NHS
Cheshire and Merseyside

Meeting of the Cheshire & Merseyside ICB System Primary Care Committee

Part B – Public Meeting

Thursday 14 August 2025
Venue: Meeting Room 1, No 1 Lakeside,
920 Centre Park Square, Warrington,
WA1 1QY (WA1 1QA for SatNav)

Timing: 10:40-13:00

Agenda

Chair: Erica Morris

AGENDA NO & TIME	ITEM	LEAD	ACTION / PURPOSE	PAGE No
10:40am	**Preliminary Business**			
SPCC 25/08/B01	**Welcome, Introductions and Apologies**	Chair	Verbal	-
SPCC 25/08/B02	**Declarations of Interest**	Chair	Verbal	-
SPCC 25/08/B03	**Questions from the public (TBC)**	Chair	Verbal	-
10:45am	**Committee Management**			
SPCC 25/08/B04	**Draft Minutes of the last meeting (Part B) –** 19 June 2025	Chair	Paper To approve	Page 3 *Click here for link to page*
SPCC 25/08/B05	**Action Log of last meeting (Part B)** 19 June 2025	Chair	Paper To note	Page 14 *Click here for link to page*
SPCC 25/08/B06	**Forward Planner**	Chris Leese	Paper To note	Page 17 *Click here for link to page*
(10:55) **SPCC 25/08/B07**	**Primary Care Risks**	Stephen Hendry	Paper To note	Page 18 *Click here for link to page*

AGENDA NO & TIME	ITEM	LEAD	ACTION / PURPOSE	PAGE No
(11:05) **SPCC 25/08/B08**	**Contractor Voice** **Frontline Impacts on Strategic Direction**	Jonathan Griffiths / All	Verbal	-
11:15am	**Contracting, Commissioning and Policy Update(s)**			
SPCC 25/08/B09	**Dental and Community Pharmacy Optometry and Primary Care Medical**	Chris Leese	Paper To note	Page 27 *Click here for link to page*
11:25am	**Key Strategic Delivery Areas**			
SPCC 25/08/B10	**Neighbourhood Health**	Clare Watson	Verbal	-
(11:35) **SPCC 25/08/B11**	**Improving Access – General Practice – Update including GP Patient Survey**	Chris Leese	Paper	Page 36 *Click here for link to page*
(11:45) **SPCC 25/08/B12**	**Healthwatch Local Survey update / presentation**	Louise Barry	Tabled	-
12:00am	**Finance**			
SPCC 25/08/B13	**Finance Update**	John Adams / Lorraine Weekes-Bailey	Paper To note	*To follow 08.08.25*
12:10am	**Quality**			
SPCC 25/08/B14	**Quality Update**	Lisa Ellis (via Teams) / Chris Leese	Paper To note	Page 45 *Click here for link to page*
(12:20) **SPCC 25/08/B15**	**When a child dies – A Framework for General Practice**	Jonathan Griffiths	Paper	Page 76 *Click here for link to page*
12:30pm	**CLOSE OF MEETING**			

Date and time of next regular meeting:
Thursday 16 October 2025 (09:00-12:30)

TEAMS ONLY

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

Thursday 19 June 2025
12:00-13:30
Meeting Room 1, Lakeside, Warrington

Unconfirmed Draft Minutes

ATTENDANCE - Membership		
Name	**Initials**	**Role**
Erica Morriss	EMo	*Chair*, Non-Executive Director, C&M ICB
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
Naomi Rankin	NRa	Primary Care Member for C&M ICB
Chris Haigh	CHa	Deputy Chief Pharmacist, C&M ICB
Jonathan Griffiths	JGr	Associate Medical Director, C&M ICB
Adam Irvine	AIr	Primary Care Partner Member
Rowan Pritchard-Jones	RPJ	Executive Medical Director, C&M ICB
Chris Leese	CLe	Associate Director of Primary Care, C&M ICB
Anthony Leo	Ale	Place Director, Halton, C&M ICB
Daniel Harle	DHa	LMC representative
Matt Harvey *(via Teams)*	MHa	LPC representative
In attendance		
Sally Thorpe	STh	*Minute taker*, Executive Assistant, C&M ICB
Rob Barnett	RBa	Secretary, Liverpool LMC
John Adams	JAd	Head of Primary Care Finance, C&M ICB
Lorraine Weekes-Bailey	LWB	Senior Primary Care Accountant, C&M ICB
Cathy Fox	CFo	Associate Director of Digital Operations, C&M ICB
Lucy Andrews	LAn	Primary Care and Corporate Estates, Cheshire East, Cheshire West and Wirral Place, C&M ICB
Ian Ashworth	IAs	Director of Population Health, C&M ICB
Lisa Ellis *(via Teams – meeting in part - agenda item SPCC 25/06/B10)*	LEl	Associate Director Quality & Safety Improvement, St Helens Place, C&M ICB
Jordan Brown *(meeting in part agenda item SPCC 25/06/B11)*	JBr	Programme Manager (Oral Health), Beyond CYP Transformation Programme, Alder Hey

Apologies		
Name	**Initials**	**Role**
Christine Douglas	CDo	Director of Nursing & Care, C&M ICB
Tony Foy	TFo	*Vice-Chair*, Non-Executive Director, C&M ICB
Susanne Lynch	SLy	Chief Pharmacist, C&M ICB
Mark Bakewell	MBa	Interim Exec Director of Finance, C&M ICB

Agenda Item, Discussion, Outcomes and Action Points

Preliminary Business

SPCC 25/06/B01 Welcome, Introductions and Apologies

EMo welcomed everyone to the meeting.

SPCC 25/06/B02 Declarations of Interest

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

SPCC 25/06/B03 Questions from the public (TBC)

A written question had been received but that it was not being discussed within the meeting today, a formal and direct response will be given in due course.

Committee Business

SPCC 25/06/B04 Minutes of the last meeting (Part B) 17 April 2025

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

SPCC 25/06/B05 Committee Action Log (Part B) 17 April 2025

In relation to Action SPCC 24/10/B13 IAs stated that it was great that this was being looked at, and was the aim to make inequalities more business as usual, it is important that, we as an organisation, demonstrate and tackle inequalities. This is monitored at board and there is a healthcare inequalities and strategy on this.

It was further advised that with regard to making decisions, along with QIA, this formed part of the primary care access recovery plan and how this is embedded and the impact on local communities.

It was suggested that there did not need to be a separate piece of work on but that there should be consideration of health inequalities within all areas. Further suggesting that within presented papers there should be a section within the format of the paper template.

LDC colleagues highlighted that there view is that the current dental team is under capacity, , therefore there is a need to be looking at this more effectively. Considerations also around taking Urgent Care into account and that it is still gaps in general dental provision to improving oral health. Noted that UC is very good at dealing with emergencies but that there are some underserved groups, with concern around residential care homes and children that cannot access dentistry. These are all the pieces of work to do, but there is little or no capacity.

In response it was recognised that it was the same dental contracting team inherited from NHSE but agreed that there was still a lot to do - that dentistry remained a priority and one of the key outcomes of the future operating model will be to look at a more integrated team across the four contractor groups.

The remaining action on the Log were considered and updated accordingly, the Action Log was **NOTED** and that updates would be included in the next version.

SPCC 25/06/B06 Forward Planner

The Forward Planner was **NOTED**, and amendments please to CLe.

SPCC 25/06/B07 Contractor Forums Updates

i) Issues for awareness

General Practice

Advised that the new weight management medication 'Tirzepatide' (brand name Mounjaro) has been made available to NHS patient to support weight loss. NICE approved this late last year but was unaffordable by the NHS and so the 90 days was extended to 6 months and came with restrictions on use. The period of 6 months is up next week. After this time, this medication should be able to be prescribed for a very restricted cohort of patients. In terms of the ICB, this is not out of alignment with other ICBs and we are looking to commission this in the future through a set service.

It was advised that this would be available within each place, but if it cannot be prescribed then it will be to look to provide an existing weight management service to see if they can provide it. Noted that there will be a service in each area, but with the request for GPs to please not prescribe in the interim period due to this wrap around service.

Post meeting note, communication released by the C&M Medical Director on 25th June 2026, for clarity GPs are not directly able to prescribe Tirzepatide (or other GLP1 drugs) for weight loss (they are for diabetes) in Cheshire and Merseyside. In line with the requirements of the NICE TA 1026 we're currently in the process of establishing new community-based weight management prescribing services, which are set to launch this summer.

It was outlined that there is likely a much larger cohort of patients who will come and ask for the drug and who are not eligible as opposed to those who meet the very strict conditions and eligible.

National eligibility is limited only to people who have a BMI of 40 or more, plus four of the five long-term specified conditions.

Noted that this will carry a cost pressure potentially for the ICB. NHSE have given an allocation for the numbers they feel C&M will get, but it is believed that figures will be much higher than projected. Initially looking to potentially have a cap, possible on a first come first served basis. It will be easier to do this on a localised service rather than through individual GPs. Communications have gone out and more will be due out.

RPJ outlined that he had met with colleagues at Greater Manchester earlier who had advised that they were looking to actively invite eligible patients in, but that it was unclear how many patients would take up the offer, of course, even those eligible might not take up the offer. Further noting that looking at the eligible cohort, they are already disproportionately represented in deprivation, we are going out to support the right people and moving in step with Manchester and can do a coordinated approach as needed.

There was concern expressed that by December the funding will run out for the weight management medication, and whilst the system are not making it easy for patients (which is good) there will need to be good engagement in the wrap-around service. There also may be an issue around anxiety for those patients who have been prescribed it, that they may not be able to come off it or stop taking it completely. It is know that most GPs will act responsibly around this medication issue, but that there will be some pressure from some patients in some practices who will feel it is their right to have it, and it will be the responsibility of the GPs to say No, this could cause some issues.

It was questioned whether there were any domiciliary considerations for housebound patients with a weight issue, in response it was stated that the ICB had submitted a bid for the designing of a primary care pathway, and that the group in Warrington have been successful with this pathway but were awaiting the level of the award, it was outlined that patients who are housebound will be considered.

In terms of collective action, it was outlined that the GPC were no longer in dispute with the Department of Health and therefore collective action is no longer being pursued. GPC Local Medical Committees will still work on issues where work is unpaid (this is what the collective action was around) and will in essence look to create a 'list' of the work that would be considered for stopping.

It was outlined that there has been ongoing push back on unfunded work for some time now, and that there are working groups who are looking at these. A list was discussed at the Cheshire county meeting which included a mandate and comms were sent out to all practices and system partners.

Noted that the advice from BMA is appropriate, and all comms for Cheshire LMC went out yesterday, practices have been given notice on the lists of work for specific areas in Cheshire and that after three months (by 1st October) they will no longer do that work. It was emphasised that they may want to consider patient safety and where not appropriate to do as well.

Noted that this may be all, none or some of the practices, and there will be a review of discretionary spend in primary care with a view to trying to harmonise across the patch. It is likely that this exercise will highlight where there may be a commissioning gap, and this then needs to be worked through.

It was outlined that in Liverpool nothing was being done as systematic as in Cheshire, but that they have a choice whether to continue with some items or not. It will be for the system to make a decision as to what it wants to do going forward.

Dentistry

Advised that Healthwatch Warrington had produced a really good report around talking with people about dental provision, which highlighted a number of issues that have been seen elsewhere, in particular a focus on the 0-5 year olds. Additionally to make sure that the commitment continues on this within Urgent Care.

Figures show that people are being admitted to hospital for dental issues therefore it is important for those people to have been seen and intervened well in advance of needing that, important that we need to continue to invest in making sure that our services are hitting the right areas and understand how effective they are being. There does seem to be a bottleneck in triage and this further results in not being able to use the full capacity of the network.

Pharmacy

To be mindful of any 'noise' or any symptoms locally in relation to one of the mainline wholesalers who appears to have stopped delivering on a Saturday to a number of pharmacies, this is not replicated everywhere but there may be a delay in dispensing as most pharmacies will still be contractually employed to dispense if a prescription comes in and they have to hold back until the Monday.

Secondly, in relation to dispensing, when subscribing to a subscription and if an original pack is within 10% of that prescription, then the pharmacy can issue the original pack rather than splitting a pack or adding two packs to make the prescription length. This is something that is rolling out more and more with the system pharmacy provider, whilst it is not a new thing, it is more for information in case there is 'noise' in the system and there is rationale behind it.

Ophthalmology

Outlined that most of the issues experienced come back to national problems, for example, PCSE (the management software company for an eye test) made changes to the software but did not communicate out, which meant that when somebody came in for an eye test you had to put in the outcome of the eye test before it was done

There remain concerns in relation to the National Insurance increase, the LOC are hearing about lots of practices who are not taking on any new staff, or that pre-reg staff are not finding places because practices do not want to take them on.

Concern about time limited pilots was also expressed.

There is an issue in shortsightedness in children, exacerbated by health inequalities which was highlighted as a future challenge.

There are lots of primary care optometry that can help in terms of neighbourhood communities and the services that will be needed, referring back to the 10 year plan and the 3 shifts/

ACTION: to be fully engaged with all four contractors in terms of the 10 year plan and future developments

The Committee **NOTED** the updates.

Contracting, Commissioning and Policy Update(s)

SPCC 25/06/B08 Dental and Community Pharmacy, Optometry and Primary Care Medical

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

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

The paper highlights:
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
The Committee were asked to ;
Note the updates in respect of commissioning, contracting and policy for the four contractor groups.
Note and be assured of actions to support any particular issues raised in respect of Cheshire and Merseyside contractors
The report was noted to be for ***information*** and ***no decisions*** required

Discussion
Noted that these were national urgent care appointments, and that the scheme went live in April and that we are now 18% off trajectory which is being monitored, we just need to rectify the position.

The Committee gave thanks for the informative paper, adding that it was really positive to see the delegation agreement and that they were all showing as green. Noted that we will be accountable and responsible for this going forward.

The Committee **NOTED** the report and were **ASSURED** of the actions to date.

Finance

SPCC 25/06/B09 Finance Update

The report provides the Primary Care Commissioning Committee of the Cheshire and Merseyside Integrated Care Board (ICB), with a detailed overview of the preliminary financial position related to primary care expenditure as at the end of May 2025 (Month 02).

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 highlighted key variances within the financial position, in respect of the forecast outturn, compared to the allocated budgets.

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

It also provided the most up to date breakdown of the Additional Roles Reimbursement Scheme (ARRS) allocation.

The Committee were asked to:
Note the preliminary combined financial summary position outlined in the financial report as at 31 May 2025
Note the Additional Roles allocation
Note the capital position

Discussion
Advised that this showed a £4.6m overspend on delegated budgets and in relation to the PMS premium it was due to the CCG in Knowsley, at that time did not agree to this this. Advised that the cost per weighted population core values shows as much higher, and that now this has been put into the local discretionary funding. Noted that this was similar to running costs in that it cannot just be moved from local. The delegated spend will remain underspent but discussions are still underway.

In relation to delegated budgets it was advised that we would need to reimburse the GDRs and this increased locum costs, this will continue to be monitored, but that depending on how things go it may be necessary to bring a paper to a future SPCC meeting. Advised that in-year this will be funded from allocation but that next year discussions will need to take place around funding.

In terms of QOF, there is a circa £400k overspend, and despite good achievements whilst this is good from a general practice perspective, this does give a £400k pressure.

Relating to prescribing, there is a £2m pressure from last year, advised that the waste programme last year did not achieve its projected outcome, however the programme is ongoing so hopefully will see some improvement on this.

In terms of the delegated primary dental it was questioned whether this included the additional programmes that were running? It was advised that it was right on target for GDS, but was this £23m additional? In response, JAd stated that this was correct and that it included the investment plan, which at this stage was very much an estimate, adding that he was very happy to talk more about this at a later time.

It was questioned whether the Knowsley and PMS premium had balanced out? In response it was advised that this was always balanced as now in-line however this was about them being funded by the correct pots of funding. **It was added that it would be useful to see the table and was agreed that this will be presented to the next SPCC meeting.**

Relating to capital, it was advised that there are different 'pots' and that we are confident that we will spend it all, there is a reserve list for the U&M work that can be used if any scheduled schemes fall off

or are withdrawn. It remains business as usual for digital. Costs to be confirmed where there is a change in lease, but there is a notional amount of £1.3m, this may not all be needed but when confirmed we will have a better idea and that it will be for this Committee to decide whether it be for estates or digital etc.

Noted that Month 3 will show actuals.

The Committee gave thanks and **NOTED** the report and update.

Quality and Performance

SPCC 25/06/B10 Quality Update

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

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

The paper included an update on quality assurance across Cheshire and Merseyside by highlighting:

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

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

Discussion
Outlined that the oversight arrangements provides a level of reassurance and that there are robust measures in place, noted that this feeds into the report.

The complaint information has been included within the report and that there is more work to do, will also start to add in compliments/positive feedback.

Noted that compared to where we were, this shows there has been great progress and that it has been a good piece of cross organisational work. Having the complaints information will also help to triangulate as this information is also received by the QPC Committee.

It was noted by LDC colleagues that they had only read the information re dental visits for the first time within the report and asked that going forward if they could have sight of it before the final version so they can add their support in advance. It was noted that the information was received by the dental operational group but agreed that they would not have seen the framework, therefore they would look to seek LDC support going forward.

Noted that there are some wider quality assurances in terms of primary medical, and that this will now become a regular item presented to SPCC each meeting. This item was agreed to be in review for a period of time to ensure that reporting does not become too onerous.

The Committee gave thanks for the report and **NOTED** the report.

SPCC 25/06/B11 Evidence based oral health improvement programme (All Together Smiling (ATS) – progress update

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

Discussion
The Committee welcomed Jordan Brown to the meeting for this item of discussion.

IAs presented this item to the committee outlining that it had been agreed at this committee (in October 2023) to support with the supervised brushing campaign, advising that not only would this help to reduce demand on healthcare services both in admissions but also the pain that children have to go through as well as the impact this will have on dental services.

Outlined that table 2 in the pack showed progress on the impact factors, to mobilise from April 2024, and that for eligible settings this is considerable across the nine Places. Currently this is sitting at 30% of the eligible settings that we wanted to deliver to and this is aimed to be 50% by the end of Q2.

There has been absolute support from most of the settings and there has been real positive recognition in this space, both with a national visit and an announcement from the DoH around the oral health programme for 3-5 year olds supervised brushing, noting that this is non-recurrent but that it will enhance what was already there and not to duplicate.

Outlined that it would be great to do more, to look at universal offers beyond targeting our 2-7 year olds in deprived areas and for our communities.

Noted that this is currently funding to 2026-27, and now it is about what options there are for this moving forwards.

This has been trail-blazed and tested to roll out at Place and on scale. Outlined that there are two Local Authorities (as shown in the paper) that have been shown it to be hugely beneficial to the success of the initial roll out of innovation. The significant number of packs that have been distributed and after holding a targeted approach on data, whereby families have said they had not had access to toothbrush or paste, the results really show the need and the poverty they are facing. The valuable feedback provides the assurance that this is having the correct impact.

Recently it was national smile month so by delivering a roadshow using a mobile unit to visit each place those meaningful conversations with families have taken place and have been able to distribute the resources where it has been needed. It is recognised the difficulty in encouraging children to brush their teeth, but it is well documented around the impact of decay and the impact of extractions this has both on the child and on the family units so it is great to start to see some of those real long term habits forming.

Any questions/ challenges on this.

The Committee noted that it gave great pleasure to be able to approve this at the time, and it is great to receive the assurance and to see best practice on this, thanks were extended to the team and all involved in this work.

Key that going forward we look at the evidenced based commitment and the impact this is making and the funding going forwards.

It was questioned as to when the Committee might see a tangible reduction? In response it was advised that Dr Yvonne Dailey was working on this, but to remind all that there may be an initial increase in terms of finding dental decay because of this targeted work, and that a reduction of around 43-50% in most deprived areas over 24 month period potentially was over estimated. However this is more about the longer term / medium term commitment and impact.

Noted that this firmly sits within the preventative space, and what work the local authorities are doing so it is an even offer rather than us finding ways. Yes this is really important and key to link in with public health and the champs team across the nine local authority areas. Key to remember if you want this to work well it really cannot be duplicated.

A baseline exercise was conducted in relation to a 0-19 school nurse service being in some Places and other Places having nothing at all. Now that it is a national launch it is a smaller group, but it does bring in resources to link this up. Noted that our resources need to go to where it needs the most. Also keen to protect the ATS branding as part of the All Together Fairer plan.

Finance is tapered at 2026/27. Considerations going forward.

The Committee gave thanks and **NOTED** the update.

SPCC 25/06/B12 Advice and Guidance

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

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

The Committee is asked to ;
Note the updates in respect of Advice and Guidance
Agree the key actions as outlined in 4.2 of the paper

Discussion
It was outlined that traditionally seeking advice from a colleague would be done via email with usually a fairly speedy response back, and that seeking advice from a consultant colleague might just negate the need for a patient to go to hospital, it is cheaper, in terms of it not being on an outpatient tariff rate, and it retains responsibility with a GP for that patient, however it might mean picking up additional work if potentially the advice gives extra work.

Advice and Guidance has now been in place for a while but it has not been paid for the GP, however this has now been recognised by national negotiations from GPC and from this year there is now an enhanced service fee or when they request advice and guidance at a cost of £20 per query.

The paper outlines that (we) are now receiving a set amount of money that cannot be used for anything else, and that we are not able to spend over that limit. The ask of the Committee is to agree a cap that is based on that amount of money divided by the population and then that cap would be applied to practices so that each practice would receive a weighed capital value. In addition to this, there has been negotiation to with hospital colleagues who will receive £100 for that guidance (noting that the national guidance was over £200).

The issue with this is around patient choice, and that if seeking Advice and Guidance then one does not need to offer choice, but at what point will you offer patient choice as to where they want to go.

Also need to think about what happens when the cap is reached - Would this mean that practices/ colleagues can no longer asking for Advice and Guidance or if they did ask, it would not be funded, but then we would still pay the £100 to the hospital as a default position, this seems inequitable.

It was additionally pointed out that GPs would be funded £20 for seeing a patient, taking their full history etc as part of that initial consultation to then pose a question to consultant colleague who provides a one sentence reply (usually saying 'we will see the patient') for which they are paid £100, one consideration is that the £100 is only paid for 'true' advice and not just 'we will see the patient' for example.

Additionally there have been instances when the advice or recommendation has been to refer, but then the patient is rejected and the hospital still receives the payment.

Noted that language is key here and that this should be referenced as Practices and Hospitals and not GP and Consultants as this is not relating to individuals themselves.

Outlined that NHSE have been asked to monitor this through the Primary Care Secondary Care Interface Groups (PCSCI) groups, and that locally for C&M we have a number of these groups which sit in a local footprint or as an oversight group and support was sought from SPCC to be able to push back as needed in terms of appropriateness of some of the data being asked for.

The plan is that a report will be produced on a quarterly basis, it is known that Practices are not utilising this service effectively as they do not know what the cap is, so getting this information early would hugely help. Other considerations to be aware of is around the potential issue of any potential underspend, but noted that this is a discussion for a later meeting and is not the ask of the committee today.

RPJ stated (recognising his COI as a working consultant), that if money is available and practices are really getting on with such advice, he would like to think there would become a plateau and a degree of learning, there are always new treatments and new ways of investigating.

In relation to patient choice it was questioned where this fitted in, and whether we know how many in practice GPs are offering patient choice in reality, how big a problem is this for patients not being given a choice? In response, **JGr and LBa agreed to discuss outside of SPCC**.

Noted that in Merseyside, there is a triage referral advice service and that if a patient needs to be seen it goes through that service rather than via the GP directly.

Following discussions;

- The Committee **AGREED** that the best place to start would be that there has to be a cap to start with, and to put this forward as a pilot, to learn and review it for 6 months (Month 8 thereabouts) to come back to Committee with a report and update (or sooner if required)

- To seek a finance view at a later date if there is an underspend projected

- JGr and CLe to hold the ring on the Interface meetings and how these will be improved, what steps and what reassurance will be put into place

Transformation

SPCC 25/06/B13 Estates Programme Update

It was advised that this paper was for the Committee to Note, and that for every SPCC meeting there will be a deep dive on various elements of the Estates programme. It was noted that this paper was focusing on the Strategy element of Estates and looked to provide an update on the ICS Infrastructure Strategy and associated actions.

The Committee noted that it was useful to understand the terminology and that the position of our estates is quite daunting, good that the conversations continue.

It was questioned as to how we might engage with partners and investment on wider neighbourhood health, and that this is around a strategic estates strategy. Noted that over the last few meetings, LCR (Liverpool City Region) have started attending the group and that the challenge from Board is to have representation from all nine local authority areas.

Noted that this programme receives oversight from the Strategic Estates Board and check and challenge/delivery is managed through Place Estates Groups. There remain resource issues within the Place for certain elements of delivery. The Core, Flex and Tail classifications have been provided to support Board members understanding but noting this was an example and work is ongoing to establish the NHS position for C&M. The intention is for this to be expanded to wider ICS colleagues including the local authority.

The Committee gave thanks and **NOTED** the report and update.

CLOSE OF MEETING

Date of Next Meeting: Thursday 14 August 2025 (09:00-12:30)
F2F, Lakeside, Warrington

CHESHIRE MERSEYSIDE
INTEGRATED CARE BOARD

Action Log 2025/26 *updated Aug 2025*

SPCC (B - Public) Action Log - Live Actions

Action Log No.	Original Meeting Date	Description	Action Requirements from the Meetings	By Whom	By When	Comments/ Updates Outside of the Meetings	Status
SPCC 24/08/B10a	15-Aug-24	Contracting, Commissioning and Policy update : Community Pharmacy and Dental	Request at the December SPCC meeting for a view of progress of PC Strategies on Inequalities/ deprivation . Discussion held at April SPCC and further conversation to be held between Clare Watson and Ian Ashworth around availability of Inequality data for future meeting	Clare Watson	June 2025	*Ian detailed ineqaulty assurance to date, general comment robust narrative in all Primay care papers going forwads*	COMPLETED
SPCC 24/10/B13	17-Oct-24	Local Dental Improvement Plan	Ian Ashworth or the Beyond Team to be invited to a future meeting to give progress on oral health - to come as part of the improvement plan	Ian Ashworth & Team	June/August 2025	*scheduled on June 2025 agenda*	COMPLETED
SPCC 24/12/B07	19-Dec-24	System pressures	Various conversations within SPCC about progress of PCARP and the movement of metrics against the patient experience, brief verbal update from survey from Healthwatch in Feb and full review in April SPCC with actions for Board in July 25. SPCC August action to review feedback from Board in July and confirm action plan approach and further reporting.	Clare Watson/ Chris Leese	01-Aug-25	*June 2025 update - action plan to be within board paper July 2025* *Thorough research document presented by Healthwatch to April SPCC - response will be required to HW plus action plan to Board in July* *merged with Action Log #SPCC 25/02/B13ii with the narrative 'Subject to fitting into national timescales, the June action plan (mandated by NHSE) will be an item for June's SPCC, this will outline expected actions and key metrics to deliver the operational planning guidance / access improvement for 25/26, including relevant patient experience measures'.*	ONGOING
SPCC 25/02/B14i	20-Feb-25	Contract Performance Indicators	Discuss at next meeting under revised planning guidance asks	Chris Leese	April & June 2025	*Chris Leese delivered a detailed update on the "asks' with a final report to be completed in June. This will be included within the agenda for June SPCC.*	COMPLETED
SPCC 25/02/B15	20-Feb-25	Community Pharmacy Access Review	Confirm that rota review underway.	Tom Knight	Aug 2025		COMPLETED

Action Log No.	Original Meeting Date	Description	Action Requirements from the Meetings	By Whom	By When	Comments/ Updates Outside of the Meetings	Status
SPCC 24/08/B10a	15-Aug-24	Contracting, Commissioning and Policy update : Community Pharmacy and Dental	Request at the December SPCC meeting for a view of progress of PC Strategies on Inequalities/ deprivation . Discussion held at April SPCC and further conversation to be held between Clare Watson and Ian Ashworth around availability of Inequality data for future meeting	Clare Watson	June 2025	*Ian detailed ineqaulty assurance to date, general comment robust narrative in all Primay care papers going forwads*	COMPLETED
SPCC 25/04/B04	17-Apr-25	Primary Care Risk Report	Thorough review of all risks to achieving strategic aims across the 4 contractor groups taken forward. Initial feedback from SPCC in June and depper dive on agenda for August 25.	Dawn Boyer / Gavin Wraige	Aug 2025	*Review of all risks across the 4 Contractor groups in August SPCC*	ONGOING
SPCC 25/04/B10	17-Apr-25	Healthwatch - General Practice Access survey results	i) on behalf of the Healthwatch's would formally send the final report to the ICB. CWa inviting a response as part of the official release	Louise Barry / Clare Watson	May 2025	*Formally received and will be presented to Board in July 25*	COMPLETED
SPCC 25/04/B10	17-Apr-25	Healthwatch - General Practice Access survey results	ii) to include an update on this survey in the Chair's report to Board in Many with the full report, actions agreed and the earlier mentioned 'June' plan returning to Board in July	Clare Watson / Erica Morriss / Chris Leese	May Board	*Included in report and verbal update given to Board with thanks to Healthwatch*	COMPLETED
SPCC 25/04/B10	17-Apr-25	Healthwatch - General Practice Access survey results	iii) A further discussion around around the investment made by the ICB via SDF / PCARP would be picked up by CWa as part of future Exec funding discussion with Place	Clare Watson	May - Executive conversations		COMPLETED
SPCC 25/04/B10	17-Apr-25	Healthwatch - General Practice Access survey results	iv) share this presentation with Place Primary Care leads in advance of the final report	Chris Leese	By August 25	*Received and actioned by Chris Leese*	COMPLETED
SPCC 25/04/B11	17-Apr-25	Operational Planning Guidance - Access Improvement Oversight (Primary Medical)	i) to continue to hold the ring on this work and to bring the June plan to the next committee meeting (subject to any national agreement re timelines)	Chris Leese	June - TBC	*Included within within June agenda and led by Chris Leese*	COMPLETED
SPCC 25/04/B11	17-Apr-25	Operational Planning Guidance - Access Improvement Oversight (Primary Medical)	ii) to pick up further the framework discussions as part of Exec work on the future operating model	Clare Watson	May - Executive conversations	*Included within current operating model review*	COMPLETED
SPCC 25/04/B11	17-Apr-25	Operational Planning Guidance - Access Improvement Oversight (Primary Medical)	iii) that the June plan be presented to the July ICB Board as noted in earlier actions, as part of an overall Access Improvement paper	Clare Watson	July Board	*Presentation to Board scheduled for July to incorporate Healthwatch survey results and ICB Plan.*	COMPLETED

Action Log No.	Original Meeting Date	Description	Action Requirements from the Meetings	By Whom	By When	Comments/ Updates Outside of the Meetings	Status
SPCC 24/08/B10a	15-Aug-24	Contracting, Commissioning and Policy update : Community Pharmacy and Dental	Request at the December SPCC meeting for a view of progress of PC Strategies on Inequalities/ deprivation . Discussion held at April SPCC and further conversation to be held between Clare Watson and Ian Ashworth around availability of Inequality data for future meeting	Clare Watson	June 2025	*Ian detailed ineqaulty assurance to date, general comment robust narrative in all Primay care papers going forwads*	COMPLETED
SPCC 25/04/B12	17-Apr-25	Finance Update	Update on ADHD dropped from action logged and SRO to be contacted and diary date agreed for next presentation.	Chris Leese/Clare Watson	01-Aug-25	*Laura Marsh to present update to SPCC in Aug 2025* *scheduled on Agenda for August 2025*	ONGOING
SPCC 25/04/B14	17-Apr-25	Freedom to Speak Up	that the narrative be reworded to give clarity around the PCN pharmacist	Chris Douglas & Temitayo Roberts	May	*Actioned through conversation between Chris/Temitayo*	COMPLETED
SPCC 25/04/B15	17-Apr-25	Digital - Shared Care (Connected Care records)	i) a representative from each of the four contractor groups to liaise and link in with Lesley Kitchen	May/June	outside of SPCC	*No further action*	COMPLETED
SPCC 25/04/B15	17-Apr-25	Digital - Shared Care (Connected Care records)	ii) regular 6 monthly update to SPCC Committee	Kevin Highfield / Cathy Fox	October 2025		ONGOING
SPCC 25/06/B12	19-Jun-25	Advice and Guidance	Pilot in place, for a period of 6 months to allow for review, to come back to SPCC with a report and update (sooner than 6 months if necessary)	Jonathan Griffiths	October 2025		NEW

Forward Planner 2025/26 : System Primary Care Committee

updated July 2025

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

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

Date: 14th August 2025

Committee Risk Report

Agenda Item No: SPCC 25/08/B07

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

Committee Risk Report

1. Purpose of the Report

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

2. Executive Summary

2.1 As previously reported, arrangements for the reporting and oversight of primary care risks remain under review as the ICB transitions towards the national model ICB blueprint. Workshops and discussions have also continued since the April 2025 committee meeting to develop key risks to 2025/26 key strategic objectives - applicable across all four contractor groups. Updates in terms of progress with this development work and proposed new risks are contained within the report.

2.2 The April 2025 committee report proposed the creation of 22 'new' corporate risks, with 9 of the proposed risks applied across all four primary care contractor groups. Following the publication of the NHS 'Ten Year Plan' on 4th July 2025, the risks proposed in April 2025 have been further assessed (also within the context of the future ICB operating model) and have subsequently been reduced from 22 to a total of 16 risks, which comprise the following:

- **GP primary care** – 7 risks including access & demand, financial constraints at national and local level, workforce, estates
- **Dental services** – 4 risks including workforce, access & demand and financial constraints at both national and local level
- **Community pharmacy** – 3 risks including access & demand and financial constraints at a national and local level
- **Optometry**– risk to be discussed further at operational group.
- **Neighbourhood Health** – further discussion in relation to this is required.

One principal risk from the ICB's 2024/25 Board Assurance Framework **(P6)** has been delegated to committee level for a decision on future management. It should be noted that **P6** has been superseded by the new proposed primary care risks for 2025/26 relating to access and demand, and the committee is therefore asked to consider the closure of this risk.

Dental risk **PD2** was reviewed in August 2025 and has been rated as moderate (12) with moderate potential impact (representing an increase in score from the April 2025 meeting).

Discussions continue to take place with colleagues in other ICB directorates to support the assessment of the risks in relation to finance and estates.

A summary table of the new and existing risks can be found in **Appendix 1**.

2.3 At the April 2025 meeting, the committee agreed with the recommendations to close the following risks, which have been subsequently removed from the committee risk register.

Risk ID/title	Rating at close	Reason for removal
1PC - Sustainability and Resilience of Primary Care workforce (General Practice, Community Pharmacy & General Dental Services	**16**	Superseded by new risks for specific contractor group
8PC - Potential Collective Action and GPs working to contract only in response to the 24/25 Contract Offer, impacting on patient care and access to services	**16**	24/25 contract offer accepted. Risk of further collective action in 2025/26 will be assessed.

2.5 A review of all primary care themed risks at 'place' level is currently underway to ensure consistency of approach and alignment with the proposed committee level risks for 2025/26. An analysis of primary care risks reported at place level has concluded that the majority would be superseded by the new risks proposed and discussions will continue with place primary care colleagues during August and September 2025 to further develop the delegation of 'risks in common' and place reporting arrangements.

3. Ask of the Committee and Recommendations

3.1 **The Committee is asked to:**

3.1.1 **APPROVE** the creation of 7 new risks for GP primary care listed in Appendix 1
3.1.2 **APPROVE** the creation of 3 new risks for dental services listed in Appendix 1
3.1.3 **APPROVE** the creation of 3 new risks for community pharmacy listed in Appendix 1
3.1.5 **APPROVE** the recommended closure of BAF risk **P6**
3.1.6 **APPROVE** the step-down of risk **PD2** to Operational Group level for management and review
3.1.7 **NOTE** the proposal to complete detailed assessments for 'new' risks., subject to approval by the committee (including proposed arrangements for reporting and assurance which will be brought to the October 2025 meeting).
3.1.8 **NOTE t**he risk areas where further discussion is required to understand and finalise pending agreement.

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 environmental factors, with the identification of risks the responsibility of all ICB staff. This is done proactively, via regular planning and management activities and reactively, in response to inspections, alerts, incidents and complaints. The committee is asked to consider whether any further risks should be included.

4.4 Reviews of all primary care risks – including their oversight and reporting arrangements will continue within the context of 2025/26 national priorities, the ICB's strategic objectives and existing / emerging risk themes applicable across the four contractor groups. The new risks presented in this report have been developed based on these principles.

5. Background

5.1 The establishment of effective risk management systems is vital to the sustainability of both 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 which are rated as high or above are escalated to the committee risk register. Committees will receive an overview of all relevant risks on first identification and annually, including those not meeting the threshold for escalation, to enable oversight of the full risk profile.

5.3 This committee risk report sets out proposals developed through a thorough review of the ICB's primary care risks. This includes a draft Committee Risk Register (Appendix 1) which reflects the outcome of the review.

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, supports 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 of plans and objectives.

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

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

8. Link to meeting CQC ICS Themes and Quality Statements

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

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

9. Risks

9.1 The review of primary care risks has resulted in the identification of 16 risks, based on the key strategic objectives and risk themes agreed by the Committee Chair and Lead Officers. The risks have been applied to each of the 4 contractor groups as appropriate based on the ICB's responsibilities in relation to each group and the current risk environment.

9.3 Risk **PD2** (Dental workforce) has been assessed in August 2025 as having a moderate potential impact (12), an increase in score since the April 2025 meeting.

9.4 Responsibility for dental services, community pharmacy and optometry lie with the central Primary Care contracting Team(s). Responsibilities for GP primary care are split between corporate and place teams. Therefore, a number of risks on the current primary care risk register have been escalated from places, comprising 3 place risks in common and 9 unique place risks. It is considered that all 'risks in common' and potentially individual place risks are covered by the new risks proposed.

9.5 The continued review of primary care risks aims to ensure a more consistent approach to describing and managing 'risks in common' across places for GP primary care. It is anticipated that ownership of such risks and control action will be split between the corporate and place teams based on the nature of the risk and respective responsibilities.

9.6 As there are a large number of proposed 'new' risks for 2025/26 it is essential that the Committee is supported in its oversight and assurance role by the sub-

groups reporting to the Committee (e.g. Operational Contractor Groups, Primary Care Workforce Group, Primary Care Estates Group). The ICB's Risk Management Strategy and process require that the Committee retains direct oversight and responsibility for providing assurance to the Board in relation to all BAF and Corporate Risk Register (Extreme+) risks but allows oversight of other risks to be delegated with appropriate reporting arrangements.

9 Finance

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

10 Communication and Engagement

11.1 No patient and public engagement has been undertaken.

11 Equality, Diversity and Inclusion

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

12 Climate Change / Sustainability

13.1 No identified impacts.

14 Next Steps and Responsible Person to take forward

14.1 Subject to the Committee's approval of the new risks, the nominated operational lead for each risk will be asked to complete a risk assessment using the ICB's risk summary template. Support is available to leads from the Corporate Affairs and Governance team.

14.2 In respect of GP primary care risks and 'risks in common', discussions are ongoing with place primary care leads to establish a consistent approach / process to describing and managing such risks and assigning ownership.

14.3 Should the Committee approve the recommendations, detailed risk assessments, together with proposals for oversight, assurance and reporting arrangements will be brought to the October 2025 meeting of the Committee for approval. Reporting to Committee Sub-Groups will commence following approval, supported by a briefing on Sub-Groups responsibilities at the initial meeting.

15 Officer contact details for more information

Stephen Hendry
Head of Business Support
NHS Cheshire and Merseyside ICB
stephen.hendry@cheshireandmerseyside.nhs.uk

16 Appendices

Appendix One: System Primary Care Commissioning Committee Risk Register Summary (August 2025)

Appendix One: Primary Care Committee Corporate Risk Register Summary – July 2025 (Version4)

Risk ID	Risk Title	Senior Responsible Owner	Inherent Risk Score	Current Risk Score	Previous Risk Score	Target Score	Risk Proximity
All Contractor Groups							
P6	Demand continues to exceed available capacity in primary care, exacerbating health inequalities and equity of access for our population **Stepped down from 2025/26 BAF for management / oversight at Committee level [Subsumed by new risks]**	Clare Watson	**20**	**12**	**12**	**12**	B – within financial year
GP Primary Care							
PG1	Access to general practice services will not meet demand, impacting negatively on patient experience and outcomes and delivery of the access improvement plan.	Chris Leese	**4x4=16**	**12**	**NEW**	**8**	B – within financial year
PG4	Inability to recruit and retain GP primary care workforce may curtail or delay access improvement plan success, impacting on quality and increasing pressure on remaining staff	Chris Leese	**4x4 = 16**	**12**	**NEW**	**8**	B – within financial year
PG6	Reduction in capital development funding for estates may curtail or delay GP primary care access improvement plans, impacting on quality and trust and confidence in the ICB	James Burchall	**3x5=15**	**15**	**NEW**	**10**	B – within financial year
PG7a	National financial constraints / pressures may limit funding available to deliver strategic aims for GP primary care impacting on quality and trust and confidence in the ICB	John Adams	**4x4 = 16**	**12**	**NEW**	**8**	B – within financial year
PG7b	ICB financial constraints / pressures may limit funding available to deliver strategic aims for GP primary care impacting on quality and trust and confidence in the ICB	John Adams	**5x4=20**	**16**	**NEW**	**8**	B – within financial year
PG8	GP primary care estates capacity constraints may curtail or delay access improvement plans, impacting on quality and trust and confidence in the ICB	David Cooper/Chris Leese	**3x5=15**	**15**	**NEW**	**10**	B – within financial year
13DR	There is a risk that the introduction of new core clinical system suppliers through the GP IT Futures Tech Innovation Framework Early Adopter Programme results in a more fragmented infrastructure and has a negative impact on record sharing	John Llewelyn	**4x4 = 16**	**12**	**12**	**4**	A – within Quarter
Dental Services							
PD1	Access to dental services will not meet demand, impacting negatively on patient experience and outcomes	Tom Knight	**4x4 = 16**	**12**	TBC	**8**	B – within financial year

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

NHS
Cheshire and Merseyside

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

Primary Care Commissioning, Contracting and Policy Update

Agenda Item No: SPCC 25/08/B09

August 2025

1. Purpose of the Report

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

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

This paper contains ;

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

2. Ask of the Committee and Recommendations

The Committee is asked to ;

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

3. Background

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

3.2 The current number of GP Practices and PCNs in Cheshire and Merseyside is given below plus relevant contract statuses ;

	Number of GP Practices by contract	PCNs	GMS	PMS	APMS	Dispensing	Single Handed
Cheshire West	43	9	35	4	4	3	1
East Cheshire	36	9	21	14	1	5	2
Halton	14	2	1	13	0	0	0
Warrington	26	5	8	18	0	1	0

Liverpool	83	9	77	1	5	0	18
Knowsley	23	3	8	15	0	0	6
Sefton	40	2	23	11	6	0	3
St Helens	29	4	22	6	1	0	10
Wirral	45	6	27	15	3	0	2
Total	339	49	222	97	20	9	42

3.3 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

3.4 Management of **General Ophthalmic Services contracts** is undertaken by a small central team, underpinned via the National Policy Book for Eye Health NHS England » Policy Book for Eye Health . Provision of General Ophthalmic Services (GOS) including sight testing and dispensing is agreed by contract and there are 2 types of contracts: Mandatory Services contracts, which are contracts allowing provision of GOS in a fixed premises and Additional Services (domiciliary) contracts, which allow provision of GOS to a patient in their home address if a patients cannot attend a fixed premises unaccompanied. There are currently 219 mandatory (High Street) services and 69 additional (domiciliary) providers operating within Cheshire and Merseyside ICB. GOS contracting is managed at system level via the **General Ophthalmic Services Operations Group**, which reports to this Committee. Further contract information can also be found here https://www.nhsbsa.nhs.uk/provider-assurance-ophthalmic/gos-contract-management

4. Primary Medical Services Update

4.1 Since the last Committee meeting, the **NHS 10 Year Plan** was released - and some key areas within the plan that relate to general practice, are summarised below ;

10 Year Plan – Primary Medical Summary	
Area	**Status**
Access further prioritisation of supporting improved access *including* commitment to training more GPs and building on *digital elements/tools* such as the NHS app	Actions/Plans already in place which will be developed further - Digital work already underway, supporting maximisation of digital tools, and key enablers for sharing patient records. Key document (s) - ICB June Plan - Operational Planning Guidance

Finance – Redesigning the Carr Hill formula to improve the allocation of primary care funding to address health inequalities	Awaiting information
New **contracts** for neighbourhood health General Practice as part of the **neighbourhood health model**	Awaiting information on the new contract Building on work already underway in care communities, PCNs through neighbourhood health workstreams
Workforce - 10 Year workforce plan due out later this year	Building on existing work and in line with future ICB functions in this respect Noting national commitment to recruiting more GPs
Implementing recommendations from the **Red Tape Challenge** review	Further information awaited, building on existing work undertaken as part of the primary/secondary care interface work

4.2 NHS England have released the **seasonal flu vaccination service** specifications for general practice for 2025/26, with minor updates made from last year's versions and payment arrangements remaining the same – key links are given below

- GP Enhanced Service specification (adults & at-risk)
- GP Enhanced Service specification (childhood)
- Flu Collaboration Agreement
- GP additional guidance on recording flu vaccination events, payments and collaboration
- Further information about the flu programme for 25/26 are contained within the annual Flu Letter.

4.3 GP practices are asked to participate in **a national vaccination and immunisation campaign each year**, as a requirement of the GP contract - and this is agreed by NHS England. This year, the campaign is a catch-up for HPV (human papillomavirus vaccination) -the HPV vaccination programme is reporting uptake levels below the national target. For the 2025/26 GP campaign, GP Practices are asked to ;

- Check all eligible patient immunisation records have been updated following notification of vaccination events

- Invite those identified as unvaccinated aged 16-24 (inclusive) for vaccination
- Update records for patients who do not respond to invites or attend appointments
- Continue to offer opportunistic vaccination to anyone currently unvaccinated aged 14 or over
- This campaign runs until 31 March 2026 and more information is published on the website here: https://www.england.nhs.uk/publication/confirmation-of-national-human-papillomavirus-hpv-vaccination-and-immunisation-catch-up-campaign-for-2025-26/

NHS England and ICB staff are currently working through the asks in relation to the above, to support.

4.4 An update on the **June plan/Access** is given via a separate update paper to the Committee.

5 General Ophthalmic Services

5.1 **Service Provision** - Current eyecare provision is steady across the ICB with a slight growth in domiciliary (additional) services.

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

5.3 **Local Eye Health Network –** The Local Eye Health Network (LEHN) met in July, key points discussed included a workforce report for 2024/2025 itemising spend from the Workforce Fund, discussion around the 10 Year Plan and the role of optometry going forward, the Anti-Racism Network and the adaptation of a Greener Eyecare toolkit to be communicated across the profession.

5.4 **Eyecare for patients with Learning disabilities/autism -** Primary Eyecare Services (PES) have shared their Easy Eyecare 2024/2025 report on provision of eyecare for patients with LD/Autism. 214 sight tests were completed across the region through the year with 100% patient satisfaction with the service reported. PES are currently looking to enhance the programme in Cheshire and Merseyside using learnings from the work in Lancashire and South Cumbria.

5.5 **Programme of Blood Pressure case finding in optical practices (AF/CVD) –** Mobilisation of the service is underway and there have been over 200 blood pressure checks to date with a number of high/very high readings leading to referrals and positive patient outcomes.

5.6 **Escalations from the Optometry Operations Group** are highlighted in the Primary Care Quality Report.

6.0 Dental

6.1 **Dental contract reform consultation launched** on 8 July 2025 and closes 19 August 2025. The aim is expand urgent access, embed prevention, and the addition of a quality element. Earliest implementation would be April 2026 (subject to feedback). The headline proposals are:

- Mandated urgent-care slots (£70 flat fee + £5 retainer).
- Three new complex-care tariffs (£272–£680).
- Skill-mix & prevention: fluoride-varnish by EDN; fissure-sealants now Band 2.
- Personalised recall intervals aligned to NICE guidance.
- £3.4 k per practice for quality-improvement; associate model contract.

6.2 Whilst ICB's are not required to formally respond we would encourage all interested parties to comment. Further information from the following link: NHS dentistry contract: quality and payment reforms - consultation document - GOV.UK

6.3 Dental commissioners will begin a process of assessing the impact of the proposed changes and how this will be managed in the context of a requirement (or not) of a local dental improvement plan beyond March 2026. Fundamental to this will be a financial impact assessment and the implications for local flexible commissioning.

6.4 The **Urgent dental care national programme** commenced on 1/4/25 and NHS C+M was asked to deliver 46,617 appts by end of March 2026 - its share of the 700k appointments promised by government across all ICBs. As of June data the ICB is 18.3% off trajectory. The commissioning team has been working with stakeholders and contractors to seek improvement. Monthly progress reports are required by NHSE and a meeting on 7/8/25 with the 3 NW ICBS has been arranged to review progress and share potential solutions to under delivery. Actions are also being taken nationally to resolve potential delivery issues. For context Greater Manchester ICB are also under trajectory (at a not dissimilar rate to C+M) as are Lancashire and South Cumbria to a lesser degree. C and M ICB performance is shown *below* :

Metric (NHS Cheshire & Merseyside ICB)	Apr-25	May-25	Jun-25
FP17 baseline (÷ 12)	17 187	17 187	17 187
ICB planned trajectory (share of 700 k)	3 882	3 885	3 885
Total required activity	**21 069**	**21 072**	**21 072**
BSA FP17 activity	17 480	17 721	17 224
Difference	**-3 589**	**-3 351**	**-3 848**
% off trajectory (difference ÷ total required)	**-17.1 %**	**-15.9 %**	**-18.3 %**

NB PROVIDERS HAVE 60 DAYS TO SUBMIT ALL RETURNS SO JUNE DATA WILL NOT BE CONFIRMED UNTIL AUGUST

6.5 NHSE have asked that all ICBs reprofile activity for the remaining 9 months of 25/26. The scheme is monitored by NHSBSA who provide information to NHSE and ICBs on the number of FP17s lodged by providers. There are discrepancies in this FP17 reporting that commissioners have been reviewing and when comparing to our locally collected data we are achieving slightly over the monthly trajectory. This has been flagged with NHSE NW but as yet has not resulted in anything positive in terms of delivery. All actions are being taken to rectify the position by Quarter 2 including communications to patients, contractors and other stakeholders.

6.6 **The commissioning team continue to manage business** as usual via the Dental Operations Group which last met on 30/7/25. The group reviewed a number of issues relating to:

- Partnership arrangements
- Contract hand backs – none reported at this time
- Additional location for delivering UDA's
- Proposal for sub-contracting
- No quality concerns were escalated to the Quality group
- Contractual delivery issue and consideration of contractual reduction

7.0 Community Pharmacy

7.1 A Rota review meeting has been scheduled for 7/8/25 with LPC, finance and commissioning colleagues. The purpose of the first meeting will be to set the scope of review and agree terms of reference.It should be noted that a contract uplift has been applied to the existing arrangements in line with ICB agreed policy.

7.2 Incident and Quality reporting is reviewed at the Pharmacy Operations Group and at the most recent meeting of 1/7/25 the following incidents were reported:

INCIDENTS REPORTED	Nature of incidents
0 X Red	Dispensing error x 1
8 X AMBER	Wrong Dosage x 2
5 X GREEN	
12 X RED still open (rolling total)	Medication not received x 1

6 X RED closed this month There were no escalations required to Quality Group.	Wrong Medication x 2 Dispensing Error x 1 Other x 6

7.3 **Contract monitoring** – under the Community Pharmacy Assurance Framework 13 visits were completed with 10 action plans being issued. There are 3 reports to be completed by Clinical Advisors and will then be sent out to contractors. Temporary Suspension of Services – 36 unplanned closures were submitted.

7.4 **ROTA arrangements for Christmas 2025** was issued to contractors in May and are subject to regulatory timescales requiring consultation and appeals process/timescales.

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

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

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

9 Link to meeting CQC ICS Themes and Quality Statements

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

10 Risks

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

11 Finance

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

12 Communication and Engagement

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

13 Equality, Diversity and Inclusion

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

14 Next Steps and Responsible Person to take forward

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

15 Officer contact details for more information

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

NHS
Cheshire and Merseyside

Meeting of the System Primary Care Committee

NHS Cheshire and Merseyside

Update - Access to Primary Medical (General Practice) Services

Agenda Item No: **SPCC 25/08/B11**

Responsible Director: Clare Watson, Assistant Chief Executive

1. Purpose of the Report

1.1 To update the Committee on:

(i) 25/26 key actions to support improving access to general practice - outlined within the plan agreed in June by the Committee.

(ii) Summary of feedback from the GP Patient Survey (presentation in **Appendix 1**)

(iii) The Committee will also be receiving a presentation from Healthwatch which will be tabled at the Committee, in respect of the local patient experience survey.

2. Progress on June Plan

2.1 The ICB have been verbally advised that there is no further feedback on the plan submitted– the ICB are still waiting for confirmation of the national reporting metrics to be reported by ICBs to NHS England which is expected in September. Pending that, a summary of progress for Q1 is given below, on high level actions;

Table 1 – Progress Areas on June Plan Q1

Section of June Plan	RAG	Narrative
1. Tackling Unwarranted Variation		
(a) Data – Qualitative and Quantitative (Practice Level)		Initial L1 and L2 practice outlier lists produced and currently being worked through -cross referencing underway for finalising at August oversight meeting Access to GPD (GP Dashboard) in place with new data sets added. CBT (Cloud based telephony) dashboard launched and accessed
(b) Data - ICB Strategic Level		Key data sets in place for strategic oversight (pending NHSE reporting data set)
(c) Planned actions to address unwarranted variation		PLS (Practice Level Support) national funding offer work complete - 43 practices initially identified, currently being finalised with the provider.
2. Improving Contract Oversight		
(a) Proportionate Contract Review approaches		Enhanced Services review underway. GP Contract 25/26 actions underway – focused on supporting implementation of contract asks from 1.10.
(b) Support for contractual management and governance		Will need to be finalised post ICB operating model changes though initial discussions underway at oversight group.
3. Improving Commissioning and Transformation		

(a) Improving access through Commissioning and Transformation Support (CATS) approach and high quality evidence based support/assessment tools		PLS/MGP (Modern General Practice) Actions already in train. Estates programme/NH workstreams in train which further support this area Sharing success and learning – first sessions held on line with practice – other actions planned.
(b) Maximising other enablers and infrastructure to improve patient access and experience		MGP assessments underway in each place to support identification of variation. SDF funding streams agreed. Digital - Pilot report for one digital tool to SPCC in Aug.
4. Governance and Monitoring		Oversight Group in place - SPCC reporting in place/Board updated – will be reviewed post new ICB operating model/governance agreed.

2.2 **Key actions for Quarter 2 25/26**

- Follow up in relation to agreed outlier list to ensure consistency of variation work - finalised at August oversight meeting based on existing data set. Any required improvement plans to be in place by Q3 including agreed individual practice level trajectories.
- Finalisation of key performance metrics in September, dependent on NHSE releasing/confirming their data set and expectations - key metrics will then be presented at this Committee in October. ICB need to ensure that a plan is in place to respond as required to the data asks, working with business intelligence colleagues.
- SDF funding allocation spending plans for targeted access/resilience by Q3, initial list to be discussed at August oversight meeting alongside key principles/application information.
- Embedding further sharing success actions – including peer ambassadors and further learning sessions.
- Continued focus on key contract 25/26 actions for 1.10 implementation (e.g. on line consultations)

3. General Practice Patient Survey (GPPS)

3.1 In July, NHS England published the results of the annual GP Patient Survey - which is an England-wide survey that gathers feedback from patients about their experiences with their GP practices and other local NHS services. The fieldwork for the survey was undertaken earlier this year and is administered nationally, direct to a randomised sample of patients. The link to the full information is given here GP Patient Survey.

3.2 Last year the questions were amended, so this year is the first time we can compare results directly for this new set of questions. The results are available at ICB, PCN and individual practice level. **Appendix 1** gives a high level summary of key indicators in presentation slide form. In summary ;

- **Slide 2** gives a comparison of this ICB over 2 years, comparison with with the national figure – and the two other north west ICBs. The questions chosen are key areas in relation to patient experience/ understanding from initial contact, care received and overall experience
- **Slide 3** focuses on areas where previous patient experience feedback had highlighted most challenges, particularly around telephone access, convenience of appointment and understanding of all methods of contacting a practice - particularly to make an appointment. The figures in brackets give the 2 years results side by side.
- **Slide 4** themes key areas for actions based on the GP Patient Survey and Healthwatch local survey – addressing variation ;sharing success ; ensuring that we support all patients in all aspects of modern general practice – and links to future models that will support management of demand, for example, neighbourhood health.

4 Ask of the Committee and Recommendations

The Committee is asked to ***discuss and note*** ;

(i) The update on the implementation of the 'June' plan for access improvement, for 25/26.
(ii) The patient experience feedback presented in relation to the GP Patient survey and Healthwatch local survey.

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

- Tackling Health Inequalities in outcomes, experience and access (all 8 Marmot Principles)
- Improve population health and healthcare.

6 Link to meeting CQC ICS Themes and Quality Statements

- Supporting to People to live healthier lives
- Safe and effective staffing
- Equity in access
- Equity in experience and outcomes
- Care provision, integration and continuity
- How staff, teams and services work together.

7 Risks

Supports the following BAF risks ;

- P6.

8 Finance

No finance decisions are required

9 Communication and Engagement

Are outlined in the survey details nationally and by Healthwatch for the local survey.

10 Equality, Diversity and Inclusion

Are considered as part of the national survey roll out – and were outlined in the June plan.

11 Officer contact details for more information

Christopher Leese, Associate Director of Primary Care – chris.leese@cheshireandmerseyside.nhs.uk

NHS
Cheshire and Merseyside

Patient Experience – Access to General Practice

National GP Patient Survey 2025

Key Areas comparison

Survey sample – 38,222 responses (ICS 27 %/National 25.8 %)

NHS
Cheshire and Merseyside

Question	2024	2025	National	LSC	GM
Patients knowing next steps / contact	82	83	83	83	83
Good Experience of contact	68	70	70	73	72
Had Confidence and Trust	93	93	93	93	92
Felt Involvement in decisions	92	92	91	92	91
Felt Needs were met	91	91	90	91	90
Good Overall Experience	76	78	75	78	77

Focus Areas (2 year comparison results in brackets)

NHS
Cheshire and Merseyside

- Previous concern areas – process of making an appointment in particular by phone / convenience of and face to face.
- Access by telephone (68/64) remains most popular way of accessing - experience Easy (48/52) Difficult (40/36)
- Mixture of functionality use of telephone systems in evidence, including call back/queue waiting
- Other forms of access wider usage - NHS App – Easy (45/50) Difficult (41/36) Use of on- line booking – risen across all reasons - making an appointment / repeat prescriptions etc
- Contact outcomes – Services offered - appointment (72/72) and a prescription (20/20) most common
- Couldn't contact – outcome - try again (56/51) no action (17/19)
- Time till appt – varied timescales but overall – about right (70/71) too long (30/29)
- How appt took place – remote (29/26) face to face (71/74) appt with a GP (65/63)

Action Areas

NHS
Cheshire and Merseyside

Addressing variation

Good overall experience range (100 to 19)

Very difficult - phone access (55 to 0)

Very difficult - NHS App - (60 to 0)

Appointments within 2 weeks (ICB ambition was 90 per cent appts within 2 weeks)

The June plan covers actions to support this (addressing variation framework etc)

Sharing success/best practice

Improvements across some key question areas in line with national trends - learning/ sharing across place and other ICBs. Utilisation of national practice level support scheme

Actions underway and outlined in the June Plan

Modern General Practice – actions to further support/understanding

Recognising challenges from the Healthwatch local survey in areas such as care navigation/additional roles - Further support for digital / on- line tools - and telephone as still most popular access point NHS App usage varies

Demand/ future models

Using this and continued feedback to inform our ‘Access’, 10 YP response/strategy and June plan actions - and as part of Neighbourhood Health‘ model/outcomes’.

Use of demand ‘data’ such as telephony

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

Date: 14th August 2025

Primary Care Services - Quality Report

Agenda Item No: SPCC 25/08/B14

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

Primary Care Services - Quality Report

1. Purpose of the Report

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

a) General Practice
b) Dental Services
c) General Ophthalmic Services
d) Community Pharmacy Services

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

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

2. Ask of the Committee and Recommendations

2.1 The Committee is asked to:

a) **Note** the updates relating to Quality in Primary Care Services for the four contractor groups listed above.
b) **Note and be assured** of actions raised to support any quality issues.
c) This report is for **information** and **no decisions** are required.
d) **Approve** the proposed quality metrics for General Practice

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

3.1 General Practice

a) Clinical Outcomes & Care Quality Indicators

3.1.1 Place Primary Care Quality Leads Group took place recently to discuss and agree Quality Indicators for General Practice across Cheshire and Merseyside. It was agreed at this meeting that the data collected in the GP National Dashboard will form the quality metrics for reporting on General Practice across Cheshire and Merseyside. System Primary Care Committee are asked to approve the proposed quality metrics.

3.1.2 The GP National Dashboard provides an overview of quality across the 9 places in Cheshire and Merseyside, and is already in use systematically for contractual areas such as access variation. The dashboard reports on positive and negative variation across quality data sets nationally which allows us to

understand where quality improvements can be considered in a consistent manner across the 9 places.

3.1.3 We can consolidate key performance and quality metrics for each practice, which will allow teams within place to more effectively collaborate and identify practices that may need additional support or targeted intervention.

Source of Data	Clinical Outcome & Care Quality Indicator	Frequency of update
National DBoard	CQC Overall GP Practice Rating	Monthly
National DBoard	Overall QOF achievement	Annual
National DBoard	(CHD015) Secondary prevention of coronary heart disease (CHD)	Annual
National DBoard	(DM020) Diabetes Mellitus % of patients with diabetes on the registers without moderate or severe frailty with Hba1c reading	Annual
National DBoard	(DM021) Diabetes % patients with diabetes without moderate or severe frailty with an Hba1c < 75T2DM	Annual
National DBoard	(DEM004) % patients diagnosed with dementia with care plan review	Annual
National DBoard	(COPD010) % patients with COPD on the register, who have had a review in the preceding 12 months	Annual
National DBoard	% patients (aged 14 years or over) who have received a learning disability health check by a GP Practice	Monthly
National DBoard	% patients with Severe Mental Health Issues (SMI) to receive the complete list of physical health checks in the preceding 12 months	Quarterly
National DBoard	Cancer detection rates	Quarterly
National DBoard	Emergency Cancer admissions	Quarterly
National DBoard	Patients with GP recorded hypertension, whose last blood pressure reading is to the appropriate treatment threshold	NEW - Quarterly

3.1.4 The Business Information Portal (BIP) also gathers metrics on immunisations, vaccinations and screening, however this is monitored and reviewed by Public Health. To avoid duplication Primary Care Place Leads propose we will not report on this data, however we will continue to support any quality improvement identified by Public Health.

3.1.5 For clarity, the immunisation, vaccination and screening data below will not form part of the ICB quality metrics for General Practice:

Clinical Outcome & Care Quality Indicator
% MMR 1 @ 2 Years
% MMR 1 @ 5 Years
% MMR 2 @ 5 Years
Bowel Screening Rate
Breast Screening Rate
Cervical Screening Coverage (Age Group 25 to 49)
Cervical Screening Coverage (Age Group 50 to 64)
Flu uptake 2 – 5-year-olds
Flu uptake over 65s

b) Out of Hours GP Practices

3.1.6 GP Practices providing out of hours provision is not recorded on the National GP Dashboard. Primary Care Quality Place Leads are currently establishing who these providers are to agree how quality improvement is monitored across the nine places.

i. Cheshire West - Central Cheshire Integrated Partnership (CCIP) provide community services across Cheshire East and vale Royal on behalf of Mid Cheshire Hospitals Foundation Trust (MCHFT). CCIP have recently identified a problem with the new digital dictation software, Fluency Flex. Due to an error in process approx. 1,300 patient letters have not been delivered to Primary Care. The Integrated Respiratory Team have used this system since October 2024 to dictate letters to Primary Care. Letters may contain requests for follow-up blood tests, further investigations, medication changes, referrals to other services. CCIP are actively working on a solution to ensure these letters are forwarded to each practice urgently. CCIP have added this issue to the risk register and are conducting a review. The ICB Quality Team have reached out to Mid Cheshire Hospitals Governance Team for a full update on actions and mitigations.

ii. Cheshire West – Some GP Practices have handed back elements of the LES for wound care. Cheshire and Wirral Partnership Trust (CWP) provide community services for Cheshire West. CWP have said that they are not able to provide these services for the funding available. This leaves a gap in service for patients who need complex dressings. The Head of Primary Care is liaising with the Place Clinical Director and ICB to find a solution.

3.2 Dental Services

3.2.1 A provider in Liverpool has been issued with two consecutive breach notices for failing to meet their contractual obligations due to no performers being made available at the practice during core hours. The provider has also consistently underperformed on their contract for the last 4 years and to date has failed to make payments towards their underperformance debt which stands at c.£350,000. Contractual payments have been withheld for 22 months. Legal advice has been requested regarding next steps. The Provider is not engaging and continues to push back on proposed meetings, offering times/dates outside of working hours i.e. Saturday or Monday at 9pm.

3.3 General Ophthalmic Services

3.3.1 A contractor was issued with a letter to address an issue within 28 days in relation to health and safety – assurance had been received and is being followed up.

3.3.2 Issues identified by a neighbouring ICB in relation to a contractor have been followed up by the ICB with a response sought by 31.7.2025.

3.4 Community Pharmacy Services

3.4.1 No update

4 Quality Issues for Advising (ongoing monitoring)

4.1 General Practice

4.1.1 GP Practices with CQC Rating – Requires Improvement - There are 326 GP Practices across the nine places. Sixteen of those practices require improvement. There are five GP Practices where there is currently no CQC rating. Four GP Practices are rated outstanding, and the remainder rated as good. For those practices who require improvement action plans are in place in response to the rating and practices are supported where appropriate by place Primary Care and Quality Teams.

4.1.2 Warrington Place – care home x 1 withdrawal of GP Services due to concerns around patient safety, poor organisation, lack of continuity in care and frequently changing. Primary Care and Quality Place teams are working with both parties to address all challenges to support a resolution.

4.2 Dental Services

4.2.1 Access to urgent dental care – 103 dental practices are undertaking the urgent care plus scheme in 25/26 to support the national initiative to provide 700k more urgent care appointments across England. The scheme in C&M provides patients accessing urgent dental care with an opportunity for a full examination and any treatment requirements identified completed (not just

for the urgent care presentation. Commissioners are monitoring the number of urgent FP17s being transmitted across C&M, to meet the local target of circa 46k extra urgent care appointments in 25/26. Practices have been reminded of the need to submit an urgent FP17 for every patient seen as part of the UDC Plus scheme and new communications have been issued to stakeholders to promote the initiative.

4.2.2 Clinical governance visits and record card audits – one Dental Practice Advisor report was noted at June's Dental Operational Group meeting relating to a provider/performer who has completed more than 12,000 UDAs within a 12-month period, which is considered high for one dentist. The report concluded that the clinical records did not meet the required standard. Actions have been agreed with the dentist and the practice will be re-visited in 3 months.

4.3 General Ophthalmic Services

4.3.1 Post payment verification actions with contractors are ongoing.

4.4 Community Pharmacy Services

4.4.1 No Update

5 Quality Issues for Assurance (assurance received)

5.1 General Practice

5.1.1 CQC Ratings – Four GP Practices flagged as outstanding and 301 flagged as good.

5.1.2 Diabetes Mellitus % of patients with diabetes on the registers without moderate or severe frailty with Hba1c reading - All GP Practices across the nine places are above the national average.

5.1.3 National GP Patient Survey 2025 Results – a separate update in relation to this will be presented at the Committee.

5.2 Dental Services

5.2.1 Clinical governance visits and record card audits – two further Dental Practice Advisor reports were noted at June's Dental Operational Group meeting relating to providers/performers who have completed more than 12,000 UDAs within a 12-month period, which is considered high for one dentist. The practice visits and record audits concluded for both performers that there were no clinical concerns, the record keeping was of the required standard and that no further actions were required. Two practice visits also took place

because of applications to relocate premises. The Dental Practice Advisor reported at June's Dental Operational Group meeting that both practices passed the inspection, and no further actions are required.

5.3 General Ophthalmic Services

5.3.1 Following the current cycle of Quality in Optometry (QIO) self-assessments and as a requirement from the Eye Health Policy Book, the ICB Optometry team has begun the process of conducting 4 follow up visits through 2025/2026 and potentially 4 more in 2026/2027 and in 2027/2028. This is based on the recommended quota of 5% of ophthalmic contractors being inspected, the contractors are chosen at random with a geographical spread across all Places split between Cheshire and Merseyside and with a mix of large corporate, independent contractors and domiciliary providers. There will also be potential provision for additional visits for contractors for whom concerns about delivery have been raised. These are dependent on availanle capacity with the central contracts team.

5.3.2 The ICB were informed of an issue with regards to an electronic referral with a GP practice - An e-mail was produced and sent by the ICB Contracts Team following discussion with the Optical Adviser which reminds all contractors sending urgent referrals to inform the relevant GP practice in advance. This has been sent to all GOS contractors

5.4 Community Pharmacy Services

5.4.1 No update

6 Complaints

6.1 No update

7 Reasons for Recommendations

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

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

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

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

9 Link to meeting CQC ICS Themes and Quality Statements

a) Quality & Safety - QS2, QS3, QS5
b) Integration – QS7, QS8
c) Leadership – QS10, QS13, QS15

10 Risks

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

11 Finance

11.1 Will be covered in separate Finance update.

12 Communication and Engagement

12.1 Not required in respect of this paper.

13 Equality, Diversity and Inclusion

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

14 Next Steps and Responsible Person to take forward

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

15 Appendices

Appendix One: *General Practice Quality Indicators & Process*

General Practice - Quality Indicators &

Appendix Two: *Optometry Quality Oversight Process*

OPTOMETRY QUALITY OVERSIGHT

Appendix Three: *Dental National Assurance Process*

NHS England » Policy book for primary dental services

Appendix Four: *Community Pharmacy Quality Scheme*

Pharmacy Quality Scheme.pdf

NHS
Cheshire and Merseyside

Primary Care – General Practice - Quality Assurance & Improvement Process

Primary Care in Cheshire & Merseyside

Cheshire and Merseyside is a large and complex system with a population of circa 2.7 million

- 9 Places
  - **349 GP Practices**
  - 559 Pharmacies
  - 590 Community Pharmacies
  - 335 Dental Practices
  - 220 Ophthalmic Services plus
  - 60 Domiciliary Ophthalmic Services
  - 2 Out Of Hours (OOH) Providers

The purpose of this report is to focus on : General Practice Quality Assurance.

Clinical Outcomes and Care Quality Indicators

NHS
Cheshire and Merseyside

Source of Data	Clinical Outcome & Care Quality Indicator
Both DBoard	CQC Overall GP Practice Rating
Both DBoard	Overall QOF achievement
National DBoard	(CHD015) Secondary prevention of Coronary Heart Disease (CHD)
National DBoard	(DM020) Diabetes Mellitus % of patients with diabetes on the registers without moderate or severe frailty with Hba1c reading
National DBoard	(DM021) Diabetes % patients with diabetes without moderate or severe frailty with an Hba1c < 75T2DM
National DBoard	(DEM004) % patients diagnosed with dementia with care plan review
National DBoard	(COPD010) % patients with COPD on the register, who have had a review in the preceding 12 months
Both DBoard	% patients (aged 14 years or over) who have received a learning disability health check by a GP Practice
Both DBoard	% patients with Severe Mental Health Issues (SMI) to receive the complete list of physical health checks in the preceding 12 months
National DBoard	Cancer detection rates
National DBoard	Emergency Cancer admissions

Clinical Outcomes and Care Quality Indicators

NHS
Cheshire and Merseyside

Source of Data	Clinical Outcome & Care Quality Indicator
BIP	% MMR 1 @ 2 Years
BIP	% MMR 1 @ 5 Years
BIP	% MMR 2 @ 5 Years
BIP	Bowel Screening Rate
BIP	Breast Screening Rate
BIP	Cervical Screening Coverage (Age Group 25 to 49)
BIP	Cervical Screening Coverage (Age Group 50 to 64)
BIP	Flu uptake 2 – 5 year olds
BIP	Flu uptake over 65s

All data taken from the C & M Business Intelligence Portal (BIP) and GP National Dashboard. Local intelligence feeds through from C & M Place Leads Quality Meeting

General Practice Contractual, Quality & Performance

Escalation Pathways

Contractual Concerns

National or local contracting issues should be escalated via Place Primary Care Leads/Teams in the first instance – this includes urgent operational issues.

Routine contractual questions in relation to the national contract and DES's can also be directed to the central contracting team @Central Primary Care who can liaise with the relevant Place Commissioner

Quality & Safety Issues & Concerns

All quality & safety concerns should follow the target operating model and onward escalation reporting based on risk categorisation

Performance concerns should be reviewed at Place Primary Care meetings to distinguish between contractual or quality issue.

Professional Concerns

All professional concerns should be reported to:
C&M / NHSE Professional Concerns
england.northwestprofessionalstandards@nhs.net
Mon – Fri 9am – 5pm

For urgent matters outside of these hours contact

Julie-Ann Bowden
Head of Professional Standards
NHS England (North West Region
julie-ann.bowden@nhs.net

General Practice Quality Assurance - Target Operating Model

Triangulation of intelligence should be completed at Place to identifying practices of concern

Examples of quality intelligence sources:	Examples of other intelligence sources
- Quality & Performance dashboard - Patient Safety Incidents / LFPSE - Patient experience / complaints / PALs - Health watch - CQC	- MMT data and intelligence - PCN CD feedback - Contractual concerns / breaches - Soft Intelligence - Out of Hours information

Actions required to mitigate risk and decision making on level of input required

- Desktop review – to triangulate all intelligence and evidence
- Request for practice to provide assurance and mitigations that issue is being addressed
- Development of practice action plans to support improvement
- **NB Where assurance can not be obtained from the practice consideration of the requirement for a Quality Practice visit should be made.**

Reporting requirements

Low/Medium & High Risk	➢ Place Quality & Performance Groups and Place Primary Care Meetings
Medium and high risk	1. Monthly reporting for inclusion in highlight report via ADQ's to C&M Quality & Performance Committee 2. Quartey Report, utilising template to C&M Primary Care Quality Group

General Practice Quality - Risk Categorisation

Low risk issue examples (for management at Place) :

- Practice triggered on dashboard - *however assurances have been received or risks mitigated*
- Soft Intelligence - *however assurances have been received or risks mitigated*
- Patient Safety Incidents / LFPSE - *however assurances have been received or risks mitigated*
- CQC 'Good' inspection reports with 'must' and 'should' recommendations
- *Safeguarding concerns, which are considered to be low risk, and managed at Place*
- *IPC Outbreaks- managed at Place*

Medium & high risk examples (reportable to C&M Q&P Committee and C&M PC Quality Group) :

- CQC 'Inadequate' or 'Requires Improvement' inspection report
- Potential ICB reputation damage
- Substantiated Whistle blower
- Major concern with a practice
- Patient Safety Incidents / LFPSE - *where assurances have not been received and risk not mitigated*
- Regulation 28
- *Primary care QIA's above 12*
- Any identified issues where there may be wider learning or risk

NB: This list is not exhaustive and provided as examples of what might be considered as low, medium & high risk

Reporting and Escalation Governance

Primary Care Quality issue identified

- Managed and mitigate at Place between the quality and primary care team as appropriate.
- Desktop analysis to triangulate intelligence and assess risk and appropriate response.
- Utilisation of interventions such as Provider assurance response, quality improvement plans with escalation to intervention such as Quality Assurance practice visit as necessary.

Place level reporting

- Reported to Place level meetings
  - ➢ Primary Care Forums
  - ➢ Quality & Performance Groups

C&M level reporting

- ➢ Continue to report by escalation medium & high level risks to C&M Q&P Committee via the highlight report, ensuring timely reporting of practices in escalation.
- ➢ Quarterly reporting to Primary Care Quality Group utilising template.
- ➢ C&M Primary Care Quality Group would be responsible for providing C&M Primary Care Committee & Quality & Performance Committee a quarterly summary report

Key issues arising from the ICB Place meeting held ……

ALERT (matters of concern, non-compliance or matters requiring a **response/action/decision** from the **C&M ICB Quality & Performance Committee**

Issue	Place Quality & Performance Group comments	Action taken to date	Limited/Partial/ Full Assurance at Place	

ADVISE (general update in respect of ongoing monitoring where an update has been requested/provided)

Issue	Place Quality & Performance Group update	Action taken to date	Limited/Partial/ Full Assurance at Place	Timescale

ASSURE (issues for which the committee requires or has received assurance)

Issue	Place Quality & Performance Group update	Action taken to date	Limited/Partial/ Full Assurance at Place	Timescale

OPTOMETRY QUALITY OVERSIGHT PROCESS

- A concern with a performer would be flagged by an advisor and referred to PAG (Performer Advisory Group) for potential investigation at a monthly meeting. This process is currently managed by NHS England through the Professional Standards team england.northwestprofessionalstandards@nhs.net .
- Normally performers are referred to PAG by a clinical advisor
- Any concerns flagged at the meeting where a different advisor assesses the referral to avoid potential conflict of interest.
- If a decision impacts an ICB held contract, the ICB would be informed. There are no current applicable cases.
- Ophthalmic contractors currently complete a self assessment checklist through the Quality in Optometry website managed by LOCSU (link below)

https://www.qualityinoptometry.co.uk/

- The checklists are collated and checked by the Optometry team and any queries are raised and resolved.
- The latest 3 year cycle runs up to the end of 2025, all QIO checklists have been completed and checked.

QIO follow up visits

- Following QIO The ICB optom team begin a cycle of follow up contract assurance visits with the aim of 1 per quarter over 3 years (total of 12)..
- This will involve the random selection of providers for the visits with a fair geographical spread and a mix of larger corporate and smaller independent contractors. There is also potential for further inspections based on soft intelligence/concerns around a contractor.
- A list of contractors has been agreed and the 1st inspection will begin through Quarter 1 2025/2026
- Actions are in line with guidance from the Eye Health Policy Book NHS England » Policy Book for Eye Health section 6 onwards - If concerns arise outside of these quality processes then additional steps/assurance and visits can be sought/arranged
- General contactor quality issues are flagged through system level primary care quality using the standard template. There is currently 1 domiciliary provider who is being investigated with potential for contractual sanctions to be imposed.

OPTOMETRY – indicators

Key markers in QIO (Quality in Optometry) https://www.qualityinoptometry.co.uk/ also identified at further inspection.

- Ensuring that key company policies and registrations are regularly updated in most cases on an annual basis
- Complaints returns are regularly completed and returned within the agreed cycle.

- Company details i.e. address, contact details and Companies House registration is maintained and the ICB are informed of any changes.
- Hours of provision of General Ophthalmic Services (GOS) match what is listed in the providers contract
- Following QIO The ICB optom team begin a cycle of follow up contract assurance visits with the aim of 1 per quarter over 3 years (total of 12). As QIO is self assessment, the vast majority of providers score 100% but the follow up visits are a process of checking that the answers given are accurate.
- This will involve the random selection of providers for clinical inspections with a fair geographical spread and a mix of larger corporate and smaller independent opticians.
- The inspection will identify any contractual issues, an action plan will be produced and any major concerns will be reported through the operations group for further investigation and logged on the quality template.

PPV (Post Payment Verification)

- In addition the ICB optom team receive regular quarterly updates from NHSBSA listing providers with GOS activity outlier data who the optom team then identify for PPV investigation.
- 2 of the highest outliers identified from NHSBSA claim defined metrics are checked on a quarterly basis by the NHSBSA PPV team working in conjunction with the ICB optom team and Counter Fraud team and any potential overclaim is identified and deducted.
- The deduction is approved by the Heads of Finance and Primary Care. Through 2024/2025 £50k was reclaimed through this process and the new programme has begun for 2025/2026

Pharmacy Quality Scheme (PQS) 2025/26

1. PQS 2025/26 gateway criterion

1.1 To qualify for the Pharmacy Quality Scheme (PQS) 2025/26 payment, pharmacy contractors will have to meet the gateway criterion in Table 1 by the end of 31 August 2025. Pharmacy contractors must claim payment for the PQS 2025/26 quality criteria during the declaration period, which is between 09:00 on 2 February 2026 and 23:59 on 27 February 2026.

1.2 Meeting the gateway criterion will not, in and of itself, earn a PQS payment for the pharmacy contractor, as these payments are also subject to the payment conditions relating to the domains, which are made up of the quality criteria set out in section 2.

Table 1. Gateway criterion

Domain	Description of the Gateway criterion
Gateway Criterion	**Advanced services – Pharmacy First & Pharmacy Contraception Service** Contractors must have signed up to deliver the Pharmacy First Service and the Pharmacy Contraception service by the end of 31 August 2025 and remain registered for **both** services until the end of the scheme, 31 March 2026. *Further information for contractors who open or change ownership from 1 September 2025 is detailed in 3.1.* Contractors will not be required to make a declaration for this gateway criterion as this will be verified by a post payment review of the contractor's declaration to deliver the service and subsequent registration from 1 September 2025 until the end of the scheme, 31 March 2026. Contractors should note that they will **not** be able to claim payment for the quality criteria during the declaration period if the gateway criterion has not been met. *Please note that following de-registration from the Pharmacy First and/or Pharmacy Contraception Service the contractor will not be able to re-register for the service for a period of four months from the final day of their 30 days' notice. Any contractors that de-register between the 1 September 2025 until the end of the scheme, 31 March 2026 will not meet the Gateway Criterion for this scheme. Contractors who deregister before the declaration window will not be able to make a declaration; those who deregister after the close of the declaration but before the 31 March 2026 will have their payments recovered by the NHSBSA.*

2. **PQS 2025/26 domains**

2.1 To receive a PQS payment the pharmacy contractor must have met the gateway criterion by the end of 31 August 2025. The contractor must also declare between 09:00 on 2 February 2026 and 23:59 on 27 February 2026 as having met and have evidence demonstrating meeting one or more of the domains in Table 2 (please note, contractors must meet all of the quality criteria in each domain to be eligible for a PQS payment in respect of that domain).No PQS payment will be made to contractors that fail to submit their declaration by 23:59 on 27 February 2026, even if they have evidence to demonstrate that they have undertaken the work to meet the scheme requirements. The overall level of the PQS payment will depend on how many of the domains the pharmacy contractor declares it has met.

2.2 Please note, the validity period for training for the PQS 2025/26 runs until the end of 31 March 2026 so, for example, if a pharmacist needs to complete the Consulting with people with mental health problems e-learning, this will need to be completed within the 4 years prior to 31 March 2026 (between 1 April 2022 and the end of 31 March 2026).

Table 2. Domains and Quality Criteria

Domain	Description of the Quality criterion
Medicines Optimisation	**Palliative and End of Life Care Action Plan** As soon as possible after 1 April 2025 and by the end of 31 March 2026 the contractor: • must have updated NHS Profile Manager to show they are a 'Pharmacy palliative care medication stockholder' if they routinely hold the 16 palliative and end of life critical medicines listed below and can support local access to parenteral haloperidol. If NHS Profile Manager is updated centrally by head office, it will need to be confirmed that this will be done by the end of 31 March 2026. Contractors who claimed for the Medicines Safety & Optimisation domain in 2023/24 must ensure their status is correct and updated for 2025/26 by logging into NHS Profile Manager and confirming this between 1 April 2025 and by the end of 31 March 2026 by verifying their account at https://organisation.nhswebsite.nhs.uk/sign-in If this verification has not been completed a contractor will not have met this requirement even if their profile is still showing them as a stock holder. Contractors with profiles that cannot currently be updated via NHS Profile Manager, may still claim for this domain and update the Directory of Services (DoS) profile by contacting their Regional DoS lead. Contact details available here. If contractors are not a stockholder of these 16 palliative and end of life critical medicines, they are not required to update NHS Profile Manager. The 16 palliative and end of life critical medicines are: - Cyclizine solution for injection ampoules 50mg/1ml - Cyclizine tablets 50mg - Dexamethasone solution for injection ampoules 3.3mg/1ml - Dexamethasone tablets 2mg - Haloperidol tablets 500mcg (or 1.5mg tablets or 5mg/5ml liquid) - Hyoscine butylbromide solution for injection 20mg/1ml - Levomepromazine solution for injection ampoules 25mg/1ml - Metoclopramide solution for injection ampoules 10mg/2ml - Midazolam solution for injection ampoules 10mg/2ml - Morphine sulfate oral solution 10mg/5ml - Morphine sulfate solution for injection ampoules 10mg/1ml - Morphine sulfate solution for injection ampoules 30mg/1ml - Oxycodone solution for injection ampoules 10mg/1ml - Oxycodone oral solution sugar free 5mg/5ml - Sodium chloride 0.9% solution for injection ampoules 10ml - Water for injections 10ml By the end of 31 March 2026, contractors must have an action plan in place to use when they do not have the required stock of the 16 palliative and end of life critical medicines and/or parenteral haloperidol available for a patient. This must include collated information from pharmacies in their area to be able to aid a patient, relative/carer in obtaining medication as swiftly as possible by redirecting them to the nearest open community pharmacy that stocks the 16 palliative and end of life critical medicines and/or parenteral haloperidol. To qualify for payment all contractors must have this action plan irrespective of whether they do or do not routinely stock the 16 palliative and end of life critical medicines listed above.

	The action plan must include: • an awareness of any locally commissioned services for palliative care including any on call and delivery arrangements; • a list of community pharmacies stocking the 16 palliative and end of life critical medicines for palliative/end of life care in their area and noting the ability to check the DoS to find pharmacies stocking these medicines; • details of where parenteral haloperidol can be accessed locally, e.g. through any local commissioning arrangements; • awareness of other support services that may be useful for patients/relatives/ carers. The action plan for 2025/26 must be available for inspection from the end of 31 March 2026 at premises level and must be retained for 3 years for PPV purposes. For contractors who claimed for the Medicines Safety & Optimisation domain in 2023/24, an update to the previous action plan will be required. When making a declaration for this criterion, the following information must be reported on the MYS application: • Confirm if the pharmacy does or does not stock the 16 palliative and end of life critical medicines. • If the pharmacy does stock the 16 palliative and end of life critical medicines, a declaration that by the end of 31 March 2026,the DoS will have been updated to indicate that the pharmacy is a 'Pharmacy palliative care medication stockholder'. • A declaration that by the end of 31 March 2026, the pharmacy will have a new or updated action plan in place on the premises, available for inspection, with collated information from pharmacies in their local area to be able to aid a patient, relative/ carer in obtaining medication as swiftly as possible by redirecting them to the nearest open community pharmacy that stocks the 16 palliative and end of life critical medicines and/or parenteral haloperidol. **Consulting with people with mental health problems - CPPE Learning** To support the quality of New Medicine Service consultations following the expansion of the service, by the end of 31 March 2026, all pharmacists working at the pharmacy on the day of the declaration must have satisfactorily completed, within the last 4 years (between 1 April 2022 and end of 31 March 2026), the Consulting with people with mental health problems e-learning CPPE online training. Since there is no e-assessment for the e-learning, pharmacists will need to confirm completion of the Consulting with people with mental health problems e-learning in their CPPE record. When a pharmacist has confirmed completion, they will be able to download a certificate of study. Contractors will need to have evidence to demonstrate that all pharmacists working at the pharmacy on the day of the declaration have satisfactorily completed, within the last 4 years (between 1 April 2022 and end of 31 March 2026) the CPPE online training. This evidence must be available for inspection from the end of 31 March 2026 at premises level and must be retained for 3 years for PPV purposes. When making a declaration for this criterion, the following information must be reported on the MYS application: • the total number of pharmacists working at the pharmacy on the day of the declaration who have satisfactorily completed the CPPE online training since 1 April 2022. • the total number of pharmacists working at the pharmacy on the day of the declaration who have not satisfactorily completed the CPPE online training since 1

April 2022 but who will undertake this requirement between the day of the declaration and the end of 31 March 2026.

- That the contractor has the evidence to demonstrate that all pharmacists working at the pharmacy on the day of the declaration have satisfactorily completed, within the last 4 years (between 1 April 2022 and end of 31 March 2026) the CPPE online training.

Respiratory

Use of a Spacer in Patients Aged 5-15 Years

By the end of 31 March 2026, the pharmacy must be able to evidence that between 1 April 2025 and the day of the declaration they have:

- checked that all children aged 5 to 15 (inclusive) prescribed a press and breathe pressurised MDI for asthma have a spacer device, where appropriate, in line with NICE TA38 and
- referred children aged 5 to 15 (inclusive) with asthma to an appropriate healthcare professional where this is not the case.

When making a declaration for this criterion, the following information must be reported on the MYS application:

- the total number of children aged 5 to 15 (inclusive) referred to a prescriber for a spacer device, where appropriate, in line with NICE TA38 between 1 April 2025 and the day of the declaration.

Referrals for patients using 3 or more short-acting bronchodilator inhalers in 6 months

By the end of 31 March 2026, the pharmacy must be able to evidence that between 1 April 2025 and the day of the declaration that patients with asthma, for whom three or more short-acting bronchodilator inhalers were dispensed without any corticosteroid inhaler within a six-month period have, since the last review point, been referred to an appropriate healthcare professional for an asthma review.

For contractors who claimed elements of these criteria previously as part of PQS 2023/24, a new review will be required. In addition, the pharmacy team's knowledge and understanding of the process to identify suitable patients should be reviewed. Methods used to identify 'at risk' patients for referral should be reviewed for effectiveness.

Where no patients are identified for referral under any of the criteria of the domain, the contractor will still be eligible for payment if they can evidence that they have robustly attempted to identify suitable patients and that they have processes in place for referrals should they identify a patient who is suitable. They will need to declare no patients have been identified as needing these interventions on the MYS declaration. Contractors are advised to record any intervention and/or referrals made in the patient medication record (PMR).

When making a declaration for this criterion, the following information must be reported on the MYS application:

- the total number of patients with asthma, for whom three or more short-acting bronchodilator inhalers were dispensed without any corticosteroid inhaler within a six-month period and who were referred to an appropriate healthcare professional for an asthma review between 1 April 2025 and the day of the declaration.

The evidence for meeting the requirements of both of the respiratory criteria above must be available for inspection from the end of 31 March 2026 at premises level and must be retained for 3 years for PPV purposes.

	Emergency Contraception - CPPE Learning & E-Assessment To support the quality of Pharmacy Contraception Service consultations following the expansion of the service to include Emergency Contraception, by the end of 31 March 2026, all pharmacists and any pharmacy technicians intending to provide the Pharmacy Contraception Service working at the pharmacy on the day of the declaration, must have satisfactorily completed, within the last 3 years (between 1 April 2023 and end of 31 March 2026), the CPPE online training and passed the e-assessment. Contractors will need to have evidence to demonstrate that all pharmacists and any pharmacy technicians intending to provide the Pharmacy Contraception Service working at the pharmacy on the day of the declaration have satisfactorily completed, within the last 3 years (between 1 April 2023 and end of 31 March 2026) the CPPE online training and passed the e-assessment. This evidence must be available for inspection from the end of 31 March 2026 at premises level and must be retained for 3 years for PPV purposes. When making a declaration for this criterion, the following information must be reported on the MYS application: • the total number of pharmacists and any pharmacy technicians involved in the supply of Emergency Contraception working at the pharmacy on the day of the declaration who have satisfactorily completed the CPPE online training and passed the associated e-assessment since 1 April 2023. • the total number of pharmacists and any pharmacy technicians involved in the supply of Emergency Contraception working at the pharmacy on the day of the declaration who have not satisfactorily completed the CPPE online training and passed the associated e-assessment since 1 April 2023 but who will undertake this requirement between the day of the declaration and the end of 31 March 2026. • That the contractor has the evidence to demonstrate that all pharmacists and any pharmacy technicians involved in the supply of Emergency Contraception working at the pharmacy on the day of the declaration have satisfactorily completed, within the last 3 years (between 1 April 2023 and end of 31 March 2026) the CPPE online training and passed the e-assessment.

Patient Safety	**Antimicrobial Stewardship - Pharmacy First consultations - Clinical Audit** Contractors must complete a clinical audit, which will concern the clinical advice and consultations provided to patients scoring FeverPAIN 0-3 on the Pharmacy First Sore Throat clinical pathway. The 2025/26 clinical audit should be conducted from 1 September 2025 and completed no later than 31 March 2026. The audit must be carried out with a minimum of 10 patients over four weeks, or over an eight-week period if 10 patients are not achieved. Contractors should make a record of the start and end date of the audit as they will be required to enter this information into the MYS application when they make their declaration. Contractors should choose an eight-week consecutive period between the audit launch and 3 February 2026 to commence the data collection (please ensure you complete the audit no later than 31 March 2026). The pharmacy must have completed the audit, sharing their anonymised data with NHS England, and incorporating any learnings from the audit into future practice by the end of 31 March 2026. The information that needs to be submitted to NHS England is included in the audit document, which will be accessible from the NHSBSA website by the end of May 2025, and must be reported on the MYS data collection tool. Completing the audit data submission is an essential requirement for meeting the audit criterion. Undertaking the audit without submitting the data will mean the contractor will not have met the requirements of this domain. MYS allows a contractor to start their data collection and then return to it later should this be necessary. Where a data collection has been started but not submitted, it will not be eligible for payment. Contractors who successfully complete their data collection submission will receive a data collection submission confirmation email as evidence that their submission has been successful. This email must be provided if a contractor needs to demonstrate that they have successfully completed their data collection submission. Should a contractor not receive this data submission confirmation email within one hour of submitting their declaration then, after first checking their junk email folder, they should email the provider assurance team at pharmacysupport@nhsbsa.nhs.uk immediately to make them aware of the issue. **No patient identifiable data should be entered onto the MYS data collection tool.** Where no patients are identified for the audit, the contractor will still be eligible for payment if: • the contractor can evidence that they have robustly attempted to identify suitable patients and; • they will need to declare no patients have been identified as being suitable for review on the data collection tool on MYS by the end of 31 March 2026. When making a declaration for this criterion, the following must be confirmed on the MYS application: • a declaration that by the end of 31 March 2026 the contractor will have completed the clinical audit; • the start and end date of the audit period (which may be different from the date data are first entered on the MYS data collection tool); • a declaration that by the end of 31 March 2026 the contractor will have shared their anonymised data or have declared that no patients have been identified as being suitable for audit via the data collection tool on the MYS application. That the contractor has or will have incorporated any learnings from the audit into their future practice by the end of 31 March 2026.

Sepsis - CPPE Learning & E-assessment

By the end of 31 March 2026, all registered pharmacy professionals working at the pharmacy on the day of the declaration must have satisfactorily completed, within the last two years (between 1 April 2024 and end of 31 March 2026), the CPPE sepsis online training and passed the e-assessment.

Contractors will need to have evidence to demonstrate that all registered pharmacy professionals working at the pharmacy on the day of the declaration have satisfactorily completed, within the last 2 years (between 1 April 2024 and end of 31 March 2026) the CPPE sepsis online training and passed the e-assessment. This evidence must be available for inspection from the end of 31 March 2026 at premises level and must be retained for 3 years for PPV purposes.

When making a declaration for this criterion, the following information must be reported on the MYS application:

- the total number of registered pharmacy professionals working at the pharmacy on the day of the declaration who have satisfactorily completed the CPPE sepsis online training[1] and passed the associated e-assessment[2] since 1 April 2024.
- the total number of registered pharmacy professionals working at the pharmacy on the day of the declaration who have not satisfactorily completed the CPPE sepsis online training[1] and passed the associated e-assessment[2] since 1 April 2024 but who will undertake this requirement between the day of the declaration and the end of 31 March 2026.
- That the contractor has the evidence to demonstrate that all registered pharmacy professionals working at the pharmacy on the day of the declaration have satisfactorily completed, within the last 2 years (between 01April 2024 and end of 31 March 2026) the CPPE sepsis online training and passed the e-assessment.

Regularising Enhanced DBS Checks for registered pharmacy professionals

By the end of 31 March 2026, all registered pharmacy professionals working at the pharmacy on the day of the declaration must have undertaken an enhanced DBS check to support the safe provision of clinical services, with a certificate issued within the last three years (between 1 April 2023 and end of 31 March 2026), to regularise the frequency of performing these checks in line with other healthcare professionals in the NHS.

Contractors will need to have evidence to demonstrate that all registered pharmacy professionals working at the pharmacy on the day of the declaration must have requested an enhanced DBS check to support the safe provision of clinical services, with a certificate issued within the last three years (between 1 April 2023 and end of 31 March 2026). This evidence must be available for inspection from the end of 31 March 2026 at premises level and must be retained for 3 years for PPV purposes.

When making a declaration for this criterion, the following information must be reported on the MYS application:

- the total number of registered pharmacy professionals working at the pharmacy on the day of the declaration who have undertaken an enhanced DBS check and received a certificate since 1 April 2023.
- the total number of registered pharmacy professionals working at the pharmacy on the day of the declaration who have not undertaken an enhanced DBS check since 1 April 2023 but who will undertake this requirement between the day of the declaration and the end of 31 March 2026.
- That the contractor has the evidence to demonstrate that all registered pharmacy professionals working at the pharmacy on the day of the declaration have undertaken an enhanced DBS check and received a certificate to support the safe provision of clinical services within the last three years (between 1 April 2023 and end of 31 March 2026).

2.3 The following applies to all training that is associated with PQS 2025/26. Many of the criteria in this scheme include training and related assessments being undertaken by pharmacy team members. The following terms are used in the requirements to define different types of staff:

- **Registered pharmacy professionals** are pharmacists and pharmacy technicians.
- **Patient-facing pharmacy staff** include all registered pharmacy professionals, trainee pharmacists, trainee pharmacy technicians, dispensary staff, medicine counter assistants and delivery drivers. Contractors may also have other staff that can be identified as having patient-facing roles.
- **Non-registered pharmacy staff** include all trainee pharmacists, trainee pharmacy technicians, dispensary staff, medicine counter assistants and delivery drivers.
- **Patient-facing staff that provide advice on medicines or healthcare** include all registered pharmacy professionals, trainee pharmacists, trainee pharmacy technicians, dispensary staff and medicine counter assistants.
- **Non-registered patient-facing pharmacy staff who provide health advice** includes trainee pharmacists, trainee pharmacy technicians, dispensary staff and medicine counter assistants.

2.4 An electronic certificate of completion of the training will be provided following the completion of each of the e-assessments. Contractors must keep a copy of the certificate for each member of staff as evidence that the training and e-assessment has been completed. As there is no e-assessment specifically linked to the CPPE *Consulting with people with mental health problems* e-learning, pharmacy professionals will need to confirm completion by downloading a certificate of study from their CPPE learning record.

2.5 If staff members have previously completed any of the training and, where applicable, successfully passed the e-assessments which are within the validity period as explained in 2.2, they are not required to complete this training again.

2.6 All training and e-assessments must have been successfully completed by the end of 31 March 2026. However, in relation to training requirements where new staff who have recently joined the pharmacy or staff returning from long term leave, for example maternity leave, have not undertaken the training and assessment by the end of 31 March 2026 the pharmacy contractor can count them as having completed the training and assessment, if the pharmacy contractor has a training plan in place to ensure that these staff complete the training and assessment within 30 days of the day of the declaration or by the end of 31 March 2026, whichever is the later. This training plan and demonstrable evidence of completion of training and assessment must be retained at the pharmacy to demonstrate that the pharmacy contractor has met this quality criterion.

2.7 By the end of 31 March 2026, the contractor must have for each staff member, excluding those staff for whom there is a training plan in place as described above, at premises level, an electronic copy of the personalised certificate (stored and accessible digitally) provided upon completion of the training and assessment (where applicable), as evidence that all relevant members of staff have completed the training.

3. Payment for PQS 2025/26

3.1 Pharmacy contractors must claim payment for the PQS 2025/26 quality domains during the declaration period which is between 09:00 on 2 February 2026 and 23:59 on 27 February 2026. Contractors must have evidence to demonstrate meeting the gateway criterion* and the domains that they have claimed for by the end of 31 March 2026.

* Contractors, who opened from 1 September 2025 up until 31 December 2025 or had a change of ownership resulting in a new ODS code, must sign up to deliver the Pharmacy First Service and Pharmacy Contraception service, within two weeks of opening under the new ODS code, and remain registered until the end of the scheme, 31 March 2026 to qualify for payment for PQS 2025/26.

Contractors, who opened or had a change of ownership from 1 January 2026 resulting in a new ODS code will not be eligible for the gateway criteria and will not qualify for payment for PQS 2025/26.

3.2 Pharmacy contractors will need to make a declaration to the NHSBSA using the MYS application. MYS is available at https://www.nhsbsa.nhs.uk/pharmacies-gp-practices-and-appliance-contractors/dispensing- contractors-information/manage-your-service-mys.

3.3 Completing the declaration is an essential requirement for meeting the scheme requirements. Undertaking some or all the scheme requirements without submitting the final declaration will not enable a payment to be made. MYS allows a contractor to start their declaration and then return to it later should this be necessary. Where a declaration has been started but not submitted, it will not be eligible for payment. Contractors who successfully complete their declaration will receive a declaration confirmation email as evidence that their declaration has been successful. This email must be provided if a contractor needs to demonstrate that they have successfully completed their declaration. Should a contractor not receive this declaration confirmation email within one hour of submitting their declaration then, after checking their junk email folder, they should email the provider assurance team at pharmacysupport@nhsbsa.nhs.uk immediately to make them aware of the issue.

3.4 The domain(s) have a designated maximum number of points dependent on the participating contractor's total prescription volume in 2024/25*/**/***/**** according to the NHSBSA's payment data as shown in Table 3.

* Contractors, who opened part way through 2024/25, will have their total prescription volume determined as the average number of prescriptions dispensed per month during the full months they were open in 2024/25 multiplied by 12. Please note that change in ownership for the purpose of the PQS banding only is not treated as a new contractor.

** Contractors, who opened after 1 April 2025, will be placed in band 2 for PQS 2025/26. Please note that change in ownership for the purpose of the PQS banding only is not treated as a new contractor.

*** Contractors, who are eligible for the Pharmacy Access Scheme (PhAS), are automatically placed in band 2

**** Where two pharmacies have consolidated, in accordance with Regulation 26A,161 since 1 April 2024, the total prescription volume of the continuing pharmacy will be determined as the item volume for the continuing pharmacy only. The item volume for the closing pharmacy will not be attributed to the continuing pharmacy. This is not the same as a change in ownership situation.

Table 3. Maximum number of points per domain

Band	**Band 1**	**Band 2**
Annual Items	**0-1,800**	**1,801 and above**
Medicines Optimisation	1.50	30.00
Patient Safety	1.00	20.00
Total	**2.50**	**50.00**

3.5 The total funding for PQS 2025/26 is £30 million. The funding will be divided between qualifying pharmacies based on the number of points they have achieved up to a maximum £115.00 per point. Each point will have a minimum value of £57.50, based on all contractors achieving maximum points. Payments will be made to eligible contractors depending on the band they are placed in, how many domains they have declared they are meeting, and hence points claimed.

3.6 For example:
Assuming the number of contractors in each band and the average number of points achieved by each contractor is as set out in Table 4, we can calculate how many points in total were delivered and therefore the value of each point:

Table 4

	Number of contractors	Average points per contractor
Band 1	13	2
Band 2	8,347	30

The total number of points is 250,436 which means £30 million would deliver a value per point of £119.79.

However, each point is capped at a total of £115.00. So, the contractor would receive £115.00 per point they earned. This would mean that around £1.2 million (out of the £30 million) would remain undelivered through the PQS and would be taken into account in the delivery of the overall Community Pharmacy Contractual Framework funding agreement.

4. Aspiration payment

4.1 Contractors will be able to claim an aspiration payment. The aspiration payment is optional for pharmacy contractors and not claiming it will not impact on the pharmacy contractor's ability to claim payment for PQS 2025/26.

4.2 Pharmacy contractors will need to make a declaration to the NHSBSA using MYS and indicate which domains they intend to achieve before the end of the declaration period. MYS is available at https://www.nhsbsa.nhs.uk/pharmacies-gp-practices-and-appliance-contractors/dispensing-contractors-information/manage-your-service-mys. The aspiration payment must be claimed between 09:00 on 1 May 2025 to 23:59 on 16 May 2025 for contractors to receive payment on 1 July 2025.

4.3 Completing the declaration within the declaration window is essential to receive an aspiration payment. MYS allows a contractor to start their declaration and then return to it later should this be necessary. Where a declaration has been started but not submitted, it will not be eligible for payment. Contractors who successfully complete their declaration will receive a declaration confirmation email as evidence that their declaration has been successful. This email must be provided if a contractor needs to demonstrate that they have successfully completed their declaration. Should a contractor not receive this declaration confirmation email within one hour of submitting their declaration then, after checking their junk email folder, they should email the provider assurance team at pharmacysupport@nhsbsa.nhs.uk immediately to make them aware of the issue.

4.4 The maximum number of points for which a pharmacy contractor can be paid an aspiration payment is 75% of the number of points available. The value of each point for the aspiration payment is set at £57.50 (i.e. the minimum value of a point for PQS 2025/26).

4.5 The aspiration payment will be reconciled with the payment for the PQS 2025/26 on 1 April 2026. Where there is a change of ownership during the course of 2025/26 and the previous contractor received an aspiration payment and does not make a declaration between 09:00 on 2 February 2026 and 23:59 on 27 February 2026, this aspiration payment will be recovered from the previous contractor. A new contractor cannot rely upon the PQS activities conducted by a previous contractor for PQS payment where a change of ownership has occurred resulting in a new ODS code being issued for the contractor.

4.6 For example:

PQS Band for 2025/26	Band 2
Maximum 'aspiration points' which can be paid	37.5
Points intended to deliver, as per Aspiration payment declaration	50
Aspiration payment (paid at £57.50 per aspiration point)	£2,156.25
Points actually delivered, as per 2025/2026 declaration (made between 09:00 on 2 February 2026 and 23:59 on 27 February 2026,	50
Reconciliation payment (1 April 2026) (based on final value of £80.00 per point)	£1843.75
Total 2025/26 PQS payment	£4,000.00

The pharmacy's prescription volume in 2024/25 would put them in Band 2 for 2025/26 PQS. They intend to achieve 50 points in 2025/26 (i.e. the maximum available for Band 2). They receive an aspiration payment of £2,156.25 (i.e. 75% of 50 points is 37.5, and 37.5 multiplied by £57.50 is £2,156.25). The pharmacy achieves the 50 points as intended. In addition, the points delivered by all contractors mean the value of a point is set at £80.00. In the reconciliation payment the pharmacy contractor receives £1,843.75.

5. Validation of Claims

5.1 NHS England has a duty to be assured that where contractors choose to take part in the PQS that they meet the requirements of the scheme and earn the payments claimed. NHS England will

work with the NHSBSA Provider Assurance Team to undertake verification checks on all declarations. The verification checks include comparing the information provided by contractors in their declarations against the datasets and evidence sources available, as well as evidence held by the pharmacy to demonstrate meeting the scheme requirements.

5.2 When contractors make their submission for the PQS 2025/26, they are making a declaration that they have met the gateway criterion and will meet the quality criteria in each of the domains they are claiming for by the end of 31 March 2026. It is the contractor's responsibility to be able to provide evidence of meeting the scheme requirements and this may be required by the NHSBSA for post-payment verification.

5.3 Contractors experiencing any difficulty with collating evidence of meeting the scheme requirements or making the declarations for the PQS 2025/26 can contact the NHSBSA Provider Assurance Team at pharmacysupport@nhsbsa.nhs.uk. to make them aware of these difficulties at the time the difficulties occur.

5.4 In cases where NHS England consider that a claim has been made for a PQS payment for which the contractor is not eligible, it will be treated as an overpayment. In such cases, contractors will be contacted by the NHSBSA and notified of the overpayment recovery process. Any overpayment recovery would not prejudice any action that NHS England may also seek to take under the performance related sanctions and market exit powers within The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013.

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

When a Child Dies – A Framework for General Practice

Agenda Item No: SPCC 25/08/B15

August 2025

Responsible Director: Dr Jonathan Griffiths

1. Purpose of the Report

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

- Information regarding the publication of the ICB document 'When a Child Dies – a Framework for General Practice – link here Child Death Framework - NHS Cheshire and Merseyside but full report attached.
- A summary of how this has been received both locally and nationally
- Opportunity to ask any questions about this work and raise any issues

2. Ask of the Committee and Recommendations

The Committee is asked to ;

a. ***Note*** the updates in respect to this publication

3 Background

3.1 There are over 3500 child deaths in England each year (Child death data release 2024 | National Child Mortality Database). Despite this, child death is a rarely talked about 'taboo' subject. Bereaved parents can therefore feel unheard, struggling for support at this most challenging of times.

3.2 As a relatively rare event for General Practice, GPs are often unsure how to practically manage the event of a child death, and how best to approach supporting the bereaved parent(s).

3.3 NHS Cheshire and Merseyside worked with The Alder Centre and Clare House Children's Hospice to develop this framework. Listening events were held with bereaved parents to hear their stories in relation to General Practice interactions to ensure this is a co-produced document.

3.4 The resulting framework includes a checklist of actions for practices, practical advice regarding how to support bereaved relatives and a section on how to support staff within the practice itself. There is a glossary of frequently used terms, and an appendix of further resources that relatives can be signposted to.

3.5 Please see 'Communication and Engagement' paragraph 9 re impact locally and nationally

4.0 Ask of the Committee

4.1 To note the Framework and associated work to promote.

4.2 To note the wider interest in this framework from NHS partners, ICBs and media.

5.0 Risks

- No corporate risks identified.

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

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

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

6 Link to meeting CQC ICS Themes and Quality Statements

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

7 Risks

n/a

8 Finance

No financial risk or pressure

9 Communication, Engagement and feedback

9.1 Patient/bereaved parent feedback has already been received, with positive feedback and thanks.

9.2 The Royal College of General Practitioners has reviewed the framework. As this is a Cheshire and Merseyside specific piece of work, the RCGP were unable to fully endorse it, but have provided a supportive statement: "*The death of a child is a rarely talked about, deeply traumatic and upsetting event. At the heart there are grieving parents who need care, compassion and support. 'When a Child Dies – a Framework for General Practice' provides an essential checklist of actions to take bolstered by a wealth of practical suggestions and resources. This Framework will help GPs to support parents through devastating grief while also looking to support themselves through the process. NHS Cheshire and Merseyside have produced a resource that will help GPs and thereby help the patients they serve. We would encourage all to read and adapt for their own local settings."*

9.3 The framework has been shared with General Practice across Cheshire and Merseyside and has been well received. A webinar for GPs took place on 23rd July and we plan further educational events to promote the work. We have an October date arranged to provide education to the GP Registrars in the local Deanery.

9.4 NHS England have seen the framework and are looking to see how they can spread wider. It has been pinned to the opening page of the NHSE Safeguarding Future NHS platform, shared across the National Network of Named GPs (for safeguarding) and shared with national stakeholders within the NHSE Maternity and Neonatal programme.

9.5 We have received a number of enquiries from ICBs around the country asking if they can use our framework as the basis for their own work.

9.6 National organisations including the NHS Confederation and National Child Mortality Database are also looking to share with their partners.

9.7 There has been some media interest. An article in Pulse Online was published on 30th July 2025, and an interview with The General Practice Podcast has been recorded, with publication date yet to be announced at time of writing.

10 Equality, Diversity and Inclusion

Consideration was made to Equality, Diversity and Inclusion as part of this framework development.

11 Next Steps and Responsible Person to take forward

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

Dr Bryony Kendall
Bryony.Kendall@cheshireandmerseyside.nhs.uk

NHS
Cheshire and Merseyside

When a Child Dies

An NHS Cheshire and Merseyside Framework for General Practice

Published July 2025

Forward

While GPs and their practices are well-versed in dealing with bereavement, it is felt that a slightly different approach is required when a child dies. This guidance is for General Practitioners and their teams and is intended to support practices and empower professionals in managing these thankfully rare, but challenging situations.

"This event entirely changes lives… you're always grieving – you learn to get through each day"

We would encourage practices to review this guidance and discuss with staff. Practices may wish to develop their own 'in-house' protocols based on this document. We would further encourage you to consider whether it would be appropriate for you to identify someone within your practice to be a lead for child death. This individual could promote awareness of this document, facilitate education and training for staff and identify local support agencies for families.

This document was produced in collaboration with The Alder Centre and Claire House Children's Hospice with input from bereaved parents and general practice staff. We acknowledge and appreciate all the families and professionals whose lived and learned experiences have contributed to this document.

Dr Jonathan Griffiths and Dr Bryony Kendall

NHS Cheshire and Merseyside

Contents

Background

This guidance has been informed by conversations with bereaved parents who have a voice that should be heard, and stories that are important for us to hear.

Underpinning many of the described challenges is the assertion that people do not want to talk about child death. It is a deeply upsetting subject for many, yet as doctors, we do need to accept the reality that children do, sometimes, die. We need to provide solace and support to parents, families and communities in an appropriate way through their grief during the acute bereavement and on through the rest of their lives.

"I lived through the trauma of him living, the trauma of him dying, and the trauma of living without him"

The NHS-funded National Child Mortality Database (NCMD) was launched on 1 April 2019 and collates data collected by Child Death Overview Panels (CDOPs) in England, from reviews of all children who die at any time after birth and before their 18th birthday. Their most recent data release reports that there were 3,577 child deaths (age 0-17 years) during the year ending 31st March 2024[1].

Deaths of infants (babies under 1 year of age) accounted for 61% of all child deaths. Neonatal deaths (babies under 28 days of age) accounted for 42% of all child deaths.

While the overall estimated rate of child death remains low, it is worth noting where risks are higher. The child death rate was highest for those of black or black British ethnicity, although over a 5-year period, the rate was highest for those of an Asian Pakistani ethnicity. The child death rate for children resident in the most deprived neighbourhoods of England was more than twice that of children resident in the least deprived neighbourhoods.

***"Don't put a time limit on grief…
you'll never 'be over it'"***

Child deaths are a stark and sensitive indicator of the social determinants of health, and the link between higher indices of multiple deprivation and child death is a consistent feature in reviews of deaths in Cheshire and Merseyside. Within Cheshire

[1] Child death data release 2024 | National Child Mortality Database: https://www.ncmd.info/publications/child-death-review-data-release-2024/

and Merseyside, we have an ethnically diverse population and significant pockets of deprivation.

One of the co-authors of this guidance is a bereaved parent himself. He has shared his personal story, and you can read about some of the challenges he feels bereaved parents face in his blog[2].

You can also watch a short video here where a bereaved parent talks about her experience.

[2] The challenges of being a Bereaved Parent – Dr Jon Griffiths: https://drjongriffiths.wordpress.com/2024/07/12/the-challenges-of-being-a-bereaved-parent/

Practical guidance – a checklist

- Deduct the child from the NHS spine as soon as possible to ensure that no inappropriate contact is made.
- Inform the Child Health Information Service (CHIS) to ensure no immunisation invitations are sent out. (Contact us - SCW Child Health Information Service (CHIS))
- Inform the regular/named GP as soon as possible (if away then inform duty doctor).
- Notify whole practice using usual processes highlighting that this is the death of a child.
- Consider who to notify:
    - Midwife, Health Visitor, School Nurse.
    - Paediatric consultant (if under specialist care and the consultant unaware of the death). This provides an opportunity for a conversation between professional colleagues.
    - Nominated Community Pharmacy who may have been supplying medications (and who may be about to deliver more).
- If this is an expected death in the community, then undertake Medical Certificate of Cause of Death process including contacting the Medical Examiner as per usual practice.
- **If you are involved in the sudden and unexpected death of a child in the community then follow your local SUDIC protocol.**
    - **Merseyside:** **https://trixcms.trixonline.co.uk/api/assets/sthelensscp/ef07c1df-7b63-4fe8-8329-7db4cdf94880/sudic-protocol-may-2024.pdf**
    - **Cheshire:** **https://www.cheshireandmerseyside.nhs.uk/media/i0pd0zhx/pan-cheshire-sudic-documentation-proforma-and-guidance-april-2023.pdf**
- If the regular GP is different to the named GP consider making the regular GP the named GP.
- Ensure entire household has the same named GP unless parents request otherwise.
- Regular/named GP or other more appropriate person to contact parent(s):
    - An initial text or letter may be appropriate to alert the parents to expect contact.

- We would recommend offering a face-to-face consultation, which may need to be a home visit depending on circumstances, but initial phone contact may be appropriate.
- Be aware that this consultation may be lengthy and be emotionally draining. Consider timing appropriately to allow you the time and emotional space you may need.
- Be alert to language needs and the possibility that translation services may be required.
- Consider asking in this initial consultation if a fit note is required. You may wish to ask about all household members and speaking to them at the time if needed, providing notes as indicated.
- **Please see the next section for more details on supporting the bereaved family.**

➢ Add a Significant and Active code to the parents' record; we recommend the SNOMED code 'Child of patient deceased'.

- Consider adding an 'alert' to the parents' record. Be aware this is not auditable, will not transfer with the EMIS or SystmOne record if the patient moves practice, and will remain there indefinitely if not reviewed.

"I hoped the receptionist knew [because] they make you retell your story; don't make it hard to make an appointment"

➢ After discussion with parent(s) you may need to record bereavement codes on additional family members such as siblings, grandparents, others.

➢ When requested, engage with the Child Death Review (CDR) process (Child death review guidance and support (ncmd.info).

➢ Where a neonatal death has occurred, ensure that the mother still receives an invitation for a 6-week post-natal check. **This should be at a time separate to your usual 'baby clinic'.**

➢ Consider a review meeting within the practice, especially if GPs have been involved in care for the child.

➢ Remember the father/non-birthing parent. This may cause an issue if they are not registered with you, and/or the parents are estranged. You may need to ask about other significant carers.

➢ If you become aware that a child has died abroad and especially in cases where the child has been buried in the country where they have died, ensure that

notifications have been made to your local CDOP and other relevant agencies. This is unusual so do contact for support and signposting.

- Merseyside and Isle of Man CDOP: CDOPTeam@liverpool.gov.uk 0151 233 1551
- Cheshire CDOP: CDOP@mcht.nhs.uk 01270 826060

Supporting bereaved parents

We would suggest that the nature of support required will be determined by the initial contact with the parent(s) and tailored to their needs. That said, we include some thoughts here regarding the potential actions that may be appropriate as well as highlighting some things to consider in your approach. The circumstances surrounding the death will be highly relevant and will help you determine the need. Bereavement following a child who has died following a long life-limiting illness will require different support to where a child has died suddenly and unexpectedly, either by illness or trauma.

"Say 'I don't know how you're feeling, but I want to help'… say 'I can't make it any better, but I can listen'"

"It's the importance of bearing witness even in our baby steps of grief"

Where death has occurred or been confirmed in a hospital or hospice setting, parents will likely already have spoken to a health care professional (often many) and received advice, support and onward signposting. Remember that as a GP you will also see patients who have been bereaved some time ago or indeed see older patients whose adult child has died. In these situations, you may be the first health care professional dealing with their bereavement.

The following suggestions are intended to be considered as part of long-term support for the family. The pointers are not all appropriate for an initial conversation, and we would encourage flexibility and retaining an open invitation for parents to contact for support.

- **An early face-to-face conversation** with the bereaved parent(s).
    - This may need to be a home visit as attending a health care setting may be too upsetting for the parent(s).
    - This enables both parents to receive support.
    - This will primarily be a listening exercise for you where you can understand what support is in place and what additional help may be required.
    - Explore who is at home, and what extended family/friend support is available.
    - Explore who else may need support – estranged parent/siblings/grandparents.

- Explore what (if any) signposting to helplines/counselling/support services has occurred. Ascertain if there is support being received from a specialist palliative care service or hospice.
- Ensure parents have received the 'What to do if a child or baby dies' information which can be found here: What to do after someone dies: What to do if a child or baby dies - GOV.UK. We would recommend you read this yourself before you speak to the parents.
- Be alert to language needs and the possibility that translation services may be required.
- **Parents we listened to appreciated contact from their GP when this had occurred and were disappointed when it had not.**

"I was taken aback in a good way… it took bravery and gave me something good in a dark time"

➢ **Signposting**

- A list of organisations that may be appropriate to signpost to is available in appendix A, please do review this.
- Familiarise yourself with services local to you.
- Local children's hospices and children's bereavement centres welcome enquiries from GPs wanting to engage and find out more.
- Be aware that children's hospices may not be able to provide bereavement support unless the child was previously known to them either before death or if the family used the hospice's dedicated cold rooms immediately after the death. They may be able to provide helpful signposting to other available services.
- Generic mental health services/talking therapies may not be able to provide the specialised support required.
- Local faith-based support is likely to be available if appropriate for the family.
- **Parents we spoke to often struggled to find appropriate support.**

"Help grieving parents navigate through… no one gives you control, so as a GP, give it back"

- Is a **fit note** required?
    - This is an opportunity to ask about others, most notably the father/non-birthing parent, but also other family members who may not otherwise present to you.
    - During your initial contact you may wish to provide notes to all relevant family members, asking to speak to them on the same call if needed.
    - Parents whose children required time on the neonatal unit may be eligible for time off under the new Neonatal Care Leave Act.

"Terminology is really important… what you write impacts other things such as insurance, so talk to the parents about what you are going to say"

- **Returning to work**
    - Encourage parents to engage with the Occupational Health via their employer.
    - You may wish to help them consider the support that may be required when they return to work. Does the nature of their work raise specific challenges?
    - Bereaved parents who are healthcare workers may have to undergo annual CPR training including resuscitation of children – how will they cope with this?
    - Many job roles require mandatory safeguarding training (often now via eLearning). Safeguarding issues can be triggering for bereaved parents and they may need to think about this on return to work.
    - Child Bereavement UK have this excellent resource for employers: How you can help someone return to work after their baby or child has died? Guidance for employers | Child Bereavement UK
    - **Fathers tend to return to work sooner or may not have had any significant time off work. This can be driven by financial pressures. Consider being proactive and enquiring about work and whether time off is required.**

"There's a vacuum as a dad that you won't have any contact with the GP, and you cope until you don't… I didn't feel seen"

➢ **Language**

- We have provided a glossary of sorts in Appendix B. This includes medical and legal terminology as well as some commonly used lay words/phrases you may need to be aware of.
- Please think carefully about your choice of words.
- Try not to use medical terminology that may not be understood. For bereaved parents who are health care professionals, check which language they wish to use.
- **In our engagement with bereaved parents, language and communication were key important themes – remember every word counts.**

"Non-verbal communication needs to be congruent; it will be hard – lean in and learn from it"

➢ **Ask if it is appropriate to use the child's name**

- This links to language and continuity. Ask about the name of the child and don't be afraid to use it if the family are happy with this.
- Be aware of cultural differences as in some cultures it is more respectful not to use the name of a deceased person. This practice is observed by peoples in many parts of the world, including the indigenous peoples of northern Australia, Siberia, Southern India, the Sahara, Sub Saharan Africa, and the Americas.

➢ **Continuity**

- "If continuity was a drug… then it would be top of what we write on our prescriptions every single day"[3].
- Bereaved parents value continuity. They do not want to have to continually re-tell their story. They benefit from a consistent approach from someone who knows them.
- Please consider how you will achieve this in your practice bearing in mind which clinician the parent(s) may prefer to see.

[3] Continuity of Care 'Achievable, Improves Services, Admissions, Mortality': https://www.medscape.co.uk/viewarticle/continuity-care-achievable-improves-services-admissions-2021a10021jh

- **Bereaved parents who spoke to us valued speaking to the same GP to a much greater extent that you might expect.**

➢ **Access**

- This is where appropriately used alerts on the record can help reception and triaging staff to facilitate smooth access and continuity.
- Consider how you can provide easier access to appointments to the regular GP for bereaved parents.

"An e-consult is even more impersonal… the capacity to make an appointment, get dressed, [and] function has gone"

➢ **Listening**

- Your main role through all of this may be to bear witness to the pain, loss and grief experienced.
- You cannot 'fix this', but you can be there for them and listen to their story.
- Be present.
- This quote from Nicholas Wolterstorff may help you to frame things:

  "*Don't say it's not really so bad. Because it is. Death is awful, demonic. If you think your task as comforter is to tell me that really, all things considered, it's not so bad, you do not sit with me in my grief but place yourself off in the distance away from me. Over there, you are of no help. What I need to hear from you is that you recognise how painful it is. I need to hear from you that you are with me in my desperation. To comfort me, you have to come close. Come sit beside me on my mourning bench.*"[4]

"I can't imagine means I don't want to imagine"

"Being well-intentioned is not enough – be honest if you've not encountered this before"

"Make contacts more than transactional"

---

[4] Wolterstorff, N (1987). Lament for a Son. Grand Rapids: Wm. B. Eerdmans

- **Awareness**
    - Be aware that the parent(s) may be part of multiple processes and receiving information from many different sources, especially if there is involvement of the coroner.
    - Note that for sudden and unexpected deaths there may be police and safeguarding involvement.

- **Milk Bank Donation after Loss**
    - Lactating women may wish to donate to the Milk Bank at Chester. This is something that women from across England can do, not just those living in or near to Chester.
    - Please also note that cabergoline is green on formulary to suppress lactation in women who have suffered loss of the baby.

- **Try not to over-medicalise**
    - Grief is not the same as depression or anxiety.
    - We should be cautious about labelling grief as abnormal and avoid jumping to diagnoses without good cause.
    - There are models of grief that may be useful:
        - Kübler-Ross[5]
        - 'Growing around Grief' (Tonkin 1966)[6]
        - 'The Whirlpool of Grief' (Wilson)[7]
        - 'The duel process model of grief' (Strobe and Schut 1995)[8]
    - Parents reported to us that they were offered antidepressants when they really did not feel they were required.
    - Think very carefully about prescribing sedatives, even for challenging situations like funerals. Funeral rituals are important, you may wish to explore whether an individual would wish to be sedated for such a key event.

[5] Understanding the five stages of grief: https://www.cruse.org.uk/understanding-grief/effects-of-grief/five-stages-of-grief/
[6] Growing around Grief: Dr. Tonkin's Model of Grief | Sue Ryder: https://www.sueryder.org/grief-support/about-bereavement-and-grief/growing-around-grief/
[7] Whirlpool of Grief (reimagined using animation): https://www.youtube.com/watch?v=VpNViACSKw4
[8] Stroebe M, Schut H. The dual process model of coping with bereavement: rationale and description. Death Stud. 1999 Apr-May;23(3):197-224. https://pubmed.ncbi.nlm.nih.gov/10848151/

- Please be alert to the fact that some cultures do not recognise or have a language around mental distress and may express it in terms of physical/somatic symptoms.
- **Parents we spoke to did not wish to be labelled as depressed or prescribed antidepressants for their bereavement and grief.**

"Don't just reach for medication… validate the feeling – you're not going mad, this is a normal reaction to an abnormal event"

➢ **Preparing for future pregnancy**

- Bereaved parents may want a conversation about this.
- The circumstances surrounding their child's death will determine the nature of this conversation and specialist input may be required, especially where genetic causes were, or were thought possible to have been a cause.
- Future pregnancies may bring mixed feelings including anxiety, guilt and fear as well as joy and healing.
- Be aware of the emotional impact that future pregnancies may cause in parents and look to support.
- The term 'Rainbow Baby' is increasingly used to describe a baby born to a family who have previously suffered baby loss, and this term may be used during subsequent pregnancy.

"We couldn't face going back to the hospital where she was born"

"Our thresholds have changed – we know how easy it is to die"

➢ **The challenges of Sudden and Unexpected Death in Childhood (SUDIC)**

- "This encompasses all cases in which there is death (or collapse leading to death) of a child, which would not have been reasonably expected to

occur 24 hours previously and in whom no pre-existing medical cause of death is apparent"[9].

- Be aware that all cases of SUDIC will trigger a safeguarding review, this does not necessarily mean there are safeguarding concerns.
- There may well be police involvement which can be very upsetting for parents.
- There is currently a national lack of paediatric pathologists, so post-mortem can be delayed for many months.
- Certain genetic testing can take additional time for results.
- A Coroner's inquest will want any post-mortem findings, so expect significant delays.
- Be prepared to support the family through a prolonged period of waiting for 'answers'.

[9] Sudden unexpected death in infancy and childhood – multi-agency guidelines for care and investigation: https://childprotection.rcpch.ac.uk/resources/sudden-unexpected-death-in-infancy-and-childhood-multi-agency-guidelines-for-care-and-investigation/

Supporting each other

The death of a child is a traumatic event, and members of the practice team could find this challenging. We suggest that the surgery proactively addresses this.

The first step is to acknowledge that this may be an issue. People work professionally and will likely compartmentalise their feelings from their work. You may not be aware that anyone is struggling unless you ask.

- **Check in with each other.**
    - Specifically check on:
        - The individual who took the call.
        - The GP dealing with the family.
        - The GP who may have verified the death. The Alder Centre can provide specific support to clinicians who have found this traumatic.
        - Anyone who personally knew the child and/or the family (remember that GPs and their staff frequently live and work in the community).
        - Wider team members such as pharmacists (who may have been communicating with the family for many years).
- Are there members of your team who are bereaved parents?
    - Be aware that this event could be very triggering for them.
    - Note that in general, any bereaved parents in your team may need support with annual mandatory training including Basic Life Support and Safeguarding.
    - Be aware of this resource for employers from Child Bereavement UK: How you can help someone return to work after their baby or child has died? Guidance for employers | Child Bereavement UK.
- Staff members who are struggling may benefit from signposting to support services (see appendix A).

Appendix A – signposting

Please familiarise yourself with these support services/websites which may be appropriate for signposting.

For bereaved parents/families

What to do after someone dies: What to do if a child or baby dies - GOV.UK

- Helpful practical information from the government detailing actions that parents need to/may need to take.

Child Death Helpline – Home

- National free helpline staffed by volunteers who are bereaved parents. Run by the Alder Centre. For anyone affected by the death of a child at any age.

Alder Centre – Alder Hey Children's Hospital Trust

- Based at Alder Hey Children's Hospital in Liverpool. Offering individual counselling as well as a wide variety of activities for anyone affected by the death of a child. Includes coffee mornings and the ability to drop in Mon-Fri.

Home | Claire House Children's Hospice | Make a Difference Today

- Children's Hospice on The Wirral and now also in Liverpool.

Love Jasmine – Supporting bereaved families following the loss of a child

- Liverpool based charity supporting families bereaved of a child.

2wish.org.uk

- Charity currently covering Cheshire for all those affected by the sudden and unexpected death of a child or young adult aged 25 or under to receive the bereavement support they need and deserve.

I need support with a bereavement | Hospice UK

- Website providing wealth of resources around bereavement including further signposting to support services.

Survivors of Bereavement by Suicide – Overcoming the isolation of people bereaved by suicide (uksobs.com)

- Support specifically for where someone has died by suicide.

Support for Bereaved Parents and Siblings in the UK (slowgroup.co.uk)

- Support groups (face-to-face in London or Zoom meetings) for bereaved parents and siblings.

Child Bereavement UK

- Support for those grieving the death of a child.

The Compassionate Friends (tcf.org.uk)

- Support for bereaved parents and families.

Sands | Saving babies' lives. Supporting bereaved families.

- Support for all types of baby loss – miscarriage, molar pregnancy, ectopic pregnancy, stillbirth, neonatal death, Termination for Medical Reasons, Sudden Infant Death Syndrome.

Home | The Lullaby Trust

- Support for those who have experienced sudden and unexpected death of a child.

Dad Still Standing | baby loss support for dads

- A podcast and resources specifically for fathers who have experienced child loss.

Sands United | Sands - Saving babies' lives. Supporting bereaved families.

- Bereavement support for dads.

Peeps HIE Charity | HIE Awareness & Support

- Bereavement support for those affected by Hypoxic-Ischaemic Encephalopathy (H.I.E.) also sometimes referred to as birth asphyxia.

The PABL Project

- Trauma based physiotherapy support for postpartum recovery after baby loss.

Sudden Unexpected Death in Childhood

- Resources for families and professionals.

Bliss

- Bereavement support and professional resources relating to babies born prematurely.

Winston's Wish - Bereavement Support for Children

- Bereavement support for children and young adults (up to the age of 25 years).

For professionals

Practitioner Health

- Mental health support for healthcare professionals.

Health Assured | EAP, Workplace Health & Wellbeing Provider

- Mental health support and counselling currently commissioned for practice staff in Cheshire and Merseyside.

British Association of Perinatal Medicine

- Management of lactation following the death of a baby.

Working Together to Safeguard Children (2023)

- Chapter 6 for statutory guidance on child death reviews.

Sudden Unexpected Death in Childhood

- Resources for families and professionals.

Alder Centre – Alder Hey Children's Hospital Trust

- Based at Alder Hey Children's Hospital in Liverpool. Offering individual counselling as well as a wide variety of activities for anyone affected by the death of a child. Includes coffee mornings and the ability to drop in Mon-Fri.
- Additionally can provide advice and support to help you support bereaved parents.

Course: Pregnancy Loss and Child Bereavement | RCGP Learning

- RCGP eLearning on Pregnancy Loss and Child Bereavement.
- Requires log-in to access.

Appendix B – glossary

Baby loss	Death of a baby which could be during pregnancy or shortly after birth
Child death	Death of a child under the age of 18 years
Hypoxic-Ischaemic Encephalopathy (HIE)	Also known as birth asphyxia
Infant death	Death of a child under the age of 1 year
Miscarriage	The loss of a pregnancy before 24 weeks of gestation (note this guidance is not aimed at supporting those who have experienced miscarriage)
Neonatal death	Death of a baby under the age of 28 days
Perinatal event	Between 22 weeks of pregnancy and 7 days of life
Rainbow baby	A child born to a family who have previously experienced baby loss due to miscarriage, stillbirth, ectopic pregnancy, termination for medical reasons or death during infancy
Stillbirth	The death of a baby after 24 weeks gestation, but before birth
Sudden unexpected death in childhood (SUDIC)	As SUDI (below) but for a child aged 1-18 years
Sudden unexpected death in infancy (SUDI) – also referred to as **Sudden Infant Death Syndrome (SIDS)**	Sudden and unexpected death of an infant where no cause can be found after detailed post-mortem examination
Termination for Medical Reasons (TFMR) – also referred to as **Termination of Pregnancy for Fetal Anomaly (TOPFA)**	Where a pregnancy is ended for medical reasons by medical intervention

NHS Cheshire and Merseyside

No 1 Lakeside

920 Centre Park

Warrington

WA1 1QY

enquiries@cheshireandmerseyside.nhs.uk