NHS
Cheshire and Merseyside

Meeting of the Cheshire & Merseyside ICB System Primary Care Committee

Part B (Public)

Friday 8 September 2023
Venue: Meeting Room 1, No 1 Lakeside,
920 Centre Park Square, Warrington,
WA1 1QY (WA1 1QA for Sat Nav)

Timing: 14:40-16:00

Agenda

Chair: Erica Morris

AGENDA NO & TIME	ITEM	LEAD	ACTION / PURPOSE	PAGE NUMBER
14:40pm	**Preliminary Business**			
SPCC 23/09/B01	Welcome, Introductions and Apologies	Chair	Verbal	-
SPCC 23/09/B02	Declarations of Interest	Chair	Verbal	-
14:50pm	**Committee Business**			
SPCC 23/09/B03	Minutes of the last meeting (Part B) 22nd June 2023	Chair	Paper	Page 3
SPCC 23/09/B04	Action Log of last meeting (Part B) 22nd June 2023	Chair	Paper	Page 11
SPCC 23/09/B05	Questions from the public (TBC)	Chair	Verbal	-
15:00 **SPCC 23/09/B06**	Risk Register	Hilary Southern	Paper / For decision	Page 12
15:10 **SPCC 23/09/B07**	System Pressures	Jon Griffiths	Verbal	-
15:20 **SPCC 23/09/B08**	Contracting and Commissioning Update *(includes update on dental improvement plan)*	Chris Leese / Tom Knight	Paper / For information and assurance	Page 36

AGENDA NO & TIME	ITEM	LEAD	ACTION / PURPOSE	PAGE NUMBER
15:30 **SPCC 23/09/B09**	Transformation – Access Recovery and Improvement Plan – Progress and Update	Clare Watson *(Chris Leese / Tom Knight / Tony Leo / Jon Griffiths)*	Paper For information and assurance	Page 45
15:40 **SPCC 23/09/B10**	GP Patient Survey - Summary	Chris Leese	Paper For information and assurance	Page 57
15:50 **SPCC 23/09/B11**	Primary Care Strategic Framework	Jon Griffiths	Paper For information and assurance	Page 63
16:00	**CLOSE OF MEETING**			

Date and time of next regular meeting:
Thursday 19th October 2023 (09:00-12:30)

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

System Primary Care Committee Meeting
Part B (Public)

1 Lakeside, 920 Centre Park Square, Warrington, England, WA1 1QY.
22 June 2023
10:45 – 12:20

UNCONFIRMED Draft Minutes

MEMBERSHIP		
Name	**Initials**	**Role**
Erica Morriss	EMo	Chair, Non-Executive Director
Chris Leese	CLe	Primary Care Associate Director, C&M ICB
Clare Watson	CWa	Assistant Chief Executive, C&M ICB
Tony Foy	TFo	Non-Executive Director
Adam Irvine	AIr	Primary Care Partner, ICB
Christine Douglas	CDo	Director of Nursing and Care, C&M ICB
Dr Daniel Harle	DHa	LMC Representative
Tony Leo	TLe	Place Director, C&M ICB
John Adams	J Ad	Head of Primary Care Finance ICB
Louise Barry	LBa	Chief Executive C&M Health Watch

IN ATTENDANCE		
Lorraine Weekes- Bailey	FMo	Senior Primary Care Accountant, C&M ICB
Cathy Bentley	CBe	Project Support Officer, Minutes, C&M ICB
Fionnuala Stott	FSt	LOC representative
Dr Jonathan Griffiths	JGr	GP & Associate Medical Director
Mark Woodger	MWo	LDC representative
Tom Knight	TKn	Head of Primary Care, C&M ICB
Susanne Lynch	SLy	Chief Pharmacist ICB
Matthew Harvey	MHa	LPC representative
Naomi Rankin	NRa	Primary Care rep ICB
Luci Devenport	LDe	Senior for Primary Care Manager for Dental C&M ICB

Apologies		
Name	**Initials**	**Role**
Delyth Curtis	DCu	Place Director C&M ICB
Rowan Pritchard-Jones	RPj	Medical Director, C&M ICB

Item	Discussion, Outcomes and Action Points	Action by
	Preliminary Business	
PCC/06/23/P01	**Welcome, Introductions and Apologies**	
	EMo welcomed all present at the meeting. Apologies noted above.	
PCC/06/23/P02	**Declarations of Interest**	
	There are currently four standing declarations of interest for the below colleagues, however, the papers had no DOIs to be presented at the committee today. • Dr Jonathan Griffiths • Matthew Harvey • Susanne Lynch • Adam Irvine	
PCC/06/23/P03	**Minutes of the last meeting – date**	
	Members reviewed the minutes of the meeting held on 20th April 2023 and agreed that they were a true reflection of the discussions and decisions made with the exception of one amendment. **FSt requested that in the optometry item 'Recruitment is not an issue' be amended to read 'recruitment is an issue but is being managed.'**	**ECo**
PCC/06/23/P04	**Action Log**	
	The Committee received the action log for review. The report was taken as read and members noted the completed actions. Further updates were provided as follows: **The action for AIr to share the integration paper has now been superseded by additional work and can be closed.** **The SPCC Committee noted and discussed the updates.**	**ECo**
PCC/06/23/P05	**Questions from the Public**	
	EMo read out the questions from the public. **Questions Regarding Warrington Place** Under the initiative for the Prime Ministers' office relating to improvement access to GP practices in Warrington: **1)** Under the initiative from the Prime Minister's Office relating to improving access to GP practices. **How will you undertake and improve the access to GP surgeries within Warrington Place over the next 12 months?** **2)** Currently there are a number of students in the later part of their training to become a GP within Warrington Place. **How do intend to try and encourage those trainees to come back into a surgery within Warrington Place?** **3)** Since June 2022 and the loss of The Health Forum/Patient Voice in Warrington, we have had little or no Engagement/Consultation, in Warrington. The ICB did adopt the successful Patient Rep policy from Warrington that won Green Stars from NHS England, While	

Item	Discussion, Outcomes and Action Points	Action by
	we Healthwatch, they are corporate company that do not have the same connection to GP practice PPG's and the Patient Voice , even the PCN Networks pay little attention to the PV. **How do you intend to listen and actively support the PV within Warrington Place?** Questions 1, 2 and 3 have been forwarded to Warrington Place for a response which will be then sent by EM to the question originator. LBa asked will that by default ensure that Healthwatch Warrington work with place and EM confirmed she will ensure this is captured in the response back to place. **Questions from Paula Barker, MP** **1)** How does the Committee believe the decision to close Park View Medical Centre in Tuebrook helps deliver the objective to Build Capacity in Primary Care, as set out in the 'Delivery Plan for Recovering Access to Primary Care', May 2023? **2)** How does the Committee believe that the decision to close Park View Medical Centre, dispersing 2500 patients to existing practices, will help address the problems with access for patients which have led to a fall in patient satisfaction? (Page 11, Delivery Plan for Recovering Access to Primary Care, May 2023) **3)** How does the Committee believe that the decision to close Park View Medical Centre supports the objective to "improve access, experience and outcomes for all" as stated in the Delivery Plan for Recovering Access to Primary Care, May 2023? **4)** Will the Committee carry out an urgent review of its decision to close Park View Medical Centre, to review the decision's compatibility with the Delivery Plan for Recovering Access to Primary Care, in meaningful consultation with patients, political representatives and the local community? This is now in a process and questions will be responded to and provided within the prescribed timeframe for MP responses. **Action: CWa to check on MP response progress so that this can be expedited.**	
	Business Items	
PCC/06/23/P06	**System Pressures**	
	Primary Care GP Practices JGr noted the following have contributed to increased demand for Primary Care services: • The recent hot weather • The backlog following the pandemic- i.e. many patients have not seen a GP f2f and are now wishing to. • Restored services and at least equal numbers of f2f. • Long elective waits result in those on lists wishing to see GPs Other significant issues: Primary Secondary Care interface – the number of actions coming out of	

Item	Discussion, Outcomes and Action Points	Action by
	hospital asking GPs to perform when most could be managed by the hospital. This is leading to extra work such as admin and prescribing. This is being worked on across the system and at Place. Stock shortages of medicines. Patients are moving between community pharmacy and GP. This is taking up a lot of Primary Care resource. Pharmacists are needed just to deal with the stock shortage issues. **Community Pharmacy** MHa agreed that the above pressures are the same for Community Pharmacists. Pharmacist is dealing with stock shortage issues only. Pharmacists may not always be aware of what a medication has been prescribed for as they do not have access to the EMIS System. DHa reiterated the point that stock shortages are a major problem as well as: Digital outpatient validation changes, tele dermatology changes to GI pathways and other issues. These measures are introduced to alleviate pressures in the system elsewhere, but this is not sustainable without additional estate and workforce. DHa and colleagues have been looking at solutions but there is no estate. The impact of the recent pharmacy closures across the system have increased so the implications of short notice closures mean patients will go somewhere else. It is difficult for the remaining pharmacies to forecast extra demand on services. **Optometry** FSt noted there are similar issues in optometry to those highlighted above, issues with recruiting but also around the uncertainty re the demands on staff as changes begin to happen. There are some communication challenges re signposting to services. Better signposting is required for the Urgent Eyecare Service for both patients and professionals. There is a new IT system across the optometry sector, this has generally been received well. Waiting times for cataract procedures have been longer than in most areas. There has been some independent sector provision meaning more choice for patients. **Dentistry** MWo noted: Urgent and continuing care to dentistry has continued to be a major issue. 2 things to note which may help with pressures. 1. There has recently been a parliamentary Select Committee report published and it is hoped that many of the national contract issues will be addressed in that report 2. Locally there is a dental improvement plan on today's agenda	

Item	Discussion, Outcomes and Action Points	Action by
	highlighting local initiatives to attempt to improve services Individual practice pressures – recruitment is a problem which impacts on the ability to access services. This also puts pressure on the dentists remaining in the NHS making it a less attractive place to work. Oral health is deteriorating in many patients meaning more time is need with patients thus adding to the pressures. This needs to be addressed urgently and it is hoped that the local dental plan will alleviate some of these pressures. The Committee noted the update from all four contractor groups.	
PCC/06/23/P07	**Policy Update – Primary Care Contracting and Commissioning**	
	The paper contained updates on national policy in relation to all four primary care contractor groups -There are a few bullets regarding the access recovery plan, but a presentation will follow regarding this. EMo requested that a performance section (key KPIs) be included as part of the papers to the Committee. **Action – TK/CL/CWA/JL to arrange KPI's for next SPCC as part of Contracting Performance section. As part of this discussion would need to speak to the BI and Digital Teams** 1 - % of C & M Residents that can access NHS Dentistry 2 - Referrals from GP to Comm Pharm 3 - GP Apts - Face to face/telephony/digital. 4 - Residents using NHS App and downloaded medical records 5 - Practices which over E-Consult and Online Prescriptions. **CL noted that some of these are already reviewed as part of the ICB performance metrics that are reported to the ICB board.**	
PCC/06/23/P08	**Primary Care Access Recovery Plan**	
	CWa noted the oversight and governance of the Primary Care Recovery Plan sits with this committee and this will be taken to the board next week because of the importance board places on primary care and primary care access. CLe, TKn, TLe, and JGr gave a presentation which will be circulated after the meeting, on the approach, progress, risks and next steps. The Board noted the update and were assured. CWA expressed thanks for all the work undertaken in a short space of time to get us to this point.	
PCC/06/23/P09	**Dental Improvement Plan**	
	NHS Cheshire and Merseyside has the delegated responsibility for the commissioning of dental services including primary, community and secondary care. Access to dental services is a local, regional, and national issue impacting negatively on patients. The Dental Improvement Plan signals NHS Cheshire and Merseyside's	

Item	Discussion, Outcomes and Action Points	Action by
	commitment and ambition to ensure that access is improved for both routine, urgent, and dental care for our most vulnerable populations and communities impacted by the COVID pandemic. LDe and TKn presented the improvement plan at page 23 of the pack. TKn noted: • The improvement plan has been welcomed by all. • Some of the actions have been started already, some are yet to start. The first part of the plan outlines strategic aims around recovery dental activity. • UDAs are there as a requirement. • Focussing on access for inclusion for deprived and vulnerable population. • Delivering ambitions around how long people will wait for urgent care. • Supporting the Workforce strategic approach across C&M. (all dental staff). • There are opportunities and risks. • The first part of the plan is the operational plan requirement recovering dental activity in line with ~~operational plan~~ requirements of the plan. • Metrics are included in the plan. • Dental services are not delegated at place level and will be the responsibility of ICB LDe noted Project 1 on the plan. It is difficult to do anything without recurrent funding as planning and delivery of schemes take some time and projects rely on the goodwill of providers during these challenging times The slides provided are complicated but in summary the proposed projects come under 3 pathways: • Urgent Care • Urgent care plus • Routine access for new patients Pathways 1 & 2 are already in place and we are looking to maintain and expand Project 1 (pathway 1) relates to an existing network of practices set up as 'urgent care centres' during the pandemic. This network provide additional appointments for urgent care via the local dental helpline and provide access for a number of vulnerable patient pathways including 'looked after children', patients due to commence Adjuvant Zoledronate for breast cancer, which is due to be rolled out to further priority patients. Flexible commissioning approach and no further finding is needed for those sites but need resilience – calls to the dental helpline remain way above (30/50 % above pre covid levels NHS E agreed to maintain until end of March 2024 and we would like to continue until 2025.	

Item	Discussion, Outcomes and Action Points	Action by
	It is also noted there are some gaps in provision and a further 6 practices would be beneficial. Project no.2 is a supporting frail and elderly. (Pathway 3) This has been looked at for a while. The CQC compliance for care homes is that all residents need to have a dental plan in place, carried out by a member of the care home team This project would like to link dental practices to a selection of care homes to ensure there is support for signposting to training of care home staff, supporting staff to undertake and review oral health plan, facilitating an appointment at the practice where required. It is accepted that dental treatment within a care home is restricted to assessment only. The project will inform next steps and act as an assessment of need. Project 3- (Pathway 3) to develop ~~access~~ new patient access sessions with a caveat to dental practices that some patients are accepted from vulnerable communities identified by commissioners/LA/Place colleagues Project 4 (Pathway 3) to allow over achievement in UDA activity for all practices up to 110% of annual contracted activity for year 23/24 (as agreed for the last financial year) Project 5: ACCDP – to allow expansion of the advanced childcare dental practices supporting specialist paediatric community services LDE asked to use the dental underspend to continue to plan and undertake these projects –A National Dental Recovery Plan is due to be published (expected in June) together with a dental workforce plan. The content of the national plan may impact on local projects. All projects will be ~~worked up~~ planned, delivered and evaluated led by LDN and with MCN and provider group support. CDo asked about quality and safety, where in the improvement plan do we determine what we are delivering is of quality and is safe? Workforce Programme Where do dental nurses receive their professional leadership? What are the CPD opportunities? TKn noted health and safety issues are focussed on access and responding in the first instance. TKn to review. This is part of the Primary Care workforce Steering Group LDe works closely with CQC and has in the past has raised issues via NHSE meetings. Also attends PAG. Currently has no way to escalate those who do not engage. **Action: TKn LDe and CDo to meet to discuss quality** CLe noted he has met with Kerry and Lisa and went through the existing quality escalations for each function. A paper will be providing detail in August. This needs to be reflected in the plan.	

Item	Discussion, Outcomes and Action Points	Action by
	We need to ensure something is built in. CWa noted she agrees with all projects apart from no 6. Louise noted this has only been shared with one Healthwatch without the ability to share. The Committee needs to note a point of principle that we do not tick a box when this is not the case. EMo noted: Projects 1-5 are more articulated at this stage. TFo noted we need to ensure the underserved groups are benefiting. MWo noted the financial implications guild rate is not accurate in the paper as it changed in April 2023 and tolerance for this year's contract management as published on 19th June has changed to 90% not 96%. That will have an impact on the sum available. These schemes do not appear to increase activity delivery. This does a lot for patient access. Would urge the board to not expect UDA increases. We need to ensure we look at the whole strategic aim not just looking at UDA numbers. **Following discussion, the Committee approved projects 1-5. Further consideration is needed for projects 6, 7 and 8. Evidence to come through to this Committee on progress of that plan.** TLe would advocate for project 6 in future.	
PCC/06/23/P10	**PC Workforce Steering Group Update**	
	This paper presents updates in relation to primary care workforce, primarily based on updates from the Primary Care Workforce Steering group and ongoing initiatives across the system, complimenting work being undertaken at place level, which will be included in any place transformation updates. It should be noted that primary care workforce issues are also discussed at the People Board. A large amount of information and data was contained in this report and it was noted further work is required to refine this to place level.	
	Other Formal Business	
PCC/06/23/P11	**Closing remarks, Review and Communications**	
	The meeting scheduled for 24th August will not go ahead as it is not quorate. A new date will be agreed.	
12:20am	**CLOSE OF MEETING**	
Date, time, and location of Next Meeting: TBA		

End of Meeting

CHESHIRE MERSEYSIDE
INTEGRATED CARE BOARD SPCC COMMITTEE

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

Updated: 22 June 2023

Action Log No.	Original Meeting Date	Description	Action Requirements from the Meetings	By Whom	By When	Comments/ Updates Outside of the Meetings	Status
PCC/12/22/06a	22.12.22	Primary Care priority areas for patients - Community Pharmacy Challenges/Integration & Future ways of working as an ICB	Adam to share the integration paper further and a meeting to be arranged to discuss further actions	Adam Irvine	March 2023		COMPLETED
PCC/03/23/12	01-Mar-2023	Place update/SDF Funding 22/23	DCU advised that a further update report would be presented to the committee, following a regional return due. CL to take forward.	Chris Leese	01-Apr-2023	This has been compiled into a report - given the size, this is available to committee members on request rather than sent with the papers for June	COMPLETED
PCC/04/23/07	20-Apr-2023	Governance	CL to bring updated ToR to next meeting to sign off amendments.	Chris Leese	22-Jun-2023	As further work is required on the quality reporting, these will return to a later meeting for final sign off, but have been updated following the meeting	COMPLETED
PCC/04/23/09	20-Apr-2023	Contracting, Commissioning and Policy Update	Section 2.7 of the paper states routine care appointments will be offered within 2 weeks of contact which is inaccurate. CL to confirm the actual contract ask at the next meeting.	Chris Leese	22-Jun-2023	Clarification for the notes - this is an ambition from the IIF documentation and is not a core contract ask c	COMPLETED
PCC/04/23/10	20-Apr-2023	Strategic Framework Update / Workforce Steering Group Update	Discuss how the Primary Care & ICB workforce group/Sub Comm work together optimally - **to be concluded outside SPCC.**	Jonathan Griffiths/Chris Leese	22-Jun-2023	WSG will report to People Board but an update will be given to SPCC quarterly.	COMPLETED
PCC/06/23/P03	22-Jun-2023	Minutes from previous meeting	FSt requested that in the optometry item 'Recruitment is not an issue' be amended to read 'recruitment is an issue but is being managed.'	Ebony Cooke	08-Sep-2023		ONGOING
PCC/06/23/P05	22-Jun-2023	Questions from the public	CWa to check on MP response progress so that this can be expedited.	Cwa	08-Sep-2023		ONGOING
PCC/06/23/P06	22-Jun-2023	System pressures	TK/CL/CWA/JL to arrange KPI's for next SPCC as part of Contracting Performance section. As part of this discussion would need to speak to the BI and Digital Teams	TK/CL/CWA/JL	08-Sep-2023		ONGOING
PCC/06/23/P09	22-Jun-2023	dental improvement plan	TKn LDe and CDo to meet to discuss quality	TKn	08-Sep-2023		ONGOING

NHS Cheshire and Merseyside Primary Care Committee

Date: 8th September 2023

Corporate Risk Register Update, Month 7, Quarter 2 (2023-24)

Agenda Item No	SPCC 23/09/B06
Report author & contact details	Hilary Southern, Governance & Corporate Services Manager (St Helens Place) Hilary.southern2@sthelensccg.nhs.uk
Report approved by (sponsoring Director)	Christopher Leese, Associate Director of Primary Care
Responsible Officer to take actions forward	Dawn Boyer, Head of Corporate Affairs & Governance (ICB) Dawn.Boyer@knowsleyccg.nhs.uk

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

Primary Care Corporate Risk Register Update
Month 7, Quarter 2, 2023/24

1. Executive Summary

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

1.2 There are currently five primary care related corporate risks identified for NHS C&M, four of these are highlighted for committee overview/ review – two (1PC & 6PC) rated high-extreme (8-25); one (2PC) as the risk score has decreased, and two (4PC & 5PC) as the risk score has reduced this month and both are recommended for closure.

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

2. Introduction/ Background

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

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

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

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

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

2.5 Risk are escalated to the committee risk register which are rated as high (8+) in the context of the ICB as a whole, together with any relevant place risks rated as extreme (15+) in the context of the place. Committees will receive an overview of all relevant risks on first identification and annually, including those not meeting the threshold for escalation, to enable oversight of the full risk profile.

2.6 As requested by Committee in June, for the purposes of the September report *all* currently identified primary care-related risks are included at Appendix B, not just those scoring 15+.

3. Committee Risk Reports

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

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

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

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

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

4. Key Points Highlighted

4.1 **Overall Summary**: There are currently five primary care related corporate risks identified for NHS C&M – as per section 4.4, four of these are highlighted for committee overview/ review – two (1PC & 6PC) rated **high-extreme** (8-25); one (2PC) as the risk score has **decreased**, and two (4PC & 5PC) as the risk score has reduced this month and both are recommended for **closure**.

4.2 **Extreme/ High Risks**: As per previous reports, there is one risk currently rated as Extreme (16) – 1PC; relating to the sustainability and resilience of Primary Care workforce (General Practice, Community Pharmacy & General Dental Services). This risk was increased in June following a review of related place level risks – this month's report sees the risk remaining at a score of 16.
One risk is currently rated as high – scoring 12: 6PC, relating to an identified dental provider contract management risk – potentially leading to loss of provider and impact on general dental provision.

4.3 **Place-level risks for Escalation:** Appendix B identifies the risks currently held at place-level; as noted in section 2.5 above, these will usually only be those place-risks scoring 15 or more; however, Committee requested a view of ***all*** place-level primary care-related risks for the September report.

Place risk development is an ongoing process, with some places further along than others, but all places are working on developing their place-level risks, and support is being provided from the ICB central Governance Leads team as required; and regular reporting on progress through the ICB Risk Committee.

There is still work to do in reviewing the risks collectively and ensuring consistency across the patch; for example, eight out of nine places are currently each holding an 'extreme' (score of 16) risk relating to the sustainability and resilience of Primary Care workforce –

however Warrington Place has a similar risk scored at 9 (high). Work to be done to review all place risks collectively and ensure consistency of scoring; and work is well underway in the development of a risk management training offer – an update was presented to Risk Committee at the start of August.

All place level risks are currently managed through Place Primary Care forums, with oversight from the Place risk management structures. Risks will be escalated in accordance with the agreed process. Further information relating to these risks can be provided as required.

4.4 **Risk Score Movement:**

- Risk 2PC – relating to Extension of APMS (Alternative Providers of Medical Services) Primary Care Contracts); risk score has **decreased** to 6 (unlikely, 2 x moderate impact, 3). This follows the work undertaken by the central Procurement team, and the resolution/ update of 14 contracts, and implementation of Procurement Decisions Plan, signed off by Finance, Investment & Our Resources Committee (FIRC).
- Risk 4PC – Community Pharmacy IT provision out of contract and uncertainty around funding and commissioning intentions resulting in risk of service being withdrawn. Contract in question has been approved and PO raised; continuity in terms of the provider and no impact therefore in provision of service; therefore risk score **decreased** to 2 (rare likelihood, 1 x minimal impact, 2) and proposing risk to be **closed**.
- Risk 5PC – Notice served on significant proportion of Community Pharmacy Services stock by Provider, reducing community pharmacy provision in some areas. Process being led by national NHSE team, with weekly updates on figures sent to ICB Pharmacy team; data evidencing that so far 37/43 pharmacy units have been taken over/ in the process of being taken over under new ownership, therefore no impact on provision. Remaining 6 are in area where already sufficient pharmacy provision to prevent material impact on residents. The numbers now reflect business as usual numbers of closures/ changes, and therefore not a cause for concern. Therefore risk score **decreased** to 3 (rare likelihood, 1 x moderate impact, 3) and proposing risk to be **closed**.

4.5 **New/ Closed Risks**:

- There are no new risks to be added;
- As above, two risks are suggested for closure this month – Risks 4PC & 5PC

5. Recommendations

5.1 The Committee is asked to:

5.1.1 **APPROVE reduction** in risk scores for Risks 2PC, 4PC & 5PC

5.1.2 **APPROVE closure** of risks 4PC & 5PC

5.1.3 **NOTE** the current position in relation to the risks escalated to this committee, identify any further risks for inclusion, and consider the level of assurance that can be provided to the Board and any further assurances required.

6. Next Steps

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

7. Officer contact details for more information

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Appendix A: Primary Care Committee Corporate Risk Register Summary – August 2023 (Quarter 2, 2023/24)

Risk ID	Risk Title	Senior Responsible Owner	Inherent Risk Score (LxI)	Current Risk Score (LxI)	Previous Risk Score (LxI)	Target Score	Risk Proximity
FOR COMMITTEE REVIEW – 8+ OR SCORE CHANGE							
Primary Care (General Practice, Community Pharmacy, General Dental Service and Ophthalmic)							
1PC	Sustainability and Resilience of Primary Care workforce (General Practice, Community Pharmacy & General Dental Services)	Chris Lees/ Tom Knight	12	16 ↔	16	3	A
General Practice Related							
2PC	Extension of APMS (Alternative Providers of Medical Services) Primary Care Contracts	Chris Lees	12	6 ↓	9	3	A
Community Pharmacy Related							
4PC	Community Pharmacy IT Provision out of contract, and uncertainty around funding and commissioning intentions resulting in risk of service being withdrawn	Jackie Jasper	9	2 ↓ **CLOSE**	9	3	A
5PC	Notice served on significant proportion of Community Pharmacy Services stock by Provider; reducing community pharmacy provision in some areas	Jackie Jasper	3	3 ↓ **CLOSE**	6	2	B
Dental Related							
6PC	Identified dental provider contract management risk – potentially leading to loss of provider and impact on general dental provision	Lucy Devenport	9	12 ↔	12	6	A

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

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

Risk ID	Risk Title	Current Risk Score									
		ICB Wide	Cheshire East	Cheshire West	Halton	K'sley	L'pool	Sefton	St Helens	W'ton	Wirral
FOR COMMITTEE REVIEW – 8+ OR SCORE CHANGE											
Primary Care (General Practice, Community Pharmacy, General Dental Service and Ophthalmic)											
1PC	Sustainability and Resilience of Primary Care workforce (General Practice, Community Pharmacy & General Dental Services)	16 ↔	16	16			16	16	16	9	
General Practice Related											
2PC	Extension of APMS (Alternative Providers of Medical Services) Primary Care Contracts	6 ↓									
N/A	RE: Primary Care Estate – capacity & options.								9		
N/A	RE: Service Provision – due to Contractual issues (1), Practice (financial) sustainability (1) & PCN Maturity (1)								12 (x 3)	12	
Community Pharmacy Related											
4PC	Community Pharmacy IT Provision out of contract, and uncertainty around funding and commissioning intentions resulting in risk of service being withdrawn	2 ↓ **CLOSE**									
5PC	Notice served on significant proportion of Community Pharmacy Services stock by Provider; reducing community pharmacy provision in some areas	3 ↓ **CLOSE**									
Dental Related											
6PC	Identified dental provider contract management risk – potentially leading to loss of provider and impact on general dental provision	12 ↔									
COMMITTEE NOTING ONLY (Risks scoring 8 and below)											
General Practice Related											
	N/A – No corporate risks identified currently										
Community Pharmacy Related											
	N/A – Risk Score changed – see table above										
Ophthalmic Related											
	N/A – No corporate risks identified currently										

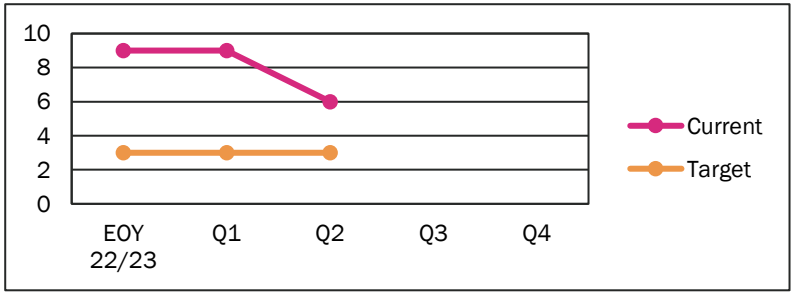
Appendix C: Primary Care Committee Risk Assurance Map – August 2023 (Quarter 2, 2023/24)

Risk ID	Risk Title	Current Risk Score	Controls					Assurance Rating
			Policies	Processes	Plans	Contracts	Reporting	
FOR COMMITTEE REVIEW – 8+ OR SCORE CHANGE								
Primary Care (General Practice, Community Pharmacy, General Dental Service and Ophthalmic)								
1PC	Sustainability and Resilience of Primary Care workforce (General Practice, Community Pharmacy & General Dental Services)	16 ↔						Reasonable
General Practice Related								
2PC	Extension of APMS (Alternative Providers of Medical Services) Primary Care Contracts	6 ↓						Significant
Community Pharmacy Related								
4PC	Community Pharmacy IT Provision out of contract, and uncertainty around funding and commissioning intentions resulting in risk of service being withdrawn	2 ↓ **CLOSE**						FULL
5PC	Notice served on significant proportion of Community Pharmacy Services stock by Provider; reducing community pharmacy provision in some areas	3 ↓ **CLOSE**						FULL
Dental Related								
6PC	Identified dental provider contract management risk – potentially leading to loss of provider and impact on general dental provision	12 ↔						Significant

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

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

FOR COMMITTEE APPROVAL – SCORE MOVEMENT

ID No: 2PC	Risk Title: Extension of APMS (Alternative Providers of Medical Services) Primary Care Contracts			
	Likelihood	Impact	Risk Score	Trend
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	4	3	12	
Current Risk Score	2	3	6 ↓	
Risk Appetite/Target Risk Score	1	3	3	

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

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
TBC	Finance, governance, fraud.	A – within the next quarter	Corporate	Manage

Date Raised	Last Updated	Next Update Due
01/07/2022* *Legacy CCG Risk*	August 2023	October 2023

Risk Description

From ICB establishment in June 2022, there were a number of APMS contracts across the patch previously managed by the nine different CCGs; the rules that govern their procurement and extension are subject to the Public Contract Regulations (2015) (PCRs) and the Procurement, Patient Choice and Competition Regulations (2013) (PPCCRs), however, during Covid many of these rules were suspended. The ICB therefore inherited a mixture of contract approaches including where contracts may have been extended outside of usual approaches.

As at **August 2023**: Risk score **decreased** to 6 (possible likelihood x moderate impact). Although we continue to wait on updated procurement regulations for healthcare services (the Provider Selection Regime - potentially expected Nov 23 now); in the meantime, we continue to comply

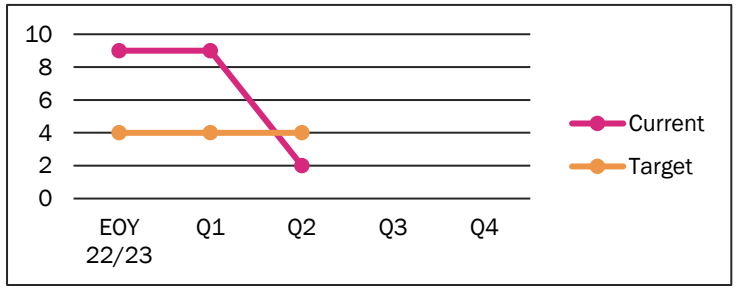
with the existing regulations as above. The ICB corporate procurement team has been working with place colleagues to understand the needs and priorities of each contract, and to renew / extend or tender as appropriate, in compliance with the regulations. Since June 2022 14 contracts have been awarded, 2 have been terminated and 4 have been agreed to go out to tender; the rest are to be reviewed and progressed when they come up for expiry. In addition, from 01/04/2023 the ICB inherited a number of dental-related contracts, which are in a similar position to the original APMS contracts back in June 2022, and require a review and processing to bring up to date. There is a paper due to go to Finance, Investment & Our Resources Committee (FIRC) in September summarizing position. The Annual Procurement Decisions Plan is in place (approved by FIRC in April 2023), and risk score is reflective of timing issues now, as the plan is worked through.		
Current Controls		**Rating**
Policies	• ICB Scheme of Reservation and Delegation and Standing Financial Instructions	
Processes	• Oversight from/ regular reporting to Finance, Investment and Our Resources Committee (FIRC) and System Primary Care Committee. • Part of ICB annual procurement decisions plan • National/ professional support identified via North of England CSU (commissioned by NHS England) to provide technical procurement oversight and management for a number of APMS contracts due to expire in 2024.	
Plans	• Each place should have a plan and process for managing APMS contracts on their patch in line with current rules, all are aware that re-procurement is required and approximate timescales for procurement. • System Primary Care Committee reporting to be established in line with their Terms of Reference following updates to ICB Scheme of Reservation and Delegation (expected following Audit Committee in Sept 2023)	
Contracts	• All contracts listed within ICB Corporate Procurement Team, and on Procurement Decisions Plan	
Reporting	• Oversight from/ regular reporting to FIRC; and reporting to System Primary Care Committee to be established.	
Gaps in control		
• Awaiting updates to Procurement regulations		

Actions planned	**Owner**	**Timescale**	**Progress Update**
As per Procurement Decisions Plan	VA	Ongoing	Plan signed off by FIRC in April 2023; to be updated with dental contracts inherited April 2023.

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

Gaps in assurance			
• Awaiting updates to Procurement regulations			
Actions planned	**Owner**	**Timescale**	**Progress Update**
As above (Control actions planned)			

ID No: 4PC	Risk Title: Community Pharmacy IT provision out of contract and uncertainty around funding and commissioning intentions resulting in risk of service being withdrawn.

	Likelihood	Impact	Risk Score	Trend
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	3	3	9	
Current Risk Score	1	2	2 ↓	
Risk Appetite/Target Risk Score	2	2	4	

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Tom Knight, Head of Primary Care	Jackie Jasper, PC Manager (NHSE)	Assistant Chief Executive/ Place Primary Care Structures	System Primary Care Committee Report to Finance Committee

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

Date Raised	Last Updated	Next Update Due
April 2023 – *transferred from NHSE to ICB*	August 2023	October 2023

Risk Description

Community Pharmacy IT provision out of contract and uncertainty around funding and commissioning intentions resulting in risk of service being withdrawn. Funding to be identified and prioritised within ICS system to ensure the continuation of commissioning some IT systems for GP and Community Pharmacies to underpin and support service provision post 31/03/23. Specifically, but not exclusively – Flu, RA function, GP CPCS, DMS, SCS, minor ailments, GP referral into Hypertension Case Finding. Although assurance has been given that the contract will be 'picked up' and the current provider has confirmed they will continue in the interim, out of contract since 31/03.

At **August 2023:** Contract in question has been approved and the Purchase Order raised; continuity in terms of the provider and no impact therefore in provision of service; therefore risk core **reduced** to 2 (rare likelihood, 1 x minimal impact, 2) and proposing risk to be **closed**.

Current Controls	Rating

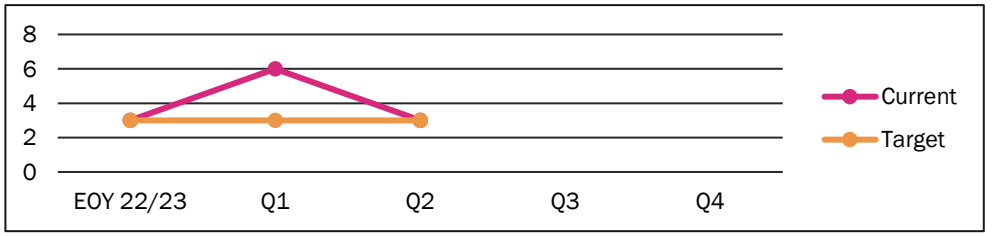
Policies		
Processes	• Discussions with Head of Digital Technology (Cheshire and Merseyside), NHS England and NHS Improvement – North West & Kevin Highfield (ICB) to review current contracts, and ensure they are recognised as part of the overall digital strategy.	
Plans	• Contract approved, and PO currently being progressed.	
Contracts	• Contract approved	
Reporting		

Gaps in control			
N/A – None identified.			
Actions planned	**Owner**	**Timescale**	**Progress Update**

Assurances		
Planned	**Actual**	**Rating**
	Contract has been approved – continuity of service provider & provision	

Gaps in assurance			
N/A – None identified			
Actions planned	**Owner**	**Timescale**	**Progress Update**
N/A – see above			

ID No: 5PC	Risk Title: Notice served on significant proportion of Community Pharmacy Services stock by Provider, reducing community pharmacy provision in some areas.

	Likelihood	Impact	Risk Score	Trend
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	3	2	6	
Current Risk Score	1	2	3 ↓	
Risk Appetite/Target Risk Score	1	2	3	

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Tom Knight, Head of Primary Care	Jackie Jasper, PC Manager (NHSE)	Assistant Chief Executive/ Place Primary Care Structures	System Primary Care Committee Report to Finance Committee

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

Date Raised	Last Updated	Next Update Due
April 2023 – *transferred from NHSE to ICB*	June 2023	Aug/ Sept 2023

Risk Description

Community Pharmacy provider has served notice on proportion of Pharmacies (within supermarket stock) – affects both 40 & 100 hour contracts; potential will result in reduced community pharmacy provision in areas affected – in particular extended hours provision; bank hols etc – not covered by high street pharmacies.

August 2023: Risk **reduced** to 3 (rare likelihood, 1 x minimal impact, 2), and proposing risk to be **closed**. Process being led by national NHSE team, with weekly updates on figures sent to ICB Pharmacy team; data evidencing that so far 37 pharmacy units have been taken over/ in the process of being taken over under new ownership, therefore no impact on provision. There remains 6 not yet resolved, but these are in area where already sufficient pharmacy provision to prevent material impact on residents. The numbers now reflect business as usual numbers of closures/ changes, and therefore not a cause for concern.

Current Controls		Rating
Policies		
Processes	• Statutory process in place to raise potential issue with Health & Wellbeing Boards/ Local Authorities • NHSE National Team leading	
Plans	• NHSE National Team leading – weekly updates being provided to ICB	
Contracts		
Reporting	• System Primary Care Committee overview • Health & Wellbeing Boards	

Gaps in control
N/A – None identified

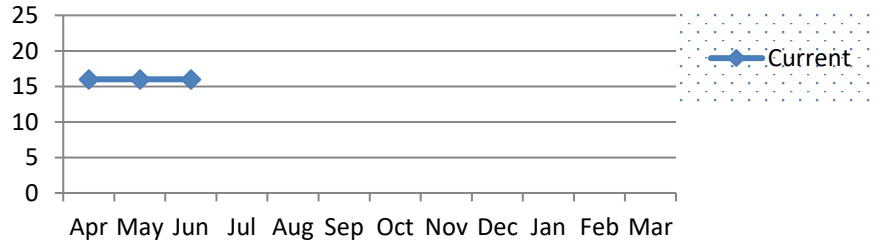
Actions planned	Owner	Timescale	Progress Update

Assurances		
Planned	**Actual**	**Rating**
	• As expected, majority simple change of ownership, and 6 remaining unresolved in areas where already sufficient provision therefore no new PNA needed • Process led by national central NHSE Community Pharmacy team – receiving weekly updates on figures/ reporting.	

Gaps in assurance
• The PNA will only be updated in line with regulatory timeframes.

Actions planned	Owner	Timescale	Progress Update
As above			

FOR COMMITTEE REVIEW – SCORES 8+

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

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

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

Date Raised	Last Updated	Next Update Due
10/05/2023	07/07/2023	15/09/2023

Risk Description

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

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

Gaps in control

- Primary Care Strategic Framework – version 2 to be completed & formally signed off
- Primary Care Access Recovery Plan yet to be completed

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

Assurances

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

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

Gaps in assurance

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

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

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

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

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

Date Raised	Last Updated	Next Update Due
01/07/2022* *Legacy CCG Risk*	August 2023	October 2023

Risk Description

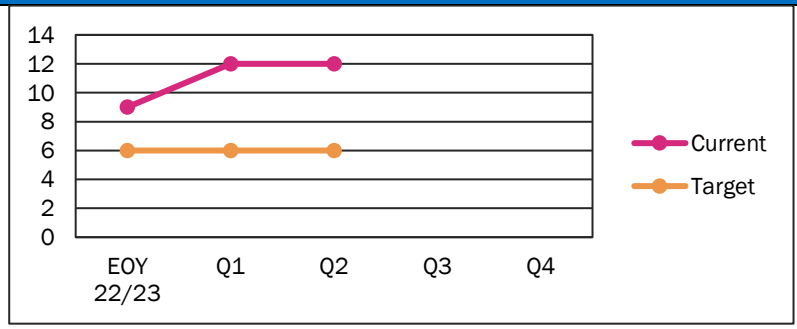
Resilience and sustainability of Primary Care in terms of demand, workforce pressure and external factors such as industrial action, peaks in public concern such as (A Strep). Previously a legacy CCG risk across all 9 CCGs; this has been further expanded to include similar pressures across Community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

captured on local place risk registers, but this combined issue needs capturing on the overall corporate ICB risk register so that there can be assurances in respect of the overall resilience and sustainability of primary care – and that enabling factors should as workforce are included. At **August 2023**: Ongoing pressures in general across Community Pharmacy, Dental and General Practice, where a lack of key trained primary professional staff, in particular GPs, Pharmacists and Dentists (in the NHS family) is causing issues. In addition recently published guidance around delivering operational resilience across the NHS this winter identifying improvement targets to be met.		
Current Controls		**Rating**
Policies	• National Stocktakes and Guidance in relation to Primary Care • Delivery Plan for recovering access to Primary Care https://www.england.nhs.uk/publication/delivery-plan-for-recovering-access-to-primary-care/ • Delivering Operational Resilience across the NHS Winter 2023 guidance	
Processes	• System Primary Care Committee • Managed operationally at place level through place structures/ governance (escalation to SPCC as needed). • Working with National Team and DoH on workforce issues and support. • Primary Care Workforce Steering Group reporting	
Plans	• Primary Care Strategic Framework – ICB level and Place level, place workforce plans • Clinical Strategy • Workforce/ People plans via People Board inc Primary Care Workforce Strategy • ICB engagement with HEE and Liverpool Dental School • Dental Improvement Plan • GP retention plan (submitted May 2023) • ICB Access Recovery plan (to Board October)	
Contracts	• GMS PMS APMS GDS PDS Contracts updated • Local Enhanced/Quality Contracts/ Directed Enhanced Services • Community Pharmacy Contracts	
Reporting	• Primary Care workforce Steering Group/ • Community Pharmacy National Workforce Development Group • NHSE National Teams (looking at wider workforce issues across Primary Care) • Place reporting to place primary care structures/ forums • Place reporting to System Primary Care Committee through reporting template already agreed noting a clearer risk principal escalation process is to be developed • System Primary Care Committee reporting through to Northwest Regional Structures • Reporting to PSRC Committee and through community pharmacy commissioning Team	

Gaps in control			
• Risk escalation process to be refined further between place and system • Reporting between People Board and SPCC to be developed • Consistent single set of data to be discussed at WSG and reported to People Board/ SPCC			
Actions planned	**Owner**	**Timescale**	**Progress Update**
ICB PCARP response	CWatson	Ongoing	Programme board set up – first meeting held 02/06/23 Due to ICB Board October

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

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

ID No: 6PC	Risk Title: Identified dental provider contract management risk – potentially leading to loss of provider and impact on dental provision			
	Likelihood	**Impact**	**Risk Score**	**Trend**
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	3	3	9	
Current Risk Score	3	3	12 ↔	
Risk Appetite/Target Risk Score	2	3	6	

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

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

Date Raised	Last Updated	Next Update Due
April 2023 – *transferred from NHSE to ICB*	August 2023	October 2023

Risk Description

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

Current Controls		Rating
Policies	• NHS England Dental Policy book 2018	
Processes	• Legal advice has been followed throughout	
Plans	• Request a one-off payment to address the current debt and then work with the provider on a meaningful action plan. If one off payment is refused move to terminate.	
Contracts	• Multiple – managed by Contracts Team	
Reporting	• System Primary Care Committee	

Gaps in control

- Issue has been ongoing for over 12 months
- 4 additional contracts delivered in area which may be destabilized by this issue.
- Wider impact on neighboring ICBs
- Stakeholder response to termination
- Changes to Performer List by Validation Exercise – detail unknown at this time re: quality assurance.

Actions planned	Owner	Timescale	Progress Update
Forward breach notices for each of the above contracts	Luci Devenport	w/c 10/04/23	Outstanding – report due to SPCC 22/06/23
Confirm actual debt amounts	Luci D/ Finance	w/c 10/04/23	Outstanding – report due to SPCC 22/06/23
Arrange meeting with provider	Luci Devenport	w/c 17/04/23	Outstanding – report due to SPCC 22/06/23

Assurances

Planned	Actual	Rating
• Breach notices to be formally issued • National guidance awaited re: Dental Foundation Trainee programme (2023/24). Impact due following year.	• Legal advice has been received and used to progress next steps	

Gaps in assurance

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

Actions planned	Owner	Timescale	Progress Update
As above			

NHS Cheshire and Merseyside System Primary Care Committee

Date: 8th September 2023

Primary Care Commissioning, Contracting and Policy Update

Agenda Item No	SPCC 23/09/B08
Report author & contact details	Christopher Leese Associate Director Primary Care c.leese@nhs.net Tom Knight Head Of Primary Care tom.knight1@nhs.net
Report approved by (sponsoring Director)	Clare Watson, Assistant Chief Executive
Responsible Officer to take actions forward	Christopher Leese/Tom Knight

Primary Care Commissioning, Contracting and Policy Update

<table>
<tr><td>Executive Summary</td><td colspan="5">The Primary Care Policy and Contracting Update provides the Committee with information and assurance in respect of key national policy and related local actions in respect of the four primary care contractor groups that now fall under the remit of the System Primary Care Committee ;

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

This paper contains ;

• An update on any key areas of policy in the above groups
• Any update on Cheshire and Merseyside issues that the committee need to be aware of for assurance purposes</td></tr>
<tr><td rowspan="2">Purpose (x)</td><td>For information / note</td><td>For decision / approval</td><td>For assurance</td><td>For ratification</td><td>For endorsement</td></tr>
<tr><td>X</td><td></td><td>X</td><td></td><td></td></tr>
<tr><td>Recommendation</td><td colspan="5">The Committee is asked to:

• Note the updates in respect of commissioning, contracting and policy for the four primary care contractor groups.
• Note and be assured of actions to support any particular issues raised in respect of Cheshire and Merseyside specific contractors</td></tr>
<tr><td>Key risks</td><td colspan="5">Risk registers for all four contractor groups are the subject of separate ongoing paper(s) presented to the Committee</td></tr>
<tr><td rowspan="4">Impact (x)
(further detail to be provided in body of paper)</td><td>Financial</td><td>IM &T</td><td>Workforce</td><td colspan="2">Estate</td></tr>
<tr><td>X</td><td>X</td><td>X</td><td colspan="2">X</td></tr>
<tr><td>Legal</td><td>Health Inequalities</td><td>EDI</td><td colspan="2">Sustainability</td></tr>
<tr><td>X</td><td>X</td><td>X</td><td colspan="2">X</td></tr>
<tr><td>Route to this meeting</td><td colspan="5">None</td></tr>
<tr><td>Management of Conflicts of Interest</td><td colspan="5">Will be managed in accordance with the conflict details and by the management of the Chair of the meeting</td></tr>
<tr><td>Patient and Public Engagement</td><td colspan="5">None for this report, but for relevant actions for contract issues under national policy will have patient and public engagement expectations.</td></tr>
</table>

Equality, Diversity and Inclusion	None for this report, but for relevant actions under national policy will have expectations for Equality, Diversity and Inclusion.
Health inequalities	None for this report, but for relevant actions under national policy will have expectations for health inequalities.
Next Steps	Any next steps are including in the report narrative.
Appendices	

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

Primary Care Commissioning, Contracting and Policy Update

1.0 Background

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

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

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

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

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

1.4 In addition, since 1st July, the National Community Pharmacy Contracts held previously by NHS England were transferred to the ICB as a core function under similar arrangements to Primary Medical Contracts, following a national assurance process. More information about the national Community Pharmacy Contract can be found via this link https://www.england.nhs.uk/primary-care/pharmacy/community-pharmacy-contractual-framework/. The number of community pharmacy contracts in Cheshire and Merseyside is 590.

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

1.6 Management of general ophthalmic services is via the National Policy Book for Eye Health NHS England » Policy Book for Eye Health . Provision of General Ophthalmic Services (GOS) including sight testing and dispensing is agreed by contract and there are 2 types of contracts: Mandatory Services contracts, which are contracts allowing provision of GOS in a fixed premises and Additional Services (domiciliary) contracts, which allow provision of GOS to a patient in their home address if a patients cannot attend a fixed premises unaccompanied. There are currently 228 mandatory (High Street) services and 58 additional (domiciliary) providers operating within Cheshire and Merseyside ICB.

2.0 Primary Medical Services (General Practice) Update

2.1 At the last meeting the Committee were updated in respect of '**Recovering Access to Primary Care**'. A separate paper will outline progress in this major tranche of national policy.

2.2 NHS England released information in relation to **Winter Resilience**, including expectations in primary care. The work is being coordinated by the planning/performance team and primary care are represented on the oversight group. More information on expectations in this respect can be found here https://www.england.nhs.uk/long-read/delivering-operational-resilience-across-the-nhs-this-winter/

2.3 Negotiations in respect of the **GP Contract for 24/25 onwards** are ongoing, including the direction of travel for what is currently the PCN DES (Primary Care Network Directed Enhanced Service) which has been a major feature in respect of the current delivery model of primary care services.

2.4 The **Covid 19 National Enhanced Service** specification for PCNs has been released alongside the GP Seasonal Influenza Enhanced Service Specification with an amended item of service fee along and a clinical ambition to co adminster the two vaccines. Further information can be found here NHS England » GP COVID-19 enhanced service specification

2.5 NHS England have released a review of the commissioning and management of **Special Allocation Schemes (SAS)** which are primary care services for patients who have been removed from mainstream general practice to be managed in a different, secure setting because of behaviour that caused concern – patients that are put into the scheme are managed through an agreed national process. This report sets out the key findings from national work to review the consistency of commissioned Special Allocation Scheme services against the Primary Medical Care Policy and Guidance Manual (PGM) and makes recommendations for improvement.

2.6 Integrated Care Boards (ICBs) as commissioners of SAS services should review this report and treat its finding and recommendations as interim guidance, using it to support improvements in the commissioning and management of SAS services where appropriate. NHS England is also taking forward this report to review and update the PGM in response, meaning current national policy and guidance is subject to change in support. The review document has been shared with place commissioners and the full report can be made available to committee members on request

2.7 **Contract variations for GMS/PMS** national (core) contracting with the final remaining wording now agreed for this years contract have been released, full details via the following link https://www.england.nhs.uk/gp/investment/gp-contract/

3.0 Dental Update

3.1 Following approval the commissioning team are now working on implementing the dental improvement plan. The focus of the work is on three areas in the plan:

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

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

3.3 The team are now engaged in the End of Year process with finance colleagues and will be working with practices to agree final positions including contractual claw-back and reallocation of activity.

3.4 A new Dental Policy Management Book has been published by NHS England and the team will be attending training sessions to understand the new policy and any changes to previous versions.

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

3.6 Contract meetings have commenced with Community Dental Service providers and those primary care orthodontic providers who as a result of the recent procurement will no longer be providing a service.

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

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

4.0 Community Pharmacy Update

4.1 Ongoing Changes to Pharmacy Landscape**.**

Since the beginning of the year, there has been a steady stream of Pharmacy closures. In May, regulatory changes came into force allowing 100-hour contracts to reduce their opening to a minimum of 72 hours. Although Lloyds is undergoing a UK wide sell off, the effect across C&M is looking minimal due to successful change of ownerships.

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Permanent Closures since Jan 2023

Place	Lloyds	Other Contractors	Total
Liverpool	2	5	7
Sefton	1	0	1
Halton	0	2	2
St.Helens	0	0	0
Knowsley	0	0	0
Cheshire East	2	1	3
Cheshire West	3	2	5
Warrington	0	0	0
Wirral	2	0	2

Totals across ICB	**10**	**10**	**20**

100-hour reductions

Place	No. applications to date	Total reduction in hours per week
Liverpool	7	184
Sefton	2	56
Halton	3	84
St.Helens	5	140
Knowsley	3	79.75
Cheshire East	5	116.5
Cheshire West	2	56
Warrington	4	79.5
Wirral	6	152
Totals across ICB	**37**	**947.75**

Lloyds Changes

Place	Change of Ownership	Branches remaining at present
Liverpool	8	2
Sefton	1	0
Halton	1	0
St.Helens	4	0
Knowsley	2	0
Cheshire East	4	1
Cheshire West	8	2
Warrington	5	0
Wirral	4	1
Totals across ICB	**37**	**6**

At present, any risk from this reduction in hours and premises is minimal as the majority of 100-hour contracts came about purely due to the exemption rather than a need having been identified. The reduction in pharmacy numbers will likely result in a more sustainable pharmacy landscape employing a wider multi-disciplinary team that then enables wide ranging delivery of services, subject to adequate commissioning pathways.

4.2 Medicine Supply Issues

Stock issues continue to cause disruption to the medicines supply chain. Unsustainable price increases and widespread unavailability are the most common cause of disruption. The situation is further complicated due to routine prescribing of ‘branded’ generics which does not allow the Pharmacist any flexibility in the product they dispense. Scripts are having to be re-written to reflect the brands that are available at any given time. This is causing a large increase in workload for both GP practices and Pharmacies, with associated costs involved, as well as a

great deal of disruption and potential risk for patients. The LPCs are currently working on a 'key messages' document that is intended for distribution to all Contractors and patients. Medicines Management teams, Community Pharmacy and Finance teams may need to look at a more holistic approach to overcome the issue.

4.3 Community Pharmacy Workforce Survey

The Community Pharmacy Workforce Survey has been published by NHS England. This year's survey was completed by 95% of pharmacy contractors, compared to last year's 47%.
The data is intended to support decisions about where the community pharmacy workforce can contribute to NHS clinical service expansion.
The key findings are:

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

4.4 Winter planning and community pharmacy arrangements.

A selection of pharmacies are formally directed to open over the Christmas and New Year bank holiday period as part of the Pharmacy Rota arrangements in accordance with the NHS Pharmaceutical Services Regulations. The ICB liaise with all the LPC's across within the ICB to ensure that each area is adequately covered. Additional pharmacies are signed up to a service level agreement, which contractually obliges them to open all bank holidays. It is highly likely that pharmacies located within supermarkets or pharmacies located on retail parks will choose to open (despite not being contractually obliged to open.) The only exception is Christmas day. Additional pharmacies are therefore directed to open on Christmas day. A number of Contractors are signed up as antiviral stockholding sites and are therefore also obliged to open on Bank Holidays. These branches are identified on the DoS system. The formal rota process of directing Contractors is completed in accordance with the timetable set out in the Pharmacy Manual. For Christmas, all directions were sent out by the end of August. These directions may be subject to an appeals process. The rota will be cascaded early December and DOS teams will be notified accordingly.

4.5 Primary Care Access Plan

The implementation of Independent Prescribing Pathfinder Programme has been announced. This forms part of the Primary Care Access Recovery as it plans to make better use of the clinical skills in community pharmacy teams through the expansion of clinical services.

The programme is aiming to recruit up to 210 community pharmacy sites across England. Community pharmacy contractors will be able to claim reimbursement for sessional time for an IP pharmacist and a setup fee using EPS as a prescribing solution to support their activity. An overall budget of up to £12m will be allocated to the Pathfinder programme. Funding will be provided to ICBs to support the operational delivery and provide support for the Pathfinder sites. No additional funding will be made available for medicines costs, which will continue to be attributed to ICBs and funded from existing allocations. ICBs will be briefed regarding the funding allocations and number of sites over the next few weeks. The ICB will take responsibility for commissioning the pharmacy pathfinder sites in their ICB and work with region and the national team to support the evaluation. A national process is underway to secure IT licenses for an assured Electronic Prescription Service web-based solution to support Pathfinder pharmacy sites.

5.0 Optometry Update

5.1 There are planned changes due through 23/24 phased in October 2023 and January 2024 to the mandatory/additional GOS (General Ophthalmic Services) contracts namely:

- Extension of notice required by family to notify ICB of termination of contract following death of a contractor
- Reduction in claim window for GOS sight test claim forms from 6 months to 3 months
- Mandating of electronic claims from January 2024

5.2 There have been complaints from an applicant around the length of time that their contract application is being processed by NHSBSA (Business Services Authority). NHSBSA are stating that this is due to capacity and reduced resource and are currently recruiting more caseworkers. FODO (Federation of Dispensing Opticians) have also complained to NHSBSA about the issue. The team will be adding this to the ICB risk register as there could be potential risks around continuity of service and reputational harm through organisational association.

6.0 Recommendations

The Committee is asked to:

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

Officer contact details for more information

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NHS Cheshire and Merseyside System Primary Care Committee

Date: 8th September 2023

Recovering Access to Primary Care: Progress and Update

Agenda Item No	SPCC 23/09/B09
Report author & contact details	Christopher Leese Associate Director Primary Care c.leese@nhs.net
Report approved by (sponsoring Director)	Clare Watson, Assistant Chief Executive
Responsible Officer to take actions forward	

Recovering Access to Primary Care: Progress and Update

Executive Summary	The Committee has previously received an update on the national policy area 'Recovering Access to Primary Care' – and the ICBs response to this thus far. This paper gives an update on progress since the last Committee meeting, in respect of the four main areas, overall delivery of the ICBs 'Improvement Plan' and key supporting actions.				
Purpose (x)	**For information / note**	**For decision / approval**	**For assurance**	**For ratification**	**For endorsement**
	x		x		
Recommendation	**The Committee is asked to:** • Note the updates in respect of the ICB's response to the national policy area 'Recovering Access to Primary Care' which is for information and assurance purposes				
Key risks	The programme area has it's own risk register and process which can be made available to committee areas in more detail				
Impact (x) (further detail to be provided in body of paper)	**Financial**	**IM &T**	**Workforce**	**Estate**	
	x	x	x	x	
	Legal	**Health Inequalities**	**EDI**	**Sustainability**	
	x	x	x	x	
Route to this meeting	None				
Management of Conflicts of Interest	Will be managed in accordance with the conflict details and by the management of the Chair of the meeting				
Patient and Public Engagement	Captured in the programme plan/templates are key actions that relate to this area, of which there are national expectations laid out.				
Equality, Diversity and Inclusion	As above				
Health inequalities	As above				
Next Steps	Captured within the paper				
Appendices	Appendix 1 – Place level improvement plan template				

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

1.0 Background and oversight

1.1 On 9th May NHS England released 'Recovering Access to Primary Care' ,a major policy area https://www.england.nhs.uk/publication/delivery-plan-for-recovering-access-to-primary-care/ with a national commitment to 'tackle the 8am rush' and make it easier and quicker for patients to get the help they need from primary care. The ICB's improvement plan 'response' has to be submitted to the ICB Board in either October or November, returning for updates in January/February 2024. It should be noted that the plan covers 24 months of actions as a minimum.

1.2 The plan seeks to support recovery by focusing this year on four areas:

- Empower patients to manage their own health
- Implement Modern General Practice Access 'model'
- Build capacity to deliver more appointments from more staff than ever
- Cut bureaucracy and reduce the workload across the interface between primary and secondary care

1.3 In response, as outlined at the last Committee meeting, the ICB set up a programme management governance structure, detailed project plan for delivery of the improvement plan, under the Executive leadership of the Assistant Chief Executive with SRO (Senior Responsible Officers) for each of the four areas above. The oversight programme board meets fortnightly, reporting to this Committee. As part of this work, a risk register is in place via the usual approaches. As well as the SROs for each area, the programme board membership also includes digital, business intelligence, finance, communications, workforce and population health leads , as these are cross cutting themes.

2.0 Progress since last Committee meeting

2.1 **Empowering Patients (SRO Tom Knight) ;**

- **Improving information and NHS App functionality**:
  - Patient Online Management Information data has identified that 61/349 practices need to enable system level appointments. 82.5% are enabled (data at 30/6/23)
  - Work is in progress regarding the definition of workstream detail around offering secure NHS App messaging to patients
  - Work is ongoing to ensure repeat prescriptions and self-directed care are fully functioning within the NHS app for all patients
- **Increasing Self Directed Care** - Self-Assessment of readiness to establish 7 self-referral pathways submitted - Work ongoing to establish the pathways, position statement for C&M due in September
- **Expanding Community Pharmacy** - Awaiting national guidance

2.2 **Implementing Modern General Practice Access (SRO Tony Leo) ;**

- **Sign up for practices ready to move from analogue to digital telephony**, and co-ordinate access to specialist procurement support - £1.1m funding has been received via MOU with NHSE for 41 practices
- **Nominate practices and PCNs for national intensive and intermediate transformation support** - The support offer is being managed nationally in phases and take-up varies across ICBs and Places and is on-going. C&M Position below ;

Region	ICS	Intermediate /Intensive phase C/D registered for webinars	Intermediate /Intensive Phase C attended webinars	Intermediate /Intensive phase C registered but didn't attend webinars	Intermediate /Intensive phase C didn't register but attended webinars	Intensive phase C signed up	Intermediate phase C signed up	Intensive total A & B participating /signed up	Intensive total all waves signed up	Intensive Share of practices	Intensive % take up of share	Intermediate total A & B participating /signed up	Intermediate total all waves signed up	Intermediate Share of practices	Intermediate % take up of share of practices
North West	Cheshire and Merseyside	13	8	4	0	0	5	10	10	41	24%	21	26	22	118%
North West	Greater Manchester	40	20	9	1	5	5	1	6	49	12%	4	9	26	35%
North West	Lancashire and South Cumbria	33	23	5	1	4	6	9	13	23	57%	10	16	12	133%

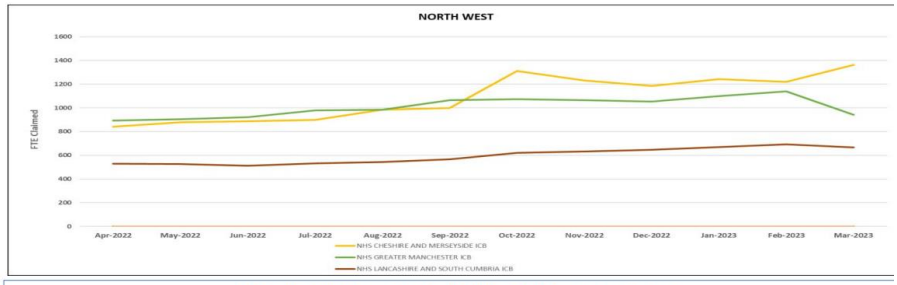
It is not a mandatory requirement for practices, and practices to self-nominate, but all practices are aware of the support packages available and places are actively encouraging practices to take up offers, as they are released, using the Support Level Framework where able.

- **Agree and distribute national transition cover and transformation support funding (average of £13.5k / per qualifying practice) in line with national arrangements and according to ICB share of national resource**. Overall deployment of resources in accordance with national requirements agreed at C&M level. Funding will be directed to those practices in greatest need of support (as identified in improvement plans) to move towards the Modern General Practice Access Model. Places will support practices and track and monitor progress against plans. National Guidance refers : https://www.england.nhs.uk/long-read/transition-cover-and-transformation-support-funding-to-move-to-a-modern-general-practice-access-model/#transition-cover-funding-process
- **Nominations and allocations to national care navigator training** (1 person per practice) Practices continue to take up the national offer and participation continues to increase across all Places.A more comprehensive local offer was already available across C&M via Connexus (up to 6 per practice) and uptake is strong.
- **Capacity and Access Improvement Plans (CAIP)**- All PCNs across C&M have completed CAIP plans which have been reviewed and signed off at Place level. These are comprehensive improvement plans which contain a series of metrics to demonstrate progress. These will be reviewed, tracked and monitored. These PCN Plans will form the basis of the overall ICB plan being developed.

2.3 **Building Capacity (SRO Christopher Leese)**

- **Reference Group** established working with Cheshire and Merseyside Training Hub
- **SDF Funding position** agreed and allocated to place to support retention and recruitment initiatives and other areas in line with the Guidance https://www.england.nhs.uk/long-read/primary-care-service-development-funding-and-general-practice-it-funding-guidance-2023-24/
- **GP retention plan** agreed (high level) and submitted to NHS England in May, place submitted place level plans as part of this which will underpin any retention planned spend
- All PCNs projected to submit **ARRS (Additional roles) Workforce Plans** by end of August to place in line with the PCN Directed Enhanced Service. This Committee will receive a summary of all plans at the October meeting, an interim snapshot is given below ;

Northwest General Practice Workforce Additional Roles Reimbursement Scheme



Indicative FTE Share of 26k Additional Roles Commitment

	20/21	21/22	22/23	23/24	In Post as at March 23
North West	**1196**	**2043**	**2682**	**3542**	**3333**
NHS Lancashire and South Cumbria ICB	282	482	632	835	780
NHS Cheshire and Merseyside ICB	425	726	953	1259	1416
NHS Greater Manchester ICB	489	835	1097	1448	1137

The NW Region indicative share of the 26,000 additional roles by 22/23 was a total of 2,682. Across the three NW systems, as of 31 March 23, PCNs have recruited a total of 3,333 additional roles under the scheme.

- **The NHS Long Term Workforce Plan** https://www.england.nhs.uk/publication/nhs-long-term-workforce-plan/ has been released and the ICB via the people board/ team will be leading any response to this. The Primary Care Workforce steering group will need to support this by setting out any long term trajectories/aims for gp, practice nurse and ARRS related numbers.

2.4 Cutting Bureaucracy (SRO Dr Jonathan Griffiths)

- **Improving the primary-secondary care interface -** Place Clinical Directors have been encouraged to develop Primary Secondary Care Interface (PCSI) meetings locally around appropriate footprints. Groups in North Mersey, Warrington and Wirral underway and groups are being developed in St Helens, Knowsley and Cheshire West.

2.5 Overall Delivery

- In July NHS England released information regarding expectations in relation to system-level access improvement plans which are expected at ICS Boards in October or November https://www.england.nhs.uk/long-read/primary-care-access-improvement-plans-briefing-note-for-system-level-plans/

- The plan is for C&M's Plan to go to the Board in November, and to this Committee at the December meeting. In recognition of the work being undertaken, led and funded at place level, including the connectivity and approval of pcn/practice plans under the Capacity and Access Improvement Payment element, each place has been asked to submit the template in Appendix 1, to underpin the final delivery

- The plan will therefore include place level improvement plans and a summary of system actions via each SRO. The final product delivery will be overseen by the programme board and it is recognised it will need to be a concise, metric heavy plan, in line with the guidance. It is also recognised that some elements, such as those reliant on national policy which is not yet in place,

will not be completed by November, hence the ask that plan progress returns to the ICS Board in February 2024

3.0 Recommendations

3.1 The Committee is asked to:

Note the updates in respect of the ICB's response to the national policy area 'Recovering Access to Primary Care' which is for ***information*** and ***assurance*** purposes

Officer contact details for more information

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

Appendix 1 – Place Template

XXX Place

Access Improvement Plan FINAL v5

Recovering Access to Primary Care & associated funding

Part of System Access Improvement Plan

This template is to bring together elements that will form part of the System Access Improvement Plan, in line with the recently released Guidance

NHS England » Primary care access improvement plans – briefing note for system-level plans

Primary Care Access Improvement Plan - Briefing note for system-level plans - Recovering Access to Primary Care - FutureNHS Collaboration Platform

https://www.england.nhs.uk/publication/delivery-plan-for-recovering-access-to-primary-care/

Name of Place	
Report Author and Contact email	
Version	
Date	

Please forward to Chris Leese c.leese@nhs.net by 20th October for collation at System Level ready for November Board final overall version.

Section Heading	Details and Links	Cross reference to NHS England » Primary care access improvement plans – briefing note for system-level plans noting you are responding as a **place**
Section 1 Overview	https://www.england.nhs.uk/publication/delivery-plan-for-recovering-access-to-primary-care/ https://www.england.nhs.uk/wp-content/uploads/2023/05/PRN00475-ii-delivery-plan-for-recovering-access-primary-care-190523-v1.1.pdf	
	1.1 Summary of place level challenges (Patient feedback, place concern, health inequalities, etc)	
	1.2 Summary of actions to address / links to other plans	
	1.3 Overall place level ambition summarised (with metrics	Is there a clear vision that aligns with the ambitions of the Delivery Plan for Recovering Access to Primary Care? Have interdependencies been considered to maximise system benefit e.g., UEC? Do plans incorporate all ICB actions from the delivery plan checklist? Do plans set out the ICB's delivery approach for all aspects of the delivery plan for recovering access to primary care i) empower patients; ii) implement modern general practice iii) build capacity; iv) cut bureaucracy? Are there clear, quantified improvement trajectories? Are there clear delivery milestones? Does the plan set out how ICBs will monitor and track delivery against trajectories and milestones? What are the mechanisms to collect, analyse and share data? Is the ICB confident that the plans will make a difference and patients will know the plans are working?

Commented [AM1]: In PM stock take we said…….

How will patients know the plan is working:

- Their calls will be handled through a queuing system and then answered or a call back offered. Engaged tones will be a thing of the past.
- They will not be asked to call back another day for an appointment. Instead, they will know on the day how their request will be managed.
- Those that prefer on-line access will increasingly find their requests are handled promptly and effectively through this route.
- They will have access to more services in their local community pharmacy

		Does the plan give the overview of progress to date?
Section 2 Access Recovery Improvement	https://www.england.nhs.uk/publication/delivery-plan-for-recovering-access-to-primary-care/ https://www.england.nhs.uk/publication/network-contract-des-capacity-and-access-improvement-payment-for-2023-24/	
	2.1 CAIP Plans Practice and PCN level agreed and progress to date	Does the ICB plan include an overview of PCN/practice plans? Assurance that all required actions have been included in plans? Delivery confidence for all aspects of the recovery plan i) empower patients; ii) implement modern general practice iii) build capacity; iv) cut bureaucracy? Are there clear, quantified improvement trajectories? Are there clear delivery milestones? Does the plan set out how ICBs will monitor and track delivery against trajectories and milestones? What are the mechanisms to collect, analyse and share data? Is the ICB confident that the plans will make a difference and patients will know the plans are working?
	2.2 Place level improvement initiatives agreed and progress to date	
	2.3 System / National ICB level improvement initiatives / place implementation of this	Take-up of support and training offers? How has place supported this Has the Support Level Framework been used with

Commented [AM2]: In PM stock take we said…….

How will patients know the plan is working:

- Their calls will be handled through a queuing system and then answered or a call back offered. Engaged tones will be a thing of the past.
- They will not be asked to call back another day for an appointment. Instead, they will know on the day how their request will be managed.
- Those that prefer on-line access will increasingly find their requests are handled promptly and effectively through this route.
- They will have access to more services in their local community pharmacy

		practice and PCNs to identify support needs? What local support is being provided/funded? How is the ICB leveraging and ensuring maximum uptake of national transformation support and training offers, including ensuring participation from PCN/practices that need support the most?
	2.4 Winter Resilience response https://www.england.nhs.uk/publication/delivering-operational-resilience-across-the-nhs-this-winter	Lead delivery of actions from the Primary Care Recovery Plan that will support winter pressures, particularly: Support the delivery of key actions from the Primary Care Recovery Plan that will support winter pressures, including over the Christmas/New Year Period by improving access to general practice – particularly: engaging and nominating their practices and PCNs to join the national general practice improvement programme supporting practices to move to cloud-based digital telephony and to access the right digital tools understanding general practice transformation maturity and support needs, via completion of the support level framework to enable ongoing local support to continue improvement: to understand and better match demand and capacity. Increasing capacity with larger multidisciplinary teams, including over the Christmas period
Section 3 Funding Stream outcomes to support retention, transformation and workforce	Please also ensure Place are sighted on the guidance/finance reporting as part of the below, please link in with place ADOFs as part of this	

	https://www.england.nhs.uk/long-read/primary-care-service-development-funding-and-general-practice-it-funding-guidance-2023-24/ https://www.england.nhs.uk/long-read/transition-cover-and-transformation-support-funding-to-move-to-a-modern-general-practice-access-model/	
	3.1 Transition Funding Summary and outcomes/awards	
	3.2 SDF Funding including outcomes of GP Retention Plans, Transformation and Development or Digital – Place priorities for spend	Is there a clear plan for how national funding will be used and maximised? How will the ICB track and report on spend and ensure funding is spent in-year Has the ICB considered how other funding could be aligned? How will the ICB ensure PCNs/practices are receiving funding and resource in a timely way to support delivery and transition?
	3.3 Other investments to support Development, via local/transformation funding pots, place discretionary funding	
Section 4 ARRS (Additional Roles)	https://www.england.nhs.uk/publication/network-contract-directed-enhanced-service-additional-roles-reimbursement-scheme-guidance/	
	4.1 Place additional roles summary/spend and posts/outcomes	Has the ICB set out plans to support and build their workforce, **including supporting PCNs to use their full ARRS budget,** delivering GP retention schemes and promoting national health and wellbeing offers?
Section 5 Health Inequalities		
	5.1 How the place approach tackles HI / access	How does the plan support equality, diversity, and inclusion? How does it support practices in areas of deprivation and practices disproportionally affected by health inequalities? **More prompts on this section to follow**
Section 6 Patient Engagement and Communications		

	6.1 Engagement and communications with patients, key stakeholders (LMCs etc) at a place level as part of place plans	Has the plan been co-produced with patients and local communities? Has the ICB put in place a robust communications delivery plan that focuses on promoting key delivery plan and **campaign messaging at place level and to local communities?** Note current plan is for this to be centrally led as much as possible
Section 7 **Place risks and mitigations**		
	7.1 Place identified risks, mitigations and management	
Section 8 **Appendices**	e.g Place CAIP Plan templates Place Patient Survey outcomes Place Funding allocated to place Place BI figures.list sizes and outcomes	

For information – Plan Timelines – working backwards from Board

- Board meeting 30th November
- Submission for papers 16th November TBC
- Sign off week 13th-16th November via Programme Board
- Final editorial Stage 2 - 6th-10th November via Programme Board
- Collation/editorial Stage 1 - 23rd October to 3rd November via Programme Board
- Place plan elements completed by 20th October and submitted to c.leese@nhs.net
- SRO elements completed 20th October and submitted to c.leese@nhs.net

NHS Cheshire and Merseyside System Primary Care Committee

Date: 8th September 2023

GP Patient Survey 2023

Agenda Item No	SPCC 23/09/B10
Report author & contact details	Christopher Leese Associate Director Primary Care c.leese@nhs.net
Report approved by (sponsoring Director)	Clare Watson, Assistant Chief Executive
Responsible Officer to take actions forward	Christopher Leese

GP Patient Survey 2023

Executive Summary	The GP Patient Survey assesses patients' experience of healthcare services provided by GP practices, including experience of access, making appointments, the quality of care received from healthcare professionals, patient health, and experience of NHS services when their GP practice was closed. The results of the survey are published by Ipsos on behalf of NHS England and the results for the ICB are summarised here, with some further place breakdown, for Committee awareness.

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

Recommendation	**The Committee is asked to:** • Note the summary of the GP Patient survey for 2023, which is for assurance/information purposes
Key risks	Risks in relation to the survey results will be managed in terms of individual practices, at place level

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

Route to this meeting	None
Management of Conflicts of Interest	Will be managed in accordance with the conflict details and by the management of the Chair of the meeting
Patient and Public Engagement	Are accommodated nationally as part of the survey
Equality, Diversity and Inclusion	As above
Health inequalities	As above
Next Steps	Any next steps are including in the report narrative.
Appendices	

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

GP Patient Survey 2023

1.0 Background

1.1 The annual GP Patient Survey assesses patients' experience of healthcare services provided by GP practices, including experience of access, making appointments, the quality of care received from healthcare professionals, patient health, and experience of NHS services when their GP practice was closed.

1.2 The survey shows the results of aggregated data collected by postal and online surveys from 3rd January 2023 to 3rd April 2023 and was published on 13th July. The latest survey consisted of around 2.65 million questionnaires sent out to patients aged 16 or over registered with GP practices in England from 3rd January 2023 to the 3rd April 2023. Around 760,000 patients completed and returned a questionnaire, resulting in a national response rate of 28.6%. Results are weighted. Weighting ensures results are more representative of the population of patients aged 16 or over registered with a GP practice.

1.3 A summary of the national results can be found via this link https://gp-patient.co.uk/downloads/2023/GPPS_2023_National_Infographic_PUBLIC.pdf

1.4 As well as in a national pack, results are released in ICB, Practice and PCN data sets. In Cheshire and Merseyside 146,613 questionnaires were sent out, and 42,511 were returned completed. This represents a response rate of 29%.

1.5 The data can be used and interpreted to help to improve GP services, in the following ways:

- **Comparison of an ICS against the national result**: this allows benchmarking of the results to identify whether the ICS is performing well, poorly, or in line with the national picture. The ICS may wish to focus on areas where it compares less favourably.
- **Analysing trends in an ICS's results over time**: this provides a sense of the direction of the ICS's performance. The ICS may wish to focus on areas which have seen a decline in results over time.
- **Comparison of PCN's results within an ICS area**: The ICS may wish to work with individual PCNs: those that are performing particularly well may be able to highlight best practice, while those with challenges could be supported further at place level.

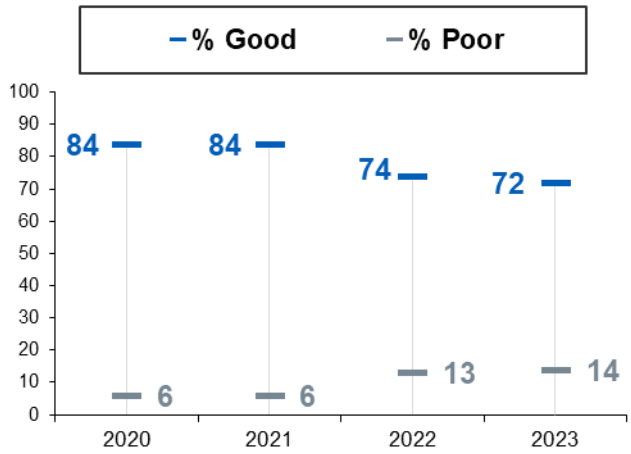
1.6 Individual slide packs for ICS's can be found here https://gp-patient.co.uk/ICSslidepacks2023

An interactive dashboard providing more detail at PCN level can be found here: https://www.gp-patient.co.uk/pcn-dashboard

Analysis portals can be found here for national, ICS, PCN and Practice level results
https://gp-patient.co.uk/surveysandreports

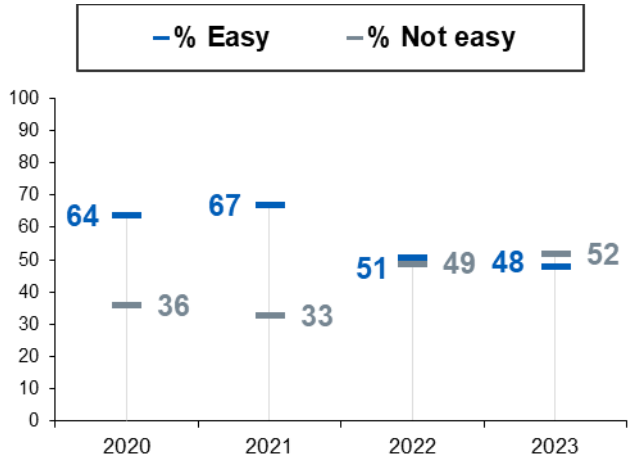
2.0 Cheshire and Merseyside results – key headlines/indicators ICS Level

2.1 Overall Experience - GP Practice



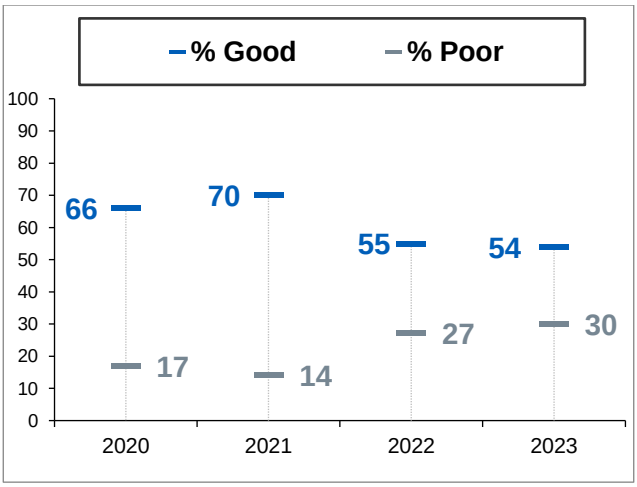
The ICS has seen a drop in this indicator, which is in line with the national picture but overall the ICS is slightly above average (Nationally the figure is 71 per cent good) and broadly in line with the other two ICS's in our region (71-75 is the median range regionally).

2.2 Ease of getting through on the phone



The ICS is below the national average on this indicator and this has fallen over the span of the above graph, with more people indicating it is 'not easy' (52%) to 'easy' (48%) with the national average(s) being 50% and 50%.

2.3 Overall experience of making an appointment



This indicator has fallen over time but is in line with the national average (54%/28%), the ICS sits at (54%/30%)

2.4 Summary of indicators

From an ICS system level overview , most indicators have seen a fall based on the analysis graphs produced by the national team. Some indicators (helpfulness of receptionists) compare favourably with the national average and the indicator 'were needs met at your appointment' remaining high both nationally (90%) and within the ICS (91%) – as does 'Treated with care and concern by healthcare professional at last appointment' (86% ICS good/84% National good). In summary the main areas of dis-satisfaction seem to relate to making/getting an appointment with the 'better' results concentrated around the actual appointment itself and the care received at that appointment. However with all indicators, practice and PCN individual results need to be analysed further to appreciate the variety of both poor and excellent feedback across the patch. It should also be noted that an analysis of results from an equality perspective is available in terms of sex, gender, age, sexual orientation and ethnicity – and also from population deprivation quintiles, for cross referencing with our approach to health inequalities.

3.0 Cheshire and Merseyside results – Place level

3.1 The results are not produced at place level as part of the national analysis, but the Business Intelligence team did produce a summary of the key indicators in place headline form ;

Group	Metric	National	ICS	Cheshire East	Cheshire West	Halton	Knowsley	Liverpool	Sefton	St Helens	Warrington	Wirral
Overall Experience	Q32. Overall, how would you describe your experience of your GP practice? **% Good** *(Very Good + Fairly Good)*	71%	72%	76%	78%	67%	63%	70%	71%	69%	71%	76%
Making an appointment	Q16. Were you satisfied with the appointment (or appointments) you were offered? **% Yes, took appt** *(Patients who selected 'I was not offered an appointment' have been excluded)*	72%	73%	77%	76%	69%	66%	72%	73%	69%	74%	74%
	Q21. Overall, how would you describe your experience of making an appointment? **% Good** *(Very Good + Fairly Good)*	54%	54%	62%	59%	42%	41%	51%	51%	50%	53%	58%
Local GP Services	Q1. Generally, how easy is it to get through to someone at your GP practice on the phone? **% Easy** *(Very Easy + Fairly Easy) (Patients who selected 'Haven't tried' have been excluded)*	50%	48%	54%	53%	35%	41%	44%	44%	47%	47%	56%
	Q2. How helpful do you find the receptionists at your GP practice? **% Helpful** *(Very helpful + Fairly Helpful) (Patients who selected 'Don't know' have been excluded)*	82%	83%	85%	87%	78%	78%	80%	83%	82%	82%	86%
	Q30. During your last general practice appointment, did you have confidence and trust in the healthcare professional you saw or spoke to? **% Yes** *(Yes, definitely + Yes, to some extent) (Patients who selected 'Don't know/doesn't apply' have been excluded)*	93%	93%	94%	96%	91%	88%	93%	93%	93%	93%	94%
	Q47. Overall, how would you describe your last experience of NHS services when you wanted to see a GP but your GP practice was closed? **% Good** *(Very Good + Fairly Good) (Patients who selected 'Don't know/can't say' have been excluded)*	45%	44%	43%	48%	45%	39%	43%	40%	49%	37%	49%
Access to on-line services	Q4. How easy is it to use your GP practice's website to look for information or access services? **% Easy** *(Very Easy + Fairly Easy) (Patients who selected 'Haven't tried' have been excluded)*	65%	66%	67%	70%	64%	57%	65%	65%	70%	62%	67%

4.0 Next Steps

4.1 As part of the work in relation to 'Recovering Access to Primary Care' results of the GP Patient survey are forming part of the improvement plans agreed by place with PCNs under the Capacity and Access Improvement process. The results will form part of the place/system level improvement plan(s) expected at the board in November.

4.2 It should be noted that the results are only part of the overall picture of patient experience general practice, and a full range of indicators are used to form the overall plans outlined in 4.1. Place will lead any individual practice/pcn assurance follow up with any individual results, but this would be triangulated with other information at place level.

4.3 The committee should be aware of the feedback in section 2.0 above in order to ensure that any access improvement plans address these improvements in patient experience - and supporting practices/pcns to manage demand. Examples of this would include the ongoing digital telephony work and maximisation of on line access / other consultation forms.

5.0 Recommendations

The Committee is asked to:

- **Note** the update in respect of the GP Patient Survey, which is for ***assurance/information*** purposes.

Officer contact details for more information

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

Committee Report

Cheshire and Merseyside ICB
System Primary Care Committee
Primary Care Strategic Framework
Date: 8/9/2023

Date of meeting:	8/9/2023
Agenda Item No:	SPCC 23/09/B11
Report title:	Primary Care Strategic Framework
Report Author & Contact Details:	Dr Jonathan Griffiths jonathan.griffiths@cheshireandmerseyside@nhs.uk
Report approved by:	Clare Watson

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

Route to this meeting / Committee/Advisory Group previously presented to (if applicable)
ICB Board agreement – the framework and approach was agreed at June ICB Board

Executive Summary and key points for discussion

Recommendation/ Action needed:	**The Committee is asked to:** • Note the first two chapters of the Primary Care Strategic Framework • Note the engagement that has taken place • Note the ongoing work to develop the final two chapters • Note the development of a workplan based on the Framework to inform ongoing plans • Note request to the communications team to prepare the document for final publication both as a pdf and web-based document

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

C&M ICB Priority report aligns with:	
Please insert **'x'** as appropriate:	
1. Delivering today	x
2. Recovery	x
3. Getting Upstream	x

C&M ICB Priority report aligns with:	
4. Building systems for integration and collaboration	x

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

Governance and Risk	Does this report provide assurance against any of the risks identified in the ICB Board Assurance Framework or any other corporate or Place risk? (*please list*)					
	What level of assurance does it provide?					
	Limited		**Reasonable**		**Significant**	
	Any other risks? Yes / No. If **YES** please identify within the main body of the report.					
	Is this report required under NHS guidance or for a statutory purpose? (*please specify*) No					
	Any **Conflicts of Interest** associated with this paper? If **YES** please state what they are and any mitigations undertaken. Author is a GP Partner in a practice in Cheshire					
	Any current services or roles that may be affected by issues as outlined within this paper?					

	Process Undertaken & Impact Considerations	**Yes**	**No**	**N/A**	**Comments** (i.e. date, method, impact e.g. feedback used). ***Greater detail to be covered in main body of report***
Document Development	Financial – any resource impact?		x		Although there may be resource implications to enable us to deliver on all of the suggested actions
	Patient / Public Involvement / Engagement	x			HealthWatch have been engaged, but no other patient engagement to date
	Clinical Involvement / Engagement	x			Delivery of the framework will require ongoing clinical involvement
	Equality Impact Analysis (EIA) - any adverse impacts identified? EIA undertaken?		x		
	Regulatory or Legal - any impact assessed or advice needed?		x		
	Health Inequalities – any impact assessed?		x		
	Sustainable Development – any impact assessed?		x		

Next Steps:	. Note the approval of the final framework, continuation with the final two chapters and the need to create a workplan to deliver on this strategic framework

Responsible Officer to take forward actions:	Dr Jonathan Griffiths Chris Leese Clare Watson

Appendices:	1) Primary Care Strategic Framework 2) Strategic Framework list of actions

Primary Care Strategic Framework

1. Executive Summary

This Primary Care Strategic Framework has been written to inform future planning relating to the commissioning of Primary Care services across Cheshire and Merseyside. Ultimately the Framework will encompass all Primary Care provider, namely General Medical (GP), Community Pharmacy, Dentistry and Optometry. We have focused initially on General Medical and Community Pharmacy, with plans to quickly add Dentistry and Optometry once the initial two chapters completed. The Framework will allow us to create a Primary Care workplan to deliver on the proposed actions.

2. Introduction / Background

Significant engagement has taken place in the creation of the Strategic Framework. Drafts have been taken on more than one occasion to the Primary Care Providers Leadership Forum, have been discussed with Local Medical Committees as well as Local Pharmaceutical Committees and Local Pharmaceutical Networks. In addition we hosted a meeting where all Primary Care Network Clinician Directors were invited to discuss the framework and contribute thoughts. A survey has also been sent to all General Practitioners and Community Pharmacists and the results used to inform the paper. We have also spoken with Healthwatch, with the Place Clinical Directors and Place Directors have been invited to comment. Feedback from all of the groups and individuals outlined above have been taken into account as the document has been drafted. We are grateful to the Innovation Agency who have helped significantly in terms of their help in hosting meetings, distributing the questionnaire and collating responses as well as help in pulling together the document into the format we now see. The framework has been approved by the ICB Board who made some recommendations for minor revisions which have now taken place. The Board has asked that the System Primary Care Committee provide final approval for publication.

3. Main Body

The Framework is set out as four chapters, one each for the four Primary Care Contractor Groups. Each chapter is then subdivided into Framework Topics. Each topic has two pages, the first of which outlines the issue, our ambition, the challenges and links to any relevant guidance. The second page describes our aims, both at a system level and with suggestions for Place based plans.

The Framework Topics are as follows:

- Commissioning, contracting and funding of Primary Care Services
- Population Health and Health Inequalities
- Improving Access
- Quality, performance, assurance and safety
- Role of General Practice
- Integration and partnership working
- Workforce and OD

- Infrastructure and intelligence
- Working with patients
- Research, innovation and future models of delivery

The Framework is intended to be a living document that will need to flex according to prioritised needs as well as to reflect any national policy changes.

There are a number of aims and intentions for the ICB described in the Framework. These have been pulled together into a single list which outlines intended timelines. While this appears to be a very long, potentially unachievable list we believe that a number of the actions are already being considered either within the Primary Care Team or with or teams such as Medical Directorate, Digital, Quality etc

4. Recommendations

The Committee is invited to:

- Note the first two chapters of the Primary Care Strategic Framework
- Note the engagement that has taken place
- Note the ongoing work to develop the final two chapters
- Note the development of a workplan based on the Framework to inform ongoing plans
- Note request to the communications team to prepare the document for final publication both as a pdf and web-based document

5. Officer contact details for more information

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

Cheshire & Merseyside Integrated Care Board

Draft

Primary Care Strategic Framework

29th June 2023

Contents

Introduction

Most NHS contacts take place within Primary Care which has an important role in managing both minor illness and chronic, complex conditions. There is also a much-needed gatekeeper function without which secondary care would be quickly overwhelmed.

This Primary Care Strategic Framework will encompass all of primary care and not just General Practice. We will need all NHS services to be working well together to deal with the challenges being faced. This framework is therefore made up of 'Chapters' to cover all Primary Care contractor groups.

Significance engagement has taken place in the development of this framework. This has included LMCs, LPCs, LPNs, Healthwatch, the Primary Care Providers Leadership Forum, PCN Clinical Directors and Place Directors and Clinical Directors. Responses from questionnaires sent to all GPs and Community Pharmacists has also been incorporated. We are presenting this as a framework which will then allow each Place to create their own strategy able to address the individual needs they will have.

The following topics are thought to be key for our framework. They can be grouped as 'Service Delivery Elements' and 'Enabling Themes'.

Framework Topics

Service Delivery Elements
Commissioning, contracting and funding of General Medical/Dental/Optometry/ Community/Pharmacy services
Population health and health inequalities
Improving Access
Quality, performance, assurance and safety
Role of General Practice/Community Pharmacy

Enabling Themes
Integration and partnership working
Workforce and organisational development
Infrastructure and intelligence
Working with patients
Research, innovation and future models of delivery

Jonathan Griffiths

GP and Associate Medical Director, Primary Care

Cheshire & Merseyside ICB

Vision for Primary Care

Primary Care is the beating heart of the NHS. With around 90% of all NHS contacts taking place in Primary Care (over 1.3 million contacts in General Practice alone during March 23, our latest reported month) it is vital that we acknowledge the essential healthcare delivered in these settings. While providing an essential gate-keeper role into secondary care, Primary Care is so much more than simply 'admission avoidance' providing a service that assesses, investigates, diagnoses and manages both acute presentations and long-term conditions.

Our vision for Primary Care in Cheshire and Merseyside is for high quality services that are responsive and accessible for patients at their point of need. Traditionally Primary Care has enjoyed high levels of satisfaction and trust from patients, although we must acknowledge that recently there has been greater dissatisfaction.

There have been a number of nationally produced reports on Primary Care and specifically General Practice published recently. These include the Fuller Report, the report from the House of Commons Health and Social Care Committee and the Hewitt Report. There has also been a change to the GP Contract as well as the publication of the Delivery Plan for Recovering Access to Primary Care.

Our Primary Care Strategic Framework needs to be read in the context of the above reports and noting that fact that demand is at an all time high, with falling numbers of GPs and high levels of reported stress and burnout. It is notable that the House of Commons Health and Social Care Committee report stresses that 'general practice is in crisis'. We need to respond to this crisis and our framework outlines the areas we believe need to be focussed upon.

We will only achieve the ambitions within the Framework through true whole-system working including primary and secondary care, commissioners, local authority, our population and other key partners. The publication of the Framework does not bring this piece of work to a close, rather it launches our approach.

Together, we aspire for Cheshire and Merseyside to have the highest quality primary care that is accessible, sustainable and delivering outstanding health outcomes for our population.

NHS England » Next steps for integrating primary care: Fuller stocktake report

The future of general practice - Health and Social Care Committee (parliament.uk)
Hewitt Review: an independent review of integrated care systems - GOV.UK (www.gov.uk)

NHS England » Changes to the GP Contract in 2023/24

NHS England » Delivery plan for recovering access to primary care

NHSE Delivery plan for recovering access to primary care

Summary action points

Empower patients by rolling out tools they can use to manage their own health, and invest up to £645 million over two years to expand services offered by community pharmacy.

1. Enable patients in over 90% of practices to see their records and practice messages, book appointments and order repeat prescriptions using the NHS App by March 2024. *aligned to section 1.9 action point 1.9.5*
2. Ensure integrated care boards (ICBs) expand self-referral pathways by September 2023, as set out in the 2023/24 Operational Planning Guidance. *aligned to section 1.9 action point 1.9.6*
3. Expand pharmacy oral contraception (OC) and blood pressure (BP) services this year, to increase access and convenience for millions of patients, subject to consultation. *aligned to section 2.6 action point 2.6.4 and section 2.8 action point 2.8.1*
4. Launch the Pharmacy Common Conditions Service so that by end of 2023 community pharmacies can supply prescription only medicines for seven common conditions. This, together with OC and BP expansion, could save 10 million appointments in general practice a year once scaled, subject to consultation. *aligned to section 2.1*

Implement 'Modern General Practice Access' so patients know on the day how their request will be handled, based on clinical need and continuing to respect their preference for a call, face-to-face appointment, or online message. We are re-targeting £240 million – for a practice still on analogue phones this could mean ~£60,000 of support over 2 years.

5. Support all practices on analogue lines to move to digital telephony, including call back functionality, if they sign up by July 2023. **aligned to section 1.3 action points 1.3.6, 1.3.9 & 1.8.20*
6. Provide all practices with the digital tools and care navigation training for Modern General Practice Access and fund transition cover for those that commit to adopt this approach before March 2025. **aligned to section 1.8 action point 1.8.21*
7. Deliver training and transformation support to all practices from May 2023 through a new National General Practice Improvement Programme. **aligned to section 1.10 action point 1.10.1*

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

8. Make available an extra £385 million in 2023/24 to employ 26,000 more direct patient care staff and deliver 50 million more appointments by March 2024 (compared to 2019). *NHSE action point*
9. Further expand GP specialty training – and make it easier for newly trained GPs who require a visa to remain in England. *NHSE action point*
10. Encourage experienced GPs to stay in practice through the pension reforms announced in the Budget and create simpler routes back to practice for the recently retired. *NHSE action point*
11. Change local authority planning guidance this year to raise the priority of primary care facilities when considering how funds from new housing developments are allocated. *NHSE action point*

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

12. Reduce time spent liaising with hospitals – by requiring ICBs to report progress on improving the interface with primary care, especially the four areas we highlight from the Academy of Medical Royal Colleges report, in a public board update this autumn. **aligned to section 1.6 action point 1.6.1*
13. Reduce requests to GPs to verify medical evidence, including by increasing self-certification, by continuing to advance the Bureaucracy Busting Concordat. *NHSE action point*
14. Streamline the Investment and Impact Fund (IIF) from 36 to five indicators – retarget £246 million – and protect 25% of Quality and Outcomes Framework (QOF) clinical indicators. *NHSE action point*

CHAPTER ONE - General Practice

Service Delivery Elements

1.1 Commissioning, contracting and funding of General Medical Services

Core Ambition:

We will develop commissioning models that ensure quality of service provision, joined up cross discipline working and that address unwarranted variation in service across C&M.

We will understand the variation in primary care funding across the ICS and develop system wide agreements to ensure equitable financial allocation that best meets the needs of local populations.

Background:

- We need to ensure quality of service provision and eliminate unwarranted variation in service delivery.
- We need ensure that all routine chronic disease management is restored following Covid-19 and maximise NHS Health Checks as prevention or early intervention measure.
- As all parts of primary care will be commissioned by the same body there is an opportunity to assess financial flows to ensure best service provision for patients
- Large elements of Primary Care funding are set within national contracting arrangements. For General Practice this includes GMS/QOF/PCN DES/IIF/ARRS. There are Local Enhanced Services and monies invested in Primary Care from Place initiatives. There is variation across Cheshire and Merseyside with regard to these monies that has arisen from historical CCG funding decisions.
- There are different models of funding across C&M and we need to ensure that deprived areas are not worse off.

Planning Guidance Cross Reference

NHSE will publish the general practice access recovery plan in the new year, as well as the themes for further engagement that will inform the negotiations for the 2024/25 contract. Delivery will be supported by funding as part of the five-year GP contract, including the Additional Roles Reimbursement Scheme. Integrated care board (ICB) primary medical allocations are being uplifted by 5.6 per cent to reflect the increases in GP contractual entitlements

GP Questionnaire key feedback- Investment and funding

⇒ Equitable funding of primary care across the ICS

⇒ Early sight of investment opportunities

⇒ People need incentivising to work together towards PCN outcomes

⇒ Streamline processes for investment in estates

Future of General Practice report cross reference:

NHS England should revise the Carr-Hill formula to ensure that core funding given to GP practices is better weighted for deprivation. NHS England must also review new PCN funding mechanisms to ensure that they do not inadvertently restrict funding for areas which already have high levels of need.

1.1 System level actions

Commissioning, contracting and funding of General Medical Services

1.1.1	As an ICS we will explore and outline how future monetary allocations will be distributed – either fair shares to Place or according to need across the whole system.
1.1.2	In the first two years we will explore different funding models (such as the John Hopkins alternative to the Carr-Hill Formula) to determine the best model for our practices
1.1.3	We will lobby the central NHSE team regarding the clear need for increased funding and support to General Practice through the GP contract.
1.1.4	An innovative contracting at scale pilot to be performed within the next 3 years
1.1.5	We will urgently undertake a review of all core and non-core General Practice spending to understand the variation including a review of discretionary payments. Following this we will produce a plan describing how we will reduce this variation
1.1.6	Consider the feasibility of a pilot of gain sharing so that PCNs and Practices reducing secondary care spend can share in the financial gains

1.1 Actions for Place based plans

Commissioning, contracting and funding of General Medical Services

1.1.7	Develop local commissioning models that are equitable across place footprints, support the areas of greatest need and deprivation and enable joined up working across disciplines, drawing on the ICB Population Health Programme.
1.1.8	Liaise with local authorities and the Cheshire & Merseyside Directors of Public Health around locally commissioned services, ensuring equity of provision and to inform prioritisation that tackles health inequalities in outcomes, experiences and access (our eight All Together Fairer principles).
1.1.9	Engage practices and the Health & Care Partnership in the work above around exploring new funding models and variation in funding across Cheshire and Merseyside

Future of General Practice reference

NHS England should support Integrated Care Systems to implement gain sharing so that Primary Care Networks and individual practices that support the reduction of secondary care expenditure, such as through reducing unplanned admissions, are able to share in the financial gains.

1.2 Population Health and Health Inequalities

integration with local authorities and Public Health

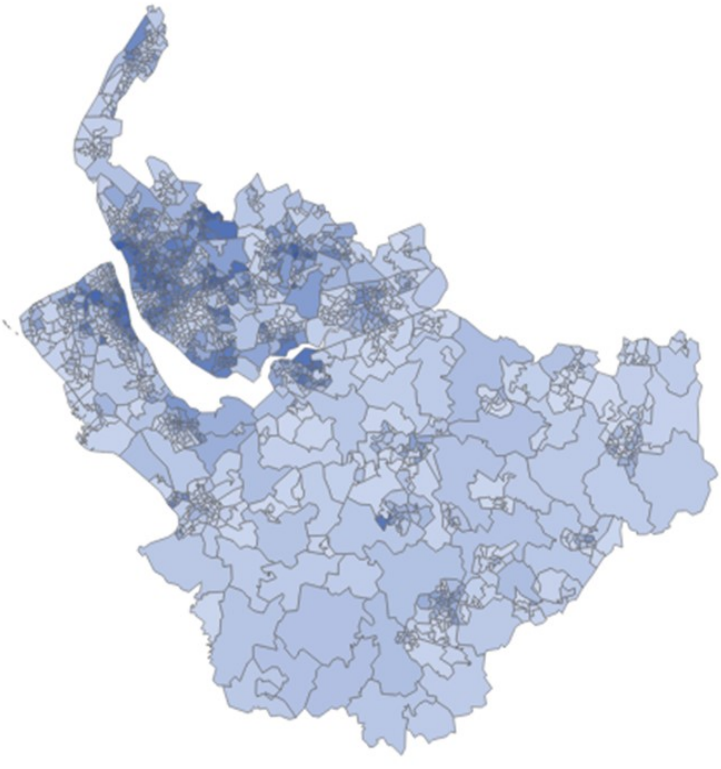
Core Ambition:

Our ambition is for Primary Care Networks to develop closer and integrated working with local authority and public health teams, to contribute to the population health programme and system wide effort in tackling the wider determinants of health.

Background:

- Primary Care is ideally placed to contribute to the population health programme and in tackling the causes of ill-health, to improve population health and healthcare.
- By increasing system wide collaboration with local authority and public health we can look to improve the health of the people that we serve.
- Cheshire and Merseyside ICS is recognised as a Marmot Community working to be an exemplar for system-level work on inequalities, including coordinated, consistent approaches to building healthy and inclusive economies and tackling the wider determinants of health and reducing health inequalities.
- The CIPHA data platform is a powerful tool that we can use to identify where best to focus our work to tackle the wider social determinants of health and to reduce health inequalities
- Let us acknowledge that holistic, relationship based care can deliver on tackling health inequalities through providing long term preventative medicine

INDEX OF MULTIPLE DEPRIVATION (IMD) SCORE BY LSOA



GP Questionnaire key feedback- population health and health inequalities

⇒ Increase focus on prevention

⇒ Target resources to reduce health inequalities

⇒ Increased business intelligence and public health support for PCNs around population health activities

⇒ GPs need to have a greater amount of time to focus on prevention chronic disease management

⇒ Focus on long term projects that may not lead to immediate change and ensure that these are funded and supported in the longer term

1.2 System level actions
Population health and health inequalities

1.2.1	Close working with Public Health teams to understand population need as well as system level integration, communication and support for PCNs to succeed.
1.2.2	The ICB will support the Deep End Cheshire and Merseyside initiative, linking this with the Population Health board and encouraging practices to engage. Deep End seeks to support practices working in the most deprived communities.
1.2.3	Review and develop a criteria for resource allocation based on population need and health inequality data.
1.2.4	Consider system projects to embed upstream prevention approaches in primary care. For example NHS Health check Pilot learning. Collaborate with the Primary Care Prevention Pledge development, following successful NHS Trust Prevention Pledge work.
1.2.5	ICB will facilitate sharing of best practice in relation to tackling health inequalities across the ICS footprint

1.2 Actions for Place based plans
Population health and health inequalities

1.2.6	A commitment that PCNs focus on priority prevention/inequalities conditions, as highlighted by the ICS emerging priorities, NHS operational guidance 23/24 and core20plus5. In the 2023/24 NHS operational planning document, the 'prevention and inequalities' section highlights the following ambitious goals: https://www.england.nhs.uk/publication/2023-24-priorities-and-operational-planning-guidance/ • Increase percentage of patients with **hypertension treated to NICE guidance** to 77% by March 2024 • Increase the percentage of patients aged between 25 and 84 years with a **CVD risk score greater than 20 percent on lipid lowering therapies** to 60% • Continue to address health inequalities and deliver on the **Core20PLUS5** approach as relevant to children and young people and adults. PLUS groups will be determined by each of the 9 local places in C&M.
1.2.7	Local areas will require the ability to flex their approach to align with population needs and adequate funding for this work will need to be identified
1.2.8	We will address health inequalities arising from discrimination based on any protected characteristic and link to System and Place Equality, Diversity and Inclusion work.
1.2.9	Support PCNs with consistent business intelligence/CIPHA to better understand their population health needs—working with system-wide data and intelligence capacity to maximise the use of Population Health Management information to inform local practice, decision making, and best practice research. Explore how PCNs and practices can work with local system partners to tackle the wider social determinants of ill health, and address health inequalities in line with our All Together Fairer recommendations.
1.2.10	**A commitment across primary care to towards delivering population health priorities that include** • smoking cessation, contributing to the SmokeFree 2030 ambition, as part of an overarching whole system strategy and pathway (to be developed) • Digital Weight Management referrals • Targeted NHS health checks- Build on learning from recent pilots to increase uptake of NHS HCs in priority groups with high CVD risk but low levels of engagement in preventative checks (areas of deprivation, ethnic minority groups, patients with SMI and LD) • Increase uptake of annual physical health checks for patients with SMI, building on learning from innovative pilots • **All Together Active**. Supporting implementation of the All Together Active strategy aimed at increasing physical activity as a way of improving population health through GP practises • **Population Health Intelligence**. Utilisation of CIPHA and other tools to underpin, inform and drive a coordinated and sustainable population health management approach targeting the most impactful cohorts for prevention and high impact measures • **Reducing Harm from Alcohol**. Supporting the strategic across Cheshire and Merseyside deliver preventative and treatment interventions that reduce alcohol harm and drug dependency. • **Making Every Contact Count**. Embedding the philosophy of Making Every Contact Count, an approach to behaviour change that maximises the opportunity within routine health and care interactions for a brief discussion on health or wellbeing factors.

1.3 Improving Access

Core Ambition:

We want to support the national ambition to deliver best care for our patients. We want to work together with our practices to support them in ensuring that patients requiring care receive appointments within an appropriate timescale. This includes supporting practices and patients to facilitate easy contact with their practice and aspire for them to receive an appointment within two weeks.

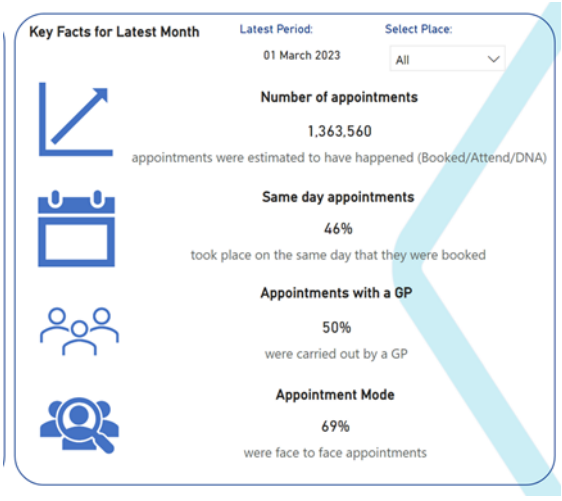
Our ambition is for resilient services that are enabled to respond to demand spikes and with appropriate ICS escalation plans to support this.

Background:

- In order to provide the services we offer, patients need to be able to access them.
- We need to use accurate and appropriate data to understand our access.
- Improving outcomes for patients includes improving their experience of services.
- Holistic, relationship based care helps with access

Fuller Framework Action Point #1

Develop a single system-wide approach to managing integrated urgent care to guarantee same-day care for patients and a more sustainable model for practices. This should be for all patients clinically assessed as requiring urgent care, where continuity from the same team is not a priority. Same-day access for urgent care would involve care from the most clinically appropriate local service and professional and the most appropriate modality, whether a remote consultation or face to face



Planning Guidance Cross Reference

Make it easier for people to contact a GP practice, including supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need

Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024

Reference to GP Contract Change

NHSE has imposed changes to the GP Contract 2023-24 requiring all patients to be either signposted to a more appropriate service or receive an assessment of need on the day. This is supported by Primary Care Access Recovery Plan.

1.3 System level actions

Improving Access

1.3.1	The ICB aims to see increased satisfaction on GP Patient Survey regarding access indicators
1.3.2	The ICB will work with media to promote GP access routes to the public and inform about multidisciplinary care models.
1.3.3	The ICB will ensure enhanced system level BI modelling to allow real time data on appointment activity, demand and capacity, enabling the service to identify and respond to demand spikes.
1.3.4	The ICB will support Place and PCNs with the NHSE Primary Care Access Recovery Plan
1.3.5	The ICB will run a series of workshops around access to share best practice and explore alternative models of access into surgery e.g. Access workshop series, action learning sets, University of Manchester model of access
1.3.6	Undertake a telephony review across PCNs and support the adoption of digital telephony (aligned to GP recovery plan action point 5)
1.3.7	Improve access, triage and referral across first-contact NHS organisations including general practice (reference from House of Commons Report)

1.3 Actions for Place based plans

Improving Access

1.3.8	Explore alternative models of access into General Practice including digital options
1.3.9	Support practices in procuring Cloud Based Telephony (aligned to GP recovery plan action point 5)
1.3.10	Develop BI modelling for activity, demand and capacity
1.3.11	Develop a local response to the national Access Recovery Plan which will include supporting practices to develop their plans for improving access in accordance with the IIF for 23-24

Case Study

Wilmslow Health Centre have developed a digital first triage model that works well for their patients. A clinician working alongside an admin colleague reviews all requests on the day and allocates them to the most appropriate assessment modality which could be a face to face, telephone or text response. They have high patient satisfaction rates and utilise their whole team effectively.

1.4 Quality, Performance, Assurance and Safety

Core Ambition:

The ICB aims to have General Practice of the highest quality. We will work with Places and Practices to monitor performance and improve outcomes.

Background:

- There are many metrics recorded with regard to General Practice Performance. This includes GP Access Data, prescribing data, QOF and IIF targets and CQC inspection reports.
- It has sometimes been difficult to identify which metrics should be used to best provide a measure of quality.
- The System Quality and Performance Committee and the System Primary Care Committee already receive reports relating to Primary Care.

1.4	System level recommendations Quality, Performance, Assurance and Safety
1.4.1	The ICB will produce a single dashboard bringing together relevant metrics describing GP quality and performance
1.4.2	The ICB will provide data for assurance to the System Quality and Performance Committee

1.4	Recommendations for Place based plans Quality, Performance, Assurance and Safety
1.4.3	Places to support practice where any performance or safety issues are identified and to escalate to System where required
1.4.4	Place to monitor prescribing data and support clinicians with quality prescribing
1.4.5	Places to consider educational activities for clinicians to improve quality of care

1.5 Role of General Practice

Core Ambition:

- **The ICB aims to have high functioning General Practice delivering quality GMS and APMS services.**
- **The ICB also aims to see high performance in QoF and IIF indicators and engaging well with other national or local enhanced services**

Background:

- The scope of tasks that General Practice *could* be asked to undertake is almost unlimited. GPs are therefore asking for clarity around what they *should* be doing. This includes tackling the perceived shift of work from secondary care.
- The 2018 Kings Fund publication 'Innovate Models of General Practice' describes 5 attributes that underpin General Practice (person-centred, holistic care; coordination; continuity; community focus). The paper also discussed innovative, new models of care that could be considered. These new models of care need to be reconsidered now in the light of the impact of the Covid-19 Pandemic.
- The ambition around primary care networks is complicated by a national contract that requires GPs to maintain their own practice, in effect there are individual businesses that are being asked to collaborate. Encouraging practices to work together as a PCN is a key priority. Methods to encourage PCN working need to be developed that benefit all involved.

House of Commons report Reference

NHS England should provide Primary Care Networks with additional funding to appoint a 'continuity lead' for at least one session per week, and additional admin staff funding to support the lead in the role. The role of the continuity lead GP would be to support practices within their network to increase the proportion of patients consulting with their named or regular GP, learning from best practice around the country. There should be a specific uplift for areas of high deprivation.

Consensus on the Primary Secondary Interface

The ICB has published it's Consensus on the Primary Secondary Care Interface. This provides high level principles that all clinicians are encouraged to follow. If adhered to this consensus would be expected to reduce unnecessary work being passed to Primary Care and streamline pathways. The consensus has been endorsed by the RCGP and received national recognition. Consensus on the Primary and Secondary Care Interface - NHS Cheshire and Merseyside

1.5	System level actions Role of General Practice
1.5.1	Within 1 year ICB to articulate a clear vision for the role of General Practice ensuring the balance between access and continuity is considered
1.5.2	ICB to identify key pathways where clarity is required regarding responsibilities.
1.5.3	The ICB will work with secondary care to deliver the 'Cutting Bureaucracy' element of the Primary Care Access Recovery Plan.

1.5	Actions for Place based plans Role of General Practice
1.5.4	Local Primary Secondary Care Interface groups will be formed around appropriate hospital footprints to consider the Consensus document and provide clarity on local pathways
1.5.5	Encourage job-shadowing of GPs by ICB Place managers as well as secondary care colleagues.
1.5.6	Consider supporting PCNs to introduce 'continuity leads' as per the House of Commons report.

Quote from GP Questionnaire Response (anon):

"The unique role of GPs and the wider practice team is deliver person-centred care that focuses on prevention, optimization and safety. This role is enhanced and more effective when patients and families build and maintain continuity with their practice and individual clinicians. The 'Needs' are -

• Need #1: To jointly improve and enhance the level of holistic, person-centred care in the management of common long term conditions and frailty. This in turn will provide clarity to the wider system of the common substantial offer from all General Practices across our places.

• Need #2: To work collaboratively between practices, on PCN wide local or Place footprints to deliver core and enhanced general practice where needed to deliver preventative, pro-active, routine and urgent general medical care.

• Need #3: To develop our clinical skills and workforce, and our infrastructure to meet the changing needs of the population through collaboration and integrated working."

General Practice Enabling Themes

1.6 Integration and Partnership

Primary care networks, care communities and the interface with secondary care

Core Ambition:

The ICB will work with and support PCNs to evolve into something fully inclusive of all components in Primary Care and integrated within the community

For patients to have a streamlined experience when moving between Primary and Secondary Care and for actions to be taken by the most appropriate service in a timely way

The ICB to support ongoing development of Care Communities/Neighbourhood Teams

Develop high functioning ICB medicines management teams that work in an integrated manner with primary and secondary care

Background:

- Primary Care Networks are new and essential parts of the NHS landscape. They are in prime position to improve the health of the people living in the community of their PCN geography.
- Currently there is little meaningful PCN engagement with Dentistry, Optometry or Community Pharmacy.
- The development of PCNs has created a new cohort of clinical leaders. Consideration needs to be given to how we develop these leaders and describe their role in the future clinical leadership of the ICS.
- There can be issues at the interface between Primary and Secondary Care and patients can find themselves stuck in the gaps between services.

Fuller Framework Action Point #3

Enable all PCNs to evolve into integrated neighbourhood teams, supporting better continuity and preventive healthcare as well as access, with a blended generalist and specialist workforce drawn from all sectors. Secondary care consultants – including, for example, geriatricians, respiratory consultants, paediatricians and psychiatrists – should be aligned to neighbourhood teams with commitments reflected in job plans, along with members of community and mental health teams.

Fuller Framework Action Point #4

Co-design and put in place the appropriate infrastructure and support for all neighbourhood teams, across their functions including digital, data, intelligence and quality improvement, HR, finance, workforce plans and models, and estates.

Primary Care Access Recovery Plan Reference

'Cut Bureaucracy'

Reduce time spent liaising with hospitals – by requiring ICBs to report progress on improving the interface with primary care, especially the four areas we highlight from the Academy of Medical Royal Colleges report, in a public board update this autumn.

House of Commons Report Reference

The Government should commission a review into short-term problems that constrain primary care including, but not limited to: the interface between primary and secondary care, prescribing from signing to dispensing, administrative tasks e.g. reports and sick notes, day-to-day usability of IT hardware and software, and reviewing of bloods, pathology and imaging reports.

1.6 System level actions

Integration and Partnership

1.6.1	Report progress on improving the interface between primary and secondary care to the ICB board (aligned to GP recovery plan action point 12)
1.6.2	The ICB will support Place and PCNs to evolve into something fully inclusive of all components in Primary Care and integrated within the community
1.6.3	We commit to the nurturing and development of PCN leaders and to describe their role in the future clinical leadership of the ICS
1.6.4	Consider developing a reporting tool for GPs to report inappropriate workload transfer
1.6.5	To provide proactive support for the Consensus on the Primary secondary Care Interface
1.6.6	The ICB to develop an ICB medicines management target operating model
1.6.7	Engage with the voluntary sector to encourage true partnership working at all levels

1.6 Actions for Place based plans

Integration and Partnership

1.6.8	Clearly articulate what is being asked of PCNs against what is being asked of General Practice
1.6.9	Support practices in identifying service areas where they can work together
1.6.10	Assess the areas where we can support PCNs to develop a model of health care delivery that is proactive rather than reactive.
1.6.11	Developing joined up care pathways and considering multidisciplinary ‘one stop shop’ clinics, working together to overcome barriers. This could include streamlined information sharing and referrals—reducing bureaucracy
1.6.12	Exploring the possibility of shared contracts to enable partners to work better together
1.6.13	Encourage ongoing development of Care Communities/Neighbourhood teams to work with local partners and address local needs and the wider determinants of ill health
1.6.14	Develop primary secondary care interface groups (as 1.5.4)
1.6.15	Implement the ICB medicines management target operating model across Place when agreed
1.6.16	Encourage neighbourhoods to engage with local voluntary sector organisations to bring about full partnership working within communities

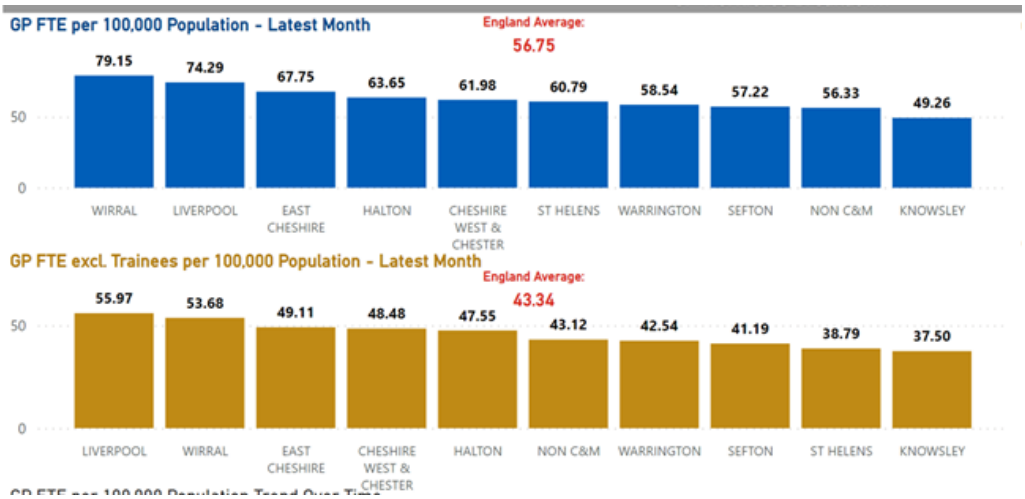
1.7 Workforce and Organisational Development

Core Ambition:

We will develop a system level primary care workforce plan, understanding the current situation and forecasting for future delivery models. System plans will be created to address expected gaps in workforce provision. Our primary care workforce will be embedded throughout our ICS governance and leadership to influence and support system planning.

Background:

- We have a Primary Care workforce crisis and we need to determine how the C&M system can support the workforce challenge. We need to understand the current situation, map ahead to forecast our likely future state and plan for any expected gaps.
- Four key enablers for action derived from the NHS People Plan have been identified to cultivate the landscape for a one workforce / whole systems approach to primary care workforce resilience; Looking after our people, belonging in the NHS, growing for the future and new ways of working and delivering care.
- The PCN Clinical Director workload has increased hugely and it is difficult to divide PCN CD role and GP role.
- There is variation in the GP FTE from place to place which may contribute to differing access rates across C&M.



Planning Guidance Cross Reference

Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024

GP Questionnaire key feedback - Workforce

- ⇒ Focus on retention including flexible working opportunities
- ⇒ Make GP a more attractive working environment e.g. portfolio careers
- ⇒ Develop a primary care workforce strategy
- ⇒ Looking after our staff is vital
- ⇒ Multidisciplinary staff roles with the right patient seeing the right professional

Future of General Practice Reference

The Government should accelerate plans to allow GP partners to operate as Limited Liability Partnerships or other similar models which limit the amount of risk to which GP partners are exposed.

Case Study

Merepark Surgery in Alsager have recognised the importance of investing in their staff. Through a positive appraisal process for employees and regular team-building/social activities they have a happy, sustainable workforce.

Fuller Framework Action Point #6

Embed primary care workforce as an integral part of system thinking, planning and delivery. Improve workforce data. Support innovative employment models and adoption of NHS terms and conditions. Support the development of training and supervision, recruitment and retention and increased participation of the workforce, including GPs.

1.7 System level actions

Workforce and Organisational Development

1.7.1	A system level primary care workforce plan including future delivery models will be co-produced and based upon accurate primary care workforce data analytics and activity modelling.
1.7.2	Targeted recruitment campaigns will be developed including promoting C&M as an attractive place to work
1.7.3	We consider the feasibility of developing C&M recruitment incentive schemes including schemes that align GP careers with secondary care to give a more flexible/portfolio career.
1.7.4	Consider developing flexible working practices for primary care staff, including more joint roles and opportunities for rotational roles. Enable the flexible deployment of staff across employing organisation, network & system boundaries using digital solutions
1.7.5	Consider the development of a collaborative primary care staff bank to increase capacity across primary care and create a new offer for local GPs / nurses etc wanting to work flexibly.
1.7.6	Embed the primary care workforce throughout the ICS governance and leadership applying the CCPL framework.
1.7.7	We have the strategic intent to continue with PLTs for GP practices and to get out from it what practices really need.
1.7.8	We will establish clear links with regional and national education and training organisations to support primary care workforce development. This will include close working with the Training Hub
1.7.9	Build PCN clinical leadership capability to drive transformation and innovation across primary care.
1.7.10	Encourage a multi-professional approach to leadership development including Practice Nurses and other professionals.
1.7.11	Provide Clinical Leadership Coaching.
1.7.12	Consider process to allow GP partners to operate as Limited Liability Partnerships or other similar models

1.7 Actions for Place based plans

Workforce and Organisational Development

1.7.13	Develop Place primary care workforce plans including understanding the current place situation, required future models and plans for addressing gaps.
1.7.14	Support PCNs in developing their clinical, workforce and OD strategies for how they can best use ARRS staff.
1.7.15	Embed the primary care workforce throughout Place governance and leadership
1.7.16	Primary care networks and their staff will be supported with clear OD and professional development opportunities.
1.7.17	Embed principles of Equality, Diversity and Inclusion in all workforce programmes
1.7.18	Work collaboratively with ICS workforce and OD leads to progress the 4 themes of the C&M People Plan and associated primary care focussed actions across PCNs.

1.8 Infrastructure and Intelligence

Core Ambition:

Digital infrastructure, solutions and services that support improved and equitable access to primary care services will be provided. This digital infrastructure will empower self-care and easy, equitable access to clinical and non-clinical care and support.

A digitally empowered Cheshire and Merseyside population taking increased control of their own physical and mental health and well-being.

A C&M wide primary care estates plan will be developed that will support a primary care estate that is fit for the future, maximises the use of our available locations and that shapes an estate that supports all primary care teams to provide effective services that patients can easily access.

Provide strong clinical and digital leadership to enable digital transformation, supporting and promoting the accelerated and widespread adoption of digital tools by General Practice. This will enable more efficient, flexible and resilient ways of working. This will Support practices to meet growing demand from patients by providing choice of digital channels, supporting transformation and innovation for modern general practice.

Background:

- We need excellent digital infrastructure and associated support services if we are to develop Primary Care into what it needs to be for future care
- We will also need a range of advanced digital solutions to improve productivity and efficiency, clinical safety and access to primary care services, plus a range of solutions to help manage demand and improve patient self-care
- The ICS has a digital and data strategy, endorsed by the ICB Board in November 2022, to which digital and data developments in primary care align
- There has been significant work to understand and start to address the issues associated with digital exclusion which may impact the public's ability to engage with 'digital first' primary care services
- Nationally, the NHS app is to become the digital 'front door' to NHS services which will ultimately replace a variety of other patient access portals through solutions such as EMIS access, Patients Knows Best and so on
- A ICB wide online/video consultation platform has been procured and is being implemented in a planned manner across PCNs / Places
- There are issues with the public's understanding and the usability of appointment booking and triage solutions.
- Improved business intelligence is required to support planning, identify data led priorities and the cohorts of patients where resource and effort needs to be focussed.
- Nationally, the NHS app is to become the digital 'front door' to NHS services which will ultimately replace a variety of other patient access portals through solutions such as EMIS access, Patients Knows Best and so on
- There is significant variation in the Primary Care estate. In order to be fit for the future we need to understand the estates we currently have and our future need.
- The PCN Service and Estate Planning Toolkit has been launched and PCNs are already engaging with this to produce both clinical and estates strategies.
- The communication with the public around the primary care digital solutions on offer could be improved to raise awareness and manage expectations. For example there has limited public engagement around the roll out of online triage and video consultation software.

Fuller Framework Action Point #10

Develop a system-wide estates plan to support fit-for-purpose buildings for neighbourhood and place teams delivering integrated primary care, taking a 'one public estate' approach and maximising the use of community assets and spaces.

1.8 System level actions - Infrastructure and intelligence

1.8.1	Every member of primary care staff that needs access to digital equipment to undertake their role will have access to reliable and fit for purpose access devices.
1.8.2	Every member of staff in primary care has access to reliable, seamless and secure network infrastructure to enable them to deliver their role, wherever they are working in Cheshire and Merseyside
1.8.3	Clinical systems that are reliable, responsive, meet clinical requirements safely and seamlessly connected to peripheral systems such as document management software, orders and results systems, remote monitoring solutions etc.
1.8.4	Provide responsive business intelligence to PCNs and practices
1.8.5	Primary Care clinical systems that are connected with the Place based (where available) and system wide shared care record, allowing two-way access for all while clearly complying with Information Governance requirements).
1.8.6	Functionality of primary care based patient engagement portals accessible via NHS App for all
1.8.7	Integration with patient communication systems to allow two-way communication and messaging (asynchronous communication).
1.8.8	Increased rollout of remote monitoring to support improved long term condition management in primary care (e.g. hypertension).
1.8.9	Hardware and software to allow online and video consultation using a system wide standard digital platform.
1.8.10	Increasing digital inclusion to ensure that as service provision becomes more digitised, more people are able to experience the benefit of digital investment in their health and care services and no-one experiences any reduction in access to services.
1.8.11	Align Primary Care Digital provision with ICB net zero / sustainability strategy
1.8.12	Strategic alignment with Primary Care solutions for patients
1.8.13	Provision of standard Digital support provision, providing effective Incident resolution of ICB locally commissioned services
1.8.14	Support Practices / PCNs with contract and service provision advice as part of PCN Digital development ambitions.
1.8.15	Provide contract and supplier management of underpinning ICB Digital Primary Care Commissioned contracts
1.8.16	Provide support for Practice merger as required as part of PCN Estates considerations
1.8.17	Co-ordinate Digital Bids to support Estates expansion and PCN working hub models and provision of Digital initiatives.
1.8.18	Scope available capital funding streams for C&M, understanding access routes and communicate funding opportunities to place when they become available.

1.8 Actions for Place based plans

Infrastructure and intelligence

1.8.19	Embed system wide online/video consultation platform across PCNs
1.8.20	Support all practices on analogue lines to move to digital and cloud based telephony, including call back functionality. - *aligned with GP recovery plan action point 5*
1.8.21	Provide all practices with the digital tools and care navigation training for Modern General Practice Access. - *aligned with GP recovery plan action point 6*
1.8.22	Improved utilisation of other ICB wide tools such as Ardens clinical decision support and the ORCHA app library
1.8.23	Review LTC management plans to increase utilisation of remote monitoring where an appropriate remote monitoring service is available
1.8.24	Access to and utilisation of Place based shared care record (and other tools if available such as care coordination technology) where this exists
1.8.25	Develop investment plans for 'levelling up' digital maturity infrastructure at place level
1.8.26	Work with local authority colleagues at Place to develop a digital inclusion plan
1.8.27	Develop plans to utilise the whole of the available place primary care estate, supporting increased access
1.8.28	Provide support to explore estate within local stakeholders e.g. One Public Estate
1.8.29	Develop plans to ensure that there is estate available for ARRS staff across general practice.
1.8.30	Review the PCN Service and Estate Planning Toolkit responses to develop place based clinical and estates strategies.

GP Questionnaire key feedback - infrastructure and intelligence

- ⇒ Support for net zero and reducing carbon footprint
- ⇒ Make it easier for practices to co-locate with other organisations
- ⇒ Greater IT integration throughout primary-secondary care interface
- ⇒ Invest in better telephony
- ⇒ Define and measure meaningful outcomes in primary care

1.9 Working with Patients

supporting greater self-care and proactive care @ home

Core Ambition:

A communication and engagement plan of activity with patients and the public will be produced to promote services, share positive examples of service improvement, explain to patients how to access services and expectations around care.

Background:

We will continue to improve our communication with the public. Promoting our excellent quality services with positive examples of how Primary Care has worked together will help rebuild the reputation.

For wider Primary Care services it is not always clear to patients which elements are covered by the NHS offer, and which elements are part or fully self-funded.

- A broad suite of initiatives will be developed looking at empowering patients to monitor their own health together with clear pathways back to the GP when support is needed.
- A key opportunity to aid with the demand and access challenges will be to empower individuals to self-care for minor self-limiting illness and also to be more involved in the care of their chronic disease.
- Consideration needs to be given to the development of Making Every Contact Count across primary care.

GP Questionnaire key feedback - Communication

⇒ Strong and supportive communication from ICB around primary care

⇒ There is work to be done to change the mindsets of patients only wanting to see a GP

⇒ Greater patient education around health management and routes into services

⇒ It is essential that primary care has a strong voice within the ICB with two way communication

Case Study

Working with our Primary Care teams to lead on the development of a pack around accessing healthcare services for asylum seekers who have been placed across hotels and accommodation. We worked closely with the primary care team, Clinical Lead as well as the Stay Well team to produce a pack containing information to help this vulnerable cohort of people. These packs were printed and displayed across the public areas of the accommodation and also sent digitally to those people with access to a mobile phone. The council also were able to translate the packs into 18 other languages. We have been advised by the council that: “The Asylum Seekers Self Care Pack has been very well received and has made a huge difference to being able to communicate information about our Health care system and various infections and illnesses to this vulnerable and poorly informed cohort of people. We have received very positive feedback from the Asylum seekers and the partners who are hosting them.”

1.9 System level actions - Working with patients

1.9.1	Develop external communications to explain how all primary care services can be accessed, what patients can expect relating to the types of appointment offers and which services should be accessed (as 1.3.2)
1.9.2	Develop positive communication campaigns to inform the public around the range of care professionals in place at GP practices to raise the publics awareness and manage expectations (as 1.3.2)
1.9.3	Bring together our Primary Care engagement groups (PPGs, PCNs, Neighbourhoods, Care Communities) together to share best practice and ideas. The ICB are committed to making this conference happen once a year at a venue in Cheshire or Merseyside whilst broadcasting to those unable to attend.
1.9.4	We will bring the Primary Care engagement groups together for this Exchange with the following aims: • Provide an update on Primary Care engagement across the ICB • Provide best practice examples of how Primary Care engagement has worked well in practice • Allow an open space to better understand how you, our local patients want to work with us

1.9 Actions for Place based plans

Working with patients

1.9.5	Enable patients in over 90% of practices to see their records and practice messages, book appointments and order repeat prescriptions using the NHS App by March 2024. (Aligned to GP recovery plan action point 1)
1.9.6	Enable the expansion of self-referral pathways. (Aligned to GP recovery plan action point 2)
1.9.7	Co-Design with Health Watch the development of communication messages and methods that the public can understand.
1.9.8	Local engagement with print media to encourage positive GP stories
1.9.9	Ensure proactive care @ home programmes is flourishing within Places including BP@Home
1.9.10	Leverage the power of local clinicians producing content for the public regarding self care
1.9.11	Create a space for PPG support information due to the vast amount of support and information available from NHS England, National Association of Patient Participation and at a place level that has been designed, bespoke to that area.
1.9.12	Engage with clinical leads about their requirements for training and support on communications and engagement for primary care teams from the ICB
1.9.13	Develop specific training/ masterclasses to support PCNs understand of their duty to involve, including case studies
1.9.14	Support and facilitate place partnerships in their development of their communication and empowerment collaborations, ensuring PCNs are an equal partner

1.10 Research and Innovation

Future models of delivery

Core Ambition:

We aim to see innovation spread across primary care services that meet our local needs and that deliver best in class services without variation. We aim to build the cultures and capability across our workforce that embrace innovation and enterprise and where new ways of working can be grown and flourish.

Background:

- For our primary care system to remain effective and responsive to changing population health needs, we must be innovative and flexible to adapt our services, practices and priorities and act on new knowledge and technology.
- Innovation is a key enabler to the sustainability of our health and care system and critical for achieving improved and joined up primary care services.
- One of the key strengths in Primary Care is the ability to innovate and change. In order to tackle inequalities we need to change the way we offer and provide services to those who most need them.
- Primary Care will need support and resources to enable the adoption of innovation as well as some much needed 'head-space' to consider this. The Innovation Agency are well placed to support this work.
- The ICS also needs to ensure we have a suitable environment for Primary Care to flourish. Place based partnerships will need to work closely with Primary Care in creating their plans and providing across their footprints.
- It can be helpful to consider at which 'layer' services are required; Local/PCN/Place/ICS. The ICS and Place both have a role in exploring this with Primary Care.
- We are also about to establish a Cheshire & Mersey IRIS (Integrated Research and Innovation) strategy group and need to consider the recently published NHS England guidance on research: NHS England » Maximising the benefits of research: Guidance for integrated care systems

Fuller Framework Action Point #5

Develop a primary care forum or network at system level, with suitable credibility and breadth of views, including professional representation. Ensure primary care is represented on all place based boards.

Fuller Framework Action Point #12

Create a clear development plan to support the sustainability of primary care and translate the framework provided by Next steps for integrated primary care into reality, across all neighbourhoods. Ensure a particular focus on unwarranted variation in access, experience and outcomes. Ensure understanding of current spending distribution across primary care, compared with the system allocation and health inequalities. Support primary care where it wants to work with other providers at scale, by establishing or joining provider collaboratives, GP federations, supra-PCNs or working with or as part of community mental health and acute providers. Tackle gaps in provision, including where appropriate, commissioning new providers in particular for the least well-served communities.

Fuller Framework Action Point #13

Work alongside local people and communities in the planning and implementation process of the actions set out above, ensuring that these plans are appropriately tailored to local needs and preferences, taking into account demographic and cultural factors.

1.10 System level actions - Research and Innovation

1.10.1	Deliver training and transformation support to all practices through the new National General Practice Improvement Programme - *aligned to GP recovery plan action point 7*
1.10.2	The ICB to work with PCN Clinical Directors to develop a proposal for how they will work together to support innovation adoption.
1.10.3	Develop system forums where new primary care ideas can be shared, developed and grown and for enabling best practice sharing, innovation spread, co-creation and networking.
1.10.4	Develop joint KPIs across primary care and shared results/remuneration to allow shared investment and innovation across services to happen (as 1.1.6)
1.10.5	The ICB to facilitate conversations with Place and PCNs around at which 'layer' primary care innovation should be focussed; Community/PCN/Place/ICS.
1.10.6	The ICB will appoint clinical leads for research (inclusive of Primary Care) to promote and endorse research within Primary Care
1.10.7	Cheshire and Merseyside will become a flagship ICB for Primary Care research and innovation

1.10 Actions for Place based plans
Research and Innovation

1.10.8	Support primary care services in delivering new and innovative services that previously may have been provided elsewhere e.g. 'trusting' pharmacists to deliver primary care services that have historically been completed in general practice
1.10.9	Enable shared decision making for innovation adoption with 'bottom up' development rather than 'top down' instruction .
1.10.10	Build collaboration between primary and secondary care to develop new cross-discipline services beyond CPCF and IIF which support the shift of patient care out of hospital and support ICS priorities.
1.10.11	Consideration of whole of primary care when developing new services to improve access to patients and utilisation of the whole primary care workforce.
1.10.12	The standardisation of a locally commissioned services framework will allow places to activate services at an appropriate level for their own needs.
1.10.13	Care communities and Place need to be key in ensuring that patients do not slip between the gaps between services and work to streamline care across the health and care system.

GP Questionnaire key feedback - R&I

- ⇒ Importance of continuity of care
- ⇒ Give permission to innovate and be innovative
- ⇒ Explore options for frailty and falls services
- ⇒ Address barriers at the primary-secondary care interface
- ⇒ Develop consistent pathways across localities
- ⇒ What is the USP of General Practice?

CHAPTER TWO - Community Pharmacy

Service Delivery Elements

2.1 Commissioning

Core Ambition

To maximise the opportunity within National and Local Commissioning of Community Pharmacy services ensuring that the patient offer and contribution to Primary Care is maximised . Transformational ways of working across PCNs to fully integrate Community Pharmacy into patient pathways increasing the breadth of offer of services to patients in a planned and managed service design , meeting the identified needs of the local population. All ICB commissioning will be in line with eh Community Pharmacy 5 Year plan and other national strategic documents including the recovery and Access Plan.

Background:

Commissioning needs to be based on local population needs. However, there is a strong need for some services to be developed over the whole ICS footprint (i.e. standardisation of Pharmacy First over the system, but the ability for a place/PCN to develop a service on a more local level.) Service standardisation (common specs, PGDs and funding across an ICS region) would allow development of a C&M service framework allowing places to activate services to an appropriate level, support improvements to quality, delivery and uptake of CP locally commissioned services.

Increased use the community pharmacy offering to support prevention, screening, urgent care, early diagnosis and health inequalities.

The use of SLAs linked to the national contract is an efficient contracting mechanism however Place should have primacy with managing the local contractual arrangements with support from the ICB Community Pharmacy contracting team when contractual concerns require managing via regulatory mechanisms.

The commissioning of the National Services for Pharmacy is agreed by the DHSS and is published as the Community Pharmacy Contractual Framework: 2019 to 2024. (The 5 Year Plan). The priorities for the year 5 settlement have also been published as part of the Recovery and Access agenda and include the following key elements :

- Launch of New Advanced Service—Common Conditions Service (PGD led service covering 7 minor illnesses)
- Expansion of the Hypertension case finding Service and Contraceptive Service
- Improvements to IT infrastructure and interoperability between CP and GP
- Amendment to legislation to give more options about how to deploy staff to release pharmacists time for increased patient facing services

Places should challenge themselves whether they are utilising the capacity, access and skills potentially available if commissioned via community pharmacy in a meaningful way

Planning Guidance Cross Reference

NHSE will publish the general practice access recovery plan in the new year, as well as the themes for further engagement that will inform the negotiations for the 2024/25 contract. Delivery will be supported by funding as part of the five-year GP contract, including the Additional Roles Reimbursement Scheme. Integrated care board (ICB) primary medical allocations are being uplifted by 5.6 per cent to reflect the increases in GP contractual entitlements

2.1 System level actions

Commissioning - Community Pharmacy

Same as GP 1.1.1	As an ICS we will explore and outline how future monetary allocations will be distributed – either fair shares to Place or according to need across the whole system.
Same as GP 1.1.3	We will lobby the central NHSE team regarding the clear need for increased funding and support to Community Pharmacy through the Global Sum and national Commissioned CP Framework
2.1.1	The ICB will continue to work with the National pharmacy Integration fund to explore opportunities for transformation of CP services and development of new innovative clinical CP services.

2.1 Actions for Place based plans

Community Pharmacy - Community Pharmacy

Same as GP 1.1.7	Develop local commissioning models that are equitable across place footprints, support the areas of greatest need and deprivation and enable joined up working across disciplines, drawing on the ICB Population Health Programme.
Same as GP 1.1.8	Liaise with local authorities and the Cheshire & Merseyside Directors of Public Health around locally commissioned services, ensuring equity of provision and to inform prioritisation that tackles health inequalities in outcomes, experiences and access (our eight All Together Fairer principles).
2.1.3	Engage practices in the work above and around opportunities to support patients via referral to CP services that can support their management if minor illnesses and the self care agenda, management of hypertension and access to Contraception. Identifying suitable cohorts of patients and ensuring that staff are trained on how and who to refer will support patients accessing timely clinical interventions and increase access
2.1.4	Ensure that plans for commissioning of services include all 4 contractor groups and that CPs are commissioned to deliver services to patients when best suited to do so.

2.2 Population Health and Health Inequalities

integration with local authorities and Public Health

Core Ambition:

Our ambition is for Primary Care Networks to develop closer and integrated working with local authority and public health teams, to contribute to population health management and support in tackling the wider determinants of health.

As a Marmot ICS we will strive to reduce health inequalities across Cheshire and Merseyside

Community Pharmacy has a defined mechanism to collaborate and support working cross sector with our Local Authority Colleagues via the Local Pharmacy Networks. Commissioning of services by Local Authorities by Community Pharmacy is long established and the contribution CPs make to the Public Health agenda is well recognised.

Maximising opportunities within the national contract of support for public health and public health campaigns is prioritised locally.

Background:

- Primary Care is ideally placed to contribute to population health and tackle the causes of ill-health.
- By increasing integration with local authority and public health we can look to improve the health of the people that we serve.
- The Pharmacy Local Professional Networks have representation by Public Health Teams to ensure collaboration and innovation is being supported by pharmacy in the PH agenda in C&M
- Cheshire and Merseyside ICS is a recognised Marmot ICS working to reduce health inequalities.
- Holistic, relationship based care can deliver on tackling health inequalities through providing long term preventative medicine and Community Pharmacy are well placed to support patients with such advice
- Community pharmacy is a recognised contributor to the Public Health agenda and delivers significant input to local and national public health priorities.
- Community Pharmacy is well placed to support the delivery of public health messages to ensure inequalities are managed and vulnerable groups are supported due to their physical locations and siting of their contracts often in the most deprived communities. As such Community Pharmacy is one of the most accessible services

2.2	System level actions Population health and health inequalities - Community Pharmacy
Same as GP 1.2.3	Review and develop a criteria for resource allocation based on population need and health inequality data. Resources to be targeted at services best placed to deliver services including community pharmacy where appropriate
Same as GP 1.2.5	ICB will facilitate sharing of best practice in relation to tackling health inequalities across the ICS footprint and across all potential providers of services including community pharmacy to increase innovation in tackling inequality.

2.2	Actions for Place based plans Population health and health inequalities - Community Pharmacy
Same as GP 1.2.7	Local areas will require the ability to flex their approach to align with population needs and adequate funding for this work will need to be identified . Working cross sector to identify needs and opportunities for outreach
Same as GP 1.2.8	We will address health inequalities arising from discrimination based on any protected characteristic and link to System and Place Equality, Diversity and Inclusion work across all providers
Same as GP 1.2.9	Support PCNs with business intelligence/CIPHA to better understand their population health needs to inform developing and prioritisation of services across all providers
Same as GP 1.2.10	Explore how PCNs and practices can work with local partners to tackle wider determinants of ill health recognising strength of key partners e.g community pharmacy in their in reach to vulnerable communities, their relationship with communities and their increased access and availability.
2.2.1	PCNs to work with CPs on PH campaigns either as part of the national framework of campaigns or via any locally agreed to ensure a cohesive PH message is delivered consistently across stakeholders. The PCN networks can assist in this development.

2.3 Improving Access

Core Ambition:

We want to support the national ambition to deliver best care for our patients. We want to work together with our practices to support them in ensuring that patients who clinically require urgent care receive same day care. This includes supporting practices and patients to facilitate easy contact with their practice and receive an appointment within two weeks.

Our ambition is for resilient services that are enabled to respond to demand spikes and with appropriate ICS escalation plans to support this.

Community pharmacy services can support this ambition by ensuring patients are seen by the most appropriate clinician within the PCN. Increased access and referral to GPCPCS, CP Hypertension Services and CP Contraceptive services can ensure that GP appointments are freed up to service a wider cohort of patients at key times. Ensuring patient path ways are designed to maximise access to CP services can ensure the widest opportunity for access to clinical services for patients.

These ambitions are clearly articulated in the Recovery and Access agenda and planning specifically in the Empowering Patients element however also will contribute strongly to over all access to services for

Background:

- In order to provide the services we offer, patients need to be able to access them—CP services support patient access to services via service delivery in traditionally OOH periods—late night and weekends
- PCNs could understand CP access by working with their CPs locally to map access and availability of services to inform system wide usage and maximise capacity
- National IT developments in 23/24 will include access to BARS for GPs to refer in to and book patients into CP services.
- Improving outcomes for patients includes improving their experience of services.
- Holistic, relationship based care helps with access

Fuller Framework Action Point #1

Develop a single system-wide approach to managing integrated urgent care to guarantee same-day care for patients and a more sustainable model for practices. This should be for all patients clinically assessed as requiring urgent care, where continuity from the same team is not a priority. Same-day access for urgent care would involve care from the most clinically appropriate local service and professional and the most appropriate modality, whether a remote consultation or face to face. Triaging of non urgent patients in to CP services can assist with patient flow and ensure that patients with minor ailments or less pressing issues are dealt with in a timely manner by an appropriate local clinician.

Planning Guidance Cross Reference

Make it easier for people to contact a GP practice, including supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need

Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024

Reference to GP Contract Change

NHSE has imposed changes to the GP Contract 2023-24 requiring all patients to be either signposted to a more appropriate service or receive an assessment of need on the day. This will be supported by a GP Access recovery Plan due for publication soon.

2.3 System level actions

Improving Access - Community Pharmacy

As GP 1.3.2	The ICB will work with media to promote healthcare access routes to the public. This will support patients in seeking support from Community Pharmacy and stress the “Pharmacy First” message.
As GP 1.3.3	The ICB will ensure enhanced system level BI modelling to allow real time data on appointment activity, demand and capacity, enabling the service to identify and respond to demand spikes. This will also inform use of the GP referral mechanisms available via EMIS and later via BARS to ensure patients at key times are triaged in to supplementary services . This planning should be undertaken in tandem with a mapping of Community Pharmacy availability and service delivery capacity to ensure that Community Pharmacists are not overwhelmed at key times, can manage workload safely and appropriately and that patient experience of triage and referral is positive.
2.3.3	Complete a review of all access related content on practice websites to inform a ‘top tips’ document to support practices in improving access patient communication and processes. Practice websites to reflect the Pharmacy First message and information on Minor Ailments and the Self
2.3.4	Utilisation of the Recovery and Access plans to capture the planned innovation in Community Pharmacy for year 5 of the Contractual Settlement in line with the announcements made as part Empowering patients workstream to increase delivery of key Community Pharmacy services. Innovate IT to support booking and referral as well as increased clinical information sharing with COPs to support Community Pharmacy clinical services. Commissioning of the Common Conditions Service, a PGD led service to support 7 key common conditions at first point of contact and reduce requirements for Community Pharmacists to send patients to GP for prescription only

2.3 Actions for Place based plans

Improving Access - Community Pharmacy

Same as GP 1.3.8	Explore alternative models of access into General Practice including digital options and IT solutions for patient access to and referral in to services from other providers including Community Pharmacy in line with nationally announced IT programme
Same as GP 1.3.10	Develop BI modelling for activity, demand and capacity across all providers within a PCN setting
Same as GP 1.3.11	Develop a local response to the national Access Recovery Plan which will include supporting practices to develop their plans for improving access in accordance with the IIF for 23-24
2.3.5	Support Practices to understand CP Services and their offer to patients and how this could support the Recovery and Access plans locally.
2.3.6	Support Practices to ensure that staff have the training necessary to understand who / how to refer patients in to CPs to ensure the offer of these services is consistent, informs patient pathways where appropriate and opportunities maximised to drive access

2.4 Role of Community Pharmacy

Core Ambition:

- **The ICB aims to have high functioning Community Pharmacy Services delivering quality Nationally and Locally Commissioned services.**
- **The ICB also aims to see high performance in quality indicators demonstrating PCN practices engaging well with CPs to deliver advanced and enhanced services, integrated into patient pathways within a PCN model**

Background:

- Community Pharmacy is commissioned via the National Regulatory Framework to deliver Essential, Advanced , Enhanced and National Enhanced Services via nationally agreed contractual arrangements.
- Community pharmacy is also commissioned at ICB level and Place level to deliver a range of Locally commissioned services.
- There is an agreement to address inequality by looking at a potential harmonisation of locally commissioned services across the ICB , where deemed suitable, to harmonise and standardise this commissioning.
- The intensions of and recommendations of the Kings Fund - Developing place-based partnerships: the foundation of effective integrated care systems Developing place-based partnerships |Developing place-based partnerships | The King's Fund (kingsfund.org.uk) identifies that Place based Partnerships will be key in delivering transformation of care for Patients within primary care and ensuring of an enhanced and cohesive offer at place and PCN level.
- The ambition around primary care networks is complicated by a national contracts contractors , who are individual businesses , to collaborate. Encouraging practices to work together as a PCN and as a PCN to include and collaborate with other providers e.g. Community Pharmacy and Dental services, is a key priority. Methods to encourage cross sector PCN working need to be developed that benefit all involved.

Consensus on the Primary Secondary Interface

The ICB has published it's Consensus on the Primary Secondary Care Interface. This provides high level principles that all clinicians are encouraged to follow. If adhered to this consensus would be expected to reduce unnecessary work being passed to Primary Care and streamline pathways. The consensus has been endorsed by the RCGP and received national recognition. Consensus on the Primary and Secondary Care Interface - NHS Cheshire and Merseyside

Community Pharmacy can assist with this Primary and Secondary Care interface via the National Essential service for Discharge Medicines Service and the Smoking Cessation Service. Trusts should be encouraged to utilise these services to support patients on Discharge to understand and manage changes in their medication and facilitate the secondary to primary care transfer of care. Currently there is variable uptake between Trusts on utilisation of these services

A CQUIN is in place for the DMS service and a CQUIN for next years contracts is in discussion nationally re the Smoking Cessation Service

There may be value in creating an interface document relating to interactions between Primary Care providers.

2.4	System level actions Role of Community Pharmacy
2.4.1	ICB to identify key pathways where Community Pharmacy can support patients within the ICB or PCN structures and offer of clinical service
2.4.2	Within 1 year ICB to articulate a clear vision for Community Pharmacy, suggest consider views and reports from Nuffield Trust and King's Fund to inform
2.4.3	The ICB, as part of it's elective recovery programme, will ensure Trusts are engaging with all services that can support patients with interface between secondary and primary care including CP services e.g. DMS and Smoking Cessation Service
2.4.4	Consider developing an interface document descrbing interactions between Primary Care providers.

2.4	Actions for Place based plans Role of Community Pharmacy
Same as GP 1.5.4	Local Primary Secondary Care Interface groups will be formed around appropriate hospital footprints to consider the Consensus document and provide clarity on local pathways which will include CP services and referral in to these
Same as GP 1.5.5	Encourage job-shadowing of Primary Care Clinicians by ICB Place managers as well as secondary care colleagues. This will improve understanding of the role of Primary Care Clinicians and pressures currently being faced. There is an example of the "Walking in my Shoes" programme that supports GPs and Community pharmacists to experience each others roles and pressures.

2.5 Quality, Performance, Assurance and Safety

Core Ambition:

The ICB aims to have Community Pharmacy providers of the highest quality. We will work with Places and Contractors to monitor performance and improve outcomes.

Background:

- There are many metrics recorded with regard to Community Pharmacy Performance. This includes PQS submissions, CPAF submissions and Contract Monitoring Visits, as well as service delivery information and metrics and service claims data.
- It has sometimes been difficult to identify which metrics should be used to best provide a measure of quality—the ICB will look to develop a relevant dashboard establishing KPIs appropriate to deliver regular assurance on performance.
- The System Quality and Performance Committee and the System Primary Care Committee already receive reports relating to Primary Care.
- The Pharmaceutical Services Regulations Committee manages the quality and performance of community pharmacies via The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 as amended and the NHS England framework for managing the regulations and nationally commissioned contractual framework.

2.5	System level actions Quality, Performance, Assurance and Safety - Community Pharmacy
Same as GP 1.4.1	The ICB will produce a single dashboard bringing together relevant metrics describing community Pharmacy quality and performance
2.5.1	The ICB will work through the PSRC using regulatory mechanisms to monitor and support Community pharmacy Contractual delivery and quality
2.5.2	The ICB recognises that elements of the national Community Pharmacy service are dependant upon referrals from other parts of the system, this will need consideration when looking at the above metrics

2.5	Actions for Place based plans Quality, Performance, Assurance and Safety - Community Pharmacy
Same as GP 1.4.3	Places to liaise with the Pharmacy Contracting team where any performance or safety issues are identified and to inform local systems where intervention or assistance is required to resolve.
Same as GP 1.4.5	Places to consider educational activities for clinicians to improve quality of care– educational events can be delivered cross sector to support joint working and collaboration.

2.6 Enabling Themes - Community Pharmacy

2.6 Integration and Partnership -

Primary care networks, care communities and the interface with secondary care

Core Ambition

The ICB will work with and support PCNs to evolve into something fully inclusive of all components in Primary Care and integrated within the community. This integration will include all aspects of Primary care including Community pharmacy and dentistry

For patients to have a streamlined experience when moving between Primary and Secondary Care and for actions to be taken by the most appropriate service in a timely way

Use of all services to support patient transfer between secondary and primary care will be supported and developed including CP services of Discharge medicines service and Stop Smoking service. Delivery of CQUIN and metrics will be sued to support the Trusts in understanding their delivery of these services.

The ICB to support ongoing development of Care Communities/Neighbourhood Teams

Background

The integration of Community Pharmacy nationally commissioned services into PCNs is essential. These services include;

- NMS—to support medicines optimisation and improve adherence and safety.
- CPCS—to support the self care agenda
- Hypertension case finding—including access to in clinic BP check and Ambulatory BP checks
- Contraceptive Services—to support women with access to oral contraception

Work at PCN level to actively increase referral rates to all CP services and joint working at PCN level to map and manage capacity for these services.

Further integration and support for referrals into the Community Pharmacist Consultation Service (routes at present: 111 telephony, nhs.uk online, General Practice with UEC/A&E .

We need to acknowledge that Community Pharmacy engagement may lead to direct cost to the provider.

Planning Guidance Cross Reference

Transfer lower acuity care away from both general practice and NHS 111 by increasing pharmacy participation in the Community Pharmacist Consultation Service.

Fuller Framework Action Point #4

Co-design and put in place the appropriate infrastructure and support for all neighbourhood teams, across their functions including digital, data, intelligence and quality improvement, HR, finance, workforce plans and models, and estates. Specifically put in place sufficient support for all PCN clinical directors and multiprofessional leadership development, and protected time for team development. Baseline the existing organisational capacity and capacity for primary care, across system, place and neighbourhood levels, to ensure systems can undertake their core operational and transformation functions.

2.6 System level actions

Integration and Partnership - Community Pharmacy

2.6.1	Report progress on the interface across a PCN between providers including GP Practice, CP and Dentistry to the ICB Board *(aligned to GP recovery plan action point 12)*
Same as GP 1.6.2	The ICB will support Place and PCNs to evolve into something fully inclusive of all components in Primary Care and integrated within the community
2.6.2	To provide clarity on the role and function of primary care providers and how they work together to deliver a primary care offer to patients
2.6.3	The ICB to develop an ICB medicines management target operating model and develop how this model will interact with Community pharmacy
2.6.4	Increasing GP practices use in 4 specific areas of the NHS Community Pharmacy Advanced Services; 1) **The Community Pharmacist Consultation Service** (GP-CPCS) 2) **The Community Pharmacy Hypertension case-finding service** (clinic checks and ABPM referrals) 3) **The Pharmacy Contraception Service** 4) **The NHS Discharge Medicines Service (DMS)** That requires; • ICB enhanced deployment for GP-CPCS (see below) • ICB targets for referrals in to CP services e.g blood pressure (clinic check and ABPM) referrals per 1,000 population per practice • Direct booking for patients for all CP Clinical Services—National Development expected early 2024 • Full roll-out of the new NHS CP contraception service
2.6.5	Enhanced deployment of the NHS Discharge Medicines Service (DMS) and Smoking Cessation Service to maximise hospital utilisation ICB support includes; • ICB to support Trusts with high level influence regarding utilisation of these services from trust at management / Chief Pharmacist Level • Support for Trust to Trust peer support and learning • Full uses of 0.2 FTE DMS Champion funding • KPIs for Trust in line with CQUIN
2.6.6	Increasing pharmacy participation in the Community Pharmacy Consultation Service, Hypertension case finding Service and Contraception Service - • increasing referral rates / routes of referral • ICB wide CP PGD based MAS scheme to overlay with GP-CPCS • PCN focus on levels of service referrals per 1,000 population per practice. • Training and implementation support for expansion of services via referrals from practice / supporting practice staff on who /when to refer and what the service will deliver for the patients. • Support for implementation of National Common Conditions Service and Locally Commissioned Minor Ailments service to increase resolution of CPCS referral for patient in single point of care. • Roll out of UEC referral in to CPCS

2.6 Actions for Place based plans

Integration and Partnership - Community Pharmacy

2.6.7	Clearly articulate what is being asked of PCNs against what is being asked of individual providers
Same as GP 1.6.8	Support practices in identifying service areas where they can work together as practices and across providers with other sectors
Same as GP 1.6.9	Assess the areas where we can support PCNs to develop a model of health care delivery that is proactive rather than reactive. Involving patient pathways that access services across providers including Community pharmacy
Same as GP 1.6.10	Developing joined up care pathways and considering multidisciplinary 'one stop shop' clinics, working together to overcome barriers. This could include streamlined information sharing and referrals—reducing bureaucracy and supporting patients to navigate access in to services across the PCN and provided by other providers including community pharmacy
2.6.8	Exploring the possibility of shared contracts to enable partners to work better together—explore cross sector working for pharmacists to increase joint working and employment satisfaction - portfolio working
Same as GP 1.6.12	Encourage ongoing development of Care Communities/Neighbourhood teams to work with local partners and address local needs and the wider determinants of ill health
Same as GP 1.6.13	Develop primary secondary care interface groups which encompass all providers working with patients at the interface between secondary are and primary care including CPs
2.6.9	Develop Place primary care workforce plans including understanding the current place situation, required future models and plans for addressing gaps. In engagement with CP services and referrals in to CP Services.
2.6.10	Work with PCN Lead Pharmacists and LPC locally to understand and maximise local opportunity with cross sector working—establish patient pathways that maximise referral and direct patients in to appropriate services.

2.7 Infrastructure and Intelligence

Core Ambition:

Digital infrastructure, solutions and services that support improved and equitable access to primary care services will be provided. This digital infrastructure will empower self-care and easy, equitable access to clinical and non-clinical care and support.. This system will allow self referral for patients and assisted referral by GP practices in to Community Pharmacy services and support.

A digitally empowered Cheshire and Merseyside population taking increased control of their own physical and mental health and well-being accessing the full range of primary care services and support across all providers.

A C&M wide primary care estates plan will be developed that will support a primary care estate that is fit for the future, maximises the use of our available locations and that shapes an estate that supports all primary care teams to provide effective services that patients can easily access.

Provide strong clinical and digital leadership to enable digital transformation, supporting and promoting the accelerated and widespread adoption of digital tools by General Practice. This will enable more efficient, flexible and resilient ways of working. This will Support practices to meet growing demand from patients by providing choice of digital channels, supporting transformation and innovation for modern general practice.

Background:

- We need excellent digital infrastructure and associated support services if we are to develop Primary Care into what it needs to be for future care . This infrastructure will support collaboration and data flow cross sector where appropriate to support patients and clinicians in providing services to patients.
- We will also need a range of advanced digital solutions to improve productivity and efficiency, clinical safety and access to primary care services, plus a range of solutions to help manage demand and improve patient self-care and access across all providers of primary care
- The ICS has a digital and data strategy which supports all providers including community pharmacy, endorsed by the ICB Board in November 2022, to which digital and data developments in primary care align
- There has been significant work to understand and start to address the issues associated with digital exclusion which may impact the public's ability to engage with 'digital first' primary care services
- Nationally, the NHS app is to become the digital 'front door' to NHS services which will ultimately replace a variety of other patient access portals through solutions such as EMIS access, Patients Knows Best and so on
- A ICB wide online/video consultation platform has been procured and is being implemented in a planned manner across PCNs / Places. Community Pharmacy have engaged to some extend with virtual consultation and should be supported to explore innovation and new ways to support access.
- There are issues with the public's understanding and the usability of appointment booking and triage solutions.
- Improved business intelligence is required to support planning, identify data led priorities and the cohorts of patients where resource and effort needs to be focussed. This can include identification of cohorts of patients where community pharmacy services could be employed to increase access and availability of services in a locality.
- Nationally, the NHS app is to become the digital 'front door' to NHS services which will ultimately replace a variety of other patient access portals through solutions such as EMIS access, Patients Knows Best and so on
- The PCN Service and Estate Planning Toolkit has been launched and PCNs are already engaging with this to produce both clinical and estates strategies.
- National plans for CP IT Infrastructure announced 2023/24 and any innovation and opportunity for IT must be capitalised on an used to the full advantage of clinicians and patients as part of local plans.

Fuller Framework Action Point #10

Develop a system-wide estates plan to support fit-for-purpose buildings for neighbourhood and place teams delivering integrated primary care, taking a 'one public estate' approach and maximising the use of community assets and spaces.

2.7 System level actions

Infrastructure and intelligence - Community Pharmacy

Same as GP 1.8.1 & 2	Every member of staff in primary care has access to reliable, seamless and secure network infrastructure to enable them to deliver their role, wherever they are working in Cheshire and Merseyside—this includes infrastructure and systems that allows data flow and clinical information cross sector to support patients accessing and receiving services in all settings. This also requires infrastructure for data flow back to GP systems regarding services provided at settings outside the practice. (As GP action)
Same as GP 1.8.3	Clinical systems that are reliable, responsive, meet clinical requirements safely and seamlessly connected to peripheral systems such as document management software, orders and results systems, remote monitoring solutions etc. (As GP action)
Same as GP 1.8.5	Primary Care clinical systems that are connected with the Place based (where available) and system wide shared care record, allowing two-way access for all while clearly complying with Information Governance requirements). Sharing of the Shared Care record with all clinicians involved in patient care including Community Pharmacy.
Same as GP 1.8.6	Functionality of primary care based patient engagement portals accessible via NHS App for all (As GP action)
Same as GP 1.8.7	Integration with patient communication systems to allow two-way communication and messaging (asynchronous communication). (As GP action)
Same as GP 1.8.8	Increased rollout of remote monitoring to support improved long term condition management in primary care (e.g. hypertension) and how this may link in with other services e.g Hypertension Case Finding Service in CP.
Same as GP 1.8.10	Increasing digital inclusion to ensure that as service provision becomes increasingly digitised, more people are able to experience the benefit of digital investment in their health and care services and no-one experiences reduction in access to services. Including support for patients to self refer digitally in to CP services.
2.7.1	ICB to support the community pharmacy strategic planning and delivery with contract and service provision advice as part of PCN Digital development ambitions.
Same as GP 1.8.15	Provide contract and supplier management of underpinning ICB Digital Primary Care Commissioned contracts
Same as GP 1.8.12	Strategic alignment with Primary Care solutions for patients
Same as GP 1.8.13	Provision of standard Digital support provision, providing effective incident resolution of ICB locally commissioned services
2.7.2	Opportunity to commission digital infrastructure as ICB giving an economy of scale rather than each place managing a smaller contract—potentially 9 contracts across C&M footprint. This would also support harmonisation and equity of approach.
Same as GP 1.8.18	Scope available capital funding streams for C&M, understanding access routes and communicate funding opportunities to place when they become available.

2.7 System level actions (continued)

Infrastructure and intelligence - Community Pharmacy

2.7.3	Support for National roll out of an integrated referral and booking pathway between General practice and CP
2.7.4	Roll out of Shared care records and enhanced access to clinical records for community pharmacies to support delivery of clinical services in the CP setting
2.7.5	Ensure access to additional content within patients GP records to include test results and patient observations
2.7.6	Sending of structured content back to patients GP records following a pharmacy consultation (e.g. meds supplied via PGD)
2.7.7	Incorporation of CP Digital plans into ICB digital strategy

2.7 Actions for Place based plans

Infrastructure and intelligence - Community Pharmacy

Same as GP 1.8.23	Review LTC management plans to increase utilisation of remote monitoring where an appropriate remote monitoring service is available—also consideration of support outside of G Practice e.g. referral in to CP clinical services for LTC support e.g. hypertension or contraceptive services
Same as GP 1.8.24	Access to and utilisation of Place based shared care record (and other tools if available such as care coordination technology) where this exists—expansion of this system to allow access for Community Pharmacy to allow clinical data to support CP based clinical services.
Same as GP 1.8.25	Develop investment plans for 'levelling up' digital maturity infrastructure at place level and to include community pharmacy in levelling up plans
Same as GP 1.8.26	Work with local authority colleagues at Place to develop a digital inclusion plan which encompasses all elements of primary care
Same as GP 1.8.27	Develop plans to utilise the whole of the available place primary care estate, supporting increased access
Same as GP 1.8.30	Review the PCN Service and Estate Planning Toolkit responses to develop place based clinical and estates strategies across the whole of the PCN including Community Pharmacy and how increased digital links can support the patient pathways
2.7.1	Provide all practices with the digital tools and care navigation training for Modern General Practice Access. Highlighting opportunities for increased access via triaging of patients in to local services and the digital solutions to support these referrals. (Aligned to GP Recovery Plan Action 6)
2.7.2	Develop Place primary care workforce plans including understanding the current place situation, required future models and plans for addressing gaps. In engagement with CP services and referrals in to CP Services.
2.7.3	Support Practice based staff to understand referral mechanism and when / how to use to support patients to access services
2.7.4	Work with PCN Lead Pharmacists and LPC locally to understand and maximise local opportunity with cross sector working—establish patient pathways that maximise referral and direct patients in to appropriate services.

2.8 Working with Patients

supporting greater self-care and proactive care @ home

Core Ambition:

A communication and engagement plan of activity with patients and the public will be produced to promote services, share positive examples of service improvement, explain to patients how to access services and expectations around care..

Support patents with active referral in to existing additional services available via community pharmacy and create patient pathways that actively seek to refer patients in to these additional services e.g. GPCPCS, Hypertension and Contraceptive services.

Background:

We will continue to improve our communication with the public . Promoting our excellent quality services with positive examples of how Primary Care has worked together will help rebuild the reputation.

This is consummate with the “empowering patients” workstream of the recovery and Access plan.

For wider Primary Care services it is not always clear to patients which elements are covered by the NHS offer, and which elements are part or fully self-funded.

A broad suite of initiatives will be developed looking at empowering patients to monitor their own health together with clear pathways back to the GP when support is needed. Community Pharmacy commissioned services will form part of this offer to patients about alternative routes to monitor and manage their care.

The community Pharmacy National Contract required CPs to be proactive in supporting patients with their self Care.

The Locally commissioned Minor Ailments Service supports the self care agenda where inequalities or demographics of deprivation may hinder a patient in proactively seeking a self care option.

New opportunities regarding the community pharmacy National Contract regarding the launch of a PGD based Common Conditions Service will augment the locally commissioned Minor Ailments Service and encourage 1st point of care solutions for patients seeking self care.

A key opportunity to aid with the demand and access challenges will be to empower individuals to self-care for minor self-limiting illness and also to be more involved in the care of their chronic disease.

Consideration needs to be given to the development of Making Every Contact Count across all providers of primary care.

PCNs developing clear patient pathways actively referring patients in to self care options will be developed to maximise the patient offer of GPCPCS, Hypertension Case Finding Service, Contraception Service Minor Ailments and the Common Conditions Service

2.8 System level actions

Working with patients - Community Pharmacy

2.8.1	Enable the expansion of self-referral pathways by September 2023 to include the new offer of the Common conditions Service and referral via GP CPCS and also in to Community Pharmacy services for Hypertension and Contraception. (Aligned to GP Recovery Plan Actions 3 & 4)
Same as GP 1.9.1	Develop external communications to explain how all primary care services can be accessed, what patients can expect relating to the types of appointment offers and which services should be accessed which includes the full Primary care offer including Community Pharmacy and Dentistry. One communication message should be used by all providers to show a common approach and advice re self care across wider primary care.
Same as GP 1.9.2	Develop positive communication campaigns to inform the public around the range of care professionals in place at GP practices and across all aspects of primary care to raise the publics awareness and manage expectations
Same as GP 1.9.3	Bring together our Primary Care engagement groups (PPGs, PCNs, Neighbourhoods, Care Communities) together to share best practice and ideas. The ICB are committed to making this conference happen once a year at a venue in Cheshire or Merseyside whilst broadcasting to those unable to attend.
Same as GP 1.9.4	We will bring the Primary Care engagement groups (encompassing all of primary care) together for this Exchange with the following aims: • Provide an update on Primary Care engagement across the ICB • Provide best practice examples of how Primary Care engagement has worked well in practice • Allow an open space to better understand how you, our local patients want to work with us

2.8 Actions for Place based plans

Working with patients - Community Pharmacy

Same as GP 1.9.7	Work closely with Health Watch in the development of communication messages and methods that the public can understand that can be used by all sectors in primary care
Same as GP 1.9.8	Local engagement with print media to encourage positive GP / Community Pharmacy / Dentistry stories
Same as GP 1.9.9	Ensure proactive care @ home programmes is flourishing within Places including BP@Home— encouraging links to CP Hypertension service to support BP@Home or developing pathways that CP can support the BP@home agenda more closely
Same as GP 1.9.10	Leverage the power of local clinicians , across all sectors, producing content for the public regarding self care and access to support via Community Pharmacies to encourage this
Same as GP 1.9.11	Create a space for PPG support information due to the vast amount of support and information available from NHS England, National Association of Patient Participation and at a place level that has been designed, bespoke to that area.
Same as GP 1.9.14	Support and facilitate place partnerships in their development of their communication and empowerment collaborations, ensuring PCNs and all primary care providers are an equal partner

2.9 Research and Innovation

Future models of delivery - Community Pharmacy

Core Ambition:

We aim to see innovation spread across all primary care services that meet our local needs and that deliver best in class services without variation. We aim to build the cultures and capability across our workforce that embrace innovation and enterprise and where new ways of working can be grown and flourish.

Background:

- For our primary care system to remain effective and responsive to changing population health needs, we must be innovative and flexible to adapt our services, practices and priorities and act on new knowledge and technology. This should capitalise on the provision by all primary care providers ensuring the best use of clinical skills and workforce.
- Innovation is a key enabler to the sustainability of our health and care system and critical for achieving improved and joined up primary care services.
- One of the key strengths in Primary Care is the ability to innovate and change. In order to tackle inequalities we need to change the way we offer and provide services to those who most need them.
- Primary Care will need support and resources to enable the adoption of innovation as well as some much needed 'head-space' to consider this. The Innovation Agency are well placed to support this work. Leaders from all sectors should be supported and encouraged to support this transformation—PCN funding for leaders from all sectors of primary care should be mandated
- The ICS also needs to ensure we have a suitable environment for Primary Care to flourish. Place based partnerships will need to work closely with all providers of Primary Care in creating their plans and providing development of services and patient pathways across their footprints.
- It can be helpful to consider at which 'layer' services are required; Local/PCN/Place/ICS. The ICS and Place both have a role in exploring this with Primary Care.

Fuller Framework Action Point #5

Develop a primary care forum or network at system level, with suitable credibility and breadth of views, including professional representation. Ensure primary care is represented on all place based boards.

Fuller Framework Action Point #12

Create a clear development plan to support the sustainability of primary care and translate the framework provided by Next steps for integrated primary care into reality, across all neighbourhoods. Ensure a particular focus on unwarranted variation in access, experience and outcomes. Ensure understanding of current spending distribution across primary care, compared with the system allocation and health inequalities. Support primary care where it wants to work with other providers at scale, by establishing or joining provider collaboratives, GP federations, supra-PCNs or working with or as part of community mental health and acute providers. Tackle gaps in provision, including where appropriate, commissioning new providers in particular for the least well-served communities.

Fuller Framework Action Point #13

Work alongside local people and communities in the planning and implementation process of the actions set out above, ensuring that these plans are appropriately tailored to local needs and preferences, taking into account demographic and cultural factors.

2.9 System level actions

Research and Innovation - Community Pharmacy

Same as GP 1.10.2	The ICB to work with PCN Clinical Directors to develop a proposal for how they will work together to support innovation adoption exploring options for the wider primary care offer as well as at GP practice level. As per GP action
Same as GP 1.10.3	Develop system forums where new primary care ideas can be shared, developed and grown and for enabling best practice sharing, innovation spread, co-creation and networking. Engagements with LPNs to share best practice and learning and locally across providers of primary care at PCN level.
Same as GP 1.10.4	Develop joint KPIs across primary care and shared results/remuneration to allow shared investment and innovation across services to happen - measure engagement with all services includng referral rates into CP services
Same as GP 1.10.5	The ICB to facilitate conversations with Place and PCNs around at which 'layer' primary care innovation should be focussed; Community/PCN/Place/ICS involving all providers of primary care at each layer of development.
Same as GP 1.10.7	Cheshire and Merseyside will become a flagship ICB for Primary Care research and innovation involving all sectors in opportunities for innovation and transformation
2.9.1	The ICB will continue to work with the national Integration Fund for Pharmacy to look at opportunities to pilot innovative ways of working or new clinical services in Community Pharmacy.

2.9 Actions for Place based plans

Research and Innovation - Community Pharmacy

Same as GP 1.10.8	Support primary care services in delivering new and innovative services that previously may have been provided elsewhere e.g. supporting wider primary care the system to understand the high quality Community pharmacy clinical Services commissioned nationally and locally
Same as GP 1.10.9	Enable shared decision making for innovation adoption with 'bottom up' development rather than 'top down' instruction inclusive of all sectors of primary care
2.9.1	Build collaboration between primary and secondary care to develop new cross-discipline services beyond CPCF and IIF which support the shift of patient care out of hospital and support ICS priorities. Utilise existing services to support patients with discharge including the Discharge Meds Service and Stop Smoking services that trusts can refer patients into for support on discharge.
Same as GP 1.10.11	Consideration of whole of primary care when developing new services to improve access to patients and utilisation of the whole primary care workforce.
Same as GP **1.10.12**	The standardisation of a locally commissioned services framework will allow places to activate services at an appropriate level for their own needs.
Same as GP 1.10.13	Care communities and Place need to be key in ensuring that patients do not slip between the gaps between services and work to streamline care across the health and care system.

2.10 Workforce and Organisational Development

Core Ambition

We will develop a system level primary care workforce plan that covers all spects of primary Care including Community pharmacy , understanding the current situation and forecasting for future delivery models. System plans will be created to address expected gaps in workforce provision. Our primary care workforce will be embedded throughout our ICS governance and leadership to influence and support system planning.

Background

- We have a Primary Care workforce crisis and we need to determine how the C&M system can support the workforce challenge. We need to understand the current situation, map ahead to forecast our likely future state and plan for any expected gaps.
- Four key enablers for action derived from the NHS People Plan have been identified to cultivate the landscape for a one workforce / whole systems approach to primary care workforce resilience; Looking after our people, belonging in the NHS, growing for the future and new ways of working and delivering care.
- There needs to be identified funding to support the role of PCN Lead Pharmacists as a distinct and identified role to support transformation and joint working cross sector. This funding is required to support the delivery of the role in coordinating and designing services at PCN level and for clinical and professional development.
- HEE have developed and will shortly publish the Community Pharmacy Workforce Survey. The ICBs workforce group should respond to the findings when published as to the impact of the workforce issues in the N West and specifically C&M
- Utilisation of the whole of the primary care workforce by utilising pharmacy professionals in all settings to improve access. Create opportunities via direct referral for patients and patient education / promotion re ability for patients to attend a pharmacy for an intervention to improve access, utilising existing opportunities for GPCPCS, Hypertension and Contraceptive services and building on this with national commissioning developments e.g common conditions service.
- Maximise the clinical skills of the community pharmacy workforce to help address. This may also reduce the shift of roles from community pharmacy to PCN and therefore help stem the flow of professionals out of community pharmacy. More use of rotational / split roles so people do not move away from one discipline of pharmacy but can flex back and forth. We need to acknowledge and help towards the recruitment / retention crisis within Community Pharmacy at present which has significant cost implications on primary care delivery.
- Consider a shared continuity plan to share pharmacy staff resources for the greater good of primary care services rather than resorting to knee-jerk reactions and panic. Utilise and train the whole workforce to work cross-sector so we have a workforce that can deliver without much notice.
- Utilisation of independent pharmacist prescribers – from 2025 every pharmacy graduate will have a prescribing qualification and we will need to capitali9se on this opportunity to support patients in a non traditional manner.
- Participation in the ICB in the National pathfinder for CPIPs will support local development of services that can utilise this skill and support PCN clinical priorities.
- Joint training between sectors to allow multiple primary care settings to be able to provide services to patients. Backfill for pharmacy teams to be able to leave the pharmacy for daytime events. So PCN/ practice pharmacists learning with community pharmacists. Standardised training approach across all healthcare sectors. Or HEE to standardise/assure the relevant training providers (CPPE RCGP…) so these can be recognised in other settings. Could include joint events with other primary care colleagues to stimulate collaboration and support integration as part of resourced protected learning time.

Fuller Framework Action Point #6

Embed primary care workforce as an integral part of system thinking, planning and delivery. Improve workforce data. Support innovative employment models and adoption of NHS terms and conditions. Support the development of training and supervision, recruitment and retention and increased participation of the workforce, including GPs.

2.10 System level actions

Workforce and Organisational Development - Community Pharmacy

Same as GP 1.7.1	A system level primary care workforce plan including future delivery models will be co-produced and based upon accurate primary care workforce data analytics and activity modelling.
Same as GP 1.7.1	Targeted recruitment campaigns will be developed including promoting C&M as an attractive place to work with consideration being given to portfolio ways of working including all sectors of pharmacy and opportunity for "portfolio" employment cross sector.
Same as GP 1.7.2	Develop flexible working practices for primary care staff, including more joint roles and opportunities for rotational roles. Enable the flexible deployment of staff across employing organisation, network & system boundaries using digital solutions. Develop a collaborative primary care staff bank to increase capacity across primary care and create a new offer for local GPs / nurses / pharmacists etc wanting to work flexibly.
Same as GP 1.7.3	Embed the primary care workforce throughout the ICS governance and leadership applying the CCPL framework.
Same as GP 1.7.1	We have the strategic intent to continue with PLTs for GP practices and for get out from it what practices really need.. This PLT could be extended to other primary care professionals including CPs to support and encourage joint working and education.
Same as GP 1.7.4	We will establish clear links with regional and national education and training organisations to support primary care workforce development. This will include close working with the Training Hub to develop training that can be delivered jointly to all sectors
Same as GP 1.7.5	Build PCN clinical leadership capability to drive transformation and innovation across primary care.
Same as GP 1.7.5	Provide Clinical Leadership Coaching to all sectors of primary Care—supporting and developing the Role of the PCN Lead Pharmacist

2.10 Actions for Place based plans

Workforce and Organisational Development - Community Pharmacy

Same as GP 1.7.6 & 7	Develop Place primary care workforce plans including understanding the current place situation, required future models and plans for addressing gaps.
	Support PCNs in developing their clinical, workforce and OD strategies for how they can best use ARRS staff. Including how they work well with other clinicians in their vicinity e.g community pharmacists and dentists
Same as GP 1.7.8 & 9	Embed the primary care workforce throughout Place governance and leadership including cross sector working to resolve gaps
	Primary care networks and their staff will be supported with clear OD and professional development opportunities.
Same as GP 1.7.10	Embed principles of Equality, Diversity and Inclusion in all workforce programmes
Same as GP 1.7.11	Work collaboratively with ICS workforce and OD leads to progress the 4 themes of the C&M People Plan and associated primary care focussed actions across PCNs.
	Work to ensure that all primary care staff are informed as to how other staff work and what their role is in supporting patients across the primary care offer whatever sector they work in

Ref	System level actions	Time	GP	CP	Den	Opt
Commissioning, contracting and funding						
1.1.1	Explore and outline how future monetary allocations will be distributed	2yrs	✓	✓		
1.1.2	Explore different funding models (such as the John Hopkins)	2yrs	✓			
1.1.3	Lobby central NHSE team re need for increased funding to Primary Care via contract	1yr	✓	✓		
1.1.4	An innovative contracting at scale pilot to be performed	3yrs	✓			
1.1.5	Review core and non-core General Practice spending. Produce a plan describing how we will reduce this variation	1-2 yrs	✓			
1.1.6	Consider pilot of gain sharing	3yrs	✓			
2.1.1	The ICB will continue to work with the National pharmacy Integration fund to explore opportunities for trans-formation of CP services and development of new innovative clinical CP services.	Every yr		✓		
Population health and health inequalities						
1.2.1	Close working with Public Health teams to understand population need as well as system level integration, communication and support for PCNs to succeed.	2yrs	✓			
1.2.2	The ICB will support the Deep End Cheshire and Merseyside initiative	2yrs	✓			
1.2.3	Develop a criteria for resource allocation based on population need and health inequality data.	3yrs	✓	✓		
1.2.4	Consider system projects to develop using health inequalities funding	2yrs	✓			
1.2.5	ICB will facilitate sharing of best practice in relation to tackling health inequalities across the ICS footprint	2yrs	✓	✓		
Improving Access						
1.3.1	See increased satisfaction on GP Patient Survey regarding access indicators	Every year	✓			
1.3.2	Work with media to promote GP & CP access routes and inform about multidisciplinary care	1yr	✓	✓		
1.3.3	BI modelling to allow real time data on appointment activity, demand and capacity,	1yr	✓	✓		
1.3.4	The ICB will support Place and PCNs with the NHSE Primary Care Access Recovery Plan	1yr	✓			
1.3.5	The ICB will run a series of workshops around access to share best practice and explore alternative models of access into surgery e.g. Access workshop series, action learning sets, University of Manchester model of access	1yr	✓			

Ref	System level actions	Time	GP	CP	Den	Opt
1.3.6	Undertake a telephony review across PCNs and support the adoption of digital telephony	1yr	✓			
1.3.7	Improve access, triage and referral across first-contact NHS organisations including general practice	2yr	✓			
2.3.3	Practice websites to reflect the Pharmacy First message and information on Minor Ailments and the Self Care agenda.	2yr		✓		
2.3.4	Utilisation of the Recovery and Access plans to capture the planned innovation in Community Pharmacy for year 5 of the Contractual Settlement in line with the announcements made as part Empowering patients workstream to increase delivery of key Community Pharmacy services. Innovate IT to support booking and referral as well as increased clinical information sharing with CPs to support Community Pharmacy clinical services. Commissioning of the Common Conditions Service, a PGD led service to support 7 key common conditions at first point of contact and reduce requirements for Community Pharmacists to send patients to GP for prescription only medicines.	1yr		✓		
Quality, performance, assurance and safety						
1.4.1	The ICB will produce a single dashboard bringing together relevant metrics describing GP quality and performance	2yr	✓	✓		
1.4.2	The ICB will provide data for assurance to the System Quality and Performance Committee	1yr	✓			
2.5.1	The ICB will work through the PSRC using regulatory mechanisms to monitor and support Community pharmacy Contractual delivery and quality	1yr		✓		
2.5.2	ICB recognises that elements of the national Community Pharmacy service are dependant upon referrals from other parts of the system, this will need consideration when looking at the above metrics	ongoing		✓		
Role of General Practice / Community Pharmacy						
1.5.1	Within 1 year ICB to articulate a clear vision for the role of General Practice	1yr	✓			
1.5.2	ICB to identify key pathways where clarity is required regarding responsibilities.	2yrs	✓			
1.5.3	Deliver the 'Cutting Bureaucracy' element of the Primary Care Access Recovery Plan	1yr	✓			
2.4.1	ICB to identify key pathways where Community Pharmacy can support patients within the ICB or PCN structures and offer of clinical service	2yr		✓		
2.4.2	Within 1 year ICB to articulate a clear vision for Community Pharmacy	1yr		✓		
2.4.3	The ICB, as part of it's elective recovery programme, will ensure Trusts are engaging with all services that can support patients with interface between secondary and primary care including CP services e.g. DMS and Smoking Cessation Service	1yr		✓		
2.4.4	Consider developing an interface document descrbing interactions between Primary Care providers.	2yr	✓	✓		

Ref	System level actions	Time	GP	CP	Den	Opt
Integration and Partnerships						
1.6.1	Report progress on the Primary Secondary Care Interface to the ICB board	6mth	✓			
1.6.2	Support Place and PCNs to evolve into something fully inclusive of all components in Primary Care and integrated within the community	3yr	✓	✓		
1.6.3	We commit to the nurturing and development of PCN leaders and to describe their role in the future clinical leadership of the ICS	2yr	✓			
1.6.4	Consider developing a reporting tool for GPs to report inappropriate workload transfer	2yr	✓			
1.6.5	To provide proactive support for the Consensus on the Primary secondary Care Interface	1yr	✓			
1.6.6	The ICB to develop an ICB medicines management target operating model	2yr	✓			
1.6.7	Engage with the voluntary sector to encourage true partnership working at all levels	3yr	✓	✓		
2.6.1	Report progress on the interface across a PCN between providers including GP Practice, CP and Dentistry to the ICB Board *(aligned to GP recovery plan action point 12)*	1yr		✓		
2.6.2	To provide clarity on the role and function of primary care providers and how they work together to deliver a primary care offer to patients	2yr		✓		
2.6.3	The ICB to develop an ICB medicines management target operating model and develop how this model will interact with Community pharmacy	2yr		✓		
2.6.4	Increasing GP practices use in 4 specific areas of the NHS Community Pharmacy Advanced Services; 1) **The Community Pharmacist Consultation Service** (GP-CPCS) 2) **The Community Pharmacy Hypertension case-finding service** (clinic checks and ABPM referrals) 3) **The Pharmacy Contraception Service** 4) **The NHS Discharge Medicines Service (DMS)** That requires; • ICB enhanced deployment for GP-CPCS (see below) • ICB targets for referrals in to CP services e.g blood pressure (clinic check and ABPM) referrals per 1,000 population per practice • Direct booking for patients for all CP Clinical Services—National Development expected early 2024 • Full roll-out of the new NHS CP contraception service	1yr		✓		

Ref	System level actions	Time	GP	CP	Den	Opt
2.6.5	Enhanced deployment of the NHS Discharge Medicines Service (DMS) and Smoking Cessation Service to maximise hospital utilisation ICB support includes; ICB to support Trusts with high level influence regarding utilisation of these services from trust at management / Chief Pharmacist Level Support for Trust to Trust peer support and learning Full uses of 0.2 FTE DMS Champion funding KPIs for Trust in line with CQUIN	1yr		✓		
2.6.6	Increasing pharmacy participation in the Community Pharmacy Consultation Service, Hypertension case finding Service and Contraception Service - increasing referral rates / routes of referral ICB wide CP PGD based MAS scheme to overlay with GP-CPCS PCN focus on levels of service referrals per 1,000 population per practice. Training and implementation support for expansion of services via referrals from practice / supporting practice staff on who /when to refer and what the service will deliver for the patients. Support for implementation of National Common Conditions Service and Locally Commissioned Minor Ailments service to increase resolution of CPCS referral for patient in single point of care. Roll out of UEC referral in to CPCS	2yr		✓		
Workforce and Organisational Development						
1.7.1	Co-produce a system level primary care workforce plan	1yr	✓			
1.7.2	Targeted recruitment campaigns will be developed including promoting C&M as an attractive place to work	2yrs	✓			
1.7.3	Consider the feasibility of developing C&M recruitment incentive schemes	1-2yr	✓			
1.7.4	Consider developing flexible working practices for primary care staff,	3yr	✓			
1.7.5	Consider the development of a collaborative primary care staff bank	1yr	✓			
1.7.6	Embed the primary care workforce throughout the ICS governance and leadership	1yr	✓			

Ref	System level actions	Time	GP	CP	Den	Opt
1.7.7	Continue with PLTs for GP practices and for get out from it what practices really need.					
1.7.8	Establish clear links with education and training organisations	1yr	✓			
1.7.9	Build PCN clinical leadership capability to drive transformation and innovation across primary care.	3yr	✓			
1.7.10	Encourage a multi-professional approach to leadership development including Practice Nurses and other professionals.	2yr	✓			
1.7.11	Provide Clinical Leadership Coaching.	3yr	✓			
1.7.12	Consider process to allow GP partners to operate as Limited Liability Partnerships or other similar models	1yr	✓			
Infrastructure and Intelligence						
1.8.1	Access to reliable and fit for purpose devices for every member of primary care staff that needs them	1yr	✓	✓		
1.8.2	Access to reliable, seamless and secure network infrastructure across all sites	1yr	✓	✓		
1.8.3	Clinical systems that are reliable, responsive, meet clinical requirements safely and seamlessly connected to peripheral systems	1yr	✓	✓		
1.8.4	Provide responsive business intelligence to PCNs and practices	2yr	✓			
1.8.5	Primary Care clinical systems connected with the Place based (where available) and system wide shared care record	3yr	✓	✓		
1.8.6	Functionality of primary care based patient engagement portals accessible via NHS App	2yr	✓	✓		
1.8.7	Integration with patient communication systems to allow two-way communication and messaging (asynchronous communication).	1yr	✓	✓		
1.8.8	Increased rollout of remote monitoring to support improved long term condition management in primary care (e.g. hypertension).	2yr	✓	✓		
1.8.9	Hardware and software to allow online and video consultation using a system wide standard digital platform.	1yr	✓			
1.8.10	Increasing digital inclusion to ensure that as service provision becomes more digitised, more people are able to experience the benefit of digital investment in their health and care services and no-one experiences any reduction in access to services.	3yr	✓	✓		
1.8.11	Align Primary Care Digital provision with ICB net zero / sustainability strategy	2yr	✓			
1.8.12	Strategic alignment with Primary Care solutions for patients	3yr	✓	✓		

Ref	System level actions	Time	GP	CP	Den	Opt
1.8.13	Provision of standard Digital support provision, providing effective Incident resolution of ICB locally commissioned services	2yr	✓	✓		
1.8.14	Support Practices / PCNs with contract and service provision advice as part of PCN Digital development ambitions.	2yr	✓			
1.8.15	Provide contract and supplier management of underpinning ICB Digital Primary Care Commissioned contracts	2yr	✓	✓		
1.8.16	Provide support for Practice merger as required as part of PCN Estates considerations	1yr	✓			
1.8.17	Co-ordinate Digital Bids to support Estates expansion and PCN working hub models and provision of Digital initiatives.	1yr	✓			
1.8.18	Scope available capital funding streams for C&M, understanding access routes and communicate funding opportunities to place when they become available.	2yr	✓	✓		
2.7.1	ICB to support the community pharmacy strategic planning and delivery with contract and service provision advice as part of PCN Digital development ambitions.	2yr		✓		
2.7.2	Opportunity to commission digital infrastructure as ICB giving an economy of scale rather than each place managing a smaller contract—potentially 9 contracts across C&M footprint. This would also support harmonisation and equity of approach.	3yr		✓		
2.7.3	Support for National roll out of an integrated referral and booking pathway between General practice and CP	2yr		✓		
2.7.4	Roll out of Shared care records and enhanced access to clinical records for community pharmacies to support delivery of clinical services in the CP setting	3yr		✓		
2.7.5	Ensure access to additional content within patients GP records to include test results and patient observations	2yr		✓		
2.7.6	Sending of structured content back to patients GP records following a pharmacy consultation (e.g. meds supplied via PGD)	2yr		✓		
2.7.7	Incorporation of CP Digital plans into ICB digital strategy	2yr		✓		
Working with Patients						
1.9.3	Bring together our Primary Care engagement groups (PPGs, PCNs, Neighbourhoods, Care Communities) together to share best practice and ideas.	1yr	✓	✓		

Ref	System level actions	Time	GP	CP	Den	Opt
1.9.4	We will bring the Primary Care engagement groups together for this Exchange with the following aims: • Provide an update on Primary Care engagement across the ICB • Provide best practice examples of how Primary Care engagement has worked well in practice • Allow an open space to better understand how you, our local patients want to work with us	1yr	✓	✓		
2.8.1	Enable the expansion of self-referral pathways by September 2023 to include the new offer of the Common conditions Service and referral via GP CPCS and also in to Community Pharmacy services for Hypertension and Contraception. (Aligned to GP Recovery Plan Actions 3 & 4)	1yr		✓		
Research and Innovation						
1.10.1	Deliver support through the new National General Practice Improvement Programme	1yr	✓			
1.10.2	Work with PCN Clinical Directors to develop a proposal to support innovation adoption.	3yr	✓	✓		
1.10.3	Develop system forums where new primary care ideas can be shared	2yr	✓	✓		
1.10.5	The ICB to facilitate conversations with Place and PCNs around at which 'layer' primary care innovation should be focussed; Community/PCN/Place/ICS.	2yr	✓	✓		
1.10.6	Appoint clinical leads for research (inclusive of Primary Care)	1yr	✓	✓		
1.10.7	C&M will become a flagship ICB for Primary Care research and innovation	3yr	✓			
2.9.1	The ICB will continue to work with the national Integration Fund for Pharmacy to look at opportunities to pilot innovative ways of working or new clinical services in Community Pharmacy.	2yr		✓		

Ref	Actions for Place based plans	Time	GP	CP	Den	Opt
Commissioning, contracting and funding						
1.1.7	Develop local commissioning models that are equitable across place footprints, support the areas of greatest need and deprivation and enable joined up working across disciplines.	2yrs	✓	✓		
1.1.8	Liaise with local authorities around locally commissioned services	2yrs	✓	✓		
1.1.9	Engage practices in the work above around exploring new funding models and variation	2yrs	✓			
2.1.3	Engage practices around opportunities to support patients via referral to CP services that can support their management if minor illnesses and the self care agenda, management of hypertension and access to Contraception.	1yr		✓		
2.1.4	Ensure that plans for commissioning of services include all 4 contractor groups and that CPs are commissioned to deliver services to patients when best suited to do so.	2yr		✓		
Population Health and Health Inequalities						
1.2.6	PCNs to focus on priority prevention/inequalities conditions as per operational planning document: • Increase percentage of patients with **hypertension treated to NICE guidance** to 77% by March 2024 • Increase the percentage of patients aged between 25 and 84 years with a **CVD risk score greater than 20 percent on lipid lowering therapies** to 60% • Continue to address health inequalities and deliver on the **Core20PLUS5** approach as relevant to children and young people and adults. PLUS groups will be determined by each of the 9 local places in C&M.	2yr	✓			
1.2.7	Local areas will require the ability to flex their approach to align with population needs and adequate funding for this work will need to be identified	3yr	✓	✓		
1.2.8	Address health inequalities arising from discrimination based on any protected characteristic	2yr	✓	✓		
1.2.9	Support PCNs with consistent business intelligence/CIPHA to better understand their population health needs	2yr	✓	✓		

Ref	Actions for Place based plans	Time	GP	CP	Den	Opt
1.2.10	Explore how PCNs and practices can work with local system partners to tackle the wider social determinants of ill health, and address health inequalities in line with our All Together Fairer recommendations. **A commitment across primary care to towards delivering population health priorities that include** • smoking cessation, contributing to the SmokeFree 2030 ambition, as part of an overarching whole system strategy and pathway (to be developed) • Digital Weight Management referrals • Targeted NHS health checks- Build on learning from recent pilots to increase uptake of NHS HCs in priority groups with high CVD risk but low levels of engagement in preventative checks (areas of deprivation, ethnic minority groups, patients with SMI and LD) • Increase uptake of annual physical health checks for patients with SMI, building on learning from innovative pilots • **All Together Active**. Supporting implementation of the All Together Active strategy aimed at increasing physical activity as a way of improving population health through GP practises • **Population Health Intelligence**. Utilisation of CIPHA and other tools to underpin, inform and drive a coordinated and sustainable population health management approach targeting the most impactful cohorts for prevention and high impact measures • **Reducing Harm from Alcohol**. Supporting the strategic across Cheshire and Merseyside deliver preventative and treatment interventions that reduce alcohol harm and drug dependency. • **Making Every Contact Count**. Embedding the philosophy of Making Every Contact Count, an approach to behaviour change that maximises the opportunity within routine health and care interactions for a brief discussion on health or wellbeing factors.	1yr	✓	✓		
2.2.1	PCNs to work with CPs on PH campaigns either as part of the national framework of campaigns or via any locally agreed to ensure a cohesive PH message is delivered consistently across stakeholders. The PCN networks can assist in this development.	3yr		✓		
Improving Access						
1.3.8	Explore alternative models of access into Primary Care including digital options	1yr	✓	✓		
1.3.9	Support practices in procuring Cloud Based Telephony	1yr	✓			
1.3.10	Develop BI modelling for activity, demand and capacity	1yr	✓	✓		
1.3.11	Develop a local response to the national Access Recovery Plan	1yr	✓	✓		
2.3.5	Support Practices to understand CP Services and their offer to patients and how this could support the Recovery and Access plans locally.	2yr		✓		
2.3.6	Support Practices to ensure that staff have the training necessary to understand who / how to refer patients in to CPs to ensure the offer of these services is consistent, informs patient pathways where appropriate and opportunities maximised to drive access	2yr		✓		

Ref	Actions for Place based plans	Time	GP	CP	Den	Opt
Quality, performance, assurance and safety						
1.4.3	Support practices with performance or safety issues and escalate to System where required	On-going	✓	✓		
1.4.4	Place to monitor prescribing data and support clinicians with quality prescribing	On-going	✓			
1.4.5	Places to consider educational activities for clinicians to improve quality of care	On-going	✓	✓		
Role of General Practice / Community Pharmacy						
1.5.4	Form local Primary Secondary Care Interface groups around appropriate hospital footprints	1yr	✓	✓		
1.5.5	Encourage job-shadowing of GPs by ICB Place managers as well as secondary care colleagues.	3yrs	✓	✓		
1.5.6	Consider supporting PCNs to introduce ‘continuity leads’	2yrs	✓			
Integration and Partnerships						
1.6.8	Clearly articulate what is being asked of PCNs against what is being asked of General Practice	1yr	✓			
1.6.9	Support practices in identifying service areas where they can work together	2yr	✓	✓		
1.6.10	Support PCNs to develop a model of health care delivery that is proactive rather than reactive.	3yr	✓	✓		
1.6.11	Develop joined up care pathways and consider multidisciplinary ‘one stop shop’ clinics	2yr	✓	✓		
1.6.12	Explore the possibility of shared contracts to enable partners to work better together	3yr	✓			
1.6.13	Encourage ongoing development of Care Communities/Neighbourhood teams	2yr	✓	✓		
1.6.15	Implement the ICB medicines management target operating model across Place when agreed	1yr	✓	✓		
1.6.16	Encourage neighbourhoods to engage with local voluntary sector organisations to bring about full partnership working within communities	3yr	✓			
2.6.7	Clearly articulate what is being asked of PCNs against what is being asked of individual providers	1yr		✓		
2.6.8	Exploring the possibility of shared contracts to enable partners to work better together—explore cross sector working for pharmacists to increase joint working and employment satisfaction - portfolio working	3yr		✓		

Ref	Actions for Place based plans	Time	GP	CP	Den	Opt
2.6.9	Develop Place primary care workforce plans including understanding the current place situation, required future models and plans for addressing gaps. In engagement with CP services and referrals in to CP Services.	2yr		✓		
2.6.10	Work with PCN Lead Pharmacists and LPC locally to understand and maximise local opportunity with cross sector working—establish patient pathways that maximise referral and direct patients in to appropriate services.	2yr		✓		
Workforce and Organisational Development						
1.7.13	Develop Place primary care workforce plans	1yr	✓	✓		
1.7.14	Support PCNs in developing their clinical, workforce and OD strategies for ARRS staff.	1yr	✓	✓		
1.7.15	Embed the primary care workforce throughout Place governance and leadership	1yr	✓			
1.7.16	Support PCNs and their staff with clear OD and professional development opportunities.	3yr	✓			
1.7.17	Embed principles of Equality, Diversity and Inclusion in all workforce programmes	On-going	✓	✓		
1.7.18	Work collaboratively with ICS workforce and OD leads to progress the 4 themes of the C&M People Plan and associated primary care focussed actions across PCNs.	2yrs	✓	✓		
Infrastructure and Intelligence						
1.8.19	Embed system wide online/video consultation platform across PCNs	1yr	✓			
1.8.20	Support all practices on analogue lines to move to digital and cloud based telephony, including call back functionality. - *aligned with GP recovery plan action point 5*	1yr	✓			
1.8.21	Provide all practices with the digital tools and care navigation training for Modern General Practice Access. - *aligned with GP recovery plan action point 6*	1yr	✓			
1.8.22	Improve utilisation ICB wide tools such as Ardens and the ORCHA app library	1yr	✓			
1.8.23	Review LTC management plans to increase utilisation of remote monitoring	2yr	✓	✓		
1.8.24	Access to and utilisation of Place based shared care record where this exists	3yr	✓	✓		
1.8.25	Develop investment plans for 'levelling up' digital maturity infrastructure at place level	2yr	✓	✓		

Ref	Actions for Place based plans	Time	GP	CP	Den	Opt
1.8.26	Work with local authority colleagues at Place to develop a digital inclusion plan	2yr	✓	✓		
1.8.27	Develop plans to utilise the whole of the available place primary care estate, supporting increased access	2yr	✓			
1.8.28	Provide support to explore estate within local stakeholders e.g. One Public Estate	3yr	✓			
1.8.29	Develop plans to ensure that there is estate available for ARRS staff across general practice.	2yr	✓			
1.8.30	Review the PCN Service and Estate Planning Toolkit responses to develop place based clinical and estates strategies.	1yr	✓	✓		
2.7.1	Provide all practices with the digital tools and care navigation training for Modern General Practice Access. Highlighting opportunities for increased access via triaging of patients in to local services and the digital solutions to support these referrals. (Aligned to GP Recovery Plan Action 6)	1yr		✓		
2.7.2	Develop Place primary care workforce plans including understanding the current place situation, required future models and plans for addressing gaps. In engagement with CP services and referrals in to CP Services.	2yr		✓		
2.7.3	Support Practice based staff to understand referral mechanism and when / how to use to support patients to access services	1yr		✓		
2.7.4	Work with PCN Lead Pharmacists and LPC locally to understand and maximise local opportunity with cross sector working—establish patient pathways that maximise referral and direct patients in to appropriate services.	2yr		✓		
Working with Patients						
1.9.5	Enable patients in over 90% of practices to see their records and practice messages, book appointments and order repeat prescriptions using the NHS App by March 2024. *Aligned to GP recovery plan action point 1*	1yr	✓			
1.9.6	Enable the expansion of self-referral pathways. *Aligned to GP recovery plan action point 2*	2yr	✓			
1.9.7	Co-Design with Health Watch the development of communication messages and methods that the public can understand.	1yr	✓	✓		
1.9.8	Local engagement with print media to encourage positive GP stories	1yr	✓	✓		
1.9.9	Ensure proactive care @ home programmes is flourishing within Places including BP@Home	1yr	✓	✓		

Ref	Actions for Place based plans	Time	GP	CP	Den	Opt
1.9.10	Leverage the power of local clinicians producing content for the public regarding self care	2yr	✓	✓		
1.9.11	Create a space for PPG support information at a place level that has been designed for that area.	2yr	✓	✓		
1.9.12	Engage with clinical leads about their requirements for training and support on communications and engagement for primary care teams from the ICB	1yr	✓			
1.9.13	Develop specific training/ masterclasses to support PCNs understand of their duty to involve, including case studies	3yr	✓			
1.9.14	Support and facilitate place partnerships in their development of their communication and empowerment collaborations, ensuring PCNs are an equal partner	2yr	✓	✓		
Research and Innovation						
1.10.8	Support primary care services in delivering new and innovative services that previously may have been provided elsewhere	2yr	✓			
1.10.9	Enable shared decision making for innovation adoption with 'bottom up' development rather than 'top down' instruction .	2yr	✓			
1.10.10	Build collaboration between primary and secondary care to develop new cross-discipline services	2yr	✓			
1.10.11	Consideration of whole of primary care when developing new services to improve access to patients and utilisation of the whole primary care workforce.	3yr	✓			
1.10.12	Consider creation of a standardised locally commissioned services framework	2yr	✓			
1.10.13	Care communities and Place working to ensure that patients do not slip between the gaps between services and work to streamline care across the health and care system.	3yr	✓			
2.9.1	Build collaboration between primary and secondary care to develop new cross-discipline services beyond CPCF and IIF which support the shift of patient care out of hospital and support ICS priorities. Utilise existing services to support patients with discharge including the Discharge Meds Service and Stop Smoking	2yr		✓		