NHS
Cheshire and Merseyside

Meeting of the Cheshire & Merseyside ICB System Primary Care Committee

Part B – Public Meeting

Thursday 19 October 2023
Venue: Meeting Room 1, No 1 Lakeside,
920 Centre Park Square, Warrington,
WA1 1QY (WA1 1QA for Sat Nav)

Timing: 10:15-12:30

Agenda

Chair: Erica Morris

AGENDA NO & TIME	ITEM	LEAD	ACTION / PURPOSE	PAGE NUMBER
10:15am	**Preliminary Business**			
SPCC 23/10/B01	Welcome, Introductions and Apologies	Chair	Verbal	-
SPCC 23/10/B02	Declarations of Interest	Chair	Verbal	-
10:25am	**Committee Business, Risk & Governance**			
SPCC 23/10/B03	Minutes of the last meeting (Part B) 08 September 2023	Chair	Paper	Page 3
SPCC 23/10/B04	Action Log of last meeting (Part B) 08 September 2023	Chair	Paper	Page 15
10:35 **SPCC 23/10/B05**	Questions from the public (TBC)	Chair	Verbal	-
10:40 **SPCC 23/10/B06**	Terms of Reference	Matthew Cunningham	Paper For information	Page 16
10:50 **SPCC 23/10/B07**	Risk Register	Hilary Southern	Paper For assurance / decision	Page 47
11:00am	**Enabling Workstreams**			
SPCC 23/10/B08	Primary Care Workforce update - Update on Workforce policy and data - Update from Primary Care Workforce Steerging - ARRS (additional roles) place / system update	Emma Hood / Chris Leese	Paper For assurance / information	Page 69

AGENDA NO & TIME	ITEM	LEAD	ACTION / PURPOSE	PAGE NUMBER
11:10 **SPCC 23/10/B09**	Primary Care Estates - Update	Nick Armstrong	Paper For information	Page 97
11:20am	**BAU and Operations**			
SPCC 23/10/B10	System Pressures	Clare Watson	Verbal For information	-
11:30 **SPCC 23/10/B11**	BAU Contracting and Commissioning Update	Chris Leese / Tom Knight	Paper For assurance / information	Page 111
11:40 **SPCC 23/10/B12**	Finance update	Lorraine Weekes-Bailey / John Adams	Paper For assurance / information	Page 124
11:50am	**Transformation**			
SPCC 23/10/B13	Recovering Access to Primary Care – update and progress	Clare Watson	Paper For assurance / information	Page 137
12:00 **SPCC 23/10/B14**	Dental Transformation / Improvement i) Dental Improvement Plan – update and progress	Tom Knight	Paper (ppt) For info	Page 142
	ii) Oral Health	Ian Ashworth	Paper For decision	Page 154
12:20 **SPCC 23/10/B15**	Pathfinder Programme	Pam Soo	Paper For decision	Page 172
12:30pm	**CLOSE OF MEETING**			

Date and time of next regular meeting:
Thursday 21st December 2023 (09:00-12:30)

F2F, Meeting Room 1, No 1 Lakeside,
920 Centre Park Square, Warrington, WA1 1QY

Cheshire & Merseyside ICB
System Primary Care Committee – Part B (Public)

F2F, Lakeside, Warrington

Friday 08 September 2023 from 14:40-16:00

Unconfirmed **Draft Minutes**

ATTENDANCE - Membership		
Name	**Initials**	**Role**
Erica Morriss	EMo	Chair, Non-Executive Director
Prof Rowan Pritchard-Jones	RPJ	Medical Director, C&M ICB
Clare Watson	CWa	Assistant Chief Executive, C&M ICB
Tom Knight	TKn	Head of Primary Care, C&M ICB
Dr Rob Barnett	RBa	Secretary, Liverpool LMC
Mark Woodger	MWo	LDC representative
Adam Irvine	AIr	Primary Care Partner Member
Christine Douglas	CDo	Director of Nursing and Care, C&M ICB
Louise Barry	LBa	Chief Executive, C&M Healthwatch
Fionnuala Stott	FSt	LOC representative
Tony Leo	TLe	Place Director, C&M ICB
Dr Jon Griffiths	JGr	GP & Associate Medical Director
Chris Leese	CLe	Associate Director of Primary Care
In Attendance		
John Adams	JAd	Head of Primary Care Finance, C&M ICB
Lorraine Weekes-Bailey	LWB	Senior Primary Care Accountant, C&M ICB
Susanne Lynch	SLy	Chief Pharmacist, C&M ICB
Sally Thorpe	STh	Executive Assistant, Minute taker, C&M ICB
Hilary Southern	HSo	Risk Manager (meeting in part)

Apologies		
Name	**Initials**	**Role**
Matthew Harvey	MHa	LPC representative
Dr Daniel Harle	DHa	LMC representative
Tony Foy	TFo	Non Executive Director, C&M ICB
Matthew Cunningham	MCu	Associate Director of Corporate Affairs & Governance
Claire Wilson	CWi	Director of Finance
Delyth Curtis	DCu	Interim Chief Executive, CWAC
Luci Devenport	LDe	Senior Primary Care Manager Dental

Item	Discussion, Outcomes and Action Points	Action by
SPCC 23/09/B01	**Welcome, Introductions and Apologies**	
	EMo welcomed everyone to the meeting, and apologies were noted. Members of the Public were welcomed to the meeting, and the Committee introduced themselves.	
SPCC 23/09/B02	**Declarations of Interest**	
	Standing DoI were noted. In addition to this; Adam Irvine noted his conflict of interest as the CEO of LPC	
SPCC 23/09/B03	**Minutes of the last meeting (Part B) 22nd June 2023**	
	The minutes of the last meeting were noted to be a true and accurate reflection of the meeting.	
SPCC 23/09/B04	**Action Log of last meeting (Part B) 22nd June 2023**	
	PCC/06/23/P03 (mins of last meeting) - **actioned** PCC/06/23/P05 (questions from public) - **actioned** PCC/06/23/P06 (System pressures) – carry forward to October meeting - **ongoing** PCC/06/23/P09 (dental improvement plan) - **actioned**	
SPCC 23/09/B05	**Questions from the public**	
	None received.	
SPCC 23/09/B06	**Risk Register**	
	Hilary Southern presented this report stating it was the first time the Committee had seen this format, and that going forwards this will be a standard report to the Public element of SPCC. It was noted that there are five risks in the report which sought approval from the Committee to reduce three (2PC, 4PC and 5PC) and to close two risks (4PC and 5PC). This rationale was highlighted on pages 15 and 16 of the papers pack. It was outlined that two risks are still scoring high, one at a score of 16 (Primary Care workforce) and one at a score of 12 (relating to an identified dental provider contract management risk), these risk scores remain unchanged this month. Section 4.3 was highlighted for information as the Committee had requested a view of all place level primary care related risks for the September report, but that usually it is just risks held at place level and only those scoring 15 or more. It was noted that there is ongoing work to review the risk collectively as an ICB and that Places are now tasked with reviewing their risks, there is a training process so they are all now approaching this in the same manner.	

	Questions from the Committee. EMo, asked how TLe (on behalf of the Places) felt about the Place risks? In response, it was outlined that they have had a session with Dawn Boyer and all risks have been looked at again, also in consideration to the PDAF, and strategic aspects and the specific operational risk by function. It was outlined that there will be more things to come and that this was about looking at the strategic risks and how this is managed. CWa outlined that there had been an ask from the Risk Committee in terms of taking a standard approach and to maintain consistency. It was reported that there are nuances that would need to be considered, for example that it is easier to recruit GPs in some areas than in others, and that it would be good to get a sense of the variance and difference across the Places. HSo agreed stated that this is the output of the work being done and that there is a consistency piece of work being done across Places. RPJ enquired regarding page 19 of the papers pack, that Appendix B showed as grey for many of the Places asking if that was because they had not risk? In response HSo outlined that this was not because they don't have a risk, or that there is not necessarily an issue, but that this work is still ongoing, there is a deadline of 6th October so there will be an update in the next report. EMo stated that due to transformational speed and the impact of quality on the area we would want to see this coming up from Place. It was asked whether it was possible to get behind some of the headlines and recognised that work is ongoing in terms of looking at the role of the Risk Committee to question where we can share the levels and how to take a consistent approach. CWa outlined that there were a number of practices come to the end of their contract life and would need reprocuring, suggestion that this was a contractual technical type of risk. It was highlighted that APMS contracts are time limited the procurement team have reviewed and reset them so they are now on a much better legal footing so there is now no immediate risk, but it is recognised there may be some 'unwarranted variation' rather than 'risk'. In relation to the recommendation for 4PC, Community Pharmacy IT provision, it was noted that this was now resolved and reprocured, and outlined that there is now no issue, therefore the recommendation to close. Supporting this, AIr stated that he felt assured that this could be closed and was safe to do so. However, in relation to 5PC, serving notice on Community Pharmacy Services stock by Provider, AIr stated that he did not feel convinced it was quite there yet and that there may be considerations at the Health & Wellbeing Boards as to whether this was an ICB or an ICS risk. There is a Pharmacy needs assessment but it is the Local Authority that assess the need. Comfortable for the ICB to close down risk but not so sure the ICS can close.	

	CWa added that currently we do not have an HCP risk register. AIr confirmed that this was being looked at Local Authority level, and that Jackie Jasper is on board. In light of this, CWa confirmed that this risk could also be closed. But was keen to note that as an SPCC Committee there are a number of risks that ought to be seen here. Adding that as a committee we need to start to think what risks may be seen following the discussions in Part A/B. RBa stated that he was surprised there is no risk regarding GP IT; EMIS in particular. Noted that there is good escalation, and that with both operational groups and working groups we all need to see how they are 'working up'. TLe added that we also need to be really clear between the definitions as to what is a 'risk' rather than an 'issue'. <u>Recommendations</u> - to approve reduction in risk scores for Risks 2PC, 4PC & 5PC – **approved** *But to explore if the scores are going down because there are fewer APMS contracts, or if it is due to the dispersal of lists and level of quality and care?* - to approve closure of risks 4PC and 5PC – **approved** - to note the current position – **noted**	
SPCC 23/09/B07	**System Pressures**	
	JGr gave a verbal on current pressures in General Practice, stating that there is always seasonal variation on what is seen in GP practices, for example Practices will, and have, seen an immediate uptake once schools go back in terms of respiratory conditions. ARI (Acute respiratory infection) Hubs are a major part of the winter planning asks – it is worth noting that currently there is no additional funding on top of transformation funding already released, specifically for these and no national policy asks through primary care, to stand these up. Existing national transformation monies are also the only current pot for winter type pressures. EMIS is an issue, noting that there had experienced a complete shut-down recently, which meant that nationally GPs had little or no access to the system for a whole morning, therefore even a relatively simple patients review was impossible to do. Incidents of aggression and on staff is a cause for concern, and we are aware that in some areas these do cause major issues, questioned what we may be able to do at a system level to support – we are pursuing this with our place colleagues. It was noted that one LMC are putting in additional support, calls regarding alerts and alarms. RBa added that with the accelerated vaccination programme for covid being brought forward, whilst not all PCNs are taking part there is lots of encouragement for Practices to take part and this will add pressure over the next 6-8 weeks.	

	Dental update: MWo stated that as they have no access to the patient summary record there are issues regarding medication reviews, i.e. having to ask patients what medications they are on, or it puts a delay in if having to contact the GP practice, this causes problems if patients have deteriorating health. EMo questioned what was the plan around this? In response MWo noted that this was about getting dental connected into the system, LBa agreed but that this was a national problem and would seem common sense. There is an awareness of some sensitivity in local areas regarding the dental resource put in at Place, now would like to see what was on the workplan as discussed at the last meeting, this is where the clinical lead at Place is really important, for example what happens in Cheshire is very different to that in Halton. RPJ stated that the shared system connectivity should be put onto the risk register and be recognised, also drug interaction, and that that secondly we should take this to the IT team, questioned to scope this out and to look at what is being done elsewhere but agree it should be done systematically. **ACTION : Noted that this will be scheduled for further discussion at a future meeting. RPJ will speak to digital teams regarding this.** AIr stated that there could be learning taken from when pharmacy starting using a shared system and that there needs to be a mandate. JGr agreed that this ought to be agreed nationally and at a higher level as there is a risk that you could end up with a local agreement, which gets complicated. RPJ added that this was also about direct patient care and that it shouldn't raise issues for IG, this deserves to be scoped and brought back. Pharmacy update: AIr outlined that pharmacy remains under pressure, noting that some have applied to reduce their operational hours from 100 hours a week down to 72, Lloyds have now withdrawn Sainsbury's, this is a decrease from around 70 to 24 in Cheshire & Merseyside. He added that there is a first national contract reduction of 12%. Secondly the expectation that the CCGs created from the dispensing contract, now sees local commissioning from local pharmacies, this has caused less national pharmacies than ever before. C&M now has 579 pharmacies, and this is having an effect on the market. Stock issues are a real problem, and there has been national news interest. Anecdotally there is a loss of £1000k alone on one drug, and there is the impact of firstly not being able to obtain the drug and secondly the cost of getting it. Noted that Lancashire have previously run a 'be kind to your pharmacy' campaign, it was questioned maybe this was worth looking at and to run the same. CWa added that given the high profile case recently, maybe we should also look to undertake a 'be kind to your GP / GP practice' Campaign based on the Cheshire one. This would compliment the national respect campaign.	

	ACTION : CWa too raise with the Comms team. In relation to the reduction of community pharmacies in the C&M footprint, it was questioned whether the actual number was not the concern, but more about <u>where</u> they are? In response to this, AIr accepted that this was a fair challenge, stating that he was not convinced that the ones closing were the ones that they wanted to close. CWa added that this was about understanding the population health picture lens vs the commercial supply lens. RBa added that locally they had seen a number of consolidations of pharmacies and when this is looked at on a wider geographical view the closures were hardly noticed, however delving deeper and looking at the detail, patients are now having to cross busy roads and/or travel further and this will be disadvantageous to some communities. It was noted that the ICB had recently refused a consolidation in the interest of the population. It was questioned whether there was an access recovery piece that could be done across the North West, in that there are more pharmacies and that they are really accessible, this could be considered for our more deprived areas and we need to keep them in mind. Questioned whether we could use a range of healthcare practitioners and could we commission pharmacies or others to practice something in a different way. Discussion as to whether Practices or PCNs or Local Authority could commission more from their pharmacies? In response to the reduction of the pharmacy hours, RPJ questioned if this was a reduction in capacity? He expressed concern that as we head into winter there will be more pressure into GP and more worryingly into A&E. AIr confirmed that the reduction was not core hours and that the weekends and evenings are protected in legislation. It was noted that it would be useful to see the impact of these suggestions, TKo stated that he had specific details if anyone wanted further information. TKo outlined that he had been reviewing the implications and that at the moment it is minimal but the assurance to come back would be appreciated. AIr added that Pharmacies are businesses and if General Practice puts on a late clinic, then the pharmacies would respond. <u>Optometry update:</u> FSc outlined concern regarding the primary care/ secondary care interface and capacity, outlining there are some problems with this interface. Noting that there are some concerns regarding patient safety where referrals are then owned when rejected by secondary care. Outlined that early October, was hoping to receive some workforce funding and the use of some primary care skills to assist with this. This also ties into optometry practices in that these are also very accessible and there is a skilled workforce across the C&M footprint who can be used across other functions.	

	Numbers in contracts have not really changed and is considered 'stable'. One issue to note is that there is no urgent eye care service in Liverpool but there is across the rest of the patch. Outlined there are no IT issues other than that already mentioned. Verbal updates were noted from colleagues.	
SPCC 23/09/B08	**Contracting and Commissioning Update**	
	CLe outlined the report which provides the Committee with information and assurance in respect of the key national policy and related to local actions in respect of the four primary care contractor groups that now fall under the remit of the SPCC. RBa stated that the Covid 19 vaccination process was on a national enhanced service so it was a contract and now being done as a joint response with the flu campaign. Some issues are being worked through, and that for a GP there is a clause around same day disposition. In terms of optometry, the team have talked this week and the issues of processing of applications by national shared business service, is ever increasing, now looking to put something on the risk register. Reputationally this also impacts on the ICB TKo outlined that the October SPCC will see more detail on dental improvement along with the expansion of the urgent care pathway and the well heard public phase of 'can't get a routine appointment for dentist', this has been escalated to Execs. In progress is the development of a flashcard on performances on practices along with a number of other targets. Place Directors have indicated that they would be keen to see this developed, and it might help towards some of the discussions as to how we work with and support better on dental issues at Place. Outlined the detail on the dental operational group, who meet every 6 weeks and there is a breadth of standing items discussion. In terms of Winter planning, this forms part of the annual cycle of planning and the team are completing this at present, medicine supplies and independent prescriber announced. RBa questioned the access to urgent dental and for this to be more accessible, MWo stated that this was an ad hoc approach, and there is the need to have robust pathways for colleagues in primary medical care, to be able to refer, and to consider the more vulnerable patients. There are lots of important patients that are seen, but that it seems to be who has complained to the right person that gets a better response, rather than the system being joined up to resolve the issues. The pace of change is very slow and the resource is very small, a plea was given to support the resource issues. In relation to emergency dental service, which provides a service for those who are in serious pain, as well as to others who are not registered with a dentist, accessibility can cause issues as they're coming to see GP's.	

	TKo asked the committee if it would be beneficial to invite Roger Hollins and Dr Yvonne Dailey to the SPCC meeting in October. It was agreed this would be very useful. **ACTION : invite to Roger Hollins and Dr Yvonne Dailey for October SPCC for the Dental Improvement Plan discussions.** **ACTION : Paper to next SPCC – Dental Improvement plan update and progress** In relation to community pharmacy, SLy raised the pathfinder programme, and to highlight that they would be reaching out to Places requesting for site hosts and asking how this could potentially work. Funding allocation is secured. <u>Recommendations</u> - To note the updates for each of the four primary care contractor groups – **noted** - To note and be assured of actions to support any particular issues raised in respect of C&M specific contractors - **noted**	
SPCC 23/09/B09	**Transformation – Access Recovery and Improvement Plan**	
	CWa outlined that there is a regular fortnightly meeting and provide assurance that this was happening, it was noted there is still a lot to do. TKo is the Senior Responsible Officer (SRO) for the Empowering Patients pillar, and he outlined that they regularly meet as a programme board, colleagues are represented from Place, as well as IT. The programme is looking at the NHS app around its functionality and increased support for patients' self-directed care and that a baseline questionnaire available. It was outlined that this also gives an idea of where we want to get to within the ICB. Additionally, this pillar also includes all changes on community pharmacy. TLe was noted to be the SRO for the Implementing Modern General Practice Access pillar, and this is around digital enhances, to support the move from analogue to digital telephony. There is baseline work being undertaken, noting that the key component is the access element. All Places signed off their access plans at the end of August, now this is being drawn together into the template. Care navigation, getting the individual to the right care, a universal offer of support to general practice for each practice if needed from a national framework, there are a number of practices that have taken this up at various levels. This is an ongoing phase so is not time limited. RPJ questioned the table on page 48 of the pack, which showed the % take up of share in red, it was outlined that this is regionally monitored and we have been given a share of a national offer, it is then up to us to take up. Noted that this might not be answerable today, but there is something about organising in practices those not ready to take up the offer. There is an intensive share of practices and this shows a fair share as opposed to what is needed.	

	It was questioned whether this was ring-fenced at all, and whether there was any discretion, TLe outlined not in practices as they themselves chose whether to be intensive, intermediate or universal. Noted that this is one national offer, not funding, for the whole of England. It was outlined that it may be prudent to wait for the evaluation in order to better understand the programme, what the offer is and how would it benefit the practices. RBa stated that the practices need breathing space to be able to go on this, and it is probably those struggling with capacity to do so that need to access this most. It needs to be seen more as medium to long term rather than a quick fix. LBa outlined that this was about timings, and questioned how would patients know that the plan was working, but also from a Healthwatch perspective, when will we expect to hear this is changing? Noting that we may not know the answer to this, but we do need to understand when we can expect to feel and see the changes. JGr outlined that whilst this is going on, demand is continuing to go up, Practices are offering far more now than before the pandemic but that the perspective is that it is worse now. Noted that as the backlog increases in secondary care, then primary care will also see this. In terms of access, it was noted that this must deliver, and it was questioned what was the impact? Is it helping the system at large? Is it helping with capacity? The investment into Primary Care is to deal with the impact on other areas of the system, we all really need to make sure that the plans that are signed off really have the desired effect. RPJ agreed with the valid points about the challenge and asked whether there were milestones and timelines? In response TLe stated that there is a plan of measures as to how this should take place, will see that in the next iteration along with timelines of what to achieve and by when. CWa added that there is a meeting, Primary Care Access Recovery Plan (PCARP) who meet every fortnight, and that there is a data set that can be shared with a future SPCC meeting and with Board thereafter. CLe is noted to be the SRO for the Building Capacity pillar, which covers workforce and estates, wellbeing and associated funding streams. It was noted that the Associate Director of Estates is bringing an update on primary care estates to the next System Primary Care Committee, which will include the estates element of this pillar. In terms of delivery we have to take an improvement plan by November, but recognised that not everything will be agreed by then, but there will be a progress update at February or March board. Emo asked when this committee would receive this plan, and given the timings it would need to come in December, with an update at the next Committee. National guidance has been released and can be seen in the document presented to Committee today.	

	JGr is noted to be the SRO for the pillar focussing on 'cut bureaucracy and reduce the workload across the interface between primary and secondary care', and 0utlined that that was about complete care, having appropriate discharge summaries, appropriate fit notes, and becoming comprehensive in terms of prescriptions when patients are in hospital, getting it done there correctly rather than having to go back to the GP after discharge. There are systems in place to give the results of investigations and the need for good communications so that consultants have a place to go back to GPs and vice versa with queries or checks. This is in the hands of consultants and our hospital colleagues. Noted that hospitals do not necessarily see this as a high priority but that one change would be to demonstrate why this is good, to use A&E attendances for example, having a really strong and robust communications kit for hospitals, to get a conference between primary care and secondary care to get the traction needed. JGr outlined that it is in our gift to cut bureaucracy, suggestion that in primary care, every practice should have a second contact phoneline to the 'back office' (i.e., not the public facing number) so that secondary care can call into a practice with specific enquiries. Not all practices are doing this but it would assist to make good referrals, asking each other what do you want from this consultation? Checking medication control, optimise the long term care of a patient at the point of being in the surgery rather than at a pre-op appointment for example. This is not about taking over other roles, but about supporting at general practice level. **ACTION : PCARP data set to come to a future SPCC, then schedule to Board**	
SPCC 23/09/B10	GP Patient Survey - Summary	
	CLe outlined the report, which comes out every year, noted that the response rate is usually quite low. The report summarises the 2023 survey and to look out for some of the key measures and metrics, requested that this be viewed in context with the access recovery plan detail. LBa offered to overlay this around the experiences of different practices across Cheshire East. CLe thanked her for this, adding that he would also like to see this across all Places. CWa noted that the results were 'ok' but looking at it on a Place level, there are some real differences. It was asked whether, through TLe, Places were really looking at this and what were they doing with it? TLe outlined that the sample size for the survey was quite small, but recognised it was a temperature check, he added that there is an issue, and that it is on the scrutiny board and is consistently raised. It was noted that this was a trend more than a snapshot and about clinical access across MDT, but still have a huge problem. It was felt that things were not 'ok', but rather getting worse, it is an national problem and we are above that national average. Noted that now was the time to do a communication piece, to have a strong plan over the next several months as to what is going on in general practice, people do not necessarily understand the offer of general practice, that there are other healthcare professionals available, not just about GPs or	

	nurses, we need to be able to manage expectations and to really sell the positive aspects. CLe did wish to highlight that some practices in some Places get outstanding results year after year, and this is in the detail if you delve down. EMo gave thanks for the detailed discussion but felt that this is such a big and important piece of work that it perhaps needs a longer/ more detailed discussion. Further question in terms of what is the response to this? Cle outlined that the findings of the survey should be coming through into the access improvement plan, through place reports. Therefore the discussion should be around access, including and taking account of the findings of the GP Patient Survey. It was agreed to reiterate this to Place Leads to ensure it was clear in the improvement plans. <u>Recommendations</u> - Note the summary of the GP Patient Survey for 2023 - **noted**	
SPCC 23/09/B11	**Primary Care Strategic Summary**	
	JGr presented this report but highlighted that the recommendations should also have included that Board had asked for SPCC to give final sign off. It was outlined that there has been significant engagement, and just the final two chapters needed for optometry and dental. Although this is noted as a potential risk due to no resource for project management and JGr is the only person assigned on the final work for this. Seeking approval from the Committee so it can be published. Next steps would be for the comms teams to upload onto the website. RBa asked that this was not a glossy document that would just sit on a shelf, but more that it became a real living and working document. CWa agreed with the risk adding that there is a real risk regarding the lack of capacity in the teams. MWo offered support via the LDCs in terms of assistance for enabling practitioners and it is within their mandate to do so. He also added his support in terms of the funding for the event and for all to be invited. TKo offered support to assist with the completion of the dental chapter. Optometry support was offered by FSc. Thanks were given to all offers of support as this was very much appreciated. <u>Recommendations</u> - To note the first two chapters of the Framework – **noted** - To note the engagement that has taken place – **noted** - To note the ongoing work to develop the final two chapters – **noted** - To note the development of a workplan based on the Framework – **noted** - To note the request to the communications team for final publication – **noted**	

	- Additional recommendation : to approve the Primary Care Strategic Framework document ready for final publication - **approved**	
	Closing remarks, review of the meeting and communications from it	
	Nothing further to note.	
Date of Next Meeting: F2F, 19th October Warrington, Lakeside		

End of Meeting

CHESHIRE MERSEYSIDE
INTEGRATED CARE BOARD

(Public) System Primary Care Committee Action Log 2022-23

Cheshire and Merseyside

Updated: Sept 2023

Action Log No.	Original Meeting Date	Description	Action Requirements from the Meetings	By Whom	By When	Comments/ Updates Outside of the Meetings	Status
PCC/06/23/P03	22-Jun-2023	Minutes from previous meeting	FSt requested that in the optometry item 'Recruitment is not an issue' be amended to read 'recruitment is an issue but is being managed.'	Ebony Cooke	08-Sep-2023	updated as advised	COMPLETED
PCC/06/23/P05	22-Jun-2023	Questions from the public	CWa to check on MP response progress so that this can be expedited.	Cwa	08-Sep-2023	MP response within ICB SLA	COMPLETED
PCC/06/23/P06	22-Jun-2023	System pressures	TK/CL/CWA/JL to arrange KPI's for next SPCC as part of Contracting Performance section. As part of this discussion would need to speak to the BI and Digital Teams	TK/CL/CWA/JL	08-Sep-2023	delayed until SPCC meeting in October (noted to be on agenda)	COMPLETED
PCC/06/23/P09	22-Jun-2023	dental improvement plan	TKn LDe and CDo to meet to discuss quality	TKn	08-Sep-2023	ongoing discussion across all 4 contractor groups and paper being presented to Board in Sept	COMPLETED
SPCC 23/09/B07	08-Sep-2023	System pressures	a) discussion at a future meeting (summary record access across Dental & GP) b) RPJ agreed to speak to digital teams regarding this	RPJ	19-Oct-2023		ONGOING
SPCC 23/09/B07	08-Sep-2023	System pressures	to look to undertake a 'be kind to your GP / GP Practice' campaign - to compliment the national respect campaign. CWa agreed to raise this with the Comms Team	CWa	19-Oct-2023		ONGOING
SPCC 23/09/B08	08-Sep-2023	Contracting and Commissioning Update	to invite Roger Hollins and Dr Yvonne Dailey to the October SPCC for the Dental Improvement Plan discussions		19-Oct-2023	noted as invited to October meeting	ONGOING
SPCC 23/09/B08	08-Sep-2023	Contracting and Commissioning Update	Paper to next SPCC - dental improvement plan update and progress		19-Oct-2023		ONGOING
SPCC 23/09/B09	08-Sep-2023	Transformation - Access Recovery and Improvement Plan	PCARP data set to come to a future SPCC, then schedule to Board		19-Oct-2023		ONGOING

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

Committee Terms of Reference

Agenda Item No: SPCC B23/10/06

Responsible Director: Clare Watson, Assistant Chief Executive

Committee Terms of Reference

1. Purpose of the Report

1.1 The Committees Terms of Reference (TOR) were last reviewed and approved in September 2022. Following the recent review of the effectiveness of the ICBs Committees there has also been a need to relook at Committee TORs to ensure consistency and clarity across them all.

1.2 Committee members are presented with an updated TOR for review and their endorsement, prior to going to the November 2023 ICB Board meeting for their approval.

2. Executive Summary

2.1 The Committee has now been in operation for over one year, and following its establishment and operation it is good practice to review a Committee TOR on an annual basis so as to ensure that it is still fit for purpose and encapsulates all areas within its remit and as outlined within the ICBs Standing Orders, Scheme of Reservation and Delegation (SORD), the Operational SORD (OSORD) and Standing Financial Instructions (SFIs).

2.2 Additions to the draft updated TOR in Appendix One are highlighted in **GREEN** and edits are highlighted in ~~RED~~.

3. Amendments to the Terms of Reference

3.1 Amendments to the Committee TOR include:

- general tidying up of the TOR format and structure, including removal of repetition, amendment of position titles
- strengthening of the information within regarding the Committees authority, including ability to form sub-committees which have the authority to discharge the duties of the Committee on behalf of the Committee, for example such as a Place Primary Care Committee
- addition of paragraphs in relation to the Committees responsibilities regarding Optometry and Dentistry
- strengthening of information regarding quoracy and declarations of interest to bring in line with the other Committees of the ICB.

3.2 The Associate Director of Corporate Affairs and Governance (ADCAG) has cross referenced the TOR with that of the other ICB Committees to ensure that there are no duplications in authority. The ADCAG has also reviewed a small sample of other ICBs Primary Care Committee TOR to ensure consistency with peer organisations. The ADCOG also believes that the increased detail within the TOR allows easier access to and understanding for staff, committee members and the

public with regards the authority of the Committee without having to also cross reference with the Constitution, SORD, OSORD and SFIs.

4. Ask of the Committee and Recommendations

4.1 **The Committee is asked to:**

- review and endorse the updated Committee Terms of Reference v1.2.

5. Reasons for Recommendations

5.1 The Committee is required to review its TOR on at least an annual basis and its endorsement of any changes is need prior to the Committee recommending these changes for approval by the ICB Board.

6. Next Steps and Responsible Person to take forward

6.1 Subject to the Committee endorsing the proposed changes:

- update the Committee Terms of Reference to reflect agreed changes and submit to the ICB Board at its meeting in November 2023 for approval.

6.2 It should be noted that further amendments to the Committee TOR may be required following the feedback received from Mersey Internal Audit Agency following their review of primary care arrangements as part of the ICBs Internal Audit Plan. Further changes may also be required following completion of work into the overview and management of primary care quality.

6.3 Additionally, a further piece of work is required to ensure the ICBs SORD and Operational SORD are updated to reflect changes within the Committees TOR.

7. Officer contact details for more information

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8. Appendices

Appendix One: draft Committee Terms of Reference v1.2 track changes
Appendix Two: draft Committee Terms of Reference v1.2 CLEAN

NHS Cheshire and Merseyside Integrated Care Board

System Primary Care Committee

Terms of Reference

Document revision history

Date	Version	Revision	Comment	Author / Editor
January 2022	1.0	Initial ToRs		Ben Vinter
25.8.2022	1.1		Revisions following first meeting of System Primary Care Committee	Christopher Leese
October 2023	1.2		Revisions following October 2023 meeting of System Primary Care Committee	Matthew Cunningham

Review due
~~**1 July 2023**~~ **01 October 2024**
V1.2 ~~1~~ approved by the ~~C&M ICB~~ Board of NHS Cheshire and Merseyside ~~29 September 2022~~ 30 November 2023

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1. Introduction

~~NHS C&M has been established to~~
- ~~improve outcomes in population health and healthcare~~
- ~~tackle inequalities in outcomes, experience and access~~
- ~~enhance productivity and value for money~~
- ~~help the NHS support broader social and economic development~~.

The System Primary Care Committee (the Committee) is established by the Board of NHS Cheshire and Merseyside (the Board) as a Committee of the Board and in accordance with its Constitution, Standing Orders, Standing Financial Instructions and its Scheme of Reservation and Delegation (SORD).

These Terms of Reference (ToR), will be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

2. Purpose

~~NHS C&M has established a series of Primary Care Committees (nine of which sit within place-based arrangements, the tenth being a System-wide Primary Care Committee with oversight of the full Cheshire & Merseyside area) to function as the corporate decision-making forum for the management of the delegated functions and the exercise of the delegated powers.~~

~~These Terms of Reference relate to the NHS C&M System-wide Primary Care Committee. Please see separate Place-Based Primary Care Committee ToR for the role of those committees within each place.~~

The Committee has been established to enable collective decision-making on the review, planning and procurement of primary care services in relation to primary medical services, community pharmacy, primary dental and primary (General Practice) ophthalmic services and as part of the ICB's statutory commissioning responsibilities across Cheshire and Merseyside under delegated authority from NHS England. In performing its role, the Committee will exercise its functions in accordance with the delegation agreement entered into between NHS Cheshire and Merseyside and NHS England (NHSE).[1]

The Committee will also provide oversight and assurance to the Board of the effective planning and provision of primary care services across Cheshire and Merseyside.

Providing assurance involves:
- **Triangulating multiple sources** of appropriate internal and external information, including:
  - Data analysis and contract performance intelligence
  - Patients', service users' and carers' reports, surveys, complaints, and concerns
  - Evidence from key system leaders

[1] https://www.cheshireandmerseyside.nhs.uk/media/cyknidfl/cm-primary-care-and-dental-delegation-agreement-2023-final-version-issued-230323.pdf

- Other intelligence agreed to be important and reliable.

- **Remedial action:** Where assurance cannot be provided in part or in full, to provide the Board with details of remedial actions being taken and or being recommended.

- **Considering efficacy and efficiency:** Things are not only in place but the right things are being done in the right way to achieve the right objectives, which support the ICS aims.

The functions of the Committee are undertaken in line with NHS Cheshire and Merseyside desire to promote ~~increased co-commissioning~~ an increase quality, efficiency, productivity and value for money and to remove administrative barriers.

~~The purpose of~~

~~**3. Statutory Framework**~~

~~The Health and Care Act 2022 amends the NHS Act 2006 by inserting the following provisions:~~

~~***13YB Directions in respect of functions relating to provision of services***~~

~~*(1) NHS England may by direction provide for any of its relevant functions to be exercised by one or more integrated care boards.*~~

~~*(2) In this section "relevant function" means—*~~

~~*(a) any function of NHS England under section 3B(1) (commissioning functions);*~~

~~*(b) any function of NHS England, not within paragraph (a), that relates to the provision of—*~~

~~*(i) primary medical services,*~~

~~*(ii) primary dental services,*~~

~~*(iii) primary ophthalmic services, or*~~

~~*(iv) services that may be provided as pharmaceutical services, or as local pharmaceutical services, under Part 7;*~~

~~*(c) any function of NHS England by virtue of section 7A or 7B (exercise of Secretary of State's public health functions);*~~

~~*(d) any other functions of NHS England so far as exercisable in connection with any functions within paragraphs (a) to (c).*~~

~~***82B Duty of integrated care boards to arrange primary medical services***~~

~~*(1) Each integrated care board must exercise its powers so as to secure the provision of primary medical services to such extent as it considers necessary to meet the reasonable requirements of the persons for whom it has responsibility.*~~

~~*(2) For the purposes of this section an integrated care board has responsibility for— (a) the group of people for whom it has core responsibility (see section 14Z31), and (b) such other people as may be prescribed (whether generally or in relation to a prescribed service).*~~

~~In exercising its functions, NHS C&M must comply with the statutory duties set out in NHS Act, as amended by the Health and Care Act 2022, including:~~

~~a) Having regard to and acting in a way that promotes the NHS Constitution (section 2 of the Health Act 1989 and section 14Z32 of the 2009 Act);~~

~~b) Exercising its functions effectively, efficiently and economically (section 14Z33 of the 2006 Act);~~
~~c) section 14Z34 (improvement in quality of services),~~
~~d) section 14Z35 (reducing inequalities),~~
~~e) section 14Z38 (obtaining appropriate advice),~~
~~f) section 14Z40 (duty in respect of research),~~
~~g) section 14Z43 (duty to have regard to effect of decisions)~~
~~h) section 14Z44 (public involvement and consultation),~~
~~i) sections 223GB to 223N (financial duties), and~~
~~j) section 116B(1) of the Local Government and Public Involvement in Health Act 2007 (duty to have regard to assessments and strategies).~~

~~In addition NHS C&M will follow the Procurement, Patient Choice and Competition (no2) Regulations 2013 and any subsequent procurement legislation that applies to the ICB.~~

3. ~~Delegated Powers and~~ Authority

~~The Committee is established as a Committee of NHS C&M Integrated Care Board (ICB) in accordance with the NHS Act, as amended by the Health and Care Act 2022, and is subject to any directions made by NHS England (NHSE) or by the Secretary of State. The Committee is also established in line with the ICB Constitution and the Delegation Agreement.~~

The Board of NHS Cheshire and Merseyside has delegated authority to the Committee as set out in these Terms of Reference and the ICB SORD, and which may be amended from time to time. Delegations are in line with the duties required of ICBs as outlined within the Health and Care Act 2022 (Annex One) and delegated functions from NHSE (Annex Two). The Committee is also subject to any directions made by NHSE or by the Secretary of State for Health and Social Care.

The duties of the Committee will be driven by the organisation's strategic objectives and the associated risks. An annual programme of business will be agreed before the start of the financial year; however this will be flexible to new and emerging priorities and risks.

The Committee is authorised by the Board to:

- investigate and approve any activity as outlined within its terms of reference
- seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these terms of reference
- commission any reports it deems necessary to help fulfil its obligations
- obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice
- establish sub-committees in order to undertake any the functions of the Committee where considered necessary by the Committee. The Committee has the authority to agree the Terms of Reference of these sub-committees, including approving any decision making authority that is normally reserved to the Committee and that can be delegated to and undertaken by the sub-committee and its members, in accordance with the ICB's constitution, standing orders, standing financial instructions, SORD and

OSORD. This authority will be outlined within a decision making matrix, approved by and overseen by the Committee. Decisions undertaken by these sub-committees will be reported back to the Committee

- establish task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups
- commission, review and approve policies where they are explicitly related to areas within the remit of the Committee as outlined within the TOR, or where specifically delegated to the Committee by the ICB Board.

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4. Role and Responsibilities of the Committee

~~The Committee has been established in accordance with the above statutory provisions to enable collective decision-making on the review, planning and procurement of primary care services in relation to GP primary medical services and community pharmacy as part of the NHS C&M's statutory commissioning responsibilities across Cheshire & Merseyside under delegated authority from NHS England.~~

~~In performing its role, the Committee will exercise its functions in accordance with the agreement entered into between NHS C&M and NHS England. The agreement will sit alongside the delegation and terms of reference in accordance with the NHS C&M constitution.~~

~~The Committee will have the authority to commission, review and authorise policies where they are explicitly related to areas within the remit of the Committee as outlined within the TOR, or where specifically delegated to the Committee by the ICB Board.~~

In carrying out its role, the Committee will work alongside any of its established sub-committees where decision making authority has been delegated ~~the nine place-based Primary Care Committees, providing oversight and assurance of effective primary care services across Cheshire & Merseyside.~~ The Committee will also work closely with the Pharmaceutical Services Regulations Committee (PSRC). These sub-committees will also provide regular reports to the Committee outlining what activity and decision have been undertaken , providing assurance to the Committee that and discharge of primary medical services, policy and statutory frameworks, (as listed in Annex Two) are carried out in line with national rules and expectations. A decision making matrix, approved by the Committee, will underpin this work

The Committee will provide regular assurance updates to the Board in relation to activities and items within its remit, as well as provide the Board with any items for escalation.

~~The functions of the Committee are undertaken in line with NHS C&M's desire to promote increased co-commissioning to increase quality, efficiency, productivity and value for money and to remove administrative barriers.~~

Commissioning of Primary (GP) Medical Services

The ~~role of the System Primary Care Committee shall be to~~ Committee shall oversee, coordinate and promote alignment of the functions amongst the nine Places of Cheshire and Merseyside relating to the commissioning of primary medical (GP) services under

section 82B of the NHS Act in relation to GP primary medical services and community pharmacy. This includes the following:

- develop a system-wide Primary Care Strategy including implementing the GP Forward View, or successor, through robust contractual arrangements with general practices and appropriate developmental support.
- review and consider the aggregate position of agreed service specifications and contractual proposals for all NHS C&M commissioned services from primary care providers
- develop outline framework/ expectations in regard to GMS, PMS and APMS contracts (including the oversight and monitoring of contracts, approving material contractual action such as removing a contract)
- Oversee the system obligations in relation to the Delegation Agreement with NHS England and the Policy and Guidance Manual and other directed enhanced service type national regulatory frameworks as centrally mandated.
- oversee the strategic direction for newly designed enhanced services and agree new specifications where appropriate
- Performance monitoring, oversight and assurance on agreed schemes and services, and compliance to NHSE; escalating issues on to NHSE in line with first level Delegation
- making recommendations related to alignment of decisions on 'discretionary' payment in Place (e.g., returner/retainer schemes).
- co-ordinate a common approach to the commissioning, contracting and delivery of primary care services
- manage the overall budget for commissioning of primary care services, including delegated rents and rates in line with Premises Directions.
- Overseeing delivery of national primary medical services policy at system level and ensuring compliance at place level.

Commissioning of Community Pharmacy

The Committee shall:

- develop outline framework/ expectations in regard to Community Pharmacy essential, advanced and national enhanced services, including associated budgets, quality assurance and all existing NHSEI functions.
- develop and agree local discretionary/ non-core schemes.
- oversee national Community Pharmacy policy at system / local level.

Commissioning of Dental Services

The Committee shall:

- develop outline framework/ expectations in regard to the national general dental, community, personal dental and orthodontic contracting, overseeing the central contracting function is discharged in line with the Dental Policy Book and national rules/frameworks
- responsible for overseeing national dental policy at ICB system and local level
- develop and agree local improvement schemes to support delivery of the national contract and policy asks.

Commissioning of Optometry

The Committee shall:

- develop outline framework/ expectations in regard to the national general ophthalmic services (GOS) contractual regulations and policy

- Responsible for overseeing national GOS policy at ICB system and local level
- Develop and agree local improvement schemes to support delivery of the national contract and policy asks.

Additional responsibilities. The Committees additional responsibilities include:

- ~~The NHS C&M Primary Care Committee will also carry out the following activities:~~
- Support Primary Care development across Cheshire & Merseyside including oversight of:
  - primary care networks (PCNs) ongoing development as the foundations of out-of-hospital care and building blocks of place-based partnerships
  - Workforce, resilience and sustainability
  - Maximisation of GP Contract opportunities such as ARRS (Additional roles) and QOF outcomes
- plan, including needs assessment, for primary care services across Cheshire & Merseyside and to support planning at scale for primary care
- have oversight of the development of an integrated Estates programme across Cheshire & Merseyside and at local level using flexibilities available through PCN arrangements, mixed estates with other partners, premises improvement grants and capital investment monies
- to consolidate risk reviews of primary care services, aggregating findings and supporting solutions/ mitigations at places
- to ensure contract proposals achieve health improvement and value for money
- to oversee quality and safety of services delivered in primary care – receiving regular reports from the ICB Quality and Performance Committee and Finance, Investment and Our Resources Committee providing updates and assurance on primary care related quality, finance and performance issues
- ensure that conflicts of interest have been mitigated in line with the NHS C&M Conflicts of Interest Policy, and all actions/ decisions involving consultation with Committee members or GPs will record any declarations of interest.
- ratifying time limited Place based recommendations related to this committee's remit or determining to 'call-in' such a recommendation and provide an alternative course of action.

Risk Management. The Committee will also ensure the appropriate management of risks in relation to primary care; receiving regular reporting of primary care related Corporate Risks, and relevant Board Assurance Framework (BAF) risk – these will include reference to relevant Place Delivery Assurance risks – both strategic and corporate as per NHS C&M Risk Management Strategy.

5. Membership & Attendance

The Committee members drawn from the ICB Board shall be appointed by the Board in accordance with the ICB Constitution. The membership shall consist of the following voting members:

- at least 1 ICB Non Executive Member (Chair)
- at least 1 ICB Partner Member (1 to be the Deputy Chair)
- ICB Assistant Chief Executive (or Deputy)
- Associate Director of Primary Care
- ICB Director of Nursing & Care

- ICB Director of Finance
- ICB Medical Director (or Associate Medical Director for Primary Care)
- Independent GP
- at least 2 Place Directors or designated individual from Place.

In attendance by invitation (non-voting):
- Healthwatch nominated representative
- Public Health representative
- Local Medical Committee (LMC) representative
- Pharmaceutical Services Regulations Committee (PSRC) representative
- LOC (Local Optical Committee) representative ~~(from 1.4.2023)~~
- LDC (Local Dental Committee) representation ~~from 1.4.2023)~~
- Membership of other Professional Groups to be agreed/discussed further dependant on agenda item.

All Committee members may appoint a deputy to represent them at meetings of the Committee. Committee members should inform the Chair of their intention to nominate a deputy to attend/act on their behalf and any such deputy should be suitably briefed and suitably qualified (in the case of clinical members).

The Committee may also request attendance by appropriate individuals to present agenda items and/or advise the Committee on particular issues.

Attendees
Only members of the Committee have the right to attend Committee meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the Committee.

Meetings of the Committee may also be attended by other individuals, by the agreement of the Chair, who are not members of the Committee for all or part of a meeting as and when appropriate.

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 particular matters.

6. Meetings

Leadership
The Committee is Chaired by an ICB Non Executive Member.

Committee members may appoint a Deputy Chair.

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

Quorum
A meeting of the Committee is quorate if the following are present:
- At least five Committee members in total, including;

- At least one ICB Non Executive Member or ~~system~~ ICB Partner Member
- At least two ICB Directors (or their nominated deputies).

If the named Chair, or Deputy Chair, are both unable to attend a meeting, and the meeting is required to proceed on the agreed date, then an alternative suitably experienced ICB Non-Executive Member will be asked Chair the meeting. Where these quorum requirements are unable to be met the meeting date will be rearranged.

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

If on an occasion a Committee meeting is due to start but the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken. Alternatively, the meeting can be called to a halt and an agreement reached to rearrange an additional meeting.

Decision-making and voting

Decisions will be taken in accordance with the Standing Orders and within the authority as delegated to the Committee, and as outlined within the ICBs SORD and Standing Financial Instructions.

~~Decisions should be taken in accordance with the financial delegation of the Executive Directors and directors present and/or any authority delegated to the committee by the ICB~~

The Committee will ordinarily make decisions by consensus. Where this is not possible, the Chair may call a vote.

Only voting members, as identified in the "Membership" section of these terms of reference, may cast a vote. Each member is allowed one vote and a majority will be conclusive on any matter.

A person attending a meeting as a deputy of a Committee member shall have the same right to vote as the Committee member they are representing.

In accordance with ICB policy, no member (or deputy) with a conflict of interest in an item of business will be allowed to vote on that item.

Where there is a split vote, with no clear majority, the Chair will have the casting vote.

If a decision is needed which cannot wait for the next scheduled 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 Committee.

Frequency

The Committee will normally meet in private. However on occasions due to some agenda items the meeting may be held in public for all or part, to be agreed by the Chair depending on advice received and agenda item to be discussed. Due process in relation to Patient Consultation requirements should be considered when making this decision.

The Committee will normally meet up to six times each year and arrangements and notice for calling meetings are set out in the ICB Standing Orders. Additional meetings may take place as required.

The Board, ICB Chair, Committee Chair, or Chief Executive may ask the Committee to convene further meetings to discuss particular issues on which they want advice.

In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

Papers for the meeting will be issued ideally one week in advance of the date the meeting is due to take place and no later than 4 working days.

Administrative Support
The Committee shall be supported with a secretariat function. Which will include ensuring that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead
- attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements
- Records of declarations of conflicts of interest, members' appointments and renewal dates are retained and the Board is prompted to renew membership and identify new members where necessary
- good quality minutes are taken in accordance with the ICB standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept
- the Chair is supported to prepare and deliver reports to the Board
- the Committee is updated on pertinent issues/ areas of interest/ policy developments; and
- action points are taken forward between meetings.

Accountability and Reporting Arrangements
The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

The minutes of the meetings shall be formally recorded by the secretary and submitted to the Board.

The Committee will submit copies of its approved minutes and a key issues report to the ICB following each of its meetings, which will draw to the attention of the Board any issues that require disclosure to the Board or require action.

The Committee will also provide a key issues report to each of the place-based primary care sub-committees of the Committee and will receive an equivalent report from each of the place-based primary care committees.

The Committee will receive regular key-issues reports from the Pharmaceutical Services Regulations Committee (PSRC).

The Committee will provide the Board with an Annual Report. The report will summarise its conclusions from the work it has done during the year.

The outputs of the group may be reported to NHSE/supporting assurance, awareness and interaction.

7. Behaviours & Conduct

Members will be expected to conduct business in line with the ICB value s and objectives and the principles set out by the ICB.

Members of, and those attending, the Committee shall behave in accordance with the ICB's constitution, Standing Orders, and Standards of Business Conduct Policy.

All members shall comply with the ICB's Managing Conflicts of Interest Policy at all times. In accordance with the ICB's policy on managing conflicts of interest, Committee members should:

- inform the chair of any interests they hold which relate to the business of the Committee.
- 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 Committee.
- 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, Committee members should:

- comply with the ICB's 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 ICB's administrative arrangements to support the Committee 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 Committee 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 Board for approval.

Annex One: Statutory Framework

The Health and Care Act 2022 amends the NHS Act 2006 by inserting the following provisions:

13YB Directions in respect of functions relating to provision of services
(1) NHS England may by direction provide for any of its relevant functions to be exercised by one or more integrated care boards.
(2) In this section "relevant function" means—
(a) any function of NHS England under section 3B(1) (commissioning functions);
(b) any function of NHS England, not within paragraph (a), that relates to the provision of—
(i) primary medical services,
(ii) primary dental services,
(iii) primary ophthalmic services, or
(iv) services that may be provided as pharmaceutical services, or as local pharmaceutical services, under Part 7;
(c) any function of NHS England by virtue of section 7A or 7B (exercise of Secretary of State's public health functions);
(d) any other functions of NHS England so far as exercisable in connection with any functions within paragraphs (a) to (c).

82B Duty of integrated care boards to arrange primary medical services
(1) Each integrated care board must exercise its powers so as to secure the provision of primary medical services to such extent as it considers necessary to meet the reasonable requirements of the persons for whom it has responsibility.
(2) For the purposes of this section an integrated care board has responsibility for— (a) the group of people for whom it has core responsibility (see section 14Z31), and (b) such other people as may be prescribed (whether generally or in relation to a prescribed service).

In exercising its functions, NHS C&M must comply with the statutory duties set out in NHS Act, as amended by the Health and Care Act 2022, including:

Having regard to and acting in a way that promotes the NHS Constitution (section 2 of the Health Act 1989 and section 14Z32 of the 2009 Act);
Exercising its functions effectively, efficiently and economically (section 14Z33 of the 2006 Act);

- section 14Z34 (improvement in quality of services),
- section 14Z35 (reducing inequalities),
- section 14Z38 (obtaining appropriate advice),
- section 14Z40 (duty in respect of research),
- section 14Z43 (duty to have regard to effect of decisions)
- section 14Z44 (public involvement and consultation),
- sections 223GB to 223N (financial duties), and
- section 116B(1) of the Local Government and Public Involvement in Health Act 2007 (duty to have regard to assessments and strategies).

In addition NHS C&M will follow the Procurement, Patient Choice and Competition (no2) Regulations 2013 and any subsequent procurement legislation that applies to the ICB.

Annex Two: Schedule 1 – Delegated Functions

A. Decisions in relation to the commissioning, procurement and management of Primary Medical Services Contracts, including but not limited to the following activities:

   - decisions in relation to Enhanced Services
   - decisions in relation to Local Incentive Schemes (including the design of such schemes)
   - decisions in relation to the establishment of new GP practices (including branch surgeries) and closure of GP practices
   - decisions about 'discretionary' payments
   - decisions about commissioning urgent care (including home visits as required) for out of area registered patients.

B. The approval of practice mergers
C. Planning primary medical care services in the Area, including carrying out needs assessments
D. Undertaking reviews of primary medical care services in the Area
E. Decisions in relation to the management of poorly performing GP practices and including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the performers list)
F. Management of the Delegated Funds in the Area
G. Premises Costs Directions functions
H. Co-ordinating a common approach to the commissioning of primary care services with other commissioners in the Area where appropriate; and
I. Such other ancillary activities as are necessary in order to exercise the Delegated Functions.

SCHEDULE 2 – RESERVED FUNCTIONS OF NHSE

A. Management of the national performers list
B. Management of the revalidation and appraisal process
C. Administration of payments in circumstances where a performer is suspended and related performers list management activities
D. Capital Expenditure functions
E. Public Health Section 7A functions under the NHS Act
F. Functions in relation to complaints management
G. Decisions in relation to the Prime Minister's Challenge Fund; and
H. Such other ancillary activities that are necessary in order to exercise the Reserved Functions.

NHS Cheshire and Merseyside Integrated Care Board

System Primary Care Committee

Terms of Reference

Document revision history

Date	Version	Revision	Comment	Author / Editor
January 2022	1.0	Initial ToRs		Ben Vinter
25.8.2022	1.1		Revisions following first meeting of System Primary Care Committee	Christopher Leese
October 2023	1.2		Revisions following October 2023 meeting of System Primary Care Committee	Matthew Cunningham

Review due
01 October 2024
V1.2 approved by the Board of NHS Cheshire and Merseyside 30 November 2023

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1. Introduction

The System Primary Care Committee (the Committee) is established by the Board of NHS Cheshire and Merseyside (the Board) as a Committee of the Board and in accordance with its Constitution, Standing Orders, Standing Financial Instructions and its Scheme of Reservation and Delegation (SORD).

These Terms of Reference (ToR), will be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

2. Purpose

The Committee has been established to enable collective decision-making on the review, planning and procurement of primary care services in relation to primary medical services, community pharmacy, primary dental and primary (General Practice) ophthalmic services and as part of the ICB's statutory commissioning responsibilities across Cheshire and Merseyside under delegated authority from NHS England. In performing its role, the Committee will exercise its functions in accordance with the delegation agreement entered into between NHS Cheshire and Merseyside and NHS England (NHSE).[1]

The Committee will also provide oversight and assurance to the Board of the effective planning and provision of primary care services across Cheshire and Merseyside.

Providing assurance involves:

- **Triangulating multiple sources** of appropriate internal and external information, including:
  - Data analysis and contract performance intelligence
  - Patients', service users' and carers' reports, surveys, complaints, and concerns
  - Evidence from key system leaders
  - Other intelligence agreed to be important and reliable.

- **Remedial action:** Where assurance cannot be provided in part or in full, to provide the Board with details of remedial actions being taken and or being recommended.

- **Considering efficacy and efficiency:** Things are not only in place, but the right things are being done in the right way to achieve the right objectives, which support the ICS aims.

The functions of the Committee are undertaken in line with NHS Cheshire and Merseyside desire to promote an increase quality, efficiency, productivity, and value for money and to remove administrative barriers.

[1] https://www.cheshireandmerseyside.nhs.uk/media/cyknidfl/cm-primary-care-and-dental-delegation-agreement-2023-final-version-issued-230323.pdf

3. Authority

The Board of NHS Cheshire and Merseyside has delegated authority to the Committee as set out in these Terms of Reference and the ICB SORD, and which may be amended from time to time. Delegations are in line with the duties required of ICBs as outlined within the Health and Care Act 2022 (Annex One) and delegated functions from NHSE (Annex Two). The Committee is also subject to any directions made by NHSE or by the Secretary of State for Health and Social Care.

The duties of the Committee will be driven by the organisation's strategic objectives and the associated risks. An annual programme of business will be agreed before the start of the financial year; however, this will be flexible to new and emerging priorities and risks.

The Committee is authorised by the Board to:

- investigate and approve any activity as outlined within its terms of reference
- seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these terms of reference
- commission any reports it deems necessary to help fulfil its obligations
- obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice
- establish sub-committees in order to undertake any the functions of the Committee were considered necessary by the Committee. The Committee has the authority to agree the Terms of Reference of these sub-committees, including approving any decision making authority that is normally reserved to the Committee and that can be delegated to and undertaken by the sub-committee and its members, in accordance with the ICB's constitution, standing orders, standing financial instructions, SORD and OSORD. This authority will be outlined within a decision making matrix, approved by and overseen by the Committee. Decisions undertaken by these sub-committees will be reported back to the Committee
- establish task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups
- commission, review and approve policies where they are explicitly related to areas within the remit of the Committee as outlined within the TOR, or where specifically delegated to the Committee by the ICB Board.

4. Role and Responsibilities of the Committee

In carrying out its role, the Committee will work alongside any of its established sub-committees where decision making authority has been delegated. The Committee will also work closely with the Pharmaceutical Services Regulations Committee (PSRC). These sub-committees will also provide regular reports to the Committee outlining what activity and decision have been undertaken , providing assurance to the Committee that and discharge of primary medical services, policy and statutory frameworks, (as listed in Annex Two) are

carried out in line with national rules and expectations. A decision making matrix, approved by the Committee, will underpin this work

The Committee will provide regular assurance updates to the Board in relation to activities and items within its remit, as well as provide the Board with any items for escalation.

Commissioning of Primary (GP) Medical Services
The Committee shall oversee, coordinate and promote alignment of the functions amongst the nine Places of Cheshire and Merseyside relating to the commissioning of primary medical (GP) services under section 82B of the NHS Act in relation to GP primary medical services and community pharmacy. This includes the following:

- develop a system-wide Primary Care Strategy including implementing the GP Forward View, or successor, through robust contractual arrangements with general practices and appropriate developmental support.
- review and consider the aggregate position of agreed service specifications and contractual proposals for all NHS C&M commissioned services from primary care providers
- develop outline framework/ expectations in regard to GMS, PMS and APMS contracts (including the oversight and monitoring of contracts, approving material contractual action such as removing a contract)
- Oversee the system obligations in relation to the Delegation Agreement with NHS England and the Policy and Guidance Manual and other directed enhanced service type national regulatory frameworks as centrally mandated.
- oversee the strategic direction for newly designed enhanced services and agree new specifications where appropriate
- Performance monitoring, oversight and assurance on agreed schemes and services, and compliance to NHSE; escalating issues on to NHSE in line with first level Delegation
- making recommendations related to alignment of decisions on ‘discretionary’ payment in Place (e.g., returner/retainer schemes).
- co-ordinate a common approach to the commissioning, contracting and delivery of primary care services
- manage the overall budget for commissioning of primary care services, including delegated rents and rates in line with Premises Directions.
- Overseeing delivery of national primary medical services policy at system level and ensuring compliance at place level.

Commissioning of Community Pharmacy
The Committee shall:

- develop outline framework/ expectations in regard to Community Pharmacy essential, advanced and national enhanced services, including associated budgets, quality assurance and all existing NHSEI functions.
- develop and agree local discretionary/ non-core schemes.
- oversee national Community Pharmacy policy at system / local level.

Commissioning of Dental Services
The Committee shall:

- develop outline framework/ expectations in regard to the national general dental, community, personal dental and orthodontic contracting, overseeing the central

contracting function is discharged in line with the Dental Policy Book and national rules/frameworks
- responsible for overseeing national dental policy at ICB system and local level
- develop and agree local improvement schemes to support delivery of the national contract and policy asks.

Commissioning of Optometry
The Committee shall:
- develop outline framework/ expectations in regard to the national general ophthalmic services (GOS) contractual regulations and policy
- Responsible for overseeing national GOS policy at ICB system and local level
- Develop and agree local improvement schemes to support delivery of the national contract and policy asks.

Additional responsibilities. The Committees additional responsibilities include:
- Support Primary Care development across Cheshire & Merseyside including oversight of:
  - primary care networks (PCNs) ongoing development as the foundations of out-of-hospital care and building blocks of place-based partnerships
  - Workforce, resilience and sustainability
  - Maximisation of GP Contract opportunities such as ARRS (Additional roles) and QOF outcomes
- plan, including needs assessment, for primary care services across Cheshire & Merseyside and to support planning at scale for primary care
- have oversight of the development of an integrated Estates programme across Cheshire & Merseyside and at local level using flexibilities available through PCN arrangements, mixed estates with other partners, premises improvement grants and capital investment monies
- to consolidate risk reviews of primary care services, aggregating findings and supporting solutions/ mitigations at places
- to ensure contract proposals achieve health improvement and value for money
- to oversee quality and safety of services delivered in primary care – receiving regular reports from the ICB Quality and Performance Committee and Finance, Investment and Our Resources Committee providing updates and assurance on primary care related quality, finance and performance issues
- ensure that conflicts of interest have been mitigated in line with the NHS C&M Conflicts of Interest Policy, and all actions/ decisions involving consultation with Committee members or GPs will record any declarations of interest.
- ratifying time limited Place based recommendations related to this committee's remit or determining to 'call-in' such a recommendation and provide an alternative course of action.

Risk Management. The Committee will also ensure the appropriate management of risks in relation to primary care; receiving regular reporting of primary care related Corporate Risks, and relevant Board Assurance Framework (BAF) risk – these will include reference to relevant Place Delivery Assurance risks – both strategic and corporate as per NHS C&M Risk Management Strategy.

5. Membership & Attendance

The Committee members drawn from the ICB Board shall be appointed by the Board in accordance with the ICB Constitution. The membership shall consist of the following voting members:

- at least 1 ICB Non Executive Member (Chair)
- at least 1 ICB Partner Member (1 to be the Deputy Chair)
- ICB Assistant Chief Executive (or Deputy)
- Associate Director of Primary Care
- ICB Director of Nursing & Care
- ICB Director of Finance
- ICB Medical Director (or Associate Medical Director for Primary Care)
- Independent GP
- at least 2 Place Directors or designated individual from Place.

In attendance by invitation (non-voting):

- Healthwatch nominated representative
- Public Health representative
- Local Medical Committee (LMC) representative
- Pharmaceutical Services Regulations Committee (PSRC) representative
- LOC (Local Optical Committee) representative
- LDC (Local Dental Committee) representation
- Membership of other Professional Groups to be agreed/discussed further dependant on agenda item.

All Committee members may appoint a deputy to represent them at meetings of the Committee. Committee members should inform the Chair of their intention to nominate a deputy to attend/act on their behalf and any such deputy should be suitably briefed and suitably qualified (in the case of clinical members).

The Committee may also request attendance by appropriate individuals to present agenda items and/or advise the Committee on particular issues.

Attendees

Only members of the Committee have the right to attend Committee meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the Committee.

Meetings of the Committee may also be attended by other individuals, by the agreement of the Chair, who are not members of the Committee for all or part of a meeting as and when appropriate.

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 particular matters.

6. Meetings

Leadership
The Committee is Chaired by an ICB Non Executive Member.

Committee members may appoint a Deputy Chair.

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

Quorum
A meeting of the Committee is quorate if the following are present:

- At least five Committee members in total, including;
  - At least one ICB Non Executive Member or ~~system~~ ICB Partner Member
  - At least one Clinically qualified Member
  - At least two ICB Directors (or their nominated deputies).

If the named Chair, or Deputy Chair, are both unable to attend a meeting, and the meeting is required to proceed on the agreed date, then an alternative suitably experienced ICB Non-Executive Member will be asked Chair the meeting. Where these quorum requirements are unable to be met the meeting date will be rearranged.

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

If on an occasion a Committee meeting is due to start but the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken. Alternatively, the meeting can be called to a halt and an agreement reached to rearrange an additional meeting.

Decision-making and voting
Decisions will be taken in accordance with the Standing Orders and within the authority as delegated to the Committee, and as outlined within the ICBs SORD and Standing Financial Instructions.

The Committee will ordinarily make decisions by consensus. Where this is not possible, the Chair may call a vote.

Only voting members, as identified in the “Membership” section of these terms of reference, may cast a vote. Each member is allowed one vote and a majority will be conclusive on any matter.

A person attending a meeting as a deputy of a Committee member shall have the same right to vote as the Committee member they are representing.

In accordance with ICB policy, no member (or deputy) with a conflict of interest in an item of business will be allowed to vote on that item.

Where there is a split vote, with no clear majority, the Chair will have the casting vote.

If a decision is needed which cannot wait for the next scheduled 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 Committee.

Frequency
The Committee will normally meet in private. However, on occasions due to some agenda items the meeting may be held in public for all or part, to be agreed by the Chair depending on advice received and agenda item to be discussed. Due process in relation to Patient Consultation requirements should be considered when making this decision.

The Committee will normally meet up to six times each year and arrangements and notice for calling meetings are set out in the ICB Standing Orders. Additional meetings may take place as required.

The Board, ICB Chair, Committee Chair, or Chief Executive may ask the Committee to convene further meetings to discuss particular issues on which they want advice.

In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

Papers for the meeting will be issued ideally one week in advance of the date the meeting is due to take place and no later than 4 working days.

Administrative Support
The Committee shall be supported with a secretariat function. Which will include ensuring that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead
- attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements
- Records of declarations of conflicts of interest, members' appointments and renewal dates are retained and the Board is prompted to renew membership and identify new members where necessary
- good quality minutes are taken in accordance with the ICB standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept
- the Chair is supported to prepare and deliver reports to the Board
- the Committee is updated on pertinent issues/ areas of interest/ policy developments; and
- action points are taken forward between meetings.

Accountability and Reporting Arrangements
The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

The minutes of the meetings shall be formally recorded by the secretary and submitted to the Board.

The Committee will submit copies of its approved minutes and a key issues report to the ICB following each of its meetings, which will draw to the attention of the Board any issues that require disclosure to the Board or require action.

The Committee will also provide a key issues report to each of the place-based primary care sub-committees of the Committee and will receive an equivalent report from each of the place-based primary care committees.

The Committee will receive regular key-issues reports from the Pharmaceutical Services Regulations Committee (PSRC).

The Committee will provide the Board with an Annual Report. The report will summarise its conclusions from the work it has done during the year.

The outputs of the group may be reported to NHSE/supporting assurance, awareness and interaction.

7. Behaviours & Conduct

Members will be expected to conduct business in line with the ICB value s and objectives and the principles set out by the ICB.

Members of, and those attending, the Committee shall behave in accordance with the ICB's constitution, Standing Orders, and Standards of Business Conduct Policy.

All members shall comply with the ICB's Managing Conflicts of Interest Policy at all times. In accordance with the ICB's policy on managing conflicts of interest, Committee members should:

- inform the chair of any interests they hold which relate to the business of the Committee.
- 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 Committee.
- 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, Committee members should:

- comply with the ICB's 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 ICB's administrative arrangements to support the Committee 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 Committee 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 Board for approval.

Annex One: Statutory Framework

The Health and Care Act 2022 amends the NHS Act 2006 by inserting the following provisions:

13YB Directions in respect of functions relating to provision of services
(1) NHS England may by direction provide for any of its relevant functions to be exercised by one or more integrated care boards.
(2) In this section "relevant function" means—
(a) any function of NHS England under section 3B(1) (commissioning functions);
(b) any function of NHS England, not within paragraph (a), that relates to the provision of—
(i) primary medical services,
(ii) primary dental services,
(iii) primary ophthalmic services, or
(iv) services that may be provided as pharmaceutical services, or as local pharmaceutical services, under Part 7;
(c) any function of NHS England by virtue of section 7A or 7B (exercise of Secretary of State's public health functions);
(d) any other functions of NHS England so far as exercisable in connection with any functions within paragraphs (a) to (c).

82B Duty of integrated care boards to arrange primary medical services
(1) Each integrated care board must exercise its powers so as to secure the provision of primary medical services to such extent as it considers necessary to meet the reasonable requirements of the persons for whom it has responsibility.
(2) For the purposes of this section an integrated care board has responsibility for— (a) the group of people for whom it has core responsibility (see section 14Z31), and (b) such other people as may be prescribed (whether generally or in relation to a prescribed service).

In exercising its functions, NHS C&M must comply with the statutory duties set out in NHS Act, as amended by the Health and Care Act 2022, including:

Having regard to and acting in a way that promotes the NHS Constitution (section 2 of the Health Act 1989 and section 14Z32 of the 2009 Act);
Exercising its functions effectively, efficiently, and economically (section 14Z33 of the 2006 Act);

- section 14Z34 (improvement in quality of services),
- section 14Z35 (reducing inequalities),
- section 14Z38 (obtaining appropriate advice),
- section 14Z40 (duty in respect of research),
- section 14Z43 (duty to have regard to effect of decisions)
- section 14Z44 (public involvement and consultation),
- sections 223GB to 223N (financial duties), and
- section 116B(1) of the Local Government and Public Involvement in Health Act 2007 (duty to have regard to assessments and strategies).

In addition, NHS C&M will follow the Procurement, Patient Choice and Competition (no2) Regulations 2013 and any subsequent procurement legislation that applies to the ICB.

Annex Two: Schedule 1 – Delegated Functions

A. Decisions in relation to the commissioning, procurement, and management of Primary Medical Services Contracts, including but not limited to the following activities:

   - decisions in relation to Enhanced Services
   - decisions in relation to Local Incentive Schemes (including the design of such schemes)
   - decisions in relation to the establishment of new GP practices (including branch surgeries) and closure of GP practices
   - decisions about 'discretionary' payments
   - decisions about commissioning urgent care (including home visits as required) for out of area registered patients.

B. The approval of practice mergers
C. Planning primary medical care services in the Area, including carrying out needs assessments
D. Undertaking reviews of primary medical care services in the Area
E. Decisions in relation to the management of poorly performing GP practices and including, without limitation, decisions, and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the performers list)
F. Management of the Delegated Funds in the Area
G. Premises Costs Directions functions
H. Co-ordinating a common approach to the commissioning of primary care services with other commissioners in the Area where appropriate; and
I. Such other ancillary activities as are necessary in order to exercise the Delegated Functions.

SCHEDULE 2 – RESERVED FUNCTIONS OF NHSE

A. Management of the national performers list
B. Management of the revalidation and appraisal process
C. Administration of payments in circumstances where a performer is suspended and related performers list management activities
D. Capital Expenditure functions
E. Public Health Section 7A functions under the NHS Act
F. Functions in relation to complaints management
G. Decisions in relation to the Prime Minister's Challenge Fund; and
H. Such other ancillary activities that are necessary in order to exercise the Reserved Functions.

NHS Cheshire and Merseyside Primary Care Committee

Date: 19th October 2023

Corporate Risk Register Update, Month 7, Quarter 3 (2023-24)

Agenda Item No	SPCC B23/10/07
Report author & contact details	Hilary Southern, Governance & Corporate Services Manager (St Helens Place) Hilary.southern2@sthelensccg.nhs.uk
Report approved by (sponsoring Director)	Christopher Leese, Associate Director of Primary Care
Responsible Officer to take actions forward	Dawn Boyer, Head of Corporate Affairs & Governance (ICB) Dawn.Boyer@knowsleyccg.nhs.uk

<table>
<tr><td>Executive Summary</td><td colspan="5">This report provides an update to the Committee on the activity of identified primary care related corporate risks – covering the areas of primary care, ophthalmic, dental and community pharmacy; as at month 7 (October) Quarter 3, 2023/24. This report forms part of the ICB Risk Management Framework, and directly supports the ICB Board Assurance Framework. The report is to provide assurance to the committee that key risks have been identified and are being appropriately managed within the Framework.</td></tr>
<tr><td rowspan="2">Purpose (x)</td><td>For information / note</td><td>For decision / approval</td><td>For assurance</td><td>For ratification</td><td>For endorsement</td></tr>
<tr><td></td><td>X</td><td>X</td><td></td><td></td></tr>
<tr><td>Recommendation</td><td colspan="5">The Committee is asked to:
APPROVE reduction in risk score for Risk 2PC and proposed closure
APPROVE addition of new risk – risk 7PC relating to dental service provision
NOTE the current position in relation to the risks escalated to this committee, identify any further risks for inclusion, and consider the level of assurance that can be provided to the Board and any further assurances required.</td></tr>
<tr><td>Key issues</td><td colspan="5">See Appendix 1 for identified Primary Care related risks.</td></tr>
<tr><td>Key risks</td><td colspan="5">See Appendix 1</td></tr>
<tr><td rowspan="4">Impact (x)
(further detail to be provided in body of paper)</td><td>Financial</td><td colspan="2">IM &T</td><td>Workforce</td><td>Estate</td></tr>
<tr><td></td><td colspan="2">x</td><td>x</td><td></td></tr>
<tr><td>Legal</td><td colspan="2">Health Inequalities</td><td>EDI</td><td>Sustainability</td></tr>
<tr><td>x</td><td colspan="2">x</td><td></td><td>x</td></tr>
<tr><td>Route to this meeting</td><td colspan="5">N/A</td></tr>
<tr><td>Management of Conflicts of Interest</td><td colspan="5">The contents of the report do not present any potential conflict of interest for any members of the ICB Primary Care Committee.</td></tr>
<tr><td>Patient and Public Engagement</td><td colspan="5">N/A – no patient and public engagement has been undertaken.</td></tr>
<tr><td>Equality, Diversity and Inclusion</td><td colspan="5">N/A – the report concerns the establishment of effective risk management systems which will not directly impact on the population or staff.</td></tr>
<tr><td>Health inequalities</td><td colspan="5">The report concerns the implementation of an effective risk management system which, while not directly impacting on health inequalities, will create a framework for the consideration, identification and mitigation of risks to health equality and provide assurance regarding the effectiveness of mitigation strategies.</td></tr>
<tr><td>Next Steps</td><td colspan="5">N/A – See recommendations above.</td></tr>
<tr><td rowspan="4">Appendices</td><td>Appendix A</td><td colspan="4">ICB PC Related Corporate Risk Register Summary</td></tr>
<tr><td>Appendix B</td><td colspan="4">Place Risk Distribution Summary</td></tr>
<tr><td>Appendix C</td><td colspan="4">Primary Care Committee Risk Assurance Map</td></tr>
<tr><td>Appendix D</td><td colspan="4">Primary Care Committee Risk Summaries</td></tr>
</table>

Primary Care Corporate Risk Register Update
Month 7 (October), Quarter 3, 2023/24

1. Executive Summary

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

1.2 **Overall Summary**: There are currently **four** primary care related corporate risks identified for NHS C&M – three (1PC, 6PC & 7PC) rated **high-extreme** (8-25); one of these (7PC) is **new** to the register this month and one (2PC) has **reduced** this month to its target score of 3 and is proposed for closure.

1.3 All these risks cover the area of primary care, including General Practice, General Dental Service, Ophthalmology and Community Pharmacy. Appendix D contains detailed summaries for each risk, including identified controls and assurances.

2. Introduction/ Background

2.1 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.

2.2 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

2.3 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.

2.4 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.

2.5 Risk are escalated to the committee risk register which are rated as high (8+) in the context of the ICB as a whole, together with any relevant place risks rated as extreme (15+) in the context of the place. 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.

3. Committee Risk Reports

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

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

3.1.2 **Committee Place Risk Distribution** (appendix B) – indicates, for risks common across all or a number of places, how risk is distributed across each of the 9 places and will also feed into place risk reporting. This may indicate that action is required in a particular place/s to strengthen the effectiveness of an existing control or to implement additional controls.

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

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

4. Key Points Highlighted

4.1 **Overall Summary**: There are currently **four** primary care related corporate risks identified for NHS C&M – three (1PC, 6PC & 7PC) rated **high-extreme** (8-25); one of these (7PC) is **new** to the register this month and one (2PC) has **reduced** this month to its target score of 3 and is proposed for closure.

4.2 **Extreme/ High Risks**: Two risks currently rated as **Extreme (16)**:

- 1PC; relating to the sustainability and resilience of Primary Care workforce (General Practice, Community Pharmacy & General Dental Services). This risk was increased in June following a review of related place level risks – this month's report sees the risk remaining at a score of 16
- 7PC – new risk relating to provision of primary dental services and risk due to a significant provider having served notice in Halton Place.

One risk is currently rated as **high (12)**:

- 6PC, relating to an identified dental provider contract management risk – potentially raising both issues around quality and access and also potential loss of provision/ impact on general dental provision.

4.3 **Place-level risks for Escalation:** Appendix B identifies the risks currently held at place-level; as noted in section 2.5 above, those scoring 15 or more. As previously reported, Place risk development is an ongoing process, with some places further along than others, but all places are working on developing their place-level risks, and support is being provided from the ICB central Governance Leads team as required to review the risks collectively to ensure consistency across the patch and also differentiate issues from risks, as there are a number of historical issues currently being managed within place primary care team business as usual work programmes.

Work is well underway in the development of a risk management training offer – an update was presented to Risk Committee in September.

All place level risks are currently managed through Place Primary Care forums, with oversight from place-level risk management structures, and links into the central risk management team. Risks will be escalated to System Primary Care Committee in accordance with the agreed process (as at section 2.5 above). Or additionally, further information relating to specific place-level risks can be provided as required.

4.4 **Risk Score Movement:**

- Risk 2PC – relating to Extension of APMS (Alternative Providers of Medical Services) Primary Care Contracts); risk score has **decreased** to 3 (rare, 1 x moderate impact, 3), and is proposed for **closure** this month. This follows the continuing work undertaken by the central Procurement team, to resolve/ update contracts, and implementation of Procurement Decisions Plan, signed off by Finance, Investment & Our Resources Committee (FIRC).

4.5 **New/ Closed Risks**:

- Risk 7PC – relating to a provider of significant primary dental services provision within Halton having served notice on their NHS contract, which provides over 65% of the place provision currently. Risk scored initially at 16 (likely likelihood x major impact);
- As above, risk 2PC is suggested for closure this month

5. Recommendations

5.1 The Committee is asked to:

i. **APPROVE** **reduction** in risk score for Risk 2PC and proposed **closure**
ii. **APPROVE** addition of new risk – risk 7PC relating to dental service provision
iii. **NOTE** the current position in relation to the risks escalated to this committee, identify any further risks for inclusion, and consider the level of assurance that can be provided to the Board and any further assurances required.

6. Next Steps

6.1 Continued work on supporting places to identify and develop their place-related primary care risks and ensure consistency of scoring across.

6.2 Provide further support and training to places to manage their place-level risks and implement robust reporting between central Risk Management Team and place risk leads, inline with the Risk Management Strategy.

7. Officer contact details for more information

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Appendix A: Primary Care Committee Corporate Risk Register Summary – October 2023 (Quarter 3, 2023/24)

Risk ID	Risk Title	Senior Responsible Owner	Inherent Risk Score (LxI)	Current Risk Score (LxI)	Previous Risk Score (LxI)	Target Score	Risk Proximity
FOR COMMITTEE REVIEW – 8+ OR SCORE CHANGE							
Primary Care (General Practice, Community Pharmacy, General Dental Service and Ophthalmic)							
1PC	Sustainability and Resilience of Primary Care workforce (General Practice, Community Pharmacy & General Dental Services)	Chris Lees/ Tom Knight	16	16 ↔	16	3	A
General Practice Related							
2PC	Extension of APMS (Alternative Providers of Medical Services) Primary Care Contracts	Chris Lees	12	3 ↓ **CLOSE**	6	3	B
Dental Related							
6PC	Identified dental provider contract management risk – potentially leading to loss of provider and impact on general dental provision	Luci Devenport	9	12 ↔	12	6	A
7PC	NEW: Notice served by provider of significant dental services provision within Halton, potentially leading to reduced/ or no service provision for existing and new dental patients in the area.	Luci Devenport	20	16 **NEW**	N/A	4	B

COMMITTEE NOTING ONLY (Risks scoring 8 and below)							
General Practice Related							
	N/A						
Community Pharmacy Related							
	N/A						
Ophthalmic Related							
	N/A						

Appendix B: Place Risk Distribution Summary – August 2023 (Quarter 2, 2023/24)

Risk ID	Risk Title	Current Risk Score									
		ICB Wide	Cheshire East	Cheshire West	Halton	K'sley	L'pool	Sefton	St Helens	W'ton	Wirral
FOR COMMITTEE REVIEW – 8+ OR SCORE CHANGE											
Primary Care (General Practice, Community Pharmacy, General Dental Service and Ophthalmic)											
1PC	Sustainability and Resilience of Primary Care workforce (General Practice, Community Pharmacy & General Dental Services)	16 ↔	16	16			16	16	16	9	
General Practice Related											
2PC	Extension of APMS (Alternative Providers of Medical Services) Primary Care Contracts	3 ↓ **CLOSE**									
Dental Related											
6PC	Identified dental provider contract management risk – potentially leading to loss of provider and impact on general dental provision	12 ↔									
7PC	NEW: Notice served by provider of significant dental services provision within Halton, potentially leading to reduced/ or no service provision for existing and new dental patients in the area.	16 **NEW**									

COMMITTEE NOTING ONLY (Risks scoring 8 and below)											
General Practice Related											
	N/A – No corporate risks identified currently										
Community Pharmacy Related											
	N/A – No corporate risks identified currently										
Ophthalmic Related											
	N/A – No corporate risks identified currently										

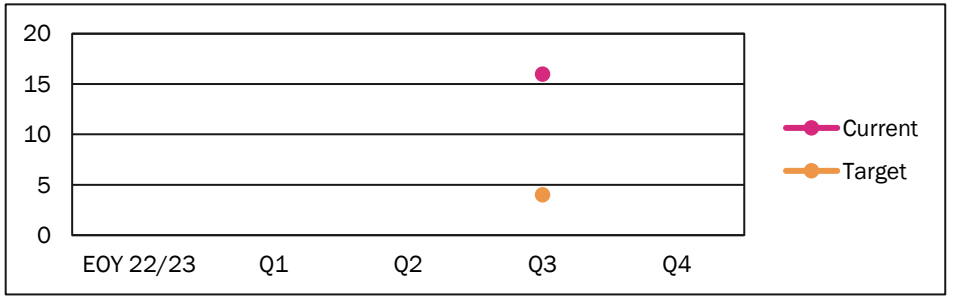
Appendix C: Primary Care Committee Risk Assurance Map – August 2023 (Quarter 2, 2023/24)

Risk ID	Risk Title	Current Risk Score	Controls					Assurance Rating
			Policies	Processes	Plans	Contracts	Reporting	
FOR COMMITTEE REVIEW – 8+ OR SCORE CHANGE								
Primary Care (General Practice, Community Pharmacy, General Dental Service and Ophthalmic)								
1PC	Sustainability and Resilience of Primary Care workforce (General Practice, Community Pharmacy & General Dental Services)	16 ↔						Reasonable
General Practice Related								
2PC	Extension of APMS (Alternative Providers of Medical Services) Primary Care Contracts	3 ↓ CLOSE						FULL
Dental Related								
6PC	Identified dental provider contract management risk – potentially leading to loss of provider and impact on general dental provision	12 ↔						Reasonable
7PC	NEW: Notice served by provider of significant dental services provision within Halton, potentially leading to reduced/ or no service provision for existing and new dental patients in the area.	16 NEW						Reasonable

COMMITTEE NOTING ONLY (Risks scoring 8 and below)								
General Practice Related								
	N/A – No corporate risks identified currently							
Community Pharmacy Related								
	N/A – No corporate risks identified currently							
Ophthalmic Related								
	N/A – No corporate risks identified currently							

Appendix D: Primary Care Committee Risk Summaries – August 2023 (Quarter 2, 2023/24)

FOR COMMITTEE APPROVAL – NEW RISK

ID No: 7PC	Risk Title: Notice served by provider of significant dental services provision within Halton, potentially leading to reduced/ or no service provision for existing and new dental patients in the area.			
	Likelihood	**Impact**	**Risk Score**	**Trend**
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	5	4	**20**	
Current Risk Score	4	4	**16 NEW**	
Risk Appetite/Target Risk Score	1	4	**4**	

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Tom Knight, Head of Primary Care	Luci Devenport, Senior Commissioning Manager	Assistant Chief Executive/ Place Primary Care Structures	System Primary Care Committee Report to Finance Committee

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
TBC	Quality, contracting, transformation.	B – within the financial year	Corporate	Manage

Date Raised	Last Updated	Next Update Due
29/09/2023	29/09/23	December 2023

Risk Description

Notice has been served (Sept 2023) by a provider of dental services within Halton – provision over 65% of total Halton dental services provision. This could lead to a potential lose of service provision for both existing patients and new patients requiring dental treatment/ services. Expected end date end of December 2023.
As at **October 2023**: Risk scored at likely likelihood, 4 x major impact, 4 (16). Conversations have been ongoing with the provider to discuss solutions/ alternatives to providing formal notice, but provider unable to sustain NHS contract provision, therefore decision has been formally made. Usual process is to scope interest of alternative local providers to pick up contracts, but initial scoping has not yet identified a solution.

Risk to both existing patients (on going care/ treatment/ repair guarantee etc) and also adding to national access pressures for new patients. Looking at possibility of providing sessional/ over performance agreements as an interim measure, but not a long term solution and potentially will need full review of contract and recommissioning exercise – this will involve significant resource pressures around time and cost.		
Current Controls		**Rating**
Policies	• Policy book for primary dental services	**G**
Processes	• Statutory process underway to scope alternative providers (similar exercise has just been concluded in Sefton place)	**A**
Plans	• Currently scoping alternative provision and potential alternative short-term contracting methods e.g. sessional	**A**
Contracts		**N/A**
Reporting	• NHSE National Team • System Primary Care Committee overview • Health & Wellbeing Boards	**G**

Gaps in control
• Lack of general dental provision is a national issue, due to shortage of qualified dental professionals

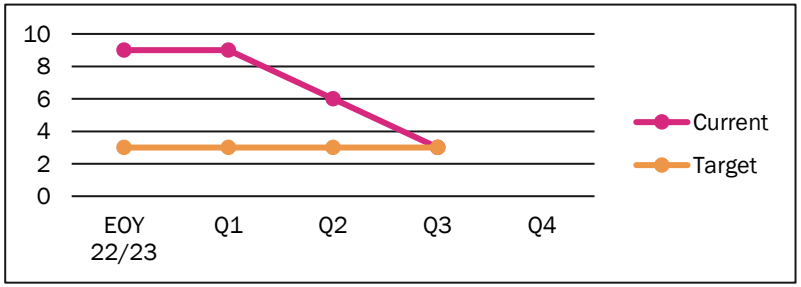
Actions planned	**Owner**	**Timescale**	**Progress Update**

Assurances		
Planned	**Actual**	**Rating**
None identified	None identified	**LIMITED**

Gaps in assurance
No assurance currently – no suitable alternative provision has been identified within Halton place at this point

Actions planned	**Owner**	**Timescale**	**Progress Update**
As above (Control actions planned)			

FOR COMMITTEE APPROVAL – SCORE MOVEMENT

ID No: 2PC	Risk Title: Extension of APMS (Alternative Providers of Medical Services) Primary Care Contracts			
	Likelihood	**Impact**	**Risk Score**	**Trend**
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	4	3	**12**	
Current Risk Score	1	3	**3 ↓**	
Risk Appetite/Target Risk Score	1	3	**3**	

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Christopher Leese, Associate Director of Primary Care	Place Primary Care Leads	Assistant Chief Executive/ Place Primary Care Structures	System Primary Care Committee Report to Finance Committee

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
TBC	Finance, governance, fraud.	B – within the financial year	Corporate	Manage

Date Raised	Last Updated	Next Update Due
01/07/2022* *Legacy CCG Risk*	29/09/23	N/A – Proposed for Closure

Risk Description

From ICB establishment in June 2022, there were a number of APMS contracts across the patch previously managed by the nine different CCGs; the rules governing their procurement/ extension are subject to the Public Contract Regulations (2015) (PCRs) and the Procurement, Patient Choice and Competition Regulations (2013) (PPCCRs), however, during Covid many of these rules were suspended. The ICB therefore inherited a mixture of contract approaches including where contracts may have been extended outside of usual approaches. In April 2023 the same challenge was identified with a number of dental-related contracts inherited by the ICB, which are in a similar position to the original APMS contracts back in June 2022, and require a review and processing to bring up to date.
As at **October 2023**: Risk score **decreased** to 3 (rare likelihood x moderate impact). Although we continue to wait on updated procurement regulations for healthcare services (the Provider Selection Regime – now expected in the New Year); work has continued on reviewing the contracts, alongside place colleagues, to understand the needs and priorities of each contract, and to renew / extend or tender as appropriate,

in compliance with existing regulations. Since June 2022 14 contracts have been awarded, 2 have been terminated and 4 have been agreed to go out to tender; the rest are to be reviewed and progressed when they come up for expiry. Paper presented to Finance, Investment & Our Resources Committee (FIRC) in September summarizing position and including an annual Procurement Decisions Plan. In summary, although the contracts still pose a challenge, they are being managed in line with the procurement team's business as usual work program, and normal cycle of reviews; and with the new regulations due in the new year, it is expected there should be greater flexibility around tendering and procurement options. Therefore, the risk has been **reduced** to it's target score, and is proposed for **closure** this month.		
Current Controls		**Rating**
Policies	• ICB Scheme of Reservation and Delegation and Standing Financial Instructions	**G**
Processes	• Oversight from/ regular reporting to Finance, Investment and Our Resources Committee (FIRC) and System Primary Care Committee. • Part of ICB annual procurement decisions plan • National/ professional support identified via North of England CSU (commissioned by NHS England) to provide technical procurement oversight and management for a number of APMS contracts due to expire in 2024.	**G**
Plans	• Annual Procurement Schedule/ Plan in place, through liaison with central team and place leads. • Contract reporting established through FIRC and working groups, and will link into System Primary Care Committee as relevant (escalating issues or concerns)	**G**
Contracts	• All contracts listed within ICB Corporate Procurement Team, and on Procurement Decisions Plan	**G**
Reporting	• Oversight from/ regular reporting to FIRC; and reporting to System Primary Care Committee to be established.	**G**

Gaps in control
• Awaiting updates to Procurement regulations – now expected in the New Year, but currently managing through existing regulations

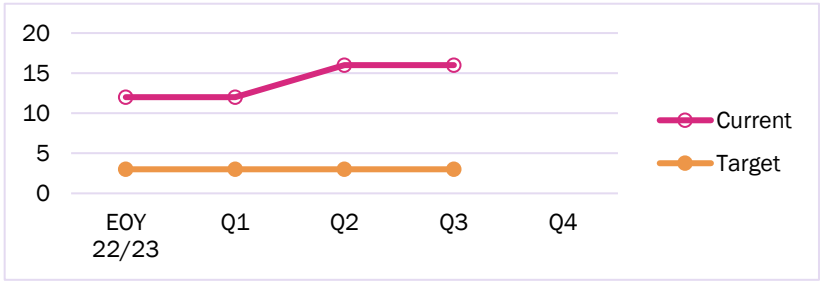
Actions planned	**Owner**	**Timescale**	**Progress Update**
As per Procurement Decisions Plan	VA	Ongoing	Plan signed off by FIRC Apr 23 & updated paper presented Sept 23.

Assurances		
Planned	**Actual**	**Rating**
Legislation/ Procurement Regulations to be updated (Nov 23)	Regular update reports to FIRC/ Procurement working group	**FULL**
	2023/24 Procurement Decisions Plan approved by FIRC (Apr)	

Gaps in assurance
None identified

Actions planned	Owner	Timescale	Progress Update
As above (Control actions planned)			

FOR COMMITTEE REVIEW – SCORES 8+

ID No: 1PC	Risk Title: Sustainability and Resilience of Primary Care workforce (General Practice, Community Pharmacy & Dental Services)			
	Likelihood	**Impact**	**Risk Score**	**Trend**
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	3	3	**9**	
Current Risk Score	3	4	**16 ↔**	
Risk Appetite/Target Risk Score	1	3	**3**	

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Christopher Leese, Associate Director of Primary Care/ Tom Knight, Head of Primary Care	Place Primary Care Leads/ ICB PC Manager (JJ)/ Senior Commissioning Mgr (LD)	Assistant Chief Executive/ Place Primary Care Structures	System Primary Care Committee Report to Finance Committee

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

Date Raised	Last Updated	Next Update Due
01/07/2022* *Legacy CCG Risk*	29/09/23	December 2023

Risk Description

Resilience and sustainability of Primary Care in terms of demand, workforce pressure and external factors such as industrial action, peaks in public concern such as (A Strep). Previously a legacy CCG risk across all 9 CCGs; this has been further expanded to include similar pressures across Community Pharmacy and General Dental Service provision. This is a national issue/ risk around contractual performance being reduced as GPs, dental practices and Pharmacies struggle to recruit suitably qualified and experienced staff. Workforce pressures are impacting on opening hours and access to services. Note individual examples of place-based practice resilience and operational concerns are

captured on local place risk registers, but this combined issue needs capturing on the overall corporate ICB risk register so that there can be assurances in respect of the overall resilience and sustainability of primary care – and that enabling factors should as workforce are included. At **October 2023**: Risk **remains** 16 – score reflective of place risk reporting – as operational management at place level – with key issues and progress fed up to System Primary Care Committee, through forums such as PC Workforce Steering Group (met 27/09). Work also continues through the Risk committee/ risk leads to review and provide consistency across the 9 place identified related risks – trying to establish a balance between what is clearly a national issue against the risks potentially being identified locally at place level. There remains an ongoing pressure in general across Community Pharmacy, Dental and General Practice, where a lack of key trained primary professional staff, in particular GPs, Pharmacists and Dentists (in the NHS family) is causing issues. In addition, pressure from recently published guidance around delivering operational resilience across the NHS this winter identifying improvement targets to be met. This is a difficult risk to identify mitigations and evidence progress made, as led by our partners and external providers; but central primary care workforce plan in place (in response to national workforce plan) and specific place-level issues are being managed as part of business-as-usual work programs within place primary care teams. Following conclusion of place risk review (mid-October), depending on the outcome, it may be proposed to close this as an issue, rather than a risk, and continue to manage identified risks relating to the national issue within place business as usual work programs/ place risk registers.

Current Controls		Rating
Policies	• National Stocktakes and Guidance in relation to Primary Care • Delivery Plan for recovering access to Primary Care https://www.england.nhs.uk/publication/delivery-plan-for-recovering-access-to-primary-care/ • Delivering Operational Resilience across the NHS Winter 2023 guidance	**G**
Processes	• System Primary Care Committee • Managed operationally at place level through place structures/ governance (escalation to SPCC as needed). • Working with National Team and DoH on workforce issues and support. • Primary Care Workforce Steering Group reporting • Access Improvement Plan Templates submission 20/10 highlighting what place actions are being undertaken	**G**
Plans	• Primary Care Strategic Framework – ICB level and Place level, place workforce plans • Clinical Strategy • Workforce/ People plans via People Board inc Primary Care Workforce Strategy • ICB engagement with HEE and Liverpool Dental School • Dental Improvement Plan • GP retention plan (submitted May 2023) • ICB Access Recovery plan (to Board October)	**G**

Contracts	• GMS PMS APMS GDS PDS Contracts updated • Local Enhanced/Quality Contracts/ Directed Enhanced Services • Community Pharmacy Contracts	**G**
Reporting	• Primary Care Workforce Steering Group/ • Community Pharmacy National Workforce Development Group • NHSE National Teams (looking at wider workforce issues across Primary Care) • Place reporting to place primary care structures/ forums - Access Improvement Plan Templates submission • Place reporting to System Primary Care Committee through reporting template already agreed noting a clearer risk principal escalation process is to be developed • System Primary Care Committee reporting through to Northwest Regional Structures • Reporting to PSRC Committee and through community pharmacy commissioning Team	**G**

Gaps in control

- Risk escalation process to be refined further between place and system
- Reporting between People Board and SPCC to be developed
- Consistent single set of data to be discussed at WSG and reported to People Board/ SPCC
- Response to Long Term Workforce Plan including primary care section

Actions planned	Owner	Timescale	Progress Update
ICB PCARP response	CWatson	Ongoing	Programme board set up – first meeting held 02/06/23 Due to ICB Board October
People Board (with support of SPCC) to lead response to Long Term Workforce Plan (including primary care section	People Board/ Chris Leese	Ongoing	

Assurances

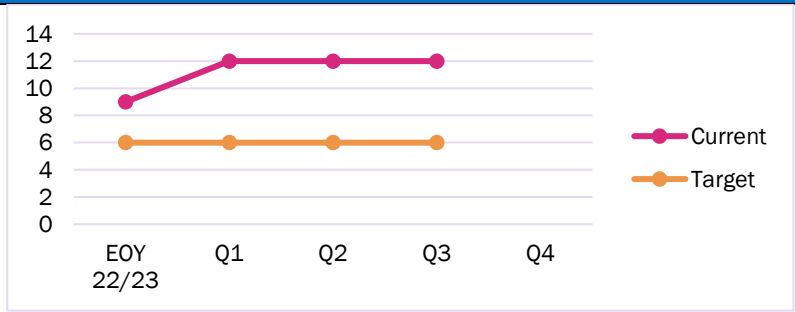
Planned	Actual	Rating
Closing BI data gaps for Workforce (Ongoing)	Regular updates at SPCC on System Pressures	**Reasonable**
	First meeting of PC workforce steering group held May 2023	

Gaps in assurance

- Some BI data gaps remain

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

ID No: 6PC	Risk Title: Identified dental provider contract management risk – potentially leading to loss of provider and impact on dental provision

	Likelihood	Impact	Risk Score	Trend
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	3	3	**9**	
Current Risk Score	3	3	**12 ↔**	
Risk Appetite/Target Risk Score	2	3	**6**	

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Tom Knight, Head of Primary Care	Luci Devenport, Senior Commissioning Manager	Assistant Chief Executive/ Place Primary Care Structures	System Primary Care Committee Report to Finance Committee

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
TBC	Quality, contracting, transformation, commissioning.	A – within the next quarter	Corporate	Manage

Date Raised	Last Updated	Next Update Due
April 2023 – *transferred from NHSE to ICB*	29/09/23	December 2023

Risk Description

Identified Dental Provider Group hold a number of GDS contracts across C&M in various guises i.e. in partnership, sole provider. Five (5) of these contracts have been under remedial action since 1 March 2022 due to no NHS dental provision being available during core hours. Legal advice has been followed; due to the size of the repayment figure (debt) for year 2022/23 and no assurances that contractual targets can be met for the next financial year the legal advice is to breach each contract as the remedial notice has not been rectified and arrange to meet with the provider (without prejudice) with a view to requesting a one-off payment of the money owed or we move to terminate. Continuing with each of these 5 contracts will result in an increasing accumulation of debt into this financial year.
As at **October 2023:** Risk **remains** 12 = 4 (likely) x 3 (moderate) – small percentage of dental practices overall and are spread out across C&M area, but still significant risk to ICB. Formal notice was served following exhaustion of local resolution procedures – termination date set 26/09, however on 16/09 provider's legal team requested further resolution discussions – thereby pausing the termination. ICB have agreed and

conversations are once again underway. Termination date extended to 30/10. In the meantime scoping exercise has been conducted to identify alternative provision to pick up the contracts, and majority of provision should be mitigated for; however can't reallocate until notice has concluded and contracts terminated – therefore there is still currently a service provision issue with patients unable to access appointments/ treatment.

Current Controls		Rating
Policies	• NHS England Dental Policy book 2018	**G**
Processes	• Legal advice has been followed throughout	**G**
Plans	• Local resolution Part 2 – until 30/10	**A**
Contracts	• Multiple – managed by Contracts Team	**G**
Reporting	• System Primary Care Committee	**G**

Gaps in control

- Issue has been ongoing for over 12 months – notice served, but currently paused again (due to end 30/10 now)
- 4 additional contracts delivered in area which may be destabilized by this issue.
- Wider impact on neighboring ICBs/ Stakeholder response to termination
- Changes to Performer List by Validation Exercise – detail unknown at this time re: quality assurance.

Actions planned	Owner	Timescale	Progress Update
Forward breach notices for each of the above contracts	Luci Devenport	30/10/2023	Extended following correspondence from provider legal team 16/09
Confirm actual debt amounts	Luci D/ Finance	Ongoing	N/A

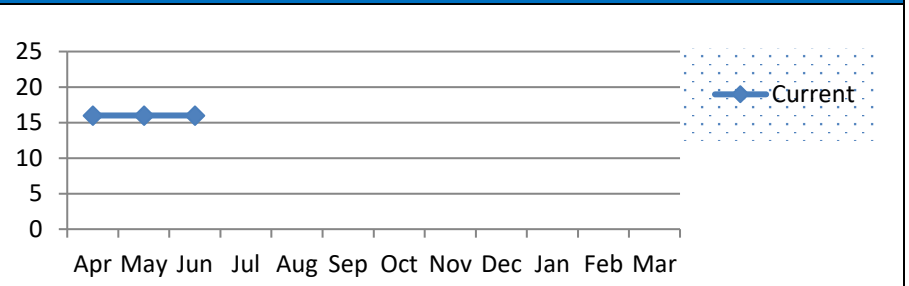
Assurances

Planned	Actual	Rating
• National guidance awaited re: Dental Foundation Trainee programme (2023/24). Impact due following year.	• Legal advice received and used to progress next steps • Breach notices to be formally issued – were issued, but currently paused as local resolution underway again	**Reasonable**

Gaps in assurance

- No assurances that contractual targets can be met for the next financial year
- Impact of Dental Foundation Trainee programme won't be felt until following year.

Actions planned	Owner	Timescale	Progress Update
As above			

ID No: BAF P6	Risk Title: Demand continues to exceed available capacity in primary care, exacerbating health inequalities and equity of access for our population			
	Likelihood	**Impact**	**Risk Score**	**Trend**
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	5	4	**20**	
Current Risk Score	4	4	**16 ↔**	
Risk Appetite/Target Risk Score	3	3	**9**	

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

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

Date Raised	Last Updated	Next Update Due
10/05/2023	24/08/2023	October TBC

Risk Description

The COVID 19 pandemic generated significant backlogs due to reduced capacity to meet routine healthcare needs and people delaying seeking healthcare interventions. There is evidence that this has exacerbated existing inequalities in access to care and health outcomes. While general practice is delivering more appointments than pre-pandemic, this increase is not keeping pace with demand and there are financial sustainability pressures in general practice in some places. Primary Care dentistry is slowly recovering and patients are presenting in greater need than pre-COVID. Access for new patients seeking an NHS dentist remains an ongoing issue. Community Pharmacy continues to play a key role in managing patient demand and creating additional GP capacity but is also under considerable pressure. The national delivery plan for recovering access to primary care focuses initially on streamlining access to care and advice. This risk relates to the potential inability of the ICB to ensure that local plans are effective in delivering against national targets for recovery of primary care access, which may result in poorer outcomes and inequity for patients. We continue to work with optometry colleagues to understand risk in this area.

Current Controls		Rating
Policies	• NHS Long Term Plan, NHS Operational Planning Guidance, National Stocktakes and Guidance in relation to Primary Care, Primary Care Access Recovery Plan, Core 20 plus 5	**G**
Processes	• System and place level operational planning, performance monitoring, contract management, system oversight framework, place maturity / assurance framework, dental reporting mid year/end year performance	**A**
Plans	• Primary Care Strategic Framework version 1, Developing Primary Care Access Recovery Plan, System Development Funding Plan, Dental Improvement Plan, ICS Operational Plan	**A**
Contracts	• GMS PMS APMS Contracts (note no specific ask in terms of number of appointments), Local Enhanced/Quality Contracts (poss stretch asks within), Directed Enhanced Services – Primary Care Networks – Enhanced Access, GDS PDS Contracts nationally determined	**G**
Reporting	• System Primary Care Committee, NW Regional Transformation Board, Quality & Performance Committee, ICB Board, HCP Board	**G**

Gaps in control
• Primary Care Strategic Framework – version 2 to be completed & formally signed off • Primary Care Access Recovery Plan yet to be completed

Actions planned	Owner	Timescale	Progress Update
Secure approval to Primary Care Strategic Framework	Jonathan Griffiths	Nov 2023	General Practice & Community Pharmacy agreed by ICB Board in June. Optometry & Dental to be completed for Board review in November.
Complete & secure approval to Primary Care Access Recovery Plan	Chris Leese	November 2023	In development. Update to System Primary Care Committee in June on Access Recovery Plan
Complete & secure approval to Dental Improvement Plan	Tom Knight	Complete	Approved by System Primary Care Committee in June
Secure agreement & establish governance arrangements	Clare Watson	Complete	

Assurances		
Planned	**Actual**	**Rating**
Sign off plans by ICB Board	System Primary Care Committee & ICB Board approval to Primary Care Strategic Framework & Dental Improvement Plan (June) (reasonable)	**Reasonable**

Reporting on delivery to System Primary Care Committee & ICB Board	System Primary Care Committee & ICB Board reports (reasonable)	
Performance Reporting to ICB Board (monthly)	Performance reporting	

Gaps in assurance

- Plans yet to be approved
- Delivery reporting yet to be established

Actions planned	Owner	Timescale	Progress Update
Secure approval to plans	Jonathan Griffiths, Chris Leese & Tom Knight	October 2023	Primary Care Strategic Framework going to ICB Board in June and System PC Committee, August. Dental Improvement Plan going to System Primary Care Committee, June. Primary Care Access Recovery Plan is in development for completion in October.
Establish delivery reporting	Chris Leese & Tom Knight	Complete	

NHS Cheshire and Merseyside System Primary Care Committee

Date: 19th October 2023

Primary Care Workforce Update

Agenda Item No	SPCC B23/10/08
Report author & contact details	Christopher Leese Emma Hood Tom Knight c.leese@nhs.net
Report approved by (sponsoring Director)	Clare Watson, Assistant Chief Executive
Responsible Officer to take actions forward	Christopher Leese

Primary Care Workforce Update

Executive Summary	The Primary Care Workforce update provides the Committee with information and assurance in respect actions to support primary care workforce, including actions/updates from the bi monthly Primary Care Workforce Steering Group which reports to the People Board, but also reports to this Committee. This paper contains ; • A general update on primary care workforce including key reporting statistics • Update from the Primary Care Workforce steering group held on 27th September including key decisions made or referred to the People Board - and for the Committee's particular attention • An update from each Place on Additional Roles (ARRS) plans which were submitted by Primary Care Networks to Place under the national Directed Enhanced Service (DES)

Purpose (x)	**For information / note**	**For decision / approval**	**For assurance**	**For ratification**	**For endorsement**
	X		X		

Recommendation	**The Committee is asked to:** • **Note and discuss** the update in respect of Primary Care workforce including next steps and issues, which is for **assurance** purposes
Key risks	A risk for workforce/sustainability is already part of the primary care risk register. Individual place risks will be managed through place where there are particular issues.

Impact (x) (further detail to be provided in body of paper)	**Financial**	**IM &T**	**Workforce**	**Estate**
	X		X	X
	Legal	**Health Inequalities**	**EDI**	**Sustainability**
		X		X

Route to this meeting	None
Management of Conflicts of Interest	Will be managed in accordance with the conflict details and by the management of the Chair of the meeting
Patient and Public Engagement	None for this report, but for relevant actions for contract issues under national policy will have patient and public engagement expectations.
Equality, Diversity and Inclusion	None for this report, but for relevant actions under national policy will have expectations for Equality, Diversity and Inclusion.
Health inequalities	None for this report, but for relevant actions under national policy will have expectations for health inequalities.

Next Steps	Any next steps are including in the report narrative.
Appendices	Appendix 1 – General Practice Workforce Data Appendix 2(a)(b) – ARRS (Additional Roles) summarys - General and place summarys Appendix 3 – Terms Of Reference (Primary Care Workforce Steering Group)

Glossary of Terms	**Explanation or clarification of abbreviations used in this paper**
Detailed in paper as part of Narrative	

Primary Care Workforce Update

1.0 National and Local Context

1.1 Actions in relation to Primary Care Workforce are an important enabling function to the work of this Committee;

- This Committee oversees major risks highlighted in relation to workforce and sustainability of all four primary care groups, and has heard from members of all disciplines in respect of challenges for recruitment, retention, wellbeing and skills shortages.
- The Committee receives regular updates in respect of 'Additional Roles' reimbursement scheme (ARRS) which are a major element of contracting for general practice under the national Primary Care Network Directed Enhanced Service (PCN DES). This DES part funds certain roles for Primary Care Networks recruited to work in line with national job descriptions and audit rules.
- Workforce is a major element of the ICBs Primary Care Strategic Framework
- Workforce actions underpin the 'Recovering Access To Primary Care' policy area, primarily under the 'Building Capacity' workstream. Many actions referred to within this update will be consolidated into the ICB's Access Improvement Plan.

1.2 In June, NHS England released the NHS Long Term Workforce Plan (Link below) https://www.england.nhs.uk/publication/nhs-long-term-workforce-plan/which covers workforce across all sectors. The plan centres around three priority areas:

- **Train:** significantly increasing education and training to record levels, as well as increasing apprenticeships and alternative routes into professional roles, to deliver more doctors and dentists, more nurses and midwives, and more of other professional groups, including new roles designed to better meet the changing needs of patients and support the ongoing

transformation of care.

- **Retain:** ensuring that the NHS keep more of the staff we have within the health service by better supporting people throughout their careers, boosting the flexibilities we offer our staff to work in ways that suit them and work for patients, and continuing to improve the culture and leadership across NHS organisations.
- **Reform**: improving productivity by working and training in different ways, building broader teams with flexible skills, changing education and training to deliver more staff in roles and services where they are needed most, and ensuring staff have the right skills to take advantage of new technology that frees up clinicians' time to care, increases flexibility in deployment, and provides the care patients need more effectively and efficiently.

1.3 The plan contains actions for the ICBs in terms of Primary Care as well as employers, system partners and central government. The People Board will oversee the response to delivering system-level NHS Long Term Workforce Plan. However, it is proposed that the ICB, via this Committee and the Primary Care Workforce Steering Group, building on existing documents already developed such as the local GP Retention Delivery Plan, produces a Primary Care Workforce Plan. This will align to the 'Building Capacity' workstream. More details will follow once the People Board have agreed the overall response.

2.0 Workforce Data and Issues

2.1 Dental - National Dental Workforce collection

A revised biannual national dental workforce collection for contractors to complete on the 1st April and 1st October will be in place for financial year 2023/24. Completion of the form is mandatory for all current GDS (general dental) contracts and PDS (personal dental) agreements in England, regardless of whether they are paid by NHSBSA, to support the Integrated Care Board's (ICBs) commissioning function. The data from the workforce collection form submissions is important because it will provide high-quality data regarding the dental workforce which will support ICBs with their commissioning function, support NHS England with dental system reform and an understanding of the following:

- Trends regarding retention and recruitment of staff;
- NHS workforce available and NHS capacity

2.2 Community Pharmacy

This year's national survey was completed by 95% of pharmacy contractors, compared to last year's 47%. The key findings are:

- The number of pharmacists remains almost constant (compared to 2021 data).

- The number of pharmacy technicians indicates a reduction (compared to 2021 data)
- Locum pharmacists are being used more as part of the staffing model and locum pharmacists are working fewer hours on average.
- There is a 37% increase in the reported number of Independent Prescribers.
- There is a slight growth in the number of pharmacy technicians working as accuracy checkers, indicating a potential shift in skill mix.
- The reported numbers for total workforce (Full-Time Equivalents) has reduced 6% in total (from 2021)
- All roles show an increase in the vacancy rate. The rates are: 20% for pharmacy technicians, 16% for pharmacists and 9% for dispensing assistants.
- There is an increasing number of trainee dispensing assistants and medicines counter assistants.

2.3 **Optometry**

- The recognition that the knowledge, skills and expertise of eye care providers can help alleviate the current pressures in general practice and the hospital eye service.
- Workforce plan highlights better image sharing between primary and secondary care – a significant step forward in joint working with other professionals.
- Focus on improving clinical placements, capacity for both pre-registration optometrists and optometrists who are undertaking higher qualifications and independent prescribing urgently needs to be supported and planned for.
- Challenges remain in respect of available data.

2.4 **General Practice** – the Cheshire and Merseyside business intelligence (BI) team have been working on sets of data to support the work above and to ensure there is the required reporting to deliver the Access Improvement Plan. The latest cuts of the workforce data available is given in **Appendix 1.** This data is available at the different levels and menu options available at shown and ICB officers have access to this set of data for interrogation at place and system level, where available Some of the key headlines being explored as part of the General Practice reporting are as follows

- **Direct Patient Care Roles** - The data shows the % achievement rate for Direct Patient Care staff compared to the original March 2019 baseline. June 23 is the latest available quarterly data that collates both NWRS workforce and PCN ARRS data. This is a nationally published data source and can be found here.

https://digital.nhs.uk/data-and-information/publications/statistical/primary-care-workforce-quarterly-update. Since March 2019 C&M ICB system has 'employed' an additional 1,453 DPC staff. This is an additional 63.8% (695) against the expected target for C&M ICB of 1,089, if we use a 'target' of the national ambition of of 26,000 DPC staff and applying a pro rata split to C&M ICB. This is a 230% increase against the Mar 19 baseline. The 5th highest ICB increase nationally against an England average of a 14.4% increase. However further analysis is needed on the roles / reasons for this in primary care and this is a proxy apportionment model only – and that each place would have a different individual narrative within this. We are currently working with NHS England in relation to expectations for 'targets'.

- **GP's** - The NHSE Long Term Workforce Plan states

9. **To meet the demand for GPs, this Plan outlines a need to increase the number of GP specialty training places by 45–60% by 2033/34.** Our ambition is to increase the number of places by 50% to 6,000 by 2031/32. In 2018 the government expanded the number of medical school places by 1,500 and the first of these graduates are now starting to join the workforce. This Plan commits to initially growing GP specialty training by 500 places in 2025/26, timed so that more of these newly qualifying doctors can train in primary care. Further expansion of GP specialty training places will then take place with 1,000 additional places (5,000 in total) in 2027/28 and 2028/29. This will offer the same opportunity to a bigger pool of doctors graduating as a result of the increase in undergraduate places outlined in this Plan.

If the ICB worked on an ICB proxy split of the 6,000 national ambition by 31/32 this would translate as 304 new GPs. If the 2031/32 ambition of 6,000 extra GPs nationally was used and adjusted to apply to March 24 it would be a proxy 'target' of 1,868 extra GPs by Mar 2024. C&M ICB have 1,847 (-21) FTE GPs against a Mar 24 target of 1,868 and are predicted to end the year with a figure of 1,836 (-32. This, again, needs to be analysed further to understand each place position as within places there will be extremes of all these figures. NHS England also need to confirm assumptions at regional assurance meetings during October, this narrative is just using a national ambition to help frame a position. Moving forward as part of the Access Improvement Plan and response to the NHS Long Term Workforce plan, the ICB will need to be clear about its aims and 'targets' in this respect.

Other roles ;

- Practice Nurses - June 23 data shows there are currently 791 FTE Nurses in C&M ICB since Sept 21. Further work is required with the ICB lead to understand the target and trajectories further
- Non clinical DPC staff (encompassing management, receptionists, administration, ancillary & estates staff) June 23 data shows there are currently 3,731 FTE Non-clinical/administrative DPC staff in C&M ICB.

2.5 Dental Local workforce local picture

- Workforce data for dental teams was collected by NHSBSA during covid and understood that this has continued to be collected. Dental commissioners have contacted NHSBA for the data available.
- All dental performers on contracts are listed on Compass (the repayment system) but there is no indication of whether they are WTE. In most cases they will provide a mix of NHS/Private (until GP workforce). Also no data is readily available on DCPs i.e dental nurses/therapists/Hygienists and reception staff. Equally these could work both for NHS and private patients.
- Currently no local data exists but will be collected this year as part of the national dental workforce return.

2.6 Community Pharmacy workforce local picture

- There are 573 Pharmacies in within the boundaries of Cheshire & Merseyside ICB
- The mandated survey for 2022 intends to build a picture of the community pharmacy workforce, while developing and strengthening the information available. This year's survey was completed by 95% of pharmacy contractors, a huge increase on last year's 47%.
- The survey provides a snapshot of the community pharmacy workforce in autumn 2022, when community pharmacy contractors submitted information on their workforce in response to an England-wide survey.
- The data is intended to support decisions about where the community pharmacy workforce can contribute to supporting NHS clinical service expansion - and ensure education reforms for the pharmacist and pharmacy technician professions enable patients to receive a wider range of services from their trusted community pharmacies.
- Headlines from the survey states that there are:
  - 1,032.8 FTE Pharmacist positions in Community Pharmacy in Cheshire & Merseyside.139.8 were vacant at the time of the survey,

resulting in a vacancy rate of 13.5%. In percentage terms, the highest vacancy rate is for Relief Pharmacists, at 20%

- Over half (52%) of respondents stated that recruiting Pharmacists was 'very difficult'
- 58 Independent Prescribers (32.9 FTE) in Community Pharmacy in Cheshire & Merseyside (vacancy data not available)
- 64 Foundation Pharmacists (62.6 FTE) in Community Pharmacy in Cheshire and Merseyside and only 4.4% of Foundation Pharmacists were also training in other sectors
- 386.9 FTE Pharmacy Technician positions in Community Pharmacy in Cheshire & Merseyside and 62.6 were vacant at the time of the survey, resulting in a vacancy rate of 16.2%. Over a third (33.8%) of respondents stated that recruiting Pharmacy Technicians was 'very difficult'. There are 32 Pre-Reg Trainee Pharmacy Technicians in Community Pharmacy in Cheshire & Merseyside
- 68.5 FTE Accuracy Checker (excluding Pharmacy Technicians) positions in Community Pharmacy in Cheshire & Merseyside. 17.1 were vacant at the time of the survey, resulting in a vacancy rate of 25%
- 1,458.5 FTE Trained Dispensing Assistant positions. 119.4 were vacant at the time of the survey, resulting in a vacancy rate of 8.2%
- 282 FTE Trained Medicines Counter Assistant positions and 24.3 were vacant at the time of the survey, resulting in a vacancy rate of 8.6%

2.7 **Optometry** - As noted above for Optometry further work is required in respect of the breadth of data and information required, and sources of this data, to present a complete picture.

3.0 General Practice - Additional Roles

3.1 Appendix 2 (a) gives a summary of the position for additional roles at a system level, to date and 2 (b) gives individual place summarys based on the information to date/submitted by PCNs by the end of August in line with the PCN DES

3.2 All places reported full submission of plans and available allocations mostly utilised with reporting and support mechanisms to support realisation of those plans. These will be further summarised/updated as part of the Access Improvement Plan. Place also report progress on ARRS as part of 'place assurance' visits.

4.0 Update from Primary Care Workforce Steering Group

4.1 The Primary Care Workforce Steering Group met in September for it's second meeting. The group formally reports to the People Board and membership is made up of representatives from stakeholders, key partners and ICB staff including place leads, with representation from all four contractor groups. The Terms of Reference is given in Appendix 3, these will be submitted to the next meeting of the People Board for formal sign off. A formal update from the meeting will also go to the People Board who will make any key decisions required. A summary however is given in 4.2, for this Committee

4.2 The main issues discussed and outcomes from the meeting held in September were ;

- A presentation / introduction to the NHS Long Term Workforce Plan. It was recognised that the ICB will need to complete a planned response, with the Steering Group overseeing the primary care workforce development & transformation elements.
- Workforce data, where available, for all contractor groups were presented and are represented in summary form in Section 2.0 above
- An update on the Building Capacity element of the Access Improvement Plan was given.
- NHS England have provided £75k for primary care wellbeing, a proposal/approach for this was broadly agreed, noting the funding is currently being held by Cheshire and MerseysideTraining Hub.
- A presentation/proposal for the primary care system level staff bank was supported and this would now proceed to the People Board for final sign off of the scoping project, with a requirement to seek sustainable funding from the ICB to move to the next phase of the business case development, tendering & commissioning of a Primary Care (General Practice) Staff Bank Serice for C&M.
- The C&M Primary Care Training Hub, a key system partner and provider to support Primary Care Workforce Development, CPD and clinical placement expansion & supervision development presented a proposed work plan. This included elements already agreed in relation to national system development funding such as mentoring and fellowships and elements which formed part of the GP retention plan agreed by NHS England in May (such as expanding career conversations). It was recognised that places, who have the remainder of the funding for this element of SDF, could choose to fund further programmes from the Training Hub – who were engaging place in conversations in this respect. A potential shortfall in funding was discussed in

relation to infrastructure for the training hub, and the impact this may have on programmes of work. Noting that different arrangements are now in place for funding, allocation and governance, some of this was being picked up by the Training Hub direct with NHS England who provide a bulk of the infrastructure funding. The steering group will oversee the primary elements of this work through regular updates – the people team at the ICB manage the overall 'contract' arrangements with the Training Hub

- A presentation on place arrangements for workforce planning was given by Halton Place.
- It was noted a further meeting is required to ensure the national GP Retention /Returners scheme is robustly managed within the ICB, now that it has been fully passed to the ICB as an end to end process.

6.0 Next Steps

6.1 It is recognised that overall workforce has many elements and spans several different teams within the ICB. Further work is required to ensure, via the primary care workforce steering group, People Board and this committee, that we have an overall grip on resources and workstreams. Current vacancies within all teams have also impacted on the ability to undertake this work.

6.2 Linkages to Place also require further work – many places have developed their own workforce groups, integrating workforce issues across many sectors within place. Place are represented at the system group with three place members of staff sitting on the primary care workforce steering group.

6.3 A data set for all contractor groups is a work in progress, with data available where possible, at place level, if current resources in the BI team allow. Good progress has been made in this area, as seen in Section 2.0 and summarised for general practice in Appendix 1.

6.4 The ICBs planned response to the National Long Term Workforce Plan, including Primary Care specific plan, is seen as a priority. The current GP retention plan, submitted to NHS England in May 2023, is an important element of this. There will be a confirmation of further funding and guidance to ICBs in due course with the emphasis being on 'training' and actions to underpin this. The primary care workforce steering group will oversee the development of a primary care response to the plan, linking in with the Cheshire and Merseyside Training Hub. It is assumed that the People Board will oversee the 'overall response'.

6.5 The need to define clearer targets are an ask in the Access Improvement Plan, which has a specific component which covers workforce – and require further modelling in line with any regional or national expectations. The impact 'on the ground' needs to also be captured along with place variations and challenges. An action to support this will be to develop a regular reporting / data set based on modelling available, for all contractor groups. This will support the delivery of 6.4 also.

6.6 Uncertainty with regards to 'Additional Roles' reimbursement scheme from 24/25 which is tied into the current national contract negotiations are being escalated to the ICB from practices and PCNs. Our current expectation is that the current arrangement will continue and we have a level of assurance regarding funding already committed within allocations but this has yet to be formally put into a policy advisory.

6.7 In respect of governance for decision making in terms of primary care workforce and associated funding, these will be made by the System Primary Care Committee who govern Primary Care funding for non-recurrent system workforce development projects. The People Board will provide recommendations in this respect for some areas, this will need to be worked through as funding streams become clearer for workforce under the new long term plan.

7.0 Recommendations

The Committee is asked to:

- **Note and discuss** the update and next steps in respect of Primary Care workforce including next steps and issues, which is for **assurance** purposes.

Officer contact details for more information

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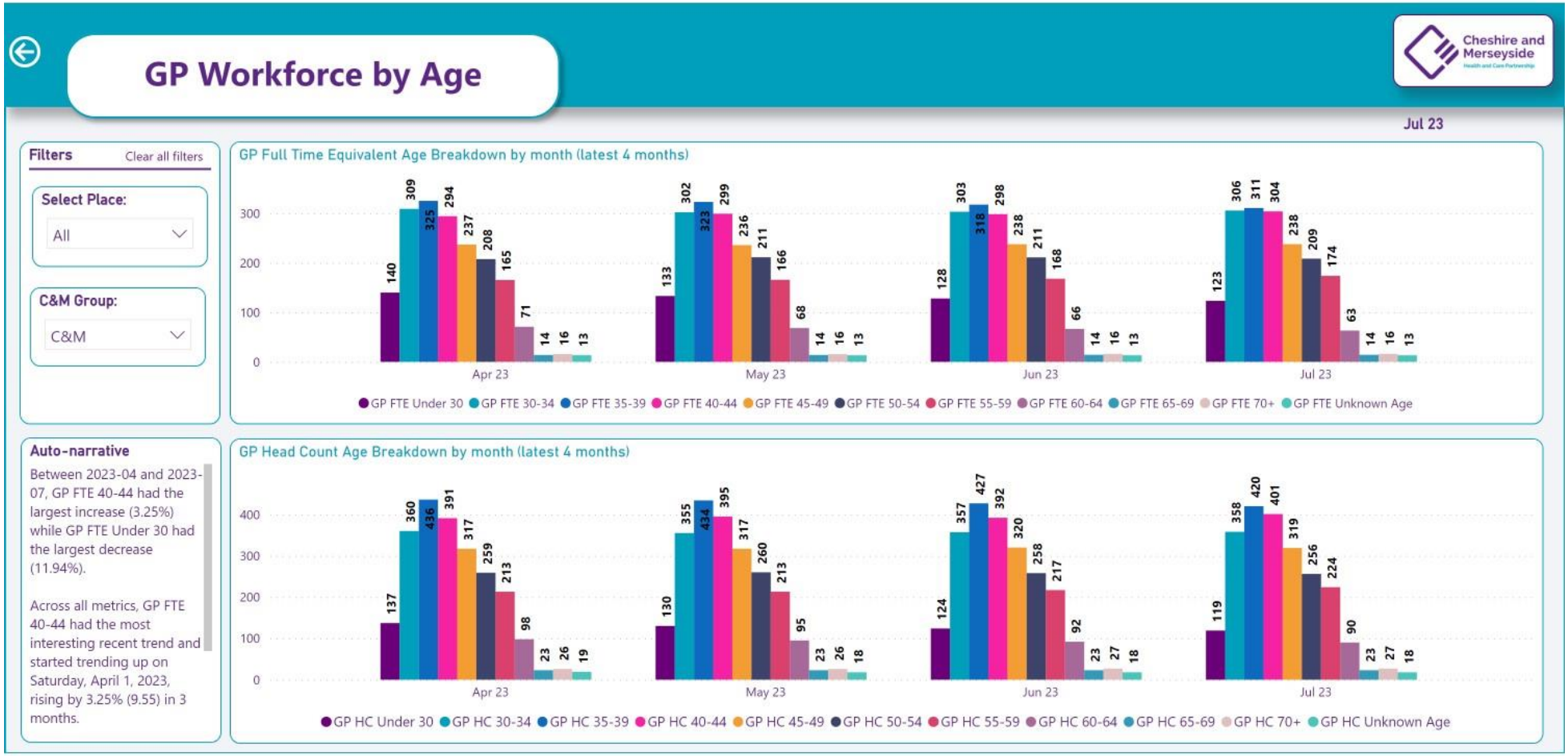
c.leese@nhs.net

Appendix 1 – General Practice Data – reporting (example key data only)



Joiners & Leavers

Cheshire and Merseyside Health and Care Partnership

June 2023

Filters Clear all filters

Select ICB: All

Select C&M: C&M

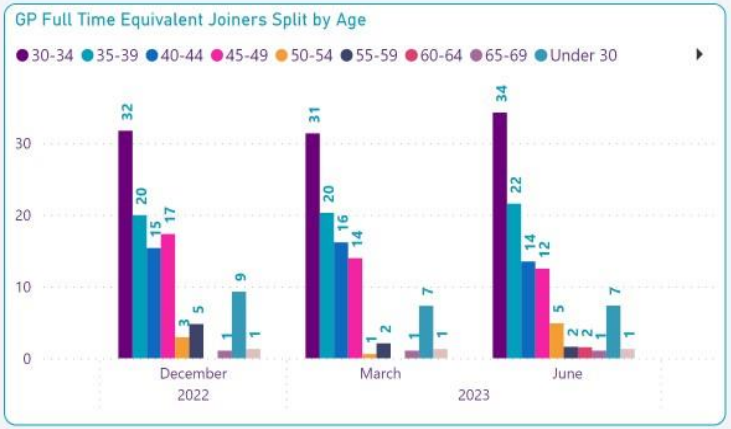
Auto-narrative

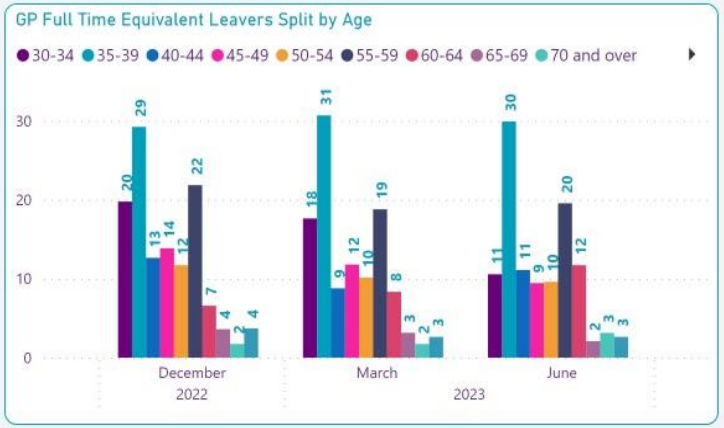
FTE for Leavers (11.96% decrease) and Joiners (4.03% decrease) both trended down between 2022-12 and 2023-06.

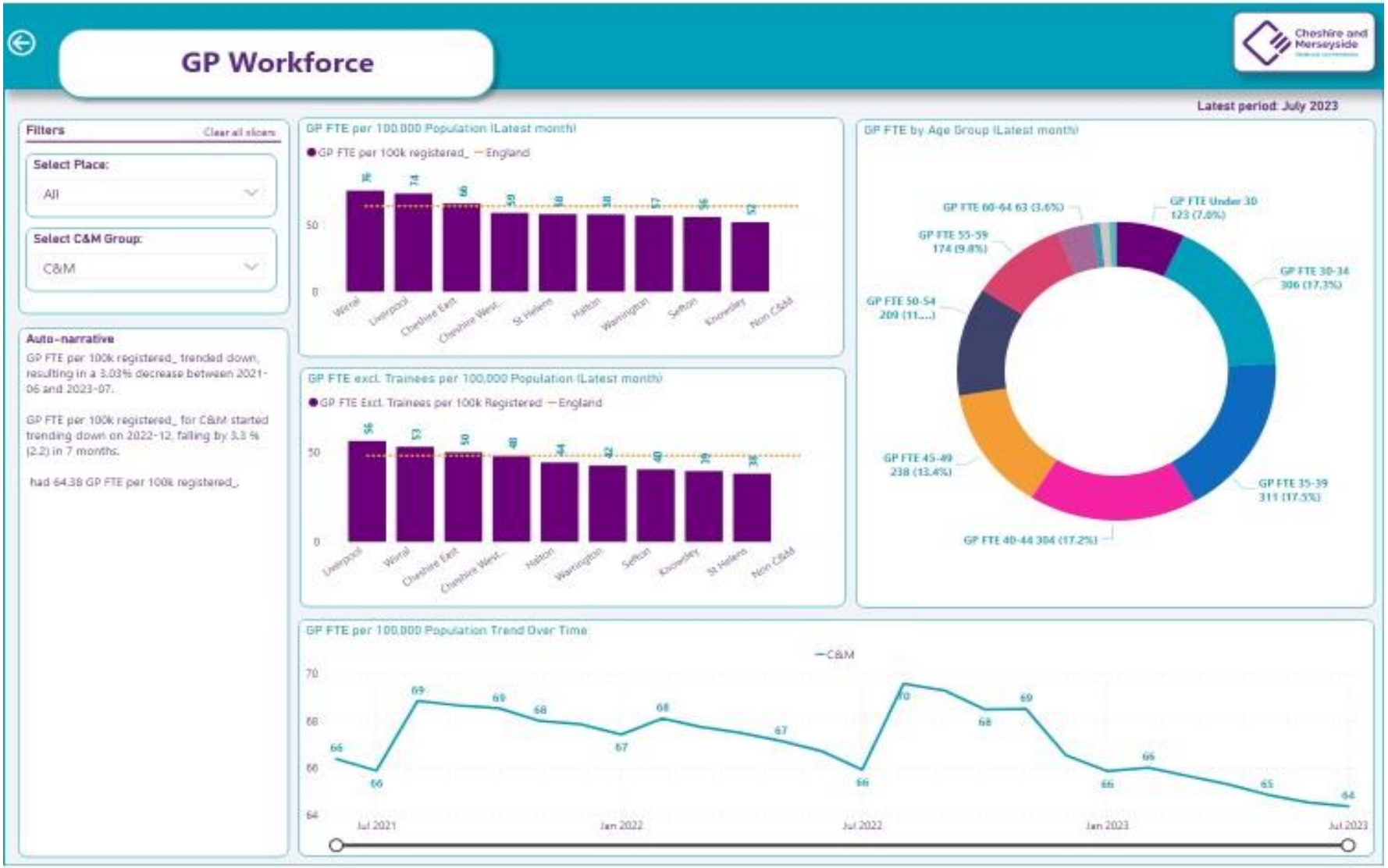
Across Measure, Leavers had the most interesting recent trend and started trending down on Thursday, December 1, 2022, falling by 11.96% (14.92) in 6 months.

HC for Leavers dropped from 183 to 163 during its steepest decline between Thursday, December 1, 2022 and Thursday, June 1, 2023.

Leavers experienced the longest period of decline in HC (-20) between Thursday, December 1, 2022 and Thursday, June 1, 2023






GP Workforce
Cheshire and Merseyside
Latest period: July 2023
Filters
Clear all slicers
Select Place:
All
Select C&M Group:
C&M
Auto-narrative
GP FTE per 100k registered_ trended down, resulting in a 3.03% decrease between 2021-06 and 2023-07.
GP FTE per 100k registered_ for C&M started trending down on 2022-12, falling by 3.3 % (2.2) in 7 months.
had 64.38 GP FTE per 100k registered_.
GP FTE per 100,000 Population (Latest month)
GP FTE per 100k registered_
England
Wirral
Liverpool
Cheshire East
Cheshire West...
St Helens
Halton
Warrington
Sefton
Knowsley
Non C&M
GP FTE excl. Trainees per 100,000 Population (Latest month)
GP FTE Excl. Trainees per 100k Registered
England
GP FTE by Age Group (Latest month)
GP FTE Under 30
123 (7.6%)
GP FTE 30-34
306 (17.3%)
GP FTE 35-39
311 (17.5%)
GP FTE 40-44 304 (17.2%)
GP FTE 45-49
238 (13.4%)
GP FTE 50-54
209 (11....)
GP FTE 55-59
174 (9.8%)
GP FTE 60-64 63 (3.6%)
GP FTE per 100,000 Population Trend Over Time
C&M
Jul 2021
Jan 2022
Jul 2022
Jan 2023
Jul 2023


DPC Workforce
Cheshire and Merseyside
Latest period: July 2023
Filters
Clear all filters
Select Place:
All
Select C&M Group:
C&M
Auto-narrative
DPC FTE per 100k registered_ trended up, resulting in a 18.72% increase between 2021-06 and 2023-07.
DPC FTE per 100k registered_ for C&M started trending up on 2022-02, rising by 10.7 % (1.9) in 1.4 years.
had 19.54 DPC FTE per 100k registered_.
DPC FTE per 100,000 Population (Latest month)
DPC FTE per 100k registered_
England
30
24
23
19
18
17
16
15
13
Cheshire West & C...
Cheshire East
Halton
Wirral
Sefton
St Helens
Warrington
Knowsley
Liverpool
Non C&M
DPC FTE by Age Group (Latest month)
DPC FTE 65-69 16 (3.0%)
DPC FTE Under 25 25 (4.7%)
DPC FTE 60-64 51 (9.4%)
DPC FTE 25-29 53 (9.8%)
DPC FTE 55-59 77 (14.2...)
DPC FTE 30-34 58 (10....)
DPC FTE 50-54 62 (11.6%)
DPC FTE 35-39 60 (11.1%)
DPC FTE 45-49 57 (10.6%)
DPC FTE 40-44 76 (14.0%)
DPC FTE per 100,000 Population Trend Over Time
C&M
16
16
17
17
18
18
18
18
18
18
19
19
19
19
20
Jul 2021
Jan 2022
Jul 2022
Jan 2023
Jul 2023

Appendix 2(a) – Additional Roles – ICB System Overview (June 2023)

Staff Role	WTE Mar 19	Current WTE (Jun 23)	Change in WTE
Pharmacists	38.87	278.69	239.81
Care Coordinators	0.00	176.34	176.34
Social Prescribing Link Workers	0.00	145.49	145.49
Pharmacy Technicians	0.00	92.71	92.71
Physician Associates	4.53	76.19	71.65
First Contact Physiotherapists	0.00	68.13	68.13
Paramedics	0.00	56.56	56.56
Other Direct Patient Care	12.37	57.87	45.50
Health and Wellbeing Coaches	0.00	42.25	42.25
Nursing Associates	2.91	44.96	42.05
General Practice Assistants	0.00	38.05	38.05
Healthcare Assistants	220.75	244.56	23.81
Advanced Pharmacist Practitioners	0.00	18.24	18.24
Mental Health Practitioners	0.00	15.40	15.40
Trainee Nursing Associates	0.00	13.60	13.60
Therapists - Occupational Therapists	0.00	11.71	11.71
Advanced Paramedic Practitioners	0.00	9.35	9.35
Phlebotomists	14.27	23.03	8.76
Health Support Workers	0.00	8.60	8.60
Podiatrists	0.00	7.83	7.83
Advanced Physiotherapist Practitioners	0.00	6.90	6.90
Apprentice - Health Care Assistants	0.00	5.19	5.19
Physiotherapists	0.40	5.05	4.65
Therapists - Others	0.37	2.39	2.01
Dieticians	0.00	2.00	2.00
Therapists - Counsellors	0.00	1.53	1.53
Apprentice - Others	0.00	1.47	1.47
Psychological Wellbeing Practitioners	0.00	1.21	1.21
Advanced Dietician Practitioners	0.00	1.00	1.00
Dispensers	35.80	24.47	-11.33
Grand Total	**330.28**	**1,480.76**	**1,150.48**

Appendix 2 (b) – Additional Roles - Place

West Cheshire

Spend fully committed, including additional requests for funding

Additional Roles Reimbursement Scheme (ARRS)

- The 9 PCNs in Cheshire West currently have recruited 180.6 WTE ARRS roles who are providing additional capacity to the PCN workforce.
- The PCNs have indicated that this number will rise to 234 WTE by March 2024.

Clinical pharmacists	**First Contact Physios**	**Paramedics**
Pharmacy Technicians	**Dieticians**	**Physicians Associates**
Adult Mental Health Workers	**Occupational Therapists**	**Care Co-ordinators**
Children & Young People's Mental Health Workers	**Health and Wellbeing Coaches**	**Advanced Practitioners**
Social Prescribing Link Workers	**Nursing Associates**	**Physicians Associates**
GP Assistants	**Trainee Nursing Associates**	**Digital & Transformation Leads**

- Cheshire West is the first Place in the country to have fully qualified First Contact Practitioner Dieticians working in PCNs.

Wirral

Wirral ARRS 2023/24 expenditure at July 23 – Month 4

Total Budget (ICB & Place)	FOT	FOT variance
£8,509,092	£6,492,667	£2,016,425

Additional Roles

NHS Cheshire and Merseyside

Current ARRS at Q2 23 -24 and planned ARRS recruitment at Q4 23 -24 WTE

	Birkenhead		Wallasey		HSW		HWW		Moreton & Meols		Total No. of roles	
	Current	Planned	Current	Planned	Current	Planned	Current	Planned	Current	Planned	Current	Planned
Pharmacy Technicians	2.8	2.8	1	2.8	1	1			1	1.5	5.8	8.1
Clinical Pharmacists	18.4	19.4	6.6	6.6	0	2	9.2	9.8	1	1	35.2	38.8
Clinical Pharmacists (Advanced)					1	1			1	1	2	2
First Contact Physiotherapists	7	9	1.7	2	0	2			1	1	9.7	14
Paramedics	4.5	5.5	5.67	5.87	2	3	2	2			14.17	16.37
Podiatrists	3	3	1.3	1.8							4.3	4.8
Clinical Practitioner Nurses	1	3					0	1	0	1	1	5
Physician Associates	0.5	1	0.93	0.93	1	3	7.6	8.6	3	2.5	13.03	16.03
Care Coordinators	9.6	12.6	1.2	2.1	4	5.5	2	3	3	3	19.8	26.2
Health & Wellbeing Coaches	3.7	4.7	1.87	2.77	3	3			2	2	10.57	12.47
Social Prescribers	6.65	5.65	6.68	3.8	1.6	1.6	8	8	2	2	24.93	21.05
Nursing Associates			1.86	1.73	2	0	1	1	1	1	5.86	3.73
Digital & Transformation Lead	1	1	1	1	1	1	1	1	0.5	0.5	4.5	4.5
Adult Mental Health Practitioner (Band 7)	1	1							1	2	2	3
GP Assistant					6	6					6	6
Adult Mental Health Practitioner (Band 6)					0	2	0	1			0	3
Apprentice PA					0	1					0	1

Sefton

- Southport and Formby £238,578 remaining ARRS Allocation – this underspend has occurred due to estates and capacity issues. Estates issues are being resolved moving forward as a mitigation.
- South Sefton £2,458 remaining ARRS allocation

Additional roles 23/24	SF	SS
Pharmacy Tech	6.8	
Clinical Pharmacists	11.93	10
Clinical Pharmacist (Advanced Practitioner)	2	
Dieticians		1
FCP	1.5	6
Occupational Therapist		1
Paramedics	1.46	9
Paramedic advanced practitioner		4
Clinical Practitioner Nurse		2
PA	4.62	
C.Co-ordinators	13.47	38
HWB Coaches	3	12
SPLW	12.04	23
Nursing Associate	1	2
Trainee Nursing Associate		2
GPAs	23	
Digital & Transformation Lead	1	1
Adult Mental Health Practitioner (band 6)	4	4
CYP Mental Health Practitioner (band 5)	0.5	4
CYP Mental Health Practitioner (band 7)	0.5	
CYP Mental Health Practitioner (band 7)	0.5	

Additional posts by March 24

- SF – 54.15
- SS - 49.2

Estates

- SS & S&F – expansion of estates planned to accommodate ARRS remains a challenge

Halton

- Confirm Full allocation committed – so all spend will be accounted for
- In addition local GP Retention funding investment plans are in development to support development of specialist GP roles which align to Place clinical priority areas.
- National health and wellbeing offers continue to be shared with practices.

PCN	Allocation 2023/24	Planned spend to 31st March 2024	Anticipated spend against allocation %	Submitted claims to 31st August 2023	% spend at 31st August %
Runcorn	£1,687,071.61	£2,057,479.85	121.96%	£663,263.96	39.31%
Widnes	£1,604,392.25	£1,666,031.11	103.84%	£385,749.86*	24.04%

*Jul/Aug claims omit practice employed ARRS as they claim quarterly.

Runcorn PCN ARRS role	23/24 Plan		Actual claims to Aug 23	
	FTE	Spend	FTE	Spend
Clinical Pharmacist	11.4	£672,390	10.5	£207,321
Pharmacy Technician	2.0	£79,332	2.0	£28,341
Social Prescribing Link Worker	2.0	£ 79,332	2.0	£32,480
Care Coordinator	9.6	£295,594	8.9	£99,292.69
First Contact Physiotherapist	4.0	£215,919	3.1	£48,013
Trainee Nursing Associate	1.0	£29,281	1.0	£11,649
Nursing Associate	1.0	£32,984	1.0	£14,011
Community Paramedic	6.0	£358,002	6.0	£128,469
Advanced Practitioner	1.0	£67,487	1.0	£26,246.45
Mental health practitioners (B6)1	1.8	£44,024	1.8	£17,934
General Practice Assistant	4.0	£115,649	5.0	£31,979
Digital Transformation Lead	1.0	£67,487	1.0	£17,529
Total	**44.8**	**£2,057,480**	**43.3**	**£ 663,263.96**

Widnes PCN ARRS role	23/24 Plan		Actual claims to Aug 23	
	WTE	Spend	WTE	Spend
Clinical Pharmacist	9.5	£566,791	5.0	£110,456
Pharmacy Technician	3.0	118,998	4.0	£29,250
Social Prescribing Link Worker			In post 04/23	£12,294
Care Coordinator	16.0	£459,419	10.6	£102,734
Physician Associate	3.0	£149,535	2.0	£25,604
First Contact Physiotherapist	0.25	£3,896		
Chiropodists / Podiatrists	1.0	£15,100		
Nursing Associate	2.0	£49,682	1.6	£12,795
Community Paramedic	3.0	£149,535	2.0	£51,564
Advanced Practitioner	3.0	£48,752	2.6	£17,139

Mental health practitioners (B6)1	2.0	£36,838	1.0	£7,952
Digital Transformation Lead	1.0	£67,487	0.5	£15,962
Total	**43.75**	**£1,666,031**	**29.3**	**£385,749.86**

St Helen's

- Confirm Full allocation committed so all spend will be accounted for – combined projected spend for the 4 St Helens PCNs is £5.17M (99.6% of reimbursement allocation)
- Number of posts/ what posts are they -summarised – what will this bring in terms of additional posts, by March 24 – proposed number of ARRS posts by 31 Mar 24 is 115.76 WTEs

St Helens PCNs workforce planning submission summary - 31 Aug 31					
	WTEs due in post by 31 Mar 24				
Role	**St Helens Central**	**Newton & Haydock**	**St Helens North**	**St Helens South**	**Total WTEs**
Pharmacy Technician	1.00		1.60	3.00	**5.60**
Pharmacist	5.00	6.00	2.40	7.67	**21.07**
Pharmacist Advanced Practitioner		0.36		1.00	**1.36**
First Contact Physiotherapist	2.00		2.00	3.00	**7.00**
Occupational Therapist		2.00		1.85	**3.85**
Paramedic		2.00		1.00	**3.00**
Podiatrist				0.60	**0.60**
Clinical Practitioner Nurse (Adv. Prac.)	1.00	0.40	1.10	1.00	**3.50**
Physician Associate	1.00			6.51	**7.51**
Apprentice Physician Associate				1.00	**1.00**
Care Co-ordinator	3.85	3.29	4.00	6.88	**18.02**
Health & Wellbeing Coach		6.00			**6.00**
Social Prescribing Link Worker	2.00	2.00	2.00	6.00	**12.00**
Nursing Associate	4.60		2.60	1.98	**9.18**
Trainee Nursing Associate				1.00	**1.00**
GP Assistant				2.97	**2.97**
Digital & Transformation Lead	0.50			0.50	**1.00**
Adult MHP (Band 6)	3.00	1.60	2.00	3.50	**10.10**
Children & Young Persons MHP (Band 6)			1.00		**1.00**
Total	**23.95**	**23.65**	**18.70**	**49.46**	**115.76**

Knowsley

2023/24 Plans submitted

Forecast of available reimbursable sums used:
Kirkby 99.69%
Central and South 92.45%
West 107.21%

Overall Knowsley 100.08%

Regular monitoring via Primary Care Group and Primary Care Steering Group

Fortnightly progress monitoring for all recruitment stages (advert/shortlisting/intervews/pre-employment checks etc) agreed with each PCN to identify variance from plan

Job Role	FTE in post 31/03/2023			Planned FTE in post 31/03/2024		
	Kirkby	Central & South	West	Kirkby	Central & South	West
Pharmacy Technician	1	-	1	2	-	1
Clinical Pharmacist	6.55	12	3.75	6.55	9	4.43
First Contact Physiotherapist	3	1	2	4	1	2
Paramedic	-	1	-	-	5	-
Physician Associate	1	-	1	1	-	2
Care Co-ordinator	3	6	12.37	9	6	16.37
Health and Wellbeing Coach	1	2	1	1	0	8
Social Prescribing Link Worker	6.7	4	5	6.7	4	3
Trainee Nursing Associate	-	0	4	-	4	3
Digital & Transformation Lead	-	-	0	-	-	1
Adult Mental Health Practitioner (B6)	1	2	1	3	2	3
Totals	**23.25**	**28**	**31.12**	**33.25**	**31**	**43.8**

Cheshire East

PCN Name	U Code	Total	Estimated total spend based on spend to date	YTD Spend 30/09/23	Variance from budget
Knutsford PCN	U06000	£548,797.21	£415,847.96	£174,673.99	£374,123.22
SMASH PCN	U25799	£1,640,465.05	£1,681,125.61	£665,109.78	£975,355.27
Middlewood PCN	U28237	£772,125.43	£837,216.48	£293,248.45	£478,876.98
Nantwich & Rural PCN	U29951	£850,884.06	£864,739.41	£358,117.51	£492,766.55
CHAW PCN	U31094	£1,074,154.17	£784,683.91	£320,857.39	£753,296.78
Crewe - Eagle Bridge PCN	U79049	£1,030,262.71	£951,392.94	£380,645.51	£649,617.20
Macclesfield PCN	U82612	£1,388,159.74	£1,165,575.00	£383,726.16	£1,004,433.58
CHOC PCN	U98152	£1,096,345.17	£857,833.28	£269,922.53	£826,422.64
Crewe - GHR PCN	U98432	£1,038,247.34	£879,954.44	£366,386.81	£671,860.53
Total		**£9,439,440.88**	**£8,438,369.02**	**£3,212,688.13**	**£6,226,752.75**

ARRs Job Role	Total
Pharmacy Technicians	19.09
Clinical Pharmacists	39.9
Clinical Pharmacists (Advanced)	1.59
First Contact Physiotherapists	18.58
Paramedic	9.6
Clinical Practitioner Nurses (Advanced)	5.8
Physician Associates	10.3
Care Co-ordinators	42.01
Social Prescribing Link Workers	29.68
Health & Wellbeing Coaches	1
Nurse Associates	7.07
Training Nurse Associates	5.83
GP Assistants	13.48
Digital & Transformation Lead	5.01
Adult MHP (Band 6)	1
Adult MHP (Band 7)	7.6
Adult MHP (Band 8a)	1
Children and Young Persons MHP (Band 5)	3
Totals	**221.54**

Warrington

PCN	ARRS Allcoation	Total indicative spend 2023/24
East Warrington PCN	£462,415.00	103% of allocation
Warrington Central East PCN	£424,715.00	100% of allocation
South Warrington PCN	£726,988.00	101% of allocation
Warrington Innovation PCN	£791,127.00	106% of allocation
Central & West Warrington PCN	£810,433.00	102% of allocation

Pharmacy Technicians	11.52	12.12
Clinical Pharmacists	21.94	26.34
Clinical Pharmacist	1	1.25

Dietitians	0	0.8
First Contact Physiotherapists	12.81	14.19
Paramedics	10.76	12.2
Clinical Practitioner Nurses	2	4.75
Physician Associates	1	1
Care Co-ordinators	18.2	18
Health and Wellbeing Coaches	2.8	2.6
Social Prescribing Link Workers	5	4
Nursing Associates	0	1
Trainee Nursing Associates	0	1.2
GP Assistants	2.2	2.2
Digital & Transformation Lead	4.4	4.4
Adult Mental Health Practitioner (Band 5)	0.8	1.8
Adult Mental Health Practitioner (Band 6)	3.6	5.2
Adult Mental Health Practitioner (Band 7)	3.73	4.5
Children and Young Persons Mental Health Practitioner (Band 5)	0	1
Children and Young Persons Mental Health Practitioner (Band 6)	0	1

Liverpool

Full allocation committed and plans received from all PCNs.

Cheshire and Merseyside ICB

Primary Care Workforce Steering Group

Terms of Reference

Document revision history

Date	Version	Revision	Comment	Author / Editor
30.3.2023	1.0	Initial ToRs		Christopher Leese Emma Hood
8.6.2023	1.1	Revisions following PCWSG meeting		Christopher Leese
1.10.2023	1.2	Revised ToRs going to People Board for agreement in November / SPCC in October	Awaiting comments from People Board to agree TORs	Christopher Leese

Review due
1.9.2024

NHS Cheshire and Merseyside ICB

Terms of Reference Primary Care Workforce Steering Group

1.0 Background

- The Primary Care Workforce Steering Group focuses upon ensuring the primary care workforce aspects of the wider ICB workforce programme are achieved. Reporting also into the C&M People Board and System Primary Care Committee to ensure that there is visibility of Primary Care Workforce developments across the health and care sector of the ICB and region . Primary Care includes – General Practice, Community Pharmacy, General Ophthalmic Services and Dental services

2.0 Purpose

- To manage and/or make recommendations for funding streams relating to primary care workforce under SDF funding and other sources, in line with delegated authority from the People Board
- To support the development of a Primary Care Workforce vision and strategy at System and Place level
- To ensure that there is a credible and agreed baseline profile for the general practice and primary care workforce within Cheshire and Merseyside, to aid effective workforce planning and modelling across Primary Care Networks (PCN).
- That critical workforce gaps and risks are clearly identified with an informed and appropriate prioritised plan developed to address the gaps & risks identified.
- To support the future development of the workforce action plan ensure it reflects the level of local progress within the context of any other emerging priorities or risks within PCNs.
- To consider and plan how the utilisation of any national and local workforce development and education initiatives, including access to available funding relevant to general practice and primary care, might be connected and presented to enable their best application and adoption within Cheshire and Merseyside through the Primary Care Training Hubs across C&M.
- To monitor and report progress on the workforce aspects of the Planning Guidance and other national policy,
- To connect place, corporate and other primary care workforce leads and stakeholders to achieve common aims of improving workforce retention, recruitment and maximisation of workforce resources

- to ensure wider workforce needs such as health, wellbeing, training, support and OD are factored into planning at all levels
- To facilitate partnership working with the training hub including overview of delivery of work programme
- To further support the NHSE delegation of Primary Care to the ICB which includes responsibility for workforce development
- Supports the role of the People Board and the Boards responsibilities.
- Supports Place in relation to it's workforce responsibilities and place level primary care workforce plans
- To receive and assess national workforce policy, guidance and contractual requirements in relation to Primary care, ensuring implications are identified
- To support the development of robust implementation plans across C&M, across all 9 Places
- To support and underpin the ICB's Primary Care Strategic Framework
- To support roll out of national contractual asks such as ARRS (Additional Roles)
- To support and lead new initiatives in relation to wellbeing of practice staff.

3.0 Membership

Core membership of the C&M primary care workforce steering group will include the following representatives who may nominate deputys to attend:

- Associate Medical Director for Primary Care (**Chair)**
- TBC Representative from People Team, ICB **(Vice Chair)**
- Associate Director of Primary Care
- Head of Primary Care
- AD for Transformation and Partnerships (PC AD Lead)
- Officer Place Representatives PC Leads x 2
- Associate GP Dean (Cheshire and Merseyside) / Deanery Representative
- BI Lead for People/Workforce
- NHS England workforce team rep
- C&M Primary Care Training Hubs Representatives
- LMC representative
- LDC representative
- LOC representative
- LPC representative
- Dental Deanery Rep
- ICB Finance representative
- ICB Lay representative

Other stakeholders will be co-opted as necessary dependant on the agenda

4.0 Working Arrangements

4.1 Frequency of Meetings:

Meetings shall be held bi monthy

4.2 Administration:

To be supported by the ICB Primary Care primary care contracting (central) team

- providing facilities to support the effective operation of the steering group

- coordinate meeting agendas and papers, distributed five working days in advance of any meeting
- providing a record of discussions and agreed actions following each meeting within 5 working days

4.3 Expectations of members:

Each member of the steering group will:

- attend or endeavour to send an appropriate delegate to each meeting to ensure the agenda moves forward to agreed timescales
- ensure there is a system in place to cascade information within their organisation
- be responsible for supporting the development and implementation of the work plan
- be open, honest and transparent
- provide the steering group with timely updates and progress against work plan

5.0 Governance and Reporting

Primary Care Workforce Steering Group will report directly to:

- Cheshire Merseyside People Board on progress and use of any allocated resource

And will update quarterly to the

- Cheshire and Merseyside System Primary Care Committee

The Primary Care Workforce Steering Group will receive reports from any task and finish group established in relation to the workforce.

Further work is required to understand the links between the above and any place workforce groups and governance.

6.0 Review

The terms of reference will be reviewed after 6 months from date of ratification

Committee Report

Cheshire and Merseyside ICB
Primary Care Estates Update
Date: 19th October 2023

Date of meeting:	19th October 2023
Agenda Item No:	SPCC B23/10/09
Report title:	Primary Care Estates Update
Report Author & Contact Details:	Nick Armstrong, Head of Estates, NHS Cheshire & Merseyside nick.armstrong@cheshireandmerseyside.nhs.uk
Report approved by:	Clare Barrow, AD of Finance (Knowsley Place) & Estates SRO, NHS Cheshire & Merseyside

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

Route to this meeting / Committee/Advisory Group previously presented to (if applicable)
Not Applicable

Executive Summary and key points for discussion
The Report aims to provide the System Primary Care Committee with an update on the NHS Cheshire & Merseyside estates team work on primary care estates for 2023/24. This includes the six key estates workstreams relating to primary care estates for 2023/24 as well as primary care leases.

Recommendation/ Action needed:	**The Committee is asked to:** Note the contents of the report.

Which purpose(s) of an Integrated Care System does this report align with?	
Please insert **'x'** as appropriate:	
1. Improve population health and healthcare	
2. Tackle health inequality, improving outcome and access to services	X
3. Enhancing quality, productivity and value for money	
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	
3. Getting Upstream	
4. Building systems for integration and collaboration	X

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

Place Priority(s) report aligns with:	

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? (*please list*) - *No*					
	What level of assurance does it provide?					
	Limited		**Reasonable**		**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*) - *No*					
	Any **Conflicts of Interest** associated with this paper? If **YES** please state what they are and any mitigations undertaken. – *None Identified*					
	Any current services or roles that may be affected by issues as outlined within this paper? - *No*					

Document Development	**Process Undertaken & Impact Considerations**	**Yes**	**No**	**N/A**	**Comments** (i.e. date, method, impact e.g. feedback used). ***Greater detail to be covered in main body of report***
	Financial – any resource impact?			X	
	Patient / Public Involvement / Engagement			X	
	Clinical Involvement / Engagement			X	
	Equality Impact Analysis (EIA) - any adverse impacts identified? EIA undertaken?			X	
	Regulatory or Legal - any impact assessed or advice needed?			X	
	Health Inequalities – any impact assessed?			X	
	Sustainable Development – any impact assessed?			X	

Next Steps:	

Responsible Officer to take forward actions:	Nick Armstrong, Head of Estates, NHS Cheshire & Merseyside

Appendices:	

Primary Care Estates Update

1. Executive Summary

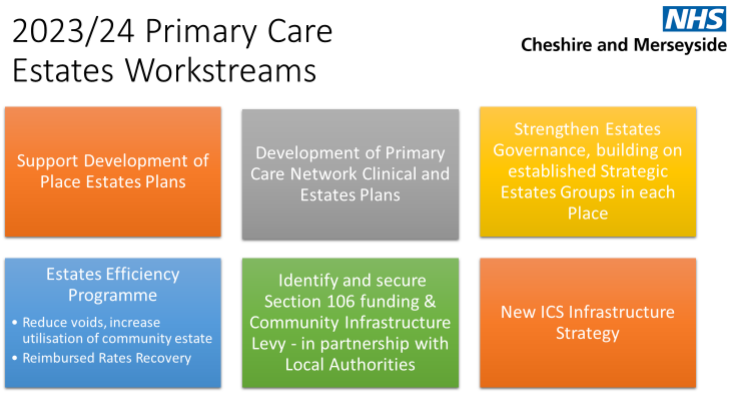
1.1. The Report aims to provide the System Primary Care Committee with an update on the NHS Cheshire & Merseyside estates team work on primary care estates for 2023/24.

1.2. This includes the six key estates workstreams relating to primary care estates for 2023/24 as well as primary care leases.

2. Background

2.1. The Cheshire & Merseyside Estates Team formed on the 1st April 2023. This comprises of NHS Cheshire & Merseyside staff from former Clinical Commissioning Groups and the Primary Care Lease team who transferred from NHS England.

2.2. In addition to business-as-usual work, the team has set six key estates workstreams relating to primary care estates for 2023/24 which are shown below:



3. Place Estates Plans

3.1. GB Partnerships were commissioned by the NHS Cheshire & Merseyside in August 2022 to support the delivery of estates place plans with each of the 9 places across Cheshire & Merseyside. For Merseyside this work was funded in partnership with One Public Estate and to ensure consistency the ICB matched this funding for Cheshire East, Cheshire West and Warrington.

3.2. The aim of the plans was to bring together NHS, local authority and other public sector estate into one baseline, ensuring the information is easy to access and will support decision making, production of strategy and expedite delivery. In addition, it was to encourage a collaborative system approach to estate and to identify opportunities to maximise the value of collective public sector estate.

3.3. The work was completed with a variety of methods in each place, including stakeholder workshops and took account of any work that had previously been completed.

3.4. The output of this work has produced for each place a detailed baseline data set of wider public estate accompanied by an Estates Place Plan documenting:

- population health challenges
- current estate mapping
- Areas of regeneration and development
- Future estate opportunities

4. Primary Care Network Clinical & Estates Plans

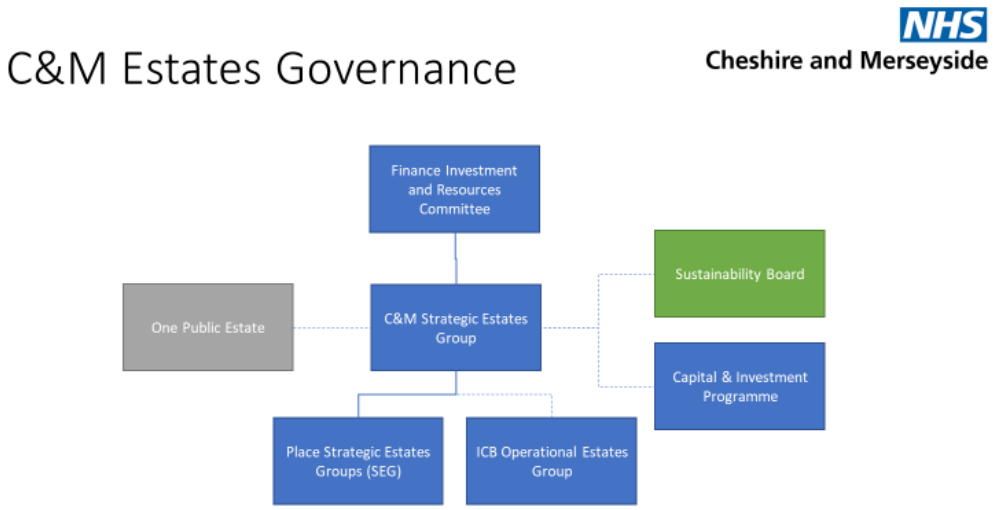
4.1. The Cheshire & Merseyside programme to support PCNs develop their clinical and estates plans was launched in November 2022. The PCNs are split over 2 waves across Cheshire & Merseyside. Due to system pressures and PCN availability to complete the work the programme is now set for the beginning of November 2023. In summary the programme has followed the steps detailed below:

4.2. As part of the programme PCNs have received dedicated clinical and estates advisors in addition to wrap around support as required to deliver their plans and complete the online toolkits. The team from Community Health Partnerships that are delivering the programming are expecting over 100 estates projects to be proposed by PCNs as a result.

4.3. Once the plans have been completed by all PCNs an enhanced priorisation process will be undertaken that is in line with both national evidence and the ICBs capital prioritisation tool. The outcome of this will be shared with ICB and place teams as part of the programme knowledge transfer and close down together with consolidated reports for the ICB and individual places.

5. Estates Governance

5.1. The structure for estates governance across Cheshire & Merseyside is shown on the diagram below. Over the past 6 months the Estates Team have been supporting places teams with the continued development and where required the establishment of place based Strategic Estates Groups.



5.2. The next phase of delivering the estates governance arrangements across Cheshire & Merseyside is the re-establishment of the C&M Strategic Estates Group. This will be chaired by Alison Lee, Place Director for Knowsley and include a cross section of representation from providers and Place Strategic Estates Groups.

6. Primary Care Leases

6.1. From 1st April 2023, the former NHS England Primary Care Lease Team joined the NHS Cheshire & Merseyside Estates Team. As a result the primary care lease function is now carried out by the ICB for all practices across Cheshire & Merseyside.

6.2. There are a total of 448 primary care properties across Cheshire & Merseyside that are tracked by the team. 335 of these by the former NHS England Team and 113 by the former Cheshire CCG team. The teams are currently in the process of completing a migration of their IT systems which will allow for combined reporting to future committees. However, in the interim there is detailed reporting on the position of leases for all places excluding Cheshire in Appendix 1.

6.3. The focus of the joint team's work is the premises where GP practices do not currently have an approved lease. As a result, NHS Cheshire & Merseyside are reimbursing estates costs outside of the Premises Costs Directions, but this also disadvantages practices who are unable to access funding such as improvement grants when they do not have a lease in place. Currently 64 properties do not have an approved list out of 448 which represents 14% of all GP premises. The numbers by each place are shown below:

Place	Number of Properties	Unapproved Leases	Percentage of Premises with Unapproved Leases
Cheshire	113	11	8%
Halton	16	1	6%
Knowsley	37	4	11%
Liverpool	99	18	18%
Sefton	50	7	14%
St Helens	41	10	24%
Warrington	35	5	14%
Wirral	57	8	14%
Total	**448**	**64**	**14%**

7. Reimbursed Rates Recovery Programme

7.1. NHS England via GL Hearn challenges primary care premises annual rateable values with Local Authorities on a rolling 5-7 year cycle. Any successful challenge provides a reimbursement of business rates for prior years and/or a reduction in future rates liabilities. Any reimbursement or refund of business rates which is viewed as a passthrough cost creates an account holders responsibility to ensure that these funds flow back to the nominated bank account of NHS England. For any payments pertaining to rates recovery after the ICB date of delegation of primary care are reconciled by the ICB and NHSE and then transferred to the ICB account.

7.2. In April 2024, NHS Cheshire & Merseyside commissioned Community Health Partnerships to support the ICB in direct collections from account holders and/or Local Authorities as well as providing an oversight and reconciliation of the GL Hearn Master Rateable Value Data Settlement.

7.3. A large proportion of the work year to date has been liaising with practices across Cheshire & Merseyside to validate data and obtain information to submit by challenge deadlines. However, recovery year to date for the ICB is forecast at £1.1m with a further £2.3m showing ongoing savings deducted from billing. The team are working with finance colleagues to continue to validate this data, recover payments and invoice as appropriate.

8. Healthcare Infrastructure Funding & Planning Policy

8.1. The national NHS Property Services Town Planning Team are supporting NHS Cheshire & Merseyside to request Section 106 (S106) healthcare contributions for major planning applications over 200 units and respond to local planning policy consultations.

8.2. Since April 2023 a total of £2.7m S106 healthcare contributions have been requested to mitigate the impact of new housing on primary care services for significant developments across Cheshire, Halton, Knowsley, St Helens and Wirral. Where we are successful in securing S106 funding the team will work directly with place primary care leads and individual practices to deliver improvements to infrastructure.

8.3. In addition, several planning policies have been responded to as part of ongoing consultations, with a view to strengthening joint working and ensuring primary care services have the mechanisms in place to secure future healthcare infrastructure funding. The consultations responded to include:

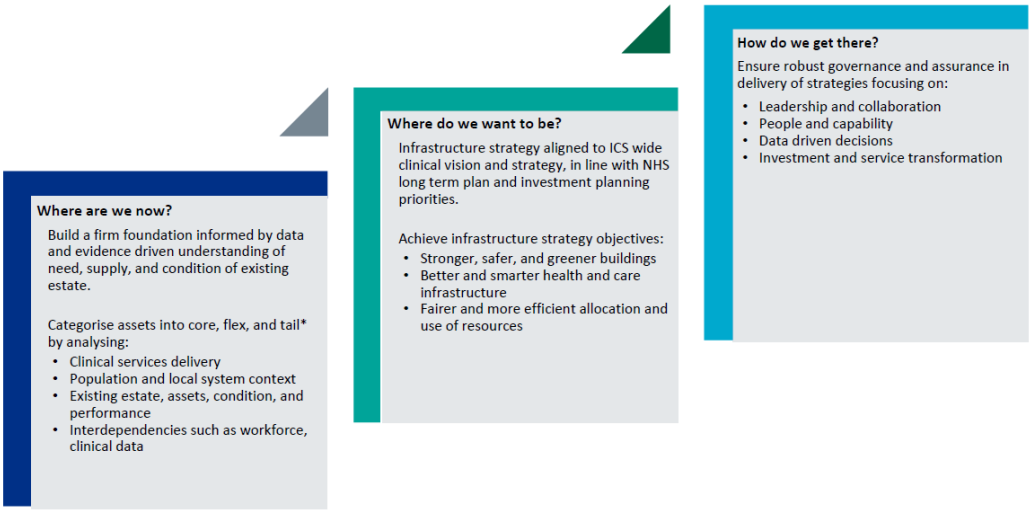
- Wirral Local Plan Examination in Public
- Warrington Planning Obligations SPD
- Cheshire East Draft Developer Contributions SPD
- Bootle Area Action Plan & Liverpool City Region and West Lancashire Recreation Mitigation on the Coast Supplementary Planning Document (SPD) Scoping Report (Sefton Council)

9. Integrated Care System Infrastructure Strategies

9.1. NHS England (NHSE) will look to produce a national strategy framework for infrastructure which will include 42 Integrated Care System (ICS) developed infrastructure plans. This approach has been supported by NHSE executive, the Department for Health and Social Care (DHSC) and the Strategic Infrastructure Board (SIB) as advisory and sponsor.

9.2. The ICS Infrastructure Programme will support ICSs in setting the overall strategic direction and priorities for their estate, digital and large-scale equipment developments. System strategies will incorporate the core strategic goals that all ICSs need to contribute to; and funding allocations to work within.

9.3. The framework is based on asking three questions and may be used to develop an ICS strategy:



9.4. The final guidance, toolkits, and support programme for ICSs is due to be launched before December 2023 with a view that draft plans will be submitted to NHSE by March 2024.

9.5. The existing work Cheshire & Merseyside work programmes of Place Estates Plans, PCN Estates Plans, Provider Estates Plans and Local Authority Local Plans and Development Strategies puts the ICS in a strong position to complete this work in line with the expected timescales.

10. Recommendations

10.1. The Committee is asked to note the contents of the report.

11. Officer contact details for more information

- Nick Armstrong, Head of Estates, NHS Cheshire & Merseyside
  nick.armstrong@cheshireandmerseyside.nhs.uk

Appendix 1 – Overview of Lease Headlines within Cheshire & Merseyside

Microsoft Word 97 - 2003 Document

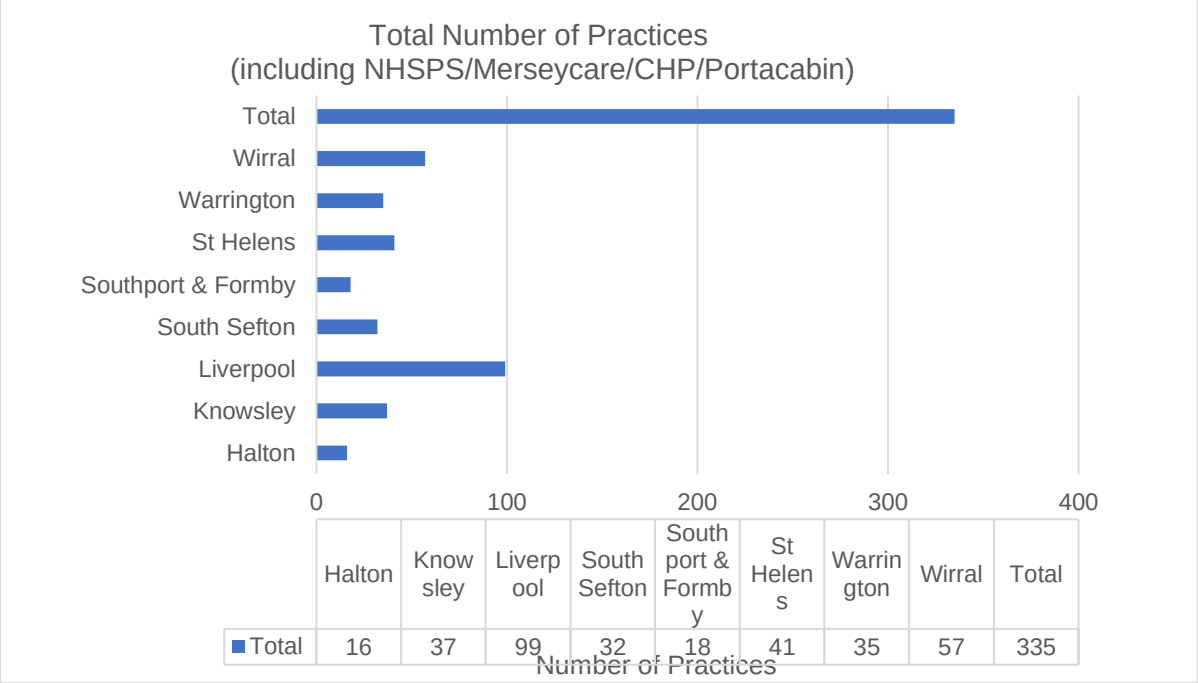
Appendix 1

1. Overview of Rental Reimbursements within C & M (excluding Cheshire East/West Local Place)

1.1 Provided below is a snapshot of the practices that receive rental reimbursement.

1.2 Table 1 – There are 335 practices, including NHSPS, Merseycare, CHP and Portacabins properties.

Table 1



	Halton	Knowsley	Liverpool	South Sefton	Southport & Formby	St Helens	Warrington	Wirral	Total
Total	16	37	99	32	18	41	35	57	335

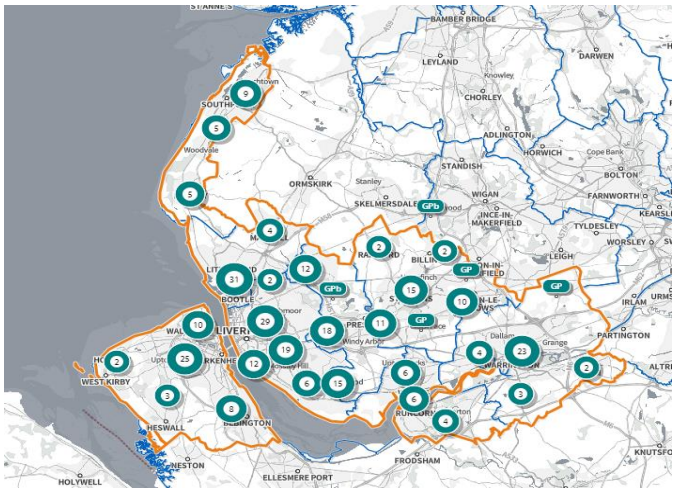
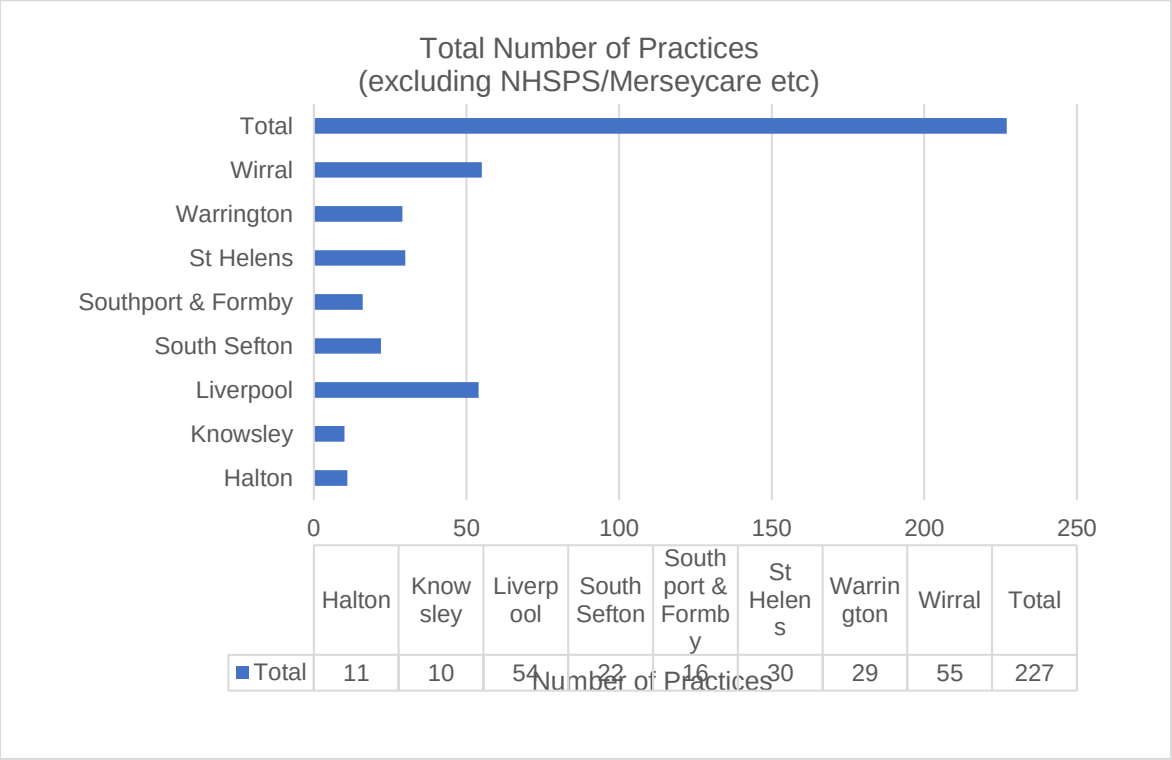


Table 2 – There are 227 practices currently receiving rental reimbursements excluding NHSPS, Merseycare, CHP and Portacabins properties.

1.3 NHSPS, Merseycare and CHP are currently dealt with by the financial teams at NHSE/Local Places with Estates expertise provided by the NHSE estates team. This is due to a historical arrangement that has not been rectified due to workforce restrictions. The above organisations should be treated as external landlords and brought back in line with the Premises Cost Directions.

Table 2



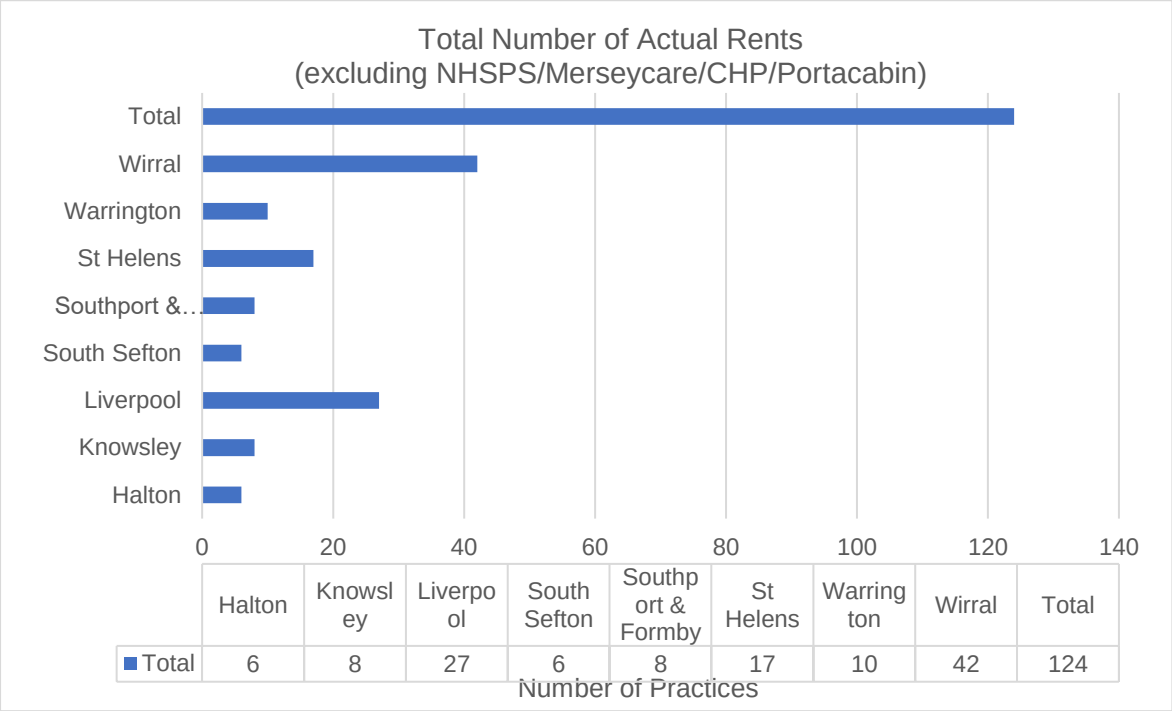
1.4 227 practices currently receive circa 13 million. Notional and Cost Rent do not attract VAT.

Notional Rent	£ 4,528,865.63
Cost Rent	£ 175,564.00
Actual Rent	£ 8,333,932.75
Total	**£13,038,362.38**

Actual Rents

1.5 Table 3 demonstrates a total of 124 practices that currently receive Actual rent

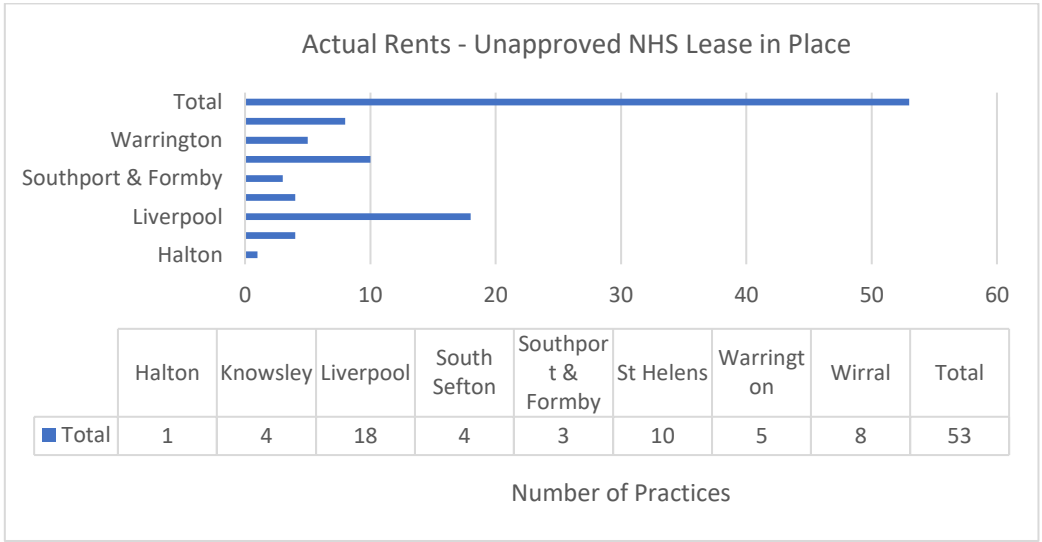
Table 3



Unapproved NHS Leases in Place (outside of Premises Cost Directions)

1.6 Table 4 - There is a significant number of practices without a current NHS approved lease in place. There are 53 across Cheshire & Merseyside (excluding Cheshire Local Place)

Table 4

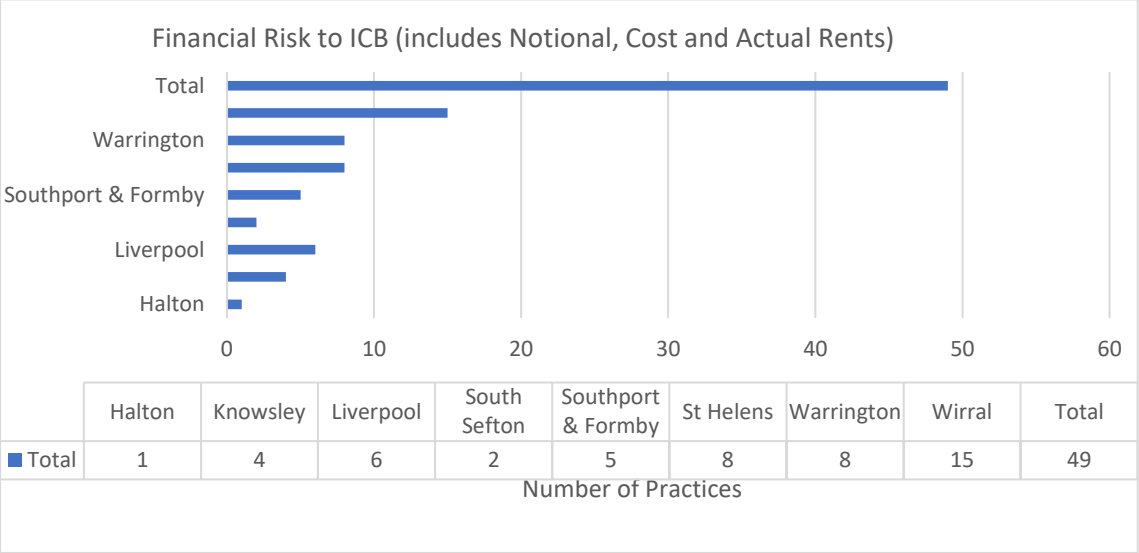


Additional Financial Risks

1.7 Table 5, shows additional financial risks including

- Practice's exceeding the 6-year financial cut off for rent reviews
- CMR forms from practice/overdue rent reviews
- Disputes not yet agreed between GP Practice and DV
- Landlord refusal to initiate rent review
- NHSE waiting on Approval or Query from Budget holder (LP)
- Lease Variation due to changes without NHS approval
    - Practice changed VAT status without NHS approval
    - Change of landlord/tenants
    - Terms and Conditions
    - Space utilisation outside of the demised space (GMS)

Table 5



Additional Financial Risk Percentage Breakdown	
CMR forms from practice/overdue rent reviews	35%
Disputes not yet agreed between GP Practice and DV	22%
Landlord refusal to initiate rent review	10%
NHSE waiting on approval or query from Budget Holder (LP)	12%
Practice changed VAT status without NHS approval	2%
Change of landlord/tenants	16%
Space utilisation outside of the demised space	2%

NHS Cheshire and Merseyside System Primary Care Committee

Date: 19th October 2023

Primary Care Commissioning, Contracting and Policy Update

Agenda Item No	SPCC B23/10/11
Report author & contact details	Christopher Leese Associate Director Primary Care c.leese@nhs.net Tom Knight Head Of Primary Care tom.knight1@nhs.net Jackie Jasper Luci Devenport Paul Carberry
Report approved by (sponsoring Director)	Clare Watson, Assistant Chief Executive

Primary Care Commissioning, Contracting and Policy Update

<table>
<tr><td>Executive Summary</td><td>The Primary Care Policy and Contracting Update provides the Committee with information and assurance in respect of key national policy and related local actions in respect of the four primary care contractor groups that now fall under the remit of the System Primary Care Committee ;

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

This paper contains ;

• An update on any key areas of policy in the above groups
• Any update on Cheshire and Merseyside issues that the committee need to be aware of for assurance purposes</td></tr>
<tr><td>Purpose (x)</td><td><table><tr><th>For information / note</th><th>For decision / approval</th><th>For assurance</th><th>For ratification</th><th>For endorsement</th></tr><tr><td>X</td><td></td><td>X</td><td></td><td></td></tr></table></td></tr>
<tr><td>Recommendation</td><td>The Committee is asked to:

• Note the updates in respect of commissioning, contracting and policy for the four primary care contractor groups which is for assurance purposes.</td></tr>
<tr><td>Key risks</td><td>Risk registers for all four contractor groups are the subject of separate ongoing paper(s) presented to the Committee</td></tr>
<tr><td>Impact (x)
(further detail to be provided in body of paper)</td><td><table><tr><th>Financial</th><th>IM &T</th><th>Workforce</th><th>Estate</th></tr><tr><td>X</td><td>X</td><td>X</td><td>X</td></tr><tr><th>Legal</th><th>Health Inequalities</th><th>EDI</th><th>Sustainability</th></tr><tr><td>X</td><td>X</td><td>X</td><td>X</td></tr></table></td></tr>
<tr><td>Route to this meeting</td><td>None</td></tr>
<tr><td>Management of Conflicts of Interest</td><td>Will be managed in accordance with the conflict details and by the management of the Chair of the meeting</td></tr>
<tr><td>Patient and Public Engagement</td><td>None for this report, but for relevant actions for contract issues under national policy will have patient and public engagement expectations.</td></tr>
<tr><td>Equality, Diversity and Inclusion</td><td>None for this report, but for relevant actions under national policy will have expectations for Equality, Diversity and Inclusion.</td></tr>
</table>

Health inequalities	None for this report, but for relevant actions under national policy will have expectations for health inequalities.
Next Steps	Any next steps are including in the report narrative.
Appendices	Appendix 1 – Terms of Reference (Draft) Primary Care Contracting

Glossary of Terms	**Explanation or clarification of abbreviations used in this paper**
Detailed in paper as part of Narrative	

Primary Care Commissioning, Contracting and Policy Update

1.0 Background

1.1 Cheshire and Merseyside ICB is responsible for the management of the national contracts for General Practice via a Delegation agreement with NHSE/I (NHS England and NHS Improvement). This delegation agreement commenced 1st July following a national assurance process. GMS, PMS, APMS (and DES) contracts are managed locally via place through the previously agreed matrix of decision making, through local primary care forums. Place are responsible for implementing any national policy changes locally, with any onward assurance collated by the central corporate team to NHS England

1.2 Current number of GP Practices and PCNs in Cheshire and Merseyside is given below ;

	Number of GP Practices	Number of PCNs
Cheshire West	43	9
East Cheshire	36	9
Halton	14	2
Warrington	26	5
Liverpool	83	9
Knowsley	25	3
Sefton	40	2
St Helens	31	4
Wirral	46	5
	344	48

1.2 Oversight of the national general practice contracts are through the Primary Medical Care Policy and Guidance Manual https://www.england.nhs.uk/publication/primary-medical-care-policy-and-guidance-manual-pgm/.

The ICB must manage the contracts in line with this Policy Book. Further detailed contract documentation can be found here NHS England » GP Contract

1.3 More information on the national community pharmacy can be found here https://www.england.nhs.uk/primary-care/pharmacy/community-pharmacy-contractual-framework/. The number of community pharmacy contracts in Cheshire and Merseyside is 590.

1.4 Management of the general dental services (GDS) and PDS contracts is via policy-book-for-dental-services.pdf (england.nhs.uk). There are 335 primary care dental contracts and 26 orthodontic contracts in Cheshire and Merseyside. In addition there are commissioned urgent care services for both in hours and out of hours, along with 4 providers of specialist community dental provision.

1.5 Management of general ophthalmic services is via the National Policy Book for Eye Health NHS England » Policy Book for Eye Health . Provision of General Ophthalmic Services (GOS) including sight testing and dispensing is agreed by contract and there are 2 types of contracts: Mandatory Services contracts, which are contracts allowing provision of GOS in a fixed premises and Additional Services (domiciliary) contracts, which allow provision of GOS to a patient in their home address if a patients cannot attend a fixed premises unaccompanied. There are currently 224 mandatory service (high street) opticians and 55 additional service (home visits) opticians currently listed.

2.0 Primary Medical Services (General Practice) Update

2.1 Nationally the main policy focus remains on actions to support delivery of improvement in access. A full update on this is given via a separate paper at this Committee meeting. NHS England recently increased assurance in this area and released further revised guidance in September, to support delivery NHS England » Delivery plan for recovering access to primary care.

2.2 The planning team have been co-ordinating Winter returns assurances for primary care including general practice. The main focus remains on capacity, schemes to support system pressures and assurances on escalation processes – all places have the latter in place but the ask is to explore a more systematic process , which is also an ask within the access recovery plan. The work in relation to this is ongoing.

2.3 Nationally there is no further details of contract arrangements for 24/25 and beyond although the expectation is that there may be a one year agreement but this is unconfirmed.

2.4 A nationally policy note was released in relation to contracting of non core ‘enhanced’ and ‘local quality’ type arrangements which mostly were previously contracted direct with practices using the NHS Standard Contract. With immediate effect contracting for these mandatory services can be via a variation on the practices core contract, in line with all variations. However a robust specification will still need to be developed by commissioners to support this contract variation. More details can be found via https://www.england.nhs.uk/long-read/local-enhanced-service-commissioning-through-gp-contracts/

2.5 An internal audit on primary care contracting is currently underway involving place commissioners (for general practice) and the outputs of this will come to the System

Primary Care Committee next time. The draft terms of reference are given in Appendix 1. At the next Committee there will be an updated decision making matrix presented to reflect where we now are with these arrangements – but also reflecting anything picked up in the audit review.

3.0 Dental Update

3.1 The commissioning team continue to work on implementing the dental improvement plan. The focus of the work is on three areas in the plan:

- Expanding the urgent care plus pathway
- Access for new patients requiring routine care
- Vulnerable groups

3.2 41 practices are signed up to the expansion of the urgent care plus pathway since the plan was signed off. This is in addition to the existing urgent care providers. Feedback from providers is positive and they report seeing very low numbers of patients who fail to attend.

3.3 2 practices have been approached to support the 'urgent care centre' network, these practices are in Southport and Knowsley.

3.4 Year end is complete however a number of practices have contacted the team requesting an extension to the repayment period citing financial difficulties.

3.5 The team are now engaged in the mid-year process.

3.6 NHSBSA have paused support for contractual changes (e.g. partnerships) this is having an impact on capacity within the team.

3.7 There continues to be a high number of Dental complaints/MP letters (approx 10 per week) and the team are asked to investigate/contribute.

3.8 All dental practices should have an IPC audit programme in Place so policies and procedures are effective and up to date. The audit should show evidence of issues identified and how they have been addressed. The programme to support the NHS practices has been re-established across the patch. Practices are required to provide an audit every 6 months which are reviewed to identify any issues. An annual declaration of compliance is also a requirement and these are being collated.

3.9 The friends and family test (FFT) is a feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. Primary dental service providers are required to complete and submit the data on a monthly basis

however there are very low rates of compliance. Work is being undertaken to encourage and support practice submissions.

3.10 The ICB is required to submit assurance regarding winter planning and in relation to urgent dental care provision. The team continue working on this and provided narrative/information as required.

3.11 The Dental Operational Group continues to meet every 6 weeks. The meeting focusses on the following areas:

- Process/Operational Log
- Contract Reductions & Hand Backs
- Contract Discussions
- Breach Notices
- MCN and LPN and inclusion of previous minutes for review
- FFT and review of latest data
- CQC update
- Finance update
- Dental Advisor update

3.12 Commissioners will be looking at the feasibility of an early warning system that will track progress and give commissioners early sight of where they may be issues with providers. Providers need to be supported particularly in areas of deprivation where there is quite often a correlation between contract performance and recruiting dentists. This then impacts on UDA delivery.

3.13 Commissioners and ICB BI team are developing a performance Flash Card by Place that will identify performance and where activity should be targeted including vulnerable groups – children and frail elderly. The Flash Care will include data on:

- Access
- Investment (UDA rate per Place and Contracted UDA's)
- Disease
- Deprivation
- Public Health Wider determinants

4.0 Community Pharmacy Update

4.1 Reduction in late opening pharmacies

Following a regulatory change at the end of May, 100-hour pharmacies can now apply to reduce their total number of core opening hours to not less than 72 hours. There are conditions attached to this to ensure that pharmaceutical provision during the early evening and at weekends is not adversely affected, and provided these conditions are

met, the ICB must approve the reduction in hours. However, the Regulations permit the pharmacies to close from 9pm on a weekday. As a result of this change, with the exception of 1 pharmacy situated in Prescot, we now have no contracts open after 9pm which will impact on ways of working for Out of Hours (OOH) providers. OOH is commissioned at Place level and therefore we will need to open dialogue with Place colleagues in order to understand the impact of this change, and, if necessary, work to design a solution.

4.2 Winter planning and community pharmacy arrangements.

Several pharmacies are formally directed to open over the Christmas and New Year bank holiday period as part of the Pharmacy Rota arrangements in accordance with the NHS Pharmaceutical Services Regulations. We liaise with the LPC's across the area to ensure that each area is adequately covered. Several additional pharmacies are signed up to a service level agreement to open. All these pharmacies are contractually obliged to open. It is highly likely that pharmacies located within supermarkets or pharmacies located on retail parks will choose to open, despite not being contractually obliged to do so. A number of Contractors are signed up as antiviral stockholding sites and are therefore also obliged to open on Bank Holidays. These branches are identified on the DoS system. The formal rota process of directing Contractors is completed in accordance with the timetable set out in the Pharmacy Manual.For Christmas, all directions were sent out by the end of August and the process for Easter has begun. These directions may be subject to an appeals process. The rota for Christmas will be cascaded early December and DOS teams will be notified accordingly. Each Place will also be notified. This enables them to manage the local media Comms as well and meet print deadlines for the press releases related to the winter 'stay well' information drive.

5.0 Optometry Update

5.1 Service provision remains steady in Cheshire and Merseyside with 224 mandatory service (high street) opticians and 55 additional service (home visits) opticians currently listed. There are also current advanced applications for new stores in Prescot and Speke and a new additional services contract in Warrington.

5.2 There are proposals following an evaluation (see link below) of the proof of concept around expansion of the eyecare in special schools programme aiming to expand the service with potential rollout date for 2024/2025. Special schools eye care – proof of concept evaluation report (england.nhs.uk).The national eyecare in special schools team are currently engaging with ICB stakeholders (see link below) asking for any feedback/comments on the proposed updated model.NHS England » Engagement – in school eye testing for pupils in special schools in England The ICB commissioning team working with clinical leads have prepared a feedback document which will be shared with the national team as part of wider engagement.

5.3 It should be noted that any further roll out of the above scheme will require on boarding support. For any future optometry transformation programmes officer support from the central team is limited as the whole team is just 2 officers, as the senior management support at NHS England did not transfer over – there may need to be further

consideration to resourcing this team through different ways of working across wider primary care teams.

6.0 Recommendations

The Committee is asked to:

- Note the updates in respect of commissioning, contracting and policy for the four primary care contractor groups which is for assurance purposes.

Officer contact details for more information

Chris Leese
Associate Director of Primary Care – c.leese@nhs.net
c.leese@nhs.net

Tom Knight
Head Of Primary Care
tom.knight1@nhs.net

Appendix 1 – Terms of Reference Primary Care Contracting Internal Audit

550C&MICB_2324_202 Primary Care Cont

Primary Care Contracts Review Terms of Reference (Draft)

NHS Cheshire and Merseyside Integrated Care Board

550C&MICB_2223_202DEF

1 Introduction and Background

As part of the agreed Internal Audit Plan for 2023/24, a review of the processes for the approval, monitoring and amendment of Primary Care Contracts will be undertaken.

NHS England (NHSE) has had a long-term policy ambition of giving systems responsibility for managing local population health needs, tackling inequalities and addressing pathways of care. A key enabler to realising this ambition is the delegation of direct commissioning functions to Integrated Care Boards to allow for local service design and development of pathways of care that better meet local priorities.

Upon its formation, the NHS Cheshire and Merseyside Integrated Care Board (C&M ICB) has received delegated responsibility for primary medical services (previously delegated to the CCGs) as well as pharmaceutical services, general ophthalmic services and dental services (primary, secondary and community).

The nature of the delegations and obligations placed on C&M ICB are covered in a formal Delegation Agreement signed off by the C&M ICB and NHSE. NHSE has developed an Assurance Framework to set out how they will gain assurance from ICBs that they are exercising the delegated functions safely, effectively and consistently within legislation and statutory guidance.

2 Audit Objective

The overall objective of the review is to assess whether the ICB has primary care commissioning arrangements in place which fulfil the requirements of the delegation agreement with reference to the supporting assurance framework.

3 Audit Scope

This review will assess the arrangements put in place by C&M ICB to meet the requirements specified in the NHSE Delegation Agreement

Sub-objective	Risk
Governance- The ICB has effective governance arrangements in place to oversee the management of Primary Medical Services contractors.	Ineffective governance arrangements can lead to poor or unsafe performance not being identified or appropriate action not being taken to rectify issues or escalated leading to potential patient harm financial waste and/or reputational damage.
Quality- The ICB manages the performance of the Primary Medical Services contractors in order to secure the needs of people who use the services, improve the quality of services and improve efficiency in the provision of the services.	Failure to ensure appropriate quality standards and to take appropriate actions to improve quality could result in patient harm and significant reputational damage.

Sub-objective	Risk
Finance- The ICB actively monitors primary care contracts to ensure value for money on behalf of NHS England and avoids making any double payments under any Primary Medical Services Contracts.	Failure to secure value for money and prevent financial loss could result in undue financial pressure on ICB budgets resulting in cuts to services and a failure to meet patient needs.
Areas within the contracts where claims for reimbursement are being made (e.g. additional role reimbursement scheme, locums, sickness and premises costs) are supported by appropriate supporting evidence.	Failure to consider and review claims for reimbursement or a lack of supporting evidence could result in payments being made for items that are not warranted leading to pressures on budgets and possible fraud.

The review will focus upon the following contractors:

- General Practitioners
- Pharmaceutical services,
- General Ophthalmic Services
- Dental services

The limitations to scope are as follows:

- The review will focus on assessing those primary care contracts delegated to the C&M ICB. It will not cover additional primary care investment activities.

4 Audit Approach

Following discussion with ICB management, it has been agreed that the review is to be undertaken both onsite and remotely. Whilst working remotely, we will ensure that regular contact is maintained throughout the audit process to feedback on progress and matters arising. We are aware that there may be restrictions which could potentially impact on the delivery of the review. We will ensure that any potential issues are escalated appropriately.

Following completion of the audit fieldwork we will meet with operational managers and/or the audit sponsor to discuss the audit findings and proposed recommendations. A draft report will be produced; your responses to these recommendations and a timetable for any actions to be carried out will be agreed and incorporated into the final report, along with the names of staff who will be responsible for their implementation. The final report will be approved by the lead Executive Director. The conclusion of all final reports is reported to the Audit Committee.

5 Information Requirements

We have provided below details of documentation we require to undertake the review. Please note that this list is not exhaustive and there may be other documents that we request once we have

commenced the fieldwork. Similarly, if you are aware of any other documents that would assist the review which are not listed below, we would be grateful if you could make these available to us:

- Terms of reference, workplan, agendas, papers and minutes: Primary Care Contracting Group, Primary Care Commissioning Committee and Sub-Groups, Finance and Performance Committee, Quality Committee and Primary Care Quality Group
- Policies and procedures relating to management of Primary Care contracts.
- NHS C&M / NHSE delegation agreement
- SFE/Premises directions

6 Proposed Timescales

Stage	Proposed Date
Fieldwork commences	September 2023
Discussion document to client	November 2023
Responses by client	November 2023
Final report	November 2023

7 Key Contacts and Report Distribution

Name	Title	Report
Claire Wilson	Executive Director of Finance	Final
Rebecca Tunstall	Associate Director of Finance – Planning and Resourcing	Final
Christopher Leese	Associate Director of Pharmacy	Draft & Final

8 Data Protection and Freedom of Information

MIAA takes its responsibility for the security and protection of information acquired and used during the delivery of its work seriously.

MIAA are compliant with the requirements of the NHS Data Security and Protection Toolkit and are Cyber Essentials certified. We have in place a comprehensive Information Security and Privacy Management system based upon ISO 27001 and ISO 27701 and have implemented a range of technical controls to protect data.

In delivering this assignment MIAA will acquire supporting information from you, some of which may be confidential or otherwise sensitive. This information will be used solely for the completion of this assignment and for informing our Head of Internal Audit Opinion.

In this context, MIAA are considered data processor for that information and, thus are subject to the requirements of the Data Protection Act and the UK General Data Protection Regulation, where personally identifiable information is concerned, and the Freedom of Information Act, where corporate information is concerned.

MIAA will, therefore, be required to not only comply with the laws and regulations in respect of our control of the data but will also be responsible for any appropriate disclosure under the legislation.

9 Your Acceptance

Please do not hesitate to contact MIAA should you have any comments regarding the Terms of Reference (these will be assumed as agreed if MIAA are not informed otherwise).

10 MIAA Key Contacts

Name	Conor Joel-Welsh	Name	Adrian Poll
Title	Delivery Manager	Title	Senior Audit Manager
	07554 227503		07798 580355
	conor.joel-welsh@miaa.nhs.uk		adrian.poll@miaa.nhs.uk

Primary Care Finance Update

NHS Cheshire and Merseyside Primary Care Committee (System Level)

Date: 19th October 2023

Date of meeting:	19th October 2023
Agenda Item No:	SPCC B23/10/12
Report title:	**23/24 Primary Care Finance Update**
Report Author & Contact Details:	Lorraine Weekes-Bailey, Senior Finance Manager - Primary Care John Adams, Head of Primary Care Finance
Report approved by:	John Adams

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

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

N/a

Executive Summary and key points for discussion

The report provides the Primary Care Commissioning Committee of the Cheshire and Merseyside Integrated Care Board (ICB), with a detailed overview of the financial position related to primary care expenditure as at the end of September 2023 (M6).

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 the reserves and flexibilities available.

It also provides a breakdown of the Additional Roles Reimbursement Scheme (ARRS) allocation at Place level and the central drawdown that is available.

At the last System Primary Committee, it was requested that a Primary Care Task and Finish group was formed, the paper provides an update on meetings to date.

Recommendation/ Action need:	**The Committee is asked to:** The Primary Care Committee is asked to: - 1. Note the financial summary position and respective resource allocation and expenditure assumptions, based on current information (at the time of writing the report). 2. Note the anticipated Primary Care reserves and flexibilities. 3. Note the Additional Role Reimbursement scheme and the current financial summary of the Place level spend. 4. Note the summary of the financial data that is being provided, to support the delivery of the Primary Care Access Recovery plan. 5. Approve that prior year capital accrual benefits should be spent on GPIT.

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

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

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

Governance and Risk						
Does this report provide assurance against any of the risks identified in the ICB Board Assurance Framework or any other corporate or Place risk? **No**						
What level of assurance does it provide?						
Limited		**Reasonable**	**x**	**Significant**		
Any other risks? **Yes**						

	If **yes,** please identify within the main body of the report.
	Is this report required under NHS guidance or for a statutory purpose? (*Please specify*) **Yes**
	Any **Conflicts of Interest** associated with this paper? If **yes,** please state what they are and any mitigations undertaken. **None**
	Any current services or roles that may be affected by issues as outlined within this paper? **No**

Primary Care Finance Update

1. Introduction and Background

1.1. The report provides the Primary Care Commissioning Committee of the Cheshire and Merseyside Integrated Care Board (ICB) with a detailed overview of the financial position in relation to primary care expenditure anticipated for 2023/24 as at 30th September 2023.

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

1.3. The financial positions for September 2023 (M06) 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 1a, as shown below, illustrates the financial position of the Primary Care and Prescribing services across Cheshire and Merseyside ICB and Table 1b shows a more detailed breakdown of the financial position.

Table 1a

Primary Care Position Summary September 2023	Budget YTD Month 1-6			Forecast Outturn M1-12		
	Budget (£000's)	Actual (£000's)	Variance (£000's)	Annual Budget (£000's)	Forecast (£000's)	Variance (£000's)
Cheshire & Merseyside ICB Primary Care						
ICB Local Primary Care	47,777	47,176	601	96,836	95,520	1,316
Delegated Primary Care	248,188	247,176	1,013	496,377	495,546	831
Prescribing	253,878	273,557	(19,679)	506,752	552,410	(45,658)
Delegated Pharmacy	35,022	35,022	(0)	70,100	70,100	0
Delegated Ophthalmology	13,512	13,512	0	27,024	27,024	0
Delegated Dental	89,387	89,387	0	183,882	183,882	0
Delegated Other	738	699	38	1,476	1,392	84
Primary Care SDF	3,521	3,616	(96)	7,041	7,041	0
ICB Primary Care Total	**692,023**	**710,145**	**(18,122)**	**1,389,488**	**1,432,916**	**(43,427)**

Table 1b

Primary Care Position Summary September 2023	Budget YTD Month 1-6			Forecast Outturn M1-12		
	Budget (£000's)	Actual (£000's)	Variance (£000's)	Annual Budget (£000's)	Forecast (£000's)	Variance (£000's)
ICB Local Place Primary Care						
Primary Care Local Enahnced Services/Other	26,616	26,229	387	54,514	53,221	1,293
Primary Care IT	7,741	7,339	401	15,482	15,516	(35)
Out of Hours	13,420	13,608	(188)	26,840	26,783	58
ICB Local Primary Care Total	**47,777**	**47,176**	**601**	**96,836**	**95,520**	**1,316**
Delegated Primary Care-Medical						
Core Contract	146,394	146,632	(238)	292,788	292,466	322
QOF	19,508	19,239	269	39,016	38,475	540
Direct Enhanced Schemes	2,231	2,298	(66)	4,463	4,664	(201)
Premises Reimbursements	24,869	25,477	(607)	49,739	50,420	(681)
Other Premises	342	342	0	684	683	1
Fees	7,364	7,026	339	14,728	14,758	(30)
Primary Care Network	25,948	24,807	1,141	51,896	50,843	1,053
Additional Roles Reimbursement Scheme	20,770	20,770	(0)	41,540	41,540	0
Other - GP Services	761	586	175	1,523	1,697	(174)
Delegated Primary Care Total	**248,188**	**247,176**	**1,013**	**496,377**	**495,546**	**831**
Prescribing						
Cheshire and Merseyside Itemised Prescription Payments	239,402	257,426	(18,024)	477,799	519,687	(41,888)
Central Drugs	7,461	8,719	(1,258)	14,922	18,344	(3,422)
Oxygen	2,651	2,908	(256)	5,303	5,757	(454)
Local Schemes	4,364	4,504	(141)	8,728	8,621	107
Preescribing Total	**253,878**	**273,557**	**(19,679)**	**506,752**	**552,410**	**(45,658)**
Delegated Pharmacy						
Delegated Pharmacy	35,022	35,022	(0)	70,100	70,100	0
Delegated Pharmacy Total	**35,022**	**35,022**	**(0)**	**70,100**	**70,100**	**0**
Delegated Ophthalmology						
Delegated Ophthalmic	13,512	13,512	0	27,024	27,024	0
Delegated Ophthalmology Total	**13,512**	**13,512**	**0**	**27,024**	**27,024**	**0**
Delegated Dental						
Delegated Primary Dental	62,286	62,286	0	129,697	129,697	0
Delegated Secondary Dental	20,891	20,891	0	41,765	41,765	0
Delegated Community Dental	6,210	6,210	0	12,420	12,420	0
Delegated Dental Total	**89,387**	**89,387**	**0**	**183,882**	**183,882**	**0**
Delegated Other						
Delegated Other	738	699	38	1,476	1,392	84
Delegated Other Total	**738**	**699**	**38**	**1,476**	**1,392**	**84**
Primary Care SDF						
Primary Care SDF	3,521	3,616	(96)	7,041	7,041	0
Primary Care SDF Total	**3,521**	**3,616**	**(96)**	**7,041**	**7,041**	**0**

Local Primary Care

2.2. **Local Enhanced Services**- The overall Local Medical Primary Care budget at the end of July 2023, currently shows a forecast underspend year to date of £1.3m. This is mainly due to the planning assumptions in Wirral Place, where they have a corresponding overspend in their delegated GP Services costs plans. This was due to the early planning assumptions regarding the transfer of Access money.

2.3. **GP IT**-There is a forecast overspend in table 1b, of £35,000 within GP IT. This is due to prior year costs at the end of 2022/23 that were higher than anticipated.

2.4. **Out of Hours-** There is a forecast underspend of £58,000 on Out of Hours services, this underspend is due to prior year costs being lower than anticipated.

Delegated Primary Care - Medical

2.5. **Core Global Sum-** There is an underspend of £0.332m, this is mainly due to the removal of some premiums in APMS contracts that had been included at budget setting. This is no longer required as the practices have been moved over to GMS rates, in line within NHSE guidance.

2.6. **QOF**- The Delegated Medical Primary Care budget shows an underspend of £0.540m within the QOF service line, this is due to year-end estimates of 2022/23 costs being less than anticipated.

2.7. **Premises reimbursements**- currently shows a forecast overspend of £0.681m, this is due to VAT implications within Warrington and Halton. This is for historic CHP invoices on which VAT had been recovered. The correction and repayment of VAT to HMRC has resulted in a pressure at Place level.

2.8. **Other GP Services**- As mentioned in section 2.2, the main driver of this overspend reflects the Wirral early planning assumptions that corresponds with the local Primary Care underspend, this attributes to £0.535m, which is shown on the Other GP Services line. However, there are also some underspends that off-set this pressure, these underspends are due to prior year costs which were lower than was anticipated.

2.9. **DDRB Settlement** - The Government has accepted the DDRB recommendation that salaried general practice staff should receive a 6% increase in salary for 2023/24. The global sum payment to practices will increase from £102.28 to £104.73 per weighted patient. Payments to practices, backdated to 1st April, will be made in October and November. The ICB will receive additional funding allocation. The reimbursable maxima for ARRS staff were uplifted earlier in the year.

Prescribing

2.10. **Prescribing** The Prescribing financial forecast outturn is currently £18.024m overspent year to date and the predicted forecast outturn is £41.888m.

Most of the cost pressure is derived from inflation which is currently approximately 8.81% compared to the national planning assumption of 2.4%.

Following national guidance, the ICB was advised to uplift plans by 2.4%, a further reduction of up to 5% was made at each Place for QIPP target.

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

Delegated Pharmacy

2.11. Delegated Pharmacy is currently showing breakeven, but high uptake of new Advanced Services has reduced the dental reserve balance from £2.6m to £0.923m. Provided the local high uptake of new Advanced Services reflects a similar position nationally, the national team will amend other fee rates within the contract in order to bring total Pharmacy Contract remuneration back down to the value agreed in the 5-year deal with the profession.

For information:-The budget service line "Delegated Other" consists of the following service costs:

Service Heading	£'000s
Transformation Team Staff	405
Reserves	882
GPIT	93
Sterile Products	80
Other	16
Total	**1,476**

3. Reserves & In-year POD Flexibilities (Pharmacy Contract, Ophthalmic, Dental & Delegated Other)

3.1 The POD budgets contain uncommitted reserve funding. Typically, they also benefit from in-year slippage on dental contract delivery. The reserves and estimated slippage are shown in table 2.

Table 2

Service		Comments	Total		
			Worst	Most Likely	Best
			£'000s	£'000s	£'000s
Pharmacy Contract	Reserve		123	623	923
Pharmacy National Action	Amend national fee rates	Qtr 3&4 fee adjustments to manage net remuneration	0	1,222	1,222
Optometry	Reserve		1,456	1,756	1,903
Other Services	Includes allocation convergence factor 24/25		882	882	882
Secondary Dental	ERF reserve (outside dental ringfence)		2,156	2,156	2,156
Corp	Less sum already included in corporate plan	Outside dental ringfence	-6,500	-6,500	-6,500
Subtotal - outside Dental Ringfence			**-1,883**	**139**	**586**
Secondary dental		Potential benefit following contract sign-off (excl of 19/20 AOB items)	2,000	4,500	4,500
Primary dental		Potential net under-performance 23/24	5,651	9,725	12,702
Corp	Less sum already included in corporate plan	Inside dental ringfence	0	0	0
Subtotal - within Dental Ringfence		**Can only be invested in dental services, unless alternative use is agreed by Julian Kelly (national CFO)**	**7,651**	**14,225**	**17,202**
Total All			**5,768**	**14,363**	**17,787**

3.2 The ICB had anticipated POD flexibilities of £6.5m. This expectation has been reflected in the table above. Additional savings of £0.139m are expected to benefit the ICB.

3.3 A further £14.225m surplus is likely to occur on primary and secondary care dental contracts, funding which is currently ringfenced and must only be invested in dental services. The surplus arises from under-delivery of contracted activity by primary care dental contractors. Due to the scale of funding to be recovered from contractors, there is some risk that not all will be recoverable.

3.4 This Committee approved a £2.9m Dental Investment plan in June. The likely expenditure resulting from this investment plan is included within the table.

4 Additional Roles

4.1 Funding for the Additional Roles Reimbursement Scheme has been significantly increased nationally for 2023/24.

4.2 The ICB spent £39.580m in the financial year 2022/2023 on Additional Roles. The current financial year 2023/24 has an allocation of £65.782m to spend.

4.3 Table 3a illustrates the budgets available for the Additional Roles reimbursement scheme identified a Place level and Table 3b, illustrates how much of the allocation each place is anticipated to spend.

Table 3a

Place	ICB Baseline Allocation	Central Allocation (held by NHSE for drawdown)	Total Allocation
Cheshire East	£5,954,322	£3,485,119	£9,439,441
Cheshire West	£5,704,604	£3,338,957	£9,043,560
Halton	£2,071,235	£1,212,313	£3,283,547
Knowsley	£2,728,757	£1,597,166	£4,325,923
Liverpool	£8,904,006	£5,211,596	£14,115,602
Sefton	£4,327,265	£2,532,788	£6,860,053
St Helens	£3,221,469	£1,885,555	£5,107,025
Warrington	£3,215,679	£1,882,166	£5,097,845
Wirral	£5,367,465	£3,141,626	£8,509,091
TOTAL	**£41,494,801**	**£24,287,286**	**£65,782,087**

Table 3b

	Year to Date			Full Year						
Place	ICB Held Budget	Actuals Month 1 - 6	Variance	Total Budget Excluding Drawdown	Available Drawdown	Total	Total FOT	Variance	Expected Drawdown from NHSE	%age Utilisation of Full Allocation
Cheshire East	£2,977,161	£3,212,688	-£235,527	£5,954,322	£3,485,119	£9,439,441	£8,438,369	£1,001,072	£2,484,047	89%
Cheshire West	£2,852,302	£3,523,015	-£670,713	£5,704,604	£3,338,957	£9,043,560	£8,600,123	£443,438	£2,895,519	95%
Halton	£1,035,617	£1,048,385	-£12,767	£2,071,235	£1,212,313	£3,283,547	£2,990,794	£292,753	£919,560	91%
Knowsley	£1,364,378	£1,080,548	£283,830	£2,728,757	£1,597,166	£4,325,923	£4,032,086	£293,838	£1,303,329	93%
Liverpool	£4,452,003	£4,566,293	-£114,290	£8,904,006	£5,211,596	£14,115,602	£14,008,116	£107,486	£5,104,110	99%
Sefton	£2,163,633	£1,562,846	£600,786	£4,327,265	£2,532,788	£6,860,053	£5,023,303	£1,836,750	£696,038	73%
St Helens	£1,610,735	£839,437	£771,298	£3,221,469	£1,885,555	£5,107,025	£4,061,319	£1,045,706	£839,850	80%
Warrington	£1,607,839	£1,987,941	-£380,102	£3,215,679	£1,882,166	£5,097,845	£4,676,964	£420,881	£1,461,285	92%
Wirral	£2,683,732	£3,118,305	-£434,573	£5,367,465	£3,141,626	£8,509,091	£7,269,489	£1,239,602	£1,902,024	85%
Total	**£20,747,401**	**£20,939,458**	**-£192,058**	**£41,494,801**	**£24,287,286**	**£65,782,087**	**£59,100,562**	**£6,681,525**	**£17,605,761**	90%

4.4 Further work is required by the Primary Care Networks, currently the Networks are providing a plan of their workforce plans. This will show how they will maximise the use of these funds and will help finance to provide an accurate forecast of these for the financial year ahead.

5 Primary Care Task and Finish Group

5.1 The System Primary Care Committee requested the setup of a Primary Care Task and Finish group. This was to identify the key drivers behind identified variances, across primary care services across the nine Cheshire and Merseyside places.

5.2 Since the last System Primary Care Committee, the finance team have met with the Contracting team, to understand the entire Primary Care envelope and to understand the Primary Care costs that are delivered within a Secondary Care setting.

5.3 In order for us to move this forward, we have incorporated the Contracts team in our future meetings. We will provide a further update at the next Primary Care committee meeting once the Contracts Team has established the Secondary Care funding that supports Primary Care services.

6 Primary Care Access and Recovery Funding and SDF

6.1 On the 9th May 2023, NHS England (NHSE) and Department of Health and Social Care (DHSC) published the “Delivery plan for recovering access to primary care”.

6.2 The plan sets out two ambitions: -

- To tackle the 8:00 am rush and reduce the number of people struggling to contact their practice.
- For patients to know on the day they contact their practice how their request will be managed.

There, are four themes that underpin this plan: -

Empower patients by rolling out tools they can use to manage their own health and invest up to £645 million over two years to expand services offered by community pharmacy. The national team is still negotiating with the professional body on what they will provide in return for the funding.

Implement ‘Modern General Practice Access’ so patients know on the day how their request will be handled, based on clinical need, and continuing to respect their preference for a call, face-to-face appointment, or online message.

Build capacity so practices can offer more appointments from more staff than ever before.

Cut bureaucracy to give practice teams more time to focus on their patients' clinical needs.

6.3 However, to deliver the ambitions of the Access Delivery Plan, NHSE acknowledge further funding is required.

6.4 Several funding streams have been awarded that underpin the delivery of the plan by either: -

- Re-targeting monies
- Providing new allocations
- Providing SDF funds

6.5 Table 4a, outlines the key funding streams that will support the delivery of the plan. To note, Cloud based Telephony and Transition Cover will be allocated at place, on a needs basis, these plans are currently still being worked through.

6.6 In addition to this funding, NHS England has funded approximately £2.7m to support GP IT direct to GP Practices.

6.7 NHS England are also providing Care Navigation training to help support the delivery of the Primary Care Access recovery programme.

Table 4a

SDF and Primary Care Access Recovery Funding	Cheshire East	Cheshire West	Halton	Knowsley	Liverpool	Sefton	St Helens	Warrington	Wirral	Central -C&M ICB	Total
GP Practice Fellowships										1,667,000	**1,667,000**
Supporting GP Mentors										392,000	**392,000**
GP IT and Resillience										606,000	**606,000**
Leadership & Management	280,342	264,149	94,485	135,827	452,343	211,450	151,603	148,866	265,770		**2,004,835**
C&M GP Retention	40,166	40,166	36,666	40,166	40,166	40,166	36,666	36,666	40,166	309,000	**659,994**
Top Slice for Digital Funding										1,828,000	**1,828,000**
Digital Pools										120,000	**120,000**
Top Slice for Comms Funding										15,000	**15,000**
Transformation Funding Pool	460,348	433,791	160,161	223,042	742,791	347,221	248,945	244,453	436,420		**3,297,171**
Capacity and Access Support Fund (CAP)	1,133,253	1,067,876	394,273	549,069	1,828,551	854,764	612,840	601,788	1,074,348		**8,116,762**
Capacity and Access and Improvement Payment (CAIP)	485,680	457,661	168,974	235,315	783,665	366,327	262,646	257,909	460,435		**3,478,612**
Transition Cover and Transition Support Funding										2,050,000	**2,050,000**
Cloud Based Telephony										1,107,000	**1,107,000**
ARRS Support	9,439,441	9,043,560	3,283,547	4,325,923	14,115,602	6,860,053	5,107,025	5,097,845	8,509,091		**65,782,087**
Pharmacy Offer (£TBC)											**0**
Total Funding	**11,518,722**	**11,002,888**	**4,006,955**	**5,333,349**	**17,470,609**	**8,428,365**	**6,231,456**	**6,201,995**	**10,480,294**	**3,157,000**	**83,831,632**

7 Capital

7.1 The Primary Care committee has approved GP Premises Improvement grants of £2.451 and agreed that the balance of the £4.703m Primary Care Capital allocation (£2.252m) should be held for GPIT projects.

7.2 Digital and Place leads are currently assessing GPIT priorities and funding streams and plan to produce GPIT capital PIDs in advance of the next Committee meeting.

7.3 An additional £0.111m has become available from prior year accruals. The Committee is asked to approve that this, and any further prior-year fallout, can also be spent on GPIT requirements.

Table 5

Cheshire & Merseyside Primary Care Capital Position - September 2023/24

Description	Cheshire & Mersey Planned £'000s	Cheshire & Mersey Received £'000s	Comments
Capital Resources			
BAU allocation	4,703	4,703	
2022/23 Improvement Grant Accrual Reversals		111	Estimate
Additional Primary Care Capital (eg Winter Support)			Potential additional capital resource, tbc
IFRS 16 - schemes not funded centrally			Potential local requirement if national funding reserve is insufficient
Total Expected Capital Resource	**4,703**	**4,814**	

Description	Cheshire & Mersey Approved £'000s	Cheshire & Mersey Spent £'000s	Comments
Planned Expenditure			
Approved Schemes			
GP Premises Improvement Grants			
Multi-year schemes approved in 2022/23	1,283	534	Prior year commitment - approved 22/23
Considered at Primary Care Committee - June	1,168		June Primary Care Committee
Subtotal Improvement Grants	**2,451**	**534**	
GPIT			
Approved NW region [month]			
Subtotal GPIT	**0**	**0**	
IFRS 16 - Schemes not funded Centrally			
Approved NW region [month]			No requirement identified
Subtotal IFRS 16	**0**	**0**	
Total Planned Expenditure	**2,451**	**534**	
Capital Resource (Remaining)/Shortfall	**-2,252**	**-4,280**	**Currently Approved Bids**
Schemes under development (memorandum item):			
Improvement Grants			Indication of date to be submitted to NW region
GPIT	2,252		Reserved at June Primary Care Committee for future GPIT PIDs
IFRS 16			Indication of date to be submitted to NW region
Subtotal schemes under development	**2,252**	**0**	
Potential (Surplus)/Deficit (memorandum item)	**0**	**-4,280**	

8 Recommendations

The Primary Care Committee is asked to:

8.1 Note the combined financial summary position outlined in the financial report as at 30th September 2023. Noting the relative lack of availability of some in-year information.

8.2 Note the anticipated Primary Care reserves and flexibilities.

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

8.4 Note the financial information provided to support the delivery of the Primary Care Access Recovery Plan.

8.5 Approve that prior year capital accrual benefits should be spent on GPIT.

9 Officer contact details for more information

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NHS Cheshire and Merseyside System Primary Care Committee

Date: 19th October 2023

Access Improvement Plan Update

Agenda Item No	SPCC B23/10/13
Report author & contact details	Christopher Leese Associate Director Primary Care c.leese@nhs.net Paper presented by Clare Watson
Report approved by (sponsoring Director)	Clare Watson, Assistant Chief Executive
Responsible Officer to take actions forward	Christopher Leese

Access Improvement Plan - Update

Executive Summary	This paper updates the Committee on progress in relation to the delivery of the ICB's Access Improvement Plan, a national policy ask of ICBs and primary care. It outlines a summary of progress to date, next steps and other issues pertinent to delivery. The Plan will be submitted to the Board in November.				
Purpose (x)	**For information / note**	**For decision / approval**	**For assurance**	**For ratification**	**For endorsement**
	X		X		
Recommendation	**The Committee is asked to:** • Note and discuss the update in respect of the progress of the delivery of the Access Improvement Plan.				
Key risks	A programme risk register is in place, available to Committee members				
Impact (x) (further detail to be provided in body of paper)	**Financial**	**IM &T**	**Workforce**	**Estate**	
	Legal	**Health Inequalities**	**EI**	**Sustainability**	
				X	
Route to this meeting	None				
Management of Conflicts of Interest	Will be managed in accordance with the conflict details and by the management of the Chair of the meeting				
Patient and Public Engagement	As part of the plan/in development				
Equality, Diversity and Inclusion	As above				
Health inequalities	As above				
Next Steps	Any next steps are including in the report narrative.				
Appendices					

Glossary of Terms	**Explanation or clarification of abbreviations used in this paper**
Detailed in paper as part of Narrative	

Access Improvement Plan - Update

1.0 Background

1.1 As previously summarised to the Committee, the requirement for an ICB Access Improvement plan is laid down in the recovering access to primary care guidance, released earlier this year https://www.england.nhs.uk/publication/delivery-plan-for-recovering-access-to-primary-care/. Overall, Access remains a key priority area for the ICB.

1.2 Primarily aimed at General Practice and Community Pharmacy its core aims are;

- Tackling the 8am rush to ensure patients can receive same day support and guidance from their local practice
- Enabling patients to know how their needs will be met when they contact their practice
- A step toward delivering the vision set out in the Fuller Report Next Steps for Integrating Primary Care
- Supporting practices to deliver the above

1.3 To tackle the increasing demands on Primary Care, the plan focuses on four areas to alleviate pressure and support general practice further

- Empowering Patients
- Implementing Modern General Practice Access
- Building Capacity
- Cutting bureaucracy

1.4 The ICB has set up a governance/programme structure to deliver this, linking in with place, system and senior responsible officer (SRO) leads to deliver the November plan. The plan being submitted in November will therefore contain summaries of 9 place level improvement plans, combined with system level actions, reflecting the asks and needs of patients, practice and PCN level improvements agreed, and progress in key areas such as workforce and digital.

1.5 To support delivery, NHS England have released a series of updates support guidance which are being used by the programme leads to inform the final product. The link to further information is found here; https://www.england.nhs.uk/long-read/primary-care-access-improvement-plans-briefing-note-for-system-level-plans/

2.0 Exceptions

2.1 The ICB recently completed a return to NHS England on plan progress and from that we have pulled the key exception areas that were deemed as 'behind' along with areas of concern from our overall project plan;

- Elements of the Pharmacy workstream are not yet in place, due to delays in agreeing national elements
- Self referral pathways work, will require further work after the initial deadlines in the guidance, to meet the national targets prescribed
- There is concern regarding 'Transition Funding' plans and spend of the full allocation. Further work is required in this area to ensure a fully committed spend in line with the Guidance.
- Confirmation of some of the workforce targets are required to give a clear trajectory for improvement at system level – these are also highlighted in the workforce paper also on the committee agenda today.
- Some other national guidance / agreements are not yet clear / agreed and these remain as is for the time being.
- The plan submitted in November will contain ambitions that have yet to be realised on a longer term level, such as workforce, but will have clear progress in most areas. The plan will be accurate as at October in terms of narrative and data, and the plan will be returning so that progress against targets can be assessed.
- Resourcing in terms of staff supporting delivery of the plans is an issue at both system and place level - some further dedicated programme delivery resource in areas such as self referral pathways will need to be considered.

2.2 It is expected that key stakeholders such as LMCs (Local Medical Committees) and Healthwatches are engaged at system and place level in the plan development. At a system level Healthwatches and LMCs have been updated of progress and expectation, but this should be an ongoing process over the lifetime of the plan (and, at place level).

2.3 An equality and health inequality analysis/impact assessment is in development – this has already been presented in draft form to the programme board and will accompany the plan in November. It should be recognised that this will also not be a completed document, as the plan develops this will need to be amended to reflect the progress and challenges.

3.0 Next Steps

3.1 Place level improvement plans are being submitted by the 20th October to allow for a period of refinement and futher summarising. System SRO Leads will also have finalised their area's summaries by that date also.

3.2 The Programme Board will oversee a key editorial process between the above date and 10th November to finalise a draft signed off by Clare Watson as Executive

Lead for Primary Care, ready for submission to the Board for the meeting on the 30th November.

3.3 This Committee will have the Board version presented to it in December, and the Plan will return to Board early in 2024 for progress reports and updates.

3.4 It is important to reiterate the Improvement plan should clearly set out improvements in terms of metrics where able, that are measurable - but also recognise the areas where further work is required to meet the asks of the national guidance.

3.5 Place will have a similar local process for monitoring and progress reporting on the place level improvement plans.

4.0 Recommendations

The Committee is asked to**:**

- Note the update in respect of the progress of the delivery of the Access Improvement Plan.

Officer contact details for more information

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NHS
Cheshire and Merseyside

PRIMARY CARE DENTAL IMPROVEMENT PLAN 2023 - 2025

SPCC UPDATE OCTOBER 2023

STRATEGIC AIMS

TO IMPROVE ACCESS TO GENERAL DENTAL SERVICES AND URGENT CARE

- **Recovering dental activity, improving delivery of units of dental activity (UDAs) towards pre-pandemic levels and in line with Operational Plan trajectories**
- **Focussing on access for inclusion health and deprived populations and make sure they are prioritised**
- **Delivering the ambition that no patient will wait longer than the nationally defined period for an urgent appointment at a General Dental Practice**
- **Support greater workforce resilience and development in conjunction with NHSE colleagues (formerly HEE) and other partners**

CHALLENGES AND SUMMARY

KEY RISKS

- Workforce recruitment, retention and fatigue
- NHS contract hand backs and practice resilience
- Pace of restoration delivery requirements
- Lack of flexibility with national contract to innovate
- Patient demand and oral health needs post COVID
- Commissioning capacity

Overall PROGRESS SUMMARY

PROJECT	CURRENT STATUS
1. Improving Access Urgent Care	
2. Improving Access Urgent Care - Care Homes	
3. Improving Access - New Patients	
4. Improving Access Urgent Care – Over achievement	
5. Improving Access Urgent Care – Advanced Child Care	
6. Improving Access Urgent Care – Integrated approach at Place	NOT CURRENTLY APPROVED
7. Access for hard to reach and vulnerable groups	NOT CURRENTLY APPROVED
8. Workforce	
9. Stakeholder Engagement	

To note:

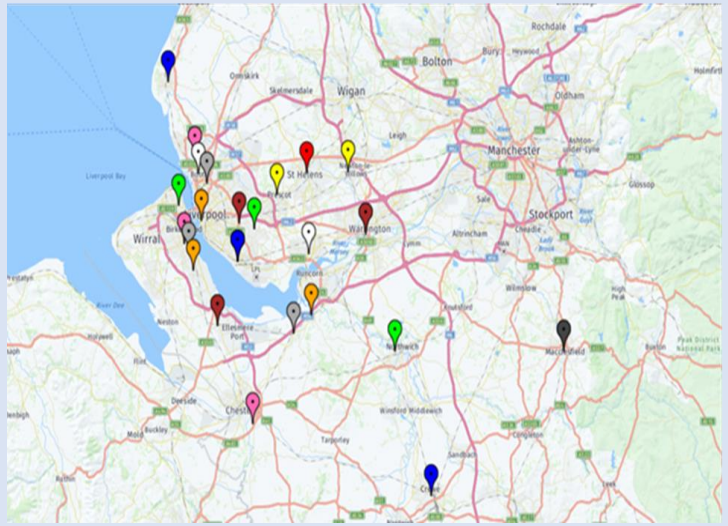
Project 2 planned to commence October 2023

Project 3 and 6 (subject to approval) due to commence September 2023

RECOVER DENTAL ACTIVITY IN LINE WITH OPERATIONAL PLAN REQUIRMENTS	Supporting contractors in the delivery of UDA trajectories Recover and aim to commission previous levels of activity across the ICB. Monitor and review dental activity reporting. Commission dental services in line with NHSE Dental Policy Manual Work with Places to develop ways of working and integrating into commissioning cycle BUT not delegating to Place Ensure compliance with Dental Assurance Framework to monitor quality and safety. Encourage skill mix and increased use of wider dental team STATUS **RED**	• Increased activity by quarter and improved access to routine care • Contracts that are under performing as part of the mid-year review process are required to submit action plans to identify recovery • Reallocate UDAs where activity is handed back non-recurrently. • Practices that are more resilient and commissioners are informed earlier when a practice is struggling. • Practices that are performing well are able to accept additional UDA activity. • Early identification practices where there are quality concerns.	**National System Oversight Framework (SOF) measure:** **Units of Dental Activity delivered as a proportion of all units of dental activity contracted** **Latest period Aug 23** **Month** — **% Delivery** Aug 22 — 75.6% Sept 22 — 68.4% Oct 22 — 74.0% Nov 22 — 91.9% Dec 22 — 73.9% Jan 23 — 80.0% Feb 23 — 86.5% March 23 — 97.7% April 23 — 56.9% May 23 — 75.4% June 23 — 76.1% July 23 — 81.7% Aug 23 — 87.3% National target 100% Region value 95% National value 92.3% Latest Rank 25/42	2023/24 dental allocation to ICB	**COMMENTS** The data is variable month to month, it's the trend over time rather than per month, that provides a more telling picture because monthly reporting can drastically fluctuate due to season, workforce recruitment or delivery of service issues. Restoration and recovery of primary care dentistry remains a challenge both locally and nationally. National contract is not fit for purpose despite some recent minor reforms in July2022. Recruitment and retention of dentists is a local and national challenge Oral health is now worse for some of our population as a result of COVID. Treatment may take longer as needs have changed and this impacts on capacity.

PRIORITY	ACTIONS AND TIMESCALES FOR DELIVERY	UPDATE SUMMARY
IMPROVING ACCESS AND URGENT CARE	**PROJECT 1** Continuation of network of practices formerly known as Urgent Care Centres. Maintain existing 24 sites for a further 12 months up to March 2025 with review in place in 2023/24 to influence 2024/25 Add additional 6 sites based on local needs in Knowsley Sefton East Cheshire Warrington Halton Chester Run EOI process on rolling basis. Delivery will continue through Q2 2023/24 to Q4 2023/24. STATUS **GREEN**	Sessions have been commissioned following a request for 'Expressions of Interest' from existing providers . Under normal circumstances additional services would be targeted based on needs assessment, however with the current challenges NHS dental practices are facing, particularly with workforce issues and sustainability this is not possible. We are continually seeking to recruit additional sessions in more deprived areas e.g Knowsley Since April 2023 and August 2023 the practices providing this service have booked in 3203 patients, of these, 2680 adults were seen and 377 children seen, 146 did not attend.

Place	Number of practices signed up following EOI	Number of additional 3.5 hr sessions per week	Total number of additional hours commissioned per week
East Cheshire	4	6	21
Cheshire West	14	17	59.5
Halton	2	3	10.5
Knowsley	2	3	10.5
Liverpool	7	14	49
Sefton	3	3	10.5
St Helens	2	4	14
Warrington	2	4	14
Wirral	7	9	31.5
Total	43	63	220.5



A referral pathway has been created for cancer patients who do not have a regular dentist.

Since April 2023 collaboration with Clatterbridge, the dental team have found 60 appointments for referrals direct from the Breast cancer dept via this pathway. Work is currently being undertaken to add the pathway to the e-referral system and extend to other priority groups.

Working in collaboration the LDN and dental public health, the dental team created an extension to the urgent care pathway, allowing patients who have attended an urgent care appointment to attend a separately commissioned session where they are offered a full examination and any substantive treatment to get them dentally fit

There are 23 Urgent Dental care centres and two additional sites have been identified to expand the network (in Knowsley and Southport due to need/demand). These sites should be operational by 1 November 2023. Further sites to be confirmed by December 2023.

PRIORITY	ACTIONS	UPDATE SUMMARY
IMPROVING ACCESS AND URGENT CARE	**PROJECT 2** Dental practices in place linked with care homes to support/facilitate with individual oral health plans/training/appt at practice where required/end of life care. Pilot for 2 months with 2 practices and subject to evaluation then roll out across C+M. Assumed start date for the project was October 2023 as defined in financial profile information. Q2 2023 Run EOI process in each Place completed. Revised start date for rollout is currently end Q3 December 2023 STATUS **AMBER**	Historically, domiciliary visits were commissioned to provide care to patients in residential care. The majority of patients would have been edentulous and therefore, in the main, the care would have restricted to denture/laboratory work. As people are living longer and retaining their own teeth, dental care outside of a dental surgery is very limited, mostly to assessment only. With collaboration we have investigated how to deliver support to care/residential homes however there is anxiety amongst the profession that there is a huge unmet need in this cohort of patients and limited capacity within NHS dentistry to deliver, therefore identifying a need and not being in a position to address it. It has been agreed that we can link dental practices with care homes to: • Support with CQC requirements • Signpost to appropriate training for staff (mouth care matters) • Triage patients where there is an oral health concern • Arrange an appointment at the practice for care One of the barriers to this project is dental practices do not have access to ambulance/volunteer drivers to ensure patients can be brought to a dental practice. Patients may have no family members and staff within the care home could be limited, this makes the project more challenging. Capacity within the dental team and dental public health has impacted on the roll out of this project. EOIs have been sent out and the following practices have signed up to join the project.

Place	Number of practices signed up following EOI
East Cheshire	4
Cheshire West	11
Halton	0
Knowsley	0
Liverpool	9
Sefton	2
St Helens	2
Warrington	4
Wirral	11
Total	43

PRIORITY	ACTIONS	UPDATE SUMMARY
IMPROVING ACCESS AND URGENT CARE	**PROJECT 3** Develop access sessions for all new patients across 60 practices. Capacity for additional 30,000 appointments Commissioners will also link with local authorities to identify suitable organisations who work with vulnerable populations Assumed September 2023 start date Q2 2023 Run EOI process in each Place completed. Q3 2023 Establish Pilot site in Belle Vale, Liverpool where a Provider has recently relocated but maintained the practice which is currently vacant. The provider has agreed to delivering 20 sessions per week for new children and nursing/pregnant women from 1 November 2023 Seek to increase number of practices through EOI process to 60 from current 38 Q4 2023 Wider roll out STATUS **AMBER**	Due to capacity both within the Dental team and Dental Public Health this project has been delayed. A September 2023 start was assumed for this project. However discussions with local authorities to identify individual priority vulnerable groups have commenced and EOIs have been obtained from providers.

Place	Number of practices signed up following EOI
East Cheshire	2
Cheshire West	11
Halton	1
Knowsley	0
Liverpool	7
Sefton	2
St Helens	1
Warrington	3
Wirral	11
Total	38

PRIORITY	ACTIONS	UPDATE SUMMARY
IMPROVING ACCESS AND URGENT CARE	**PROJECT 4** Pay for over achievement in UDA activity for all practices up to 110% of annual contracted activity for year 23/24 (as agreed for the last financial year) Monitor compliance with NICE recall guidance and ensure access for those with greatest care needs. Delivery will continue through Q1-4 2023 with practices identified by commissioners on an ongoing basis or at the request of contractors Q3 2023 commissioners to agree monitoring/reporting process for NICE guidance compliance STATUS **AMBER**	All NHS Dental providers were informed following approval by SPPC that the ICB would pay for over delivery of annual contracted activity. This would occur through the year. Mid year data collection is currently underway which may give some indication of increased activity for Q1, Q2 2023/24 Recent example of a practice being asked to undertake additional activity on Wirral This has been agreed on the basis that the contractor treats solely NHS patients and additional activity has been with children and new/high need patient cohorts as identified by commissioners, as opposed to recalling existing patients for routing check-ups). Where other contractors have exceeded 110% of contracted activity, commissioners will check that they can see children and new/high need patient cohorts.

PRIORITY	ACTIONS	UPDATE SUMMARY
IMPROVING ACCESS AND URGENT CARE	**PROJECT 5** Expansion of Advanced Child Care Dental Practices (ACCDP) across C&M Training and development for practice teams prior to accepting referrals. Onward referral via the e-referral management system to a primary care dental practice where on assessment the child is deemed unsuitable for specialist service. Q2 2023 Run EOI process in each Place completed. Q3 2023 Review pathway and agree revisions Confirm suitable providers and agree start dates Q4 2023 Rollout and monitoring. STATUS **AMBER**	This pilot was agreed and led by Paediatric Managed Clinical Network in conjunction with Local Dental Network. It commenced in Liverpool, Knowsley and Sefton where Merseycare Trust hold the contract for Special care paeds/exodontia. Low numbers had been reported and following evaluation the MCN identified the issues and are working to develop/amend the pathway. Between April 23 and August 23 ACCDP practices had received 42 Referrals in the there areas piloted. Commissioners have completed the EOI process to identify providers by Place:

Place	Number of practices signed up following EOI
East Cheshire	1
Cheshire West	6
Halton	2
Knowsley	0
Liverpool	5
Sefton	1
St Helens	1
Warrington	3
Wirral	9
Total	28

PRIORITY	ACTIONS	OUTCOMES	REPORTING OWNER AND METRICS	FUNDING	JOINT FORWARD PLAN AND HCP OBJECTIVES
IMPROVING ACCESS AND URGENT CARE **CURRENTLY NOT APPROVED BY SPPC BUT FOR CONSIDERATION**	**PROJECT 6** Develop integrated approach with primary care teams at Place across the ICB Identify Lead clinician at Place level Provision of training in leadership for local clinicians. Q3 2023 Assumed start date.	• Integration of dental commissioning at Place level and improved feedback loop • Identified lead for peer support for practices • Supporting Place with challenges/issues arising feeding into LDN • Support integration of wide primary care and working with PCNs	Dental Commissioning Group System Primary Care Commissioning Committee **METRICS** **Reporting:** • Number of monthly sessions • Number of lead clinicians identified	Funding required: BD Guild rate £340 per 3.5 hours Rate can be split depending on attendance at meetings Variable cost: 9 x 340 x 50 maximum (one session per week annually) = £153,000 Funding required 2023/24 £89K Funding required £153K	**IMPROVING POPULATION HEALTH AND HEALTHCARE.** **TACKLING HEALTH INEQUALITIES IN OUTCOMES, EXPERIENCES AND ACCESS**

ACCESS FOR HARD TO REACH AND VULNERABLE GROUPS CURRENTLY NOT APPROVED BY SPCC	PROJECT 7 Special care MCN lead development of referral process for non-dental professionals Purchase of Bariactric chairs for CDS and one primary care practice per place (may need funding per referral for primary care Paediatric MCN review of needs assessment working towards single point of contact for referrals and collaborative working Ensuring MCM training completed for all care homes in C&M Pilot for MMCM in Alder Hey & Special school in Knowsley (Bluebell Park) Collaboration with Clatterbridge/LUFT – to further expand breast cancer pathway to other priority patients (cancer/cardiac) Starting Well-prevention schemes (in practice/ Community based) Introduction of enhanced UDAs to support higher needs patients, recognising the range of different treatment options currently remunerated under Band 2.	UPDATE SUMMARY Work has not yet commenced on the costing up of these projects in collaboration with the Managed Clinical Networks and the Local Professional Network. However as reported the Breast cancer pathway is already in place and a proposal has been received for the purchase of a bariatric chair for CDS. Q3 2023 commissioners to meet and agree LPN Plan and implementation. LPN keen to commence and support the work. Bring costed proposal back to SPCC November.

WORKFORCE	PROJECT 8	UPDATE SUMMARY
	Work with existing providers and develop training provision at River Alt and Leasowe. Produce baseline information of current arrangements with Trainees and Foundation Dentists. Consider development of one existing DFT training practice in each Place. Continue to develop links with Liverpool University School of Dentistry Link to ICB Primary Care Workforce Steering Group as part of overall future work plans Undertake dental workforce survey to inform overall C+M workforce strategy Investigating the use of PGDs to enable extended roles (DCPs) Long term development of a model for Centres of Dental Development STATUS **AMBER**	Programme Board established and met in September 2023 Initial membership broadened to include commissioned services. Project Initiation Document and Programme Plan to be agreed Q3 November 2023. Q4 2023 – Q1 2024 Implement programme plan once agreed initially developing existing provision. National Dental workforce collection tool published and will be completed every October and April by contractors. This is a new contractual requirement and will give detailed workforce information for the first time. Information has been sent to all contractors in C+M. Q4 2023 results published from workforce survey Dental commissioners are represented on ICB Primary Care Workforce Steering Group. The NHS Long Term Workforce Plan, published at the end of June, proposed plans to train thousands more dentists in England over the next five to ten years. As part of the plan, it stated training places for dental therapists and hygiene professionals will be increased to more than 500 by 2031/32. Training places for dentists will also increase by 40% to more than 1,100 by this same year. In support of this, training places for dental therapy and hygiene professionals will be increased by 28% by 2028/29, with an increase of 24% for dentists to 1,000 places over the same period.

STAKEHOLDER ENGAGEMENT	Establish Dental stakeholder group building on existing LPN structures. Continued Engagement with Healthwatch across C+M Continuing to work in partnership with dental public health teams in local authority Continued collaboration with NHSE NW regional Dental Public Health team. Development of combined oral health strategy with LAs. Support Place Directors / Place Teams when briefing HWBs and local stakeholders. Utliise ICB Patient Experience Teams at Place level STATUS **GREEN**	**UPDATE SUMMARY** Commissioners have continued to support Place Directors and colleagues when requested to do so including: • Warrington • Halton • Wirral • St Helens • Knowsley A number of presentations/reports and updates have been given to local authority partners including: • HWBs • Scrutiny Committees • Performance and Quality Groups • Partnership Boards A new Primary Care Dental Dashboard has been developed and will contain key information at Place level. Reporting and frequency to be agreed. A proposal to improve the oral health of the child population of Cheshire & Merseyside (CM) by implementing a co-ordinated, evidence-based oral health improvement programme across both community and clinical settings will be submitted to SPCC at October meeting in a separate proposal. The majority of the programme will be targeted to support “ those children “ residing in the most deprived areas within C&M localities. Regular meetings with Healthwatch need to re established however informal contacts are made on a regular basis in some areas. Commissioners continue to receive ongoing support from NHSE NW regional Dental Public Health team. Links are being made in Halton with the local authority public health team and commissioners have supported other local authority colleagues in discussions regarding primary care dentistry and challenges faced. Q3 Agree dates for regular Healthwatch meetings.

Q4 Agree date for combined LPN/Stakeholder meeting.

Committee Report

Cheshire and Merseyside ICB
Place Primary Care Meeting
Date: 19th October 2023

Date of meeting:	19 October 2023
Agenda Item No:	SPCC B23/10/14ii
Report title:	Proposal to establish a consistent, evidence based oral health improvement programme across Cheshire and Merseyside
Report Author & Contact Details:	Prof. Ian Ashworth Director of Population Health Ian.Ashworth@cheshireandmerseyside.nhs.uk Dr Yvonne Dailey Lead Consultant Dental Public Health, NHS England NW
Report approved by:	

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

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

Executive Summary and key points for discussion

To improve the oral health of the child population of Cheshire & Merseyside (C&M) by implementing a co-ordinated, evidence-based oral health improvement programme across both community and clinical settings. The majority of the programme will be targeted to support children residing in the most deprived areas within each C&M local authority.

Oral health is an important part of general health and wellbeing. A healthy mouth enables children to communicate, eat and enjoy a variety of foods, socialise and attend school as well as contributing to their self-esteem, confidence and readiness to learn.

Dental caries (tooth decay) is the leading cause of admission to hospital for children aged between 6 and 10 years. Extractions in hospital due to caries in children (0-19) cost the NHS £50.9 million in the financial year 2021-22. Dental decay is highly prevalent in C&M and the impact on both society and the individual is significant, causing pain, discomfort, sleepless nights, limitation in eating leading to poor nutrition, and time off school and work.

The 2019 National Dental Epidemiological Survey showed that, 5-year-old children living in the most deprived areas in the country (37%) were almost 3 times more likely to have experienced dental caries than children living in the least deprived areas (13%). Nearly 67, 000 (42%) of our 2-7 years old in Cheshire and Merseyside live in the 20% most deprived areas of the country. With 8 of our 9 places all worse than the England average for dental decay in 5-year-olds.

Poor oral health is one of the earliest indicators that families may be struggling to establish healthy diets and key hygiene behaviours. Dental extractions under general anaesthesia are also the most common reason for children aged five to nine to be admitted to hospital, with more than twice as many hospital admissions as the next most common reason of tonsillitis, this trend and associated costs is rising in C&M.

Given the significant demands on our dental services and the capacity challenges being faced, the ICB has an opportunity to enhance an upstream, evidence-based population health at scale programme across Cheshire and Merseyside. Increasing access to toothbrushing and pastes to targeted children most at risk of dental decay, and supported with a supervised toothbrushing scheme, at scale across the sub region.

This programme will directly contribute towards reducing the oral heath NHSCORE20PLU5 indicator for tackling under 10s tooth extractions in our 20% most deprived communities. It will also reduce demand for future dental and urgent services in forthcoming years and contribute to our Joint Forward Plan and strategic All Together Fairer aim of giving every child the best start in life.

Recommendation/ Action needed:	▪ Agree to the proposal to support the establishment of a consistent, evidence based oral health improvement programme across Cheshire and Merseyside. ▪ Agree to the funding envelope for the programme from the primary care dental underspend.

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	
4. Helping the NHS to support broader social and economic development	

C&M ICB Priority report aligns with:	
Please insert **'x'** as appropriate:	
1. Delivering today	X

C&M ICB Priority report aligns with:	
2. Recovery	
3. Getting Upstream	X
4. Building systems for integration and collaboration	

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? (*please list*)					
What level of assurance does it provide?					
Limited		**Reasonable**		**Significant**	
Any other risks? 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*) No					
Any **Conflicts of Interest** associated with this paper? If **YES** please state what they are and any mitigations undertaken. No					
Any current services or roles that may be affected by issues as outlined within this paper? No					

Document Development	**Process Undertaken & Impact Considerations**	**Yes**	**No**	**N/A**	**Comments** (i.e. date, method, impact e.g. feedback used). ***Greater detail to be covered in main body of report***
	Financial – any resource impact?	X			Estimated costs of proposal included in the main body of the report
	Patient / Public Involvement / Engagement				
	Clinical Involvement / Engagement				
	Equality Impact Analysis (EIA) - any adverse impacts identified? EIA undertaken?	x			The targeted nature of the programme is aimed to reduce overall inequalities of outcome and experience across C&M. However, there will be pockets of poor oral health within other areas of C&M. Through the course of the programme, it is intended to seek to share benefits across C&M systems .

	Regulatory or Legal - any impact assessed or advice needed?				
	Health Inequalities – any impact assessed?	X			In addition, the dominant preventive approach in dentistry, i.e. narrowly focusing on changing the behaviours of high-risk individuals, has failed to effectively reduce oral health inequalities, and may indeed have increased the oral health equity gap. This programme aims to reduce oral health inequalities, by supporting the delivery of tailored behaviour change advice directly to individuals, but also by providing supportive environments to ensure that every child's caregiver has the opportunity and essential resources to carry out those behaviours. This work will also directly work towards the health care inequality NHSCORE20PLUS5 indicator to address the backlog of tooth extractions in hospital for under 10s.
	Sustainable Development – any impact assessed?				

Next Steps:	

Responsible Officer to take forward actions:	

Appendices:	

1. Executive Summary

1.1. To improve the oral health of the child population of Cheshire & Merseyside (C&M) by implementing an evidence-based oral health improvement programme across both community and clinical settings. The majority of the programme will be targeted to support children residing in the most deprived areas within each C&M locality.

1.2. Oral health is an important part of general health and wellbeing. A healthy mouth enables children to communicate, eat and enjoy a variety of foods, socialise and attend school as well as contributing to their self-esteem, confidence and readiness to learn.

1.3. Dental caries (tooth decay) is the leading cause of admission to hospital for children aged between 6 and 10 years. Extractions in hospital due to caries in children (0-19) cost the NHS £50.9 million in the financial year 2021-22. Dental decay is highly prevalent in C&M and the impacts on both society and the individual are significant, causing pain, discomfort, sleepless nights, limitation in eating leading to poor nutrition, and time off school and work.

1.4. The 2019 National Dental Epidemiological Survey showed that, 5-year-old children living in the most deprived areas in the country (37%) were almost 3 times more likely to have experienced dental caries than children living in the least deprived areas (13%). Nearly 67, 000 (42%) of our 2-7 years old in Cheshire and Merseyside live in the 20% most deprived areas of the country. With 8 of our 9 places all worse than the England average for dental decay in 5-year-olds.

1.5. Poor oral health is one of the earliest indicators that families may be struggling to establish healthy diets and key hygiene behaviours. Dental extractions under general anaesthesia are also the most common reason for children aged five to nine to be admitted to hospital, with more than twice as many hospital admissions as the next most common reason of tonsillitis, this trend and associated costs is rising in C&M.

1.6. Given the significant demands on our dental services and the capacity challenges being faced, the ICB has an opportunity to enhance an upstream, evidence-based population health at scale programme in Cheshire and Merseyside. Increasing access to toothbrushing and pastes to children most at risk of dental decay, and supported with a supervised toothbrushing scheme, at scale across the sub region.

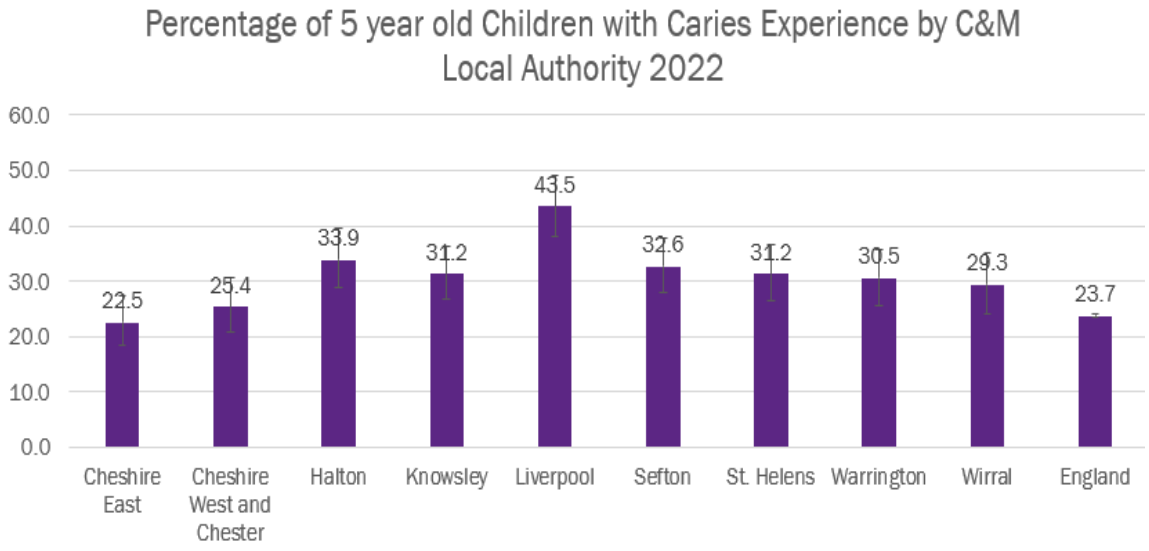
1.7. This programme will directly contribute towards reducing the oral heath NHSCORE20PLU5 indicator for tackling under 10s tooth extractions in our 20% most deprived communities. It will also reduce demand for future dental and urgent services in forthcoming years and contribute to our Joint Forward Plan and All Together Fairer aim of giving every child the best start in life.

2. Introduction / Background

2.1. Oral health is an important part of general health and wellbeing. A healthy mouth enables children to communicate, eat and enjoy a variety of foods, socialise and attend school as well as contributing to their self-esteem, confidence and readiness to learn.

2.2. Dental decay is highly prevalent in C&M and the impacts on both society and the individual are significant, causing pain, discomfort, sleepless nights, limitation in eating leading to poor nutrition, and time off school and work. Poor oral health is one of the earliest indicators that families may be struggling to establish healthy diets and key hygiene behaviours. This can be viewed in Figure 1 (NDEP Survey) with 8 of our 9 local authority areas all worse than England average.

Figure 1: Percentage of 5-year-old children with Dental Caries in C&M



2.3. Dental extractions under general anaesthesia (GA) are the most common reason for children aged five to nine to be admitted to hospital, with more than twice as many hospital admissions as the next most common reason of tonsillitis. Extractions in hospital due to caries in children (0-19) cost the NHS £50.9 million [1]in the financial year 2021-22.

2.4. Across England the rate of hospital admission for dental GA in children (0-19) living in the most deprived areas is three[2] times that of the least deprived (PHE 2020).

[1] Hospital tooth extractions in 0 to 19 year olds 2022 - GOV.UK (www.gov.uk)

[2] Inequalities in oral health in England (publishing.service.gov.uk)

2.5. The ICB faces significant challenges in increasing the access to dental services across all 9 of our local authorities. This paper provides an opportunity to develop a prevention at scale programme, to help reduce the rising future demand on services and reduce the significant costs associated with dental decay and the opportunity resource costs forgone, given it is the most common reason for 5–9-year-olds to be admitted to hospital.

3. Report

3.1. As a result of the transfer of Dental Public Health Functions from PCTs to Local Authorities as part of the Health and Social Care Act (2012), Local Authorities have a statutory responsibility (SI 2012/3094) to monitor the oral health of their populations and secure the provision of oral health promotion programmes in accordance with local need.

3.2. Whilst there are elements of evidence-based oral health promotion initiatives across C&M, they are not being delivered on an ‘industrial scale’. The variation in approach across C&M to oral health improvement has shown variation in outcomes. A structured intervention supported by dental public health specialist advice and leadership, providing co-ordinated opportunities at scale across CM localities shall reduce these inequalities. The key to the effectiveness of the proposed interventions will be high population coverage and uptake, with sustained delivery over the long-term.

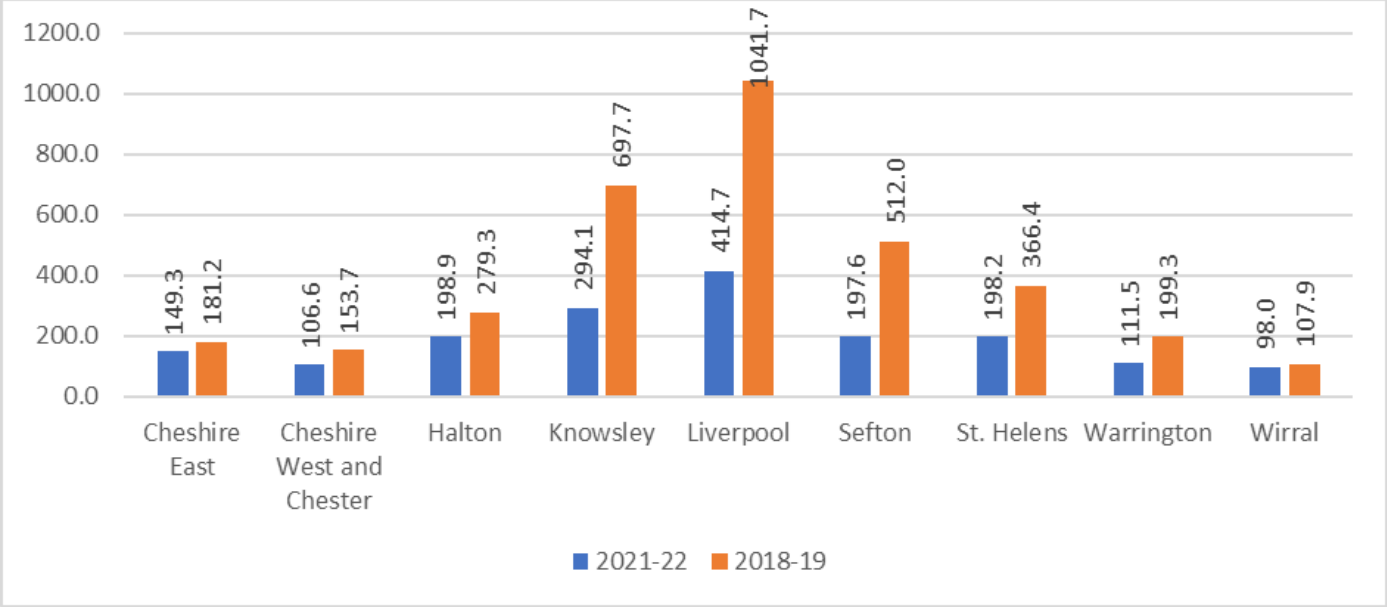
3.3. Our under 5 children are experiencing poor dental decay compared to England with significant variation across all 9 areas. This is leading to an increase in admission for extraction under GA due to poor oral health, which is preventable.

3.4. The ICB Population Health Intelliegnce team has conducted an initial review of SUS data that has been coded under teeth extraction (OPCS F09 &F10) which included the associated costs for 2–7-year-olds. The estimated cost of GA in C&M for children aged 2-7 was £400,000 in 2022/23 made up of 850 admissions (Appendix 1).

3.5. These figures do not include the additional cost of primary care appointments, referral or assessment at the specialist service centres. It is also an underestimate of the number of GA episodes, as the community dental service (CDS) provide dental extractions within hospital premises, and we are aware that episodes may not be included in hospital data recording (via hospital episode statistics (HES) data). This initial cost analysis also does not include the costs of treatment episodes for children up to 10 years, where poor baby teeth can last until the age of 10 and therefore cause further health implications.

3.6. The COVID-19 pandemic also had a significant impact on the delivery of oral healthcare services, particularly for children. The closure of dental services and the suspension of routine check-ups and treatments have resulted in significant barriers to accessing treatment in both primary and secondary care, resulting in fewer episodes of GA when comparing 2018/19 with 2021/22 (Figure 2).

Figure 2: Rate of Finished Consultant Episodes, where a tooth extraction was performed on a child aged 10 years and under, due to tooth decay, per 100,000 resident population, by LA.



3.7. Extraction represents a relatively extreme treatment, typically following long term pain and sepsis, with multiple prescriptions for antibiotics and associated implications for antimicrobial resistance. Sadly, it is not uncommon for families and children to undergo repeated episodes of hospital extractions as a result of further dental decay caused by continued exposure to high sugar diets and lack of regular tooth brushing and exposure to fluoride from a young age.

3.8. Oral Health and Dental Healthcare inequalities exist in Cheshire and Merseyside. The 2019 5 year old National Dental Epidemiological Survey (NDEP) showed that 34% living in the 10% most deprived areas of the country and 14% living in the 10% least deprived areas had experienced dental caries. Deprivation explained 38% of the variation in prevalence of dental caries and 42% of the variation in severity of dental caries.

3.9. The NDEP showed 5-year-old children living in the most deprived areas in the country (37%) were almost 3 times more likely to have experienced dental caries than children living in the least deprived areas (13%).

3.10. This is reflected previously in Figure 1, with 8 of our 9 areas all having worse dental outcomes in 5-year-olds compared to England average (with Cheshire East having a similar proportion to England). However, this can also mask significant variation between each of our 9 places and inequalities that exist within each area. As Table 1 describes, approximately 67,000 of our 2–7-year-olds are living in the most 20% deprived communities.

Table 1: Number of Children aged 2-7 years by Sub ICB Place, Cheshire and Merseyside

Area	Number of 2-7 year olds	Number in 20% Most Deprived	%
Halton	8,213	4,603	56.0%
Knowsley	12,214	8,365	68.5%
South Sefton	9,898	5,145	52.0%
Southport and Formby	6,268	822	13.1%
St Helens	12,205	6,176	50.6%
Warrington	13,456	2,939	21.8%
Wirral	20,107	8,853	44.0%
Cheshire	40,514	6,018	14.9%
Liverpool	35,096	24,007	68.4%
	157,971	**66,928**	**42.4%**

3.11. In 2014, both NICE and PHE published key documents, which upon reviewing the evidence of effectiveness of oral health improvement programmes, both recommended the commissioning of targeted supervised tooth brushing programs in early years settings. It also produced a return on investment tool to help inform resource allocation and priorities for cost effective intervention (PHE, 2016)[3].

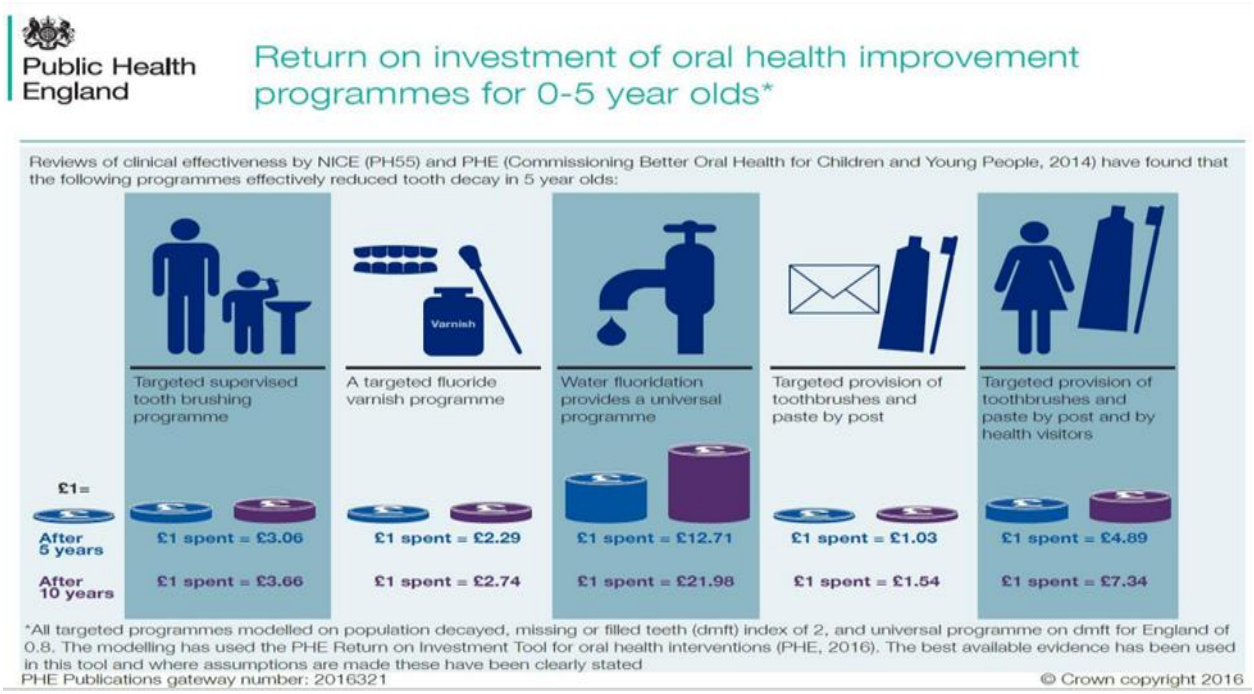
[3] PHE Child Oral Health Improvement Board. (2016). Return on investment of oral health improvement programmes for 0-5 year olds *. Retrieved from https://www.gov.uk/government/publications/improving-the-oral-health-of-children-cost-effective-commissioning

3.12. The three targeted oral health interventions which have the strongest evidence base, feasibility of implementation and show the greatest financial return on investment are:

- Daily supervised brushing programmes in all nursery and reception classes
- Distribution of free toothbrush and toothpaste packs
- Fluoride varnish application at least twice yearly for every child

3.13. After Water Fluoridation, supervised brushing in early years settings shows the strongest return on investment of the targeted programmes, for every £1 spent there is £3.06 after 5 years, rising further after 10 years. The targeted distribution of free toothbrush and toothpaste packs also shows the second strongest return on investment of the targeted programmes in the PHE Return on Investment Tool (PHE, 2016). As described in Figure 3.

Figure 3: Return on Investment of Oral Health Improvement programmes.



3.14. Evidence from the "Childsmile" national supervised tooth brushing programme in Scotland has shown that coverage of at least 50% of all early-years settings is required to see substantial improvements in population level oral health indicators (Macpherson et al., 2013)[4].

[4] Macpherson, L. M. D., Anopa, Y., Conway, D. I., & MC&Mahon, a D. (2013). National supervised toothbrushing program and dental decay in Scotland. *Journal of Dental Research*, *92*(2), 109–13. http://doi.org/10.1177/0022034512470690

3.15. Since the introduction of a national supervised tooth brushing programme in Scotland, the severity of tooth decay in five-year-old children (dmft) has reduced by 32% (Macpherson et al., 2013).

3.16. Targeted distribution of toothbrush and toothpaste through health visitors and other contacts prompts early commencement of brushing and ensures that all families have the essential resources to carry out effective home care.

3.17. The proposal outlined in this paper, is based on this described evidence base and we are seeking to introduce an at scale targeted supervised tooth brushing programme and a targeted provision of free toothbrushing and pastes to 2-7 year olds in the 20% most deprived communities for each of our localities.

3.18. The proposal will create a co-ordinated response, targeted towards increasing coverage and uptake of those interventions which have the strongest evidence base for effectiveness, feasibility and return on investment. Further it will provide the necessary funding and clinical expertise for monitoring of children's oral health, across all localities within C&M.

3.19. The aim of this proposal is to support the establishment of a consistent, evidence based oral health improvement programme across Cheshire and Merseyside, – to deliver "what we know works", at scale. The proposed interventions of supervised brushing in early years settings and reception classes, distribution of free-toothbrush and toothpaste packs through health visitors, and increasing the application of fluoride varnish in dental practices have the strongest evidence base, highest return on investment, and highest feasibility of implementation.

3.20. Through this proposal, we would want to work as an integrated care system with each of our 9 local places identifying those local settings which would increase uptake and access to our most deprived communities by building on established effective community led interventions around foodbanks, social prescribing, family hubs, holiday activity programmes and community centres etc. Working with our Place Directors and Local Authority colleagues to ensure effective role out with their existing relationships with Early Years services and primary school settings will be essential.

3.21. Where existing local oral health improvement programmes are known to be in place, we would seek local places to lead on enhancing their existing offers to those targeted children and families.

3.22. **Alignment to ICB strategies**

3.22.1. The proposal contributes directly to the dental recovery strategy in reducing demand and need and the ICB strategic objectives, outlined in the Joint Forward Plan which includes improving population health outcomes, tackling health inequalities and contributing to the ICB/ HCP shared strategic ambitions around All together Fairer and creating the best start in life for our children.

3.23. **Finance and costs**

3.23.1. It is assumed that the proposal, using primary care dental underspend will fund the first 3 years of delivery with an indicative cost of £600k per year.

3.23.2. The key fiscal savings are reduced secondary dental care (extractions under general anaesthetic) and reduced primary dental care (fillings), reductions in demand for treatment are highly cashable by the commissioners.

4. Programme Proposal Overview and Indicative Costs

4.1. Based on a similar model and costings in Greater Manchester ICS (2-5 year cohort and had approx. 66,264 children across their 4 targeted localities) , the following costs and resources have been identified in Table 2 (but will be subject more recent inflationary cost rises).

Table 2: Indicative Annual Resource Costs for Targeted Supervised Toothbrushing and Targeted Access Programme for 2–7-year-olds across Cheshire and Merseyside.

Cost category	Predicted annual costs (£)	Predicted costs notes/ assumptions
Programme Coordinator	£50,000	1 WTE Agenda for Change Band 7, as taken from PSSRU, including on-costs
Oral Health Project Officers	£70,000	2 WTE Agenda for Change Band 5, taken from PSSRU, including on-costs
Administration Officers	£45,420	2 WTE Agenda for Change Band 3, as taken from PSSRU, including on-costs
Oral Health Improvement Officers	£	Potential requirement for these
Travel expenses	£2,000	£250 per year per staff member
Nursery toothpaste	£56,403	4 x 100ml tubes per child per year @ £1 each
Nursery tooth brushes	£56,403	4 brushes per child per year @ £1 each
Nursery brush buses (storage)	£84,000	10 buses per setting (600) @£14 each
Take home packs	£70,000	3 per year per child @£1.25 each
Cleaning charts and audit paper work	£1,000	

Programme protocol in hard and electronic format	£6,000	one per setting (600) @£10
Parent/Guardian information booklet	£9,503	1 per child @20p each - 0.5 per child replacement stock years 2 and 3
Consent forms	£3,801	1 per child @8p each - 0.5 per child replacement stock years 2 and 3
Training Preschool Nursery teams	£12,000	4 launch call to action conferences @£3000 in year 1. Smaller training sessions thereafter
Training Health Visitors	£12,000	4 HV team conferences @£3000 in year 1. 2 conferences in following years
Brushing for life packs (12 month check)	£12,500	10000 packs per year @£1.25
Brushing for life packs (24-30 month check)	£12,500	10000 packs per year @£1.25
Sub Total	**£503,530**	

4.2. **What will the Resources Fund?**

4.2.1. Co-ordinated programme of work, to include the provision of:

- Interventions delivered by the early years workforce.
- Daily supervised tooth brushing programme in all early years and reception class in primary school settings. Support will include training, protocols, equipment, and supplies, including take-home toothbrush and paste packs for school holidays.

Resource allocation will cover the following for this scheme:

- Toothpaste
- Tooth brushes
- Brush buses (storage)
- Take home packs
- Cleaning charts and audit paper work
- Programme protocol in hard and electronic format
- Parent/guardian information booklet
- Training preschool nursery teams

- Integrated oral health and healthy infant feeding advice, plus distribution of 1,450ppm fluoride toothpaste and toothbrush packs by health visitors. Support will include training and supplies to distribute at 9 month and 2-year reviews.

Resource allocation will cover the following for this scheme:

- Training health visitors
- Brushing for life packs for 2 year check

- Brushing for life packs for 9 month check

4.2.2. Programme Co-oordination: The fund will cover the costs of personnal to co-ordiante the programme, it is proposed to work through the ICS Beyond Group given their established children and young people partnership. The programme coordinator working with the oral health leads from each of the localities to ensure implementation plans are in place for the delivery of the evidence based interventions.

- In the start-up phase the programme team will work through the commissioning process to ensure that when commissioning the oral health project officers work will be done with localities and providers (which may be the locality)
- The programme team will resource the products.
- The programme team will review the contracts that are currently in place in some localities on the provision of toothbrush/paste packs to ensure there is no duplication and ensure the commissioning of the resources is fit for purpose and seamless.
- In addition, the supervised toothbrushing in early years settings will require consent for children's engagement in the supervised toothbrushing programme. We can review an 'opt out' option but will seek legal advice on this approach and review with GM their current model for lessons learnt and implementation.
- A target consent rate will need to be set (GM was 95% and achieved 97%,
- The oral health programme may bring to light safeguarding concerns and the processes for safeguarding will need to be implemented /followed.

4.2.3. In order to monitor the impact and inform the targeted approach of the oral health improvement programme it is proposed an additional £100k is allocated to fund the NEDP Oral Health survey for 5-year-olds in 2025/26.

4.2.4. Base line data is available from localities (8/9) who have already funded the 23/23 NDEP oral heath survey of five year olds. It is recommended that the full impact of this programme is evaluated by funding the NEDP, Oral Health Survey of Five-year-olds (2025/2026), when all children will have had the opportunity to receive the full schedule of interventions. Individual localities will then be able to consider commissioning enhanced samples to increase the precision of their survey estimates and measure the impact of oral health in their communities.

4.2.5. If approval in principle for this programme is granted, a supporting, proactive public facing oral health campaign would be required to help promote oral health improvement to our targeted at the communities to assist in embedding the programme and increasing positive oral health behaviour change. The costing for this would need further scoping but indicatively would be an additional £100k.

4.2.6. In order to introduce a targeted 3 year supervised toothbrushing programme and targeted distribution of brushes and pastes to 2-7 year olds in 20% most deprived communities, resource allocation will need to be in the region of £1.8m.

4.2.7. If approval in principle is granted for this programme, further detailed cost analysis with our finance and procurement leads will be undertaken.

4.3. **Expected outcomes**

4.3.1. It is expected that this programme will result in:

- Reductions in the proportion (%) of children affected by tooth decay and narrowing of oral health inequalities across C&M. This will in turn lead to improved quality of life due to reduced incidence of pain, fewer sleepless nights, missed school days and days off work for parents.
- Treatment costs in primary and secondary dental care will be reduced, with fewer episodes of general anaesthetic required. This will also contribute to reducing the C&M-wide pressures on paediatric general anaesthetic sessions as dental extractions are the most common reason for hospital admissions in primary school children.
- There are potential wider benefits of the programme – e.g. reduced obesity and school readiness.

Outcomes	Measures
To improve quality of life and readiness to learn amongst CM 2-7 year olds in most deprived communities.	Change in oral health related quality of life (QofL) scores.
Narrowing of oral health inequalities across C&M.	Severity of tooth decay at age 5 (dmft) by deprivation quintile across C&M.
To reduce the prevalence and severity of tooth decay in young children	Proportion of C&M 5 year olds with tooth decay (%) and severity (dmft).

Fewer general anaesthetics required due to extensive tooth decay.	New referrals for extraction of decayed teeth as (%) of population. Admissions for extraction of decayed teeth as proportion (%)of child population.
Reduced treatment costs within dental services.	Proportion (%) of dental courses of dental treatment provided to children that include fillings or extractions.

4.4. Enabling functions to maximise success

4.4.1. Critical success factors are as follows:

- Ownership, sustainability and resilience of delivery of the interventions by localities.
- Support from Finance and Procurement to assure cost effective resource allocation and procurement (e.g. following associated sustainability guidance [5])
- Buy-in from key partners Local Authorities, Health Visiting, early years settings and schools.
- Interventions need to be delivered across a large percentage of the whole population of that age group.

4.4.2. The interventions rely on buy-in from services and a wide population reach (of that age group). This will be a challenge in itself with the number of settings and schools and diversity in each locality - the communication plan and implementation will need to be robust to address this. Delivery and storage of toothbrush/paste packs for HV and early years settings/schools will be a challenge to delivery but this is well known from the programme that runs in Greater Manchester.

4.4.3. In addition to the targeted interventions, all localities are encouraged to consider universal measures to reduce population sugar intake. Examples include planning restrictions on take aways, ice-cream vans and sweet shops close to schools, and establishing healthy food and drinks policies in all childhood settings. This can build on the promotion of the Cheshire and Merseyside's existing work with Food Active and Give Up Loving Pop campaigns and interventions being led through Local Authority Healthy Weight Declarations

4.4.4. Training in oral health messages to support the delivery of tailored infant feeding and tooth brushing advice is recommended as part of the core offer for all health and social care staff in contact with children and families.

[5] Sustainable Dentistry: How-to Guide for Dental Practices | Centre for Sustainable Healthcare

5. Recommendations

The Committee is asked to:

- Agree to the proposal to support the establishment of a consistent, evidence based oral health improvement programme across Cheshire and Merseyside.
- Agree to the proposed funding envelope for the programme from the primary care dental underspend.

6. Officer contact details for more information

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Appendix 1: Estimated Teeth Extraction costs for 2-7 year olds across Cheshire and Merseyside between 2018 and 2023. (SUS Data source, using PCS F09 & F10 produced 10/10/2023)

Z_SPELL_AGE	(Multiple Items)											
	Column Labels											
	2018/19		2019/20		2020/21		2021/22		2022/23			
Row Labels	Sum of Z_ADJUSTED	Sum of Admissions	Sum of Z_ADJUSTED	Sum of Admissions	Sum of Z_ADJUSTED	Sum of Admissions	Sum of Z_ADJUSTED	Sum of Admissions	Sum of Z_ADJUSTED	Sum of Admissions		
Cheshire	£ 53,268.540	91	£ 76,770.760	128	£ 32,726.280	73	£ 66,466.400	115	£ 92,368.220	181		
Halton	£ 14,485.590	21	£ 8,772.980	15	£ 8,650.330	24	£ 16,047.120	20	£ 17,123.380	21		
Knowsley	£ 47,077.970	119	£ 45,364.980	100	£ 14,937.300	47	£ 37,569.750	62	£ 34,571.220	63		
Liverpool	£ 98,522.010	480	£ 89,630.020	469	£ 37,717.270	189	£ 71,091.760	196	£ 88,965.070	243		
South Sefton	£ 41,426.970	92	£ 40,595.420	80	£ 11,698.330	37	£ 23,888.800	41	£ 24,298.570	38		
Southport and Form	£ 16,301.650	29	£ 9,849.730	14	£ 4,318.860	13	£ 7,397.070	11	£ 18,077.070	24		
St Helens	£ 36,149.420	68	£ 24,558.120	40	£ 8,050.840	32	£ 23,611.120	37	£ 27,216.870	42		
Warrington	£ 16,212.500	28	£ 13,918.590	24	£ 7,537.480	21	£ 14,900.570	22	£ 19,263.650	29		
Wirral	£ 12,686.830	20	£ 12,060.280	19	£ 10,945.190	28	£ 62,594.770	143	£ 77,612.310	209		
Grand Total	£ 336,131.48	948	£ 321,520.88	889	£ 136,581.88	464	£ 323,567.36	647	£ 399,496.36	850		

NHS Cheshire and Merseyside System Primary Care Committee

Date: 19th October 2023

The national community pharmacy independent prescribing (CPIP) pathfinder programme

Agenda Item No	SPCC B23/10/15
Report author & contact details	Pam Soo (Pam.Soo@nhs.net) Susanne Lynch (susanne.lynch@southseftonccg.nhs.uk)
Report approved by (sponsoring Director)	Clare Watson
Responsible Officer to take actions forward	*Pam Soo*

Executive Summary	The aim of the national 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. 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: • Improved patient access to healthcare across the system • Ensuring community pharmacists are working to their full potential • Supporting General Practice • Enabling better Integrated Care System (ICS)/Integrated Care Board (ICB)1 service delivery planning • 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. The pathfinder programme is being established to test and develop models of using Community Pharmacy prescribers to meet the needs of patients and to be integrated in to existing primary care systems and service provision. Cheshire and Merseyside has worked closely with regional colleagues and has submitted an EOI in line with those submitted from Lancashire and South Cumbria ICB and Greater Manchester Care Partnership. The national process for EOI closed on 28th Feb 2023. The moderation process has now completed with the EOI submissions going to national panel for an outcome regarding successful EOIs and funding allocations. Cheshire and Merseyside being successful in being allocated £479,052 for project management and clinical support to deliver a commissioned pathfinder site in 7 pharmacies in the ICB footprint. Each pathfinder site has been finances for set up and up to six (4 hour) clinical sessions a week for 39 weeks. Total £48,268.84 per live site.

Purpose (x)	**For information / note**	**For decision / approval**	**For assurance**	**For ratification**	**For endorsement**
		x			

Recommendation	The Committee is asked to: •

	• Approve Cheshire and Merseyside ICB support for involvement in this programme. • Support further development of this programme in line with the EOI proposal • Note the National Allocation of funding for this programme for Cheshire and Merseyside. • Approve development of this programme and commissioning of up to 7 CPIP pathfinder sites in Cheshire and Merseyside in line with the National Funding provided • Support development of the programme design including local clinical pathways, integration of the CPIP pathfinder sites in to local quality and assurance frameworks and local patient pathways at PCN, Place and ICB level.
Key issues	Development of a NHS community pharmacy clinical services incorporating independent prescribing for patients in primary care would be consummate with the four ICS Strategic Objectives
Key risks	Not delivering a pathfinder site in Cheshire and Merseyside would mean loss of opportunity to shape the next steps nationally for CP IP Programmes and would delay possible implementation and testing of services that would be beneficial to patients and could support access to services.

Impact (x) (further detail to be provided in body of paper)	**Financial**	**IM &T**	**Workforce**	**Estate**
	X	X	X	X
	Legal	**Health Inequalities**	**EDI**	**Sustainability**
	X	X	X	X

Route to this meeting	Verbal presentation of this programme was given to System primary care Committee by Pam Soo on 2nd March 2023. EOI process and national processes have been followed as directed nationally to ensure Cheshire and Merseyside ICB have opportunity to engage on this programme as it develops subject to committee approval to proceed.
Management of Conflicts of Interest	Conflicts of Interest (COI) to be declared at every meeting. The Community Pharmacy Integration Lead Pharmacist has led on this piece of work with support/input from the Chief Pharmacist who has a declared COI in relation to the commissioning of services from community pharmacy (husband is a pharmacy contractor in C&M)
Patient and Public Engagement	Engagement to date has been via both the Cheshire and Merseyside LPNs. Engagement with the Directors of Place occurred at the ICB Executive Committee and with place Heads of Medicines Management and Prescribing Leads (where appropriate)
Equality, Diversity and Inclusion	 CM%20ICB%20QIA%20Template%20-%20C  EIA%20CP%20Pharmacy%20independent% DPIA to be completed (if appropriate) based on commissioning of National and Local resources (to be agreed).

Health inequalities	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 better Integrated Capitalising on these benefits and ensuring that the Pathfiner 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. 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. 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. 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.

Next Steps	Further detailed work up of the service model is required to inform an accurate description and design for the service in Cheshire and Merseyside including implementation and service design development within the envelope of funding allocated by the national Programme. This will be supported by Programme support who will be commissioned Regionally to support this programme , funded via the national allocations allocated to each of the three North West ICBs. Engagement with Place has begun to look at proposed sites identified subsequent to tier 1 and tier 2 of a local EOI for community pharmacy having been undertaken with respect to a quality and assurance process for prospective sites.

	An ICB Stakeholder group will be formed which I turn will support place Operational groups to support this programme. Mapping and development of IT provision is ongoing. Mapping and development of both Clinical and Quality pathways and support for this programme is ongoing.
Appendices	Appendix 1 – Programme fund allocation request and breakdown submitted with EOI

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. If selected we will commission PIP sessions from pharmacy contractors allowing them to offer a flexible hybrid solution, stratified to the local needs via three key care components.

2.2.1. 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).

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

2.3.1. This would focus on either:

2.3.1.1. 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.

2.3.1.2. 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.

2.4. Following successful delivery of the primary and secondary components, as a step-wise enhancement, contractors could further expand sessions to a tertiary offer for all three clinical areas above or add another service, based on competencies and need, - e.g. linked to prescribing within the forthcoming NHS Pharmacy Contraceptive Service.

3. Main Body of report

3.1. In conjunction with the Cheshire and Merseyside LPCs we have mapped current Independent prescriber resource employed in Community Pharmacies in Cheshire and Merseyside. The EOI that was submitted as part of the national process suggested we could 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 is equivalent to 7 pathfinder sites across Cheshire and Merseyside

3.2. 148 responses were received from a PharmOutcomes CPIP survey;

3.2.1. 23 CPs employ pharmacists who have a prescribing qualification,

3.2.2. 10 have pharmacists who are currently in training and
3.2.3. 10 have pharmacists who are about the begin training
3.2.4. (these responses represent 37 unique pharmacies).

3.3. We are engaging with the multiples who also have declared that they have CPIPs employed in Cheshire and Merseyside and we are currently mapping this resource.

3.4. PIP will 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 will ensure this programme complies 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):

3.4.1. Items which should not routinely be prescribed in primary care items-which-should-not-routinely-be-prescribed-in-primary-care-v2.1.pdf (england.nhs.uk)

3.4.2. British National Formulary (BNF)

3.4.3. Summary of Product Characteristics (SPC)

3.4.4. Area Prescribing Guidance

3.4.5. 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 will 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 has been selected as we understood from a local survey that this was an area where a number of Community Pharmacy IPs had a specialism and that we know a range of respiratory review services are delivered across Cheshire and Merseyside currently and are 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 has been 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 areas will contribute to the Recovery and Access agenda.

3.11. Working on the basis of 15 minute consultations for minor ailments and 20 minute consultations for Respiratory or Antidepressant Therapy Review we estimate that the service could offer between 420 – 700 consultations a week for the primary service and 150 – 420 sessions a week for the secondary service. That is 7 x contractors undertaking 16-25 hours a week for the primary offer and 7 x undertaking 10-20 hours a week for the secondary offer. An allowance would be 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. Our proposed pathfinder service model is based on a combination of both referrals and a walk-in service to maximise PIP sessional utilisation. This will be done in a controlled manner that gives priority to primary care and urgent care referrals. We will explore the use of patient self-booking and the NHS bookings and referral service (BARS).

3.13. The service model is based on face to face however the option of remote access can be considered. Remote access would be via NHS approved care processes with the PIP situated at the pharmacy premises. As NHS Virtual Wards develop we may explore how home / offsite PIP visits could be developed within the scope of the initial pathfinder. Arrangements for remote consultations will include recall if a face-to-face assessment is required.

3.14. Effective working partnership working between pharmacists and general practice/PCNs is the 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 groups, and PIP participation in PCN meetings and other relevant forums.

3.15. The following will be incorporated into the service model;

3.15.1. Our service models will be based on the best use of clinical systems and to help PIPs fully consider existing patient medication.

3.15.2. Utilise a digital pathway for communication between PIPs and general practices regarding the care provided, including integration of care provision into practice medical record systems.

3.15.3. 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.

3.15.4. Governance pathways will be established through the ICB with oversight of this programme by the ICB NMP group.

3.15.5. Programme development will have ICB clinical support via a set up of a programme steering group whilst we establish this programme and ongoing to ensure clinical governance

3.16. Processes will be established to ensure there is sufficient the clinical governance oversight, supporting quality improvement risk and incident management.

3.17. Development of and implementation of comprehensive clinical governance policies and procedures to ensure that the service model operates in a safe, effective, and appropriate manner. These policies will cover the management of risks and incidents within the service model and the development of mitigation strategies to address identified risks. This would involve incorporation of the PIPs and CPIPs into existing governance and oversight processes and policies regarding management of NMPs in the ICB:

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

3.17.2. Implementation of a robust incident reporting and management system to ensure that incidents are reported, investigated, and acted upon in a timely manner. This will include 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.

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

3.17.4. Full consideration of 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.

3.17.5. Some specific areas include conflicts if a PIP had a financial incentive for prescribing particular brands or formulations such as discounts or rebates from a pharmaceutical company. This conflict may influence the

3.17.6. Decision-making of the PIP, leading to the preference of certain medications or treatments over others.

3.17.7. PIPs will have 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.

3.17.8. Working with the Place Clinical Leads 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

3.18. The ICB will ensure 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 will monitor prescribing patters and formulary compliance.

3.19. Regional experience of clinical oversight with dispensing doctors to regularly review individual prescribing and item volumes against local formularies and comparisons with other contractors mitigates against on site dispensing influencing service outputs.

3.20. In collaboration with other pathfinder ICBs, development of clear ethical and clinical guidelines so that PIPs demonstrate that their professional judgement is not compromised and that all dispensing arrangements are transparent in relation to ensuring;

3.20.1. There is no prescription direction or restricting a person's choice of dispenser.

3.20.2. Any prescribing errors detected at dispensing are reported through an agreed ICB process in line with other IPs

3.21. Contractors s and CPIPs will undertake an assurance process in line with the current ICB NMP processes before they are registered as a pathfinder site or as a CPIP practicing within the ICB. This will cover:

3.21.1. Site appropriateness and readiness

3.21.2. Processes and policies to support CPIPs and the process of prescribing

3.21.3. Risk assessment specific to service

3.21.4. Risk assessment specific to prescribing and dispensing on same site

3.21.5. CPIP professional assurance and documentation re training and current competence

3.21.6. CPIP areas of clinical competence

3.22. A second Pharmacist should be involved in carrying out the final accuracy check and the check for clinical appropriateness. We will ensure that the PIP declares they will ensure there are robust procedures and arrangements in place for this and weigh up the risks of supplying against not supplying. Patients should always be given the choice to take their prescription to another pharmacy for supply.

3.23. The PIP service model described in the EOI has been derived 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 either; respiratory disease or antidepressant therapy review. This ensures that the initiative delivers high-quality care that is inclusive and accessible to all sections of the local population.

3.24. Pathfinder sites will ensure that the initiative is inclusive and accessible to all sections of the local population, including marginalized and disadvantaged groups.

3.25. The pathfinder sites will work to meeting the recommendations of the Fuller Stocktake report, "Next steps in integrating primary care" by using PIPs to;

3.25.1. Streamline access to care and advice for people, where and when they need it.

3.25.2. Provide more proactive, personalised care.

3.25.3. Help people to stay well for longer as part of a more ambitious and joined-up approach to prevention.

3.25.4. Improve the health of children and young people.

3.25.5. Support people to stay well and independent, acting sooner to help those with preventable conditions.

3.25.6. Support those with long-term conditions and those with multiple needs as populations age get the best care as quickly as possible.

3.26. To do this within the PIP initiative it is planned;

3.26.1. Collaborate with local stakeholders, including general practices, PCNs, community organisations, and patient groups, to ensure that the initiative is tailored to meet the specific needs of the local population and to ensure that it is delivered in a way that is accessible and acceptable to patients.

3.26.2. Monitor and evaluate the progress of the initiative regularly to ensure that it is achieving its intended outcomes and to identify areas for improvement.

3.26.3. This evaluation could involve collecting data on patient outcomes, patient satisfaction, and health inequalities, and using this data to make informed decisions about the future direction of the initiative.

3.27. Work will be required to resolve the requirements of the digital agenda for this programme. Work will be undertaken with digital partners and regional colleagues to procure an IT platform that provides pharmacists with the details they need, such as patient histories, previous test results and care plans.

3.28. This system will also integrate with the NHS Electronic Prescription Service and ensure that pharmacist-prescribed medication is incorporated into medical records for safe and effective prescribing and collaboration among healthcare providers.

3.29. PIPs must have 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 are providing access for Pathfinder sites to GP Connect, Cleo and supporting Pharmacy System providers to provide referral system compliant with the Booking and referral standards.

3.30. IT resources such as decision support tools, drug information databases, and drug interaction checkers will be facilitated to support CPIPs to prescribe based on informed decisions, avoid errors, and provide the best possible care.

3.31. The key project management elements required in this initiative include:

3.31.1. Project planning to define project goals, objectives, scope, timeline, budget, and resources required to achieve the desired outcomes.

3.31.2. Stakeholder engagement to understand their needs and expectations to ensure the project is aligned with their interests.

3.31.3. 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 achieves its goals.

3.31.4. Quality assurance processes to ensure quality aspects are paramount and elements of clinical governance and guidance e.g. Infection Control policies are adhered to

3.31.5. Communications, ensuring regular and effective communication between project team members, stakeholders, and relevant parties.

3.31.6. Continuously monitoring progress, identifying issues, and making necessary adjustments to keep the project on track.

3.31.7. Evaluation and review to assessing the performance of the initiative and conducting regular evaluations to identify areas for improvement, and making necessary changes to ensure that future projects are even more successful.

3.32. The input of our PIPs in the planned evaluation process is crucial to develop the initiative further to review model delivery, key governance requirements and standards, the digital and clinical system functionality and considerations, assurance framework development and the core KPIs of the initiative.

3.33. The following steps would be taken to create a supportive environment for participants in the evaluation process;

3.33.1. 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.

3.33.2. 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.

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

3.33.4. 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.

3.34. 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

3.35. As a result of this analysis we have 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 – Minor Ailments and Respiratory
- Halton – Minor Ailments and Respiratory
- Sefton – Minor Ailments and Antidepressant Deprescribing

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

4. Engagement

4.1 Initial engagement has been 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 have been briefed at monthly MOP meetings to ensure that they are informed and can inform the programme development.

4.3 A meeting was held Thursday 12th October 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 toas having potential viable sites for development into pathfinder status.

4.4 It is proposed that identified programme leads from these Places along with other interested parties including internal ICB and external Stakeholders will form an ICB Steering Group to shape and develop this programme, to ensure key deliverables are optimised including patient pathways, quality and safety governance arrangements, clinical supervision and mentorship, IT arrangements, AMR agendas delivered, IP policies are delivered and support etc

4.5 Under this steering group each place may have arrangements in place to develop a local operational group with Key Place representation and Stakeholders local to Place. This will be 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 initial draft of the SLA will be requited to be shared with and consulted on with Cheshire and Merseyside ICBs. It is proposed that the initial SLA will detail the minor Ailments / Low Acuity Conditions service with further appendices for the Respiratory Service and De-Prescribing of Anti-Depressants being added as these services are developed and are launched.

5. Quality and Safety

5.1 Work has been 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 Pathfindersites.

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

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

5.4 This work will also support and underpin the nationally agreed and supported Evaluation process for this programme.

6. Digital

6.1 We have begun discussions with Kathy Fox and John Llewelyn to ensure that the National digital plans for this programme are visible to the ICB Digital leads. This also allows feedback to the National programme and where we can influence the arrangements or implement local digital plans to support.

6.2 The National Digital implementation plan includes provision of GP Connect to allow access to clinical information and Cleo to allow production of EPS prescriptions.

6.3 Pharmacy System providers are developing solutions for recording clinical sessions and supporting reporting of outcomes to GP Clinical Systems in an integrated manner

7. Finance

7.1 This programme is not requiring any financial input from the ICB in that all funding will be provided from the National Allocation.
The ICB will provide support to the programme via staff as part of their day-to-day roles and responsibilities and any additional programme or clinical support will be funded by the national allocation.

7.2 Nationally, an overall budget of up to £12m will be allocated to the Pathfinder programme. Funding will be 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 made available to ICBs will be available to pharmacies involved in delivery of the programme.

These sites will be 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 will be made available for medicines costs, which will continue to be attributed to ICBs and funded from existing allocations as usual.

7.3 Cheshire and Merseyside have been allocated finding equivalent to 7 sites. For context NHS Lancashire and South Cumbria ICB have been allocated 7 Sites and NHS Greater Manchester ICB 10 sites.

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

Pharmacy Allocation	7 pathfinder sites
ICB level funding (Paid to ICB)	
Project management	£30,571.20
Professional support	£3,250
Non-pharmacy evaluation (£426 per pharmacy site)	£2,982
Clinical IP support / mentorship (£1586 per pharmacy site)	£11,102
Pharmacy level funding (Paid to Pharmacy Contractor)	
Set-up Fee (Upon registration per site)	£1,500
Complex Service additional fee * (up to £493 per site)	£493
Clinical session fees** (4 hourly session, £197.76, capped at 6 sessions per week over a 39 week period)	£46,275.84

* The complex service additional funding is to support models that may require additional support and greater level of clinical mentorship or additional set up support. The criteria for this is still to be defined and whether paid to pharmacy contractor direct or pooled via ICB.

** 6 sessions a week is the maximum that sites can deliver. The pharmacies will claim services through NHSBSA via a local services route and recharged to the ICB. However, it is not confirmed at this stage if will be paid to ICB as a lump sum to cover pharmacy session fee costs or a reimbursement to ICBs based upon pharmacy claims.

7.5 The initial project management support has been paid over to ICBs already and

Finance have noted this allocation has been received.
This has been done to support ICBs to get started on the programme ASAP and by paying this key resource over in advance to support set up including training and advance arrangements.

7.6 It is intended that this funding will fully cover the costs associated with this programme.

7.7 Prescribing costs will be recharged to the ICB as agreed nationally.

7.8 It is anticipated that any prescribing undertaken in this programme will not be over an above prescribing that would happen under current arrangements and will seek to instead provide the same prescribing provision in an alternative location.

Recommendations

7.1. The Committee is asked to:

7.1.1. Approve Cheshire and Merseyside ICB support for involvement in this programme.

7.1.2. Support further development of this programme in line with the EOI proposal

7.1.3. Note the National Allocation of funding for this programme for Cheshire and Merseyside.

7.1.4. Approve development of this programme and commissioning of up to 7 CPIP pathfinder sites in Cheshire and Merseyside in line with the National Funding provided

7.1.5. Support development of the programme design including local clinical pathways, integration of the CPIP pathfinder sites in to local quality and assurance frameworks and local patient pathways at PCN, Place and ICB level.

8. Officer contact details for more information

Pamela Soo
Clinical Lead for Community Pharmacy Integration for Cheshire and Merseyside ICB

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e: Pam.Soo@nhs.net
w: www.england.nhs.uk
Regatta Place Summers Road Brunswick Business Park **Liverpool** Merseyside L3 4BL

Appendices

Appendix 1: National Comms

IP Funding Model August 2023 0.3 ICB

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_Indepen dent Prescribing in

Appendix 3: MOU

Cheshire and Merseyside ICB.docx

Appendix 4: SLA template

IP Pathfinder Programme – Supple

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.

Independent Prescribing Pathfinder Programme

Site Allocation and Funding

ICB Update 8th August 2023

Funding Model 2023-24

- Overall budget (£12m)

- ICB level (£1.84m)
  - Project management and support
  - Professional support for prescribers, intended to support peer networks, mentoring and clinical supervision
  - Additional funding for clinical support and evaluation available if needed
  - August payment cycle – first transfer

- Pathfinder Sites (£10.14m)
  - n = 210 Pathfinder Sites (range 2 to 12 per ICB)
  - PIP Sessional time (equivalent of 6 sessions per week) £198 per 4-hour session
  - Set up costs: Core set up £1,500 plus potential additional set up fee dependent on clinical model

- Digital
  - EPS Licences
  - Bespoke support for some service models if needed

Site Allocation

Modelling Considerations

- Pathfinder sites across every ICB
- Geography, Population and Population Density
- Clinical Models
- Regional Moderation
- RSPIL feedback

Region	ICB Name	Population estimate 2021	Population rank	Area to Mean High Water Excluding Area of Inland Water (Land Area)	Geographic size rank	population dens
East	Bedfordshire, Luton and Milton Keynes ICB	959,098	31	619.28	30	1,548.74
East	Cambridgeshire and Peterborough ICB	896,725	33	1,336.72	16	670.84
East	Hertfordshire and West Essex ICB	1,488,061	16	996.64	24	1,493.08
East	Mid and South Essex ICB	1,199,296	20	767.83	29	1,561.92
East	Norfolk and Waveney ICB	1,032,661	26	2,221.26	5	464.90
East	Suffolk and North East Essex ICB	987,177	28	1,580.65	8	624.54
London	North Central London ICB	1,526,582	14	90.28	42	16,910.34
London	North East London ICB	2,036,470	6	124.16	40	16,401.71
London	North West London ICB	2,111,469	5	143.21	37	14,743.57
London	South East London ICB	1,818,226	9	134.70	39	13,498.76
London	South West London ICB	1,509,741	15	114.63	41	13,170.84
Midlands	Birmingham and Solihull ICB	1,179,731	21	172.23	36	6,849.71
Midlands	Black Country ICB	1,380,809	18	137.81	38	10,019.89
Midlands	Coventry and Warwickshire ICB	963,173	30	800.67	28	1,202.95
Midlands	Derby and Derbyshire ICB	1,030,393	27	1,013.41	23	1,016.75
Midlands	Herefordshire and Worcestershire ICB	791,685	34	1,513.62	10	523.04
Midlands	Leicester, Leicestershire and Rutland ICB	1,107,597	24	979.95	25	1,130.26
Midlands	Lincolnshire ICB	766,333	36	2,292.36	4	334.30
Midlands	Northamptonshire ICB	740,111	38	912.75	26	810.86
Midlands	Nottingham and Nottinghamshire ICB	1,170,475	22	833.74	27	1,403.88
Midlands	Shropshire, Telford and Wrekin ICB	506,737	42	1,346.58	15	376.32
Midlands	Staffordshire and Stoke-on-Trent ICB	1,139,794	23	1,047.78	20	1,087.82
NEY	Humber and North Yorkshire ICB	1,708,723	12	4,110.52	2	415.69
NEY	North East and North Cumbria ICB	3,000,432	1	5,245.93	1	571.95
NEY	South Yorkshire ICB	1,415,054	17	599.05	32	2,362.17
NEY	West Yorkshire ICB	2,396,517	4	1,184.61	18	2,023.04
NW	Cheshire and Merseyside ICB	2,503,902	3	1,157.63	19	2,162.96
NW	Greater Manchester ICB	2,881,890	2	492.68	33	5,849.44
NW	Lancashire and South Cumbria ICB	1,701,655	13	1,917.24	7	887.55
SE	Buckinghamshire, Oxfordshire and Berkshire West ICB	1,723,447	10	1,931.88	6	892.11
SE	Frimley ICB	746,739	37	231.98	35	3,218.95
SE	Hampshire and Isle Of Wight ICB	1,831,473	8	1,554.91	9	1,177.86
SE	Kent And Medway ICB	1,868,199	7	1,443.17	12	1,294.51
SE	Surrey Heartlands ICB	1,052,425	25	613.18	31	1,716.33
SE	Sussex ICB	1,711,539	11	1,434.56	13	1,193.07
SW	Bath and North East Somerset, Swindon And Wiltshire ICB	929,964	32	1,490.86	11	623.78
SW	Bristol, North Somerset and South Gloucestershire ICB	969,256	29	378.56	34	2,560.38
SW	Cornwall and the Isles Of Scilly ICB	575,525	40	1,375.14	14	418.52
SW	Devon ICB	1,209,773	19	2,589.34	3	467.21
SW	Dorset ICB	776,780	35	1,024.21	21	758.42
SW	Gloucestershire ICB	640,650	39	1,024.15	22	625.55

East of England

NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board	4
NHS Cambridgeshire and Peterborough Integrated Care Board	5
NHS Hertfordshire and West Essex Integrated Care Board	5
NHS Mid and South Essex Integrated Care Board	4
NHS Norfolk and Waveney Integrated Care Board	3
NHS Suffolk and North East Essex Integrated Care Board	6

London

NHS North Central London Integrated Care Board	3
NHS North East London Integrated Care Board	6
NHS North West London Integrated Care Board	5
NHS South East London Integrated Care Board	5
NHS South West London Integrated Care Board	4

Midlands

NHS Birmingham and Solihull Integrated Care Board	4
NHS Black Country Integrated Care Board	4
NHS Coventry and Warwickshire Integrated Care Board	4
NHS Derby and Derbyshire Integrated Care Board	4
NHS Herefordshire and Worcestershire Integrated Care Board	3
NHS Leicester, Leicestershire and Rutland Integrated Care Board	4
NHS Lincolnshire Integrated Care Board	4
NHS Northamptonshire Integrated Care Board	4
NHS Nottingham and Nottinghamshire Integrated Care Board	4
NHS Shropshire, Telford and Wrekin Integrated Care Board	3
NHS Staffordshire and Stoke-on-Trent Integrated Care Board	5

North East and Yorkshire

NHS Humber and North Yorkshire Integrated Care Board	11
NHS North East and North Cumbria Integrated Care Board	10
NHS South Yorkshire Integrated Care Board	10
NHS West Yorkshire Integrated Care Board	10

North West

NHS Cheshire and Merseyside Integrated Care Board	7
NHS Greater Manchester Integrated Care Board	10
NHS Lancashire and South Cumbria Integrated Care Board	7

South East

NHS Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board	6
NHS Frimley Integrated Care Board	3
NHS Hampshire and Isle of Wight Integrated Care Board	6
NHS Kent and Medway Integrated Care Board	2
NHS Surrey Heartlands Integrated Care Board	2
NHS Sussex Integrated Care Board	2

South West

NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board	5
NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board	3
NHS Cornwall and the Isles of Scilly Integrated Care Board	4
NHS Devon Integrated Care Board	8
NHS Dorset Integrated Care Board	4
NHS Gloucestershire Integrated Care Board	3
NHS Somerset Integrated Care Board	4

Next Steps

(supported by Regional Senior Pharmacy Integration Leads)

- Letter to ICBs (going through PAC clearance)
- Support Documentation
  - FAQs
  - Service specification and SLA template
  - MOU between ICB and NHS England
- Detailed funding for each ICB
- ICBs
  - Agree to support the Pathfinder programme
  - Management support
  - Find, register (via BSA) Pathfinder sites
- Comms
  - Stakeholders informed
  - Webinars
  - Media enquiries – through national NHSE Press Office
- Formative Evaluation supported by MLCSU

To: ICB:

- Chief executives
- Chief pharmacist
- Director of medicines and pharmacy
- Medical director

cc. Regional:

- Director public health and primary care
- Chief pharmacist
- Heads of primary care.
- Senior pharmacy integration lead

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

14 August 2023

Dear Colleague,

Independent Prescribing in Community Pharmacy Pathfinder Programme

Community Pharmacy is an important facet of the Delivery Plan for Recovering Access to Primary Care[1] and marks the next step in the journey we started in 2019 to make better use of the clinical skills in community pharmacy teams through the expansion of clinical services and better integrate community pharmacies into the NHS by making them the first port of call for minor common conditions. The Plan also says:

"…[NHS England] are supporting a series of further pathfinder sites across England over the coming year to test independent prescribing models."

The strategic aim of the Pathfinder programme is to develop a commissioning framework that will support the commissioning of independent prescribing as part of clinical services in community pharmacy.

Pharmacists based in hospitals and general practice teams have been independent prescribers since 2006, offering people safe access to medicines to improve outcomes. There are already a small number of pharmacist prescribers working in community pharmacy in England but there are currently no clinical services commissioned nationally by NHS England that enable NHS prescriptions to be issued. Some local NHS services are, however, commissioned where prescription medicines are supplied using patient group directions to treat some minor illness conditions. Community pharmacist prescriber models are already in place in Wales and Scotland for a limited range of services. From September 2026 all newly qualified pharmacists will be independent prescribers on the first day of registration, and this presents an opportunity for NHS England to commission clinical services from community pharmacists.

[1] https://www.england.nhs.uk/publication/delivery-plan-for-recovering-access-to-primary-care

In January 2023 all integrated care boards (ICB) submitted an expression of interest to be part of the Pathfinder programme. A number of prescribing models and pathways were proposed by ICBs and we have undertaken a moderation process working with regional colleagues and through the national Independent Prescribing Oversight Group. As a result of this, NHS England has concluded that the programme should evaluate new prescribing models in community pharmacy that fall into three broad categories:

1. Existing community pharmacy commissioned services, e.g. NHS Community Pharmacist Consultation Service, Common Conditions Service or NHS Contraception Service.
2. Long term conditions, e.g. prescribing for cardiovascular disease (hypertension, lipid optimisation, e.g. statins, anticoagulation in atrial fibrillation) and respiratory disease (inhaler optimisation, rescue therapy).
3. Novel services, e.g. a small number of ICBs proposed services such as deprescribing (reducing over prescribing for patients on repeat prescriptions for multiple medicines), reviewing antidepressants, and menopause services. Where feasible, these services will be considered so that we can evaluate the impact of pharmacist prescribing in community pharmacy across a broad range of prescribing models.

We plan to include up to 210 community pharmacy sites across the 42 ICBs in the Pathfinder programme so that each ICB can participate; allocation of the actual number of sites in each ICB is based on proposed prescribing models, geography and population, and how the ICB proposes to support the sites.

Funding
An overall budget of up to £12m will be allocated to the Pathfinder programme.

Funding will be 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 made available to ICBs will be available to pharmacies involved in delivery of the programme. These sites will be 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 will be made available for medicines costs, which will continue to be attributed to ICBs and funded from existing allocations as usual.

Digital
A national process is underway to secure IT licenses for an assured Electronic Prescription Service web-based solution to support Pathfinder pharmacy sites. This solution will support prescribing in Pathfinder sites with the evaluation of the programme informing a future digital

strategy for community pharmacy. Further details of the digital support and IT requirements for Pathfinder sites will be provided through a separate briefing for ICB teams. It is anticipated that ICBs will identify local business-as-usual support for any local IT needs, e.g. access to local health care records.

The Pathfinder programme will run from July 2023 to March 2024; through our usual planning cycle, we will be reviewing budgets for 2024-25 in light of the evaluation to determine next steps for continuation of the programme.

Evaluation
The Pathfinder programme will be evaluated using formative assessment to support implementation and working with evaluation partners to assess quantitative and qualitative information simultaneously, to understand how the service is developing, and how it might inform commissioning at scale in the future. We anticipate that the evaluation will rely upon the valuable contributions of a range of stakeholders including ICB primary care assurance teams and medicines management teams, patients, and colleagues in community pharmacy, general practice, community services and secondary care teams.

Next steps for ICBs
ICBs are asked to support this programme, and the evaluation, as set out above.

A briefing will be provided through NHS England Regional Senior Pharmacy Integration Leads to set out further detail including the sites, a template pharmacy site service specification and initial funding allocations that will be provided in August (as the earliest transfer period) to secure programme management support. A further funding allocation will be made to the ICB once additional set up costs have been identified, where they are essential to support the service delivery.

Many thanks for your support in implementing this Independent Prescribing in Community Pharmacy Pathfinder Programme. NHS England will work with the Regional Senior Pharmacy Integration Leads to develop support for the programme. If you have any further queries, please contact Anne Joshua, Head of Pharmacy Integration: annejoshua@nhs.net or england.pharmacyintegration@nhs.net.

Yours sincerely

Ali Sparke
Director of Pharmacy, Dental and Optometry
NHS England

David Webb
Chief Pharmaceutical Officer for England
NHS England

MEMORANDUM OF UNDERSTANDING

MADE BETWEEN

NHS England

AND

NHS Cheshire and Merseyside Integrated Care Board

RELATING TO THE SUCCESSFUL APPLICATION TO PARTICIPATE IN THE PHARMACY INTEGRATION FUND COMMUNITY PHARMACY INDEPENDENT PRESCRIBING PATHFINDER PROGRAMME

1. PARTIES

1.1 The Parties to this Memorandum of Understanding ("MOU") are:
a) NHS ENGLAND
b) NHS Cheshire and Merseyside Integrated Care Board (the "ICB")

2. BACKGROUND TO THE MOU

2.1 This MOU is to support the ICB to participate in the NHS England Pharmacy Integration Fund (PhIF) Independent Prescribing Pathfinders Programme. It sets out the funding to be made available to the ICB, how that funding is to be used and the obligations of NHS England and the ICB in relation to the Independent Prescribing Pathfinders Programme.

2.2 The Independent Prescribing Programme is currently funded until March 2024, with the expectation that this will be extended into 2024/25. The funding is provided for a number of elements to enable delivery of the Pathfinder including project management by the ICB, professional support for the Pathfinder sites, commissioning and assurance of the pharmacy sites to deliver the Pathfinder clinical service, and approving payment of the pharmacy sites for sessional time for independent prescribers, clinical support/ mentorship of prescribers and set up costs. Details can be found in Schedule 1.

2.3 Contact details for the parties to this MOU are as follows (**Please Complete**):

Lead ICB name and address: NHS Cheshire and Merseyside Integrated Care Board No 1 Lakeside, 920 Centre Park, Warrington WA1 1QY Lead ICB contact/role: Lead ICB contact telephone number and email address:

ICB invoicing contact name and email address:

ICB Finance Lead and contact details

Community Pharmacy Independent Prescribing Pathfinder Programme (NHS England) contact/role:
Anne Joshua (Head of Pharmacy Integration, NHS England)
Programme email address: england.pharmacyintegration@nhs.net

3. COMMENCEMENT AND PERIOD OF OPERATION

This MOU takes effect on 31 August 2023 and applies for the duration of the Community Pharmacy Independent Prescribing Pathfinder Programme.

4. OBLIGATIONS OF THE ICB

4.1 As a condition of participation in the Community Pharmacy Independent Prescribing Pathfinder Programme and the provision by NHS England of the funding, the ICB will provide reporting on the key deliverables set out in Schedule 2.

4.2 The ICB will deliver the pathfinder programme in line with the service proposals approved in their Expression of Interest. Any changes must be agreed with the national team via your Regional Senior Pharmacy Integration Lead (RSPIL).

4.3 ICBs will deliver programme management support for the CP Pathfinder Programme using the funding provided by NHS England

4.4 ICBs will support pathfinder sites to use ICB prescribing policies and formulary.

4.5 ICBs will be responsible for identifying and setting up Pathfinder sites. This includes but is not limited to identifying appropriate clinical models and competent Independent Prescribing Pharmacists

4.6 ICBs will design and seek internal approval for their final clinical model through local governance processes.

4.7 ICBs will finalise their clinical model in consultation and agreement with the region.

4.8 ICBs will develop clinical support/ mentorship and governance models appropriate to the clinical models being tested

4.9 Once Pathfinder Sites are live, ICBs will provide ongoing programme support and ensure key data sets are collected (Schedule 2)

4.10 The ICB will support the evaluation partner where needed and provide appropriate to access appropriate data sets and information.

4.11 NHS England may withhold, suspend or withdraw funding, at its absolute discretion, should the ICB fail to do so.

5. DIGITAL

5.1 ICB will use a nationally procured solution for prescribing from Community Pharmacy, that will allow the prescription to be transmitted through EPS. There is currently only one IT solution available for use which has been assured by NHS England against the FHIR standard API. Procurement of this solution is underway and access will be provided to all pathfinder sites.

5.2 The funding allocation for pathfinder sites will be for the nationally procured prescribing solution only. ICBs are not permitted to undertake their own procurement for any other prescribing solutions to support the pathfinder sites.

5.3 Existing IT systems for prescribing via EPS e.g.GP IT and urgent care systems using EPS, are not assured by NHS England for use in community pharmacies. These will not be supported for use.

5.4 Community Pharmacy Pathfinder sites must only use existing local IT solutions to access clinical records, record consultations, share information with GPs and request pathology.

5.5 Bespoke solutions for some clinical services (e.g. deprescribing) will need to be individually approved by NHS England

6. FUNDING

6.1 NHS England will transfer funding to the ICB as set out in Schedule 1.

6.2 Payments will be made to the ICB on the understanding that the ICB undertakes duties outlined in this MOU.

6.3 The ICB will provide a defined report (minimal dataset) to NHS England, in a timely manner, on progress against key deliverables as set out in Schedule 2.

7. REVIEW

7.1 The Parties will continually review the programme delivery and governance against the programme criteria and deliverables and agree with the Pathfinder sites any appropriate actions (including withholding further funding).

8. CONTACT POINTS

8.1 The representatives of the Parties listed in paragraph 2.3 along the with Regional Senior Pharmacy Integration Leads will be the primary points of contact for all matters in respect of this MOU and the Community Pharmacy Independent Prescribing Pathfinder Programme.

9. VARIATION

9.1 This MOU may be varied with the prior written agreement of both Parties. Agreement on the part of NHS England must be authorised by the Community Pharmacy Independent Prescribing Pathfinder Programme Lead or the Head of Pharmacy Integration (NHS England).

10. TERMINATION

10.1 Either Party may terminate this MOU by giving to the other at least 60 days prior notice in writing of its intention to do so.

10.2 The Parties may otherwise terminate this MOU at any time by mutual agreement.

10.3 Either Party may terminate this MOU for material breach of its provisions by the other Party if, following written escalation of concerns to the nominated representative of the other Party, the breach in question has not been remedied after a period of 40 days.

10.4 It is expected that by 30th November 2023, the ICB will have commenced delivery of at least one pathfinder, or have a robust plan for commencement of the programme in place. If, by this date, an ICB cannot demonstrate a robust plan to commence delivery to implement the programme, NHS England reserve the right to terminate this agreement.

10.5 NHS England reserve the right to recoup any funding in the event that no actions have been taken.

11. CONFIDENTIALITY, FREEDOM OF INFORMATION AND TRANSPARENCY

11.1 There is an obligation under common law to treat personal information held by the Parties as private and confidential because it has been disclosed for a strictly limited purpose. It is not anticipated that any personally identifiable information will be passed between the two parties to this MoU – neither as a result of the reporting mechanisms in Schedule 2, nor for any other reason.

11.2 Each Party agrees to treat as confidential, and to continue in perpetuity to treat as confidential, information relating to the other Party's technology, technical processes, business affairs, finances, employees or officers or confidential

information relating to other individuals obtained in the course of delivering the MOU and the Community Pharmacy Independent Prescribing Pathfinder Programme.

11.3 The Parties must co-operate with each other in handling and disposing of requests made to either of them under the Freedom of Information Act 2000.

11.4 The Parties acknowledge that they are both subject to any existing or future policies or legislation in respect of openness and transparency and accept that each of them needs to comply with those policies and legislation.

12. PUBLICITY

12.1 NHS England will decide whether to publicise matters for which it has primary responsibility under or in connection with the MOU or the Community Pharmacy Independent Prescribing Pathfinder Programme.

12.2 ICBs will work with NHS England in relation to marketing and publicity at ICS level.

13. DATA PROTECTION

13.1 The Parties must comply with all applicable data protection legislation, laws, regulations and Data Guidance including, but not necessarily limited to, the Data Protection Act 1998, the Human Rights Act 1998, the Health and Social Care (Safety and Quality) Act 2015, the common law duty of confidentiality, the Privacy and Electronic Communications (EC Directive) Regulations, the General Data Protection Regulation and any other laws and regulations relating to the processing of personal data and privacy which apply to a Party and, if applicable, the guidance and codes of practice issued by the Information Commissioner or other relevant data protection or supervisory authority from time to time. The Parties must comply with the Freedom of Information Act 2000 and the Environmental Information Regulations 2004. The Parties must assist each other as necessary to enable each other to comply with these obligations.

13.2 Whether or not a Party is a data controller or data processor will be determined in accordance with relevant law and guidance (including that referred to in paragraph 13.1 above). The Parties acknowledge that a Party may act as both a data controller and a data processor.

14. INTELLECTUAL PROPERTY RIGHTS

14.1 Any materials developed as part of this project and information gathered will remain the property of NHS England. Apart from published personal stories where consent has been obtained, any confidential and sensitive information will be made anonymous.

15. NO PARTNERSHIP OR AGENCY

15.1 Nothing in this MOU shall be construed as creating a partnership.

15.2 Neither Party shall be deemed to be an agent of the other and neither Party shall hold itself out as having authority or power to bind the other Party in any way.

15.3 Neither Party shall have any liability to the other party for any redundancy costs arising from termination of this MOU, whether by the passage of time or any earlier termination, or otherwise in connection with this MOU or the Community Pharmacy Independent Prescribing Pathfinder programme.

16. NOT LEGALLY BINDING

16.1 The Parties recognise that the Agreement is not a legally binding contract but nevertheless will honour, observe and perform as if it was.

16.2 This MOU is not intended to be contractually binding in a court of law or to give rise to any other legally enforceable rights or obligations, nor does this document constitute an offer to purchase or to supply services or goods on the terms set out in this document or at all.

16.3 No Party shall be deemed to be an agent of any other Party and no Party shall hold itself out as having authority or power to bind any other Party in any way.

16.4 Neither Party shall have any liability to the other Party for any redundancy costs arising either from delivery of the services or by the termination of the MOU, whether by the passage of time or any earlier termination.

17. LIABILITY

17.1 Neither Party excludes or limits its liability for: death or personal injury; or fraud or fraudulent misrepresentation by it or its employees.

17.2 In no event shall either Party be liable to the other for any:

- loss of revenue;
- loss of or damage to goodwill;
- loss of savings (whether anticipated or otherwise); and/or
- any indirect, special or consequential loss or damage.

Signed for and on behalf of the ICB

……

Name:……

Position:……

Date:……..

Signed for and on behalf of NHS England

Name: Ali Sparks

Position: Director for Dentistry, Community Pharmacy and Optometry, NHSE

Date: 7 September 2023

SCHEDULE 1

FUNDING

1. This funding is based on your allocated sites of 7 Pathfinder Community Pharmacy sites.

2. Where ICBs cannot recruit the number allocated, ICBs should work with their Regional Senior Pharmacy Integration Leads to seek to increase participation.

3. Subject to paragraph 4 of this MOU, NHS England will make payments to the ICB as outlined in Table 1.

4. NHS England reserves the right to recover any monies paid if the ICB Pathfinder Programme cannot demonstrate a robust plan for delivery of the pathfinder programme by 30th November 2023 or the deliverables of the Pathfinder Programme not being met.

Table 1: Payment Schedule

The first payment for project management costs will be made in August 2023 followed by other costs once sites and models have been identified.

ICB level costs	**£ Per ICB**
Number of Pathfinders	7
Project management Project Management Costs (£30,571 per ICB.)	£30,571
Professional support (£3,250 per ICB)	£3,250
Non-pharmacy evaluation if needed (£426 per registered site; 2 to 12 sites* per ICB)	£ 2,982
Clinical Support (£1,586 per registered site; 2 to 12 sites* per ICB)	£11,102
*Registered with BSA and ready to commence delivery.	
Transferred in August 2023	£30,571
Paid once programme set up, sites and models have been identified and agreed	£17,334
Total available for 2023-24	**£47,404**

SCHEDULE 2
ICB DELIVERABLES

A) REPORTING AGAINST KEY DELIVERABLES

The ICB will provide regular accurate reporting to NHS England to provide assurance that the Pathfinder Programme is being set up and delivered. Some of these data will be collected in partnership with CSU and Evaluation partners. Data collection tools will be co-developed with the ICB and the CSU/Evaluation partners. These indicators include but are not limited to:

Pathfinder set up:

- Pathfinder sites
    - Number of registered Pathfinder community pharmacies
    - Number of community pharmacy sites in preparation / live
- Clinical Models and service types
- Clinical support/ mentorship model and sessions
- Governance model
- Issues and barriers to implementation

Once Pathfinder Sites are live (we will work with ICBs to agree data sources):

- Number of sites actively prescribing
- Barriers and enablers
- Incidents and issues
- Governance issues
- Supporting evaluation partners with interviews
- Deregistration of sites who withdraw from the programme.

The ICB will support the evaluation partner where needed and provide appropriate to access appropriate data sets and information.

A highlight proforma will be provided in due course. The frequency of this report may be reviewed after three months when the programme is more established. There will be other data reporting requirements related to performance indicators which are specific to individual pathfinder sites.

B) REGULAR ENGAGEMENT AND CONTACT WITH STAKEHOLDERS

The ICB will be expected to fully participate in regular engagement associated with the Pathfinder programme, including:

- Contact with the Community Pharmacy Independent Prescribing Pathfinder Programme Lead, Pharmacy Integration Team and Regional Senior Pharmacy Integration Lead
- Contact with the Community Pharmacy Independent Prescribing Pathfinder Programme Evaluation Partners
- Engaging in Pathfinder programme Action Learning Sets
- Where applicable, participating with relevant Community of Practice

C) INTELLECTUAL PROPERTY AND SHARING OF INFORMATION
The ICB agrees to:

- Share without limitation the reports, findings and learnings with the NHS England, the Regional Senior Pharmacy Integration Lead and associated health and care community, regardless of type of organisation (NHS, private, not-for-profit, etc.)
- Be open and transparent with Evaluation Partners
- Assist the Community Pharmacy Independent Prescribing Pathfinder Programme and Pharmacy Integration Team and the Evaluation Partner to work collectively to develop a summary report, incorporating the data and findings of the project and distributing and communicating without restriction
- Support the Evaluation of the Community Pharmacy Independent Prescribing Pathfinder Programme as outlined by the Logic Model.

D) PARTNER & STAKEHOLDER ORGANISATIONAL COMMITMENT

- Confirmation that all stakeholders are signed-up to the project and associated delivery timetable.

SCHEDULE 3
DATA PROTECTION AND SECURITY

[A data processing agreement may be required]

Supplementary Notes: NHS Community Pharmacy Independent Prescribing Service Pathfinder Programme – Service Specification

The following points may be considered by Integrated Care Boards when developing the service specification requirements for the service and service description.

Requirements for the service

- The times at which and days on which the service is to be provided where relevant to the clinical service model.
- Any specific training, experience, knowledge, or qualifications that the staff providing the service must have.
- Access to local digital and IT systems e.g., local shared records, pathology records, blood test ordering.
- Equipment requirements for consultations.
- Adherence to any relevant clinical guidelines and medicines formulary.
- Process to register an independent prescribing pharmacist to pathfinder site and pathfinder site cost centre.
- Process to update smartcard authorisation.
- DBS and safeguarding requirement for the clinical model.
- Requirements for the provision of the service via remote consultations.

Service Description

- Description of the clinical service model.
- How will the service be accessed or referred into?
- Inclusion and exclusion criteria for the service.
- Format and structure of the consultation.
- Use of the EPS solution assured by NHS England as part of the patient consultation.
- Prescription duration.
- Process for repeat dispensing.
- Performing, ordering, and interpreting examinations and investigations.
- Outcomes and next steps following the consultation.
- Record and documentation of the consultation.
- Post event messaging to the person's registered general practice.
- Flow diagram of the service.

NHS Community Pharmacy Independent Prescribing Service Pathfinder Programme

Service Level Agreement

Pharmacy Local Enhanced Service

1 Document history

Document changes

Highlight major changes to this document in this table.

Version	Date	Change	Name

Approvals

This document requires the following approvals (to be approved in line with the ICB governance structure):

Name	Title	Status

2 Parties to the agreement

2.1 **This agreement is between**

Name of Integrated Care Board (the commissioner)

and the Provider (the pharmacy contractor)

Trading name and address of the pharmacy contractor

.....

.....

.....

Pharmacy contractor ODS code: F

2.2 For the provision of an independent prescribing service delivered by pharmacist independent prescribers in community pharmacy. This will inform the development of a national framework for the future commissioning of NHS community pharmacy clinical services incorporating independent prescribing for patients in primary care. The pathfinder programme is being commissioned as a local enhanced service as defined by Part 4 paragraph 14(1)(e) of the Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2013 (as amended).

2.3 By signing up to the service level agreement (SLA) you are agreeing that you fully comply with the Terms of Service as outlined in the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 and agree to comply with the full terms and conditions as outlined in the SLA and the service specification. The commissioner reserves the right to remove you from the pathfinder programme if you, for whatever reason, cannot meet your Terms of Service during the period of the pathfinder programme.

2.4 Failure to comply with the full terms and conditions as outlined in the SLA and the service specification may result in suspension from the pathfinder programme. Before any suspension, the pharmacy contractor and the commissioner will discuss the reason for the suspension to identify a possible resolution.

2.5 Sign up to the pathfinder programme is via the NHS Business Services Authority (NHSBSA) website: **[link to be inserted when the webpage is live]**

2.6 By registering to sign up to the pathfinder programme you are agreeing to the terms and conditions outlined in the SLA and the service specification.

3 Purpose and scope

3.1 The NHS Community Pharmacy Independent Prescribing Service Pathfinder Programme aims to establish a framework for the future commissioning of NHS community pharmacy clinical services incorporating independent prescribing for patients in primary care.

3.2 Recognition that harnessing the skills and workforce capabilities of pharmacist independent prescribers and enhanced pharmacy technician roles would enable pharmacist independent prescribers to support patients with access to treatment in a community pharmacy setting.

3.3 To support the Fuller Stocktake report's vision for transforming access to services, improving experience for patients with long term conditions and preventing ill health through integration with neighbourhood teams.

3.4 To ensure we maximise the opportunities for service delivery available from 2026 when all newly qualified pharmacists will become independent prescribers at qualification and create the opportunity to train undergraduate and foundation programme trainee pharmacists as independent prescribers within the community pharmacy sector.

3.5 To build on the investment set out in the delivery plan for recovering access in primary care that sets the ambition to introduce a community pharmacy Common Conditions Service and expand the NHS Blood Pressure Check Service and the NHS Pharmacy Contraception Service.

4 Timescale

4.1 This agreement and delivery of the pathfinder programme covers the period **31 August 2023** until the end of the pathfinder programme service evaluation (estimated to be in April 2025). The pathfinder programme may end sooner depending on progress. In this case, the pharmacy contractor will be notified that the pathfinder programme will end with one months' notice by the commissioner in writing.

5 Termination and notice period

5.1 One month's notice of termination must be given in writing to the commissioner if the pharmacy contractor wishes to terminate this agreement before the end of the pathfinder programme service evaluation. The pharmacy contractor may be asked for a reason for terminating this agreement.

5.2 The commissioner may suspend or terminate this agreement forthwith if there are reasonable grounds for concern including, but not limited to, malpractice, negligence, or fraud on the part of the pharmacy contractor.

5.3 One month's notice of termination will be given in writing by the commissioner to the pharmacy contractor to inform the pharmacy contractor of the cessation of the service prior to April 2025 (estimated end date of the pathfinder programme service evaluation).

6 Obligations

6.1 The pharmacy contractor must provide the service in accordance with the service specification and ensure that all pharmacists and pharmacy staff, including locum staff engaged by the pharmacy contractor, are aware of it.

6.2 The service must be provided by a pharmacist independent prescriber who has qualified as an independent prescriber and has an annotation added to the pharmacist's General Pharmaceutical Council (GPhC) register entry to reflect this. The commissioner may request evidence of qualification and registration.

6.3 The pharmacy contractor must ensure that any pharmacist independent prescriber delivering the service is clinically and professionally competent to deliver the service.

6.4 The service must be provided by a pharmacist independent prescriber who has completed the required training and development detailed in the service specification and who is competent to deliver the service. The commissioner may request evidence of any required training and development completed.

6.5 The pharmacy contractor and any pharmacist independent prescriber delivering the service must engage with local stakeholders in relation to the service as required by the commissioner e.g., general practice, primary care networks.

6.6 The pharmacy contractor and pharmacy staff engaged in delivering the service will participate fully in the pathfinder programme service evaluation and provide the information set out in the service specification within any timescales specified.

6.7 The commissioner will monitor and assure the service in accordance with the service specification.

7 Standards

7.1 The service will be provided in accordance with the standards detailed in the service specification.

8 Eligibility criteria

8.1 The pharmacy contractor must satisfy the following criteria to demonstrate their ability to take part in the pathfinder programme:

- Fully compliant with the essential services and clinical governance requirements of the Community Pharmacy Contractual Framework (CPCF).
- In good standing with the commissioner.
- Must be invited to participate by the commissioner.
- Registered with the NHSBSA to provide the service.
- Can comply with all the elements described in the service specification.
- Ability to mobilise within the agreed timescale set by the commissioner.
- Independent prescribing pharmacists available to provide the service within the agreed location(s).
- Agree to participate in peer networks and community of practice as required by the commissioner.
- Capability to use the Electronic Prescription Service (EPS) solution assured by NHS England.
- Capability to use GP Connect and/or any local health records as required by the commissioner.
- [ICB to add any digital systems or tools that are required by the commissioner locally based on the service requirements and service description].
- The pharmacy must be able to offer face to face appointments inside a confidential consultation room that complies with relevant GPhC standards. The consultation area must be clearly signed as a private consultation area and must be an area where service users and the pharmacy team member are able to sit and speak normally, without being overheard (note: delivery of the service via remote consultations must be agreed with the commissioner in advance).

9 Confidentiality

9.1 All parties shall adhere to applicable data protection legislation, including the Data Protection Act 2018, and to the Freedom of Information Act 2000.

9.3 Registered pharmacy professionals are expected to follow the most recent GPhC guidance on confidentiality.

9.4 The pharmacy contractor must have in place a whistleblowing policy. The aim of which is to allow an employee to raise at the earliest opportunity, any general concern that they might have about a risk, malpractice, or wrongdoing at work, which might affect patients, the public, other staff, or the organisation itself.

9.5 Any approaches by the media for comments or interviews relating to this service must be referred to the commissioner.

10 Indemnity

10.1 The pharmacy contractor and any pharmacist independent prescriber delivering the service shall maintain adequate insurance for public liability and professional indemnity against any claims which may arise from the delivery of the service and terms and conditions of this agreement. Any litigation resulting from an accident or negligence on the part of the pharmacy contractor and/or any pharmacist independent prescriber delivering the service is the responsibility of the pharmacy contractor and/or pharmacist independent prescriber who will meet the costs and any claims for compensation, at no cost to the commissioner.

NHS Community Pharmacy Independent Prescribing Service Pathfinder Programme

Service Specification

Pharmacy Local Enhanced Service

Equalities and health inequalities statement

[ICB Equalities and health inequalities statement]

Contents

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2 Service objectives 2

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Appendix [appendix number] – Requirements for service provision and service description of [clinical model name] 9

A. Requirements for service provision 9

B. Service description 9

1 Service background

1.1 From September 2026 all newly qualified pharmacists will enter the General Pharmaceutical Council (GPhC) register as independent prescribers. Until recently pharmacists had to undertake a minimum of 2 years' post-registration experience before they could apply for a prescribing course after joining the GPhC register. Whereas a pharmacist would previously have undertaken a 4-year master's degree and then a one-year pre-registration work experience placement, this is being replaced by an integrated approach along the same lines as the medical degree, so that trainee pharmacists learn a range of clinical skills throughout a 5-year combined master's and place-based foundation programme. This is a significant professional transformation for pharmacists expanding career pathways, enabling NHS commissioners to harness this skilled and sustainable workforce to transform health care delivery across systems.

1.2 There are a number of training and education initiatives funded through the Pharmacy Integration Fund (PhIF) to support the existing community pharmacy workforce (e.g., Independent Prescribing and clinical skills training for pharmacists and pharmacy technicians). It is envisaged that the pathfinder programme will act as a catalyst to support the NHS Long Term Workforce Plan for community pharmacy and create an environment where undergraduate and foundation trainee pharmacists can undertake place-based prescribing training.

1.3 Introducing independent prescribing (IP) as part of the Community Pharmacy Contractual Framework (CPCF) from 2025 (subject to funding and negotiation) will provide the foundations through which pharmacist training and clinical service delivery can be harnessed to work towards an integrated workforce model in primary care. This will allow the development and implementation of integrated clinical services that will enable Integrated Care Boards (ICBs) to commission pathways to widen access to care and tackle health inequalities using the unique footprint that community pharmacy creates in local neighbourhoods.

2 Service objectives

2.1 Strategic aim: Establish a framework for the future commissioning of NHS community pharmacy clinical services incorporating independent prescribing for patients in primary care.

2.2 Objectives:

- To establish a community pharmacy independent prescribing programme of work that will inform the development of a framework for the future commissioning of NHS community pharmacy clinical services incorporating independent prescribing for patients in primary care within the agreed timetable;
- To establish pathfinder sites across England to identify and test the delivery of pharmacist independent prescribing;

- To identify the optimum processes including governance, reimbursement and digital requirements required to enable NHS commissioned independent prescribing services in community pharmacy;
- To inform the development of assurance processes for professional and clinical service standards that support independent prescribing activities in the context of NHS community pharmacy services;
- To inform the professional development needs of community pharmacists and wider workforce strategy for pharmacy professionals in primary care;
- To inform the post 2019-2024 CPCF clinical strategy;
- To inform the ICB delegation responsibilities necessary to support national and local commissioning of community pharmacy clinical services that may include access to independent prescribing services;
- To undertake appropriate local and national quantitative and qualitative evaluation / research, including patient experience and the experience of community pharmacy, general practice, community services and secondary care teams with a view to establishing safe and effective community pharmacy clinical services incorporating independent prescribing for patients in primary care.

3 Requirements for service provision

3.1 Prior to provision of the service, the pharmacy contractor must:

- be satisfactorily complying with their obligations under Schedule 4 of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 (Terms of Service of NHS pharmacists) in respect of the provision of essential services and an acceptable system of clinical governance.
- notify the commissioner that they intend to provide the pathfinder programme service by completing a registration declaration via the NHS Business Services Authority (NHSBSA) website: [link to be inserted when the webpage is live]
- work with the commissioner to engage with local stakeholders e.g., general practice colleagues, primary care network colleagues, to make them aware the pharmacy is participating in this service.

3.2 The service must be provided by a pharmacist independent prescriber who has qualified as an independent prescriber and has an annotation added to the pharmacist's GPhC register entry to reflect this.

3.3 The service must be provided by a pharmacist independent prescriber who has completed the required training and development detailed in the service specification and who is competent to deliver the service.

3.4 The pharmacy must have a consultation room that will be used for the provision of the service which meets the requirements of the Terms of Service. Where a face-to-face consultation is the preferred access model for the person eligible for the service, these consultations must be delivered from the consultation room at the pharmacy. Delivery

of the service via remote consultations must be agreed with the commissioner in advance.

3.5 The pharmacy contractor must use the Electronic Prescription Service (EPS) solution assured by NHS England.

3.6 Specific requirements for service provision for [clinical model name] can be found in Appendix [insert appendix number].

4 Service description

4.1 The service description for [clinical model name] can be found in Appendix [insert appendix number].

5 Governance arrangements

5.1 Insert governance arrangements that have/need to be put into place for the pathfinder programme either by the ICB or the pharmacy contractor e.g., roles and responsibilities, assurance, independent prescribing pharmacist competency assessment, management of breaches of requirements, risk assessment, standard operating procedures, clinical support, clinical supervision, audit, site visits, information governance, business continuity plan.

6 Indemnity

6.1 Pharmacy Contractors must ensure that this service, and all clinical professionals and other staff working within it, are covered by appropriate indemnity.

6.2 Pharmacy contractor must ensure they have adequate commercial insurance in place to cover all liabilities (e.g., public and employers).

7 Safety and incident reporting

7.1 The pharmacy contractor is required to report any patient safety incidents in line with the 2012 NHS guidance on Clinical Governance Approved Particulars for Pharmacies.

7.2 Any patient safety incidents must be reported to the commissioner by [detail local process in place to report safety incidents].

7.3 Any complaints about the service must be reported to the commissioner by [detail local process in place to report complaints].

8 Data and information management

8.1 All parties shall adhere to applicable data protection legislation including the Data Protection Act 2018 and to the Freedom of Information Act 2000. The requirement for confidentiality will be balanced with the needs of the person accessing the service.

9 Consent

9.1 The pharmacy contractor and/or the pharmacist independent prescriber delivering the service will be required to obtain consent from the person eligible to receive the service for the following purposes:

9.2 To participate in the pathfinder programme service and agree to a consultation and clinical review in line with the service specification.

- There will be a requirement to obtain verbal consent from the person to proceed with a consultation.

9.3 To share referral advice and shared decisions with the person's registered general practice.

- This consent informs the person that their information and results will be shared with their registered general practice to enable the provision of appropriate care and stored by the pharmacy in line with the Records Management Code of Practice for Health and Social Care.
- If the person does not consent with sharing information with their registered general practice, there may be circumstances where the consultation can still proceed, and a post event message will not need to be sent. A record to confirm the response should be retained.

9.4 To share demographic and clinical data

- This consent is to allow the person's pseudonymised data to be shared with commissioners and service evaluation teams for payment of the service and for service evaluation purposes.
- People accessing the service will be asked in the pharmacy if they consent to being contacted by a service evaluation team to complete a service user survey and/or interview. If a person does not consent to participate in the service evaluation, they can still access the service.

9.5 Evidence of consent should be retained for an appropriate period of time. As pharmacy contractors are the data controller, it is for each contractor to determine what the appropriate length of time is. Decisions on this matter must be documented and should be in line with the Records Management Code of Practice for Health and Social Care.

10 Payment arrangements

10.1 The pharmacy contractor will be eligible for the following payments:

Item	Payment
Pharmacist independent prescriber sessional payment	Payment of **£197.76** per four-hour session (up to **six** sessions per week or **twenty-four** sessions per month) This will be paid based on the number of pharmacist independent prescriber sessions reported by the pharmacy contractor each month.
Pathfinder site readiness payment	One-off payment of **£1500** per pharmacy premises to support pathfinder site set-up (including IT support) and participation in all evaluation activities. This will be paid following registration via the NHSBSA website.
Pathfinder site additional set-up payment	One-off payment of **£…..** per pharmacy premises. This will be paid following agreement and authorisation by the commissioner. Additional set-up payment to be removed/updated depending on eligibility for the additional payment

10.2 Reimbursement will be paid on the condition that the service is provided in accordance with the service specification.

10.3 Claims for payment should be submitted within one month of, and no later than three months from the claim period for the chargeable activity provided. Claims which relate to work completed more than three months after the claim period in question, will not be paid [to be updated based on local grace period agreed for making claims].

10.4 If the pharmacy contractor is commissioned to deliver any related services, the contractor may not claim twice for the same activity.

10.5 The commissioner reserves the right to revise fees during the pathfinder programme.

11 Withdrawal from the service

11.1 If the pharmacy contractor wishes to stop providing the service, they must notify the commissioner that they are no longer going to provide the service giving at least one month's notice in writing prior to cessation of the service. The pharmacy contractor may be asked for a reason for withdrawal from the service.

11.2 Where the pharmacy contractor withdraws from the service, an appropriate handover of services must be agreed with the commissioner. There will also be a requirement to participate in all review, evaluation, monitoring, and payment verification set out in the service specification.

11.3 The pharmacy contractor must continue to provide the service for the duration of the notice period and the pharmacy contractor must de-register from the service via the NHSBSA website at the end of the notice period.

11.4 If a pharmacy contractor de-registers from the service or ceases trading within 30 days of registration, they will not qualify for the site readiness payment and any additional set-up payment. In this event and where payment has already been made for the site readiness and evaluation and additional set-up to the pharmacy contractor, this money will be claimed back.

12 Monitoring and post-payment verification

12.1 The pharmacy contractor shall provide information, reports, and other data as and when required by the commissioner and authorised agents for the purposes of service monitoring and service evaluation.

12.2 The commissioner reserves the right to audit or conduct post-payment verification on the information and data held by the pharmacy contractor in respect of this service.

12.3 It is the pharmacy contractor's responsibility to be able to provide evidence of claims when requested by the commissioner for post-payment verification.

13 Review and Evaluation

13.1 As a pathfinder programme, independent evaluation of the service and its outcomes is key to ongoing development of the service models, and review of the effectiveness of the pathfinder programme.

13.2 The evaluation will assess whether the service has provided the anticipated benefits of:

- Improved patient access to healthcare across the system.
- Ensuring community pharmacists are working to their full clinical potential.
- Supporting general practice.
- Enabling ICBs to plan service delivery.

13.3 The pharmacy contractor is required to participate in evaluation:

a) by ensuring all relevant data is submitted accurately and in a timely manner, AND

b) by taking part in focus groups and semi-structured interviews, and other qualitative data collections such as surveys and questionnaires, as requested by the commissioner.

c) any interviews and focus groups carried out in 13.3 will be carried out online.

13.4 Evaluations may include local evaluations managed by the commissioner, and national evaluations carried out by NHS England and/or its service evaluation partner(s).

13.5 Evaluation will assess a number of aspects of the service, including but not limited to the following:

- IT / digital requirements
- Safety
- Operational impact
- Stakeholder acceptability ('stakeholder' is taken to mean anyone impacted by the service including, but not limited to, pharmacy staff, patients, and other local stakeholders e.g., general practice staff and secondary care staff).
- Sustainability and implementation (i.e., whether the experience of the pathfinder site is likely to aid understanding of whether the service could be introduced for a sustained period of time and/or on a larger scale).

13.6 The pharmacy contractor will be required to promote participation in evaluation amongst other stakeholders and may be required to collect information from patients to facilitate their participation in evaluation (e.g., focus groups and semi-structured interviews, and other qualitative data collections such as surveys and questionnaires).

Appendix [appendix number] – Requirements for service provision and service description of [clinical model name]

A. Requirements for service provision

1.1
1.2
1.3

B. Service description

1.1
1.2
1.3

Independent Prescribing in Community Pharmacy Pathfinder Programme

Steve Riley
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Independent Prescribing Pathfinder Programme

- 2025/26 onwards all new pharmacists joining the GPhC register will be qualified as Independent Prescribers.
- The Independent Prescribing (IP) in Community Pharmacy Pathfinder programme has been developed with the national NHSE Pharmacy Integration Fund (PhIF) Team.
- The programme is to inform the right commissioning framework to introduce independent prescribing in community pharmacy services.
- This programme is intended to explore how community pharmacists and their teams can deliver an integrated clinical service aligning prescribing activity with general practice and the population needs of local communities.
- Integrated Care Systems (ICSs) were invited to submit an expression of interest that is supported by their Integrated Care Board (ICB). Funding will be provided a through the NHSE Pharmacy Integration Fund to support the service delivery and evaluation of the programme.
- We are working to establish Pathfinder sites to identify and test the delivery of independent prescribing across all regions in England.

Process Overview

- Each NW ICS submitted an EOI to participate in the programme.
- Regional Moderation Panel reviewed the EOIs in March 2023, panel included Dr Paula Cowan. Each EOI was approved to move to the national moderation stage.
- National moderation was undertaken in April 2023, each NW EOI was approved.
- Final national programme budgets and approval was given in August 2023.
- ICBs are now seeking confirmatory governance approval to proceed.
- The IP service element will be commissioned by ICB via the Community Pharmacy Contractual Framework, as a Local Enhanced Service.

Northwest Approach

- Led by the Deputy Regional Chief Pharmacist the Northwest ICSs are working in a collaborative approach.

- A Northwest oversight and delivery group has been established, including each ICS Chief Pharmacist.

- A co-ordinated approach has been taken to developing shared core principles for key programme aspects across the NW:
    - Governance / Assurance
    - Service KPIs
    - Standardised Pharmacy EOI process
    - Review of digital systems
    - Ensuring IP Community Pharmacists are supported and treated the same as other NMPs

- The system Pharmacy Local Professional Network Chairs are supporting the programme.

- Each ICB will have an implementation and delivery oversight group that will include LPC and community pharmacy contractor team representation.

- Each ICB are currently undertaking an EOI process with community pharmacies to be involved.

Programme Funding 2023/24

- Overall budget (£12m)

- ICB level (£1.84m)
  - Project management and support
  - Professional support for ICBs e.g. governance, peer support networks set up
  - Ongoing Clinical support for prescribers (clinical support peer networks, mentoring)
  - Additional funding for non-community pharmacy evaluation available if needed

- Pathfinder Sites (£10.14m)
  - n = 210 Pathfinder Sites (range 2 to 12 per ICB)
  - Pharmacist IP Sessional time (equivalent of 6 sessions per week), 4 hours per session
  - Set up costs

- Digital
    - Additional funding agreed via NHSE PhIF business case.

- NW pharmacy allocation
    - C&M 7 pharmacies
    - GM 10 pharmacies
    - L&SC 7 pharmacy

ICB Funding

- Resource to support delivery for 2023/24
- Project support resource
- Professional support (e.g. clinical governance, peer support networks set up).
- Non-pharmacy evaluation support resource (e.g. GP practice, patient forums, etc).
- Pharmacist IP clinical mentorship/ support resource.

ICB Resource	Funding
Project Management	£30,571 (fixed per ICB)
Professional Support	£3,250 (fixed per ICB)
Non-Pharmacy Evaluation (£426 per pharmacy site)	£2,982 – C&M and L&SC £4,260 - GM
Pharmacist IP Clinical mentorship (£1,586 per pharmacy site)	£11,102 – C&M and L&SC £15,860 - GM

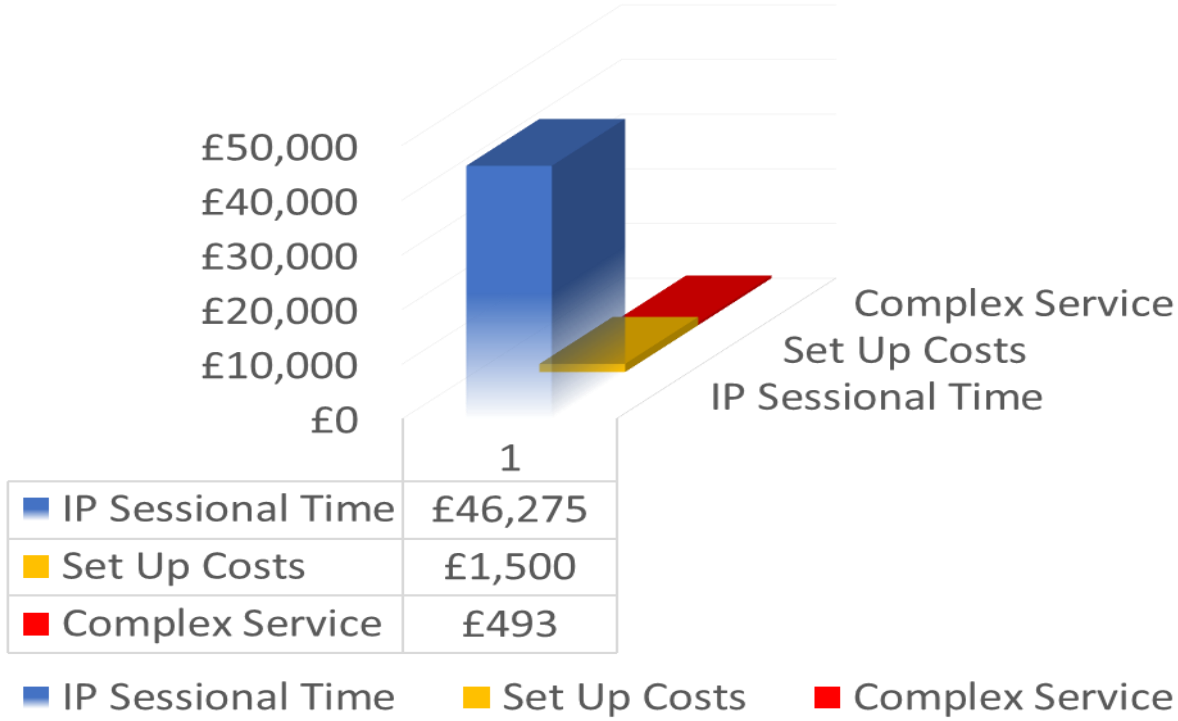
Community Pharmacy Funding

North West Clinical Directorate

Connect and collaborate - listen to understand - respect our differences

Pathfinder Site Funding

Up to £10,136,260 for 210 Pathfinder Sites
£47,775 to £48,268 per Pathfinder Site



Additional payment for non-CPCF services

- CVD – training and equipment
- Contraception + female health
- CVD2&3, Respiratory, Menopause, Deprescribing – training and greatest supervision.

- Site readiness & evaluation: £1000
- IT support: £500

- 6 sessions per week
- Delivered over 39 weeks
- 4 hours in a session
- Hourly rate: £49.44

NHSE PhIF Team Support

- Nationally procured digital solution for community pharmacies to generate EPS prescriptions.
- Service Level Agreement template to support consistent commissioning of the IP service element.
- FAQ / Support documents to support ICB and pharmacy site deliver.
- Risk assessment templates and governance support tools.
- Commissioning an evaluation partner for the programme and CSU support for the formative set up.
- Establishing communities of practice between ICBs delivering similar clinical models for support.
- Professional leadership support via the Chief Pharmaceutical Officer.
- Communications team support for the programme.

Cheshire and Merseyside ICB Models

1. Minor Infection Service (core service)

    This would be prescribing for minor infections
    Indications are still being scoped linking to CPCS conditions
    Likely to include UTIs, bacterial conjunctivitis for children and sore throats, for example
    Referrals and walk-ins

2. Respiratory Service (additional service)

    Focusing on switching to greener inhalers
    Including inhaler technique, Medicines Optimisation linked to care plans and disposal
    Booked referrals
    Sessional basis

3. Step Down of SSRI / Antidepressant Therapy (additional service)

    Step down of Anti-depressant therapy where appropriate following Stepdown Pathway

Contractors can express an interest in delivering the core – minor ailments service and may additionally express interest in delivering one or both of the additional services

Delivery of all services by an individual pharmacist will be dependent on their areas of clinical prescribing practice and clinical competency

Greater Manchester ICB Models

1. Minor Illness (core service)
   - Referrals and walk-in
   - Linked to CPCS
   - Min 15 hours per week dedicated time

2. Cardiovascular disease (additional)
   - Referrals and walk-in
   - Linked to Hypertension case-finding service

3. Respiratory disease (additional)
   - Referrals and walk-in
   - Referrals from Acute respiratory Infections hub (ARI) or practices
   - Including inhaler technique, medicines optimisation linked to care plans

Contractors must deliver the core service and can express an interest for either additional service dependent upon prescriber clinical competency

Lancashire and South Cumbria ICB Models

1. Minor infection service

- This would be prescribing for minor infections
- Indications are still being scoped
- Likely to include UTIs, bacterial conjunctivitis, sore throats, and oral thrush, for example
- Referrals and walk-ins

2. Respiratory service

- Focusing on switching to greener inhalers
- Including inhaler technique, Medicines Optimisation linked to care plans and disposal
- Booked referrals
- Most likely sessional basis

Contractors can express an interest for one or both services

Next Steps

- Supporting ICBs with key priorities:
  - ICB governance sign off and approval to proceed with the programme
  - Commissioning project management support – plan to pool resource and commission via CSU
  - Complete the pharmacy site EOI process at ICB level
  - Develop ICB specific clinical models and pathways
  - Establish project delivery groups at ICB level.
- Ask of SMT:
  - Endorse and support programme across the NW
  - Support the ICB governance sign off process via ICB Medical Directors and ICB leads.

Community Pharmacy
Independent Prescribing Pathfinder Programme

26th July 2023

Anne Joshua
Head of Pharmacy Integration
NHS England

Community Pharmacy Independent Prescribing Programme

Pathfinder strategic aim: establish a framework for the future commissioning of NHS community pharmacy clinical services incorporating independent prescribing for patients in primary care.

Purpose

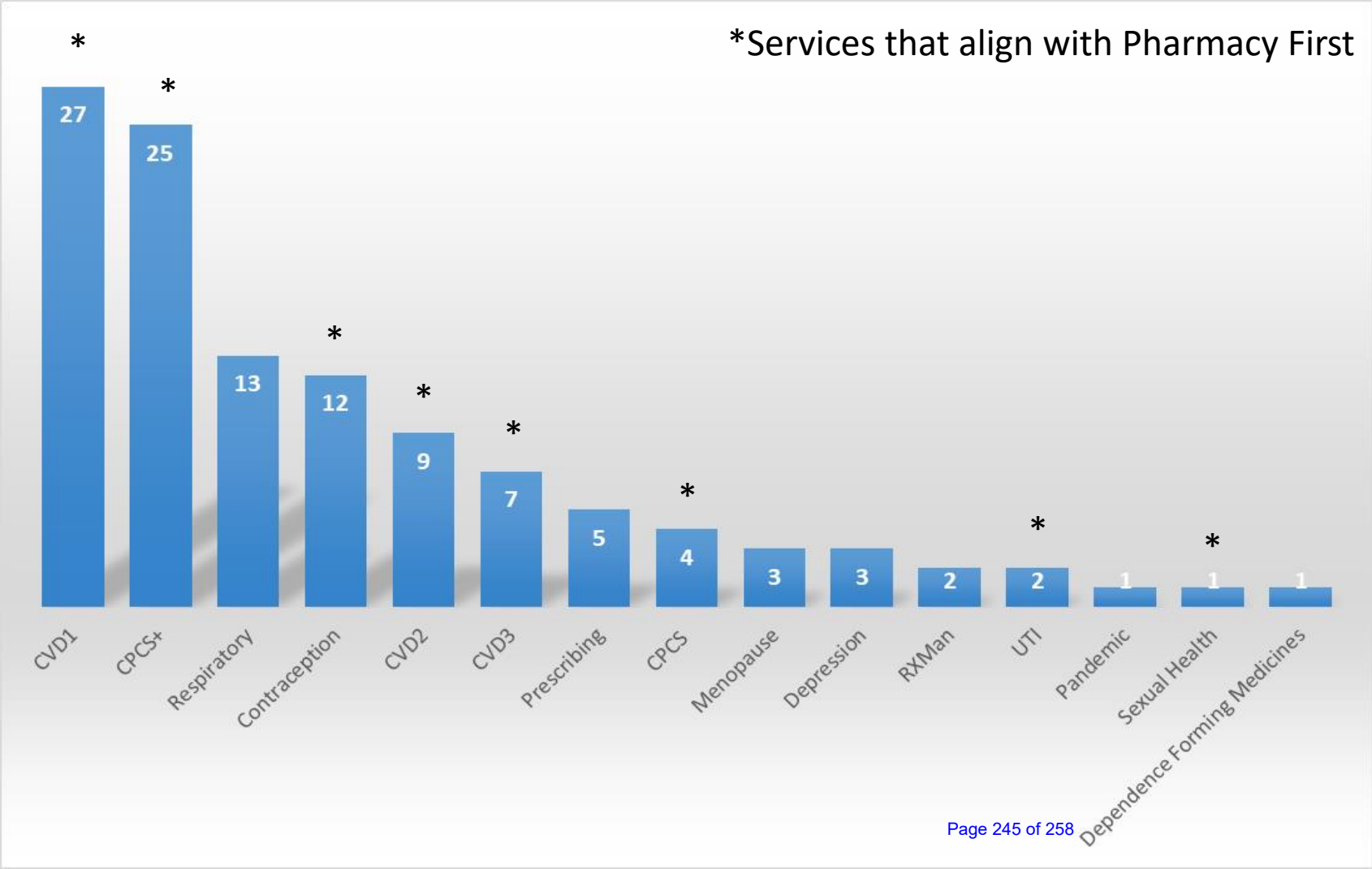
- Recognition that harnessing the skills and workforce capabilities of pharmacist prescribers and enhanced pharmacy technician roles would enable independent prescribers to support patients with access to treatment.
- To support the Fuller Stocktake reports vision for transforming access to services, improving experience for patients with long term conditions and preventing ill health through integration with neighbourhood teams.
- To build on the investment set out in the Delivery Plan for recovering access in primary care that sets the ambition to introduce a community pharmacy Common Conditions Service and expand the BP Check and Contraception services.

Benefits include

- Improved patient access to healthcare across the system
- Ensuring community pharmacists are working to their full clinical potential
- Supporting General Practice
- Better enables ICB level service delivery planning

Regional Moderation and National Moderation

Each region carried out a review process using a moderation panel and follow up with their ICBs which was then reviewed by national programme team and approved at the IP Oversight Group .



- Three key areas of testing
  - CPCF clinical services (e.g. Common Conditions Service, Contraception)
  - Long Term Conditions (CVD, respiratory)
  - Bespoke, novel clinical areas (deprescribing, antidepressants)

What do we need ICBs to do?

An MOU will be established with each ICB to support the programme to set out responsibilities including:

- Commission and assure the ICB pathfinder service using a Local Enhanced Service agreement (under the Pharmaceutical Services regulations)
- Project management
- Facilitation of local clinical mentoring, peer networks
- Facilitation of non-pharmacy evaluation participation
- Reporting on progress using programme proforma
- Participation in national/regional programme meetings as required

Regions will brief ICBs about the number of pharmacies that will be funded per ICB and the outcome of the moderation for the approved clinical models.

What do community pharmacies need to do?

Pharmacy sites will be recruited by each ICB.

A template service specification and SLA agreement for a local enhanced service will be provided to be adapted by each ICB to support the clinical pathway being tested.

Pharmacies will be able to claim:

- Setup costs (variable depending on the service structure)
- 4 hour Sessional time for pharmacist IP delivering on average 6 sessions per week up to a maximum of 24 sessions per month which can be used over a working day or half day timeframes

Pharmacists will be required to participate in clinical mentoring, peer networks and any national communities of practices set up by the programme.

Pharmacy teams will be required to participate in the evaluation to include interviews and/or focus groups, and support the participation of patients in surveys and interviews as set out by the programme evaluation partners.

Digital and IT considerations

- EPS licenses for a web-based standalone solution will be provided for all Pathfinder sites. [Procurement is underway –timescales for availability TBC]
- Condition of the funding allocation is that the EPS nationally procured solution will be the only one funded by the programme.
- **Important Note**: GPIT EPS assured solutions have not been assured to be used in NHS community pharmacy clinical services.
- Access to GP patient records will be via Community pharmacy IT clinical systems in the community pharmacy using GP Connect
- Access to local shared records and pathology services will need to be identified locally and any associated costs identified to regions to seek approval for any additional funding requirements that are critical to the clinical pathway and patient safety.

Funding – details subject to financial approval

ICB Allocation:

- Project management
- Evaluation and professional support

Pharmacy site

- IP Pharmacist 4 hour session: up to 24 sessions per month
- Core set up fee plus extra allocation depending on clinical pathway

More detail will be shared via Regional briefing sessions.

EPS licenses and access to appropriate shared records and pathology services will be funded through the programme where agreed.

Evaluation Update

- Evaluation plan
- CSU formative evaluation
- Evaluation partner procurement

Evaluation plan

- Digital
- Safety
- Operational
- Stakeholder Acceptability
- Sustainability and Implementability

Evaluation plan

		Operational	Digital	Safety	Stakeholder Acceptability	Sustainability
Formative	Quantitative					
	Qualitative					
Live	Quantitative					
	Qualitative					

Note: Stakeholders include: Patients, Carers, Pharmacy and GP practice teams, and ICB teams

CSU Formative Evaluation

1. Identify reporting measures
2. Support pathfinder sites to ‘go live’
3. Developing peer to peer support mechanisms - established at pace
4. Establishing the rules around support for development

Other background

- An operational letter communicates what ICBs will be expected to deliver
- We expect CSU to work alongside ICBs observing the following (loosely enforced) principles:
  - **We want local systems. We want to understand whether those with strong governance have a good chance of succeeding**
  - **We don't want to introduce something that would work in the Pathfinder which would not work in the real world**
  - **We want to know when service models would prefer to pool resources, and at what level**

KPIs

- The IP Delivery Group will report each month through to IPOG and PhOG on progress highlighting risk and issues and associated mitigations and decisions
- The following KPIs are indicative and may change as the programme develops.

Monthly	Fortnightly
Funding allocations to regions and ICBs Drug costs per ICB Number of prescriptions per pharmacy Set-up fee allocations Evaluation milestones Pharmacist sessions	Number of registered pathfinder of pharmacies Number of sites in preparation / live Range of clinical service types in preparation/ live Number of Clinical supervision sessions IT system mobilisation readiness [TBC] Number of interviews with pharmacy staff, GP teams, patients

Evaluation Partner Procurement

- Invitation to tender being prepared
- NHS BSA is on board to input into the quantitative analysis
- We anticipate bringing another evaluation partner on board for Qualitative analysis but also quantitative analysis of pathfinder sites delivering working with novel service models

Proposed timetable

August

- ICB mobilisation – local approvals and governance
- Recruitment of pharmacy sites
- Identify local IT requirements and support to establish pharmacy sites
- National procurement EPS web based system
- Establish digital squad

September/October

- Early adopters for prescribing e.g. CPCS/CCS, Contraception
- Phase 1 Evaluation initiated led by CSU

November

- Mobilise further sites dependent on clinical model
- Identify opportunities for peer networks and mentoring

January 24 – Review and consideration for 24/25 extension
March 24 – Phase 2 evaluation

Next Steps

National team is drafting MoUs for the pathfinder ICBs

National team is drafting the LES service specification and SLA in collaboration with RSPILs and Stakeholder Operational Delivery Group

RSPILs to hold regional meetings to inform ICBs of their allocation

Ensure implementation in pharmacy sites initiated by 30th November 2023 or there may be financial clawback

Any Comms must be coordinated through NHSE RSPILs and Press enquiries via NHSE National Press office

National webinar being planned to brief pharmacy stakeholders