with supplier. Proposed monthly funding of - Up to 24 sessions per site - £4,747.40 - £160 IT costs

	Contractual Framework.		- Total up to £4902.40/site/ month Total = £34,314 per month for all 7 sites delivering full 24 clinical sessions per month.

11.10 Recommended Option to negate Risk and to future proof ongoing viability of services as they transition within the national framework - is Option 4

11.11 Option 2 should be considered as fall back position if Option 4 is not deemed financially viable.

12 Recommendations

12.1 The SPCC Committee will be asked formally to :

12.1.1 Note the Programme continuance for the nationally proposed "Transition Period" 1st Jan – 31st March 2026 @24 sessions per site per month.

12.1.2 Note that Transition Period sessional costs will result in a Maximum Spend of £99,590.40

12.1.3 Note that this will leave a residual funding of £18,925.00 (minimum residual budge based on all 7 sites claiming and delivering maximum allocation of 24 clinical sessions per month for 3 months Transitional Period activity)

12.1.4 This residual budget will ensure that any unforeseen additional programme closedown costs will be funded from programme Allocation and will not result in any cost pressures to the ICB.

12.1.5 Consider options for any commissioning intensions for Cheshire and Merseyside ICB for period following "Transition Period" – i.e. Financial year 2026/27 – From the options appraisal Option 4 is the preferred Option with Option 2 being a secondary option if Option 4 is judged not financially viable.

13 Officer contact details for more information

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Appendices

Appendix 1: National Strategy

NHS England – Medium Term Planning Framework delivering change together 2026/27 to 2028/29 -

https://www.england.nhs.uk/wp-content/uploads/2025/10/medium-term-planning-framework-delivering-change-together-2026-27-to-2028-29.pdf

NHS Long Term Workforce Plan –

https://www.google.com/search?q=NHS+Long+Term+Workforce+Plan&mstk=AUtExfAYicfKprsEhBlBXK6KBoZWTyRpJLXX0a1BjYtw3FGJV3OwsXLBZ6pFOR8TD8930nIGvJazhLudF2di-EwfkLjL1SMQg02O_yygxC09wRVXg9xCbEMICIMTK2kjuKdCWEuiLHfDCLFl74dCgeq_86aFhASIM7DI_TmLAkEurrxm4g8&csui=3&ved=2ahUKEwjDvO_dg8mQAxUHUkEAHZaqEIQQgK4QegQIBhAC

NHS 10 Year Plan -


NHS%2010%20Year%20Plan%20Commu


Referenced%20Summary%20Pharmacy%


Summary%20Pharmacy%20and%20Pharn

Medium term planning framework - delivering change together 2026/27 to 2028/29

Appendix 2: National Comms

IP Funding Model August 2023 0.3 ICB Aug 2023

PRN02171_Letter_Independent Prescribing Oct 2025

Appendix 2: letter to ICB Chief Executives / Chief Pharmacist/ Director of Medicines and Pharmacy and Medical Director from Ali Sparke Director of Pharmacy, Dental and Optometry – NHS England ref PR00641 – 14th August 2023.

PRN00641_Independent Prescribing in

Appendix 3: MOU

Cheshire and Merseyside ICB.docx

Appendix 4: SLA template

IP Pathfinder Programme – Suppl

20230912 IP Pathfinder programı

Appendix 5 – Local Presentations used with Stakeholder groups to support this programme


NW SMT CP IP Pathfinder Programı


20230725 IP Pathfinder Slides v0.

Appendix 6- CPMG contracts for Service development /


CM-CHL SLA IP Pathfinder PharmOut


Signed Contract- RA. PS signature.rtf

October Stakeholder Data sets –


Oct%20Minor%20Illness%20dashboard%2


Oct%20Resp%20dashboard%20CPMG.xls›0


03112025%20V2%2redacted%20report%

NHS
Cheshire and Merseyside

Meeting of the System Primary Care Committee

NHS Cheshire and Merseyside

Access to Primary Medical (General Practice) Services 'June 2025' plan assurance update

Agenda Item No: SPCC 25/12/B14

Responsible Director: Clare Watson, Assistant Chief Executive

1. Purpose of the Report

1.1 To update the Committee on:

(i) 25/26 key ongoing actions and outcomes to support improving access to general practice - outlined within the plan agreed in June by the Committee- and a key strategic priority of the ICB.
(ii) This report and committee update forms part of the assurance to NHS England in respect of delivery of improved access and the above plan.
(iii) This update includes information and updates at system and place level.

2. Executive Summary

2.1 In January 2025, NHS England published the operational planning guidance NHS England » 2025/26 priorities and operational planning guidance and for primary medical services, there was a focus on assurance of actions expected by ICBs to support improved access following two years of investment and policy measures. By June 2025, the ICB was required to expand on this response, and produce a single agreed action plan which sets out practical actions to improve contract oversight, commissioning and transformation for general practice - and address unwarranted variation. Collectively, these actions would support delivery of the overall planning guidance priority **to enable patients to access general practice in a timelier way and improve patient experience**

2.2 In June this Committee signed off the agreed plan which centered around specific actions to support ;

- Tackling Unwarranted Variation
- Improving Contract Oversight
- Improving Commissioning and Transformation

Which was to be achieved by key enablers, **including** ;

- Supporting delivery of modern general practice including maximisation of digital tools and other services to improve access
- Implementing the 2025/2026 GP contract and maximising available commissioning and contracting levers
- Use of key data sets and patient experience feedback, to inform progress

2.3 In line with NHS England expectations, and as part of the governance and overview in line with the plan submitted, regular updates to the committee on improving access to primary medical services are expected. It was agreed that this would be combined with an update from Healthwatch's in relation to current patient experience and feedback on access.

2.4 **Appendix 1** outlines in more specific detail, updates per area of the 'June' plan but in summary ;

Key progress areas to date;

- Progress has been made in relation to **use of consistent data sets, to understand variation - and applying a framework to identify further actions with practices -** this includes access to and usage of the national GP dashboard as the base set of data and this triangulating with local data sources and intelligence. This has enabled the identification of practices across the ICB into a single list with consistent reasoning – and supported onward assurance to NHS England in terms of actions to address access variation at a specific level. This information will need to be tracked and monitored over time to enable the ICB to the measure impact of the variation work at both system and specific practice level. The numbers of practices identified and those being supported are given in Appendix 1.It should be noted that the data set for the national GP dashboard has changed over the summer period hence why recent actions have concentrated on the triangulation, as the data set and names of practices was updated.
- A good response to the national **practice level support** (PLS) scheme for 25/26 by practices, (noting that many other practices have already been on the scheme in previous years) which enabled the ICB to use a large proportion of the national funding available before the end of June. 34 practices are on the scheme which gives support to understand areas such as demand, capacity and access with trained facilitators. For some levels this includes shared cohort learning between practices and access to on line portals/further learning for all levels to use, after the cohort ends. Some PLS offer levels also include on site visits from the facilitators.
- **Data and patient experience** - As previously reported to the Committee the GPPS (GP Patient Survey) had shown improvements prior to the 25/26 plan implementation - including meeting the national average for key indicators as previously reported to the Committee. For ongoing patient experience measurements a key data from the ONS (Office for National Statistics) set is pulled out into Appendix 1 and is being tracked throughout the year. The ICB also need to ensure the actions identified via the Healthwatch local survey are followed up. The number of appointments overall is within the 2 per cent planning guidance ambition reported so far and 12 month comparisons with appointment types and numbers show an increase, in particular with on line. There remains a slight reduction in the overall number of appointments within 2 weeks and although the current figure is around the 90 per cent ambition, there are variations in year.
- **Contracting and governance** – progress has been made in developing more oversight to support consistency which for example includes use of single templates and the data variation work above. The new commissioning oversight group which has been in place since July has brought together commissioners to over see areas for consistency and ensuring priority asks are covered – any further developments in governance will form part of the ICB blueprint work as the ICB operating model moves forward.

- **Specific examples** of some of the improved access measures and results are given in the place examples in **Appendix 2.**

Areas for further focus

- Measuring/understanding **demand** and use of the new CBT (Cloud based telephony) dashboard and data which is now publicly available. Some systems information was not fully integrated into the dashboard in earlier versions.
- **Health Inequalities mapping and access** – further work to understand areas of deprivation and access, some of which has been included in the variation work to date but a more systematic correlation and approach is required.
- **Measuring improvements** – as this report is based on information/actions primarily from June-December further work is required to understand any impact – including, of the specific practice level improvements agreed from the variation work. Patient experience measures reported in 26/27 will be key to this.
- Further **contract risk assessment** work as outlined in the June plan will be an ongoing action, as part of the ICBs revised operating model.
- The impact of the **1.10 contractual changes**, in particular on line consultations - on patient experience and practice demand/appointments will need to be assessed at a future update.
- **Modern General Practice** – ongoing awareness of use of digital tools – this was raised as an issue by colleagues from Healthwatch. As part of the variation work there may need to be more targeted work required to support actions around data inclusion.
- **Modern General Practice** – a particular emphasis on referrals to Pharmacy First as part of the variation work (latest data included as part of the Commissioning/Policy update).
- **Outcomes from Risk Stratification (PCN DES requirement)**. This is also a key enabling element of neighbourhood health working, as this work progresses the key findings, some of which have been referenced in the place level updates – need to be assessed and impact reported.

2.5 An ICB ‘scorecard’ position on key areas of access has also been developed by NHS England which has been shared in draft with ICBs and will form part of ongoing ICB assurance. The ICB June plan targets and data will be reviewed against this once confirmed

3. Ask of the Committee and recommendations

The Committee is asked to ***discuss and note*** the update on actions to support improving access to general practice, as part of the ‘June Plan’ submission - which is for assurance purposes.

4. Appendices

Appendix 1 – June Plan - update against plan areas

Appendix 2 - Place specific updates

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 following BAF risks ;

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

8. Finance

- No finance decisions are required

9. Communication and Engagement

Ongoing patient communications and engagement were outlined where required in the original June plan. Some areas were part of national campaigns, such as the NHS App. Regular patient experience feedback via surveys and data is a key consideration in the original June plan.

10. Equality, Diversity and Inclusion

Were outlined in the original June plan in terms of data considerations and impact. Further work is required in understanding access and deprivation as outlined.

11. Officer contact details for more information

Christopher Leese, Associate Director of Primary Care –
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Appendix 1 – June Plan Update

<table>
<tr><th>Section of June Plan</th><th>Update</th><th>Data sets from original plan - updated</th></tr>
<tr><td colspan="3">1.Tackling Unwarranted Variation</td></tr>
<tr><td>(a) Data – Qualitative and Quantitative (Practice Level)</td><td>From April 2025 all ICB PC Commissioners will have access to the ICB (local) Primary Care Scorecard and using data systematically - complete
From end of May 2025 all ICB PC Commissioners to have access to the national GP Dashboard (GPD) using the data systematically – complete
June Action Plan sign off at System Primary Care Committee on 19th June 2025 and submission to NHSE by 23rd June 2025 - complete
From July 2025 all ICB PC Commissioners will work to the single list / outputs and levels and agreed variation framework complete – the work with practices is ongoing.
Variation and data reports at new primary care (medical) commissioning oversight group – outlier and variation updates in place at each meeting - in place
Commissioner led/Practice level plans, where agreed to be developed, in place by end of August 2025 for practices initially identified, each plan will have specific key actions/trajectories /dates and timelines supported by appropriate data – those numbers are captured in the data section, this work is ongoing
Updates to System Primary Care Committee commencing August 2025 from the oversight commissioning group, by exception – ongoing, will be reported as part of the access improvement and BAU updates to the committee, in place/ongoing. Specific overall improvements will be expected by March 2026 when overall progress will be assessed – to be reported at SPCC in April 2026 meeting with full year data following this committee report as an interim.</td><td>• 22 practices (6.7% of practices) identified through GPD** as outliers in Access (noting the national data set has changed this year several times with more added , but the numbers have fallen from the initial list / number of 26 although names of some practices have also changed)
• If we compare this with other ICBs nationally on the GPD where the variation ranges from 17.7% and 1.6&, C&M ICB is in the middle range
• Following further work, a total of 42 Practices were identified for further discussion and understanding in terms of access (noting not all these are on the GPD but may have been identified through local measurements/data or other data sources such as QOF) and this work is ongoing.
• 6 Commissioner led improvement plans in place so far which will capture individual trajectories for at practice level

Reminder of GP dashboard data sets as below for Access **
Number of general practice appointments per 1,000 registered patients
Percentage of appointments not usually booked in advance seen with 14 days of booking
Percentage of patients describing their overall experience of their GP practice as "very good" or "good"
Percentage of patients describing their overall experience of contacting their GP practice on this occasion as "very good" or "good"
Emergency ambulatory care sensitive (ACS) admissions per 1,000 registered patients (UC-03)
Emergency admissions per 1,000 registered patients (UC-02)
CBT (indicator tbc)
The percentage of calls to 111 during GP operating hours (Monday- Friday, 0800-1830)
Rate of online consultations per 1,000 patients registered at practices known to have an online consultation system
Percentage of appointments with a GP as a total of all general practice appointments (excl. estimates, covid vaccs, and PCN appointments</td></tr>
<tr><td>(b) Data - ICB Strategic Level</td><td>Key data sets agreed for strategic oversight– in place and reported in data section
Patient Experience -
June 2025 Final Local Healthwatch survey released and responded to, underpinning local actions and priorities - Complete and also reported to Board also – regular patient experience updates commencing at SPCC in December.

GPPS released and assessment update on progress at August SPCC and</td><td>GPPS results – ICB aim in improvement plan to meet the national average and improve on the previous year in key question areas below (reported to committee / board previously)
<table>
<tr><td>Question</td><td>2024</td><td>2025</td><td>National</td></tr>
<tr><td>Patients knowing next steps / contact</td><td>82</td><td>83</td><td>83</td></tr>
<tr><td>Good Experience of contact</td><td>68</td><td>70</td><td>70</td></tr>
</table></td></tr>
</table>

informing any practice/local level action plans - Complete and reported to Board also

GPPS results are included in the 1(a) data sets to support variation work. Regular overall updates from August/October 2025, dependant on review of ICB's operating model – first new format reporting at December's Committee meeting.
ONS Health Insight Survey dashboard improvement check in at updated survey release points, dates ongoing through 25/26 – tracked results given in data section on key question.

Had Confidence and Trust	93	93	93
Felt Involvement in decisions	92	92	91
Felt Needs were met	91	91	90
Good Overall Experience	76	78	75

Method and mode of appointment (to increase across all forms to meet demand)

Area	12 months ago from most recent	Most recent
Number of appointments (total)	1,253,935	1,364,319 *Within 2 per cent overall growth for the planning guidance*
Number of face to face appointments	800,347	816,462
Number of telephone appointments	324,984	351,828
Number of on line /appointments *	84,792	143,772
Number of on line consultations *	165,570	211,547
% and number appointments same day	46.44% 582,318	47.82% 652,373
% within 14 days ICB target 90%	90.09%	89.62%

*Further data work ongoing with other sources regarding these areas and to triangulate with the new OLC dashboard

ONS (Health Insights Data) summary
Overall good experience in line with the national average – plus other key indicators (ongoing)

Date	**Percentage**
Sept 2024	70.2
April 2025	78.6
Jul 2025	73.9
Oct 2025	74.7

(c) Planned actions to address unwarranted variation	**Individual action plans for outliers** will detail individual practice actions and contract expectations as commissioner. This is in progress as part of the work outlined in 1(a) above **Supporting improvements in experience of making appointments** and strengthening actions to utilise other methods of contacting practices to further support management of telephone demand – the ICB continue to support on line consultation implementation and all practices utilise cloud based telephony systems and reporting/data in place for access from late November (further work required in use of this data). The ICB has engaged with and been working with it's **PLS (Practice Level Support)** delivery partners since February to agree/shape its delivered support programme for practices focusing on those practices who have identified access issues as outlined in the reducing variation section - with a priority to maximise the National SLF offer which closed on 30th June. This programme is now progressing with numbers reported in the data column. **Outputs from PLS reports** will detail further tangible plans/dates for achievement –findings/improvements from PLS will be reported as the programme cohorts complete Dec 2025-March 2026 Outputs from the **MGP Modern General Practice** Assessment(s)- this work is ongoing and forms part of the outlier work above. **Risk Stratification/ Continuity of care** approaches are currently being collated as part of the PCN DES (Primary Care Network) Directed Enhanced Service approaches and CAIP(Capacity and Access Improvement Payment) work – all practices have been given support in relation to the risk stratification tool required across the ICB and this work is ongoing – outputs from this will be reported at the end of the year – number of claims are given in the data column.	• See section 1(a) above for individual number of practices identified as outliers • Practice level support - 43 practices initially referred for Practice level support /discussion through funded national offer • Final numbers on PLS 34 - all funded via national funding so no additional ICB resource required • In addition, 8 practices undertaking support level framework outside of Practice Level Support • A number of practices proposed for SDF support and this will be agreed/finalised at the beginning of December. • 57 practices have declared and claimed the PCN DES payment for achieving the ask in relation to risk stratification of patients
2.Improving Contract Oversight		
(a) Proportionate Contract Review approaches (b) Support for contractual management and governance	The ICB will be **risk assess contracts** in a single list using data and information set out in section 1, in relation to access (but other key measures used to assess contract compliance – quality/concerns and other measurements) to be used , to identify practices for standard reviews/visits or other support (variation approach is given in section 1) and using a CATS escalation type approach (see section 3). Single data sets actions in place and usage is being embedded (See above section 1 for timescales and actions). This work is ongoing but will need to be finalised post any review of the ICBs operating model and structures. Contracts are currently assessed and managed in line with existing governance and oversight arrangements with consistency managed as part of the oversight group. A new single **commissioning oversight group** at system level for contractual consistency across the ICB will be in place pending any further outcomes of the new ICB operating model –This group has been in place since July but other aspects of alignment will be finalised once the ICBs future operating model and supporting governance is confirmed	• 44 practices have claimed the PCN DES payment for achieving the ask in relation to Modern General Practice • Compliance with new contract requirements 1.10 – 99 per cent for OLC • Expected 100 per cent for 'You and Your GP' to be confirmed following the national edec review (Dec/Jan) • GP Connect data shows some areas of non- compliance which are being followed up, as below ;: HTML Activated: 333/336 (99%) Meds & Allergies Activated: 322/336 (96%) Remainder Activated: 305/336 (91%) All 3 Activated: 305/336 (91%)

	Standard contractual templates are already in place but some further harmonisation of approach and single SOPs will be taken forward as part of the future operating model. A separate piece of work has commenced reviewing cv (contract variations) processes. Focus areas for the **GP Contract 25/26** monitored via the new commissioning oversight group and at place level - and reported by exception to SPCC - in place and reported, variation managed through oversight group. It should be noted that NHS England have put in place several separate assurances in this area which have all been responded to. The ICB are already also using a **MGP (Modern General Practice** Assessment) tool (x2) to support practices/PCNs to identify areas where support/maximisation of MGPA – some variation in relation to Pharmacy First and NHS App usage being followed up at oversight group The ICB has put in place a single system oversight group for **Advice and Guidance** blended with the Primary/Secondary Care interface group – this group will oversee actions in respect of the A/G baseline assessment/action plan –an update on Advice and Guidance is given separately on this agenda including progress on spend and capping – and an overall improvement plan is being developed currently. **Local commissioned services that have been secured, are managed, and reviewed if needed, as part of the above work** – maximising contract levers to support increased access and strengthening contract and commissioning oversight for local contracts. This could include using local contract levers to support bespoke population based improvement in some patients groups. Local contracts are currently under review and that includes those that may target access issues for populations. **A single standard progress report by exception to SPCC**– reported here for December 2025 **A regular access / patient experience agenda item** with Healthwatch to check patient experience feedback throughout the year, at SPCC – update here for December 2025	
3. Improving Commissioning and Transformation		
(a) Improving access through Commissioning and Transformation Support (CATS) approach and high quality evidence based support/assessment tools	**CATS assessment tool** In April 2025 the NHS England CATs tool was completed to assess the position for key actions under the planning guidance – this original plan was to redo this in September but this will now be undertaken following completion of the ICBs blueprint and management of change process. Actions identified in the original assessment have been pulled into this plan where able including the governance/oversight, key metrics and enabling functions**.**	

(b) Maximising other enablers and infrastructure to improve patient access and experience	**Estates**
	The Committee has previously received an update on the estates work in general but highlighting access related areas for progress include (i) Core, Flex and Tail classifications identified capacity and/or expansion challenges within Flex/Tail assets (ii) action plans to be developed Development plan on a page being produced for each Neighbourhood underway (iii) PACE (Productivity Acceleration in Community Estates) Programme underway within Community Health Partnership premises (iv) Cheshire and Merseyside prioritisation exercise for transformation projects undertaken to support long term capital investment planning for all Places (v) Capital allocations released for next 4 years, prioritisation of funding to include assessments of GP Dashboard via national and local indicators for access and supporting Modern General Practice.
	Digital
	Continuation/maximisation of digital tools with identification of practices who require support with the delivery of modern general practice in accordance with defined time lines ongoing in 25/26, via the modern general practice assessment work. This includes exploration of options for expansion of digital pilots to ensure access to solution fit to deliver neighbourhood working in line with national priorities currently underway. NHS app usage remains variable and further data sets have been produced at practice level to support further local conversations with practices to support/increase uptake, as part of the variation work (NHS App data is in the next column). Healthwatch had previously flagged concerns in relation to all patients being able to access/use digital tools including for example, the NHS App and this is an area of work the ICB need to continue to monitor.
	BI and data tools
	The ICB are accessing the range of additional tools that have been developed to support the management of the contract and access related issues – further work is required in respect of the CBT (Cloud Based Telephony) dashboard which analyses call data into practices – and is a useful tool for demand management. In addition there are some gaps with practice systems where data is not included yet for some on the on-line consultations and cbt dashboards so these cannot be fully utilised. Data pulls for these areas will be reported at the next meeting.
	Peer Ambassadors
	The ICB has one peer ambassador but we are understanding what resources can be used to increase and maximise this area.
	Demand
	Further work is required on quantifying demand using available metrics (including CBT above) but this remains a priority area for development
		• As at Sep-25 (latest available data) the ICB had 2,146 ARRS (additional roles) WTEs
		• For the 25/26 financial year, the number of ARRS roles has reduced by approx. 9 WTE, however it has increased between June-25 and September-25 by approx. 54 WTE so the overall trend remains an increase
		• 52 per cent ARRS spend so far in 25/26
		• Cloud based telephony data will need to be reported/analysed in due course (call volumes etc) when all systems data is available. This will also enable further understanding of overall demand.
		• NHS App data
		  ○ Percentage of patients registered with the App – 71 per cent national , ICB 67 %
		  ○ Appointments booked oct 2025 6071 (rising)
		  ○ Appointments cancelled oct 2025 11852 (rising)
		  ○ Prescriptions 360,839 (rising)
		  ○ Messages ICB 191k
		  ○ Message numbers/percentage and actions is consistent with the national average and is a further focus area.

	Funding streams The ICB allocated a proportion of SDF spend to targeted access and resilience and this is being finalised currently following work with practices with challenges based on our variation work above. The ICB had already been able to access a substantial portion of the national funding for PLS allocated to it to meet all the requirements of our practices so no additional funding was required from within the ICB. **Referrals to Pharmacy First** A steering group has been in place for this for several months, data sets and variation information is shared with all places and discussion at oversight group – this work is ongoing with a particular focus on variation (***latest data is reported in the commissioning and policy update***).	

Appendix 2 – additional Place updates

Warrington

Improving Access to Primary Care (General Practice)

NHS Cheshire and Merseyside

Name of Place	Warrington

What actions/outcomes to address variation within place

3 Warrington GP practices have completed the Support Level Framework and developed associated action plans. Practices identif ied using both outliers on for access indicatiors on the General Practice dashboard and soft localised intelligence.
1 practice commenced the GPIP in October 2025

What actions/outcomes in relation to patient experience feedback/data

National GP Patient Survey and Healthwatch Access Survey results have been shared with PCNs and GP practices for review and i dentification of improvement needs.
All of Warrington's 5 Primary Care Networks carry out in house access surveys throughout the year, which are generally bette r engaged with than national surveys.

GP connect: 17 of Warrington's GP practices are still working towards compliance for all three areas of GP connect. Guidance for compliance has now been shared from TPP. ICB place team working with practices to improve compliance.

Overall Improvement headlines/ areas of best practice or other narrative

Online consultations: Compliance audit undertaken in October and all practices now compliant; detailed feedback has been shar ed with central team on findings and steps undertaken.

Primary Care Utilisation and Modernisation Fund: Final NHSE DOF approval has now been granted for 3 schemes. Schemes are unde rway and expected to be completed by March 2026. Schemes focus on repurposing or refurbishing existing and underutilised space to increase estates capacity for appointments and access

Halton

Improving Access to Primary Care (General Practice)

NHS Cheshire and Merseyside

Name of Place	Halton

What actions/outcomes to address variation within place

Practice	Actions / Improvement Plan	Progress
Practice 1 & 2 Level 1 review: C&M outlier & National GP Dashboard outlier	Met in May 2025 to review / understand data & identify support opportunities. Accepted referral onto PLS. SDF Access and Resilience funding offered for consideration, 1 Practice submitted application as telephone access is area of concern (NPS.)	Progress reviewed via PLS programme, N.GPD and local Place GP dashboard indicators, and via Place Same Day Primary Care programme. Implementing Digital Front Door via Paco Blinx.
Practice 3, 4 & 5 Level 1 review: National & local GP dashboard outlier	Met in May 2025 to review / understand data & identify support opportunities. 2 Practice declined PLS (not the right time) & 1 accepted. SDF Access and Resilience funding offered for consideration.	1 Practice undertook SLF facilitated discussion in 2024 with Place team and follow -up meeting held in November 2025. 1 Practice SLF facilitated discussion with Place team held November 2025. Progress reviewed via N.GPD and local Place GP dashboard indicators, and via Place Same Day Primary Care programme. Implementing Digital Front Door via Paco Blinx.
Practice 6 & 7 Additional local intelligence	Met 1 Practice in Sept 2025 and 1 in November 2025 to review / understand data & identify support opportunities. SDF Access and Resilience funding offered for consideration. Support offered with building management and IP concerns - Practice co-located with other services which impacts on patient population, performance and explains outlying position. Ongoing meetings held with regards to estates issues which impacts outlying position of 1 Practice.	Implemented Digital Front Door via Paco Blinx.

What actions/outcomes in relation to patient experience feedback/data

- 5/7 practices above also showed below average scores on NPS access indicators; action taken as noted above.
- No specific practice identified through local Health Watch, but general access challenges reported.
- NHS App uptake is good (63% Sept 2025) and reviewed regularly with Practice Managers with continued discussions on how practi ces, PCNs and Place can increase utilisation.

Overall Improvement headlines/ areas of best practice or other narrative

- All 3 practices undertaking PLS participated in GBL2 meeting in November and provided positive feedback on the process, areas for improvement and implementing change.
- 4/6 practices in Runcorn have moved to total clinical triage in addition to the MGPAM. A 5th practice applied for SDF funding to support clinical triage & access improvement, 6 th considering clinical triage in the New Year.
- Local OC survey undertaken to assess numbers per practice, changes in ways of working & challenges, and to support ongoing sh aring of best practice and learning.
- Paco Blinx Digital Front Door : All 8 practices in Widnes are implementing this as part of the C&M pilot. All 6 practices in Runcorn have also signed up and are commencing initial implementation.
- Place wide implementation of Paco Blinx is supporting consistent access model & wider discussions of benefits to support Neig hbourhood working, providing additional opportunities to improve access to wider services.
- Key development area is ensuring patients understand MGPAM & clinical triage access models, to support patient expectations, with limited comms support.

Liverpool

Improving Access to Primary Care (General Practice)

NHS Cheshire and Merseyside

Name of Place	Liverpool

What actions/outcomes to address variation within place

PLS
12 practices have been asked to participate this year in the Practice Level Support programme based on meeting 2 or more of t he following criteria:
- scored the lowest 20% in the city for QOF for 2024/25
- ranked Requires Improvement in last CQC inspection
- did not achieve 3 or more of the 8 local quality contract (24/25 GP Specification) indicators were not 100% achieved
- negative variation on the access element of the NHSE GP Dashboard.

9 of the 12 above practices are currently participating in the PLS; the remaining 3 remain part of other follow up routes (quality/SDF resilience funds). In addition, 4 practices volunteered to take part
2. SDF Resilience funds
As at 06/11/25 x4 Liverpool practices with particular resilience issues have been offered this funding, and none have confirmed acceptance to progress to application stage as yet. A further 5 practices are on the list for consideration of these funds depending on confirmation of factors such as quality visit/status of issues/progress .

What actions/outcomes in relation to patient experience feedback/data

1. National patient survey
Results have been shared with PCNs and in the bulletin to all practices. Overall experience of the GP Practice being good: IC S 78%, national 75%; The ICS results have improved compared to the 2024 results. x4 Liverpool PCNs fell below 75%, however these PCNs either maintained or improved performance compared to 2024.
2. October 2025 contractual change implementation
Online consultations: Compliance audit undertaken in October and all practices now compliant; detailed feedback has been shar ed with central team on findings and steps undertaken.
GP connect: Practices are fully compliant.
You and your General Practice: Fully compliant.
LfPSE: System sign up details have been shared with all practices and some PCNs scheduling demos with central patient safety team; awaiting system sign up data from safety team.
3. CAIP Standing agenda item at bi-monthly PCN meetings; to date 1 PCN (4 practices) have declared compliance with all domains (Brownlow PCN).

Overall Improvement headlines/ areas of best practice or other narrative

Primary Care Utilisation and Modernisation Fund: Final NHSE DOF approval has now been granted for 7 of these schemes with one awaited. Schemes are underway and expected to be underway in September for completion by February 2026. Schemes focus on repurposing or refurbishing existing and underutilised space to increase e states capacity for appointments and access
Aintree Hospital site development: This is a proposed new development on the Aintree Hospital site that would house 3 GP practices currently within 'tail' estat e in the Aintree area, alongside wider community and neighbourhood services. A task and finish group has been established and an initial cost / benefit analysis conducted. Th is vision aligns with the NHS 10 Year Plan and Neighbourhood Health Guidelines.
ARRS: All 9 Liverpool PCNs are maximising ARRS funding and are on track to spend 100% of allocations. Recruitment has stabilised an d is generally now limited to replacement roles. Childwall & Wavertree PCN have successfully applied to fund a new role under ARRS for a Trainee Pharmacy Technician which supports career developme nt and retention. 8 out of 9 Liverpool PCNs now employ newly qualified GPs (within the last two years). Approx 428 FTE staff are employed through ARRS in Liverpool
Local quality contract: The local quality contract evaluation of outcomes (2024/25) highlights several areas of good practice and progress made to support vulnerable patient cohorts, movi ng to proactive care approaches and shaping services around the needs of high risk cohorts.

Cheshire West

Improving Access to Primary Care (General Practice)

NHS Cheshire and Merseyside

Name of Place	Cheshire West

What actions/outcomes to address variation within place

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All elements of the GP Patient Survey results are considered when identifying the practices with both positive and negative v ariation.

We have undertaken SLF visits in 84% of practices, feedback has been extremely positive from those practices that have engage d with the visits. Will continue to offer these to those remining practices yet to have a visit.

Six practices have taken up the PLS support offer, with positive outcomes and feedback reported.

What actions/outcomes in relation to patient experience feedback/data

The Place level GP Survey results and the comparison data for C&M have been shared with all practices. A number of practices have undertaken their own patient surveys which have yealded higher response rates and generally more positive results. The Healthwatch Survey results have also been shared with practices.

We continue to encourage practices to maximise the number of their patients using the NHS App and this is increasing.

Overall Improvement headlines/ areas of best practice or other narrative

Details of excellence and innovation identified as part of the SLF visits with practices has been shared and adopted across p ractices in Cheshire West Place. This has resulted in cancers being picked up on patients that would not have otherwise been the case as well as an increase in screening uptake for hard to reach groups.

Cheshire West Place has held Neighbourhood health workshops to encourage practices and PCNs to engage with this way with an i nitial focus on improving the MDT arrangements in order to optimise their benefits.

Sefton

Improving Access to Primary Care (General Practice)

NHS Cheshire and Merseyside

Name of Place	Sefton

What actions/outcomes to address variation within place

- A piece of work was undertaken in August to identify practices based on August General Practice Dashboard data. Practices with 4 or more negative variations in the access and experience domain, or 7 or more negative variations across all GPD domains, FFT, ICB Business Intelligence Portal (for those practices not part of a PCN), Complaints and outcomes of Phase 10 LQC were identified for a practice visit.
- Eleven contracts (various providers) across Sefton were contacted in September by letter with a screenshot of GPD August data across all domains which highlighted both negative and positive variations, or ICB BI portal information. The letter also detailed April– June FFT, LQC phase 10 achievement, year to date Phase 11 progress, and any complaints received. Practice visits were planned in October/November. Before each practice visit, the data within the letter was refreshed to reflect the latest data available
- At the time of the visits there were several caveats on the GPD website in relation to vaccinations, workforce, and medicines management data, caution should be used in respect of this data .
- Given the time lapse between writing to practices and the visits taking place, and the above GPD caveats identified there had been a change in some practice GPD indicators highlighted as negative/positive. As an example, one practice identified for a visit in August, would not have been identified based on the GPD data in October, this demonstrates the fluidity and sensitivity of the data, and the need to understand each practice.
- Following the visits an action plan has been put in place for each contract and a bid submitted for resilience funding to support the work required for improvements

Examples of Actions

- Review GPAD configuration and set up of clinics, identify any missed opportunities in recording of practice activity, act on any anomalies– includes mapping for patients seen within 14 days of booking , update practice Processes– sessions with Clinicians re GPAD processes and recording of practice activity
- Refresh care navigation training for members of staff to maximise signposting to local services
- Development of F12 keys (a keyboard shortcut used for accessing various templates/clinical guidance to streamline clinical and administrative workflows), and practice templates for implementation
- Review current call and recall processes with Place Primary Care Nurse Lead, adopt any learning from local peers, implement within the practice
- Clinical audit of emergency ambulatory care sensitive admissions, or emergency admissions with cascade of learning
- Practice Urgent Care Clinical Lead to provide in-house training for registrars in local admission avoidance pathways
- Clinical audit of GP recorded hypertension where last blood pressure was not to the appropriate treatment threshold to understand the BP recorded and source, with cascade of learning

What actions/outcomes in relation to patient experience feedback/data

- Review processes for collection of FFT responses, meet with iMerseyside re digital options
- Continue to review FFT to understand any themes
- Work with Community Champions/Healthwatch re practice models/ ARRS roles etc.
- Patient engagement- newsletters/leaflets
- Continue to review telephony data
- There will be a focus on the NHS app in Sefton's 26/27 Local Quality Contract

Overall Improvement headlines/ areas of best practice or other narrative

- Sefton practices compliant with contractual changes introduced on 1st October 2025

Wirral

Improving Access to Primary Care (General Practice)

NHS Cheshire and Merseyside

Name of Place	Wirral

What actions/outcomes to address variation within place

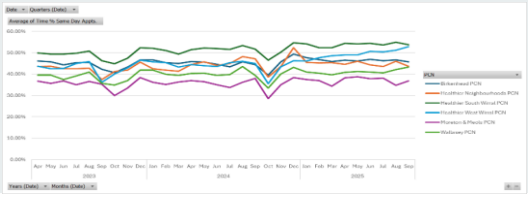
. 6 practices identified as Level 1 and 3 identified as Level 2 for unwarranted variation. Unwarranted visits/meetings progressing with practices to understand the data and full context of their position and determine ongoing developments. PLS/GPIP continues to be promoted, with positive feedback received from practices who have/are participating with RCGP led programme. SLF conversations continue to be promoted with practices, however uptake remains low.

What actions/outcomes in relation to patient experience feedback/data

. GPPS results shared with all practices/PCNs. All elements of GPPS are considered when identifying the practices with unwarranted variation and discussed. Additional local surveys undertaken by some practices to gather more timely feedback on access and experience. Healthwatch commissioned locally for a 2-year period to review Access, PCARP and enhanced access – this consisted of engagement with PMs, PCNs and patient surveys with c4,700 responses. Full report released Oct 2025. Wider feedback in terms of digital access , total triage and telephone messages highlighted by Healthwatch from patient feedback – workshop planned with practices for Jan 26 to focus on further developments/improvements to around MGP, Access, OC etc.

Overall Improvement headlines/ areas of best practice or other narrative

Increase in same day appointments for a number of PCNs (as shown in chart below) as a result of a combination of various contributors such as MGP, care navigation, implementation of the INT/frailty model. CBT reported by various practices as easing the phone rush (although some issues with 1 provider). Each PCN progressing with neighbourhood health, including the introduction of NH Boards in each PCN.



St Helens

Improving Access to Primary Care (General Practice)

NHS Cheshire and Merseyside

Name of Place	St Helens

What actions/outcomes to address variation within place

- Practices are being offered Support Level Framework visits to understand what they are doing well and where they may need add itional support. 13 Practices have participated in this conversation.
- Practices indicated as outliers with Negative Variation on the GPD can be referred to the National Practice Level Support Pro gramme for additional Support. St Helens has referred 3 practices to this programme in 25/26 who are currently receiving National support and have gone through the diagno stic stage are now working on improvement plans.

What actions/outcomes in relation to patient experience feedback/data

- 23 Practices have Footfall Websites which have been upgraded to Foundation Solution which encompasses the latest NHS England guidelines on usability and accessibility for GP websites to improve patient's experience.
- All Practices are compliant with NHS App System enablement - 58% of St Helens population are Registered for the NHS App, support is being provided by the Digital Inclusion Team.
- Cheshire and Wirral Partnership have a bus which supports St Helens one day a week with a focus on hard -to-reach areas where vaccination rates are low. This includes Covid, Flu vaccinations and Health checks.
- Kenneth MacRae Medical Centre deserves special recognition as they received 100% in the GP Patient survey for overall patient satisfaction and were one of only 4 practices nationally to achieve this.
- PCNs have set up their own Patient Surveys with responses confirming over 92% patient satisfaction.

Overall Improvement headlines/ areas of best practice or other narrative

- Urgent Care Hubs are being developed to support general practice and will also benefit the wider system, in particular A&E wh o receive the fallout of an overwhelmed and overburden primary care urgent demand. North PCN has successfully piloted the Hub, and plans are being developed to mainstream the Hub across North PCN with development to roll out across the other PCNs.
- This year's Quality improvement project is designed to encourage practices to work collaboratively, in their PCNs, to focus o n two key areas, Personalised Care Planning and Annual Health Checks for people with Severe Mental Health Conditions (SMI reviews)
- 436 Referrals were made to Pharmacy First in September 2025.
- Three PCNs (22 practices) have confirmed that all their practices have met the requirements of 25/26 CAIP and are now in rece ipt of that incentive funding.
- Telephone data is reviewed monthly and additional support is provided to practices as required by our Digital Inclusion team.
- Place has PC Access Dashboard which is updated quarterly and shared with PCN Managers.
- St Helens have been selected to be part of the first wave Neighbourhood Health Implementation Programme. There is a Neighbour hood Health workshop for Primary Care taking place 27th November.

Cheshire East

Improving Access to Primary Care (General Practice)

NHS Cheshire and Merseyside

Name of Place	Cheshire East Place

What actions/outcomes to address variation within place

Outlier practice / improvement plans/specific actions with some practices/areas of concern/ contract reviews or visits undert aken. SLF referral.

Overall Cheshire East Practices perform well compared to other areas within Cheshire and Merseyside.
There is some variation, predominantly with Crewe GHR PCN and CHOC PCN.

Place has conducted Practice level conversations to support action planning where negative variation exists and has sought as surance of compliance with the October contract changes relating to on line consultations.

Due to historical agreements between the former Central Eastern Cheshire PCT and then commissioners of General Practice, 3 pr actices in Churchview Primary Care Centre have arrangements where by the main doors to the building are closed between 8 -8.30am and 6 – 6.30 PM as part of a multi tenanted building which includes Commu nity Services and Dentistry.
A plan is in place with the practices to ensure that the doors are opened fully during core GMS hours and patients are able to walk in and book an appointment from December 2025.

What actions/outcomes in relation to patient experience feedback/data

Review of the data suggests that Cheshire East Place performs better than C&M Benchmark and National Averages for Accessibili ty to General Practice, Overall Experience of General Practice, use of the NHS App and ability and use of practice websites.

At a local level, Place teams will continue to engage with Practices to understand any concerns or improvement needs.

Overall Improvement headlines/ areas of best practice or other narrative

Eg. Any data that shows specific improvements or areas of MGP that practices have flagged etc

Cheshire East Place has seen significant improvements in patient experience as a result of early interventions and proactive care support using a population segmentation approach through the Care communities / Neighbourhoods.

Using an MDT / holistic methodology and focusing on a data driven approach, within the chosen cohorts. This is set against a general rise in NHS system usage / touch points within the complex frailty and HIU population.

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

Date: 18th December 2025

Primary Care Services - Quality Report

Agenda Item No: SPCC 25/12/B16

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

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

Clinical Waste (General Practice/Community Pharmacy) - The group noted that the Executive Committee had agreed an extension of existing arrangements for 26/27 subject to confirmation of contract process by the contracts team

Occupational health services for needlestick and blood borne virus - This service had not transferred yet and was still being managed by NHS England - confirmation was sought as to who would oversee the safe transfer of the service and where it would be overseen within the ICB. The funding currently sitting within NHS England would need to transfer over.

Availability of Chlamydia Testing kits (male and female) for over 25s - Ongoing supply challenges relating to LUFT who co-ordinate shipments. Requests for information

and meetings gave been convened with LUFT in an effort to clarify funding arrangements and agree a sustainable supply solution. However, as a resolution has not yet been reached, the issues have been escalated via Place Director of Finance. As an interim measure, practices are advised to direct patients to the local sexual health provider to arrange postal testing via their website.

Repatriation of delayed patient results = 900 from CDC - LWH/LUHFT Trusts Community Diagnostics Centre and GP Practices not being in receipt of historical ultrasound scan results and which could potentially affect all practices. This has been on the PCMG issues logs since 12th March and affecting c900 scan results: A test is scheduled for 15-20 patients at practice 20th October, to test the technical mechanism to send these results back to GP Practices electronically directly into the patient record. This will be followed by a technical review by Informatics Merseyside, pending any further rollout of this fix and communications to practices. There is a plan in place to repatriate delayed results from CDC. Practices in Liverpool, Sefton and Knowsley affected with varying numbers of delayed results. Mather Avenue has been a pilot site for return of results and auditing of review and uploading – successful. Three-week plan for total repatriation due completion in November 2025.

3.2 Dental Services

- No issues to update

3.3 General Ophthalmic Services

- The group were updated on a live and ongoing issue in relation to a contractor and an incident / concerns raised via another ICB who holds also holds a contract with the same provider. The group noted and were supportive of the further advice being sought in this respect – and the actions so far to mitigate any risk.

3.4 Community Pharmacy Services

- No issues to update

4. Quality Issues for Advising (ongoing monitoring)

4.1 General Practice

- No issues to update

4.2 Dental Services

- Provider in breach of contract in Liverpool. This is an ongoing matter previously reported on. We have most recently issued the provider with their year-end 24/25 and mid-year 25/26 performance letters, including a year-end breach notice and invited the provider to attend a contract monitoring meeting (not accepted to date)

with a view to rebasing the contract down to levels at which the provider is currently performing or terminating the contract. We continue to attempt to contact the provider and will be providing a deadline for response, after which time next steps will be taken.

- Retirement of Dental Practice Advisor. One of our Dental Clinical Advisors retired at the end of October. We now have one Dental Clinical Advisor, who provides sessions for ICB and NHSE 2 days a week. This reduction in capacity, will significantly impact our ability to carry out routine clinical governance visits, which are key to providing assurance on clinical standards in dental practices. Going forward, visits will need to be prioritised to those that are most urgent.

4.3 General Ophthalmic Services

- The group were advised of actions where contractors had failed to submit annual complaints information noting some of those contracts would have no activity, so that would be followed up accordingly.

4.4 Community Pharmacy Services

- No issues to update

5. Quality Issues for Assurance (assurance received)

5.1 General Practice

- **Learning Disability Annual Health Checks** – Compliance across Cheshire and Merseyside is within trajectory. Most GP Practices complete checks in the last quarter. Compliance has increased year on year.

5.2 Dental Services

- A dental practice in Alsager recently closed without notice. After investigation, it was found that this single-handed provider had suffered a sudden bereavement. This person was also the practice's sole Dental Nurse and Practice Manager. After some difficulties in communicating with the provider, we have now received assurance that the practice has re-opened, with temporary staff now in place

5.3 General Ophthalmic Services

- Three issues of assurance were noted as part of the report submitted which were being taken forward via the optometry operations group.

5.4 Community Pharmacy Services

- No issues to update

6. Complaints

6.1 Report not due

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