NHS
Cheshire and Merseyside

Meeting of the Cheshire & Merseyside ICB System Primary Care Committee

Part B – Public Meeting

Thursday 22 February 2024
Venue: Meeting Room 1, No 1 Lakeside,
920 Centre Park Square, Warrington,
WA1 1QY (WA1 1QA for Sat Nav)

Timing: 10:30-12:30

Agenda

Chair: Erica Morris

AGENDA NO & TIME	ITEM	LEAD	ACTION / PURPOSE	PAGE NUMBER
10:30am	**Preliminary Business**			
SPCC 24/02/B01	Welcome, Introductions and Apologies	Chair	Verbal	-
SPCC 24/02/B02	Declarations of Interest	Chair	Verbal	-
10:35am	**Committee Business, Risk & Governance**			
SPCC 24/02/B03	Minutes of the last meeting (Part B) 21 December 2023	Chair	Paper	Page 3
SPCC 24/02/B04	Action Log of last meeting (Part B) 21 December 2023	Chair	Paper	Page 14
SPCC 24/02/B05	Forward Planner	Chair	Paper	Page 16
SPCC 24/02/B06	Questions from the public (TBC)	Chair	Verbal	-
(11:40) **SPCC 24/02/B07**	Risk Register (inc. Place Risk Registers)	Hilary Southern *(via Teams)*	Paper To approve	Page 18
10:50am	**BAU and operations**			
SPCC 24/02/B08	BAU Contracting and Commissioning Policy Update	Chris Leese / Tom Knight	Paper For assurance	Page 41

AGENDA NO & TIME	ITEM	LEAD	ACTION / PURPOSE	PAGE NUMBER
11:00 **SPCC 24/02/B09**	Finance update	Lorraine Weekes-Bailey / John Adams	Paper For assurance / to note	Page 51
11:10am	**Quality and Performance**			
SPCC 24/02/B10	NMP	Susanne Lynch	Verbal For Info	-
11:20am	**Transformation**			
SPCC 24/02/B11	System Pressures	Jonathan Griffiths	Verbal For Info	-
11:30 -11:40 **SPCC 24/02/B12**	Update – Policy – Primary Care Transformation	Jonathan Griffiths	Verbal For Info	-
11:50 **SPCC 24/02/B13**	Dental Improvement Plan Update	Tom Knight	Paper For Info	*To Follow*
12:00 **SPCC 24/02/B14**	Dental National Recovery Plan	Tom Knight	Presentation For Info	Page 63
12:30pm	**CLOSE OF MEETING**			

Date and time of next regular meeting:
Thursday 18 April 2024 (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

F2F, Lakeside, Warrington

Thursday 21 December 2023 from 10:15-12:30

Unconfirmed **Draft Minutes**

ATTENDANCE		
Name	**Initials**	**Role**
Erica Morriss	EMo	*Chair*, Non-Executive Director
Clare Watson	CWa	Assistant Chief Executive, C&M ICB
Tom Knight	TKo	Head of Primary Care, C&M ICB
Louise Barry	LBa	Chief Executive, Healthwatch Cheshire
Fionnuala Stott	FSt	LOC representative
Mark Woodger	MWo	LDC representative
Adam Irvine *Via Teams*	AIr	Primary Care Partner Member
Dr Daniel Harle *Via Teams*	DHa	LMC representative
Dr Naomi Rankin	NRa	Primary Care Member for C&M ICB
Susanne Lynch	SLy	Chief Pharmacist, C&M ICB
Chris Leese	CLe	Associate Director of Primary Care, C&M ICB
Rowan Pritchard-Jones	RPJ	Executive Medical Director, C&M ICB
Anthony Leo	Ale	Place Director, Halton
Jonathan Griffiths	JGr	Associate Medical Director, C&M ICB
Matt Harvey	MHa	LPC representative
Sally Thorpe	STh	*Minute taker*, Executive Assistant, C&M ICB
John Adams	JAd	Head of Primary Care Finance, C&M ICB
Kevin Highfield	KHi	Interim Head of ICB Digital Services
Colette Morris *Meeting in part*	CMo	Head of Digital Engagement, Strategy & Planning

Apologies		
Name	**Initials**	**Role**
Tony Foy	TFo	*Vice-Chair*, Non-Executive Director, C&M ICB
Christine Douglas	CDo	Director of Nursing & Care, C&M ICB

Item	Discussion, Outcomes and Action Points	Action by
SPCC 23/12/B01	**Welcome, Introductions and Apologies**	
	EMo welcomed everyone to the meeting. Apologies were noted.	
SPCC 23/12/B02	**Declarations of Interest**	
	Standing DOI were noted.	
SPCC 23/12/B03a	**Minutes of the last meeting (Part B) 19 October 2023**	
	Subject to an amendment to the attendance list, the minutes were approved and agreed as a true and accurate reflection.	
SPCC 23/12/3b	**Action Log of last meeting (Part B) 19 October 2023**	
	The Action Log was updated accordingly.	
SPCC 23/12/B04	**Forward Planner**	
	Noted, and if anyone has anything they wish to add then please let the Committee administrator know.	
SPCC 23/12/B05	**Questions from the public**	
	Nil received.	
SPCC 23/12/B06	**BAU Contracting and Commissioning Update**	
	General Practice - CLe outlined issues with the EDEC (E Declaration for practices, which is a contractual ask, for last years' return which hopefully have now been resolved, enabling a full analysis for 2024 when released. Noted that more detail(s) will come next time regarding the new procurement regulations that come into force in in January 2024 and CLe will liaise with the wider contracting team in that respect. The report was noted to contain more detail, but to highlight: TKn stated that there had been an update of websites for patient access communicated to providers and that there is a requirement to refresh this every 90 days, this is particularly important for dental. In terms of pharmacy, the report contains information on Pharmacy First, which launches on 31st January 2024. Noted that this is part of the delivery plan for recovering access to primary care, there is lots of work going on with this. For optometry, there is a planned expansion of the eyecare in special schools programme there has been 'hot' feedback on the progression of the pilots in Warrington and St Helens. CWa added that Dr Clare Fuller, NHSE Medical Director for Primary Care had been conducting a tour of the North West ICBs, the 'Fuller Review', in this new role and in light of the pending general election, there is much progress on this and we are now seeing a ramping up of assurance requests across the region. Its main focus nationally is around integrated teams, building on PCNs and care communities, and the wrapping care around	

	patients. As an ICB we are supportive of this. As part of the planning round we will conduct an audit, and will aim to triangulate Hewitt and Fuller etc. Noted that there are a number of asks from the Fuller review, in particular the requirement of clinical peer ambassadors, JGr is attending an event in London in February, and has a call tomorrow as clinical lead for primary care. Clare Fuller is looking for a single general practice lead in each ICB and is also looking to meet with the other three contractor groups as this is not just about general practice, but that the initial focus is around this will be general practice. JGr noted that a briefing note is due out tomorrow regarding the peer ambassadors going out tomorrow, and that this is about local work done by individuals to offer support for leadership, however there is no offer of funding. Will wait to see who comes forward. RPJ stated that it was good to meet Clare Fuller and to think how might we go about managing and measuring quality in primary care, either in general practice or more widely in primary care, good to start the conversation. **Action : JGr will provide a verbal update next time on his meeting(s)** **The Committee noted the report**	**JGr**
SPCC 23/12/B07	**Finance Update**	
	John Adams presented the report which was noted to be in the same format as usual, he highlighted main areas of change as follows; The overall financial position shows as a £5.6m surplus on all areas, the presentation of this in the report was different to normal as now included delegated pharmacy, optometry and dental, previously this has shown a break even position, there is now a national change in stance of ring fenced and ICB position and as such the ICBs were issued with a number of actions to review and actions to take. The 'bottom line' now shows the financial position. The report previously showed reserves and flexibilities and now it can be used to support the ICB financial plan. In terms of capital, as discussed earlier in part A of todays' meeting and on seeing the individual documents, there is slippage on two premises where the improvement grants have been withdrawn, this means there is more capital resource available. One involves another practice who have advised they will not need the funding, and therefore the other option is to ask the digital team to spend on IT equipment. KHi advised that the new build practice in Great Sutton is considerably larger than the existing site and is a big investment of £0.25m infrastructure spend, so it seems a pragmatic plan. Concern was expressed in terms of spending unnecessary time going backwards especially as we are almost into the new year, and that it would be more prudent to look at the allocations going forwards (which is the focus of the Task & Finish group), and to speed the process up for next year rather than looking backwards.	

	It was suggested to look at the variations of the nine places and benchmark across all of them, looking at what enhanced services are across each of them. The key challenge is not to pay twice, look at the core contracts, and to keep in mind that the recommendation to the LMC local quality schemes remain the key business streams, but that the specs are reviewed and the outcomes and outputs are looked at. Let us be clear what we are paying for. If there are a number of LES's across C&M then we need to look to be consistent as part of the delegation agreement at place. **ACTION : Bring to next meeting (John Adams / LWB), T&F group, and where up to and what next.** JGr agreed that there would be variation for places to meet their local needs and that it was key to have harmonisation of prescribing across the patch. It is when the variation leads to very different pathways that is difficult, a scoping exercise will be conducted in the new year as to what needs to sit where, to do it once and then this is the specification as a decision across the ICB, or indeed where we absolutely leave in place for local process. TLe stated that in place the focus was to really look at the outcomes (we) are trying to drive and how do (we) manage this in the right way. In relation to the ringfenced position, it was noted that the key thing was that these budgets remain in the contractor groups for this year only, and would rather the underspend was used locally rather than historically going back to centre, particularly around dental that has not taken place it is for underspend of activity, and we are still working through the funding for the rest of this financial year and to commission the activity that we agreed to. The Committee agreed that they would like to understand the total for which contracts are with which providers for next year, and to have a corporate approach. SLy noted that the prescribing budget has been much improved and have had some very fortunate price reductions. The place management teams, with support from the Place Directors, have worked really hard to 'squeeze' as much as possible and are working really hard to improve the financial provision. We have a huge potential to stop duplication and key for in the future to try to do more as a system approach. SLy added that last year some places had heavily relied on branded generics, it is a transition, and work is ongoing this year in order to bring all places together to look at a list/ menu. It was noted that there are real issues around patient/ public perceptions of being offered a cheaper brand/ alternative, suggestion that communications are wrapped around this to give more context and to inform that a change in medication was not necessarily just a financial drive but has greater efficacy for example. It was enquired as to how the public might feel if they were told that a particular medication was cheaper / just as effective but costs us less. SLy stated that in her experience most patients feel that they are doing their bit	**JAd / LWB**

	to help the NHS and helps towards the public taking some ownership of their own health. As an organisation we need to be honest and to collectively think how we might tailor and focus the messages to the public, the NHS is under pressure, let us be honest, caution to say it is not because it is cheaper, but that it represents better value. AIr agreed with this saying that it is also key around the quality of the patient experience, not just to be told via text message but having an actual conversation. Patients are anecdotally saying they have no idea why they have had a medication change, if we get the comms right, and to actually have a script that says what the process is to change a medication then this will be much improved for all. Also noted that there is an additional cost, one that is not seen and not accounted for, in that the GPs spend a huge amount of resource talking to the patient(s) as to why their medication is changing. Rember 'every contact counts', this is a great opportunity at every patient contact, for example, *'I have your inhalers for this week, they look different because …'* **ACTION : Meting in February to look at the themes – SLy**	**SLy**
SPCC 23/12/B08	**Approach to Quality & Performance**	
	It was noted that there have been a number of conversations here in SPCC and offline questioning where this sits, but also the recognition of the assurance and how primary care quality is managed and overseen. Noted that the ICB are not responsible for the contractors themselves, but that there is a group at region, which CLe and JGr now attend so the gap is closed on this. Two suggestions have been put forward to Execs; - To manage between the four different groups, POD and for GP using the place based reporting and this would all go to the Quality & Performance Committee (QPC) direct as part of 4 summaries - To have an overarching Quality, Safety and Assurance Group (QSAG) for primary care and a summary of this to go to System Primary Care Committee, reporting to QPC Whilst it may not have been the preferred option, following discussions at Execs it is agreed to go with the former option. Awareness for this Committee is around the dashboard and mechanisms and that the metrics must be right, with the first reports being received by QPC in January 2024. It was noted that section 4.5 of the report still have some identified issues, but it was recognised that these are not for this Committee to find the solution, i.e. there is a need for an ICB system level primary care quality lead and a practice nurse lead to support wider at scale primary care priorities. There has been lots of work ongoing, and thanks was given to JGr, CLe and TK for holding the ring on this.	

	It was agreed that this work did sit with within quality and performance, and that it feels right for all contractors. Noted that a separate group has been set up to meet to discuss themes as an integration piece and as part of the deep dives. LBa questioned whether we had assurance that there will be nine same approaches for general practice? In response to this, JGr was noted as working with Quality on a single dashboard around this and work is ongoing. Additionally each place is noted to be collecting all degrees of data and that there may be a need for a collective core of what is collected to look locally for a consistent approach. LBa was keen to understand what capacity Healthwatch need/ be able to give so they can dovetail any support. Noted that the interface with region was also important, additionally the region have requested for a forum in C&M that they would like to come back to, and this would be the Q&PC. It was questioned why, if we felt that option B was preferred, what was the rationale for the Execs to choose option A. CWa outlined that it was on a practical reasoning around capacity on workload and who would be leading on it etc. CLe expressed his preference for the QSAG type approach which could have been for a limited time until we had single dashboard and identified leads set up, as this would put everything into one forum rather than 3 plus place forums. Noted that whatever process is used there will be continual monitoring and that it will gather more traction once it has gone to Q&PC and works through this. It was suggested that the initial report (in January) from the four contractual groups would see mocked up dashboards. An offline discussion between CWa, RPJ and CDo/Quality will take place around who the primary care quality lead might be and if there is any additional resource required for the practice lead nurse. The Committee supported the decision made and it was suggested to sense check at 6 months and 12 months within SPCC **ACTION : to note on the forward planner. Quality CDo to bring update/report to next SPCC supported by CLe and JGr**	
SPCC 23/12/B09	**System Pressures**	
	As a pre-cursor to this agenda item, EMo asked the Committee to think about what the key priorities are and whether we think we are on a journey to improve them? She added that if there are clear issues that we are not mapping out in our plans then what can we do. It was asked that this be an agenda item for the next meeting and onwards. **ACTION : key priorities and improvement, map out in plans for Feb 2024 discussion**	

	General practice JGr stated that demand was high with winter viruses, covid and flu amongst many others, the number of appointments continue to go up. As a comparative there were 50k more appointments in October 2023 compared to last year. Industrial action continues to impact, junior doctors are taking action on three days this month (December) and four working days in January. To put this into context, for C&M trainees, based on assumptions of working full time and them seeing about 20 patients a day this equates to 43,500 appointments lost. Pharmacy MHa reported continued pressures stating that if the public cannot been seen in general practice then they are signposted to Pharmacies, this causes a real knock-on effect. It was reported that the pressures are not any different; workforce challenges continue and that there is more being done or expected to do, but with fewer pharmacies. The out of stock of medications situation has improved slightly (blockbuster products) but it is still a pressure. Reported that this is a busy time of the year to get round new PDGs and getting clinical pathways ready for January, could have done without this but would get on with it. Dental MWo reported that the loss of the ringfenced monies was an impact, and the biggest challenge is the planning for year-end. He stated that he would like to see good, clear communications out, and for the contracting teams to write out regarding the loss of the overperformance, it is key for the practices to know for sure and to reinforce this. **Action, something is to be sent out today/tomorrow – TKn to send from the generic inbox** It was noted that the Government response to health sees no real contract reform coming any time soon, so the remit sits within the ICB. The challenges will be towards the ICB, whilst this is nothing new it is abundantly clear that if we are going to manage in the immediate term then it has to be at an ICB level. TLe added that it was important to be cognisant that we are still bound by the national framework which is really prescriptive. Optometry FSc stated that the claims process has changed a little but that the numbers have not changed so much, they continue to have long-term working to alleviate the problems in secondary care. There is some work ongoing with an accelerator programme for the IT interface. Noted that there is a misunderstanding of where the Optometrists send their work, but confirmed it was general practice, however it was questioned whether this was a duplication of referrals or whether patients were turning up in general practice instead of optometry. Workforce was noted to still be quite reliant on locums and there is a need to make sure they are aware of all the availability.	**TKn**

	The special school work is noted to be ongoing. JGr commented in terms of general practice and oral health, there needs to be one single message to the public, as the public will come to a GP (who is free) and will be questioned 'have you seen a dentist' to which they reply, 'no, can't get in'. **The verbal updates were noted.**	
SPCC 23/12/B10	**Access Improvement Plan**	
	CWa reported that an enormous amount of work has been done on this, and that the Committee would be aware that it had been published in May of this year and was presented to Board last month (November). The Board approved the Plan, and the next version will be due in March 2024. There has been a lot of investment and trajectories and there is a rich source of data - but this is also about making sure all the schemes are in place and that we are spending the money in the right places and that there is a real impact on patients. Over time the challenge will be the 'so what. It terms of how we bring it together there is a patient survey in January which will not report until July time so a conversation with the Healthwatch's via CLe and the communications team about further 'measuring' of impact over the next few months. **Action : CLe will contact/email LBa on behalf of all Healthwatch's to meet to discuss the above work** CLe highlighted section 2.9 of the report around the follow-on actions requested by the Board and agreement of next steps. Additionally TKn advised that we also now know that Pharmacy First will be launched. In terms of the four pillars and specific Self-directed care - working with places and what we need to get to in the future, there is lots of variation across C&M and is a big piece of work. Digital team – fantastic work to support and where we have got to (noted that this sits within the empowering patients pillar). Cutting bureaucracy - lots still to work on, now have primary care / secondary care interface groups, and we are writing a communications toolkit and checklist for trusts to work with. It is felt that we are beginning to see a difference, although the survey in January might not reflect this therefore we need to have our expectations in check and feel that we will see, year on year, that our resource is likely to go down – be prepared. **The Committee noted the report and Access Improvement Plan as presented.**	**CLe**
SPCC 23/12/B11	**Primary Care Strategic framework - update**	
	JGr presented this item, stating that this was now available on the website, and would share the link with members, additionally that a podcast is also on the innovation website.	

	Questioned; - The need to turn attention as to what we do with the framework, - To raise the risk of completing the framework for dental and optometry, and to have generous offers of support and the need to find a way within the teams whether they may be any capacity within the teams to write this LBa added that if any information was required for the nine areas to please give warning so the information can be obtained. **The Committee noted the verbal update.**	
SPCC 23/12/B12	**Primary Care Digital**	
	Collette Morris was welcomed to the meeting she gave highlights from the report. In terms of the current workstreams, there are funding and digital opportunities, and that there is now an assured and agreed process for future funding opportunities. The same approach is used in terms of any slippage funding. CMo reported an interest in the PCARP discussions and that digital would be a key enabler as well as to the Access Recovery Plan, noting that this was not just about the IT kit itself, but also about business change and using the technology to support. Technology equipment is issued through the three IT providers and it is recognised that this does vary across the nine places. There is work ongoing to standardise and maximise the digital opportunities that they can support. Telephony access is a key metric, noting that C&M are in receipt of over £4m funding for telephony solutions (cloud-based and desktop options) to improve patient experience. However noting that it does still need to be manned from a workforce point of view. This programme is ongoing through to the end of March 2024 and there is full engagement with practices. Reported that by the end of March 2024, with the funding, they have been able secure 344 practices, of which 215 will be on cloud-based, and the remainder are working towards that solution. It is unknown at this time what happens with the funding after March 2024. NRa added that practices have been targeted on a priority basis and that this aspect really matters from a patient experience point of view. Noted that this support will hopefully put us in a much better position than where we are now. Other aspects where the digital team are involved is the patient app, and all the digital tools to support the PCARP agenda to give improved access and give other options. In terms of digital inclusion/ exclusion there is a dedicated member of the team working on this, to ensure that there is not just an offer that is solely digital but supporting a non-digital route to cover all our population.	

	The current digital pathways framework supports many of the products already out there, SMS messaging for example, but it is key to bring some consistency and best value/practice from a commissioning perspective, outlines some of the regional and national support. Electronic Patient Records (EPR) solutions offers our clinical partners a framework from April, and it was reported that we have a mix of digital systems across C&M to support practices out there if they want to move to a digital system, they have a choice and the digital team have the ability and everything is in place to do this. KHi noted that all funding for EPR is by NHSE to which the framework allows the practice to call off their own. He stated there are four new providers on the framework and that they are new to the market. He expressed caution that there needs to be clear understanding of that change and the impact it may have as it will be a huge business change if the practice goes with any of those (new) options. Noted that there are a number of practices who have indicated their interest in a new clinical system. SLy requested to understand that this was for individual practices to decide which clinical system they wish to use? In response it was confirmed that the ICB nor the digital team have any mandate to have x, y or z system however they are asking places and PCNs to have conversations around where it makes business sense and any implications that may arise around any potential change. RPJ gave thanks for the paper but indicated some degree of surprise that there is no element of the shared care record and the integration of this, he questioned how this might feed into primary care. Regarding new entrants to the market, he noted that they would offer something cheaper to get the business, and questioned whether we have any high quality clinical safety cases around making this sort of move? Practices will need to be really clear on any potential risk(s). It was noted that for practices, it was system of choice, convergence rather than divergence, but that everyone will be aware of the problems around EMiS and TPP, and whether there was not anything that we can do to improve this? Suggested whether we can manage this in terms of the choices offered. It was noted that the contract was managed nationally, as we did when we were CCGs, but not now as an ICB. Therefore ultimately we are accountable to NHSE, and that we have no contractual levers. In terms of corporate risks, KHi outlined that they had just established a digital care board and that risk will be on this agenda. JGr advised that it was not just about the tech issues, but that there are practices who are actively driving digital innovation in their own areas. He added that he was not surprised to see the two Cheshire places had indicated their interest in other available systems. He noted that some practices and some individuals have a big influence, they are respected people and that this might start a domino effect.	

	EMo noted that she would alert the Board within her Committee Chair report, and what influence we might have on the current system(s), and the fact of the divergence which goes against what we are about. DHa added that there was a real risk of the domino effect for change in providers without a full understanding of the inadequacies of the other providers, he added that there are issues with the providers which are not necessarily noted locally, it is important that we have the totality risks. CMo noted that there is cost associated with the Primary Care System Services (PCSS) framework, such as software licences, not necessarily supporting core provision. The Committee were specifically asked to approve two items: - Digital Primary Care Capital bids, the approach and proposed capital allocations by Place. - Tech Innovation Framework Early Adopter Programme, the approval for five practices listed in the paper who are interested in this programme. Noting the support and the acknowledgment of this and would keep a close eye on risks **The Committee approved these as presented** KHi added an additional approval from the Committee as discussed in Part A, of the bid estate supporting PID It was noted that all in Sefton had indicated their plan to change, they have not signed the contracts yet, but are moving along the journey into the next stage. **ACTION : EMo to escalate this within the Committee Chairs report** In terms of the additional recommendation, the Committee approved the allocation of the PIDs. It was agreed to include the 2.3 initially (with 148k added to Part A). If assuring SPCC, the £4.7m on capital, that if not spent and goes back to central then to spend it centrally. **ACTION : Approve remotely, EMo and CWa to approve rapidly outside of meeting, KHi to send it through**	**EMo** **EMo / CWa**
	Closing remarks, review of the meeting and communications from it	
	Nothing further to note.	

Date of Next Meeting:
F2F, 22 February 2024
Warrington, Lakeside

End of Meeting

CHESHIRE MERSEYSIDE
INTEGRATED CARE BOARD

NHS
Cheshire and Merseyside

(Public) System Primary Care Committee Action Log 2023-24

Updated: Dec 2023

Action Log No.	Original Meeting Date	Description	Action Requirements from the Meetings	By Whom	By When	Comments/ Updates Outside of the Meetings	Status
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	Rowan Pritchard Jones	21-Dec-2023	19.10.23 - RPJ is on the case with this. CWa agreed to liaise with him for update	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	Tom Knight	21-Dec-2023	unable to attend in October, invite will extend to next Meeting (December)	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	Chris Leese / Tom Knight	19-Oct-2023	general update presented to SPCC Oct 2023, full and more detailed paper to come to next meeting in December 2023	COMPLETED
SPCC 23/10/B06	19-Oct-2023	Terms of Reference	Suggested changes to be made and then submitted to the November ICB Board for ratification	Matthew Cunningham	01-Nov-2023		COMPLETED
SPCC 23/10/B07	19-Oct-2023	Risk Register	"Quality" to be put on both the SPCC and the Quality & Performance Committee so that discussion is being held and recorded	Christine Douglas			ONGOING
SPCC 23/10/B08	19-Oct-2023	Primary Care Workforce update	Primary Care training hub from HEE to come to a future meeting for futher discussion	Chris Leese	21-Dec-2023	People rep already attended and next Workforce update on forward planner	COMPLETED
SPCC 23/10/B08	19-Oct-2023	Primary Care Workforce update	Suggestion to commission through the Primary Care Workforce group to do some of the (ARRS) work for us	Chris Leese	21-Dec-2023		COMPLETED
SPCC 23/10/B09	19-Oct-2023	Primary Care Estates - update	To come back to a future SPCC with an update	Nick Armstrong	01-Feb-2024	is on forward planner	COMPLETED
SPCC 23/10/B10	19-Oct-2023	System pressures	Digital Update to the next SPCC meeting in December	John Llewellyn	21-Dec-2023	is on forward planner	COMPLETED
SPCC 23/10/B10	19-Oct-2023	System pressures	Standard OPEL to be used across all nine Places, forms part of the Access Recovery Plan - update to next meeting in December	Antony Leo	21-Dec-2023	is onto BAU / PCARP work as a programme of work	CLOSED
SPCC 23/10/B11	19-Oct-2023	BAU Contracting and Commissioning Update	To attach one flashcard (for info) to the minutes	Tom Knight			COMPLETED
SPCC 23/10/B14	19-Oct-2023	Oral Health	agreed to share the Prevention story with HCP and the C&YP Committee	Clare Watson	01-Nov-2023		ONGOING

(Public) System Primary Care Committee Action Log 2023-24

NHS Cheshire and Merseyside

Updated: Dec 2023

Action Log No.	Original Meeting Date	Description	Action Requirements from the Meetings	By Whom	By When	Comments/ Updates Outside of the Meetings	Status
SPCC 23/12/B06	21-Dec-2023	BAU Contracting and Commissioning Update	JGr will provide a verbal update next time on his meeting(s)	Jonathan Griffiths	22-Feb-2024		ONGOING
SPCC 23/12/B07	21-Dec-2023	Finance Update	T&F Group - bring back to next meeting - and where up to and what next.	JAd / LWB	22-Feb-2024		ONGOING
SPCC 23/12/B07	21-Dec-2023	Finance Update	Meeting in February to look at the themes	Susanne Lynch	22-Feb-2024		ONGOING
SPCC 23/12/B08	21-Dec-2023	Approach to Quality & Performance	To note on the forward planner. Quality CDo to bring update / report to next SPCC supported by CLe and JGr	Christine Douglas	22-Feb-2024	Picked up also in Part A	ONGOING
SPCC 23/12/B09	21-Dec-2023	System pressures	Dental : something to be sent out today/tomorrow (re ringfenced monies) from the generic inbox	Tom Knight	21-Dec-2023	Discussions already had with providers and ring fence reference has now gone out with dental recovery plan update	COMPLETED
SPCC 23/12/B10	21-Dec-2023	Access Improvement Plan	CLe will contact / email LBa on behalf of all Healthwatch's to meet to discuss the above work	Chris Leese			COMPLETED
SPCC 23/12/B12	21-Dec-2023	Primary Crae Digital	Approve remotely, EMo and Cwa to approve rapidly outside of meeting, KHi to send it through	Erica Morriss / Clare Watson / Kevin Highfield			ONGOING

Last updated: 11.1.2024

Cheshire & Merseyside System Primary Care Committee Forward Planner

Item	Frequency	Who	Part A / B	June 23	Sep 23	Oct 23	Dec 23	Feb 24
Standing Items Committee Business								
Apologies	Every meeting	EM	Both	yes	yes	yes	yes	yes
Declarations of Interest	Every meeting	EM	Both	yes	yes	yes	yes	yes
Minutes of last meeting	Every meeting	EM	Both	yes	yes	yes	yes	yes
Action & Decision Log	Every meeting	EM	Both	yes	yes	yes	yes	yes
Forward Planner/Annual Plan Review	Every meeting	EM	Both	yes	yes	yes	yes	yes
Committee Risk Register	Every other meeting	HS/CL	B	yes	yes	yes	no	Yes with place updates
Questions from the public (where recv'd)	Every meeting	EM	B	yes	yes	yes	yes	yes
Forward Planner	Every meeting	CL	B				yes	yes
Governance and Committee Performance								
Review of Terms of Reference	Yearly	EM/MC	n/a	no	no	Yes	no	no
Self-Assessment of Committee Effectiveness	Yearly	EM	n/a	no	no	no	yes	no
Recurrent Papers/Updates								
Finance Update*	Every Meeting	LWB	A	yes	yes	yes	yes	yes
PSRC Minutes/Update Minutes/Update from Pharmacy Operations Group and highlights	Every Meeting	TK	A	yes	yes	yes	yes	yes
Policy Update – Primary Care Contracting and Commissioning	Every Meeting	CL/TK	B	yes	yes	yes	yes	yes
Escalation from Place Primary Care Forums	Where Place indicate	CL	A	yes, where raised	yes, where raised	yes, where raised	yes, where raised	yes, where raised
Update on Primary Care Quality/Patient Safety	Every Meeting	CD/KW	A	No	No	No	No	Yes
Primary Care Quality Deep Dives	2 meetings per year	CD/KW						TBC – topics and when
Update from PC Workforce Steering Group	Quarterly	JG/CL	B	yes	no	Yes	no	no
Digital Primary Care Update	Quarterly	JL	B	no	no	no	Yes	no
System Pressures	Every Meeting	JG/CL	B	Yes	Yes	Yes	Yes	Yes
Primary Care Estates Update	Quarterly	TBC	B	No	No	Yes	No	Yes
Key Business items (to populate)								
Primary Care Strategic Framework		JG	B	No	Yes	No	Yes	No
Outcome of ExtraO Meeting		Chair/TK	A	yes	Yes	No	No	No
**Primary Care Access Recovery Plan including performance dashboard for Access, EQIA		CW/CL	B	Yes	yes – update	yes - Update	yes - Actual Plan (post board)	No
Dental Improvement Plan - Progress		TK	B	yes	Yes	Yes	No	Yes
Place ARRS Spend Plans		Place Leads	B	No	no	Yes	no	In finance paper and AIP
Update on Primary Care Quality/Patient Safety		CW/CD	B		no	Yes Verbal	Yes full paper	Yes extra paper this time
****Deep dive Quality Reviews - 3 per year prompted by intelligence from Q & P.								TBC ?
****Performance paper - tba								TBC?
*Finance Task and Finish Update?		LWB	A		Yes	Yes as part of finance update	Yes as part of finance update	Yes separate presentation
Summary – GP Patient Survey (System Level)		CL	B		Yes	No		
dental primary care and community procurements		TK	A			No	Yes	No
MIAA Audit findings / outcomes/ changes to decision making matrix		CL	B			No	No	Yes
Dental Paper – Part Year performance		TK	A				No	Yes
Pharmacy Closures Impact Assessment		TK/JJ	A				Yes	No
Section on provider selection regime part of Contracting update							Yes part of	More detail

Last updated: 11.1.2024

Cheshire & Merseyside System Primary Care Committee Forward Planner

Item	Frequency	Who	Part A / B	June 23	Sep 23	Oct 23	Dec 23	Feb 24
							contract update	for contract BAU update (CL ask VA)
TOR of PSRC		TK	A				Yes	No
Update on development of PSRC as sub of SPCC and additional lay role development.		TK	A					Yes
Dental Workplan 24/25		TK	B					Yes
Wirral Place issue		IS	A					Yes?

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

Date: 22 February 2024

Committee Risk Report,

Month 11, Quarter 4, (2023-24)

Agenda Item No: SPCC 24/02/B07

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

Committee Risk Report

1. Purpose of the Report

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

2. Executive Summary

2.1 There are twenty-three risks covered by this report including one principal risk, three corporate risks and nineteen place risks escalated in accordance with the Risk Management Strategy.

2.2 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.

3. Ask of the Committee and Recommendations

3.1 **The Committee is asked to:**

3.1.1 **NOTE** the current position in relation to the risks escalated to this committee, identify any further risks for inclusion, and consider the level of assurance that can be provided to the Board and any further assurances required.
3.1.2 **NOTE** outcome of place-level PC risk review
3.1.3 **AGREE** recommended **reduction** of Risk 1PC and **reduction** & **closure** of 6PC

4. Reasons for Recommendations

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

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

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

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

5. Background

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

5.2 Risk are escalated to the committee risk register which are rated as high (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.

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

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

5.3.2 **Committee Place Risk Distribution** (appendix two) – which indicates, for risks common across 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.

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

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

Implications and Comments

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

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

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

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

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

8. Link to meeting CQC ICS Themes and Quality Statements

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

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

9. Risks

9.1 Corporate Risks

9.1.1 **Overall Summary**: There are currently **three** primary care related corporate risks identified for NHS C&M – two of these scoring **high-extreme** (8-25), one scoring low (4) and proposed for closure. Copies of all risk summaries can be found at Appendix 4.

9.1.2 **Risk (1PC)** Sustainability and Resilience of Primary Care workforce (General Practice, Community Pharmacy & General Dental Services) has been reviewed against similar risks currently held on place-level risk registers – and while there remains an ongoing pressure in general across Dental, General Practice and beginning to emerge within Community Pharmacy – with a lack of key trained primary professional staff, in particular GPs, Pharmacists and Dentists (in the NHS family) – these issues are not consistent across our 9 places, and are currently being managed effectively. Six of our seven places have scored the risk 9 or 12, with just one place continuing to reflect place specific pressures and scoring the risk extreme -16. Further work will be undertaken to look at places to see what additional support needs to be provided.

It is the responsibility of our places to escalate where there is a risk of significant magnitude/ impact they are unable to manage at a place level e.g. imminent risk of a practice collapse. With the majority of risks being effectively managed within existing place level arrangements and business as usual work programmes.

Therefore, following the review of current place risks 'in common' to this risk, it is **recommended** the risk score is **reduced** to 9, with a reduction in likelihood from 4 (likely) to 3 (possible) and impact from 4 (major) to 3 (moderate).

9.1.3 **Risk (7PC)** 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. All dental activity has been successfully redistributed under a Preferred Provider award – and notice of intention to award to be published. Due process has been followed, and full assurance new provider can pick up full allocation without any impact on continuity of service to registered patients. Therefore, risk score **reduced** to target score of 4 and recommended for **closure** from risk register.

9.1.4 **Risk (6PC)** Identified dental provider contract management risk – potentially leading to loss of provider and impact on dental provision. Risk **remains** 12; formal notice served following exhaustion of local resolution procedures – termination date set 26/09, however on 16/09 provider's legal team requested further resolution discussions. Gone to Primary Care Appeals (PCA) and still awaiting outcome.

9.2 Place-level Primary Care related risks

9.2.1 Usually, place-level reporting to System Primary Care Committee is limited to the criteria set out in 5.2 above; with day-to-day management facilitated at place level through Place Primary Care forums.

9.2.2 However, following a request from System Primary Care Committee in December, a summary of all current place-level primary care related risks is provided below. Committee is asked to note that all places continue to make steady progress in identifying and assessing their risks and implementing local reporting channels prior to escalation; some places have well established reporting and oversight in place, whilst others are still maturing. All places have place-level Primary Care Forums established and adhering to NHS C&M's risk management framework guidance and templates.

9.2.3 There are currently nineteen primary care related risks within the nine places of NHS C&M:

Place	Date Raised	Theme	Risk	Initial Score	Current Score	Relates to SPCC Risk
Cheshire East	01/07/2022	Sustainability: Workforce	Increased demand, funding and workforce pressures impacting on delivery of high-quality Primary Care Services and resilience of practices and practice estate, resulting in poor care and potential provider failure.	16 (4x4)	12 (4x3)	1PC
Cheshire West	01/07/2022	Sustainability: Workforce	Increased demand, funding and workforce pressures impacting on delivery of high-quality Primary Care Services and resilience of practices and practice estate, resulting in poor care and potential provider failure.	16 (4x4)	12 (4x3)	1PC
Knowsley	01/07/2023	Sustainability: Workforce	(PC01) Risk that sustainability and resilience of primary care workforce is insufficient to deliver the Primary Care Access recovery plan	8 (2x4)	12 (3x4)	1PC
Liverpool	18/07/2023	PCNs: Maturity	(LPCG001) Variation in the development, coordination and maturity of the PCNs will affect the ability of PCNs to deliver at scale and/or with other partners	12 (3x4)	12 (3x4)	-
Liverpool	18/07/2023	Sustainability: Demand	(LPCG003) Failure to effectively recover to a sustainable operational model for Primary Care services post Covid, could result in significant levels of unmet demand and exacerbate health inequalities	12 (3x4)	12 (3x4)	-
Liverpool	18/07/2023	Sustainability: Workforce	(PLPCG004) Workforce challenges in General Practice (recruitment and retention of all staffing levels), threatens the delivery model in General Practice reducing patient access to services	16 (4x4)	12 (3x4)	1PC
Liverpool	18/07/2023	Sustainability: Workforce	(LPCG005) PCNs unable to recruit to ARRS roles to meet the workforce commitments with underspend of ARRS funding resulting in widening of health inequalities	12 (4x3)	9 (3x3)	1PC
Liverpool	18/07/2023	Estates	(LPCG007) Lack of NHS estates capacity and limited estates options across the city, risks the ability of the PCNs to deliver services collectively	16 (4x4)	12 (3x4)	-
Liverpool	18/07/2023	Sustainability: Contractual	(LPCG008) Failure of the APMS procurement process could result in practice closures in Liverpool - risk that patients are unable to access to Primary Care Medical Services upon contract termination	8 (2x4)	8 (2x4)	-
Sefton	03/01/2024	Estates	(SPRR7) Risk to the ability of PCNs to deliver service specifications due to lack of estates to operate from.	12 (4x3)	9 (3x3)	-
Sefton	01/07/2023	Access	(SPRR7) risk of inequitable access to Targeted Lung Health Checks (TLHC) due to some practices not participating in the national programme.	9 (3x3)	12 (4x3)	-
St Helens	01/07/2022	Sustainability: Workforce	(1PCC) Insufficient clinician (GPs, Practice Nurses and ANPs) capacity & capability could lead to unsafe practices and restricted access to primary care.	12 (3x4)	16 (4x4)	1PC
St Helens	01/07/2022	Estates	(2PCC) Risks relating to provision of Primary Care Estates	9 (3x3)	15 (3x5)	-
St Helens	01/07/2022	Sustainability: Workforce (ICB PC Team)	(7PCC) Limited Capacity within the Place Primary Care Team to ensure effective completion of all Core workstreams, DES Monitoring and response to urgent matters as they arise.	12 (3x4)	12 (3x4)	1PC
St Helens	01/07/2022	PCNs: Maturity	(8PCC) Enhanced Access – PCNs meeting requirements as outlined in the specification	12 (3x4)	9 (3x3)	-

St Helens	01/07/2022	Sustainability: Financial	(9PCC) Financial Sustainability of St Helens Practices.	16 (4x4)	12 (3x4)	1PC
Warrington	27/07/2023	Sustainability: Workforce	(131) Due to local and national recruitment difficulties and an ageing workforce in primary care, there may be a negative impact on the availability and quality of service offered to patients. This will result in safety and reputational issues.	9 (3x3)	9 (3x3)	1PC
Wirral	01/09/2022	Sustainability: workforce	Primary Care Resilience	9 (3x3)	9 (3x3)	1PC
Wirral	08/01/2024	PCNs: Maturity	PCN diversity in delivery	TBC	TBC	-

9.2.4 There are seven risks relating to the corporate risk **1PC "Sustainability and Resilience of Primary Care workforce (General Practice, Community Pharmacy & General Dental Services)"**; scoring as follows:

Cheshire East	Cheshire West	Halton	Knowsley	Liverpool	Sefton	St Helens	Warrington	Wirral
12	12	N/A	12	12	N/A	16	9	9

10. Finance

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

11. Communication and Engagement

11.1 No patient and public engagement has been undertaken.

12. Equality, Diversity and Inclusion

12.1 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.

13. Climate Change / Sustainability

13.1 No identified impacts.

14. Next Steps and Responsible Person to take forward

14.1 Continued work on supporting places to develop their place-related primary care risks and implement robust reporting – with clear lines of escalation through to SPCC. With a particular focus on the risk relating to 1PC, and other risks in common across the nine places.

14.2 Roll out of specific Risk training to places to support management of their place-level risks and implement robust reporting between central Risk Management Team and place risk leads, in line with the Risk Management Strategy.

14.3 Develop a robust process for providing assurance to the System Primary Care Committee that Place Assurance Groups/ forums are effectively managing risks local to their places – including around risks that do not meet the escalation criteria to committee. Chris Leese and Matthew Cunningham are currently exploring the options e.g. use of key issues reports from place assurance groups, or committee being sighted on minutes etc.

15. Officer contact details for more information

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16. Appendices

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

Cheshire and Merseyside ICB
Primary Care Committee Meeting

NHS Cheshire and Merseyside

Appendix One: Primary Care Committee Corporate Risk Register Summary – February 2024 (Quarter 4, 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	12 ↓	16	12	A
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	4 ↓ **CLOSE**	16	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 Two: Place Risk Distribution Summary – February 2024 (Quarter 4, 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)	12 ↓	12	12	N/A	12	12	N/A	16	9	9
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.	4 ↓ **CLOSE**									

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 Three: Primary Care Committee Risk Assurance Map – February 2024 (Quarter 4, 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)	12 ↓						Significant
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.	4 ↓ **CLOSE**						Full

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							

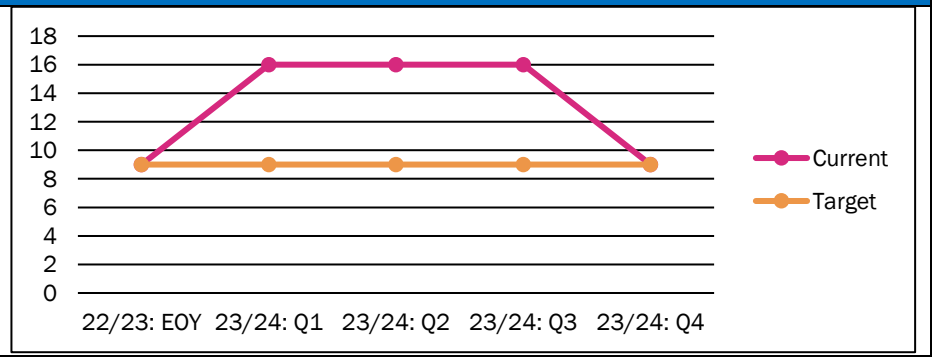
Cheshire and Merseyside ICB
Primary Care Committee Meeting

NHS Cheshire and Merseyside

Appendix Four: Primary Care Committee Risk Summaries – February 2024 (Quarter 4, 2023/24)

FOR COMMITTEE APPROVAL – SCORE MOVEMENT

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	3	**9** ↓	
Risk Appetite/Target Risk Score	3	3	12	

Cheshire East	Cheshire West	Halton	Knowsley	Liverpool	Sefton	St Helens	Warrington	Wirral
12	12	N/A	12	12	N/A	16	9	9

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

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

Date Raised	Last Updated	Next Update Due
01/07/2022* *Legacy CCG Risk*	05/02/24	April 2024

Risk Description
Resilience and sustainability of Primary Care in terms of demand, workforce pressure and external factors such as industrial action, peaks in public concern such as (A Strep). Previously a legacy CCG risk across all 9 CCGs; this has been further expanded to include similar pressures across Community Pharmacy and General Dental Service provision. This is a national issue (more than a risk) around contractual performance being reduced as GPs, dental practices and Pharmacies struggle to recruit suitably qualified and experienced staff. Workforce pressures are impacting on opening hours and access to services. Note individual examples of place-based practice resilience and operational concerns are captured on local place risk registers, but the combined issue across C&M is captured on the overall corporate ICB risk register so that there can be assurances in respect of the overall resilience and sustainability of primary care. At **February 2024**: Primary Care workforce, in particular, within general practice and dental services remains challenged, therefore there is a continued risk in continuity of service provision; seven of our nine places are reporting a risk to sustainability of primary care services, however on review of these risks, the driving forces differ across the places e.g. some are related to workforce (GP turnover, succession planning etc), others are related to provision of estate e.g. to house the new ARRS roles. Of these one is extreme (16) and the other six high (9-12). Overall controls and mitigations across the places are robust; although 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); work continues alongside our primary care partners to respond to national asks/ targets and local demand/ pressures, and all places have robust local oversight & reporting arrangements in place. Robust urgent care process in place for dental treatment for vulnerable patients; and mitigating wider national issue relating to the dental services contract with some flexible arrangements and negotiation of financial values. In addition, for GP workforce there has been a positive uptake of ARRS across most of the nine places, helping bolster the primary care workforce with alternative roles; updates on Pharmacy resilience are presented to SPCC, but mitigations are limited due to the nature of the contracting arrangements. Therefore, it is recommended the risk score is **reduced** to 9, with a reduction in likelihood from 4 (likely) to 3 (possible) and in impact from 4 (major) to 3 (moderate).

Current Controls		Rating
Policies	• National Stock takes and Guidance in relation to Primary Care • Delivery Plan for recovering access to Primary Care https://www.england.nhs.uk/publication/delivery-plan-for-recovering-access-to-primary-care/ • Delivering Operational Resilience across the NHS Winter 2023	**G**
Processes	• System Primary Care Committee – escalation to/ from • Managed operationally at place level through place governance (escalation to SPCC as needed). • Working with National Team and DoH on workforce issues and support. • Primary Care Workforce Steering Group reporting • Access Improvement Plan Templates submission 20/10 highlighting what place actions are being undertaken	**G**

Plans	• Primary Care Strategic Framework – ICB level and Place level, place workforce plans • Clinical Strategy • Workforce/ People plans via People Board inc Primary Care Workforce Strategy • ICB engagement with HEE and Liverpool Dental School • Dental Improvement Plan & Dental Foundation Trainee programme • GP retention plan (submitted May 2023) • ICB Access Recovery plan approved by ICB Board (October)	**G**
Contracts	• GMS PMS APMS GDS PDS Contracts updated • Local Enhanced/Quality Contracts/ Directed Enhanced Services • Community Pharmacy Contracts	**G**
Reporting	• Primary Care Workforce Steering Group/ • Community Pharmacy National Workforce Development Group • NHSE National Teams (looking at wider workforce issues across Primary Care) • Place reporting to place primary care structures/ forums - Access Improvement Plan Templates submission • Place reporting to System Primary Care Committee through reporting template already agreed noting a clearer risk principal escalation process is to be developed • System Primary Care Committee reporting through to Northwest Regional Structures • Reporting to PSRC Committee and through community pharmacy commissioning Team	**G**

Gaps in control

- Reporting between People Board and SPCC to be developed
- Consistent single set of data to be reported to People Board/ SPCC

Actions planned	Owner	Timescale	Progress Update
Dental Improvement Plan workforce actions	Tom Knight	Feb 2024	Improvement Plan submitted to SPCC June 23 – update to SPCC February 2024 on Q4 23/24 progress and seek approval for new 2024/25 plan

Assurances

Planned	Actual	Rating
Closing BI data gaps for Workforce (Ongoing)	Regular updates at SPCC on System Pressures	**Significant**
	First meeting of PC workforce steering group held May 2023	
	Primary Care Access Recovery Improvement Plan approved by ICB Board in November	

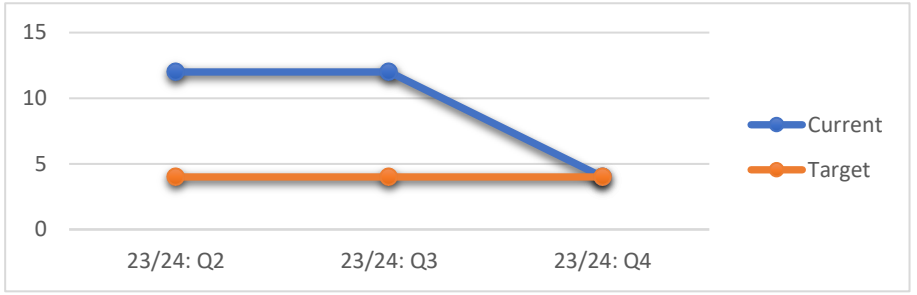
	Review of Place risks to establish position/ scoring – SPCC risk summary updated to reflect distribution of risk across places and collaborative actions to mitigate	

Gaps in assurance

[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]

- Some BI data gaps remain

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

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	**4 ↓**	
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 **February 2024**: Some units of dental activity removed, the rest of the allocation has been successfully redistributed under a Preferred Provider award – and notice of intention to award to be published. Due process has been followed, and full assurance new provider can pick up full allocation without any impact on continuity of service to registered patients. Therefore, risk score **reduced** to target score of 4 and recommended for **closure** from risk register.

Current Controls		Rating
Policies	• Policy book for primary dental services	**G**
Processes	• Statutory process followed to scope alternative providers	**G**

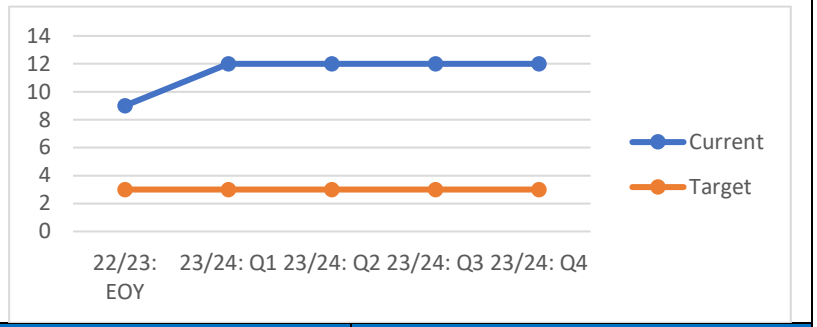
Plans	• allocation has been successfully redistributed under a Preferred Provider award – and notice of intention to award to be published.	**G**
Contracts		**N/A**
Reporting	• NHSE National Team • System Primary Care Committee overview • Health & Wellbeing Boards	**G**

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	Due process followed – full assurance in preferred provider	**FULL**

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 REVIEW – SCORES 8+ STATIC/ NO MOVEMENT THIS PERIOD

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*	05/02/24	April 2024

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 **February 2024**: Risk **remains** 12 = 4 (likely) x 3 (moderate). 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. Gone to Primary Care Appeals (PCA) and still awaiting outcome. In the meantime work continues to identify potential 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	• Awaiting national steer from Primary Care Appeals (PCA)	**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 with Primary Care Appeals (PCA)
- 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	TBC	Awaiting PCA outcome
Confirm actual debt amounts	Luci D/ Finance	Ongoing	N/A

Assurances

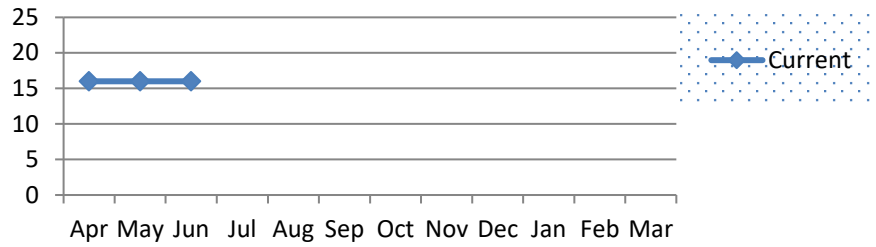
Planned	Actual	Rating
• National guidance awaited re: Dental Foundation Trainee programme (2023/24). Impact due following year.	• Legal advice received and used to progress next steps • Breach notices to be formally issued – were issued, then paused as local resolution underway again; now paused whilst awaiting PCA outcome	**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	03/01/2024	February 2024

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. Recognising that majority of Primary Care resources sit in Place the need to understand aggregate Place actions to understand this risk.

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, Place Level Access Improvement Plans x 9	**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
- Ongoing successful delivery of the access recovery / improvement plans required over a 2-3 year period to close gap

Actions planned	Owner	Timescale	Progress Update
Secure approval to Primary Care Strategic Framework – Stage One	Jonathan Griffiths	Complete	General Practice & Community Pharmacy are part of Stage One Approved.
Secure approval to Primary Care Strategic Framework – Stage Two	Jonathan Griffiths	TBC	
Complete & secure approval to Primary Care Access Recovery Plan	Chris Leese	Complete	
Delivery of Access Recovery and Improvement Plans	Corporate & Place Primary Care Leads	Ongoing to 2025	
Dental Improvement in place agreed and progressing	Tom Knight		Implementation slowed down due to financial impact. Dental ringfence removed nationally which has resulted in the implementation aspirations

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, Dental Improvement Plan Update – Oct 2023 (reasonable) New update due in February 2024.	
Performance Reporting to ICB Board (monthly)	Performance reporting Q&P reporting showing progress on delivery of on target of UDA	
Monthly access improvement and related transformation actions reporting template in place reporting monthly till end of March	In place first report due end of December.	
Implementation of Pharmacy First Contracept Service and Hypertension	Pharmacy First to be launched January 31st 2024 Contracept Service and Hypertension already commenced	

Gaps in assurance
• Plans yet to be approved

Actions planned	Owner	Timescale	Progress Update
Secure approval to plans	Jonathan Griffiths, Chris Leese & Tom Knight	April 2024	Primary Care Strategic Framework will be going to ICB Board in June and System Primary Care Committee in August. Dental Improvement Plan will be going to System Primary Care Committee in February. Primary Care Access Recovery Plan is in development for completion in November. Framework now agreed in September 2023 but stage two still requires development (dental and opthom).

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

February 2024

Primary Care Commissioning, Contracting and Policy Update

Agenda Item No: SPCC 24/02/B08

1. Purpose of the Report

1.1 The Primary Care Policy and Contracting Update provides the Committee with information and assurance in respect of key national policy and related local actions in respect of the four primary care contractor groups that 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

2. Ask of the Committee and Recommendations

The Committee is asked to ;

- Note the updates in respect of commissioning, contracting and policy for the four primary care contractor groups.
- Note and be assured of actions to support any particular issues raised in respect of Cheshire and Merseyside specific contractors

3. Background

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

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

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

	Number of GP Practices by contract	PCNs	GMS	PMS	APMS	Dispensing	Single Handed
Cheshire West	43	9	35	4	4	3	1
East Cheshire	36	9	21	14	1	5	3
Halton	14	2	1	13	0	0	0
Warrington	26	5	8	18	0	1	0
Liverpool	83	9	77	1	5	0	21
Knowsley	25	3	10	15	0	0	6
Sefton	40	2	23	11	6	0	3
St Helens	31	4	24	6	1	0	10
Wirral	46	5	28	15	3	0	4
Total	344	48	227	97	20	9	48

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

3.5 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. Community Pharmacy contracting is managed solely at system level via the Community Pharmacy Operations Group and PSRC (Pharmacy Services Regulatory Committee), which report to this Committee.

3.6 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. General Dental Services contracting is managed solely at system level via the Dental Operations Group, which reports to this Committee.

3.7 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 (High Street) services and 60 additional (domiciliary) providers operating within Cheshire and Merseyside ICB. GOS contracting is managed solely at system level via the General Ophthalmic Services Operations Group, which reports to this Committee.

4. General Practice

4.1 No further definitive Guidance has been released in respect of contract arrangements for 24/25 and beyond, and the working assumption is currently that several key areas such as the Primary Care Network DES (Directed Enhanced Service) will continue.

4.2 Actions to support delivery of the national 'Recovering Access to Primary Care' Policy continue;

- A summary of progress to date, challenges and priorities for the next two quarters, will be presented to the ICB Board in March. Given the short time since the full Access Improvement Plan was presented to the Board at the end of November, this update will not be substantial enough to gauge more quantifiable results and therefore the plan will return again in late Summer/early Autumn.
- The March Board presentation will come to this Committee in April
- The ICS does complete a monthly return to NHS England for assurance purposes and present updates to the Regional Transformation/Assurance Board.
- Key actions and timescales in relation to Cloud Based Telephony, Self Referral, Secondary/Primary interface and Additional Roles continue to have a renewed focus – these will form key parts of the March update.
- Key Actions for Quarter 1 of 24/25 include the Capacity and Access Improvement Plans that were agreed with each PCN last year- Place will be signing off the measurable improvements from these in line with the Guidance.
- Further work with the 9 Healthwatch's is ongoing to understand the impact of the improvement plan on overall patient experience.

4.3 In November 2023 NHS England agreed the that the 2023/24 national vaccinations and immunisations catch-up campaign would focus on measles, mumps, and rubella (MMR). Participation in these campaigns is a core general practice contract requirement.

4.4 Due to an increase in cases nationally, there is a renewed focus on this and the ICS has put in place an internal structure to support – Data on uptake and reporting overall is via the Quality and Performance Committee and supporting place vaccs/imms meetings

4.5 Link to the full specification and national guidance is below
https://www.england.nhs.uk/long-read/confirmation-of-national-vaccination-and-immunisation-catch-up-campaign-for-2023-24/

4.6 NHS England are in discussions with the ICS in relation to delegated primary care assurance – including expected new systematic notifications for contract areas in all four contractor groups, and a new regular assurance document. This will in turn require an amendment to the primary care medical services

decision making matrix for general practice that is in place with system and place commissioners – a revised matrix and update on the operating model for primary medical services is due to return to the committee in April and therefore any instructions from NHS England in this respect will need to be accounted for.

5. General Dental

Mini Mouth Care Matter

5.1 In partnership with dental commissioners and NHSE NW dental Public Health Consultant Alder Hey has just launched Mini Mouth Care Matters.

5.2 Please see the link to watch the children's videos: https://www.alderhey.nhs.uk/mini-mouthcare-matters/.

5.3 Alder Hey have also developed a training video for staff and e-learning package that have been downloaded on the Alder Hey intranet. All these resources will be available nationally through Mini Mouth Care Matters at the end of March 2024.

5.4 Training for staff on the wards will be provided, making sure that the programme is embedded in Alder Hey. The aim is that this will help to improve the oral health of the children and young adults in Liverpool and wider

NHS Business Services Authority (NHSBSA)

5.5 Dental Commissioners have been notified that NHS England and NHSBSA have agreed a new service specification. This specification sees some of the work undertaken for ICBs stopping. Mainly focussed on the contract variation process this will impact on the dental commissioning team as they will now have to perform this function.

Mid-Year contract review process 23/24

5.6 A total of 69 practices were found to be below the threshold of 30% at the mid-year point.15 did not reply to a commissioner request for an action plan and therefore received a remedial notice.

5.7 The NHBSA are withholding money from practices – process which started in January was approx. £736k. This debt will them come off any shortfall at year end.

5.8 One contractor had a non-recurrent reduction in year, and one is reducing from 1st April 2024.

5.9 The theme from majority of the actions plans was workforce issues.

5.10 All practices are being offered an early repayment process for 8 months starting April 2024.

Contract hand backs

5.11 The commissioning team are currently working on two hand backs. Both are ongoing and the team are following the process as laid out in the Dental Management Policy handbook.

Performance snapshot

5.12 Adult patients seen in the previous 24 months and child patients seen in the previous 12 months as a percentage of the population as at 30 June 2023:

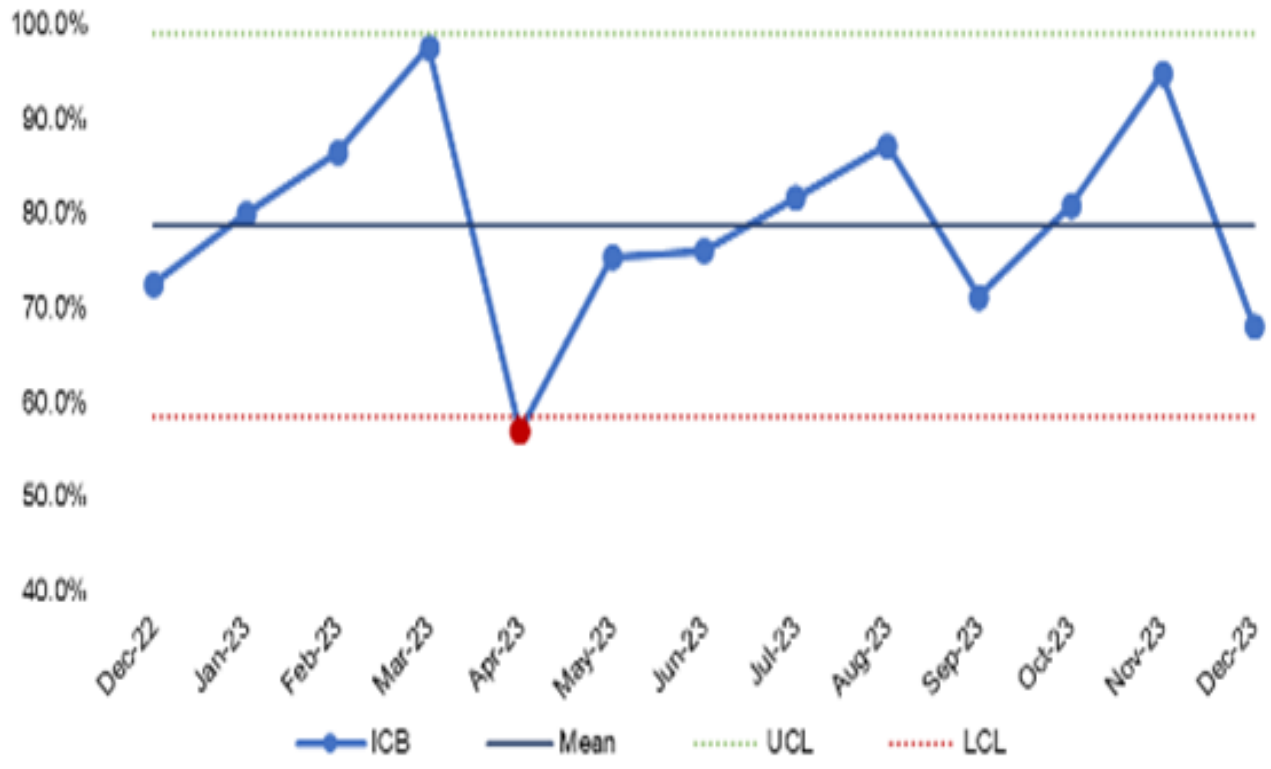
- Adults 46.4% Child 58.2%

5.13 This shows a slight increase in previously reported data regarding access.

5.14 In comparison with the rest of the Northwest adult patients seen in the previous 24 months and child patients seen in the previous 12 months as a percentage of the population as at 30 June 2023

- Adults 45.8% Child 59.4%

5.15 NHS Operational plan UDA target delivery is illustrated in the table below and taken from the latest ICB Performance report. This shows what percentage of contracted activity dentists in C&M are currently delivering.



National Dental Improvement Plan

5.12 Patients will benefit from millions more NHS dental appointments over the next year, thanks to a major new plan to ensure easier and faster access to NHS dental care across England.

5.13 Under the plans, supported by £200m of government funding, NHS dentists will be given a 'new patient' payment of between £15-£50 (depending on treatment need) to treat around a million new patients who have not seen an NHS dentist in two years or more.

5.14 Published on 7 February the plan could see up to 2.5 million additional NHS dental appointments delivered for patients over the next 12 months, including up to 1.5 million extra treatments being delivered.

5.15 The plan sets out how the NHS and government will drive a major new focus on prevention and good oral health in young children and deliver an expanded dental workforce.

5.16 The plan will also see the government roll out a new 'Smile For Life' programme which will see parents and parents-to-be offered advice for baby gums and milk teeth, with the aim that by the time children go to school, every child will see tooth brushing as a normal part of their day.

5.17 To attract new NHS dentists and improve access to care in areas with the highest demand, around 240 dentists will be offered one-off payments of up to £20,000 for working in under-served areas for up to three years.

5.18 The public will also be able to see which practices in their local area are accepting new patients on the NHS website and the NHS App. To promote the increased availability of appointments, the government will also roll out a marketing campaign encouraging anyone who has not been seen by a dentist for the past two years to access treatment.

5.19 NHS work will also be made more attractive to dental teams with the minimum value of activity increasing to £28 (from £23).

5.20 New ways of delivering care in rural and coastal areas will also be rolled out, including launching 'dental vans' to help reach the most isolated communities.

6. Community Pharmacy

Financial position

6.1 At the 31st December 23 we reported a £930k underspend for Community Pharmacy Services with a Year-end forecast outturn of £1.25m underspend.

6.2 On the 1st April 23 the new Flat fee replaced the old Transitional payment, the Flat fee's are lower than the Transitional payments so the surplus budget has been realigned to partly fund the increased Advanced service costs.

6.3 The Advanced services spend is higher than plan as the costs for the New Medicine Service, Community Pharmacy Consultation Service & Hypertension schemes are all increasing.

6.4 The national allocation for Quality payments has reduced from £75m to £45m this was announced as the Aspiration payments were made. This underspend is partly funding other Pharmacy overspends the balance is contributing to the underspend.

Pharmacy First

6.5 Launched 31st January, early data indicated that nationally their had been in excess of 5000 referrals received on the first morning some functionality issues affecting the delivery of Pharmacy First came to light in the first few days of the service. These issues affected both PharmOutcomes IT platform and the EMIS Local Services Referral Function and Pharm Refer Referral Functions.

6.6 An implementation plan, communication plan and a stakeholder group have all been developed/established oversee this national programme -that is also a key part of the Cheshire and Merseyside Primary Care Access Recovery Plan.

6.7 Patients in Cheshire and Merseyside will be able to get treatment for seven common conditions through their high street pharmacy from today, as part of a major transformation in the way the NHS delivers care.

6.8 Over 95% of community pharmacies have signed up to the programme in Cheshire and Merseyside.

6.9 Highly trained pharmacists will be able to assess and treat patients for each of the following conditions, without the need for a GP appointment or prescription first:

- sinusitis
- sore throat
- earache
- infected insect bite
- impetigo
- shingles
- uncomplicated urinary tract infections in women

6.10 The Pharmacy First service will be available to patients on referral by their GP practice, NHS 111, and NHS Walk-in Centres/Urgent Treatment Centres – as well as by contacting their pharmacy directly.

Pharmaceutical Needs Assessments

6.11 The next PNAs for the 9 Health & Wellbeing boards are due for publication April 1st, 2025. The initial planning meeting with all contributors' is planned for April.

7. General Ophthalmic Services

7.1 There are currently 224 mandatory (high street) opticians and 60 additional (domiciliary sight test) opticians within Cheshire and Merseyside. Service provision is currently steady and capacity stable.

7.2 Sight test activity increased in the calendar year 2023 with a total of 657,159 GOS sight tests compared to 613,420 in 2022 (7% increase)

7.3 It should be noted that wider eye health transformation pathways and local commissioned services are managed at place/cross place level reporting via place/providers forums and transformation routes. Some support is given to these areas by the relevant clinical adviser but these are not reported into this Committee.

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

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

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

9. Link to meeting CQC ICS Themes and Quality Statements

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

10. Risks

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

11. Finance

There are no additional finance risks or asks associated with this paper

12. Communication and Engagement

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

13. Equality, Diversity and Inclusion

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

14. Next Steps and Responsible Person to take forward

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

15. Officer contact details for more information

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

NHS
Cheshire and Merseyside

Primary Care Finance Update

NHS Cheshire and Merseyside Primary Care Committee (System Level)

Date: 22nd February 2024

Agenda Item : SPCC 24/09/B09

Date of meeting:	22nd February 2024
Agenda Item No:	SPCC 24/02/B09
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 January 2024 (M10).

The report covers seven areas of spend: -

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

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

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

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

NHS Cheshire and Merseyside
Primary Care Committee (System Level)

NHS Cheshire and Merseyside

Recommendation/ Action need:	**The Committee is asked to:** The Primary Care Committee is asked to: - 1. Note the combined financial summary position outlined in the financial report as at 31st January 2024. 2. Note the Additional Roles spend to date and the anticipated forecast outturn and predicted central drawdown. 3. Note the approach to 2024/25 planning.

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

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

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

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

Primary Care Finance Update

1. Introduction and Background

1.1. The report provides the Primary Care Commissioning Committee of the Cheshire and Merseyside Integrated Care Board (ICB) with a detailed overview of the financial position in relation to primary care expenditure anticipated for 2023/24 as at 31st January 2024.

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

1.3. The financial positions for January 2024 (M10) are based on the historical recurrent expenditure at each Place plus in-year amendments, including any uplifts for national assumptions.

2. Financial Position

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

Table 1a

Primary Care Position Summary - Month10 ICB TOTAL	Year To Date			Forecast Outturn		
	Budget (£000's)	Actual (£000's)	Variance (£000's)	Annual Budget (£000's)	FOT (£000's)	Variance (£000's)
Delegated Medical Primary Care						
Core Contract	253,855	253,394	461	304,627	304,367	260
QOF	32,513	30,931	1,582	39,016	37,334	1,682
Premises Reimbursements	41,449	43,696	(2,247)	49,739	52,478	(2,739)
Other Premises	570	570	1	684	686	(2)
Direct Enhanced Schemes	3,719	3,931	(212)	4,463	4,756	(293)
Primary Care Network	43,247	40,909	2,338	51,896	49,622	2,274
Additional Roles Reimbursement Scheme	50,932	50,932	(0)	47,540	47,540	0
Fees	8,361	8,560	(199)	10,033	10,482	(449)
Other - GP Services	1,269	1,057	212	1,523	1,328	195
DELEGATED PRIMARY CARE TOTAL	**435,915**	**433,979**	**1,936**	**509,521**	**508,593**	**928**
Local Primary Care						
GP Local Enhanced Service Specification	26,985	25,588	1,396	32,459	30,474	1,985
Local Enhanced Services	11,231	11,533	(302)	13,445	13,193	252
Commissioning Schemes	1,642	1,736	(94)	1,971	2,118	(147)
Out Of Hours	22,501	23,187	(686)	27,002	27,837	(835)
GP IT	11,746	10,066	1,680	14,022	12,656	1,366
Primary Care Other	3,368	2,460	909	4,041	2,647	1,394
Primary Care SDF	7,603	5,900	1,703	9,069	7,329	1,740
Pay Costs Local	371	260	111	446	309	136
LOCAL PRIMARY CARE TOTAL	**85,447**	**80,730**	**4,717**	**102,455**	**96,564**	**5,890**
Prescribing						
Central Drugs	12,435	14,682	(2,246)	14,922	17,499	(2,577)
Medicines Management - Clinical	2,237	2,212	25	2,685	2,673	11
Oxygen	4,419	2,795	1,624	5,303	3,789	1,514
Pay Costs Prescribing	5,038	4,848	191	6,032	5,862	170
Prescribing BSA	387,784	399,615	(11,830)	464,966	482,658	(17,692)
Prescribing Other	11,774	17,111	(5,336)	14,029	17,686	(3,658)
PRESCRIBING TOTAL	**423,688**	**441,262**	**(17,573)**	**507,937**	**530,169**	**(22,232)**
Delegated Pharmacy Optoms Dental and Other						
Delegated Community Dental	10,480	10,071	409	12,576	12,084	492
Delegated Ophthalmic	22,520	20,754	1,766	27,024	25,249	1,775
Delegated Pharmacy	58,482	57,771	711	70,100	69,039	1,061
Delegated Primary Dental	112,318	99,385	12,932	134,781	116,432	18,349
Delegated Other Costs	1,230	399	831	1,476	470	1,006
Delegated Secondary Dental	35,417	32,081	3,336	42,556	38,424	4,132
PHARMACY, OPTOMS, DENTAL & OTHER TOTAL	**240,446**	**220,460**	**19,986**	**288,513**	**261,700**	**26,813**
TOTAL	**1,185,497**	**1,176,431**	**9,066**	**1,408,426**	**1,397,026**	**11,400**

3. Delegated Primary Care - Medical

3.1. **Core Global Sum-** There is an underspend of £0.260m, 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 with NHSE guidance. This underspend has reduced since the last System Primary Care financial report, as this now factors in-year list size adjustments.

3.2. **Quality Outcomes Framework- (QOF)**- The Delegated Medical Primary Care budget shows an underspend of £1.682m within the QOF service line. £0.540m of this is due to year-end costs of 2022/23 being less than anticipated/accrued. The remainder is a reduction in the in-year forecast as we are anticipating 23/24 costs should be similar to the 2022/23 outturn.

3.3. **Premises Reimbursements**- currently shows a forecast overspend of £2.739m. There are several factors that have contributed to this overspend. The majority is a reflection of the current annual billing schedules from Community Health Partnership and NHS Property Services. These annual schedules of reimbursables and subsidy costs include the impact of gas and electricity increases. There is also a forecast pressure of £1.1m, due to the latest rent valuations and projected outcome of ongoing reviews.

3.4. However, there is a benefit of £1.46m that mitigates some of the projected overspend on Premises reimbursements. This is for refunds of prior year business rates and follows work undertaken by GL Hearn/Community Health Partnership to discover where GP practice premises had been incorrectly assessed by Local Authorities.

3.5. **Direct Enhanced Services-** There is a projected overspend of £0.293m for the Direct Enhanced Services (DES). This is due to an increase in activity and uptake in the current financial year. DES activity such as Minor Surgery and Learning Disability Health checks have increased this year.

3.6. **Primary Care Network (PCN)-** The costs that are covered within Primary Care Network, are payments linked to the PCN DES, such as participation payments, Clinical Director payments and the Impact and Investment fund. This area is projected to underspend by £2.274m, mainly due to the underachievement of the Impact Investment fund in 2022/23.

3.7. **Fees-** There is currently a projected overspend of £0.449m relating to Fees, this is due to the increase in the Professional prescribing fees that we pay. Within the Prescribing budget we pay “dispensing drug costs”. Where dispensing costs are paid, there is an associated Professional Prescribing fee that is paid to the GP Practice. Due to the increase in dispensing fees, we have seen an increase in the associated Professional Prescribing fee. The overspend on Fees has increased by approximately £0.2m since the last Primary Care finance report. This is due to an increase in sickness locum costs that have been paid out to GP Practices. We are seeing an increase in sickness costs across a number of places, which is heavily impacting on the budgeted allocation.

3.8. **Other GP Services**- There is an underspend of £0.195m, this underspend is due to prior year funding that was anticipated but has not been utilised.

4. Local Primary Care

4.1. **GP Local Enhanced Service Specification**- The GP Local Enhanced Service Specification at the end of January 2024, shows a forecast underspend of £1.985m. This is due to prior year under-achievement of GP Local Enhanced Service Specification and the downward revision of expected annual achievement based on actual Quarter1-3 data.

4.2. **Local Enhanced Services**- There is an underspend of £0.252m, this is due to lower than planned activity on Local Enhanced Services in the current financial year and prior year costs also being lower than anticipated/accrued.

4.3. **Out of Hours-** There is a forecast overspend of £0.835m on Out of Hours services, six of our nine Places commission Primary Care 24 to deliver their Out of Hours provision. It has been agreed that during the winter months of October to March, an increased clinical profile will be rostered to support the winter activity that is predicted. For the remaining 3 Places we have seen a slight increase due to the doctors’ pay award.

4.4. **GP IT**-There is a forecast underspend of £1.366m as accruals for costs at the end of 2022/23 were higher than the actual final cost charged in 2023/24.

4.5. **Primary Care Other-** There is a forecast underspend of £1.394m 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.

4.6. **System Development Funding-SDF**- £1.740m of funds will be used to support the financial position. £1.2m relates to Digital funds that were ringfenced to support digital projects, which are now paused until 2024/25. There is £0.120m for Digital Pools, these will also be paused for 2023/24, and the remaining £0.420m is for GP Transformational projects, where projects were still being worked up and will also be paused until 2024/25. All these pauses to projects, were agreed by Place or Digital Leads.

5. Prescribing

5.1. The Prescribing financial forecast is £17.753m overspent year to date and a a projected overspend of £22.232m at year end.

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

5.3. 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.

5.4. The M10 forecast overspend has decreased significantly from the £46m that was forecast at the beginning of the year. There are a number of contributors, principally a reduction in the overall cost/price pressures of £16m and an estimated reduction in costs of £6m due to the benefit of savings on apixaban.

5.5. Oxygen costs are also anticipated to be underspent. There is an in-year cost pressure of £0.486m due to tariff increases. However, this has been mitigated by £2m VAT savings that we have been advised are claimable against our Oxygen contracts. The VAT savings we are anticipating cover a period of 5 years, therefore include historic former CCG contracts.

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

6. Delegated Pharmacy

6.1. In December, the national team confirmed that they would not amend fee rates within the contract to bring total Pharmacy Contract remuneration back down to the 2023/24 value agreed in the 5-year deal with the profession. This is a financial risk for all ICBs.

6.2. The uptake of New Advanced Services continues to grow and as other fees are not being reduced to compensate, the forecast Pharmacy Contract underspend has reduced to £1.1m (previously £1.8m). The underspend is held in reserve to support the overall ICB financial position.

6.3. The new "Pharmacy First" contract started on 31st January. All costs of this scheme are expected to be funded.

7. Delegated Optometry

7.1. Delegated Optometry is forecast to underspend by £1.8m (no change). The underspend is held in reserve to support the overall ICB financial position.

8. Delegated Other Costs

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**

8.1. Delegated Other Costs is forecast to underspend by £1.0m (no change). The underspend is held in reserve to support the overall ICB financial position.

9. Delegated Dental

9.1. With effect from period 8, NHSE confirmed that reserves and forecast surpluses previously contained within the "Dental Ringfence" should be used to support ICB financial positions. In period 10, the Dental forecast underspend is unchanged at £22.97m.

9.2. In accordance with the requirements of the national dental contract, mid-year performance reviews of primary care dental contracts have been undertaken by the BSA and the ICB Commissioning team.

9.3. The primary care dental contracts for which termination notices were issued in 2023, itself the culmination of action begun by NHSE prior to delegation, have now progressed to appeal.

10. Additional Roles Reimbursement Scheme

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

10.2 The ICB spent £39.580m in 2022/2023. In the current financial year 2023/24 the ICB has an allocation of £65.782m available to spend.

10.3 Table 2a illustrates the budgets available for the Additional Roles reimbursement scheme identified at Place level and Table 2b illustrates how much of the allocation each place is anticipated to spend.

10.4 The projected forecast outturn for the ARRS schemes for NHS Cheshire and Merseyside ICB as at Month 10 is £62,451,395.

10.5 For NHS England to transfer our share of the centrally funded NHS England ARRS funding, we have had to provide assurance to NHS England to support our projected costs. We have now had confirmation of assurance from NHS England and we expect to receive the funding in Month 11.

Table 2a

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 2b

Place	Total ICB Budget Excluding Drawdown	Available Drawdown	Total	Total FOT	Variance	Expected Drawdown from NHSE	%age Utilisation of Available Drawdown
Cheshire East	£5,954,322	£3,485,119	£9,439,441	£8,618,615	£820,826	£2,664,293	76%
Cheshire West	£5,704,604	£3,338,957	£9,043,560	£8,951,829	£91,731	£3,247,226	97%
Halton	£2,071,235	£1,212,313	£3,283,548	£3,326,945	-£43,398	£1,255,710	104%
Knowsley	£2,729,022	£1,597,166	£4,326,188	£4,197,841	£128,347	£1,468,819	92%
Liverpool	£8,904,871	£5,211,596	£14,116,467	£14,874,769	-£758,302	£5,969,898	115%
Sefton	£4,327,265	£2,532,788	£6,860,053	£5,318,689	£1,541,364	£991,424	39%
St Helens	£3,265,519	£1,885,555	£5,151,074	£4,363,498	£787,576	£1,097,979	58%
Warrington	£3,215,678	£1,882,166	£5,097,844	£4,964,831	£133,013	£1,749,153	93%
Wirral	£5,367,465	£3,141,626	£8,509,091	£7,834,377	£674,714	£2,466,912	79%
Total	**£41,539,981**	**£24,287,286**	**£65,827,267**	**£62,451,395**	**£3,375,871**	**£20,911,415**	**86%**

11. Planning 2024/25

11.1 National guidance for 2024/25 planning has been delayed. At the time of writing, partial guidance on planning assumptions and allocations is starting to be received. Draft financial plans for 2024/25 have been prepared on a 'rollover' basis, adjusted for part year effects, known investments and contract changes, and one-off items. They will be updated to reflect national guidance including suggested inflation and growth factors, price changes and local & national commissioning intentions.

11.2 The ICB is reviewing the distribution of funding to Place. Initially this will change variances at Place level. In the longer term it will influence investment and disinvestment decisions for services commissioned by Place.

12. Capital

12.1 Table 3 below shows the latest primary care capital expenditure plan.

Table 3

Cheshire & Merseyside ICB Primary Care Capital Plan 2023/24

Description	Plan £'000s
Capital Resources	
BAU allocation	4,700
2022/23 Acquisition Accrual Reversals	23
2022/23 Improvement Grant Accrual Reversals	70
IFRS 16 - schemes funded centrally	898
Total Expected Capital Resource	**5,691**
Planned Expenditure	
GP Premises Improvement Grants (under way)	**2,041**
GPIT	
PIDs Approved by NW Region DoF	2,068
PID Submitted for NW Region DoF approval *1	359
PID Submitted for NW Region DoF approval *2	223
PID Submitted for NW Region DoF approval *3	100
Subtotal GPIT	**2,750**
IFRS 16 - Schemes funded Centrally	**898**
Total Planned Expenditure	**5,689**
Capital Resource (Remaining)/Shortfall	**-3**

Note:
*1 - Kit refresh, StHelens, Knowsley & Halton Places
*2 - Kit and core infrastructure Great Sutton Practice
*3 - Cyber Security, Cheshire East & West and Warrington Places

12.2 GP Premises Improvements supported by ICB Grants totalling £2.041m are under way.

12.3 £2.068m of GPIT PIDs that were approved by this committee in December have since been signed off by NHSE and IT equipment is being procured.

12.4 A further £682k of GPIT PIDs (highlighted in yellow) have been approved under authority delegated to the Chair and Director of Primary Care. These are awaiting sign-off by NHSE before IT equipment is procured.

12.5 IFRS16 schemes are accounting adjustments for leases. This is managed by the ICB Corporate team.

13.Recommendations

The Primary Care Committee is asked to:

13.1 Note the combined financial summary position outlined in the financial report as at 3[1st] January 2024.

13.2 Note the Additional Roles spend to date and the anticipated forecast outturn and agreed central drawdown.

13.3 Note the approach to 2024/25 planning.

14. Officer contact details for more information

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Cheshire and Merseyside

NHS DENTAL RECOVERY PLAN FEBRUARY 2024

Agenda Item : SPCC 24/02/B14

Faster for patients through our new patient premium to support dentists to take on new patients and a new marketing campaign to help everyone who needs one to find a dentist

Simpler for patients and for dental staff by streamlining and tackling bureaucracy, with a wider set of workforce reforms to maximise the skills across the entire dental clinical team

Fairer, particularly for our rural and coastal communities, by introducing new dental vans to bring dental care to our most isolated communities, offering ‘golden hello’ incentives to encourage dentists into under-served areas and supporting those practices with the lowest rates of payment for their work

Plan has 3 components.

NHS
Cheshire and Merseyside

- **In 2024, significantly expand access** so that everyone who needs to see a dentist will be able to. This will begin with measures to ensure those who have been unable to access care in the past 2 years will be able to do so - by offering a significant incentive to dentists to deliver this valuable NHS care. We are introducing mobile dental vans to take dentists and surgeries to isolated under-served communities.

- **Launch 'Smile for Life'** - a major new focus on prevention and good oral health in young children, to be delivered via nurseries and other settings providing Start for Life services, and promoted by Family Hubs. We will also introduce dental outreach to primary schools in under-served areas, and take forward a consultation on expanding fluoridation of water to the north-east of England - a highly effective public health measure.

- **Ramp up the level of dental provision in the medium and longer term by supporting and developing the whole dental workforce**, increasing workforce capacity as we have committed to do in the NHS Long Term Workforce Plan, reducing bureaucracy and setting the trajectory for longer-term reforms of the NHS dental contract.

Launch Smile for Life: a new ambitious programme to promote good oral health across the life course

Support Family Hubs and other settings that provide Start for Life services across England to promote prevention initiatives to improve the oral health of pregnant mums, and guidance for parents about how to protect baby gums and milk teeth from decay

Support nurseries and other early years settings to incorporate Smile for Life good oral hygiene into the daily routines of infants and toddlers so that, by the time they reach primary school, every child sees daily toothbrushing as a part of their normal routine starting later this year, deploy mobile dental teams into schools in under-served areas to provide advice and deliver preventative fluoride varnish treatments to more than 165,000 children, strengthening their teeth and preventing tooth decay

Consult on expanding water fluoridation, initially to the north-east of England, so more people benefit from the prevention of dental decay

Make access faster and fairer for patients by investing in care delivered to new patients and rolling out new ways of delivering care in rural and coastal areas through dental vans

- Increase access for new patients by immediately introducing a new patient payment of either £50 or £15 for each patient, depending on treatment need, in addition to the funding the practice would already receive for their care support dentists to treat around a million new patients and launch a new public health campaign to raise awareness of how to find and access a dentist when you need one. The new patient payment will be in place until March 2025

- Launch a new dental van service for the most rural and communities, with the first vans up and running later this year

- Raise the minimum UDA value to £28 this year, making NHS work more attractive and sustainable attract dentists into areas in need with ***'golden hello'*** payments, starting with a first cohort of up to 240 dentists later this year

- Apply a firmer ringfence on NHS dentistry budgets for 2024 to 2025 so ICBs can seek to improve dental access with this budget

- Commence work this year to ensure that the funding provided to ICBs for NHS dentistry better reflects changing population demographics, such as ageing in coastal communities

- Bring forward legislation early this year to enable dental care professionals to work to their full scope of practice

Reducing bureaucracy and making NHS dentistry simpler for patients and all dental professionals

- As part of the NHS Long Term Workforce Plan, build a pipeline of new dentists for the future by expanding dental undergraduate training places by 40% to more than 1,100 per year by 2031 to 2032, with an initial 24% increase to 1,000 places by 2028 to 2029

- Consult this spring on ‘tie-ins’ to NHS for dentist graduates

- Increase the number of dental therapists and other dental care professionals, through a 40% increase to more than 500 training places per year by 2031 to 2032

- Make it easier for NHS practices to recruit overseas dentists who meet the UK’s highest regulatory standards

Reform the contract to make NHS work more attractive

Cheshire and Merseyside

- We have listened to concerns from dental professionals around how NHS dental care is funded and how the current contract and business models may not support the high-quality, personalised and prevention-focused care dental teams want to provide. While our new patient premium will support practices to accept patients who are struggling to access care they urgently need, and contract changes already delivered last year reward practices more fairly for complex care, we know that further change is still needed for care of some patients who require more significant and ongoing treatment to improve their oral health.

- Building on our guidance to support ICBs who are seeking to develop local services, we are developing further recommendations for dental contract reform to properly reflect the care needed by different patients and more fairly remunerate practices. We will also review what further action we can take to support professional development and skill mix within NHS dentistry, to make NHS dental care an attractive career choice where all professionals can work to their full scope of practice.

- We expect to develop options for consultation with the dental profession in advance of a further announcement later this year. Any changes would be phased in from 2025 onwards.

Enable practices to deliver more NHS care if they are willing and able

NHS
Cheshire and Merseyside

- Prior to our improvements to the NHS dental contract in 2022, practices were only able to deliver up to 104% of the activity committed to in their contract, with the extra 4% of activity carried forward into the next year. This meant practices that wanted to go further and treat more patients were limited in doing so.

- NHS England will work with ICBs over the course of 2024 to 2025 **to identify opportunities to support contractors to deliver additional capacity beyond their existing contractual requirements (up to 110%).**

- Free up funding for practices that can deliver more by addressing persistent contract under-performance. Unfortunately, at present, not all practices deliver the full amount of activity they have committed to and been funded for in their NHS contract. The amount of care that was commissioned but not delivered was equal to around £150 million in 2021 to 2022. Even before the pandemic, there was a substantial volume of practices that failed to deliver their expected contracted activity, leading to a loss of NHS oral healthcare, which could have been available for patients.

- Commissioners will be able to permanently and unilaterally amend NHS dental contracts that fail to deliver their contracted amount of dental activity over 3 consecutive non-COVID-19 years, releasing these UDAs to others to deliver instead. We will keep these new powers under review and consider whether further action is required.

Between 2020 and 2022, at least 7 million fewer patients saw an NHS dentist compared with pre-pandemic levels (2022 data compared with 2019). As those patients have returned to dental practices, they have found it difficult to get the care they need.

Embed good oral health habits across all parts of society - including a renewed focus on early years and our most deprived communities.

The NHS dental service is an essential cradle-to-grave prevention service. The government's launch of Smile for Life and the focus on early years is welcome. The consultation on expanding water fluoridation in some parts of England is an opportunity to improve the oral health of communities for generations to come