NHS
Cheshire and Merseyside

Meeting of the Cheshire & Merseyside ICB System Primary Care Committee

Part B – Public Meeting

Thursday 17 April 2025
Venue: Meeting Room 1, No 1 Lakeside,
920 Centre Park Square, Warrington,
WA1 1QY (WA1 1QA for SatNav)

Timing: 09:30-12:30

Agenda (V2) *issued 16.04.25*

Chair: Erica Morris

AGENDA NO & TIME	ITEM	LEAD	ACTION / PURPOSE	PAGE No
09:30am	**Preliminary Business**			
SPCC 25/04/B01	**Welcome, Introductions and Apologies**	Chair	Verbal	-
SPCC 25/04/B02	**Declarations of Interest**	Chair	Verbal	-
SPCC 25/04/B03	**Questions from the public (TBC)**	Chair	Verbal	-
09:35am	**Committee Business, risk and governance**			
SPCC 25/04/B04	**Primary Care Risk Report**	Dawn Boyer	Paper To approve	**Page 4** *Click here for link to page*
09:45 **SPCC 25/04/B05**	**Minutes of the last meeting (Part B)** 20 February 2025	Chair	Paper For info	**Page 14** *Click here for link to page*
09:55 **SPCC 25/04/B06**	**Action Log of last meeting (Part B)** 20 February 2024	Chair	Paper To note	**Page 25** *Click here for link to page*
10:05 **SPCC 25/04/B07**	**Forward Planner**	Chris Leese	Paper To note	**Page 27** *Click here for link to page*

AGENDA NO & TIME	ITEM	LEAD	ACTION / PURPOSE	PAGE No
10:15am	**BAU and Operations**			
SPCC 25/04/B08	**Contractor Operations Updates** i) **Issues for awareness**	Clare Watson / All	Verbal	-
	ii) **Update from LGPN**	TBC	Verbal	-
	iii) **Feedback from Primary Care Forum**	TBC	Verbal	-
10:30am	**Contracting, Commissioning and Policy Update(s)**			
SPCC 25/04/B09	i) **Dental and Community Pharmacy**	Chris Leese	Paper To note	**Page 28** *Click here for link to page*
	ii) **Optometry and Primary Care Medical**	Chris Leese	Paper To note	**Page 47** *Click here for link to page*
10:45am	**Access Improvement**			
SPCC 25/04/B10	**Healthwatch – General Practice Access survey results**	Louise Barry	Presentation For Info	**Tabled on day**
10:55 **SPCC 25/04/B11**	**Operational Planning Guidance – Access Improvement Oversight (Primary Medical) 25/26**	Chris Leese	Paper For Info	**Page 58** *click here for link to page*
11:10am	**Finance**			
SPCC 25/04/B12	**Finance Update**	John Adams / Lorraine Weekes Bailey	*Paper* To note	**Page 72** *Click here for link to page*
11:20 **SPCC 25/04/B13**	**General Practice Capital Allocation 2025/2026 – Estates and Digital**	Pauline Underwood / Kevin Highfield	Paper For Approval	**Page 83** *Click here for link to page*

AGENDA NO & TIME	ITEM	LEAD	ACTION / PURPOSE	PAGE No
11:35am	**Quality and Performance**			
SPCC 25/04/B14	**Freedom to Speak up**	Chris Douglas	Paper To note & Support	**Page 108** *Click here for link to page*
11:45pm	**Transformation**			
SPCC 25/04/B15	**Digital – Shared Care (Connected Care records)**	Cathy Fox / Lesley Kitchen	Presentatation on day For Info	-
12:05 **SPCC 25/04/B16**	**Update from Primary Care Workforce Steering Group**	Chris Leese	Paper For Info	**Page 129** *Click here for link to page*
12:20pm	**CLOSE OF MEETING**			

Date and time of next regular meeting:
Thursday 19 June 2025 (09:00-12:30)

F2F, Lakeside, Warrington

NHS
Cheshire and Merseyside

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

Date: 17 April 2025

Committee Risk Report

Agenda Item No: SPCC 25/04/B04

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

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Committee Risk Report

1. Purpose of the Report

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

2. Executive Summary

2.1 As reported in February, the primary care risks, oversight and reporting arrangements are under review. A workshop has been held to develop risks based on agreed key strategic objectives and risk themes applicable across the 4 contractor groups. The outcome of this work forms the basis of this report, which includes proposals to create new risks and to close existing risks.

2.2 The report proposes the creation of 22 new corporate risks, comprising 9 risks applying across some or all of the 4 contractor groups, listed in appendix one and summarised below:

- GP primary care – 9 risks including patient experience, collective action, patient safety, workforce, financial, estates and neighbourhood working
- Dental services – 6 risks including patient experience, workforce, financial and estates
- Community pharmacy – 6 risks including patient experience, collective action, workforce, financial and estates
- Ophthalmology – 1 risk relating to workforce

2.3 Inherent risk scores, reflecting the position before the ICB takes action to control the risk, have been assessed for 12 of the risks with 1 rated as extreme (15+), 10 high (8-12) and 1 moderate. It is likely that current scores reflecting controls already in place would be lower for some of these risks. Discussions are taking place with colleagues in other directorates to support the assessment of the risks in relation to finance and estates.

2.4 As a result of the review, it is proposed that the following risks which are subsumed into the proposed new risks are closed:

- 1PC - Sustainability and Resilience of Primary Care workforce (General Practice, Community Pharmacy & General Dental Services), currently rated as extreme (16)
- 8PC - Potential Collective Action and GPs working to contract only in response to the 24/25 Contract Offer, impacting on patient care and access to services, currently rated as extreme (15)

2.5 There are currently 3 place risks in common and 9 unique place risks escalated in accordance with the Risk Management Strategy (scoring high+), all relating to GP primary care. It is considered that all of the in common risks and potentially some of the unique place risks are covered by the new risks proposed. Further

discussion will take place with place primary care leads to seek a consistent approach to describing and managing these risks.

2.6 The quarter 4 reviews of BAF risks, including P6 - Demand continues to exceed available capacity in primary care, exacerbating health inequalities and equity of access for our population, are currently underway. This will include consideration of whether to propose continuation, amendment, or de-escalation from the BAF in 2025-26, which would be subject to a decision and approval by the Board.

3. Ask of the Committee and Recommendations

3.1 **The Committee is asked to:**

3.1.1 **APPROVE** the creation of 9 new risks for GP primary care, PG1-9 listed in appendix one
3.1.2 **APPROVE** the creation of 5 new risks for dental services, PD1 and PD3-6 listed in appendix one
3.1.3 **APPROVE** the creation of 6 new risks for community pharmacy, PP1-6 listed in appendix one
3.1.4 **APPROVE** the creation of 1 new risk for ophthalmology, PO1 listed in appendix one
3.1.5 **APPROVE** the closure of risks 1PC and 8PC
3.1.6 **NOTE** the work proposed to complete detailed assessments for new risks, subject to approval by the committee, and proposed arrangements for reporting and assurance which will be brought to the next meeting

4. Reasons for Recommendations

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

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

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

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

4.4 A review of the primary care risks, oversight and reporting arrangements was agreed following discussion at the October meeting of the Primary Care Committee. The Committee Chair and Lead Officers agreed on key strategic objectives and risk themes applicable across the 4 contractor groups, and the new risks proposed in this report have been developed based on these.

5. Background

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

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

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

Implications and Comments

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

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

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

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

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

8. Link to meeting CQC ICS Themes and Quality Statements

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

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

9. Risks

9.1 The review of primary care risks has resulted in the identification of 9 risks, based on the key strategic objectives and risk themes agreed by the Committee Chair and Lead Officers. The risks have been applied to each of the 4 contractor groups as appropriate based on the ICB's responsibilities in relation to each group and the current risk environment.

9.2 The risks identified and their application to each contractor group are:

- **Patient Experience** - Experience of access is not improving potentially impacting on overall health and wellbeing and increasing demand on other services (GP, Dental, Pharmacy)
- **Collective Action** - Collective action by contracted providers may lead to poor patient experience impacting on quality and trust and confidence in the ICB (GP, Pharmacy)
- **Patient Safety** - Workforce capacity constraints may result in a rise in patient safety incidents, impact on access and increase pressure on other staff (GP)
- **Workforce** - Inability to recruit and retain primary care workforce may curtail or delay access improvement plan success, impacting on quality and increasing pressure on remaining staff (GP, Dental, Ophthalmology)
- **Financial Sustainability** - Reduction in financial sustainability of contracted providers may lead to closures and reduced capacity impacting on quality and trust and confidence in the ICB (GP, Dental, Pharmacy)
- **Capital Funding** - Reduction in capital development funding may curtail or delay access improvement plans impacting on quality and trust and confidence in the ICB (GP, Dental, Pharmacy)
- **Financial Constraints** - ICB financial constraints may limit funding available to deliver strategic aims plans impacting on quality and trust and confidence in the ICB (GP, Dental, Pharmacy)
- **Estates** - Primary care estates capacity constraints may curtail or delay access improvement plans impacting on quality and trust and confidence in the ICB (GP, Dental, Pharmacy)
- **Neighbourhood** - Delivery of the national transformation policy for primary care in relation to neighbourhood working may impact on access, integration, poorer/unequal patient experience and ICB reputation (GP)

9.3 Although workforce has been identified as a risk in relation to dental services, this has been assessed as moderate (6) with only a minor potential impact. It is therefore proposed that this risk is tolerated with no further action required. This should be kept under review and could be reactivated should there be a change in the situation.

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

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

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

9 Finance

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

10 Communication and Engagement

11.1 No patient and public engagement has been undertaken.

11 Equality, Diversity and Inclusion

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

12 Climate Change / Sustainability

13.1 No identified impacts.

14 Next Steps and Responsible Person to take forward

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

14.2 In respect of GP primary care risks a meeting with place primary care leads is proposed to discuss the development of a consistent approach to describing and managing such risks and assigning ownership.

14.3 The completed risk assessments, together with proposals for oversight, assurance and reporting arrangements will be brought to the June meeting of the Committee for approval. Reporting to Committee Sub-Groups will

commence following approval, supported by a briefing on Sub-Groups responsibilities at the initial meeting.

15 Officer contact details for more information

Dawn Boyer
Head of Corporate Affairs & Governance
NHS Cheshire and Merseyside ICB
dawn.boyer@cheshireandmerseyside.nhs.uk

16 Appendices

Appendix One: Risk Register

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

Risk ID	Risk Title	Senior Responsible Owner	Inherent Risk Score	Current Risk Score	Previous Risk Score	Target Score	Risk Proximity
All Contractor Groups							
P6 (BAF)	Demand continues to exceed available capacity in primary care, exacerbating health inequalities and equity of access for our population	Clare Watson	**20**	**12**	**12**	12	A – within 3 months
1PC	Sustainability and Resilience of Primary Care workforce (General Practice, Community Pharmacy & General Dental Services) **RECOMMENDED FOR CLOSURE**	Chris Lees/ Tom Knight	**16**	**16**	**16**	9	A – within 3 months
GP Primary Care							
PG1	Experience of GP primary care access is not improving potentially impacting on overall health and wellbeing and increasing demand on other services	Chris Lees	**12**	**TBC**	**NEW**	TBC	TBC
PG2	Collective action by GP primary care providers may lead to poor patient experience impacting on quality and trust and confidence in the ICB	Chris Lees	**12**	**TBC**	**NEW**	TBC	TBC
PG3	GP primary care workforce capacity constraints may result in a rise in patient safety incidents	Chris Lees	**12**	**TBC**	**NEW**	TBC	TBC
PG4	Inability to recruit and retain GP primary care workforce may curtail or delay access improvement plan success, impacting on quality and increasing pressure on remaining staff	Chris Lees	**12**	**TBC**	**NEW**	TBC	TBC
PG5	Reduction in financial sustainability of GP primary care providers may lead to closures and reduced capacity impacting on quality and trust and confidence in the ICB	Chris Lees	**16**	**TBC**	**NEW**	TBC	TBC
PG6	Reduction in capital development funding may curtail or delay GP primary care access improvement plans impacting on quality and trust and confidence in the ICB	John Adams	**TBC**	**TBC**	**NEW**	TBC	TBC
PG7	ICB financial constraints may limit funding available to deliver strategic aims for GP primary care impacting on quality and trust and confidence in the ICB	John Adams	**TBC**	**TBC**	**NEW**	TBC	TBC

PG8	GP primary care estates capacity constraints may curtail or delay access improvement plans impacting on quality and trust and confidence in the ICB	David Cooper	**TBC**	**TBC**	**NEW**	TBC	TBC
PG9	Delivery of the national transformation policy for primary care in relation to neighbourhood working may impact on access, integration, poorer/unequal patient experience and ICB reputation	TBC	**9**	**TBC**	**NEW**	TBC	TBC
8PC	Potential Collective Action and GPs working to contract only in response to the 24/25 Contract Offer, impacting on patient care and access to services **RECOMMENDED FOR CLOSURE**	Chris Lees/ Tom Knight	**15**	**15**	**15**	12	B – within 12 months
13DR	There is a risk that the introduction of new core clinical system suppliers through the GP IT Futures Tech Innovation Framework Early Adopter Programme results in a more fragmented infrastructure and has a negative impact on record sharing	John Llewelyn	**16**	**10**	**12**	2	A – within 3 months
Dental Services							
PD1	Experience of dental services access is not improving potentially impacting on overall health and wellbeing and increasing demand on other services	Tom Knight	**12**	**TBC**	**NEW**	TBC	TBC
PD2	Inability to recruit and retain dental services workforce may curtail or delay access improvement plan success, impacting on quality and increasing pressure on remaining staff **RECOMMEND RISK IS TOLERATED – NO FURTHER ACTION**	Tom Knight	**6**	**TBC**	**NEW**	TBC	TBC
PD3	Reduction in financial sustainability of dental services providers may lead to closures and reduced capacity impacting on quality and trust and confidence in the ICB	Tom Knight	**12**	**TBC**	**NEW**	TBC	TBC
PD4	Reduction in capital development funding may curtail or delay dental services access improvement plans impacting on quality and trust and confidence in the ICB	John Adams	**TBC**	**TBC**	**NEW**	TBC	TBC
PD5	ICB financial constraints may limit funding available to deliver strategic aims for dental services impacting on quality and trust and confidence in the ICB	John Adams	**TBC**	**TBC**	**NEW**	TBC	TBC
PD6	Dental services estates capacity constraints may curtail or delay access improvement plans impacting on quality and trust and confidence in the ICB	David Cooper	**TBC**	**TBC**	**NEW**	TBC	TBC
Community Pharmacy							

PP1	Experience of community pharmacy access is not improving potentially impacting on overall health and wellbeing and increasing demand on other services	Tom Knight	**12**	**TBC**	**NEW**	TBC	TBC
PP2	Collective action by community pharmacy providers may lead to poor patient experience impacting on quality and trust and confidence in the ICB	Tom Knight	**9**	**TBC**	**NEW**	TBC	TBC
PP3	Reduction in financial sustainability of community pharmacy providers may lead to closures and reduced capacity impacting on quality and trust and confidence in the ICB	Tom Knight	**12**	**TBC**	**NEW**	TBC	TBC
PP4	Reduction in capital development funding may curtail or delay community pharmacy access improvement plans impacting on quality and trust and confidence in the ICB	John Adams	**TBC**	**TBC**	**NEW**	TBC	TBC
PP5	ICB financial constraints may limit funding available to deliver strategic aims for community pharmacy impacting on quality and trust and confidence in the ICB	John Adams	**TBC**	**TBC**	**NEW**	TBC	TBC
PP6	Community pharmacy estates capacity constraints may curtail or delay access improvement plans impacting on quality and trust and confidence in the ICB	David Cooper	**TBC**	**TBC**	**NEW**	TBC	TBC
Ophthalmology							
PO1	Inability to recruit and retain ophthalmology workforce may curtail or delay access improvement plan success, impacting on quality and increasing pressure on remaining staff	Chris Lees	**TBC**	**TBC**	**NEW**	TBC	TBC

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

Thursday 20 February 2025
10:00-12:30

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

Unconfirmed Draft Minutes

ATTENDANCE - Membership		
Name	**Initials**	**Role**
Erica Morriss	EMo	*Chair*, Non-Executive Director
Clare Watson	CWa	Assistant Chief Executive, C&M ICB
Tom Knight	TKo	Associate Director of Primary Care, C&M ICB
Louise Barry	LBa	Chief Executive, Healthwatch Cheshire
Fionnuala Stott	FSt	LOC representative
Mark Bakewell	MBa	Interim Director of Finance
Mark Woodger	MWo	LDC representative
Tony Foy	TFo	*Vice-Chair*, Non-Executive Director, C&M ICB
Naomi Rankin	NRa	Primary Care Member for C&M ICB
Chris Haigh	CHa	Deputy Chief Pharmacist, C&M ICB
Chris Leese	CLe	Associate Director of Primary Care, C&M ICB
Adam Irvine	AIr	Primary Care Partner Member
Christine Douglas	CDo	Director of Nursing & Care, C&M ICB
Rowan Pritchard-Jones	RPJ	Executive Medical Director, C&M ICB
Jonathan Griffiths	JGr	Associate Medical Director, C&M ICB
In attendance		
Sally Thorpe	STh	*Minute taker*, Executive Assistant, C&M ICB
Cathy Fox	CFo	Associate Director of Digital Operations, C&M ICB
Rob Barnett *(via Teams)*	RBa	Liverpool LMC representative
Loraine Weekes-Bailey	LWB	Senior Primary Care Accountant
Dawn Boyer	DBo	Head of Corporate Affairs and Governance

Apologies		
Name	**Initials**	**Role**
Anthony Leo	Ale	Place Director, Halton
Daniel Harle	DHa	LMC representative
Matt Harvey	MHa	LPC representative
Susanne Lynch	SLy	Chief Pharmacist, C&M ICB

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Agenda Item, Discussion, Outcomes and Action Points

Preliminary Business

SPCC 25/02/B01 Welcome, Introductions and Apologies

The Chair welcomed everyone to the meeting and respective apologies were noted.

SPCC 25/02/B02 Declarations of Interest

Standing DoI accepted. There were no further declarations.

SP SPCC 25/02/B03 CC 24/12/B03 Questions from the public (TBC)

There were no questions raised in advance of the meeting.

Committee Business, risk and governance

SPCC 25/02/B04 Minutes of the last meeting (Part B) 19 December 2024

The Committee **approved** the Minutes as a true and accurate reflection of the meeting.

SPCC 25/02/B05 Committee Action Log (Part B) 19 December 2024

The Action Log was **noted** and updated accordingly.

SPCC 25/02/B06 Forward Planner

The Committee **noted** the forward planner.

SPCC 25/02/B07 Risk Register

Dawn Boyer presented this item, which covered 16 committee risks including 1 BAF risk delegated by the Board, 3 corporate risks, 3 place risks in common and 9 unique place risks, escalated as scoring high and above in accordance with the Risk Management Strategy.

The report highlighted the two most significant risks, in relation to GP collective action and sustainability and resilience of primary care workforce, which are rated extreme and which are escalated to the Corporate Risk Register.

It was noted that this was an update since the October report, and included the following changes;

- 6PC: Identified dental provider contract management risk potentially leading to loss of provider and impact on general dental provision, recommended for closure as Primary Care Appeals made a decision in the ICBs favour
- 13DR: a risk that the introduction of new core clinical system suppliers through the GP IT Futures Tech Innovation Framework Early Adopter Programme results in a more fragmented infrastructure and has a negative impact on record sharing, has been allocated to this Committee
- Estates risks in relation to general practice meeting the criteria for committee escalation as identified by four Places and therefore deemed a risk in common.

In terms of the ask of the committee, DBo outlined the request to;

- Approve the closure of risk 6PC,
- To note the current position in relation to the risks escalated to the committee,
- To note the review of primary care risks, oversight and reporting arrangements currently underway

JGr outlined that the issues around workforce was still very much important and it is appropriate that these are still referenced and are considered a significant risk.

He added that this was not about more GPs this is about non GPs assuming the roles in general practice, and that due to the changes in the ARRS scheme practices can now employ a non-salaried GP, this has caused a national issue, and along with a lack of significant update to the national contract, it now causes an odd situation, in that we need more GPs but we are facing a GP unemployment crisis at the same

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time. He added that they were doing what they can through the workforce steering group, which covers things like wellbeing and retention schemes.

In terms of Collective Action, JGr stated that they are already seeing a number of practices turning off ScriptSwitch. This will potentially impact in savings not being met which we were relying on to save some prescribing monies.

In terms of Shared Care agreements, it was noted that GPs do not have to take on shared care, and this puts pressure on the hospital to continue with the prescribing, which is currently being absorbed by the hospitals, although it is noted that some are being handed back. Ironically, it is suspected that the hospitals will challenge to say they cannot do this element without extra funding, which is exactly what general practice are saying hence the collection action around this item.

Additionally there is a risk to enhanced services. Cheshire LMC are conducing a review and the conclusion of this work is due next month. At this time it is unclear what the LMC will say on this, and this will leave the ICB with a challenge on the horizon that is getting closer.

RBa stated that there is an issue with shared care across C&M, and that it is across all nine places, where some are paid but not in others.

In terms of Collective action, a lot will depend on what the Secretary of State has in mind later in the month, however it is believed that the situation will escalate. Additionally the LMC have a special conference in mid-March and this may or may not result in more things happening.

The increase on NI and minimum wage will definitely hit general practice as well as other contractors, it is still not known what effect this will have, so there are definitely other issues coming up.

CWa stated that the Shared Care is a known issue and had had a conversation with the LMCs last week, it was noted that this coming year 2025-26 is the year we need to look to 'bite the bullet' and to really look at consistency or lack of consistency across the nine places. However it is important to note that the cost to try to look at consistency comes with a big caveat, in that it is not an automatic *level up*, but to have a baseline and shared understanding. It is known that places have separate budget lines with differentials and there will be a conversation in March with the LMC and the GP network to do a piece of work with others to work on this.

The Committee noted that it was really helpful to have Collective Action on the agenda and to be aware of the other primary care contractors, thanks were given for all the work on this and the associated risks. Having the dental risk highlighted shows positive news and there has been lots of work over the last two years and an extended thanks was given to the dental team who have been a huge support.

CHa stated in terms of pharmacy, they were looking at the context of quality schemes. ScriptSwitch are in active negotiations with that provider and the contracts team to get this resolved as soon as possible. JGr added that the decision to not use ScriptSwitch was not only part of the Collective Action but also because of those working (or non-working) issues.

AIr stated for pharmacy, that there has been no offer for this year but felt that they were on the brink of tipping over, he stated that there has been a ballot to the independent contractors and believe there is a conversation to be held around what offer might be available, the outcome of this will guide the conversations.

It was questioned by LGa as to what impact there was around the Shared Care issue? In response JGr stated that it depended on the situation and gave an example in terms of arthritis and the continued blood monitoring associated with this.

It was also noted that this was about the standardisation of additional contracts in general practice, and that we do need to be careful around the communication of this and to work with the GP forum around the talk of levelling up. This was acknowledged and agreed that this was not about reducing income to general practice but may be about reducing the number of targeted schemes and initiatives.

In conclusion, CWa agreed that this was a conversation to be held collectively and to look to a more strategic and consistent approach.

JGr agreed that this was not also about Collective Action being solely within health, local authorities are also going to field some of this as well, for example some practices will not be prescribing a smoking cessation service, therefore the local authority will feel the pain of this as well.

RPJ added that he had met with the GMC earlier this week and that there is a need to work with general practice to work with and support training and supervision and this will have an implication for the workforce in years. He added that he is profoundly concerned for the people caught up in the debate, for the good of the patients.

The Chair agreed with all the points raised and thanked everyone for their discussion. It was noted that the risk conversation had developed and covered part of the next agenda item therefore it showed how things were interlinked.

Recommendations

- The Committee **approved** the closure of risk 6PC
- **Noted** the current position
- **Noted** the review of primary care risks

BAU Policy Operations

SPCC 25/02/B08 Contractor Operations Updates

JGr gave a verbal update, noting that quite a lot of the discussion had been held as part of the risk item previously.

i) System pressures

General Practice

Noted that this is still Winter, and general practice are still seeing the usual respiratory illnesses. Urgent Care is very 'hot' and we are still experiencing long elective waits.

RBa added that in Liverpool they run a survey of practices, which covers half the population of Liverpool, the survey shows an increase in pressures in general practice and if we were to compare with the hospital status it would be classed as OPEL 2 or OPEL 3.

It was outlined that Liverpool are the only area that have a functioning service to do such a survey. There have been discussions to look to nationally agree to a piece of work to match OPEL status within general practice, however work on that is paused. JGr advised that he is waiting on region liaising with that national piece of work, JGr stated that he would keep an eye on it.

Optometry

FSt advised that it is not just GP practices that have been doing services through goodwill and Optometry have been asked to do things which are not funded so when considering stopping doing these services or funding them it is important to not just do this for one contractor group in isolation. In terms of the risk register co-morbidity is rated as high risk, yet a small CVD Optometry pilot that has received funding has come up against considerable resistance from Gp's. She questioned why contractor groups couldn't help as part of a solution, adding that some work needs to be done with general practice to understand some of the barriers.

In terms of special schools, FSt advised that this really needs an impact assessment, the proposed new specification carries an £85 fee, she added that we need to be very careful of the unintended consequences of not having this and that the impact on this vulnerable group of patients will be huge for a small saving of money.

In response, CLe advised that this was not ICB designed but nationally led, and that there had been some queries raised already regarding this. FSt stated that she understood the complications but these are very vulnerable patients and that it will fail without the right support.

In terms of workforce development, FSt advised that they were going to have about 35 optometrists, who, as part of their qualification (FP10 starting in January 2026) will need to do a placement within a Trust (this is equivalent to 24 sessions per optometrist). She advised that they have requested support from the Trusts and the ICB for their commitment to this programme. She added that whilst the Trusts have given a verbal commitment to facilitate, it would be helpful to have a much more formal agreement. **CWa agreed to have a conversation with FSt outside of SPCC meeting, suggesting that RPJ might be able to write out to the Trust Medical Directors asking for commitment to support.**

It was noted that this would be a supervision ask, so is therefore a resource ask, HEE are coming back to ICBs on this as they do not have the contacts.

NRa added that for pharmacy there are lots of PCNs taking on foundation pharmacists but it is important to note there is a significant clinical input required for these placements and the impact on appointments lost. It was asked to acknowledge that this is not just at Trust level, the impact is also felt at PCN level.

CDo enquired from a nursing and midwifery point of view, it was worth checking on the placement costs. **RPJ and CDo agreed to have a discussion about this as responsibility lies with the Chief Nurse.**

In addition, FSt stated they were ready to roll out the glaucoma enhanced service which will have a significant beneficial impact on primary to secondary care however ,there was a problem identifying a commissioning and contracting lead , it was questioned what we can do about this.

ACTION : FSt to let CLe know which Place this related to so that the relevant Place Commissioner could be advised/ escalated accordingly

It was asked that in 'fixing NHS dentistry' there are more vacancies for dentists and dental therapists in C&M and questioned why this might be, and whether this is anything we can do to support. TKn agreed this was part of the agenda for discussion.

EMo enquired whether we might be able to get some assistance / support from the People Board?

<u>Pharmacy</u>

AIr outlined the pressures in pharmacy, costs and workload both continue to increase, volume is growing and more services keep being added on but the funding settlement has remained the same since 2018 with no inflationary or workload adjustments after a previous cut prior to that. This has driven changes in the market and there is a pressure to withdraw or consolidate, there are 7% fewer pharmacies since the inception of the ICB (590 to 548).

There is real nervousness as we go into M12, as the national contract negotiations have finally opened. There is angst about the level of support and the negotiation of 2 year contracts 2024-25 and 2025-26. He added that the LPCs are trying to stay positive, but there is definitely an undertone of worry.

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He added that the NPA independent contractors have balloted, and phase 1 collective action has been voted to take place, the LPC are looking at their local services to continue or check if viable. Discussions around free of charge prescriptions, blister packs that fall outside of the equality act, data analytics and opening hours are coming in to play.

State of rota is a concern, we have lagged behind other areas adjusting their payments to recognise the real cost of opening and contractors may well be effectively left with a decision whether to take the hit of a breach as this is cheaper than running the rota.

Raised with commissioners in June 2023, no offer or change on that.

Advised that local services sit outside of this, no one is innovating but there are real pockets of will to address this, there are some early stages of good work/ services, hypertension for example, and there is good collaborative working, will engage with all stakeholders as this progresses.

The Health and Wellbeing Board (HWBB) have a requirement for Pharmacy Needs Assessment and there are drafts out there, however there is some worry where contractors have looked at hours where they have closed and the HWBB have seen these as a gap. There is tension between the HWBB process and the ICB process, and if a gap in PNA was identified, we may be obliged to commission to that need.

RBa added that from an LMC perspective he was worried about what is happening in pharmacy, there is a knock on effect of closures. He stated that he has seen patients using delivery services which then becomes a self-fulfilling prophecy as more people use service it creates a problem for community pharmacies. He added concern again regarding the effect of NI and the minimum wage increase, undoubtably this is going to affect community pharmacies as well, he added that we all need to do more to support.

In summary it was encouraging to see the ICB digital work. Additionally there has been significant work on the ICP fact finder, and key to get the newly qualified pharmacists to get placements and support to and with the supervisors. There is also a lot of work going into support events for the Pharmacy Contraception Service with the first event on the Wirral next week with other places following that.

The Committee **noted** the verbal updates.

SPCC 25/02/B09 Contracting, Commissioning and Policy Update Optom, PC Medical, Dental and Community Pharmacy

CLe advised that new guidance had come out literally as he had finished the paper, there is lots of detail that may not be fully explained and suggested a more detail discussion would come back to the SPCC meeting in April.

ACTION : a more detailed discussion to come to the April SPCC meeting.

TKn advised that we were awaiting technical guidance around urgent care appointments, and that there was good news on the friends and family test given the challenge around workforce.

The Committee **noted** the report and updates.

SPCC 25/02/B10 Finance Update

LWB presented the update and outlined the M10 position.

The Delegated Primary Care medical financial forecasts were highlighted as well as the Core Contracts, Quality Outcomes Framework (QOF) and Primary Care Networks.

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In terms of prescribing, the projected forecast has improved since the last financial paper by £5.5m outturn and shows an overspend delivery of £20, which includes a prior year pressure of £1.2m.
Expecting allocation from NHSE.

The Committee were asked to;

- Note the combined financial summary position outlined in the financial report as at 31st Jan 2025 – **NOTED**
- Note the Additional Roles spend to date and the anticipated forecast outturn and predicted central drawdown – **NOTED**
- Note the Capital position - **NOTED**

Quality and Performance

SPCC 25/02/B11 Healthwatch update : Access Improvement and Patient Experience

LBa gave a verbal update.

It was outlined that following on from the Primary Care Access Recovery Plan (PCARP), the nine Cheshire and Merseyside Healthwatch were asked to gather feedback from residents to gain an understanding of whether people were experiencing an improvement in access.

A survey was produced based on the PCARP and distribution started in October 2024. To date there have been differing response rates in each of the nine Places. Requests have been made of all areas/ Places via Primary Care Leads for practices to promote the survey through texts, but to date this has only occurred in Knowsley.

CFo agreed to pick up with LBa outside of the meeting to understand the cost being picked up by the ICB in terms of the unwarranted variation in the cap on texts.

It was noted that various routes had been taken to get responses, and these include: circulating in libraries, using free post envelopes for hard copies, presenting at community groups, parent carer forums, and asylum seekers plus others. Age profiles will also be outlined and this will be brought into the final report.

It was highlighted that primary care leads had been asked to circulate the survey in each of their areas.

From all of the responses, Healthwatch will produce an overarching report as well as splitting it down over the nine places.

Early responses indicate that people are still experiencing problems with the 8am telephone call issue, and there is still a struggle for same day appointments. Noting that some patients are then seeking alternative appointments or not going at all. There is also noted to be a digital divide, which includes issues around having a non-reliable internet access or fear of reliance.

Additionally the experience of practice staff also features in responses, there is still some challenge around reception staff regarding triage and allocation of appointments.

Having said this, there are also noted some real positives coming through, and that given the difficulties in getting an appointment, once patients had an appointment they felt they had a good experience but it was the getting of the appointment that was a problem – front door is the main issue.

In terms of ARRS roles it is reported that these are not understood, there appears to be a barrier between the reception telling the public who they are going to see and the public simply not understanding who they are / the role they play in their healthcare.

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Noted that the hearing impaired also feel there is an issue with lack of translation. Also issues around being told they have a telephone appointment but not being given a definite time so they wait in all day to receive the call.

In short, it is noted that there are mixed responses, even if with a small response rate, and feel that the report will say there is a way to go for our patients. The real asset of this will be showing the clinical staff

NRa expressed concern as she did not appear to have received the survey as a PCN lead, adding that it could have improved communication by also using the GP network.

LBa stated that she would be very happy to present this in any forum, adding that each Primary Care Lead was contacted to circulate to practice managers with the ask for all to complete. She added that there was some surprise that it was not taken up by all.

CL stated that each of the place leads were asked to link in with Healthwatch at the beginning of the process using a system level approach and then leading to a more local approach as this is where the contacts are. Part of the learning is around where it has worked and where is has not worked.

LBa stated that the CL had approached the ICB comms team for circulation amongst workforce but LB had not heard back from this as yet, so may be another opportunity for circulation before the closure of the survey.

MBa stated that there has been significant strides and that by using the evaluation and impact there will be a view to evaluate and really try to hit the mark in what we are investing in. Also an opportunity to see if the feedback we receive will reference back to what we are seeing in terms of what we believe.

CWa added that we have got the GP forum and that we have asked them to work with us on aspects of ICB policy decision making. It is important that we do use that meeting and triangulate with the national GP survey, this is a commissioned touchpoint temperature check. Additionally we need to see what Place are doing, and the evaluation of funding is important.

ACTION : CWa agreed to speak with NRa regarding the forum, and that we will need to come up with a measured response for Board, feel this is part of a piece of work regarding the evaluation. Considerations for March Board??

LBa advised that the survey was due to close on 28th February but can leave it open a little longer if needed –**to be advised.**

SPCC 25/02/B12 Quality Update

TKn presented this item for assurance. The Primary Care Quality group met yesterday and that they are looking to sync the timing of this with SPCC.

JGr questioned what the process are going to be, how to share and how to triangulate, how do we learn from patient safety events and how do we share these out. He did add there was a slight issue as to how and where we report to and that we are still in danger of reporting twice, to both Q&P and SPCC. He agreed that this was not necessarily a question to answer now but would like to know which committee it does sit with.

It was advised that it comes here to SPCC as this is the committee responsible and accountable for primary care quality. Additionally primary care is included within the Place update report to QPC but it is just an update., but the route is here to the SPCC committee.

RPJ questioned where any concerns were going? And whether there is a clear view to a quality concern and how it is managed?

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In response JGr stated that an individual practice will deal with an issue but that they are not necessarily sharing it with anyone else, there is work ongoing to triangulate this, it is coming together in a much better way than ever before.

The Committee **noted** the report.

SPCC 25/02/B13 Progress on FTSU

CDo provided this update stating that NHSE had written out from the national adoption of the policy and a letter was around the building of the progress. It is noted that nationally there was an improving picture and that the ICB FTSU guardian has been completing a scoping exercise across C&M which has identified some gaps.

By 2026 it is the aim to ensure that primary care have access to FTSU and have a process to speak up. This is an ongoing piece of work, some areas that are doing it really well and it is about how we work on this.

EMo advised that she was the NED lead, and that she champions it, it is our voice and is a learning experience. She added that the ask from NHSE to help and support the whole of primary care in the form of one person was vast. Feels that probably this is around best practice rather than a physical resource and provision.

NRa added that some PCNs had used SDF funding (which allowed staff to undertake the FTSU guardian training) and that this felt sustainable at PCN level but maybe not so at a small practice level.

The LMC are supportive of this and would be interested in knowing the gaps and where/ what they are, it was added that we need to look at other ways of providing this, and that if the NHS wants it then it should find a way to allocate resource.

ACTION i) : an update to come back in 2 months time to SPCC – CDo

ACTION ii) : invite to be extended to Temitayo Roberts to attend SPCC - EMo

SPCC 25/02/B14 Performance Indicators

CLe gave this update following an internal audit report, it is flagged for primary medical in that we do not have a single set of measures that this committee sees. He added that there are several different dashboards across Place looking at primary medical. Now, thanks to BI, there are ten indicators, there are some challenges, and that now we have seen the planning guidance perhaps we need to revisit the indicators.

He asked if the Committee could think about what core indicators they would like to see and what we now do with this.

It was agreed there has been lots of really great work on this, CWa agreed that we did need to look at the indicators in light of the planning guidance, recognising there is variance, of which we know this and their improvement plans will need to address this. It was added that if we are having a single quality dashboard, then feel we should do a single performance one.

From a GP perspective NRa stated that she really appreciated this discussion here but added that without knowing the targets there are also national targets to be matched and having a comparison of what we are aiming for it is difficult to know if it is good or bad.

Agreed that it would be good to see this not as a static piece of work and to be repeated each month / quarter to see what is improving in population health.

RPJ added that the Data Into Action (DIA) also managed who needs the access and looking at what is being done with it in terms of the levers to be pulled.

The Committee noted that this would not be the regular report the Committee would receive regularly as this needs to be triangulated with the metrics that would be gathered as part of the Planning Guidance item and resourcing of multiple reports and asks would not not be possible unless additional staffing was directed to support.

ACTION i): discuss at next meeting under planning guidance asks

ACTION ii) : Speak with Population Health colleagues perhaps as well as BI colleagues – RPJ

ACTION iii) : Framework managing, feel it is clinically lead, with clinical access to deliver patient care – JGr and RPJ to discuss

Transformation

SPCC 25/02/B15 Pharmacy Access

TKn presented this item and outlined the report. He stated this was the beginning of a process and felt the need to keep going. He added that weekends are the headlines and questioned whether there was anything in our gift to assist.

AIr gave thanks for the report and that it was at a good stage, he added that it would be good to see a couple of things like the national effects and that it would be useful to have the C&M effects, this could be learning for the next time.

Additionally there are concerns on the next PNA cycle and the need to get the balance right.

TKn agreed that he would plot the deprivation factor on the next iteration and in terms of Place.

It was questioned whether this also feds into the local authority, TKn advised it was and that PNA leads in all local authorities were aware and there had been a briefing session with all members. Additionally Healthwatch Cheshire have been very much involved in the PNA process.

Will come back in a couple of months time to feedback.

Looking to seek to acknowledge the rota fee, and will come back on this, it is a pressure so will need to look at it, but we do acknowledge.

SPCC 25/02/B16 Dental Access Improvement Plan

TKn gave the headlines for this item.

The ask of the Committee is to approve the proposal to focus on routine care and access, and this carries an additional ask to use dental ringfence monies of circa £8m.

Using the breakdown against the 2023-24 plan, it was questioned as to whether we did need to factor in 2025-26 with some degree of evaluation and to think about this work.

MWo stated that as we expand the plan, and it becomes out of core contract, he was not confident that where practices are underperforming it could be tempting for some to take out the money from deprived areas where it is difficult to provide dental services and simply move it to areas that are easier to provide.

RBa questioned how confident we were that we see dental access to urgent care, and to ensure the pathways are available, we do need to focus on urgent care and to consolidate the urgent care pathway.

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Additionally it was noted that it would be helpful to look at a more formal triage route for general practice signposting to practices who can appropriately see patients.

TKn advised that they were asking for circa £23m, but confirmed that this was not new money, and that it was within the dental budget. He further outlined that if our dental practices delivered their UDA contract that would give the ICB an enormous pressure. The budget for dental has not been spent for this year and it potentially puts a risk to the ICB at the end of the financial year, however it is noted to be the right thing to do.

The Committee **noted** the report.

CLOSE OF MEETING

Date of Next Meeting: Thursday 20 February 2025 (09:00-12:30)
F2F, Lakeside, Warrington

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CHESHIRE MERSEYSIDE
INTEGRATED CARE BOARD

Action Log 2025/26

SPCC (B - Public) Action Log - Live Actions

Action Log No.	Original Meeting Date	Description	Action Requirements from the Meetings	By Whom	By When	Comments/ Updates Outside of the Meetings	Status
SPCC 24/08/B10a	15/08/24	Contracting, Commissioning and Policy update : Community Pharmacy and Dental	Request at the December SPCC meeting for an update, and the view on deprivation	Tom Knight / Chris Leese	April 2025	UPDATE Jan 2025 : View of all 4 contractors across deprived areas and impact of closures - action reset for SPCC in April	ONGOING
SPCC 24/10/B07	17/10/24	Committee Risk Report	CLe, TKn and EMo to have a separate meeting/ discussion regarding the target of 9 for the workforce risk	Dawn Boyer	Feb 2025	UPDATE Jan 2025 - meeting outside of SPCC taken forward and report will come to Feb meeting	ONGOING
SPCC 24/10/B07	17/10/24	Committee Risk Report	DCo to come back to next meeting (December) around next steps following the establishment of a strategic estates board (first meeting in November)	David Cooper	Feb 2025		ONGOING
SPCC 24/10/B13	17/10/24	Local Dental Improvement Plan	JAd and MWo to pick up offline regarding clarity of the quality acess scheme budgeting	John Adams & Mark Woodger	Feb 2025		ONGOING
SPCC 24/10/B13	17/10/24	Local Dental Improvement Plan	Ian Ashworth or the Beyond Team to be invited to a future meeting to give progress on oral health	TBC	TBC		NEW
SPCC 24/12/B07	19/12/24	System pressures	Committee noted the risks around local commissioned services and the contracted hours. But enquired as to how we are looking after patients in all this and raised the question of 'what is the so what'	Tom Knight	Feb 2025	*UPDATE Jan 2025 - ongoing dialogue with TKn to be picked up at next SPCC*	ONGOING
SPCC 24/12/B07	19/12/24	System pressures	Shared care to go on Feb SPCC agenda	Cathy Fox	Feb 2025		ONGOING
SPCC 24/12/B07	19/12/24	System pressures	Various conversations within SPCC about possible movements in metrics HW to provide GP client experience information in Feb SPCC	Erica Morriss	Feb 2025	*UPDATE Jan 2025 - HW presenting initial report on GP Access and further discussions to follow*	ONGOING
SPCC 24/12/B09	19/12/24	Finance update	Whether we are any closer to a decision for enhanced services, was due to go to Execs or Board (not sure of sequencing) - MBa agreed to look into this and would advise DHa acordingly.	Mark Bakewell	Feb 2025		ONGOING
SPCC 24/02/B08	20/02/25	Contractor Operations Updates	FSt to let CLe know which Place this related to so that the relevant Place Commissioner could be advised /escalated accordingly	Fiona Lemmens / Chris Leese			NEW
SPCC 25/02/B09	20/02/25	Contrating, Commissioning and Policy Update, Optom, PC Medical, Dental and community Pharmacy	a more detailed discussion to come to the April SPCC meeting	Chris Leese	April 2025		NEW
SPCC 25/02/B11	20/02/25	Healthwatch Update : Access Improvement and Patient Experience	to speak with Naomi Rankin regarding the forum, and that we will need to come up with a measured response for Board, feel this is part of a piece of work regarding the evaluation - considerations for March Board??	Clare Watson			NEW
SPCC 25/02/B13i	20/02/25	Progress on FTSU	An update to come back in 2 months time to SPCC	Chris Douglas	April 2025		NEW
SPCC 25/02/B13ii	20/02/25	Progress on FTSU	invite to be extended to Temitayo Roberts to attend SPCC	Erica Morriss	April 2025		NEW
SPCC 25/02/B14i	20/02/25	Performance Indicators	discuss at next meeting under planning guidance asks		April 2025		NEW

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SPCC 25/04/B14ii	20/02/25	Performance Indicators	Speak with Population Health colleagues, perhaps as well as BI colleagues	RPJ	April 2025		NEW
SPCC 25/04/B14iii	20/02/25	Performance Indicators	Framework managing, feel it is clinically lead, with clinical access to deliver patient care	RPJ & JGr	April 2025		NEW

Forward Planner 2025/26 : System Primary Care Committee

Item	Who	Frequency	Part A/B	Apr-25	Jun-25	Aug-25	Oct-25	Dec-25	Feb-26
Standing items									
Apologies	EM	Every meeting	Both	Yes	Yes				
Declarations of Interest	EM	Every meeting	Both	Yes	Yes				
Minutes of last meeting	EM	Every meeting	Both	Yes	Yes				
Action Log & Decision Log	EM	Every meeting	B	Yes	Yes				
Questions from the public (where received)	EM	Every meeting	B	Yes	Yes				
Forward Planner (pre meeting)	CL	Every meeting	B	Yes	Yes				
Governance & Performance of Committee									
Review of Terms of Reference	EM / MC	Yearly	n/a	Yes	Yes				
Self-Assessment of Committee Effectiveness	EM	Yearly	n/a	No	TBC				
Forward Planner Annual Plan Review		Yearly							
Key Business Items									
Minutes of any ExtraO Meeting	EM/CL	If held	A	TBC	TBC				
Committee Risk Register	HS/CL	Every Other Meeting usually	B	Yes	Yes				
Finance Update	LWB	Every Meeting	A	Yes	Yes				
PSRC Minutes/Update Minutes/Update from Pharmacy Operations Group and highlights	TK	Every Meeting	A	Yes	Yes				
Policy BAU Update – Primary Care Contracting and Commissioning 2 papers Dental/CP and Primary Medical/Optom	CL/TK	Every Meeting	B	Yes new contract summary	Yes				
Escalation from Place Primary Care Forums	CL	Where Place indicate	A	Yes where raised	TBC				
Quality	CD/TK	Every Meeting	B	Yes	Yes				
Performance	CL/BW	Every Meeting	B	No part of item on planning guidance	TBC				
Primary Care Quality Deep Dives	CD/KW	2 meetings per year		TBC	TBC				
Update from PC Workforce Steering Group	JG	Quarterly	B	Yes	No				
Digital Primary Care Update	JL	Quarterly	B	No	Yes				
System Issues by exception and update from local forum(s)	JG/CL	Every Meeting	B	Yes	Yes				
Primary Care Estates Update	NA	Quarterly	B	No	Yes				
New / Ad Hoc Items									
Primary Care Strategic Framework	JG		B	TBC	TBC				
Dental Access Improvement Plan	TK		B	No	TBC				
Primary Care Access Improvement	CL		B	Healthwatch Report and Operational guidance	Standing item				
Summary – GP Patient Survey (System Level)	CL		B	No	TBC				
Dental Paper – Part Year performance note	TK		A	No	TBC				
Capital bids for agreement	KH		B	Yes	TBC				
Improvement Grant Estates Bids	NA		B	TBC	TBC				
Digital – alignment of a single system for all four contractor groups	RPJ		B	TBC	TBC				
FTSU	CD/TR		B	TBC	TBC				
APMS Procurement	SBS		A	No	TBC				
Community Pharmacy Access	TK		B	No	No				
Approach to Planning Guidance Primary Care Indicators	CL/TK		B	Yes					
Connecting care	LK			Yes					
Beyond/Oral health	IA				Yes				
FTSU paper	TBC?			Yes					
Healthwatch Report / Update as part of access update				Yes	TBC				
PCN Development				TBC					
June plan for Contract oversight					Yes				

NHS
Cheshire and Merseyside

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

April 2025

Primary Care Commissioning, Contracting and Policy Update
Community Pharmacy and Primary Care Dental Services.

Agenda Item No: SPCC 25/04/B09i

Responsible Director: Clare Watson

1. Purpose of the Report

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

- Community Pharmacy
- Primary Care Dental Services

This paper contains;

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

2. Ask of the Committee and Recommendations

The Committee is asked to ;

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

3. Primary Care Dental services

3.1 **Dental Operational Group (DOG) meeting on 27/1/25**

- Contract Reductions and Hand backs:

None to report. It was noted that there have been several Non-Recurrent (NR)increases for 24/25, but no recent NR deduction requests.

- Contract discussions

In accordance with section 5.2.1 of the Policy Book for Primary Dental Services 2024. a dental performer applied to incorporate their contract. Contract performs well. Accepting all NHS patients. No concerns with current provider. UDC & UDC Plus practice. The group agreed in principle to this request.

In accordance with section 5.2.1 of the Policy Book for Primary Dental Services 2024. a dental performer had applied to incorporate their contract. Contract performs well, although slight underperformance in previous years. Already incorporated as per CQC & Companies House back in 2017. Accepting all NHS patients. No concerns with current provider. The group agreed in principle to this request

For noting in accordance with section 5.2.1 of the Policy Book for Primary Dental Services 2024. a dental performer had applied to incorporate their contract. Contract performs well, although slight underperformance in previous years. Accepting all NHS patients. No concerns with current provider. Current provider noted that they will be leaving, and 2 other directors will be appointed. Provider has already applied to the CQC and the company has already been set up on Companies House. The group agreed in principle to this request.

- Remedial notices are due to be issued by the BSA in relation to practices who have failed to complete the annual workforce return. However, it was noted that there will be a remedy period for practices to rectify this.

- FFT results are improving and a more detailed report will be presented at the next DOG. Dental Advisors reminding practices of their contractual obligation to complete the FFT at CG visits.

- It was confirmed that SPCC have given permission for an additional spend of up to £23 million across dentistry in C&M for 25/26. The funding will be used to expand the local schemes, with a particular focus on Halton and Knowsley. The pilot scheme currently being run in Liverpool to support vulnerable groups will be extended, working closely with the Local Authority to identify local groups who will most benefit from seeing a dentist. Luci Devenport will be meeting with the Provider Group this week and will discuss how the national request for additional urgent care sessions can be best facilitated across C&M.

- Oral Surgery Tier 2 Concerns (Wirral). Dental Advisor explained that concerns have been raised regarding a tier 2 oral surgery provider on the Wirral. It has been claimed that there has been a decline in the standard of service and there is one patient complaint in the system. It was suggested contacting Wirral LDC, so views can be gathered from local providers about their experience of patient's accessing this service. Clinical Advisor will investigate further, gather evidence and discuss this with the provider, so that their side can be considered. Dental Advisor to bring this back to DOG if further actions are required.

- Gaynor Cartwright - Members noted that this was the first DOG meeting since the passing of a valued friend, colleague and member of the Dental Commissioning Team. Members expressed their deep sadness at Gaynor's passing and noted that she was a highly respected Dental Commissioner with over 30 years NHS service. She was dearly loved and will be missed by so many family, friends and work colleagues alike.

4. Community Pharmacy services

4.1 **Pharmacy Operational Group summary of meeting held on 1/4/25**

- The group reviewed a number of incidents and quality in January 25 and February 2025 and considered any escalations required.

- There were no Freedom of Information requests received.

- Up to 15 contractors have been identified as requiring visits arising from the latest Community Pharmacy Assurance Framework.

- Temporary suspension of services reporting has flagged a discrepancy between reporting to commissioners and reporting to the BSA. Contractors will be reminded that they must report any unplanned closures to the BSA.

Jan 2025
39 submissions from pharmacies
66 nil returns from BSA
5 from pharmacies via MYS portal via BSA

Feb 2025
23 returns from pharmacies
82 nil returns from BSA
2 returns from pharmacies vis MYS portal via BSA

4.2 **Community Pharmacy funding settlement**

Funding and other arrangements for community pharmacies for 2024/25 and 2025/26 have been finalised, with community pharmacy receiving the largest uplift in funding across the whole of the NHS.

Ministers have said the uplift signals the Government's commitment to stabilising the sector, and Government has given a firm commitment to work towards a sustainable funding and operational model for community pharmacies, recognising the key role they will play in future healthcare.

The settlement takes baseline annual CPCF funding for 2025/26 to £3.073 billion and secures a further £215 million to fund the continuation of Pharmacy First and other Primary Care Recovery Plan services.

The settlement also secures a write-off of historic margin overspend, with £193 million being written off, and a commitment to reviewing margin distribution.

Together, this will provide a greater than 30% uplift to funding for the community pharmacy sector over the coming financial year, as compared to 2023/24.

Further details of the settlement agreement are available as Appendices to this report.

4.3 The Committee is also asked to note that a number of draft Pharmaceutical Needs Assessments have been received and are being reviewed by the commissioning team who have been key participants in the process with local authorities.

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

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

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

6. Link to meeting CQC ICS Themes and Quality Statements

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

7. Risks

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

8. Finance

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

9. Communication and Engagement

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

10. Equality, Diversity and Inclusion

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

11. Next Steps and Responsible Person to take forward

Tom Knight, Associate Director of Primary Care (Dental and Community Pharmacy.
tom.knight@cheshireandmerseyside.nhs.uk

12. Officer contact details for more information

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March 2025

Briefing 010/25: Funding Settlement for 2024/25 and 2025/26

Community Pharmacy England, the Department of Health and Social Care (DHSC) and NHS England have announced the 2024/25 and 2025/26 funding settlement for community pharmacy. This briefing outlines the key elements of the settlement.

Overview

In this briefing we cover:

- Funding for 2025/26;
- Service developments and changes to fees;
- Pharmacy Quality Scheme (PQS);
- Regulatory changes;
- Additional points of note; and
- Appendix: Timeline of changes.

Details of the settlement on the CPCF for 2024/25 and 2025/26 are also included in the joint letter to pharmacy owners from Community Pharmacy England, DHSC and NHS England.

You can also read Community Pharmacy England's full announcement and statements on our website.

Funding for 2025/26

The settlement secures baseline funding of **£3,073 million** for provision of the Community Pharmacy Contractual Framework (CPCF) in 2025/26. £30m of spend on the HCFS and PCS, which is currently within the contract sum, will instead be funded from the Pharmacy First budget. This means the baseline funding is effectively **uplifted by 19.7%** compared to 2023/24.

A further **£215 million** (the 'Pharmacy First' budget) will fund the cost of Pharmacy First clinical pathways, the Pharmacy Contraception Service (PCS) and the Hypertension Case-Finding Service (HCFS).

The level of allowed medicines margin for 2025/26 is being **increased to £900 million**, with **£193 million of historic over-delivery also being written off**. This leaves £42 million of margin over-delivery to be recouped over the next 12 months.

Together, these elements represent an overall uplift of greater than 30% in funding for the year 2025/26, compared to the final year of the previous 5-year settlement (2023/24).

The **Single Activity Fee (SAF) will increase to £1.46** per item.

Funding changes summary:

	2023/24	2024/25	2025/26
CPCF contract sum	£2,592m	£2,698m*	£3,073m*
Margin write off			£193m
Primary Care Recovery Plan ('Pharmacy First') spend	£48m**	£140m**	£215m
Total	**£2,640m**	**£2,838m**	**£3,481m**
Percentage change Year on Year		7.5%	22.7%
Percentage change versus 2023/24		7.5%	31.9%

*Includes increased margin allowance of £850m in 2024/25 and £900m in 2025/26

**Significant portions of the Primary Care Recovery Plan budget were allocated towards historic fee write offs, marketing for Pharmacy First and IT development, and are not shown in the table above.

Service developments and changes to fees

Pharmacy First

Fees for the Minor Illness and Clinical Pathway consultations part of Pharmacy First are being uplifted to **£17**, whilst the Urgent Medicine Supply fee will remain at **£15**.

In the negotiations, we were successful in gaining agreement to moving to a banded approach for the Pharmacy First monthly payment: **£500 for those delivering 20-29 consultations** per

month and **£1,000 for those that achieve 30 or more**.

This change will commence from June 2025 and will help address the concerns from pharmacy owners who have not been able to achieve the 30 clinical pathway consultations monthly target over the last few months.

To enable the introduction of this variable monthly payment within the NHSBSA's payment systems, **the claim window for Pharmacy First consultations will be reduced to one month** from June 2025. The recent change to allow an additional twelve months to claim payment where an issue with IT systems prevented the submission of a claim will remain.

It was previously announced that 'bundling' requirements would be introduced from April 2025 requiring pharmacy owners to provide the HCFS and PCS in order to receive the Pharmacy First monthly payment, when they also meet the monthly volume target.

We have agreed revisions to this plan with a **phased introduction of 'bundling' requirements**. To receive the monthly Pharmacy First payment, subject to also achieving the relevant volume of clinical pathway consultations:

- **From June 2025**, pharmacies will need to be **registered to provide the PCS and HCFS**;
- **From October 2025**, in addition they must **deliver at least one Ambulatory Blood Pressure Monitoring** (ABPM) provision **per month**; and
- **From March 2026, a specified number of contraception consultations** (to be agreed by Community Pharmacy England, DHSC and NHS England in due course) will also need to be provided each month.

In recognition of changes to the rules around provision of Advanced and Enhanced services to patients present on the premises of Distance Selling Pharmacies (DSPs) (see further information in the Regulatory changes section below) the above requirements related to registration to provide the HCFS and the provision of at least one ABPM per month will not apply to DSPs.

DHSC has also pledged to review delivery and capping of Pharmacy First and other services.

Pharmacy Contraception Service

We have been successful in persuading DHSC and NHS England to increase the **consultation fee for both initiation and repeat supplies of contraception to £25** (a 39% increase). This

increased fee better reflects the costs of provision of the service, particularly initiation consultations, which generally take longer to provide.

Suitably trained and competent Pharmacy Technicians will also be able to provide the service, supporting greater use of skill mix by pharmacy owners, where that fits within their business plans.

From October 2025, subject to the introduction of IT updates, the service will be **expanded to include Emergency Hormonal Contraception (EHC)**, with a fee of **£20** per consultation, plus the cost of any EHC provided to the patient.

Hypertension Case-Finding Service

The service specification will be updated to clarify patient eligibility requirements, e.g. where people request frequent measurement of their blood pressure (which is outside the scope of the service) and groups of patients that general practices can appropriately refer to the service for clinic checks.

When the service was introduced in 2021, the fees were based on a pharmacist providing the service, with the expectation that they would be changed once VAT regulations were amended to allow greater skill mix to be used in this and other clinical services.

In November 2023, following changes to the VAT regulations, the service specification was changed to allow suitably trained pharmacy staff to provide the service. Accordingly, from April 2025 the fee for the clinic blood pressure check will be adjusted to **£10.00** per consultation.

There is still plenty of potential to provide more ABPM consultations within the service and to support that aim, it has been agreed that the fee for ABPM provision will be increased to **£50.85** (a 13% increase) from April 2025.

NHS England will also consider whether alternative approaches to ABPM can be taken to support the potential diagnosis of hypertension, where the patient does not wish to have ABPM.

New Medicine Service (NMS)

The payment structure for NMS will be simplified to a **£14 fee** for each Intervention or Follow up consultation provided to the patient, i.e. a total fee of £28 will be paid if the pharmacy has done both the Intervention and Follow up consultations. This change removes the current, complex fee structure, so it is clear what pharmacy owners will be paid for providing the service and it also

recognises the difficulty in reaching some patients for Follow up consultations.

Later in 2025, the NHSBSA will amend the MYS module which pharmacy owners use to claim for their provision of NMS to allow the number of Intervention consultations and Follow up consultations to be separately entered. For claims for NMS provided in April and subsequent months, up until that change is made to MYS, pharmacy owners will need to claim the total number of Intervention consultations and Follow up consultations they have provided in the month. For example:

Number of completed Intervention consultations	20
Number of completed Follow up consultations	11
Number of NMS provisions to be claimed in the MYS module	**31**

Once the NHSBSA have updated the MYS module, pharmacy owners will be able to separately report on the number of Intervention consultation and Follow up consultations, with the NHSBSA making payment based on the total number of each.

From 1st October 2025, the service will also be **expanded to include depression** within the conditions and associated medicines covered by the service. This is an addition to the therapeutic areas covered by the service which has significant support from stakeholders within pharmacy.

There will be no mandatory training related to the addition of the new therapeutic area to the service, but a related training programme on consulting with people with mental health problems will be included in the Pharmacy Quality Scheme (PQS) – further details can be found below.

Smoking Cessation Service

We have gained agreement for skill mix changes to the Smoking Cessation Service to be introduced, to allow suitably trained and competent staff to provide the service, alongside pharmacists and pharmacy technicians, who are currently able to undertake consultations.

PGDs will also be introduced to enable **provision of Varenicline and Cytisinicline (Cytisine)** under the service by both suitably trained and competent pharmacists and pharmacy technicians.

Both changes will require developments to IT systems and the date from which the changes will apply will be announced in due course.

Pharmacy Quality Scheme (PQS)

A smaller than usual PQS will run in 2025/26, worth **£30 million**, with many of the elements repeating those in previous schemes to support the ongoing embedding of these quality improvements into pharmacy practice.

The scheme will continue to be an optional part of the CPCF and pharmacy owners that choose to participate will be able to claim an **Aspiration payment of 75%** of the overall points value (**circa £2,300 per pharmacy** aspiring to undertake the whole scheme) in May for **payment on 1st July 2025**.

In summary, the scheme will consist of the following elements:

Gateway criteria	The pharmacy must be registered for and able to provide Pharmacy First and the Pharmacy Contraception Service.
Medicines Optimisation domain **30 points**	**Palliative and End of Life Care**: Pharmacies must develop or update a Palliative and End of Life Care action plan and if they stock the 16 Palliative and End of Life Care medicines, update their Directory of Services profile to confirm this. **Introduction of Depression into the NMS**: all pharmacists must complete the CPPE Consulting with people with mental health problems online training. There is no online assessment for this training. **Respiratory**: ▪ Referral of patients aged 5-15 years prescribed a pMDI and who do not have a spacer. ▪ Referral of all patients using 3 or more short-acting bronchodilators without any corticosteroid in 6 months. **Emergency Contraception**: all pharmacists must complete the CPPE Emergency contraception training and pass the online assessment, and any pharmacy technicians intending to provide the Pharmacy Contraception Service must also complete that training programme and pass the online assessment.

Patient Safety domain **20 points**	**Pharmacy First**: completion of a national clinical audit focused on antimicrobial stewardship within the Pharmacy First service. All registered professionals must have completed the CPPE Sepsis training and pass the associated online assessment. **Enhanced DBS checks**: must have been undertaken for all registered pharmacy professionals within the last three years.

Full guidance and resources are available on our **PQS hub webpage**.

Regulatory changes

In the negotiations we proposed and got agreement to a number of regulatory changes to support pharmacy owners with some of the operational and capacity issues they are facing, and to ensure the integrity and intention of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations (the PLPS Regulations).

Clinical audits

During 2025/26, there will be **no requirement to complete a nationally chosen or pharmacy owner selected clinical audit.**

Health campaigns

During 2025/26, pharmacies will only have to take part in a **maximum of two national health campaigns** and **two campaigns selected by their Integrated Care Board** (ICB).

Practice leaflets

The requirement to produce a practice leaflet **will be removed**.

References for new staff

The requirement to seek references for staff involved in NHS services **will be removed**.

Patients signing prescription declarations

The requirement for patients that pay an NHS prescription charge to complete and sign the declaration on the rear of the prescription form or EPS token **will be removed**.

NHS Profile Manager

We will work with NHS England to seek to ensure pharmacy owners' NHS website and DoS **Profiles within NHS Profile Manager are comprehensive and accurate**. This is important for the patient journey to receive NHS pharmacy services – to ensure patients go to or are referred to pharmacies that are open and provide the relevant service. This is also important for the pharmacy's provision of information to patients and compliance with their Terms of Service.

Amendment of regs' test for changing the days and times of core opening hours

In recent years, many pharmacy owners have found it difficult to change the days and times of their core opening hours, which were often set many years ago. These regulatory amendments should enable pharmacy owners **to change their opening hours to days and times that better serve their patients and likely users of the pharmacy**, and in some cases, close at quiet times or out-of-hours. The amendments should also support pharmacies with operational and capacity issues. Generally, pharmacies only receive NHS funding to provide NHS services, not just to be open, so need sufficient patient numbers during opening hours to meet the costs of opening.

The Pharmacy Manual will also reflect this change and will clarify that the contractor's evidence of the economic viability of their current opening hours should be considered alongside evidence of patient demand for the pharmacy's services during these hours and other evidence relevant to the regulatory test.

At quiet times, out-of-hours or on Bank Holidays, patients and likely users of the pharmacy may have to travel further to a pharmacy, for example, to one of the pharmacies that were permitted to open if they provided longer opening hours. Usually, these 100-hour pharmacies (now often open for only 72 hours) are open 5 – 9 pm Monday to Saturday and 11 – 4 pm on Sunday.

Exceptionally, if an ICB wants a community pharmacy to be open at quiet times, out-of-hours or on Bank Holidays and no pharmacy is available, the ICB can go through a process to direct and separately fund the pharmacy to open. This may be assisted by an out-of-hours opening rota agreed with local pharmacy owners.

Key points are:

- Changing core opening hours remains an application process – the ICB must approve any proposed change.

- The total number of core opening hours must remain the same (another provision applies for applications to reduce the number of core opening hours).
- The new/proposed core opening hours must better meet the needs of patients and likely users of the pharmacy.
- A pharmacy owner's evidence of the economic viability of their current opening hours may be considered by the ICB.
- The PLPS Regulations (Terms of Service) must be amended first – only then will this change be effective/apply.
- The Pharmacy Manual will be revised accordingly.

This change will only be effective after the PLPS regulations have been amended.

Provision of services by Distance Selling Premises (DSP) pharmacies:

The PLPS Regulations will be amended so that DSPs will no longer be able to provide Advanced and Enhanced services to patients on the pharmacy premises. Where the service specification for individual services allows remote consultations to be provided or off-site provision of a service, that will still be possible for all pharmacies, including for DSPs. **This is likely to be effective on/from 2 October 2025, after the PLPS regulations have been amended.**

NMS service change

The service requirements for the New Medicine Service (NMS) will be changed to state/clarify that the service **cannot be subcontracted to another provider**. This will stop NMS being provided via a remote consultation with the patient by a pharmacist working off the pharmacy premises who is not employed by the pharmacy owner. **This change will only be effective after the Directions for the service have been amended.**

Additional points of note

Within the final offer, the Government made the following additional statements confirming its position on some of the other matters raised during the negotiations.

Overarching points

- Crucially, recognition of the funding gap that remains for community pharmacy – given the findings of the Economic Analysis undertaken by Frontier Economics for NHS England – and that this settlement is a first step towards sustainability.

- A commitment to continuing to work with us to set out a sustainable funding and operational model to underpin the sector's contribution to healthcare.
- A commitment to working with us to manage and review both Pharmacy First delivery and the operation of the margin system.
- Confirmation that the views and points raised in the negotiations and wider discussions with us (including the findings of the Economic Analysis) will inform the ongoing work on the Government's Comprehensive Spending Review.
- An intention to begin 2026/27 negotiations shortly after the summer when the current Spending Review process has concluded.

Funding and reimbursement

- Commitment to improving the medicine margin survey and working with us to validate the results.
- Consideration of further strategies to stabilise Category M.
- Examination of ways to speed up Category M reimbursement price setting arrangements and change Category C reimbursement price setting.
- Exploration of the impact of prescribing activities (such as the use of Branded Generics) on community pharmacy medicine margin.
- Adoption of appropriate actions arising from the RPS Medicines shortages: Solutions for Empty Shelves report.
- Consideration of supporting earlier payment for dispensing (on the 1st instead of 12th of the month) but with a wider ambition to redesign the whole payment timetable to reduce complexity.

Services

- Further consideration of the use of caps, where required, to provide equity of access to funding for the clinical services.
- A pledge to conclude development of MYS APIs for all clinical services.

Appendix: Timeline of changes

April 2025

- **Margin:** allowed level increases to £900m per year
- **SAF:** increases to £1.46 per item
- **Pharmacy First:** increases to £17 fee for Minor Illness & Clinical Pathway consultations
- **HCFS:** clinic check fee reduces to £10 and the ABPM fee increases to £50.85
- **PCS:** fee increases to £25 for initiation and repeat supplies
- **NMS:** payments are simplified to a £14 fee for each Intervention or Follow-up consultation completed

May 2025

- **PQS:** Aspiration payment claiming window

June 2025

- **Pharmacy First monthly payment:** Intermediary band added (£500 for those delivering 20-29 clinical pathway consultations)
- **Pharmacy First monthly payment:** Need to be registered to provide HCFS and PCS to qualify

July 2025

- **PQS:** Aspiration payments made (1st July)

Autumn

- **Negotiations:** 2026/27 CPCF negotiations begin

October 2025

- **Pharmacy First monthly payment:** Must deliver at least 1 ABPM per month to qualify
- **PCS:** EHC added to the service (subject to IT developments)
- **NMS:** Depression added to the service as an eligible condition

March 2026

- **Pharmacy First monthly payment**: Must provide a specified number of contraception consultations per month to qualify

CPCF Settlement 2024/25 and 2025/26

Highlights

- **Over £800 million** funding increase
- Total uplift of **more than 30%**
- **Largest uplift** in funding across the whole of the NHS
- **Government recognition** of funding gap as indicated by the Economic Analysis
- Firm Government commitment to **work towards a sustainable funding and operational model** for community pharmacies

Funding

- Baseline annual CPCF funding of **£3.073 billion** for 2025/26
- **£215 million** to fund Pharmacy First and other Primary Care Recovery Plan services
- **£193 million write-off** of historic margin overspend
- 19p increase to Single Activity Fee to **£1.46 per item**
- Margin allowance increase to **£900 million** per year
- The **Economic Analysis** estimated full economic costs of the sector were £5.063 billion

Pharmacy Quality Scheme

- A smaller than usual PQS in 2025/26, worth **£30 million**
- **Aspiration payment of 75%** available to claim in May 2025
- Includes elements from previous schemes to **support embedding of quality improvements**

Services

- **£2 fee increase** for Pharmacy First Minor Illness and Clinical Pathway consultations to £17
- **£7 fee increase** for the Pharmacy Contraception Service to £25
- Payment structure for NMS **simplified**
- New **intermediary band of £500** (for 20-29 consultations) added for the Pharmacy First monthly payment
- **Phased introduction** of 'bundling' requirements from June 2025
- **Depression** will be added to NMS from October 2025
- **EHC** will be added to the Pharmacy Contraception Service from October 2025
- **Legislative changes** will be made to support greater use of skill mix

Some changes will not commence until service specifications and regulations have been updated; see our full briefing for more detail.

CPCF Settlement 2024/25 and 2025/26

Regulatory

- **No clinical audits** in 2025/26
- **Maximum of 4** health campaigns (2 national, 2 from ICB)
- More scope to **amend core opening hours** to be introduced
- Need for patients who pay NHS charge to sign prescriptions **to be removed**
- DSPs will no longer be able to provide Advanced and Enhanced services to patients **on the pharmacy premises**
- NMS subcontracting **to be stopped**

Key commitments

Government **recognition** of funding gap as indicated by the Economic Analysis of NHS Pharmaceutical Services

Pledge to review Pharmacy First delivery and margin system

Negotiating points and Economic Analysis will **inform Government Spending Review**

What this means

Step-change for the sector

Vote of confidence in its potential from new Government

Recognition of the scale of the funding gap and taking a **first step towards sustainability**

Settlement prioritises **core funding and service fee increases**

Significant concessions won on contractual easements

Community Pharmacy England

Some changes will not commence until service specifications and regulations have been updated; see our full briefing for more detail.

NHS
Cheshire and Merseyside

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

Primary Care Commissioning, Contracting and Policy Update – Primary Medical Services and Optometry
17 April 2025

Agenda Item No: SPCC 25/04/B09ii

Responsible Director: Clare Watson

1. Purpose of the Report

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

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

This paper contains ;

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

2. Ask of the Committee and Recommendations

The Committee is asked to ;

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

3. Background

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

3.2 GMS, PMS, APMS (and DES) contracts are managed locally via place through the previously agreed matrix of decision making, through local primary care forums. Place are responsible for implementing any national policy changes locally, with support from the central team of contract managers who each lean out to place.

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

	Number of GP Practices by contract	PCNs	GMS	PMS	APMS	Dispensing	Single Handed
Cheshire West	43	9	35	4	4	3	1
East Cheshire	36	9	21	14	1	5	2
Halton	14	2	1	13	0	0	0
Warrington	26	5	8	18	0	1	0
Liverpool	83	9	77	1	5	0	18
Knowsley	23	3	8	15	0	0	6
Sefton	40	2	23	11	6	0	3
St Helens	29	4	22	6	1	0	10
Wirral	45	6	27	15	3	0	2
Total	339	49	222	97	20	9	42

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

3.5 Management of **General Ophthalmic Services contracts** is undertaken by a small central team, underpinned via the National Policy Book for Eye Health NHS England » Policy Book for Eye Health . Provision of General Ophthalmic Services (GOS) including sight testing and dispensing is agreed by contract and there are 2 types of contracts: Mandatory Services contracts, which are contracts allowing provision of GOS in a fixed premises and Additional Services (domiciliary) contracts, which allow provision of GOS to a patient in their home address if a patients cannot attend a fixed premises unaccompanied. There are currently 218 mandatory (High Street) services and 62 additional (domiciliary) providers operating within Cheshire and Merseyside ICB. GOS contracting is managed solely at system level via the General Ophthalmic Services Operations Group, which reports to this Committee. Further contract information can be found here https://www.nhsbsa.nhs.uk/provider-assurance-ophthalmic/gos-contract-management

4. Primary Medical Services Update

4.1 Changes to the **national GP Contract 25/26** including the PCN DES (Primary Care Network Directed Enhanced Service) were announced and further information can be found here
NHS England » Changes to the GP Contract in 2025/26
NHS England » GP Contract
NHS England » Network Contract Directed Enhanced Service (DES)
A summary of the main points is given in **Appendix 1**

4.2 Key changes include ;

- Greater flexibilities around ARRS (Additional Roles) recruitment and staff mix
- Use of functionality in GP Connect to support continuation of care between providers
- A patient charter which will set out the standards a patient can expect from their practice, as outlined in the GP contract
- A new Advice and Guidance Enhanced Service NHS England » Enhanced service specification – General Practice Requests for Advice and Guidance
- Adjustments to QOF (Quality and Outcomes Framework) to further support reduction in premature mortality from heart disease or stroke
- Incentivising PCNs to use the intelligence gained from population health risk stratification tools to stratify their patients - including to identify those that would benefit most from continuity of care.
- Noting some of the contractual asks are not live until later in the year.

4.3 At the last Committee meeting, the operational planning guidance for primary medical was outlined – a separate update paper on this is given within the agenda but for assurance a submission was made and agreed in time for the March deadline. The Committee should note however that tracking and progress on implementation of the GP Contract for 25/26 is required as part of the planning guidance work, and this will include internal assurance of a consistent approach to this across the ICB.

4.4 A national NHS England **delegated assurance return** process which covers all four contractor groups, will commence shortly with a return required by the ICB for the end of April – given the timing of this, the return will be signed off by the Assistant Chief Executive but reported to the next meeting of this committee.

5. General Ophthalmic Services

5.1 **Service provision** remains steady across Cheshire and Merseyside -any contractor who has not demonstrated GOS activity over the previous 12 months and who has not completed mandatory returns such as annual complaints or the QIO (Quality in optometry) self-assessments will be contacted to check if they wish to maintain their contract with the aim of terminating inactive contracts. For consistency across the North West, the optometry team is working with Greater Manchester and Lancashire/South Cumbria to agree the communication request letter.

5.2 **Eye Care in special education settings (SES) programme update:**

- The intention is for the Eye Care in Special Schools programme to launch through 2025/2026. The offer covers all SES (Special Educational Settings) across Cheshire and Merseyside.
- It will ensure an annual sight test for all pupils (aged 5-25) within a SES setting with School and parent/guardian permission.

- Each pupil within the programme will have an eye health outcome report, there will be support towards glasses in line with GOS. Pupils will be offered a choice of frames.
- We have now received initial confirmed expressions of interest from schools and providers across C & M. There are provisionally 41 schools and 14 providers initially expressing interest. The service is not mandated across all schools.
- The fee for the service has been set at £85 per test. This was subject to consultation with OFNC (Optometric Fees Negotiating Committee) and it is not expected to change. Regulations to formalise the service were laid in Parliament in December 2024 and updated Directions published.
- Market engagement has been completed nationally and expressions of collated from providers and schools and the ICB has been sent details of interested providers and schools for future planning along with a finalised service specification including parent/patient consent form and model contract. 2025/2026 funding has been allocated for the programme.
- Existing Proof of Concept (POC) providers who wish to will maintain their contracts until procurement plans are put in place. Allocated funding is available to maintain the POC programme through 2025/2026
- The national model contract link is given here - General Ophthalmic Additional Services Model Contract

5.3 **Local Eye Health Network -**The Local Eye Health Network (LEHN) has been relaunched including key LOC stakeholders, LEHN Chair and meetings have been held in November 2024 and January 2025 with a meeting due in April 2025.

5.4 **Eyecare for patients with LD/Autism -** Primary Eyecare Services (PES) Ltd have published activity around the programme of sight tests for adult patients with LD and Autism. As of Q3 in 2024/2025 there were 166 sight tests undertaken across Cheshire and Merseyside.

5.5 **Programme of Blood Pressure case finding in optical practices (AF/CVD) -** The programme/pathway has now been agreed between the CVD Prevention Programme Team and Local Medical Committees, expressions of interest in participating in the programme will now be sent to optical practices this month.

5.1 **Optometry additional services - contractual review -** The central optometry contracts team is currently undertaking a piece of work to review additional optometry contracts that were historically put in place previously under CCG's. A summary of these contracts will be collated outlining the cost to the ICB and benefits to patients of the service – and any place/local actions required to support any subsequent commissioning decisions.

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

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

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

7. Link to meeting CQC ICS Themes and Quality Statements

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

8. Risks

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

9. Finance

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

10. Communication and Engagement

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

11. Equality, Diversity and Inclusion

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

12. Next Steps and Responsible Person to take forward

Christopher Leese, Associate Director Of Primary Care
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13. Officer contact details for more information

Christopher Leese, Associate Director Of Primary Care
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Any references in the below can be followed via the main link NHS England » Changes to the GP Contract in 2025/26

GP Contract Finance

1. In 2025/26 there will be an overall increase in investment of £889m across the core practice contract and the Network Contract Directed Enhanced Service (DES). This will take the combined total estimated contract value from £12,287m in 2024/25 to £13,176m.

2. This provides 7.2% cash growth on the contract funding envelope (estimated 4.8% real growth on overall 24/25 contract costs) and includes:

    a. funding an assumed increase in salaries of 2.8% in 2025/26
    b. continuation of GPs in ARRS
    c. funding to cover the costs nationally:
        i. of other cost growth pressures, including from premises and list growth
        ii. to reflect the increased level and complexity of activity.

3. A further uplift may be made following the government's response to the Doctors' and Dentists' Pay Review Body (DDRB) outcomes for 2025/26.

Core practice contract

Streamlining incentives and supporting secondary prevention - QOF

1. DHSC and NHS England will permanently retire the 32 QOF indicators income protected in 24/25 (see annex B). This equates to 212 QOF points worth c.£298m in 25/26 of which:
    a. 71 will be removed outright, with the corresponding c£100m invested into Global Sum (c£70.4m in 2025/26) and to support both an increase in the Item of Service (IoS fee) to £12.06 for routine childhood vaccinations (c£17.8m in 2025/26) and the locum reimbursement rates in the Statement of Financial Entitlements (c£12m in 2025/26).
    b. the remaining 141 redistributed proportionately across nine CVD prevention indicators (see Annex C), resulting in the balance (an additional c£198m more than 2024/25) targeted towards CVD prevention - a key driver of excess mortality.

2. In order to support the government's ambition to reduce premature mortality from heart disease or stroke by 25% within a decade:
    a. the upper achievement levels will be raised for the CVD prevention indicators that will increase in value for 25/26; and
    b. the lower thresholds will be maintained at 2024/25 levels to offer the maximum opportunity to earn QOF points for these indicators. Annex C also sets out the proposed threshold changes.

3. There will also be a small number of technical changes to QOF indicators that will bring indicators into alignment with NICE guidelines that have been updated and republished since the scheme was last published (see Annex D).

Increasing locum reimbursement payments in the SFE

4. In response to feedback from GPC England, the locum reimbursement payments in the Statement of Financial Entitlements (SFE) relating to parental leave, sickness absence, prolonged study leave (including educational allowance payment) and suspended doctors will be increased in 2025/26. These payments were increased by 6% in 2024/25 following the Government response to the Review Body on Doctors' and Dentists' Remuneration (DDRB) recommendations but had not been increased for a number of years previously.

5. The payments will increase in line with previous pay uplifts (effectively unwinding the previous freeze) with the new payment amounts set out in the 2025/26 SFE. The overall cost of this will be c£12m in 2025/26 with funding drawn from a portion of the removed QOF indicators (see paragraph 4a of this annex).

Vaccinations and Immunisations

6. Following recommendations by The Joint Committee on Vaccination and Immunisations (JCVI), the following changes will be made to the routine childhood and adult schedules in 2025/26:

    a. two changes to the childhood vaccination schedule, driven by the discontinuation of the Menitorix (Hib/MenC) vaccine, including:
        i. an additional dose of Hib-containing multivalent (6-in-1) vaccine, offered at a new immunisation visit at 18 months of age.
        ii. the second dose of MMR vaccine brought forwards from 3 years 4 months to the new immunisation visit at 18 months of age to improve coverage.

b. the exchange of MenB and PCV vaccines within the childhood schedule (subject to final ministerial agreement).
c. a change to the adult shingles programme, reflecting new evidence on the effectiveness of the vaccination for a broader severely Immunosuppressed (SIS) cohort.
d. the potential introduction of a varicella vaccine, subject to final ministerial agreement, in quarter 2 of 2025/26.
e. an amendment to the requirement to record the dried blood spot test for at risk babies, allowing that recording to take place between 12 and 18 months.

7. The detailed changes to the routine childhood schedule are attached at annex E and will be supplemented with further guidance. All changes (to both the childhood and adult routine schedules) will be included in an amended version of the SFE in 2025/26.

8. In response to feedback from GPC England and reflecting the key role that general practice plays in efforts to increase uptake in childhood vaccinations, the Item of Service (IoS) fee for routine childhood immunisations that are part of essential services will increase by £2 to £12.06 in 2025/26. There will be an evaluation during 2025/26 of the effect that these changes have on activity, uptake and inequalities in uptake.

9. The 2025/26 SFE will list all the vaccinations and immunisations which are in scope of the increase in the Item of Service fee. c.£17.8m of the funding generated through the retired QOF indicators (see paragraph 4a of this annex) will be used to cover the estimated costs of this increase.

10. The SFE will also be amended to address inconsistencies in the treatment of patients that move practice. Currently, if a patient receives a vaccination at their practice and subsequently moves to a new practice in month, either only the new practice is paid or no practice is paid, depending on the receiving GP system supplier. The SFE will make clear that the receiving practice will be paid for the intervention. This is consistent with the approach to payments for departing patients taken elsewhere in the GP contract.

Online consultation tools switched on for the duration of core hours

11. From 1 October 2025 practices will be required to keep their online consultation tool open for the duration of core hours (8.00am-6.30pm) for non-urgent appointment requests, medication queries and admin requests. This will be subject to necessary safeguards in place to avoid urgent clinical requests erroneously submitted online. Guidance will be displayed on practice websites and reflected in the wording of the patient charter.

Enabling GP Connect

12. By no later than 1 October 2025 GP contractors will be required to ensure the following functionality is enabled in GP Connect which:
    a. allows read only access to patients' care records (GP Connect Access Record HTML and Structured) by other NHS commissioned providers, for the purposes of direct patient care and read only access for providers of private healthcare (only in cases where the private provider obtains explicit permission from the patient to access their NHS GP care record, and they are providing direct care to the patient).
    b. allows Community Pharmacy registered professionals to send consultation summaries into the GP practice workflow (GP Connect Update Record).

Patient Safety Strategy

13. The primary care patient safety strategy[1] was published in September 2024. In 2025/26 GP practices will be required to have regard to the patient safety strategy and also register for an administrator account (unless their local risk management system is already connected) with the learn from patient safety events service (LFPSE) for the purposes of:

    a. recording patient safety events at the practice about the services delivered by the practice, thereby contributing to the national NHS-wide data source to support learning, improvement and learning culture.
    b. enabling the practice to record patient safety events occurring in other health care settings (for instance if a GP practice wished to record an unsafe discharge from hospital).
    c. individuals recording patient safety events being able to download a copy of the record for purposes of supporting appraisal and revalidation.

What patients can expect from general practice

14. NHS England will publish a patient charter which will set out the standards a patient can expect from their practice, as outlined in the GP contract. The charter will need to be published on the practice website. This will improve transparency for patients and make it easier for them to know how practices will handle their request and what to expect from their practice.

[1] https://www.england.nhs.uk/publication/primary-care-patient-safety-strategy/

Safe and effective provision of high quality primary medical services to patients registered out of area

15. There will be a contractual requirement that GP contractors work collaboratively with commissioners to implement out of area registration. This will provide safeguards when practice lists are expanding rapidly with the registration of out of area patients.

16. In these instances, contractors will need to seek approval of their plans to enable commissioner oversight of the safety and effectiveness of the arrangements so patients can access the full range of primary medical services.

17. The trigger for the approval being required will be commissioner determined following consultation with the Local Medical Committee (LMC). At the point that such an application is required and made, the contractors patient list should be closed to new out of area registrations until the commissioner is assured of the arrangements the contractor has in place. In making the decision, the commissioner should always seek to enable and maintain patient choice of GP practice.

Dissolution of partnerships

18. The GP Contract regulations will be amended to make clear that GMS contracts can be terminated in the situation where there is no clear successor when a partnership dissolves.

Violent patients

19. NHS England and DHSC support GP practices to immediately remove from their patient lists patients who commit acts of violence and threatening behaviour towards practice staff. The relationship between patients and practices can also breakdown for a variety of other reasons, and it is important to maintain an element of patient choice in choosing an alternative practice.

20. The process for patient removal will be made clearer in the GP Contract regulations, in a way that protects the right of practices to immediately remove violent patients, whilst ensuring patient choice is retained when patients have not been immediately removed from their previous practice.

21. The changes will also reinforce the importance of practices processing the immediate removal of violent and threatening patients alongside reporting this to the police within the period set out in regulations. It will also be made clear that police reports made after this period, should not necessarily affect patient choice of alternative provider and should not necessarily mean that the patient requires allocation through the Special Allocation Scheme.

Managing patient lists

22. Amendments will be made to the GP Contract regulations to enable NHS England to contact a patient digitally (as opposed to in writing) when it becomes aware that a patient has moved from the practice area. This will allow additional routes for NHS England to advise the patient to either obtain the contractor's agreement to remain on the contractor's list of patients or to apply for registration with another provider of essential services.

23. The notice timeframe for deregistration will be reduced from 6 to 3 months when a patient is no longer known to NHS England.

Further changes to the SFE - adjustment factor for care homes and dispensing payments

24. There will be additional amendments to the SFE to:
    a. clarify that the adjustment to Global Sum for care home patients should apply only to CQC registered nursing and residential homes.
    b. to enable claims for high-volume personally administered vaccines to be returned either via the new digital portal, or via the current process through post.

The Network Contract Directed Enhanced Service (DES)

1. The following changes will be made to the Network Contract DES in 2025/26.

The Additional Roles Reimbursement Scheme (ARRS)

2. The ARRS will be made more flexible in 2025/26 with the following changes:
    a. the continuation of funding into 2025/26 for the cohort of ARRS GPs recruited during 2024/25 which equates to £186m for the full year.
    b. combining the GP ARRS funding with the main ARRS pot (removing the GP ARRS ringfence).
    c. from the combined funding pot, allowing PCNs to claim reimbursement for GPs alongside existing ARRS roles plus practice nurse roles which will be added to the scheme.

3. The eligibility criteria for GPs will remain those individuals who have obtained the CCT within the last two years (at the point of recruitment) and who have not been previously substantively employed as a GP in general practice.

4. In order to support the recruitment of GPs via the ARRS, the salary element of the maximum reimbursement amount that PCNs can claim will be increased from £73,113 in 2024/25 (the bottom of the salaried GP pay range) to £82,418 in 2025/26 (an uplift of £9,305 representing the lower quartile of the salaried GP pay range) reflecting that some GPs will be entering their second year on the scheme. Proportionate employer on-costs will also be included within the overall maximum reimbursement amount. As in 2024/25, there will be a maximum reimbursement amount for those GPs outside London and a maximum reimbursement amount including London weighting which will be set out in the 2025/26 Network Contract DES specification.

Changes to the Capacity and Access Improvement (CAIP) Payment

5. The Capacity and Access Support Payment (CASP – worth £204m) will continue in 2025/26 and remain unconditional for PCNs. The Capacity and Access Improvement (CAIP) payment will continue (worth £87.6m) but will change from three domains down to two.

6. One domain will continue to focus on supporting modern general practice access (worth £58.4m) while the other (worth £29.2m) will incentivise PCNs to use the intelligence gained from population health risk stratification tools to stratify their patients - including to identify those that would benefit most from continuity of care.

7. The full details will be set out in the 2025/26 Network Contract DES specification and guidance.

Enhanced services

General practice requests for advice and guidance

1. Practices will have the opportunity to take part in a new enhanced service worth up to £80m for advice and guidance (which will begin in April 2025). This funding is in addition to the increase of £889m across the core practice contract and the Network Contract DES.

2. The enhanced service will incentivise even closer working between general practice and secondary care and support the government's commitment to move more care from secondary care into community settings. It will help to ensure that patients receive care in the right place at the right time via the use of specialist advice and guidance, whilst also supporting elective recovery.

3. Practices will be able to claim (subject to eligibility criteria set out in the enhanced service specification) a £20 Item of Service (IoS) for pre-referral requests.

The Weight Management Enhanced Service

4. The Weight Management Enhanced Service will continue in 2025/26. Practices will receive £11.50 per referral with total funding of £7.2m for the enhanced service.

NHS
Cheshire and Merseyside

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

Operational planning guidance response

Access Improvement - contracting and commissioning oversight 25/26 (Primary Medical)
17 April 2025

Agenda Item No: SPCC 25/04/B11

Responsible Director: Clare Watson

1. Purpose of the Report

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

- An update in respect of the ICB's response to the operational planning guidance for primary medical services for 25/26
- An outline of key initial actions that the ICB needs to put in place to support delivery of this and meet national asks
- An outline of the expected ICB approach to primary medical access improvement and contracting for 25/26. This approach will be finalised in a June plan in which the ICB will outline final plans to improve general practice contract oversight, commissioning and transformation and tackle unwarranted variation in 25/26.

2. Ask of the Committee and Recommendations

The Committee is asked to ;

a. ***Note*** the updates in respect of the operational planning guidance response.
b. ***Discuss and support*** the recommended key actions/approach listed in 4.2, that the ICB will need to put in place initially to support this (***noting*** further actions may be required once we have the final national feedback on the submission)
c. ***Note*** the risks given in 4.4.

The reason the Committee is asked to discuss and support the recommendations is to ensure our current operating model for primary medical can support delivery of the planning guidance asks and put in place due oversight.

3 Background

3.1 NHS England published the annual Priorities and Operational Planning Guidance for 25/26 in January NHS England » NHS operational planning and contracting guidance . The headline national priorities for primary care (medical) within it were ;

- Improve patients' access to general practice - ICBs are expected to continue to support general practice to enable patients to access appointments in a more timely way and improve patient experience.
- ICBs should ensure that all GP practices inform patients, on the day they first make contact, how their request will be handled, as stipulated in the GP contract.
- All ICBs are expected to put in place action plans by June 2025 to improve contract oversight, commissioning and transformation for general practice, and tackle unwarranted variation
- Continue to support the delivery of modern general practice access and target support to practices based on their ability to provide access and a good overall experience for patients

- NHS England will provide general practice teams and primary care commissioners with national guidance, evidence-based content and support tools
- NHS England will also support trusts to work with primary care to streamline the patient pathway, improving the interface between primary and secondary care, with clear recommendations through the 'Red Tape Challenge'. This guidance is currently awaited.

3.2 Alongside the operational planning guidance, guidelines were published to help ICBs, local authorities and health and care providers continue to progress **neighbourhood health** in 2025/26 in advance of the publication of the 10 Year Plan - NHS England » Neighbourhood health guidelines 2025/26 . Primary Care are a major part of this, not least through actions that support modern general practice access models.

4 Executive Summary

4.1 In response to the asks in 3.1, the ICB were asked to submit a template plan response to NHS England. The final submitted response is given in **Appendix 1**. The template plan centres around the below core elements (as requested by NHS England) ;

a. Plans to improve general practice contract oversight, commissioning and transformation and tackle unwarranted variation in 25/26
b. Support delivery of modern general practice and target support to practices to deliver access and a good overall experience for patients, including digital measures
c. Identifying practices requiring targeted support to improve access and move to modern general practice
d. Implementing the 2025/2026 GP contract

In **delivering** the above, it is noted that not all elements are core contractual requirements for Practices – but all are asks for ICBs to put plans in place to deliver.

In addition, to support the above asks, **a national data set** (GP Dashboard) will go live from April/May and this will become part of the key measurements by which the ICB will be measured on variation, over time – some further context on this is given below ;

- The GP Dashboard is being introduced as a national support tool for 2025/26 Operational Planning Guidance and the national priority to improve patients' access to general practice.
- Specifically, the GP Dashboard will support ICBs in the implementation of their action plans (required by operational planning guidance) to improve contract oversight, commissioning and transformation for general practice, and tackling unwarranted variation.
- ICBs should use the GP Dashboard alongside local information, indicators and intelligence to identify unwarranted general practice

service variation and inform their continuing risk-based approach to reviewing GP contracts, understanding practice needs and supporting improvement.

- The nation access indicators / dataset proposed to be included are (these are to be confirmed and are under development currently) ;

  Number of general practice appointments per 10,000 weighted patients
  GP Appointments - Proportion appointments within 2 weeks
  % patients describing their overall experience of their GP practice as 'very good' or 'good' (GPPS)
  % patients describing their overall experience of contacting their GP practice on this occasion as 'very good' or 'good' (GPPS)
  Emergency ACS Admissions per 1,000 Registered Patients (UC-03)
  All A&E attendance rate
  Cloud Based Telephony
  % of calls to NHS 111 in hours
  No. of OC submissions per 1000 registered population per month and both admin and clinical together
  No. of Pharmacy First common condition referral per 1000 registered population

4.2 For the ICB to meet the above asks some **key actions**, outlined in our planning return to NHS England - are recommended to be put in place. These will support a more consistent single approach to addressing access and providing onward assurance ;

a. **Oversight / assurance to the Board and NHS England will be via this Committee,** against progress on key measurements/actions - via **a standing agenda item**
b. As part of this a **progress summary report** will be included for the Committee to receive assurance on key actions. A standard template will be produced for this which will include any place reporting required, to give assurance in respect of the national asks.
c. **More regular patient experience feedback as part of the standing agenda item**– this may also include deep dives on certain areas of access - and will include progress as part of the tracking of actions from the localised **Healthwatch survey** report, which was also presented at this committee meeting.
d. That **place primary care forums undertake a mirrored approach** to track progress, to support the assurance/reporting above and ensure consistency.
e. A **consistent 'data' approach using a common dataset to identify variation in access** -currently a locally produced dashboard of indicators is used – but eventually the national GP dashboard will become the base set of indicators by which variation

is measured (alongside any other local relevant measurements). The current set used was discussed at the last Committee meeting and is given in **Appendix 3.** A regular update against key access indicators will be part of the regular standing agenda item/report / updates from place. This may be further refined when NHS England confirm the national metrics that will be used to assess ICB progress in this area, and any confirmation of expected trajectories. It should be noted that the expectation is that ICB's are working to a single list of variation indicators to target support and resources accordingly.

f. **Assurance in relation to practices identified through outlier/access variation work** for improving access and modern general practice progress. This may be in the form of an action/support plan and would include any support identified, e.g. offer of referral to GPIP (General Practice Improvement Programme/Practice Level support).
g. A **primary medical place/system commissioning group** bringing together place / system to support consistency and assurance/reporting be formed – which can also be used to share best practice/success stories and learning across place - and oversee the delivery of the planning guidance asks.

To further support the response, the Committee should also ***note*** that ;

- The ICB will have to submit by June an overall **'action plan'** to improve general practice contract oversight, commissioning and transformation and tackle unwarranted variation in 25/26. This is subject to any regional timelines being confirmed and we are currently awaiting the guidance to support the production of this plan.
- Building into the above, continued regular feedback and engagement with the **Local GP Network and LMCs.**
- **Related action plans/workstreams** will also be/are in place as below and these will feed into the overall action plan, namely ;
    - Pharmacy First (in place)
    - Digital Action Plan (to be developed)
    - Neighbourhood health – the assessment framework currently being undertaken by places to assess readiness for 'modern general practice access' is given in **Appendix 2** (this assessment is already in progress and may also be needed at practice/PCN level). There will be cross reporting into this workstream through the MGPA section (in progress).
    - Enhanced Services (already part of variation workstream, in progress)
    - Other actions/steps may need to be put in place, but this will be discussed as part of the future discussions in relation to the ICB's operating model.

4.3 Risks to delivery - As part of the operational planning guidance work, it was noted that some key risks exist, which include ;

- Staff/ resourcing.
- Data availability and at what level data is available
- Clarity from NHSE on 'interim' measurements expected pending the national GP dashboard, has been sought, to ensure the ICB approach aligns.
- Internal funding agreement to support elements of the above be made in a timely manner.
- Drivers/levers to support reduction in variation and modern general practice access and referral to GPIP.
- Flex in our current operating model to support a more single approach to respond to the national asks.
- Resources to undertake/refresh our EQHIA plan.
- That the national GP Dashboard launches as planned and all data sources pull through

These will need to be worked through as the ICB undertakes its wider review of operating costs and via the group being formed at system level (4.2(g) above).

5 Next Steps

5.1 We are currently awaiting some final feedback from NHS England nationally on our planning guidance response – verbal indications are that some further information/clarification may be required in due course.

5.2 Assurance to the Board - via the Chair's update - as to actions taken by this Committee to meet the asks and to raise awareness.

5.3 At the next meeting of this Committee, the June action plan will be presented - along with a readiness update on key areas, as part of this revised approach.

5.4 A revised overall Access Improvement Plan will need to be agreed in due course, incorporating the June plan and outputs from the awaited 10 year plan and current ICB operating model discussions.

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

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

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

money

7 Link to meeting CQC ICS Themes and Quality Statements

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

8 Risks

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

9 Finance

Will be covered in the separate Finance update to the Committee in relation to SDF funding.

10 Communication and Engagement

No external formal consultation or further engagement is required in respect of this paper. But communications and engagement with stakeholder, providers and our patients is key to understand and take forward the actions and recommendations..

11 Equality, Diversity and Inclusion

An EQHIA (Equalities Health Impact Assessment) was originally undertaken to support the original Access Improvement Plan(s) and further work will be required to support delivery of the above to understand and plan for appropriate solutions for all our population.

12 Next Steps and Responsible Person to take forward

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Appendix 1 – Operational planning guidance March submission

Key areas of focus to support delivery	**2025/26 improvement opportunity planned**	**Key delivery actions**
Guidance on completion	*Please the summarise the realisable improvement opportunity for 2025/26 and how this contributes to your planned performance (with quantification / reference to relevant metrics wherever possible). Any amendments/additions to the 27th February 2025 submission should be highlighted in RED.*	*Describe the key actions you will take to implement each piece of best practice guidance (if not already in place). Include key milestones and timings.* *Rate each action as High, Medium, or Low impact depending on how much they will improve performance for your system.*
Put in place action plans to **improve general practice contract oversight, commissioning and transformation** and tackle unwarranted variation in 25/26. [Draft action plans in place in line with PG timelines; finalised plans June 25]	**Overall improvements** 1. A more consistent approach to measuring variation across the ICB against a framework set out in the 'June Plan' ***supporting reducing variation and targeting of resources*** 2. Using a more common set of metrics across all places to achieve this (depending on where available at sub ICB level) each with an improvement trajectory ***Supporting reducing variation and targeting of resources*** 3. A stronger emphasis on improving patient experience measures as part of this, underpinned by the results of the local healthwatch survey reporting in May ***to enable quantifiable and ongoing improvement trajectories for patient experience including tracking of ONS Patient Survey*** **4.** Supporting a single/more consistent offer to patients for primary medical access, determined and reported as a system , across all 9 places ***resulting in overall improved patient experience./ reduction in variation*** *5.* Supporting Transformation of Primary Care as part of neighbourhood health workstream which ***includes Primary Care achieving MGPA and benefits of this (section 3 below)***	**How will this be achieved** 1. **The ICB will self assess capability and capacity/current approaches** using tools such as the CATS framework to assess our internal approach(s) *but there will need to be some adaptability of this tool to fit our operating model and NHSE are in discussion with the ICB about adapting this* To commence from April and outcomes in the June Plan Medium 2.**The ICB will agree a more consistent single set of metrics for measuring UV in line with the PG ask**, existing approaches/indicators and narrowing these to a common set - *These will centre around the following (to be confirmed)* *-Key Patient Experience indicators* *-Measures taken from our existing common indicator framework for primary medical which are part of our existing dashboard* *- MGPA measures (such as maximisation* of use of the NHS app) **These will become aligned to the metrics being developed as part of the GP Dashboard** reporting -- so the current set will be subject to change once those are finalised – and the GP Dashboard is live. Local patient experience measures, for example the outcomes of our local Healthwatch survey, will underpin this work further. In addition to the above **analysis of EDEC data** will also be a consideration , in particular those indicators that could be seen as impacting on access and support variation, such as in hour closures. The ICB will use these metrics as a guide to identify and understand variation, target support and any referral to PLS or other support with Practice agreement Metrics (s) will form an appendix to the June Plan GP Dashboard live date TBC Actions in progress using existing ICB data Medium/High 4.ICB teams will be asked to plan against the common measures **and use these to identify practices for potential support including PLS or additional**

		support/actions outside of PLS, e.g resilience funding. This could include targeted work with practices in our most deprived areas, as determined. In progress by April Medium 5.**Actions will be put in place to support system oversight,/grip and a more consistent approach to contract oversight** The System Primary Care Committee, working to the ICB Board and the 9 Place Primary Care Forums, will oversee the accountability and performance of this with Board agreement – this will include a standard progress report at each meeting to SPCC from Place(s) regarding variation and improvement - and a regular access / patient experience agenda item with Healthwatch to check patient experience feedback throughout the year To be Agreed at SPCC April Meeting In place from June meeting Medium In addition a central operations group has been set up with place / system representation to oversee the ongoing work in between reporting and ensure alignment Already in place Medium 6. **Production of the 'June' Plan** which will pull all of the above together into a single ICB plan with place level operational plans By June Medium **7Transformation of Primary Care** as part of neighbourhood working plans – separate workstream in progress Already commenced Medium/High 8. **Any Planned reviews of non core place level schemes or system variation work** - that could align to this work (would only happen in year) and any potential impact would be from 26/27 – place teams to confirm (ongoing/in year) Low
Support delivery of **modern general practice and target support to practices to deliver access and a good overall experience for patients**, ensuring financial support is in place for practices for MGP digital tools and that use of other services to improve access (including Pharmacy First) is optimised.	**Overall Improvements** 1 Achievement of MGPA consistently across all practices/PCNs the neighbourhood working (Please refer to neighbourhood maturity matrix for further details) This also includes related actions such as - Improved uptake in pharmacy first - Increased uptake /Utilisation of NHS App features ***to support improved access and reduce variation*** 2.***Support Better access experience by telephone through*** maximisation of Cloud Based Telephony Solutions digital tools to deliver improved online access.	**How will this be achieved** 1 ICB teams are **completing neighbourhood maturity matrix** to assess overall status against MGPA - this and other metrics can be used / drilled down to assess the overall position of practices/pcns on their journey to MGPA May Medium 2 **Supporting additional metrics** agreed as part of above work and onward monitoring (see above) April Medium 3 **ICB support/engagement and communications for MGPA** In progress/ongoing

		Medium 4 **CAIP investment in MGPA** – supporting 100 per cent of claims in line with the PCN DES spec (still awaited) In year in line with national DES spec – from April High 5 **SDF investment** agreed via Execs April High 6 The ICB has developed a **Digital Primary Care sub strategy** which is currently being implemented within resource constraints. 7 **Optimisation of Digital Tools** to support the Delivery of Modern General Practice, namely online consultations, video consultations, care navigation, patient communication, self booking, demand & capacity and cloud Based Telephony solutions. Further details on the digital plans will be shared once funding is confirmed 8 **Sharing of best practice in a more systematic way outside of PLS** - Note – consideration of use of Peer Ambassadors is under discussion. Funding dependant – TBC Medium Further details on the above in the 'June Plan'
Identify those practices (no.) requiring **targeted support to improve access and move to modern general practice**; secure/ provide high quality evidence based support to those practices from the national GPIP contract or through local arrangements, put in place engagement and improvement trajectories	**Overall Improvements** 1 A more targeted approach to supporting practices in an effort to focus on practices who have *been identified through Place variation analysis above***,** who are open to additional support (see above actions) to *reduce variation/support a* ***more single offer for primary care in particular our most deprived communities*** 2. ***Improvement patient experience and a more consistent improved experience for all our patients, regardless of location*** 3 Supporting practices to share best practice/learn and develop in areas of challenge in relation to MGPA and identify solutions to internal demand and work issues by providing support of a recognised provider, ***to enable continuous cycle of improvement/learning to further improve access and support practices to deliver this***	**How will this be achieved** 1 The ICB is working with the nationally identified training GPIP/PLS provider (RCGP) to **develop the offer for the ICB for 25/26** In progress Finalised end of April timeline/entry points for practices TBC throughout the year M 2 **ICB to engage and socialise with Practices/LMCs re this at local level,** based on learning from 23/24 In progress M 3 The ICB will use the **metrics given above to support identification of practices for support/referrals** and at what level within the training offer (noting that practices do not have to take up the offer/non 'targeted' practices may wish to take up the offer conversely) April M 4 The **ICB will support/track practices using an overall action/improvement plan** against available metrics over time In year depending on when Practices enter the programme M 6 **SDF investment** agreed via Execs ICB place teams are currently identifying indicative numbers to support Exec Discussions in April

		28 Practices took this offer up in 24/25 and the ICB is looking to build on this, dependant on number of practices who agree to the support M Further details in the 'June' Plan
Implement Primary Care Contracts including the **2025/2026 GP contract**	**Overall improvement** The ICB will seek to maximise core contract, DES and QOF opportunities ***to continue to improve access and reduce variation*** *using indicators above* and support practices to achieve MGPA via the PCN DES/Digital asks	**How will this be achieved** 1.Working through awaited guidance to **support on line consultation tool** during core hours, from 1.10 Awaiting guidance Low 2 The ICB continues to **support maximisation of ARRS roles** through the PCN DES, noting new flexibilities including a focus on GPs under the ARRS roles which supports wider ICB workforce ambitions re GP retention/recruitment In year High 3 **Maximisation of CAIP MGPA claims/actions under the PCN DES (**guidance currently awaited) supporting MGPA Actions (above) In year claims M 4.**Provide guidance and monitor enablement of GP Connect** functionality to allow read only access to patient's care records and consultation summaries to be sent by Community Pharmacies. 5.The ICB's **Data into Action** programme provides a sound basis for PCN's to risk stratify their patients in accordance with need. Further details, where relevant, in 'June' Plan

Appendix 2 – Place Modern General Practice Access Assessment extract (in progress as part of neighbourhood health workstream)

B. Modern general practice

	Completed - Confirm provision	In progress - Confirm current state and next steps	To do - Plans / and key partners to be identified
ICBs are asked to continue to support general practices with the delivery of the modern general practice model, to deliver improvements **in access, continuity overall experience for people and their carers.** This is a response to increasing demand and a foundational step to enable practices to move from a model of reactive to more proactive care.			
ICBs are expected to streamline the end-to-end access journey for people, carers and staff, making it quicker and easier to connect with the right healthcare professional, team or service, including community pharmacy, Pharmacy First Digital self-service options such as repeat prescription ordering via the NHS app. This approach will accommodate the needs of different groups and patients and support continuity of care.			
People and their carers should have the ability to access services equitably in different ways (online, telephone and in person) with highly usable and accessible online systems (the NHS app, practice websites, online consultation tools) and telephone systems. There should also be structured information gathering at the point of contact (regardless of contact channel) and clear navigation and triage based on risk and complexity of needs.			
Staff should have access to structured information about the complexity of the presenting complaint and need. This information should be organised alongside population segmentation (including by age) and risk stratification information into a single workflow. This approach will support staff in efficiently navigating and triaging needs safely and fairly, including enabling risk-based prioritisation of continuity of care and optimising use of the general practice and wider multi-professional team.			

Appendix 3 Current Primary Care Indicators used by place (access indicators are shaded) note other data is used but this is the core set

List Size
IMD Score (Average)
Female Life Expectancy (Average)
Male Life Expectancy (Average)
CQC (Inspection) Rating
Appointment rate per 1,000 population
% Face to Face appointments
% Same Day appointments
% GP Led appointments
Friends and Family - No submissions last 3 months
Friends and Family - % recommended
GP Survey Response Rate
Good Experience when contacting GP Practice %
GP WTE rate per 1,000
Nurse WTE rate per 1,000
Admin WTE rate per 1,000
DPC WTE rate per 1,000
(All) AE Rate per 1,000 - (Yearly)
Emergency Admission rate per 1,000 - (Yearly)
Emergency Admissions ACS Chronic rate per 1,000 - (Yearly)
Emergency Admissions ACS Acute rate per 1,000 - (Yearly)
GP Referred 1st OP rate per 1,000 - (Yearly)
Cervical Screening Coverage (Age Group 25 To 49)
Cervical Screening Coverage (Age Group 50 To 64)
Breast Screening Rate
Bowel Screening Rate
% MMR 1 @ 2 Years
% MMR 1 @ 5 Years
% MMR 2 @ 5 Years
QOF PCA Rate (All Domains)

Flu uptake 2 - <5 year olds
Flu Uptake over 65s
LD Annual Health Check 14+
SMI Annual Reviews

Primary Care Finance Update

NHS Cheshire and Merseyside

NHS Cheshire and Merseyside Primary Care Committee (System Level)

Date: 17th April 2025

NHS Cheshire and Merseyside
Primary Care Committee (System Level)

NHS Cheshire and Merseyside

Date of meeting:	17th April 2025
Agenda Item No:	SPCC 25/04/B12
Report title:	**24/25 Primary Care Finance Update**
Report Author & Contact Details:	Lorraine Weekes-Bailey, Senior Finance Manager - Primary Care John Adams, Head of Primary Care Finance
Report approved by:	Mark Bakewell-Director of Finance

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

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

N/A

Executive Summary and key points for discussion

The report provides the Primary Care Commissioning Committee of the Cheshire and Merseyside Integrated Care Board (ICB), with a detailed overview of the preliminary financial position related to primary care expenditure as at the end of March 2025 (M12).

The report covers seven areas of spend: -

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

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

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

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

NHS Cheshire and Merseyside
Primary Care Committee (System Level)

NHS Cheshire and Merseyside

Recommendation/ Action need:	**The Committee is asked to:** The Primary Care Committee is asked to: - 1. Note the preliminary combined financial summary position outlined in the financial report as at 31st March 2025. 2. Note the Additional Roles spend and central drawdown. 3. Note the capital position.

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

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

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

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

Primary Care Finance Update

1. Introduction and Background

1.1. The report provides the Primary Care Commissioning Committee of the Cheshire and Merseyside Integrated Care Board (ICB) with a detailed overview of the draft financial position in relation to primary care expenditure anticipated for 2024/25 as at 31st March 2025.

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

1.3. The financial positions for March 2025 (M12) are based on the historical recurrent expenditure at each Place plus in-year amendments, including any uplifts for national assumptions.

2. Financial Position

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

NHS Cheshire and Merseyside
Primary Care Committee (System Level)

NHS Cheshire and Merseyside

Table 1

Primary Care Position Summary - Month 12 ICB TOTAL	Year To Date		
	Budget (£000's)	Actual (£000's)	Variance (£000's)
Delegated Medical Primary Care			
Core Contract	330,781	329,270	1,510
QOF	39,406	39,672	(266)
Premises Reimbursements	54,375	53,949	426
Other Premises	743	699	44
Direct Enhanced Schemes	4,906	4,900	6
Primary Care Network	54,562	55,189	(626)
Additional Roles Reimbursement Scheme	67,978	68,952	(974)
Fees	10,671	10,689	(18)
Other - GP Services	1,367	1,298	69
DELEGATED PRIMARY CARE TOTAL	**564,788**	**564,617**	**171**
Local Primary Care			
GP Local Enhanced Service Specification	32,487	31,696	791
Local Enhanced Services	17,104	15,678	1,426
Commissioning Schemes	2,197	2,113	83
Out Of Hours	29,262	29,056	206
GP IT	19,913	17,434	2,479
GP Investment	303	218	85
Primary Care SDF	11,013	4,590	6,424
Primary Care Other	2,310	1,925	385
QIPP	(1,609)	0	(1,609)
PC Local Pay Costs	613	509	104
LOCAL PRIMARY CARE TOTAL	**113,594**	**103,218**	**10,376**
Prescribing			
Central Drugs	18,001	18,351	(349)
Medicines Management - Clinical	1,352	1,057	295
Oxygen	3,239	3,151	88
Pay Costs Prescribing	11,277	9,786	1,491
Prescribing BSA	490,701	514,896	(24,195)
Prescribing Other	10,895	16,795	(5,900)
PRESCRIBING TOTAL	**535,465**	**564,036**	**(28,571)**
Delegated Pharmacy Optoms Dental and Other			
Delegated Community Dental	12,983	12,859	123
Delegated Ophthalmic	26,954	26,903	51
Delegated Pharmacy	79,696	76,703	2,993
Delegated Primary Dental	136,606	136,819	(213)
Delegated Property Costs	1,512	616	895
Delegated Secondary Dental	43,166	43,061	105
PHARMACY, OPTOMS, DENTAL & OTHER TOTAL	**300,916**	**296,961**	**3,955**
TOTAL	**1,514,763**	**1,528,831**	**(14,069)**

3. Delegated Primary Care - Medical

3.1. The Delegated Medical Primary Care financial forecast for Month 12 is an expected overspend of £0.171m based on the current data and payments.

3.2. **Core Contracts-** The core contracts are currently forecast to underspend by £1.410m, principally because end-of-year list sizes are lower than expected. The quarter 4 list size has been accounted for within the financial forecast, so we do not anticipate any further changes to the forecast.

3.3. **Quality Outcomes Framework- (QOF)**- The Delegated Medical Primary Care budget shows an overspend of £0.266m within the QOF service line. This is due to year-end achievement costs in 2023/24 being higher than originally anticipated.

3.4. **Premises Reimbursements-** The expenditure anticipated for Premises reimbursement is £0.426m underspent. The finance team has been working with the estates team to ensure the data provided is robust and accurate. The costs across the Places show significant variation of underspends and overspends, with a mix of cost pressures from back-dated rent valuations, cost benefits on services charges and GL Hearn business rate recoveries. Overall, resulting in £0.426m underspend across Cheshire and Merseyside.

3.5. **Primary Care Networks-**The forecast outturn is expected to be an overspend of £0.626m, due to the actual achievement costs incurred at year end being much higher than projected.

3.6. **Additional Roles Reimbursement Scheme-** (see section 10 below).

4. Local Primary Care

4.1. **Local Primary Care**- The Local Medical Primary Care forecast for month 12 is an expected underspend of £10.376m.

4.2. **GP Local Enhanced Service GP Specification-** There is a projected underspend of £0.791m against the GP Local Enhanced Service specifications. There are two main reasons for this:

In Sefton Place, the budget was based on 100% delivery of the service specification. However, the current estimated achievement of 93.05% equates to an underspend of £0.394m.

Cheshire East place is projecting a £0.268m underspend. This was due to a duplication of budget for some services, this has now been released.

4.3. **Local Enhanced Services-** There are large variations within Local Enhanced Services across Cheshire and Merseyside, with some places overspending against their budgets and others underspending. However, the main reason for the overall underspend is the receipt of £1.426m income from the Home Office. This income is to support the Asylum seeker/refugee enhanced service/assessment costs. These costs were included within our expenditure forecast, so the income received has been offset against our expenditure.

4.4. **GP Out of Hours-** There is a projected underspend of £0.206m against the GP Out of Hours Service as actual list sizes are slightly below the estimate used to set the budget.

4.5. **GP IT**-There is a projected forecast underspend of £2.479m. This is due to savings on the cost of software licenses and additional VAT recoveries. The digital team were also able to secure some digital tools funding, which has been used to support several GP IT costs and services.

4.6. **Primary Care SDF-** The Primary Care SDF allocation is £11m. There was 2m was allocated directly to Place General Practice, a further £2.55m was allocated to support Digital projects, a GP Fellowship programme, GP Training and other transition and retention initiatives. The remaining £6.424m of SDF funding has been retained to support other system pressures.

4.7. **QIPP**- The QIPP target Local PC was £1.609m, this has been achieved through the savings mentioned above.

5. Prescribing

5.1. The Prescribing drugs financial forecast shows an overspend of £28.571m including a prior year pressure of £1.2m. There are a number of drivers attributing to the overspend, these include cost pressures and growth in activity above the national planning assumptions .

5.2. An additional month of prescribing data has now been received, this data now covers the period from April through to January. A review has been undertaken to understand likely costs for the rest of the financial year based on updated average costs per prescribing day, QIPP schemes and other initiatives (such as the waste management scheme launched in the autumn).

5.3. Dispensing days for December were exceptionally higher than anticipated, these have reduced slightly for January, our forecast anticipates a downward trajectory for February and March.

5.4. Please note the underspend of £1.491 against prescribing pay costs, this is due to a combination of vacancies within the medicines management team and costs being transferred to a corporate cost centre. Some of the Medicines Management team were previously employed by the Commissioning Support Unit (CSU), these staff transferred to the employment of the ICB during year, but the budget remains within prescribing.

6. Delegated Pharmacy

6.1. The out-turn position on the Pharmacy contract is an underspend of £3m. Previous reports recognised an ICB risk of £1.2m, but this has been removed and replaced by the surplus of £3m following receipt of several additional allocations for both the Community Pharmacy Contractual Framework and the Pharmacy First contract.

7. Delegated Optometry

7.1. Following receipt of a £182k allocation for Optometry in Special Educational Settings, the Optometry budget ends the year with a small surplus of £51k. Activity in Optometry services has risen steadily over the last year with total costs increasing by £1.5m (6%).

8. Delegated Other Costs

For information:-
The budget line “Delegated Other” consists of budgets for Transformation Team staff, NHS Mail and Remote Access costs for POD contractors, Sterile Product costs and an unallocated reserve of £0.9m.

8.1. The unallocated reserve was utilised by the ICB to mitigate pressures in the wider ICB plan and support the overall ICB financial position.

9. Delegated Dental

9.1. Dental funding is ringfenced in 2024/25 and cannot be used to support other services, with any underspends being clawed back by NHSE. Expenditure on the local dental investment plan has reduced the value clawed back.

9.2. Despite this additional investment, primary care dental contracts are still projected to underspend by £8m with this benefit been removed by NHSE through an allocation reduction.

9.3. The £15m Dental Investment Plan for 24/25 targets those patients most in need of treatment and expenditure has broadly been in line with plan. At the last meeting SPCC approved the expansion of the 2025/26 investment plan to £23.4m but will need to be managed within the overall funding envelope. Due to workforce capacity limitations, contractors appear to have been targeting their available staff resources towards the delivery of the Dental Investment Plan, resulting in slippage in core contracted activity.

9.4. Secondary care dental services underspent by £2m in 2024/25. The surplus has been removed by NHSE through an allocation reduction. Other national allocations have fully

funded the cost of 2024/25 contract uplifts and £0.5m remained following the withdrawal by Southport & Ormskirk Hospitals from the delivery of orthodontic services.

9.5. The outcome of the appeal lodged by the contractor for the five primary care dental contracts that were issued with termination notices in 2023, itself the culmination of action begun by NHSE prior to delegation, has concluded. The appeal found in favour of the ICB. The contractor had suggested that they would seek a judicial review, but they are now out of time to pursue this route. The care of patients in mid-treatment was arranged, and on-going care for displaced patients has been managed by commissioning additional UDAs from other local providers.

10. Additional Roles Reimbursement Scheme

10.1 The PCN entitlement for the Additional Roles Reimbursement Scheme for 2024/25 is £68,361,348. However, the allocation available to the ICB is £67,100,068.

10.2 As previously highlighted, due to the allocation methodology used by NHS England, the ICB currently has a shortfall in allocation available. The total shortfall for the ARRS and GP ARRS is £0.974m

10.3 Table 3 illustrates the budget and forecast at Place level and the spend forecast for GP ARRS

Table 3

Place	ARRS Allocation (Excluding GP ARRS)	Spend	%age Utilisation		GP ARRS Spend
Cheshire East	9,823,546	9,864,559	100%		175,536
Cheshire West	9,368,473	9,289,896	99%		94,595
Halton	3,418,326	3,418,325	100%		57,532
Knowsley	4,478,332	4,448,743	99%		34,381
Liverpool	14,769,221	14,685,070	99%		287,875
Sefton	7,099,621	7,117,033	100%		13,318
St Helens	5,277,580	5,169,156	98%		64,365
Warrington	5,309,567	5,321,574	100%		167,885
Wirral	8,816,683	8,653,431	98%		88,552
Total	**68,361,349**	**67,967,787**			**984,039**

11. Capital

11.1 Table 4 shows the end of year primary care capital expenditure position.

Table 4

Cheshire and Merseyside ICB Primary Care Capital Position - Month 12 2024/25

Resource	Cheshire & Mersey Planned £'000s	Cheshire & Mersey Received £'000s	Comments
Capital Resources			
BAU allocation	4,698	4,698	
BAU allocation transferred from/(to) Provider CDEL			
2024/25 Acquisition Accrual Reversals			
2024/25 Improvement Grant Accrual Reversals			
Redemption of Legal Charge	474	474	Knutsford War Memorial Hospital - legal charge redemption
IFRS 16 - schemes funded centrally	1,519	1,519	Drawn down when cost incurred. Ringfenced for IFRS16.
Total Expected Capital Resource	**6,691**	**6,691**	

Expenditure	Cheshire & Mersey Approved /Planned £'000s	Cheshire & Mersey Spent £'000s	Comments
Approved Expenditure			
GP Premises Improvement Grants			
Multi-year schemes approved in 2023/24	79	79	Approved 23/24
Schemes approved in 2024/25	1,702	1,689	Approved by Regional Director of Finance
Subtotal Improvement Grants	**1,781**	**1,768**	
GPIT			
Approved NW Region	3,388	3,383	Approved by Regional Director of Finance
Subtotal GPIT	**3,388**	**3,383**	
IFRS 16 - Schemes funded Centrally			
Disposal of The Department, Lewis's (Liverpool)	-343	-343	National team transfered funding
New Lease, Old Mkt Hse (Wirral)	253	253	National team transfered funding
Lease extension 5yrs, Ellis Centre	79	79	National team transfered funding
New Lease, Lakeside (Warrington)	1,530	1,530	National team transfered funding
Subtotal IFRS 16 - centrally funded	**1,519**	**1,519**	
Total Approved Expenditure	**6,688**	**6,670**	
Planned Expenditure Under Development			
GP Premises Improvement Grants	3		PIDs pending
GPIT	0		
IFRS 16 - Schemes not funded Centrally	0		
Subtotal Planned Additional Expenditure	**3**	**0**	
Total Approved and Planned Expenditure	**6,691**	**6,670**	
Capital Resource (Surplus)/Deficit	**0**	**-21**	

11.2 The ICB has managed to spend all bar £21k of its available primary care capital.

11.3 £1.768m has been spent on GP Premises Improvement Grant (IG) projects.

11.4 £3.388m of GPIT Projects were approved by this committee in June. PIDs for £3.383m covering all places were signed off by NHSE and the ICB's digital delivery partners have now procured the equipment. NHSE has been recharged with the cost.

11.5 IFRS16 schemes are accounting adjustments for leases. This is managed locally by the ICB Corporate team, and nationally by NHS England. The national team has released the funding to cover the ICB requirement shown in table 4.

11.6 In 2025/26 the ICB will receive an increased primary care capital allocation but will have to manage its own IFRS16 capital requirements.

12. Recommendations

The Primary Care Committee is asked to:

12.1 Note the preliminary combined financial summary position outlined in the financial report as at 31st March 2025.

12.2 Note the Additional Roles spend and central drawdown.

12.3 Note the Capital position.

13. Officer contact details for more information

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NHS
Cheshire and Merseyside

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

17th April 2025

General Practice Capital Allocation 2025/2026 – Estates and Digital

Agenda Item No: SPCC 25/04/B13

Responsible Director: **Chris Leese – Associate Director of Primary Care**

General Practice Capital Allocation 2025/2026 – Estates and Digital

1. Purpose of the Report

1.1 In line with the Scheme of Reservation and Delegation (SORD), the purpose of this paper is to seek approval on the following:

- **Approve** £8,472,714 of submitted bids for the Utilisation and Modernisation Fund
- **Approve** £2,803,151 of submitted bids for the Premises Improvement Grants (BAU Allocation – Estates Bids)
- **Approve** £1,896,849 of submitted bids for Digital requirements (BAU Allocation – Digital Bids)
- **Approve** the re-distribution of capital allocation where necessary between Estates and Digital through the Delivery Phase, where risks are escalated, and underspend is identified in either programme area.

1.2 The report also looks to highlight a summary of the robust review and pre-approval process that was undertaken prior to submission to this Committee.

2 Executive Summary

2.1 An overarching summary of this paper is affixed to this report.

2.2 Capital Allocation for Estates and Digital for 25/26 was confirmed as being a total of £9,727,000 excluding IFRS16 spending requirements. This is split between the **Utilisation and Modernisation Fund** (£5,027,000) and **the General Practice BAU Capital Allocation - Premises Improvements Grants and Digital** (£4,700,000).

2.3 The Utilisation and Modernisation Fund is a one-off capital funding stream for 2025/2026 and is intended to support estates schemes that increase the utilisation of existing primary care sites to improve patient health outcomes and increase the number of appointments delivered in primary care.

2.4 This will mainly be achieved by refurbishment or reconfiguration of the existing GP estate to maximise the clinical capacity. This fund is for Estates related bids only, therefore any associated Digital costs must be funded through the BAU Capital allocation.

2.5 The General Practice BAU Capital Allocation is a recurrent yearly allocation that can be used for Premises Improvement Grants (PIG) or other funding requests available via NHS Premise Directions 2024 or for Digital (GPIT BAU, GP Break fix and Infrastructure Investment).

2.6 As with the wider NHS Capital regime, ICB expenditure of primary care capital must not overshoot available envelope in any year. Additionally, ICBs are unable to carried forward unutilised capital resources to a subsequent year, although there may be some limited

flexibility exercisable by the regional NHSE team at their discretion, to manage the overall position across ICBs within the same region.

2.7 Place(s) and IT Providers were asked and supported in establishing a list of eligible projects for consideration and review. A full breakdown of bids is provided within Appendix One. They are summarised as:

- 73 Estates Bids across multiple Places submitted for Utilisation and Modernisation Fund
- 11 Estates Bids across multiple Places submitted for General Practice BAU Capital Allocation
- 6 Digital Bids relating to system critical infrastructure upgrades (does not include Digital 'bids' relating to Estates projects)

2.8 Wherein a revenue implication has been identified, through the due diligence stage, mitigations have been identified as below:

- If the GP Practice is GP Owned – rent is abated as per NHS Premises Directions 2024 in conjunction with District Valuer
- Revenue implications on majority of schemes likely to be immaterial due to capacity/investment being utilised on repurposing schemes.
- Revenue implications for larger scale bids have been sighted and approved by the relevant Place Governance process.

3 Ask of the Board/Committee and Recommendations

3.1 **The Board/Committee is asked to:**

- **Approve** £8,472,714 of submitted bids for the Utilisation and Modernisation Fund
- **Approve** £2,803,151 of submitted bids for the Premises Improvement Grants (BAU Allocation – Estates Bids)
- **Approve** £1,896,849 of submitted bids for Digital requirements (BAU Allocation – Digital Bids)
- **Approve** the re-distribution of capital allocation where necessary between Estates and Digital through the Delivery Phase, where risks are escalated, and underspend is identified in either programme area.

4 Reasons for Recommendations

4.1 All schemes have been reviewed against the ICS' Clinical Service Strategic Objectives and Core Estates Principles; resulting in being deemed to be value for money and essential to the ongoing delivery of General Practice services within Cheshire and Merseyside.

4.2 These projects will support General Practice in the following key areas:

- Increase in clinical and/or administrative capacity in premises
- Reconfiguration of existing premises supporting modern, fit for purpose estate

- Alleviating system pressure for access, demonstrated at a high level in Section 11
- Reliable and cyber secure networking
- Fit for purpose hardware and infrastructure to support the ongoing development of a modern General Practice

5 Background

5.1 NHS Cheshire and Merseyside ICS (the ICS) undertook a programme approach for 25/26 capital bidding. The programme was managed in stages with the intention of supporting both GP Practices and Places from a capacity and deliverability perspective.

5.2 In parallel, the Digital Providers within C&M were requested to assess what system critical investment was required in conjunction with providing Digital costs for associated Estates bids proposed to be undertaken.

5.3 Proposals were reviewed, scrutinised, and prioritised firstly by Place and a final review was undertaken by the Estates and Digital Capital Panel Review Group in order produce a final prioritised list for endorsement by the Strategic Estates Board. The Board endorsed the recommendations within this paper on 2nd April 2025.

5.4 The overall process has been strengthened since the previous financial year but there is still work to be done to support Places and GP Practices in having forward planner for submitting Expressions of Interest for new projects and ensuring the process is as streamlined as possible. As part of the output of this process, a good practice exercise will be undertaken alongside feedback gathering to make further changes to the bidding process.

5.5 An overview of the various phases of due diligence and planning for the capital allocation is below:

Stage 1 (*31/01/25-28/02/25) – Planning Phase*

- **29/01/25 –** Estates 25/26 Capital Delivery Workshop
- **31/01/25** - Expressions of Interest (EOI) Project Initiation Documents (PIDs) sent out to all General Practice and Place Primary Care Leads
- **12/02/25**– NHS England bid template released for ICB completion for utilisation and modernisation fund
- **18/02/25 –** EOI submission deadline from Places
- **25/02/25** – Estates and Digital Capital Delivery Workshop – Categorise EOIs for onward progression to Stage 2
- **28/02/25 –** NHS England template submission

Stage 2 (03/03/25/31/03/25) – Review and Due Diligence Phase

- **04/03/25** – Places informed of EOIs to progress to Stage 2 PID submission
- **13/03/25 -** Estates and Digital Capital Delivery Checkpoint
- **21/03/25 –** Digital Provider deadline for submission of costs
- **31/03/25 –** Stage 2 PID submission from Places
- **31/03/25 –** Feedback from NHS England on bid template and bulk ‘approval’

Stage 3 (01/04/25/30/04/25)– Approval Phase

- **02/04/25 -** Endorsement at **Strategic Estates Board** for allocation of Capital monies between Estates and Digital and GP Practices bids with recommendation for onward approval
- **17/04/25 –** Approval at **System Primary Care Committee**
- **18/04/25 – 30/04/25 –** Due diligence on PIDs and summary reports signed by ICB and NHS England representatives where required

Stage 4 (01/05/25 – 31/03/26) - Delivery Phase (Not Yet Started)

- Tracking progress and benefits of each scheme
- Regular reporting back to Strategic Estates Board and System Primary Care Committee
- ICB to prepare a pipeline of schemes, based on the principles of this fund, for years 2 to 5 based on similar allocations
- ICB to prepare a pipeline of potential new developments, based around supporting the development of Neighbourhood Health Service including Neighbourhood Health Hubs for years 2-5

5.6 Premises Improvement Grants (PIGs)

5.6.1 The Premises Improvement Grant (PIG) process provides the opportunity for Primary Care e.g., GP Practices to bid for capital monies to improve their premises (both GP owned and Leasehold). Proposed improvements must be in line with the NHS Premises Cost Directions 2024 which state financial approval under the following conditions:

- Up to 100% of the project work costs
- All professional fees up to 12% of the total project work cost
- Project management fees up to 1% of the total project work cost.
- The practice will fund the remaining percentage.

5.6.2 It is the intention for 25/26 to provide 100% project work costs for successful GP Practice bids.

5.6.3 If approved, scheme(s) delivery will be overseen by the practice and their appointed contractors/project manager. Payments for PIGs are made to GP practices on a reimbursement only basis, requiring them to submit invoices and evidence of payment to the contractor for work completed, it is not awarded in advance of works. All project work must be completed by 31st March 2026 (unless additional approval obtained due to the size of the works).

5.7 Digital Bids

5.7.1 The three Digital Providers across the ICB were asked to provide a 5-year capital investment strategy and undertake a risk stratification exercise using impact and likelihood to determine investment requirements for 25/26.

5.7.2 Each scheme was reviewed for Cyber compliance, NHSE 5-year tech refresh requirements for General Practice, Break fix replacements and the requirement

to move to Windows 11 with hardware capable of taking the required Microsoft upgrade.

5.7.3 Noting the ambitions and strategic drivers surrounding increasing patient access, an internal prioritization of Estates and Digital took place via the panel review group; with the associated outputs detailed in the finance section.

5.7.4 It must be noted that because of this the investment requirements for 26/27 are circa £5m for Digital, which far exceeds the current capital allocation for both enabler workstreams. It remains an ask of the Committee to consider the current allocation of capital for General Practice and the subsequent limitations this puts on redevelopment opportunities.

5.8 Methodology of Prioritisation and Scoring of Schemes

5.8.1 Estates Schemes

5.8.1.1 The approach the panel review group undertook was to maximise the deliverability of schemes for 25/26. During the EOI stage, schemes were assessed to ensure they met the following overarching criteria:

- Create Additional Patient Facing Capacity
- Improved Patient Outcomes
- Statutory Requirements e.g. Valid Lease etc.
- Alignment to ICS Strategic Drivers

5.8.1.2 Following this, Places were informed of schemes that could be progressed to Stage 2 PID submission and were informed of the rationale as to why some projects were not taken forward for 25/26 (majority of cases the projects did not align to the eligibility criteria of the NHS Premise Directions 2024)

5.8.1.3 Stage 2 PIDs have been reviewed and following receipt of all due diligence information and approval at this Committee, bid summaries will be submitted to relevant ICB and NHSE directors for sign off.

5.8.1.4 It is hoped that this process will be considerably faster than previous financial years and support GP Practices in having sufficient time and support to deliver their projects.

5.8.2 Digital Schemes

5.8.2.1 The approach of the panel was to ensure critical infrastructure requirements were delivered for 25/26. The criteria for Digital schemes included:

- Alignment to ICS Strategic Drivers
- Programme approach to risk stratification across the ICB

- Key infrastructure upgrades in Primary Care
- Cyber security priorities and other system critical upgrades both hardware and software

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

Objective One: Tackling Health Inequalities in access, outcomes and experience
Projects identified have been prioritised to increase General Practice capacity and operational efficiency, enhancing the ability of access of patients.

Objective Two: Improving Population Health and Healthcare

Projects identified have been prioritised to increase General Practice capacity and operational efficiency, enhancing the ability of access of patients.

Objective Three: Enhancing Productivity and Value for Money

Projects identified have been prioritised to increase General Practice capacity and operational efficiency, enhancing the ability of access of patients. All schemes were taken through a value for money assessment process to ensure costs are appropriate.

Objective Four: Helping to support broader social and economic

Projects identified have been prioritised to increase General Practice capacity and operational efficiency, enhancing the ability of access of patients.

7 Link to achieving the objectives of the Annual Delivery Plan

Addresses the following objectives:

- Delivery of the ICBs plan response to address the national Delivery plan for recovering access to primary care and deliver overall programme of work related to the national policy
- Post Pandemic Restoration /and increase of available General Practice appointments in line with the NHS planning guidance

8 Link to meeting CQC ICS Themes and Quality Statements

Theme One: Quality and Safety

Projects will look to improve the quality of premises, services on offer and overall fit for purpose status of premises. In some projects, proposals may look to specifically address CQC highlighted issues and or infection control requirements.

Quality Impact assessments have been undertaken to

Theme Two: Integration
N/A

Theme Three: Leadership
N/A

9 Risks

9.1 Risks have been identified and mitigated as below:

Risk	Risk Score	Workstream	Issue
Non-approval of Practice Applications	15	Estates	Pressure on the system will increase, due to practices struggle to deliver their increasing clinical requirements. Without the additional room capacity, practices are unable to retain or recruit additional workforce. Staff retention is essential, and this is supported by providing a quality and safe healthcare environment. Unable to support PCN's ARRS requirements and wider care community initiatives.
Delivery delays relating to time taken for Governance sign off	15	Estates	Schemes will suffer start up delays and potentially not deliver within financial year.

10 Finance

10.1 Capital Implication

10.1.1 There continues to be competing priorities and challenges relating to investment in Primary Care. Any large-scale schemes have a corresponding revenue impact and therefore GP Practices must work closely with their Primary Care Network and local Places to determine prioritisation of investment.

10.1.2 Through working jointly, Digital and Estates have assessed the Premises Improvement Grants (PIGs) that have undertaken full diligence as being able to start immediately, and have allocated funding as per below:

Utilisation and Modernisation Fund	Allocation	Submitted Bids	Variance
Estates*	£ 5,027,000	£ 8,472,714	£ 3,445,714

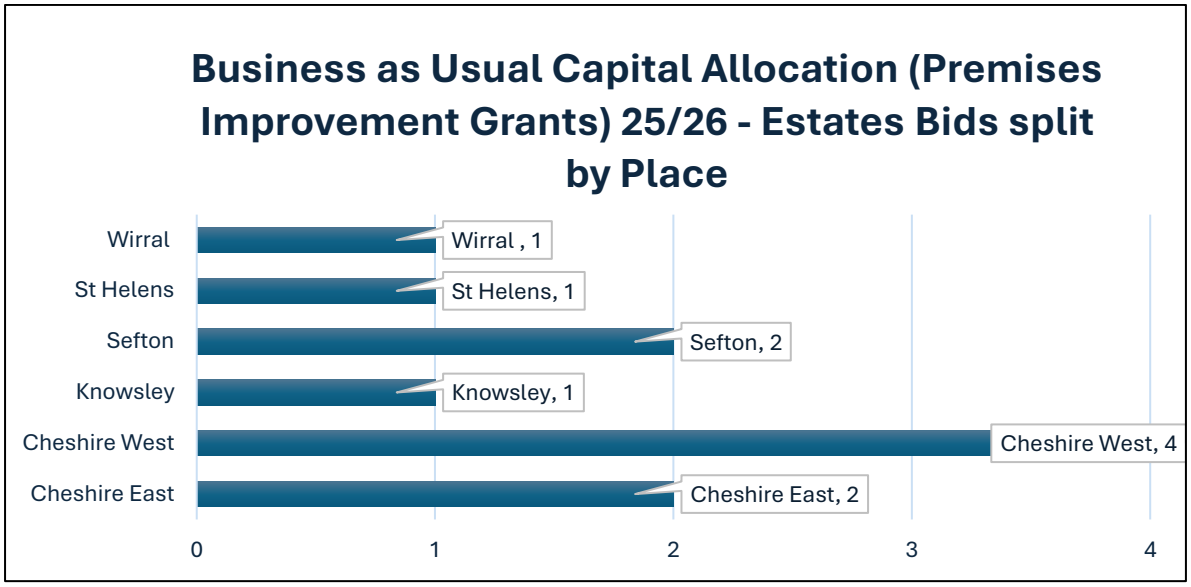
Business As Usual Capital	Allocation	Submitted Bids	Variance
	£ 4,700,000		
Estates		£ 2,803,151	£ -
Digital		£ 1,896,849	£ -

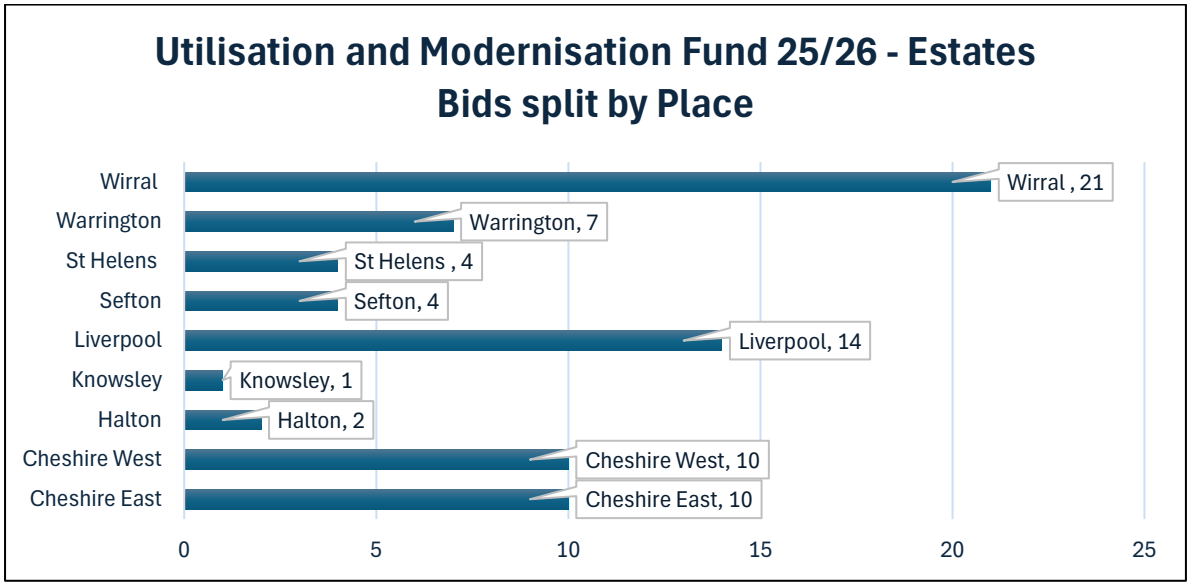
Additional Spend Requirements	Allocation	Submitted Bids	Variance
Digital**		£ 5,200,000	£ -

- *Submitted bids exceed the allocation following NHS England advise that any slippage in other ICBs may result in further capital allocation for this funding stream, bids have been submitted to seek 'pre-approval' should further monies become available.

- **Any slippage or underspend within Estates or Digital will be considered as part of the regular checkpoint meetings between both teams

10.1.3 A summary of Estates bids by Place is included below:





10.1.4 Finally, the Committee is asked to also to recognise the shortfall in capital allocation in what is required to provide the minimum levels of investment and upgrades to Infrastructure (both Digital and Estates).

10.2 **Revenue implication**

10.2.1 The revenue consequences, e.g. expansion of space, are reviewed by Place. Place teams have a reasonable understanding of the revenue impact of a scheme before they give their approval. If there is likely to be large revenue cost impact and Place has no spare resource to invest, it would not be able to support the bid.

10.2.2 Large projects are assessed by our professional advisor for an indicative rental cost prior to application approval.

10.2.3 Any increase in rent reimbursement costs, which results from the improvements, are funded via the ICB Place Primary Care delegated budgets.

10.2.4 An abatement period may be implemented in line with the Premises Directions 2024 if the GP Practice is GP owned and excluded for Landlord owned, thus partially mitigating the impact.

10.2.5 All bids within this paper have been Place reviewed and approved.

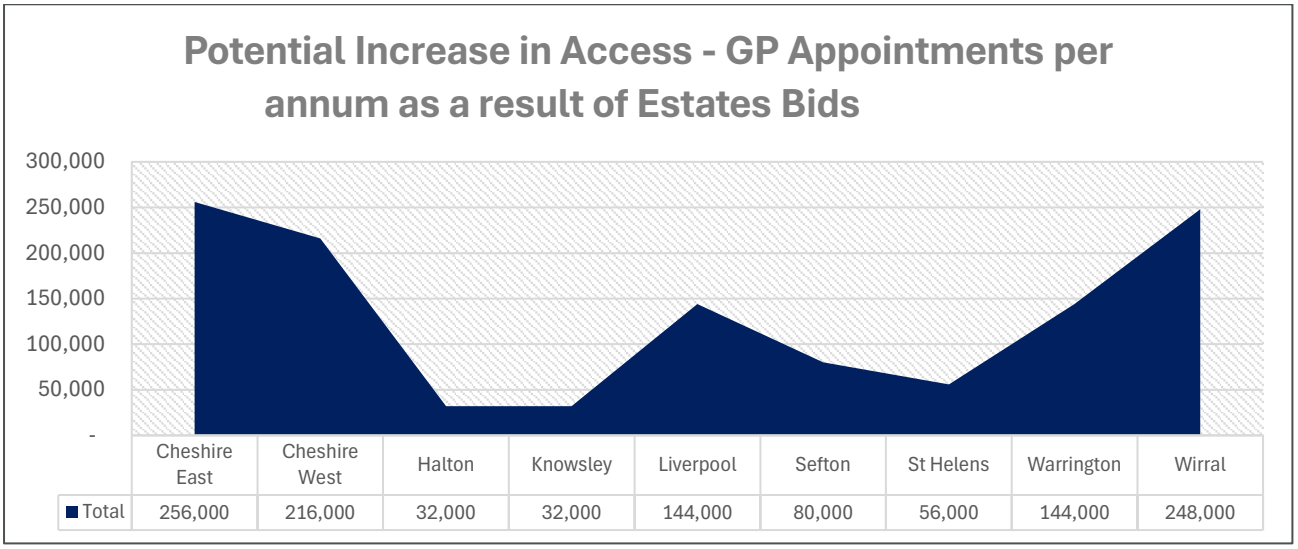
11 General Practice Access

11.1 Increasing access in General Practice has been a fundamental driver for 25/26 prioritisation of capital, during the delivery phase a tracker will be kept retaining oversight of benefits and progress of the Estates projects, which includes access.

11.2 For the purposes of prioritising schemes by the review panel and inclusion of a high-level summary for this Committee; a basic capacity model has been developed to predict potential increases in patient appointments based upon the identification in bids of increases in clinical rooms.

11.3 Methodology

- Assumption of an average GP appointment of 15 minutes (NHS Digital)
- Assumption of 4 hours in 1 session
- Assumption of 2 sessions in a day (noting GP opening hours may input into averages – tracker to detail information needed from GP Practices or other capacity modelling to be agreed)
- **Result:** Each clinical room has the ***potential*** to provide circa 32 GP appointments per day, 160 GP appointments per working week and 8,000 GP appointments per year.



12 Communication and Engagement

12.1 Patient and Public Engagement

12.1.1 Patient engagement is not specifically required as part of the process, although the GP practices may individually inform and discuss their plans with their Patient Participation Group.

12.1.2 Patient impact/quality - The implementation of the PIGs proposals will enhance the patient pathway experience and boost Primary Care capacity and capability. Services will be delivered from premises with improved physical access and rooms which are compliant with the latest equality, safety, and infection control standards. Schemes which deliver additional consulting and treatment rooms will allow practices, PCNs, and onward Care Communities to provide a wider range of services for patients and enable greater access to appointments.

12.1.3 Place Primary Care Teams and local GP practices will, subject to schemes approval, consider and action informing of scheme commencement and progress e.g., to LMCs, OSCs and local patient stakeholder groups. All schemes will enhance service delivery, and none would result in the removal or relocation of services.

13 Equality, Diversity and Inclusion

13.1 No EIA undertaken as not required, but where applicable schemes are to improve equality and disabled access will ensure that the standards set out in the Equality Act 2010 are adhered to.

13.2 Quality Impact assessments have been undertaken by GP Practices as part of the information submission to Places and ICBs, ensuring the proposals do not adversely affect delivery of care or patient experience at the practice.

14 Climate Change / Sustainability

14.1 Prior to the NHS Premise Directions 2024, sustainability initiatives were not a supported item for capital investment in General Practice. This has since changed and as a result some pipeline schemes reflect improvement in sustainability and contributes to ongoing work in delivery of the Green Plan.

15 Next Steps and Responsible Person to take forward

15.1 Summary Table:

Action	Responsible Person	Timescale
Estates Bid Summary Pack submitted to ICB Directors and NHSE for Signature	Pauline Underwood	April-May 2025
Digital Bid Summary Pack submitted to ICB Directors and NHSE for Signature	Kevin Highfield	April-May 2025
Decisions relayed to Place Teams and relevant stakeholders	Central Estates Team	May 2025
Oversee delivery of approved projects	Central Estates Team and Place Teams	Agreement Date - March 2026
Good Practice review and process amendment for 26/27	Central Estates Team	July-August 2025
Open 2026/27 Bidding Process	Central Estates Team	EOI's accepted throughout the year. Full BAU Improvement Grant process opened once budget is announced.

16 Officer contact details for more information

Lucy Andrews: lucy.andrews@cheshireandmerseyside.nhs.uk
Pauline Underwood: pauline.underwood@cheshireandmerseyside.nhs.uk
Kevin Highfield kevin.highfield@cheshireandmerseyside.nhs.uk

17 Appendices

- **Appendix One:** PIGs (Premises Improvement Grant Schemes) All Schemes
- **Appendix Two:** Short Form Summary Slides of Paper

Place	Practice Code	Practice Name(s)	Project Description	Estimated Capital Required As Per EOI Application	IT Confirmed Cost - March 25	Identified Funding Stream(s)
Cheshire East	N81002	Kenmore Medical Centre	Repurpose our endoscopy suite and relocate the nurses from rooms within the building into a dedicated nursing suite.	£200,756.20	£12,039.19	U&M
Cheshire East	N81006	Bunbury Medical Practice	Internal refurbishment of admin room into a multifunctional triage room	£12,400.00	£1,947.13	U&M
Cheshire West	N810125	Firdale Medical Centre	Reconfiguration of existing former DN Team space to facilitate creation of 5 new consultation room, utility room, WC and sub-wait area	£172,500.00	£10,967.35	U&M
Halton	N81019	Castlefields Health Centre	Create three clinical rooms within the waiting area on the first floor	£90,000.00	£8,866.40	U&M
Warrington	N81020	Penketh Medical Centre	Removal and replacement of 3 toilet cisterns containing asbestos. tos. Replacing flooring in 5 areas as the tiles have been identified as containing asbestos.	£150,000.00	£0.00	U&M
Cheshire West	N81031 N81018	Tarporley Health Centre	1. Car Park - increase in parking spaces within the current curtilage of the existing Car Park -20000 2. Improved Ventilation in Clinical Rooms with new UPVC windows-18,000	£38,000.00	£0.00	BAU
Cheshire East	N81032	Ashfields Primary Care Centre	1. Redevelopment of the Hydrotherapy Pool Space ito a clinical hub - Phase 1	£700,000.00	£35,000.00	U&M
Cheshire East	N81032	Ashfields Primary Care Centre	Redevelopment of the Hydrotherapy Pool Space ito a clinical hub - Phase 2	£140,000.00	£15,000.00	BAU
Cheshire East	N81044	Hungerford Medical Centre	Internal Reconfigeration to maximise space utilisation - 2 clinical rooms on the ground floor on the nursing corridor and additional floor above the existing meeting room to accommodate admin staff.	£50,000.00	£14,125.58	U&M
Warrington	N81048	Fearnhead Cross Medical Centre	To supply and fit stud wall including one entrance door , stud to insulated with sound proof insultation Associated cost relating, Electrics, light, sinks, flooring, window, soundproof and extend internal wall.	£176,500.00	£0.00	U&M
Cheshire East	N81052	Lawton House Surgery	Internal Reconfigeration to maximise space utilisation: The provision of the additional workstations in the current loftspace/ note store will provide a work area for the triaging team and care navigator to co-ordinate total triage, which aligns with both the PCARP and the Network DES / CAIP.	£197,000.00	£22,118.08	U&M
Cheshire West	N81060	Neston Surgery	Extension to current presmises -five new clinical rooms. Four of the rooms would be big enough to use as patient facing rooms and the smaller of the five would be used non-patient facing clinical triage room.	£540,000.00	£21,599.64	BAU
Cheshire East	N81062	Cumberland House Surgery	1. Conversion of internal 3rd floor store room to create much needed clinical admin space for up to 4 people. 2. Conversion of 3rd floor staff kitchenette into a small storage room (this will provide the required practice storage following the conversion of the existing store room).	£25,250.00	£13,575.56	U&M
Cheshire West	N81067	Oakwood Medical Centre	Reconfiguration of the recovery room and BP room. Reconfiguration of the weighing scales/BP room next to reception to become a fully useable office space for administrator and triage room for admin/clinical user. To include repurposing the current space to include IT equipment and a window.	£10,014.00	£4,945.06	U&M
Cheshire East	N81068	Gresty Brook Medical Centre & Grosvenor	Installation of Air Flow Unit to the whole building Replace Carpet flooring in 3 clinical rooms incluing replaster skirting boards and finishing Remove old sink and install 8 new IPC standard clinical sinks with clinical mixer tap,	£132,503.00	£0.00	U&M
Cheshire East	N81069	Chelford Surgery	Resurfacing and improvement of car park to include additional parking.	£59,221.44	£0.00	BAU
Warrington	N81075	Stockton Heath Medical Centre	Reconfiguration of waiting area to provide 2 clinical rooms and 1 admin room to provide additional space for ARRs team. Include new entrance area to Practice, reconfiguaron of internal atrium to provide an additional clinical room. Reconfiguration of medical records area an additional 2-3 clinical rooms. Reconfiguaration of clinical room 3 to make this 2 separate consulting rooms	£180,000.00	£22,339.12	U&M
Cheshire West	N81079	The Elms Medical Practice	Internal configuration to maximise space utilisation for consultations and group educational sessions.	£59,100.00	£6,396.63	U&M
Cheshire West	N81080	Hope Farm Medical Centre	Internal reconfigeration to maximise space utilisation and create 2 new consulting rooms.	£17,500.00	£3,525.77	U&M
Cheshire West	N81080	Northgate Medical Centre	Internal Reconfigeration Corridor Recess to maximise space for Adminstration/Consulting Space	£20,000.00	£3,558.05	U&M
Cheshire West	N81081	Garden Lane Medical Centre	Conversion of space to provide 3 additional clinical rooms and one large admin room.	£662,589.46	£5,228.65	BAU
Cheshire West	N81082	City Walls Medical Centre	Replace 14 clinical handwash basins at City Walls and 5 at the branch surgery with basins that comply with HTM guidelines. To supply and fit 2 sensors to the exisitng 2nd entrance door to ensure both doors are automatic without the need for pressing a	£52,478.09	£0.00	U&M
Cheshire West	N81093	Whitby Health Partnership	Creation of New Parking spaces, reconfiguration of existing space to create 5 new clinical examination rooms Refurbishment of patient w/c for DDA compliance. Installation of equality act compliant patient services desk, replacement skirts in clinical rooms	£113,500.00	£5,845.30	U&M
Cheshire West	N81101	The Handbridge Medical Centre	Reconfiguration of waiting area creating 2 clinical rooms in existing building	£13,461.00	£3,826.78	U&M
Cheshire West	N81102	Fountains Medical Practice	Extra room to create a working space for our FICHS (Care Home Team) who currently have to work remotely due to the lack of space within the current practice space and also to be used as multi functionional room for training purposes / Group sessions.	£34,500.00	£6,730.47	U&M
Warrington	N81107	Manchester Road	Practice Improvements as per 2 x recent infection control visits	£8,527.00	£0.00	U&M
Warrington	N81108	Lakeside Surgery	Reconfiguration of an admin room to a clinical room, reconfiguration of the waiting room to provide an additional two clinical rooms	£80,000.00	£3,525.77	U&M
Warrington	N81114	Birchwood	Reception adjustments to desk to ensure compliance for wheelchair users Sink upgrades	£60,000.00	£0.00	U&M
Halton	N81119	Hough Green Health Park	Improvement of car park and access to patient including installation of security gates Reconfigurations of records room, upgrade practice electrics to be in line with current health and safety guidance. Improved LED including external lights for patients safety	£38,000.00	£0.00	U&M
Cheshire East	N81614	Wrenbury Medical Practice	Internal Reconfiguration to maximise space utilisation on the first floor of the building. To convert one large multi function room into two further consulting rooms.	£53,000.00	£3,525.77	U&M
Cheshire East	N81632	Broken Cross	Conversion of 3rd Floor Storeroom to provide admin space for clinical team (telephone triage, GP tuition, clinical admin/audit space) and a separate storage area. Installation of 3 phone pods for the PCN	£30,850.00	£8,636.19	U&M
Liverpool	N82009	Grassendale Medical Practice	Clincal room 8 needs refurbishment and room configuration to include knocking down internal wall. Replacing sink, flooring, curtain rails and making good the room. Refurbishment of offices spaces to create a quieter room to avoid telephone noise for staff wellbeing. This involves a reconfiguration of the 3 office spaces upstairs to include electrical wiring for computers and TV sockets for staff training.	£10,500.00	£530.00	U&M
Liverpool	N82018	Ellergreen Medical Centre	Improvement to toilets to make fully compliant with infection control and health and safety legislation, including replacement of fittings/flooring Replacement of sinks/new mixer taps in 16 consulting rooms to comply with infection control legislation. Replacement of flooring in consulting rooms	£100,000.00	£0.00	U&M
Liverpool	N82024	West Derby Medical Centre	Lift replacement as current lift has been decommissioned as being unsafe due to not being able	£51,600.00	£0.00	U&M
Liverpool	N82035	Mather Avenue Surgery	Sound proof door for surgery room 4/5 Installation of sound proof door for surgery room 4/5	£9,867.00	£0.00	U&M
Liverpool	N82050	Gateacre Medical Centre	Upstairs - Installation of the patient lift and structural support, ramp, IT Server Cabinet, convert the two upstairs rooms to be used as two clinical consulting rooms with IT eqiupment etc. Convert the previous Practice Manager's office into a generic consulting room. Downstairs: Removal of the wall inbetween the waiting room and the consulting rooms on the left - to increase the size and capacity of the waiting area.This will allow ample space for wheelchairs etc Conversion of the 2 current lower floor consulting rooms into 3 seperate clinical consulting rooms, conversion of the small practice nurse room and the office reception area into two clinical consulting rooms. Conversion of the low ceiling area under the stairs into a stockroom with a padlocked door- furnished to safely stock vaccines and clinical utilities.	£231,000.00	£26,580.00	U&M

Liverpool	N82053	Aintree Park Group Practice	Small extention to middle of building to maximise space utilisation, telephone/data cabling, windows, flooring etc associated with works in a new build, extension or reconfiguration Installation of approved clinical wash and hand basin/s with associated works (taps/ splash backs) to replace non clinical equivalent/s. Curtain tracks/screens (around examination couch) fixed in situ	£98,900.00	£0.00	U&M
Liverpool	N82059	Greenbank Drive Surgery	Practice Improvements for patient access Automatic doors (front door) Pushing porch wall back and installing automatic sliding door. Electrical/builder/joiner	£26,402.00	£0.00	U&M
Liverpool	N82059	Greenbank Drive Surgery	Internal Reconfiguration to maximise space utilisation, repurposing unusable / storage space/Clinical hub and expansion of usable staff break rooms.	£50,408.00	£27,000.00	U&M
Liverpool	N82073	The Ash Surgery	Reconfiguration of the practice nurse room, reconfigure small waiting room to use as remote/telephone consultation room. 23 fire doors 6 need to have vision panels, for health and safety compliance. No door are compliant with the current regulatory safety guidance. Turn small waiting room into a new room as remote/telephone consultation room to maximise space and increase space for ARRS staff.	£65,000.00	£2,142.00	U&M
Liverpool	N82083	Jubilee Medical Centre	Reconfigure Car Park to create more spaces	£26,860.00	£0.00	U&M
Liverpool	N82104	Stoneycroft Medical Centre	Replacement with easy-clean, hygienic flooring (current flooring is uneven, posing a health and safety risk) Upgrading staff and patient toilet facilities, including WCs, sinks in clinical rooms. Reorganizing the records/storage room and upgrading the MDT room.	£47,400.00	£7,735.00	U&M
Liverpool	N82110	Long Lane Medical Centre	Improve reception desk - outer for iproved patient access, inner for staff H&S	£37,619.00	£0.00	U&M
Liverpool	N82117	Ropewalks General Practice	Reconfiguration of the Records Room – Optimising storage and accessibility. Redesign of a Large Seminar Room – Transforming it into a functional meeting room with additional desk space Conversion of Administrative Rooms – Creating four clinical rooms to enhance patient service capacity	£504,000.00	£15,947.28	U&M
Liverpool	N82671	Bigham Road Medical Centre	Increase additional car park spaces from 10 to 16	£5,000.00	£0.00	U&M
St Helens	N83002	Patterdale Lodge Medical Centre	Shower room to be converted to secure storage, partitioning fitted to existing admin space to increase room capacity and service provision, lighting floor coverings, heating,cabling and pipework associated with this work. The additional space requires an extension to existing phones systems with new cabling. Built in pod as a staff rest area.	£29,300.00	£1,772.52	U&M
Knowsley	N83018	Stockbridge Village Health Centre	Reconfiguration of old Records Room to create Admin space, reconfiguration of Exam room to a clincal room - electrical ports, reconfiguration of Exam room to a Phlebotomy room - Telephone Port / Network port. Configuration of Network Ports to the new Telephone room and internal Reconfigeration of Store room to maximise space utilisation	£9,000.00	£3,788.56	U&M
St Helens	N83019	Billinge Medical Centre	Reconfiguration of reception to bring to DDA compliant standards, installtion of hearing loop, creation of equality act compliant WC, reconfiguration of larger admin room to two clinical rooms to increase clinical room capacity, extension of central heating to new clinical rooms that do not currently have access to the main heating system. Installation of 6 fire doors to meet actions outlined in fire risk assessment, replacement of clinicl floor to meet IPC and current regualtions.	£113,500.00	£3,103.77	U&M
Knowsley	N83032	Millbrook Medical Centre	Reconfiguration to maximise clinical space Reconfiguration of staff space Reconfiguration of public space	£370,200.00	£33,301.58	BAU
St Helens	N83053	Longton Medical Centre	Reception Waiting Room area reconfiguration. Crossroads entrance waiting room to reconfigured to maximise space for reception staff working in the back office, can be used as space for staff room, staff lockers and smaller meetings. Previous Crossroads reception area, room is currently not being utilised due to having a single reception office, it is mainly now being used as a storage room, it is a large room that would be transformed into a further training educational clinical room. This can be used for tutorials/meetings and also if clinically needed.	£143,000.00	£15,417.66	BAU
St Helens	N83053	Longton Medical Centre	Reconfigure rooms 6, 7, 8, 9 Front entrance/door changes to replace with automatic doors for disabled access. Currently the entrance is difficult for disabled, wheelchair access and for prams to move through a narrow corridor.	£143,000.00	£0.00	U&M
South Sefton	N84003	High Pastures Surgery	Flooring to clinical areas, waiting & clinical room chairs, patient disabled toilet & baby change room refurbishment. Labour to remove existing waiting room seating. These are currently secured to the floor in blocks of 8. Includes skip hire to dispose of everything	£23,438.00	£0.00	U&M
Southport & Formby	N84005	Cumberland House Surgery	1) new lift to accommodate bariatric wheelchairs and mobility scooters. 2) Reconfigure back of building for disabled entrance and access	£21,000.00	£0.00	BAU
South Sefton	N84007	Liverpool Road Medical Practice	Additional car parking - Currently the practice shares a carpark with the adjoining building, the rear carpark will be solely for patients providing an additional 12 spaces and easier access to the surgery.	£103,707.60	£0.00	U&M
Sefton	N84011	Eastview Surgery	Small extension to maximise space utilisation - 2 further clinical rooms on the ground floor nursing corridor	£46,359.00	£0.00	U&M
Southport & Formby	N84017	Churchtown Medical Centre	Building internal partition wall and automatic entrance door between pharmacy and practice	£20,000.00	£0.00	BAU
South Sefton	N84023	Bridge Road Medical Centre	Contractor costs for extension and renovation current building: extension to facilitate 8 consultation rooms, 2 WC and staff facilities. Reconfiguration of admin space to the ground floor. Meeting room facility for clinical and admin staff.	£924,020.00	£52,336.00	U&M
Wirral	N85005	Eastham Group Practice	1) Internal reconfiguration of the ground floor space to maximise space utilisation including the development of 6-8 consultation rooms and a community health hub	£145,248.00	£13,743.07	U&M
Wirral	N85006	Civic Medical Centre	1) Large Administration Boardroom to be converted into 3 clinical rooms. 2) Cost of additional IT equipment for new rooms 3) 2 additional disabled carpark spaces	£98,710.00	£4,653.21	U&M
Wirral	N85007	Myrtle Group (Commonfield)	Reconfiguration of records room - Fitting out to bench style work space, additional network and electrical ports, brick up of patient access hatch, provide storage, renew electric points, redecorate and renew flooring. IT equipment - quote from MLCSU	£34,503.00	£7,002.44	U&M
Wirral	N85012	St George's Medical Centre	1) Practice Improvement to patient used areas - replace all patient carpeted areas to CQC complaint flooring	£15,000.00	£0.00	U&M
Wirral	N85016	Riverside Surgery	1) Practice Improvement - Renovation of Kitchen as highlighted in 2) Infection Control visit 3) Practice Improvement - Internal reconfiguration of Reception office to maximise space and allow for additonal call handlers	£47,006.00	£4,259.31	U&M
Wirral	N85018	The Villa Medical Centre	Reconfiguration of Records Room and all associated works.	£5,400.00	£2,439.53	U&M
Wirral	N85022	Holmlands Medical Centre	Reconfiguration of a dual room to update and create x2 clinical rooms for use. Internal reconfiguration accessible for first floor useage to modernise access from stair/stairlift to a platform lift taking from ground to first floor. Flooring for clinical room changes on reconfiguration. Infection Prevention flooring to accommodate changes and reconfiguration of clinical rooms and new to surround lift area	£48,307.00	£2,953.18	U&M
Wirral	N85025	St Hilary Group Practice	1) Reconfiguration of records room - adding electrical & data points 2) Reconfiguration of clinical staff room for use as office - adding electrical and data points	£6,395.00	£7,615.29	U&M
Wirral	N85027	Mill Lane Surgery	Reconfiguration of LG record storage in first floor meeting room and decoration to utlisie and optimise space and create study area for staff Wing A - Removal of carpet and new flooring laid in 6 clinical rooms. Wing B Replace carpet with clinical flooring in 13 rooms	£38,940.00	£1,822.88	U&M
Wirral	N85031	Gladstone Medical Centre	Practice improvements - install additional entrance doors inside the current main entrance area Reconfiguartion of record room - removal & disposal of old record storage cabinets, install heating and electical sockets and make area workable for admin use.	£25,000.00	£1,851.81	U&M
Wirral	N85038	Vittoria Medical Centre (G)	1) Internal conversion of ground floor utlities/storage space into a small consulting room for Medical Students and Education and any ARRS roles. Plus flooring.	£5,750.00	£0.00	U&M

Wirral	N85038 N85634	Vittoria Medical Centre	1) Internal conversion of Records Room (room 26 on plan) in to repurposed IT / Data administration room to maximise space utlisation 2) Internal conversaion of IT / Data Room (room 25 on plan) into space for PCN ARRS services this will maximuse space utilisation and allow the practice to host ARRS roles such as Social Prescribers, Project work for PCN administration. 3) Computer Network points for restructure of Records Room into IT/Data room	£33,822.78	£6,911.11	U&M	
Wirral	N85048	Moreton Medical Centre	Reconfiguration of admin /medical records space to create additional office space and storage for clinical supplies - 25/26 Installation of L3 Fire system and installation of fire doors to first floor rooms 15594.	£59,293.57	£2,579.52	U&M	
Wirral	N85051	Allport Medical Centre (Sunlight Group)	1) Allport site - Reconfiguration of Records Room 1 (ALLPORT) 252 PCN Toolkit Reconfiguration - Utilisation review to ensure optimisation of flex site. Digitisation of Medical Notes to Refurbish notes storage to create 1 clinical room	£6,000.00	£8,814.67	U&M	
Wirral	N85051	Parkfield Medical Centre (Sunlight Group)	Reconfiguration of Records Room 1 and 2. Replace non IPC sink units with IPC sink units as per infection control advice. Reconfiguration of old community clinics into 3 16m2 clinical rooms. Reconfiguration of 3 old community clinics into 4 16m2 clinical rooms. Replace carpeted flooring with hardwearing clinical spec flooring as per infection control advice. Internal Reconfiguration to maximise space utilisation (New) Creation of 2 new clinical rooms from old counselling room and waiting area. Internal Reconfiguration to maximise space utilisation (AD) merging of several small admin spaces to create large communal office for reception and admin.	£276,750.00	£7,512.43	U&M	
Wirral	N85054	Kings Lane Medical Centre	1) Turn records room into a private reception admin office - check if triage / clinical support?	£7,000.00	£12,311.82	U&M	
Wirral	N85057	Teehey Lane Surgery	Reconfiguartion of record room - removal & disposal of old record storage cabinets, install heating and electical sockets and make area workable for admin use.	£10,000.00	£1,822.88	U&M	
Wirral	N85617	Spital Surgery	1) Internal reconfigeration to maximise space utilisation, create an additional clinical room using current reception space on ground floor.	£26,951.00	£1,651.00	U&M	
Wirral	N85629	Egremont Medical Centre	Convert a large unused administrative room to a clinical consulting room	£30,000.00	£1,822.88	U&M	
Wirral	N85634	Vittoria Medical Centre (K)	Updating flooring as original flooring has been skimmed up to the units, but not under. Also current unit is attached to the wall, this may need plastering when this is removed. We would like to convert this room so it can be used more purposefully as a Consulting Room and also as an additional space for ARRS roles.	£6,656.36	£1,656.36	U&M	
Wirral	N85648	Black Heath Surgery	1) New entmace to building directly off car park (currrently have to walk around, no dropped kirb for wheelchair access) 2) Installation of automatic door to entrance	£50,000.00	£0.00	BAU	
Wirral	N85648	Black Heath Surgery	Change use of admin/reception area to consultation room, change current entrance to 2 consulting rooms, pull out walls for 2 consulting rooms for increased space, change conference room to IDA reception and waiting area. One of the additional consulting rooms to be designed for minor surgery and sexual health, change use of business managers room to community phlebotomy, pessary service and wound care), change use of kitchen area to room for community voluntary services with planned drop in sessions for social prescriber and wirral ways to recovery. Replace single toilet with access for wheelchair.	£170,000.00	£21,063.17	U&M	
Warrington	Y01108 & N81097	Fairfiled Dallam Lane	This scheme is for two practices Fairfield Surgery & Dallam Lane Medical Centre to co-locate into one building close to Warrington town centre. This will provide the opportunity of incorporating services such as Citizens Advice, Community Services, Cancer Support Networks, Hospital Services,etc This will help to achieve the vision set out in the Health and Wellbeing Strategy.	£171,741.00	£113,899.36	U&M	
Cheshire West		Fountains Health Centre	Installation of utility meters to all occupants of the building so costs can be apportioned correctly and accurately	£11,893.20	£6,730.47	BAU	
St Helens	N83054	Bethany Medical centre	1) Practice Improvement - 3 automated doors. 1 x external and 2 internal doors 2) Estimated cost include Fuse spurs and linking to the existing fire alarm system so that on activation of the fire alarm system	£16,703.75	£0.00	U&M	
Cheshire East	N81068	Grosvenor Medical Centre	Reconfiguration of existing space into 3 new clinical rooms. Inclusion of electric and telephone points in each. Reconfiguration of new reception area space for 2 receptions with patient facing area with a protective glass screen and glass window at the side and a private room with a telephone and a desk this area can also be used to speak with receptionist who request. privacy at the front desk. Reconfiguration of existing space to Create of a corridor to access the new rooms, creation of Windows to replace sky lights for room 7 - 9. Flooring for the Patient toilets. Extension to existing premises, 1st floor workspace. Creation of new corridor upstairs for access to the new rooms, Removal of glass apex roof and replace with roof with new hanging ceiling for the corridor below the extension. The new workspace to be split in 2 and will contain multiple telephone consultation pods including desks and telephones.	£610,512.00	£8,344.00	U&M	
Liverpool	N82066	Woolton House Medical Centre	Improvement grant in 24/25 allowed the practice to extend externally, this next applicaiton is for internal reconfiguration. The practice was waiting for confirmation from their builders if this could be completed by 31/03/2026. They have been guaranteed it can (if awarded before June 2026) Practice improvements - infection control and sound proofing throughout existing rooms Internal reconfiguration to create a new consulting room (house), Intemal reconfiguration to make 4 new consulting rooms (stable block) New lift for stable block (currently stair access only). Extention to boiler and associated plumbing work for stable block. Glazed link corridor (to internalise a small section of courtyard as part of new admin space) Improved fire safety with fire doors throughout, fire alarm panel and break glass system	£978,664.00	£14,850.00	U&M	
ALL		C & M	9.85% Variance to allow for: Potential moves from U&M into BAU to still deliver projects if additional not approved. Optimism bias - Any slight increase in final project costs after NHS approval.	£1,010,887.55			

TOTAL	**£11,275,865**
BAU	£2,803,151
U&M	£8,472,714

NHS
Cheshire and Merseyside

Cheshire and Merseyside Capital Allocation 25/26 – Estates and Digital

Executive Summary

This paper looks to seek endorsement and approval for the allocation of capital from both the General Practice Business As Usual and Utilisation and Modernisation funding schemes.

A breakdown of the full due diligence process and prioritisation process is included, alongside commentary on the continued emerging risks surrounding investment in both Estates and Digital. As enabling workstreams it is crucial to ensure that appropriate consideration and support is provided to allow the delivery of System critical schemes that support the strategic drivers of the ICS.

It is worth highlighting, that due to advisement from National and consideration of best practice moving forward for Cheshire and Merseyside, a reserve list of investment requirements has been developed. The level of capital bids received this year are far governance, previous years and demonstrate continued improvement in the process and engagement from Places.

The Strategic Estates Board is asked to provide the following endorsement for onward approval at System Primary Care Committee:

- Approve £8,472,714 of submitted bids for the Utilisation and Modernisation Fund
- Approve £2,803,151 of submitted bids for the Premises Improvement Grants (BAU Allocation – Estates Bids)
- Approve £1,896,849 of submitted bids for Digital requirements (BAU Allocation – Digital Bids)
- Approve the re-distribution of capital allocation where necessary between Estates and Digital through the Delivery Phase, where risks are escalated and underspend is identified in either programme area.

Background

NHS
Cheshire and Merseyside

Following the successful approval in 24/25 of 29 Estates Bids, a review session was undertaken to establish best practice for 25/26 and take into consideration feedback received from Places and executives regarding the process.

24/25 YTD Position

- **First Bidding Round: 23 Bids - £805,418 approved. Delivered 22 Bids - £736,280**
- **Second Bidding Round: 6 Bids - £901,873 approved. Delivered 4 Bids - £961,601**

Main Issues

Projects Withdrawn			
Practice	**Place**	**Value £**	**Details**
Upton Group Practice	Wirral	128,607	Assura (Landlord) requiring additional addendums to the lease before granting full approval.
High Street Surgery	Cheshire West	33,540	Assura (Landlord) requiring additional addendums to the lease before granting full approval.
Liverpool Road Surgery	Sefton	73,727	New Car Park couldn't start due to drainage issues. Applied this year
TOTAL		**235,874**	

Projects which requested/approved additional financial support (Exceptional Circumstances)			
Practice	**Place**	**Value £**	**Details**
The Valley Medical Centre	Liverpool	205,724	Main issues were a significant increase in mechanical engineering costs and the original lift shaft not deemed suitable after additional inspections.
Brownlow Heath Princess Park	Liverpool	33,540	CHP/Liftco process issues and increase in costs.
TOTAL		**239,264**	

Background

NHS
Cheshire and Merseyside

For 25/26 the process was split into two phases:

- Stage 1 – Expression of Interest
- Stage 2 – Submissions of Project Initiation Documents

Following endorsement of the proposed capital allocation at System Primary Care Committee, full project development bids will be received by all practices and approved by relevant signatories within the ICB and NHS England.

The above supports GP Practices in not unnecessarily incurring significant cost and draw on time until such time projects are ‘approved in principle’ on the completion of stage 2.

It is recognised that whilst the administrative element of capital bidding improved for this financial year, the timescales being asked of all parties: GP Practices, Places and the ICB to delivery major redevelopments in General Practice continues to be a major issue and risk.

There is still further work to be done to ensure this process is streamlined both for the existing process and future years. This includes ensuring GP Practices can continuously submit expressions of interest and there is a clear forward planner with key timescales mapped out for Places and wider ICB colleagues to be aware of.

It is important to highlight that the level of investment requirement within Digital over the next two financial years (25/26 and 26/27) for system critical upgrades far exceeds the usual business as usual allocation.

Scope

NHS
Cheshire and Merseyside

Capital Allocation for 25/26 was confirmed as being a total of **£9,727,000** excluding IFRS16 spending requirements. This is split between the Utilisation and Modernisation Fund **(£5,027,000)** and the General Practice BAU Capital **(£4,700,000)**. With the new NHS Premises Directions 2024 being released, the eligibility criteria of the Premises Improvement Grants (PIGs) was substantially changed to remove opportunity for investment in areas designated as minimum standards e.g. HBN complaint flooring or sinks in existing premises. There has been a renewed focus from NHS England in not supporting capital grants relating to fabric improvements and improving physical access to and within contractor premises.

Capital Fund 25/26	£	Frequency of Allocation
IFRS16 Primary Care	£1,312,000.00	Per Annum
General Practice BAU Capital	**£4,700,000.00**	**Per Annum**
National Programme - Utilisation and Modernisation	**£5,027,000.00**	**One Off**

Utilisation and Modernisation Fund – One off capital fund designed to undertake 'quick win' schemes that directly contribute to patient access
General Practice BAU Capital – Yearly allocation for schemes aligned to Digital investment requirements and the NHS Premises Directions 2024

Utilisation and Modernisation Fund

The Primary Care Utilisation Fund is intended to support estates schemes that increase the utilisation of existing primary care sites to improve patient health outcomes and increase the number of appointments delivered in primary care.

It is anticipated that most schemes will typically be transacted as minor improvement grants via the NHS (GMS – Premises Costs) Directions 2024.

Scope of projects include:

- Refurbishment of under-utilised rooms to increase clinical capacity
- Repurposing of underused rooms into clinical accommodation
- Reconfiguration of existing space to create additional clinical rooms

The fund is not intended to be used to support technology solutions or to increase the footprint by building extensions.

There is no additional revenue to support this programme so ideally schemes should be funded at 100% to minimise the impact.

General Practice BAU Capital

The 2025-26 General Practice Capital envelope is £4.7m. This can be used for Premises Improvement Grants (PIG) or other funding requests available via NHS Premise Directions 2024 or for Digital (GPIT BAU, GP Break fix and Infrastructure Investment).

Scope of projects include:

- Major redevelopments e.g. extensions and new builds
- Associated professional fees
- Internal reconfiguration to make the premises more fit for purpose and increase administrative or clinical capacity
- Works required due to a change in Legislation or Regulation
- Increase in patient access to GP premises
- Digital core investment requirements for cyber security, break fix of hardware and networking upgrades
- Digital infrastructure upgrades
- Associated Digital costs for any PIGs or any other in year Estates capital projects

Process

NHS Cheshire and Merseyside

A robust delivery programme has been established between Estates and Digital to ensure adherence to National timescales. A detailed timeline of the programme to date is provided below.

Stage 1 (*31/01/25-28/02/25*) – *Planning Phase*

- ***29/01/25 –*** *Estates 25/26 Capital Delivery Workshop*
- ***31/01/25*** *- Expressions of Interest PIDs sent out to all General Practice and Place Primary Care Leads*
- ***12/02/25****– NHS England bid template released for ICB completion*
- ***18/02/25 –*** *EOI submission deadline from Places*
- ***25/02/25*** *– Estates and Digital Capital Delivery Workshop – Categorise EOIs for onward progression to Stage 2*
- ***28/02/25 –*** NHS England template submission

Stage 2 (03/03/25/31/03/25) – Review and Due Diligence Phase

- ***04/03/25*** *– Places informed of EOIs to progress to Stage 2 PID submission*
- ***13/03/25 -*** *Estates and Digital Capital Delivery Checkpoint*
- ***21/03/25 –*** *Digital Provider deadline for submission of costs*
- ***31/03/25 –*** *Stage 2 PID submission from Places*
- ***31/03/25 –*** *Feedback from NHS England on bid template and bulk 'approval'*

Stage 3 (01/04/25/30/04/25)– Approval Phase

- ***02/04/25 -*** *Endorsement at* ***Strategic Estates Board*** *for allocation of Capital monies between Estates and Digital and GP Practices bids with recommendation for onward approval*
- ***17/04/25 –*** *Approval at* ***System Primary Care Committee***
- ***18/04/25 – 30/04/25 –*** *Due diligence on PIDs and summary reports signed by ICB and NHS England representatives*

Stage 4 (01/05/25 – 31/03/26) - Delivery Phase

- Tracking progress and benefits of each scheme
- Regular reporting back to Strategic Estates Board and System Primary Care Committee
- ICB to prepare a pipeline of schemes, based on the principles of this fund, for years 2 to 5 based on similar allocations
- ICB to prepare a pipeline of potential new developments, based around supporting the development of Neighbourhood Health Service including Neighbourhood Health Hubs for years 2-5

Prioritisation

NHS
Cheshire and Merseyside

Estates

Criteria

- Additional Patient Facing Capacity
- Improved Patient Outcomes
- Statutory Requirements e.g. Valid Lease
- Alignment to ICS Strategic Drivers

Utilisation and Modernisation

- Place prioritised initially and aligned to PCN Toolkits, Place Estates Plans and ICS Infrastructure Strategy Principles
- All eligible schemes submitted for a Primary and Reserve list (based on deliverability)
- Indicated 100% NHS contribution

BAU

- Place prioritised initially and aligned to PCN Toolkits, Place Estates Plans and ICS Infrastructure Strategy Principles
- All eligible schemes submitted for a Primary and Reserve list (based on deliverability)
- Consideration on affordability and cash flow for delivery and adherence to utilisation and modernisation principles (e.g. 100% NHS capital)

Deliverability and Value For Money

Digital

Criteria

- Alignment to ICS Strategic Drivers
- Risk Stratification Programme Requirements
- Infrastructure Upgrades for Primary Care
- Cyber Security and other system critical upgrades

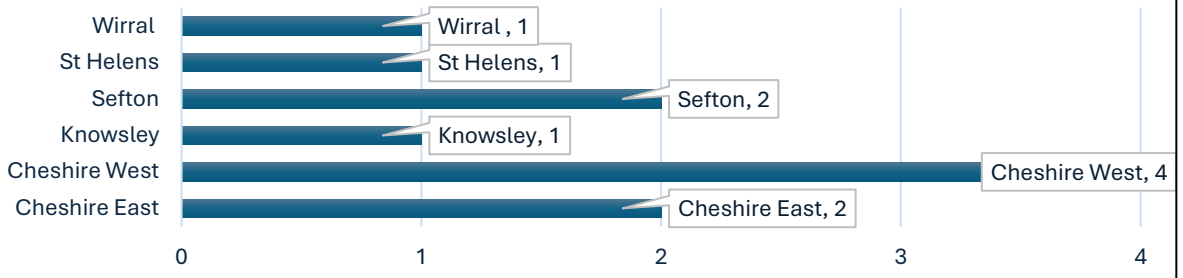
BAU

- Risk Stratification Programme undertaken across all Digital Providers to determine areas of system critical investment requirements for 25/26

Place Summary – Estates Bids

NHS Cheshire and Merseyside

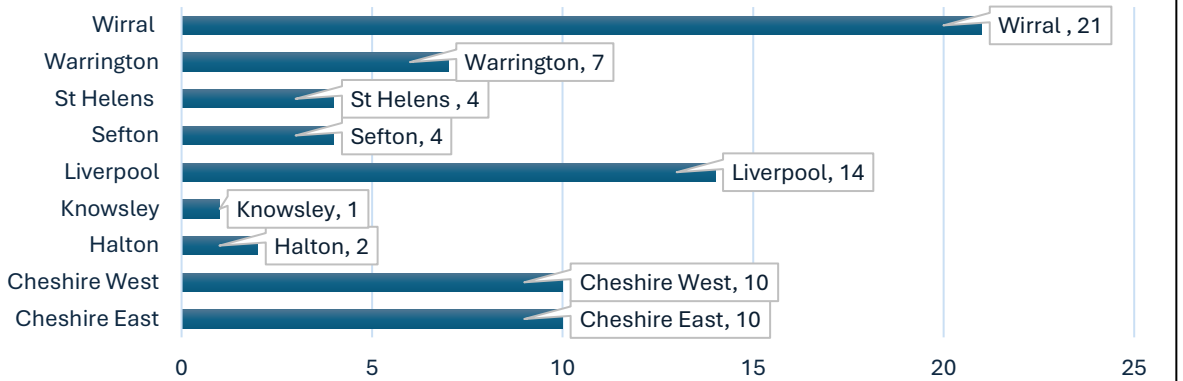
Business as Usual Capital Allocation (Premises Improvement Grants) 25/26 - Estates Bids split by Place



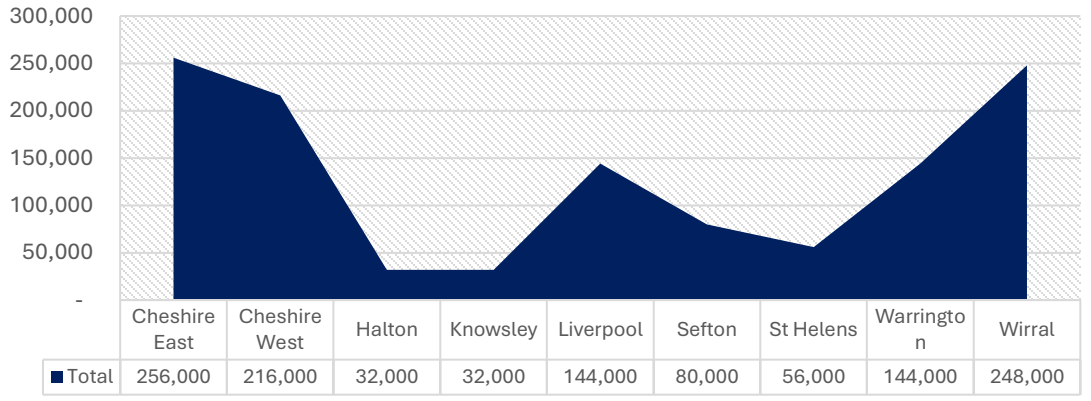
Access Methodology

- Assumption of an average GP appointment of 15 minutes (NHS Digital)
- Assumption of 4 hours in 1 session
- Assumption of 2 sessions in a day (noting GP opening hours may input into averages – tracker to detail information needed from GP Practices or other capacity modelling to be agreed)
- Result: Each clinical room has the potential to provide circa 32 GP appointments per day, 160 GP appointments per working week and 8,000 GP appointments per year.

Utilisation and Modernisation Fund 25/26 - Estates Bids split by Place



Potential Increase in Access - GP Appointments per annum as a result of Estates Bids



	Cheshire East	Cheshire West	Halton	Knowsley	Liverpool	Sefton	St Helens	Warrington	Wirral
Total	256,000	216,000	32,000	32,000	144,000	80,000	56,000	144,000	248,000

Proposed Spend

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Estates

- Additional work is being undertaken to prepare a pipeline of schemes, based on the principles of this fund, for years 2 to 5 based on similar allocations
- * Submitted bids exceed the allocation following NHS England advise that any slippage in other ICBs may result in further capital allocation for this funding stream, bids have been submitted to seek 'pre-approval' should further monies become available.

Digital

- Significant risk of investment requirement for 26/27 circa £5,000,000 for Infrastructure Upgrades/Hardware Refreshes/Cyber Security.
- All Digital IT Providers have undertaken a risk stratification exercise to determine priority for investment. The proposed 25/26 allocation meets some but not all in year investment requirements with a risk score of over 20 and will considerably impact the 26/27 allocation requirements. This includes replacement of industry standard switches and firewalls supporting Warrington, Wirral and Cheshire (£500,000)
- Digital funding for Estates Projects (BAU Capital and Utilisation and Modernisation) must come from BAU Capital

System

- Spend requirements far exceed allocation, system must recognise delivery restrictions on primary care access and Digital innovation as a result

**Any slippage or underspend within Estates or Digital will be considered as part of the regular checkpoint meetings between both teams

Utilisation and Modernisation Fund	Allocation	Submitted Bids	Variance
Estates*	£ 5,027,000	£ 8,472,714	£ 3,445,714

Business As Usual Capital	Allocation	Submitted Bids	Variance
	£ 4,700,000		
Estates		£ 2,803,151	£ -
Digital		£ 1,896,849	£ -

Additional Spend Requirements	Allocation	Submitted Bids	Variance
Digital**		£ 5,200,000	£ -

NHS
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System Primary Care Committee

17 April 2025

Freedom to Speak Up (FTSU) in Primary Care

Agenda Item No: SPCC 25/04/B14

Responsible Directors: Chris Douglas - Executive Director of Nursing & Care & FTSU Exec Lead.
Erica Morriss – Non-Executive Director for FTSU.
Thomasina Afful – Associate Director - Equality, Diversity & Inclusion & Senior Responsible Officer FTSU.

Author: Temitayo Roberts – Freedom to Speak Up Guardian Lead NHS C&M ICB

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Freedom to Speak Up (FTSU) Update

1. Introduction

1.1 What is 'Speaking Up'?

- Freedom to Speak Up (FTSU) is about encouraging a positive culture where people feel they can speak up, their voices will be heard, and their suggestions acted upon. Speaking up is about anything that gets in the way of providing good care and doing a great job!

- FTSU is for all NHS workers – anyone who works in NHS healthcare, including dentistry, general practice, pharmacy, and optometry. It includes any healthcare professionals, non-clinical workers, administrative workers, directors, managers, contractors, volunteers, students, trainees, junior doctors, locums, bank and agency workers, and former workers.

- The underlying principle is that when things go wrong, it is important to learn lessons and make improvements. The NHS believes that if an individual thinks something might be wrong, they must feel able to speak up to prevent potential harm. Even when things are good but could be better, an individual should feel able to say something.

- Staff can speak up about anything that gets in the way of patient care or affects working life. This could be something that just doesn't feel right, e.g., a way of working or a process that isn't being followed, an individual feeling discriminated against, or behaviours of others affecting the wellbeing of colleagues or patients.

- Speaking up captures a range of issues, and some may be better handled by existing processes such as HR functions, patient safety, quality, or contracting. Guardians will support individuals who are speaking up to get to the right place or advise and facilitate an outcome within the FTSU provision.

- Freedom to Speak Up (FTSU) guardians play a crucial role in providing an alternative channel for workers to voice their suggestions, concerns, or any other matter. They also work in partnership throughout the organisation to foster an environment that normalises speaking up as an integral part of everyday work.

1.2 The National Guardian's office website states that there are over 1,000 FTSU Guardians in the NHS and independent sector organisations, national bodies, and elsewhere. Between 1 April 2023 and 31 March 2024, 32,167 cases were raised.

1.3 It became mandatory for all Trusts to appoint a Freedom to Speak Up Guardian

in Oct 2016 following the NHS mid-Staffordshire hospital incidents and Sir Robert Francis inquiry. His review recommended a culture where safety is a priority, staff are valued and organisations are free from bullying, supported by visible leadership and a culture of reflective practice.
The role of FTSU Guardian is being introduced to Primary Care and other organisations – Hospices, private healthcare providers, ICB's, primary care, and social care.

2. Purpose of the Report

2.1 This paper aims to provide the System Primary Care Committee (SPCC) with an update on Cheshire and Merseyside Freedom to Speak Up (FTSU) development and the National Guardians Office (NGO) and the NHS England guidance that stipulate the expectations of Integrated Care Boards (ICBs) and Integrated Care Services (ICSs) in relation to Freedom to Speak Up in primary care including its implications for staff and patients. More information can be seen in this 'Freedom to speak up in Primary care' document - whistleblowing-guidance.pdf.

2.2 This report also includes the overview of confirmed FTSU Guardians in general practices and the feedback from the 3 other contractor groups- pharmacy, optometry and dentistry.

2.3 Based on the data and conversations with primary care providers across the four disciplines, the report will present a recommendation for a model of provision that could be adopted and implemented across Cheshire and Merseyside.

2.4 The report will also describe the supporting and coordinating roles of the System Primary Care Committee and NHS Cheshire and Merseyside in this provision.

3. Freedom to Speak Up at NHS Cheshire and Merseyside ICB

3.1 Key achievements to highlight include:

- roll out of FTSU e-learning for all staff with completion rate of 90%+.
- development of the FTSU strategy.
- development of a clear process for dealing with any speak up cases.
- development of the FTSU Ambassadors network which includes staff representatives from a range of diverse backgrounds.

- identification of a lead NED for FTSU, Erica Morriss.
- the recruitment of a dedicated FTSU Guardian, Temitayo Roberts.
- increased promotion of FTSU and the role of Guardians and Ambassadors including through staff communications, posters, the staff hub, 'we are one' session, face to face staff events, across all 9 places, corporate teams and directorates and the ICB organisational induction programme.
- celebration of FTSU speak up month in October 24 and the theme of power of active listening.
- establishment of the FTSU summit, a forum to review FTSU data and triangulate with other business intelligence from across the organisation.
- development of the FTSU page and FTSU icon on staff's desktops/laptops to improve navigation access to speak up resources and reporting.
- update of the FTSU (whistleblowing) policy to align with the NHS standard FTSU policy template according to the NGO and NHS England's guidance.
- FTSU Guardian Lead's attendance at Primary Care network meetings and practice managers meeting, dental, optometry and pharmacies operational group meetings across the 9 places to promote FTSU and gain understanding of the FTSU process they have in place and give support with developing an FTSU process where none exist.
- the development of a charter/terms of reference for our FTSU Ambassadors' network to support our ambassadors with carrying out their roles efficiently (raising awareness, signposting to FTSU Guardians and promoting FTSU) and managing expectations and requirements involved in volunteering as an FTSU Ambassador.
- work is underway with the Communications team on creating a platform on the staff hub for staff to share their good stories and a monthly FTSU newsletter of how speaking up is helping us to continuously improve from FTSU case studies.
- the improvement to the SARs process following a FTSU concern raised.
- refresher/new FTSU Ambassador training session for our old and new Ambassadors in December 2024, following the first training session in 2023 when the FTSU Ambassadors network was launched.

4. Executive Summary

4.1 The National Guardian's Office leads, trains, and supports a network of Freedom to Speak Up (FTSU) Guardians in England and provides support and challenge to the healthcare system in England regarding speaking up. The ICB's role is to gain assurance that all NHS organisations across the ICS have accessible speaking up arrangements, in line with the published guidance and policy, considering the different barriers that workers face when speaking up and actions to reduce those barriers.

4.2 NHS England has outlined its expectations of integrated care boards (ICBs) and integrated care systems (ICSs) in relation to Freedom to Speak Up and they are working with the National Guardians Office (NGO). In October 2024, NHSE asked ICBs to ensure that FTSU arrangements are in place for system partners in primary care by 2026. Work is underway with C&M ICB primary care to provide assurance to NHS England that their staff know how to reach an FTSU guardian who is trained, registered with the National Guardian's Office, and named in their local FTSU policy. This will support workers with speaking up where needed.

4.3 NHS Cheshire and Merseyside Integrated Care Board, in line with published guidelines and as the commissioner, needs to ensure that primary care workers across the ICS have access routes for speaking up, including access to an FTSU Guardian. Guardians are trained by the National Guardian's Office and its free. Being a trained Guardian enables local networks to develop and support fellow Guardians across the NHS.

4.4 Freedom to speak up is referenced in Care Quality Commission (CQC) ICS theme three, leadership QS12 and links to the ICB Board Assurance Framework risk P9. When people speak up, everyone benefits. Building a more open culture, in which leadership encourages learning and improvement, leads to safer care and treatment and improved patient experience. It also has broader links to both quality & safety, and integration.

4.5 Most NHS organisations now have Guardians who either work dedicated to FTSU or have it as part of their role and within their job description. To be known as a Guardian, individuals must have undertaken the National Guardian's training programme and be registered with the National Guardians office.

4.6 The development of the Cheshire and Merseyside ICS has seen FTSU become more structured and is considered essential to Cheshire and Merseyside's commitment to our NHS people promise.

5. Ask of the Committee and Recommendations

5.1 **The Committee is asked to:**

- **note** the overall progress in relation to developments of FTSU.
- **consider** the options for the delivery of FTSU in primary care.
- **support** and **advice** on how we can make the most impact with very limited resources.
- **endorse** a model that works

6. Freedom to Speak up process in Primary Care

6.1 There are no resources or current footprint data provided so the first step is to analyse what FTSU support exists across the 4 Contractor Groups to understand the gaps.

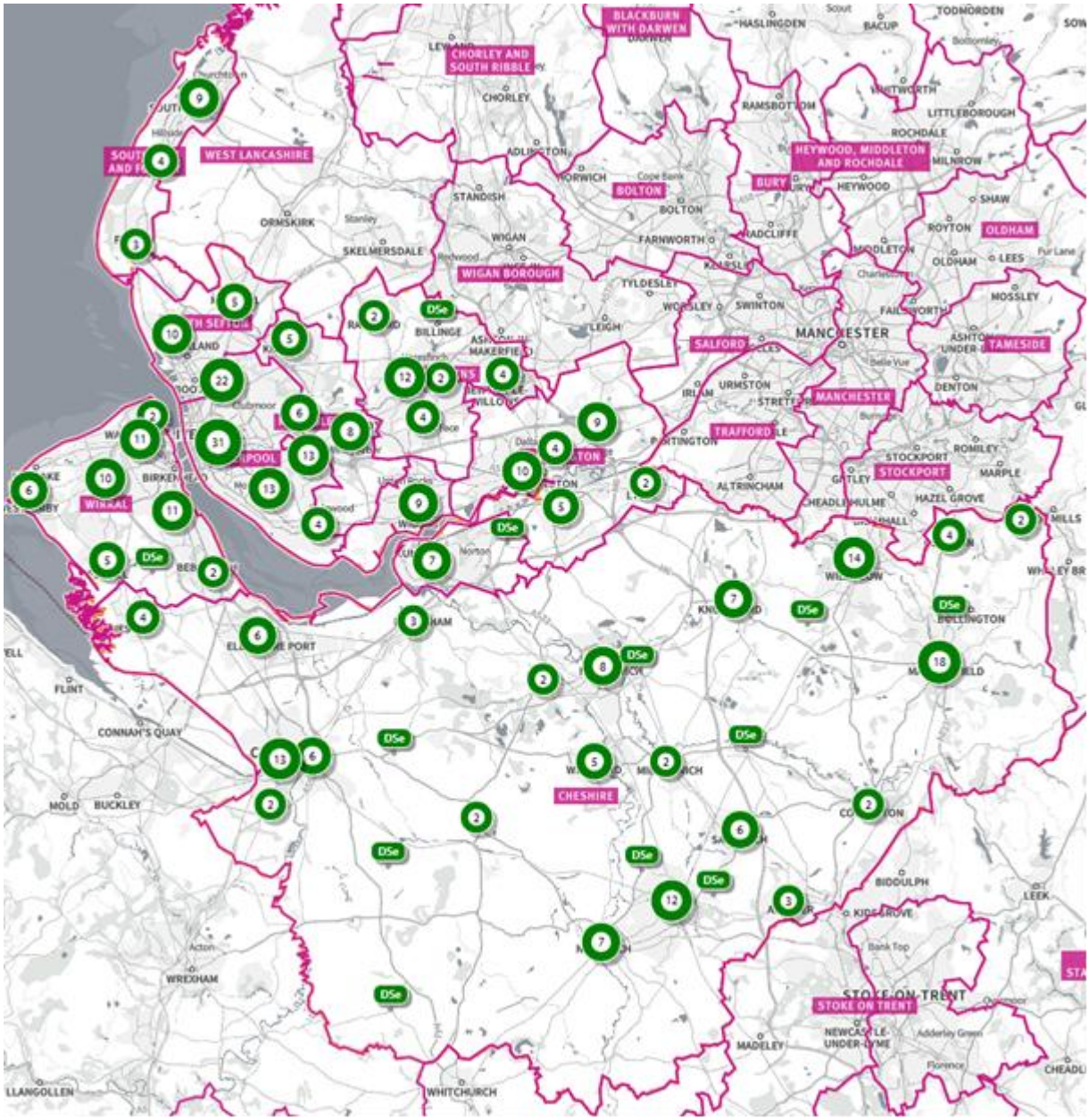
6.2 To get a picture of the Freedom to Speak Up provision across primary care, NHS Cheshire and Merseyside, ICB FTSU Guardian Lead together with the ICB Primary Care Associate Directors and the senior commissioning managers across the ICB 9 places were able to collate the lists of 348 GP practices and their FTSU Guardian coverage (shown in attachment below).

FTSU Assurance for Primary Care GP list.x

6.3 Whilst almost all PCNs and practices have got an identified FTSU Guardian, or some arrangements in place, a substantive amount are yet to complete the National Guardian's office (NGO) training offered to Guardians which leads to registration with the NGO to provide support to help deliver the role effectively.

6.4 Some of the issues raised by the PCN managers and practice managers about developing FTSU process in practice is the lack of resources such as manpower, funding and dedicated time for the role and this is echoed by the other 3 contractor groups – Dentistry, Optometry and Pharmacy.

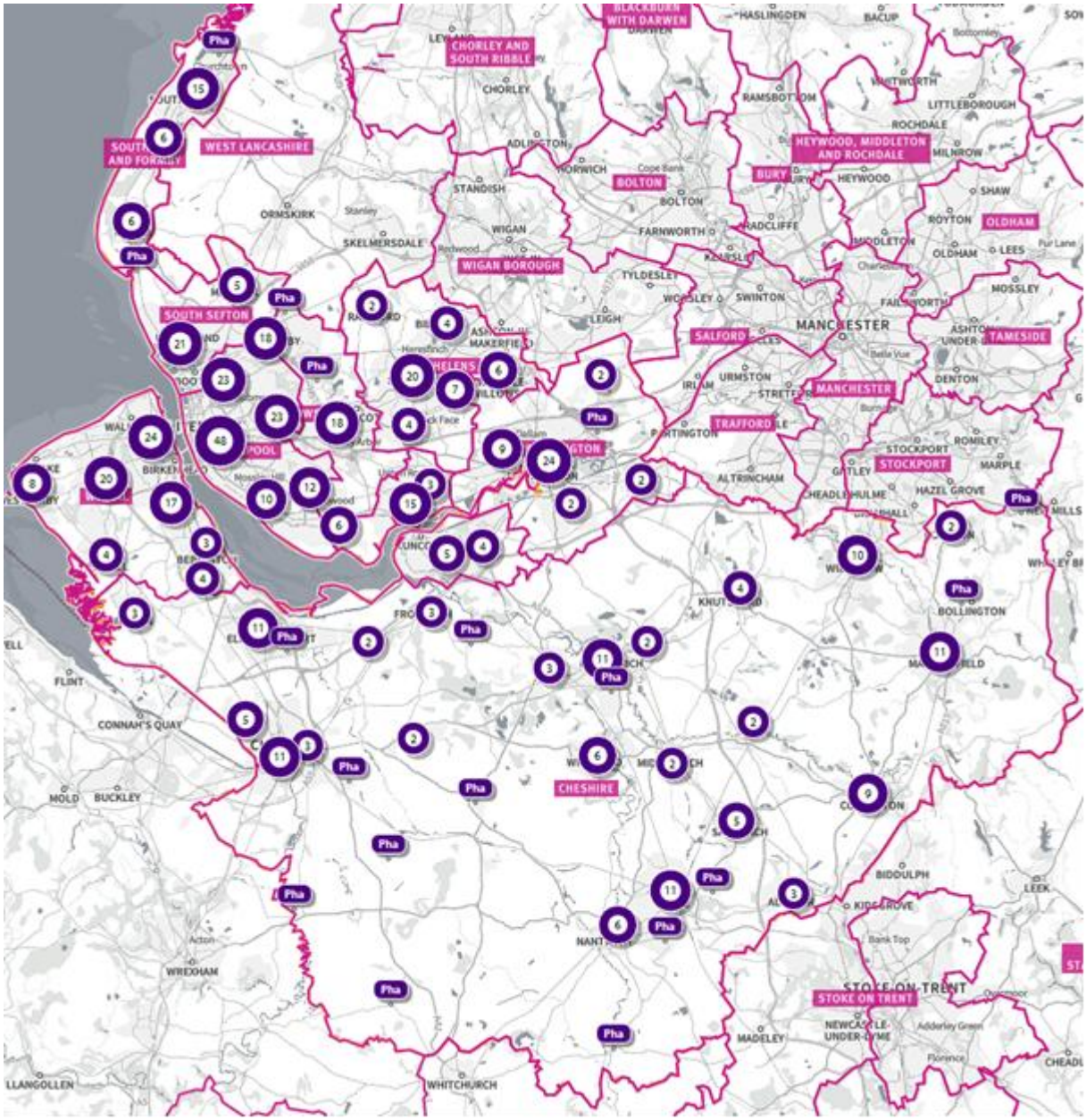
6.5 Willingness to have a FTSU process and its importance for staff wellbeing and patient safety is what all 4 contractor groups agree on but the 'how to implement', based on the limited resources, disparity, variation, system difference across PCNs and contractor groups and the way services are geographically placed is a challenging factor.



Primary Care Dental sites across Cheshire and Merseyside

Feedback for primary care dentistry:

- Initial discussions have been held with the Local Professional Network Chair. Further discussions need to be had with the Local Representative Committees.
- One proposal is to mirror work previously done by the Network and identify a Champion in dental practices. Something we did previously for AMR and Dementia
- Perhaps also need to host a specific event to go over what is required and look at options for implementation.
- The challenge that within the average Dental Practice, you are looking at a very tight group, usually with one person leading them, either the Practice Owner or a Practice Manager. An issue shared in wider primary care too.



Community Pharmacy sites across Cheshire and Merseyside.

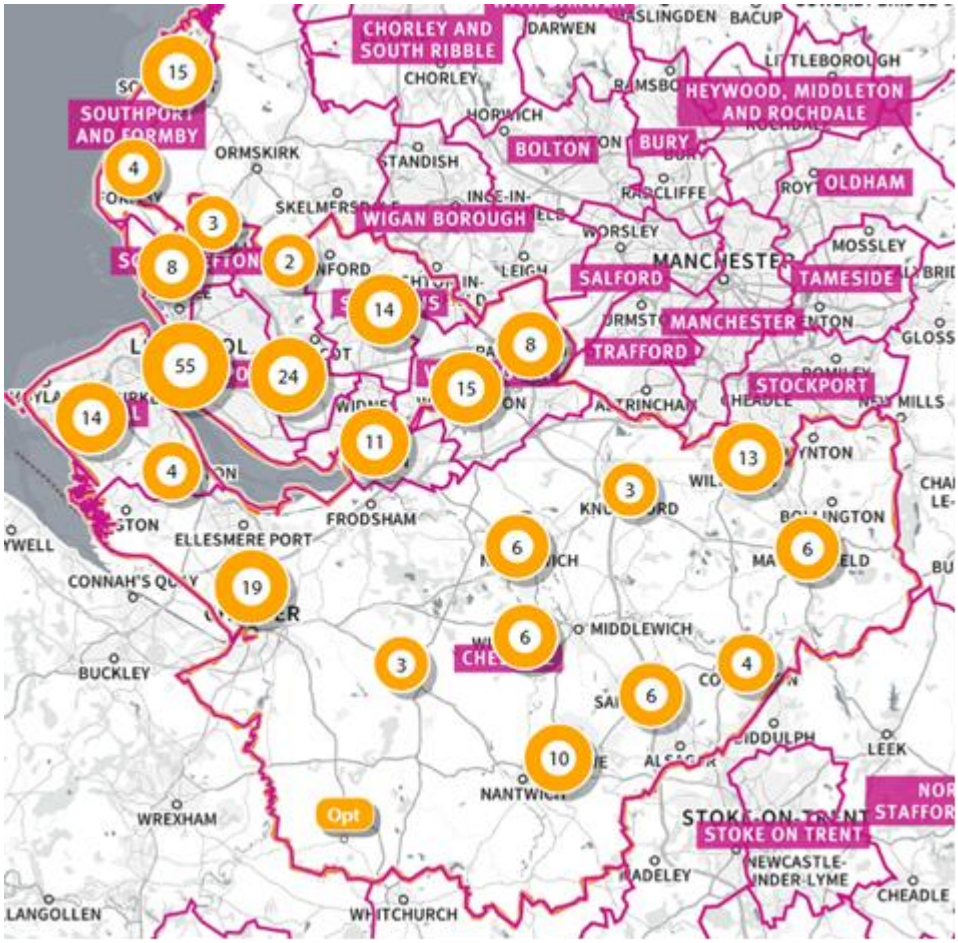
Feedback for Community Pharmacy:

- PCN pharmacists to become the “Champion” and be able to signpost pharmacy staff to an appropriate FTSU guardian.
- PCN Pharmacists could “engage as they go” but we suggest this should be part of a larger, more equitably spread engagement plan.
- In terms of a FTSU guardian there is a fundamental question about who takes on this role for an independent community pharmacy.

- There could be an ICB FTSU role that is a FTSU guardian who is trained, registered with the National Guardian's Office, and named in the local FTSU policy, whose role incorporates supporting independent contractors with speaking up where needed.

- If the PCN engagement leads are being proposed to take on the actual role of the FTSU Guardian themselves this would significantly eat into the investment in terms of training and development time for this role which would not, then be available for the PCARP agenda as originally proposed.

- Continue to utilise the Local Professional Network and Local Representative Committees



Community Optometry sites across Cheshire and Merseyside

Feedback for Community Optometry:

- Initial discussions have been held with the Local Professional Network Chairs. Further discussions are taking place at Local Representative Committees.

- The LOC Chairs agreed they would work together to identify 1 or more FSUGs who could be accessed by any people working in an optometry setting. They are

going to take this back to their next committee meetings to identify suitable individuals who may fulfil this role.

- The underlying challenge is the funding needed to do this and time out of practice for FSUGs to attend the training session(s).

6.6 The outputs from the mapping outlined some highlighted risks as below:

- Some of the FTSU Guardians representing general practices have not had any training from the National Guardians Office (NGO),
- A low number of the appointed FTSU Guardians in general practice were recruited into post via an external advert or open recruitment.
- There's no defined protected time for appointed FTSU Guardians to carry out the Freedom to Speak Up role.
- Only a few FTSU Guardians submit any quarterly data to the National Guardians Office (NGO), and it is highly likely that there is no reporting to locality or professional groups.
- Due to appointed FTSU Guardians who are yet to complete their NGO training, they lack the regional or national network support offered through the registration with the NGO.
- There is no sharing of learning or best practice or triangulation of data.
- Without a culture where concerns are heard and acted upon, risks go unnoticed, and harm can follow, especially for patient safety.

6.7 **Considerations**

To advance FTSU in primary care, the following needs to be considered:

- **Training**: All Freedom to Speak Up Guardians across primary care need to be trained and have up-to-date refresher training.
- **Access to Independent Guardians**: Staff across primary care need access to an independent guardian. While some people may feel safe raising concerns within their practice area, many may prefer an independent option.
- **Escalation Routes**: Freedom to Speak Up Guardians need clear and connected routes for escalating issues such as Quality and Safety, People and Culture, Finance, and Fraud.

- **Regular Reporting**: Quarterly reporting needs to outline themes, issues, and case numbers. This can provide learning and forewarning about themes and issues across places and disciplines.
- **Peer Support**: The role of the Freedom to Speak Up Guardian can be lonely, so it's important to ensure these individuals are linked to peer support. Guardians also need protected time to fulfil their role.
- **Promotion**: Once the above measures are in place, efforts should be made to advertise and promote Freedom to Speak Up.

7. The System Primary Care Committee is therefore asked to consider how to provide, coordinate and oversee Freedom to Speak Up.

- **Resource Allocation**: Resources are required to deliver and coordinate Freedom to Speak Up across all primary care contractor groups.
- **Coordination Options**: Coordination can be done at a Cheshire and Merseyside level, across each discipline, or across places. Coordination can help with training, ensuring everyone accesses training from the National Guardian's Office and stays up to date.
- **Advice and Support**: NHS Cheshire and Merseyside ICB Freedom to Speak Up Guardian Lead can provide advice and support (already happening), ensuring Guardians are linked to support available across Cheshire and Merseyside and at the Northwest level. The ICB will oversee the provision and act as an assurer. While escalation is currently through NHSE, future guidance may make the ICB a part of the escalation chain.
- **Networked Support**: Provide a networked approach to support Guardians and maintain a record of where Guardians are in place, actively supporting recruitment where gaps exist.
- **Reporting Infrastructure**: Establish a reporting infrastructure for FTSU as required by national guidance.

8. Model for FTSU Provision

- Freedom to Speak Up policy in line with the national policy.
- Route map for raising concerns.
- Equitable FTSU provision across the four disciplines of Primary Care.
- Trained and registered FTSU Guardians
- Database for the FTSU Guardians across Primary Care
- Mapping clear escalation routes FTSU spoken up matters.
- Review groups looking at patient safety concerns that come via FTSU.
- Quarterly data submission to National Guardians Office
- Theme reporting to board, locality and professional group area.
- Shared learning, good practice and triangulation of speaking up data.
- ICB sighted on themes/ ICB to understand the FTSU process for assurance
- Freedom to Speak Up Guardian network support.
- Freedom to Speak Up Guardian mentorship and wellbeing support.

Principles of Place Delivery

8.1 **Place Level**:

Overview:

- A Freedom to Speak Up Guardian is allocated to cater to a specific geographic area or community. This ensures the Guardian is aware of the challenges, themes, or concerns specific to that area.
- Managing and escalating issues raised can be challenging with this model of delivery.
- It would need to be adequately resourced with a strong focus on building a wide FTSU Champion network.
- FTSU Champions are not case holders, and their role is to promote FTSU and to signpost to the appropriate support services, including the Freedom to Speak Up Guardian.

Advantages:

- **Localised Expertise**: The Guardian is familiar with the unique challenges and issues specific to the area, leading to more relevant and effective responses.
- **Community Trust**: Having a dedicated Guardian for a geographic area can build trust within the community, encouraging more individuals to speak up.
- **Targeted Support**: The Guardian can provide tailored support and solutions that address the specific needs and concerns of the community.

Disadvantages:

- **Resource Intensive**: Adequate resourcing is necessary to ensure the Guardian can effectively manage and escalate issues, which may be challenging in terms of funding and staffing.
- **Coordination Challenges**: Managing and coordinating a wide network of FTSU Champions can be complex and time-consuming.
- **Potential Conflicts**: Balancing the Guardian's role with their other responsibilities might lead to potential conflicts of interest or reduced effectiveness in addressing concerns.

8.2 **Local Level:**

Overview:

- The "local" level of FTSU delivery involves coordination and integration of primary care services within a smaller, more specific area, such as a neighbourhood. This model ensures accessibility and responsiveness to the immediate themes or concerns raised.

Advantages:

- **Accessibility**: The proximity of services ensures that employees can easily access support and raise concerns without significant barriers.
- **Responsiveness**: Being closer to the source of concerns allows for quicker response times and more immediate action on issues raised.
- **Community Focus**: This model fosters a stronger sense of community and collaboration among local healthcare providers, promoting a supportive environment for speaking up.
- **Targeted Interventions**: The ability to address local themes and concerns specifically can lead to more effective and relevant interventions.

Disadvantages:

- **Resource Allocation**: Smaller areas may struggle with limited resources, making it challenging to adequately support the FTSU function.
- **Consistency**: Variations in how different neighbourhoods implement and manage the FTSU process could lead to inconsistencies in support and outcomes.
- **Integration Challenges**: Coordinating and integrating services within a specific area may require significant effort and cooperation from various stakeholders.

- Potential for Overlap: There may be overlap or confusion regarding roles and responsibilities if the local level is not clearly defined and communicated.

8.3 **Network Level:**

Overview:

- At the "network" level, Primary Care Networks (PCNs) are formed. PCNs are groups of GP practices working together to provide Freedom to Speak Up services. They aim to:
  - Share any costs in funding for the FTSU provision.
  - Share any themes and seek assurances.

Advantages:

- **Cost Sharing**: By pooling resources, PCNs can more efficiently fund the FTSU provision, reducing the financial burden on individual practices.
- **Enhanced Collaboration**: Working together within a network fosters collaboration and sharing of best practices, leading to improved overall service delivery.
- **Broad Coverage**: PCNs can provide a wider range of services and support, reaching more employees and addressing a broader spectrum of issues.
- **Unified Approach**: Having a network-level approach ensures consistent standards and practices across multiple GP practices, leading to more reliable and uniform handling of concerns.
- **Collective Learning**: Sharing themes and seeking assurances across the network promotes collective learning and continuous improvement in addressing concerns and implementing solutions.

Disadvantages:

- **Coordination Complexity**: Managing and coordinating multiple GP practices within a network can be complex and time-consuming, requiring significant administrative effort.
- **Resource Allocation**: Ensuring that resources are distributed fairly and effectively across the network can be challenging, especially in terms of staffing and funding.
- **Varying Priorities**: Different practices within the network may have varying priorities and approaches, potentially leading to conflicts or inconsistencies in the FTSU delivery.

- **Reduced Local Focus**: While networks provide broad coverage, there is a risk that specific local concerns or unique community needs might be overlooked in favour of network-wide strategies.
- **Dependency on Collaboration**: The success of the network-level model heavily relies on the willingness and ability of individual practices to collaborate and share information openly.

8.4 **Practice level:**

Overview:

- **Overview:**
  - **GP Practice, Dental Surgery, Optician, or Pharmacy:**
    - **Freedom to Speak Up Guardian Role:** Performed by or allocated to a practice worker such as a receptionist, practice manager, or GP/dentist/pharmacist/optician.

- **Internal Freedom to Speak Up Escalation Routes:**
  - Line Manager
  - Practice Manager
  - Freedom to Speak Up Guardian
  - Partner Board/Practice Leadership Team

- **Additional Internal Routes:**
  - Executive Lead
  - Lay Member
  - Clinical Lead
  - Accountable Officer
  - Chair

- **Role Responsibilities:**
  - The Freedom to Speak Up Guardian role is carried out in addition to a substantive post.
  - The Freedom to Speak Up Guardian presents their reports to the practice leadership team to embed learning within the practice.

- **Funding Considerations:**
  - No specific consideration is given to how the Freedom to Speak Up Guardian role is funded.

- **Challenges:**
  - Leaders can be too close to the issues that workers wish to speak up about, risking their impartiality in fairly resolving speaking up matters.

- Confidentiality and management of real and perceived conflicts of interest could be challenging in this structure.

- **Advantages:**

  - **Direct Access:** Employees have direct access to a familiar person within their practice, making it easier to raise concerns.
  - **Immediate Response:** Issues can be addressed more quickly and directly within the practice, leading to faster resolutions.
  - **Personalized Support:** The Guardian can provide personalized support tailored to the specific needs and context of the practice.
  - **Embedded Learning:** Reports and feedback from the Guardian can directly influence practice policies and procedures, embedding learning and improvement within the practice.
  - **Collective Approach:** A collective approach to FTSU will enable mitigation against factors such as safety, confidentiality, and capacity.

- **Disadvantages:**

  - **Resource Constraints:** The Guardian may struggle to balance their FTSU role with their substantive post, leading to potential conflicts of interest and reduced effectiveness.
  - **Impartiality:** Leaders and Guardians within the practice may be too close to the issues, risking their impartiality in resolving concerns.
  - **Confidentiality Challenges:** Managing confidentiality and perceived conflicts of interest can be difficult in a close-knit practice setting.
  - **Limited Funding**: Without specific funding considerations, the sustainability of the FTSU Guardian role may be challenging.

8.5 **Partnership Model (Recommended)**

Partnership Model Components:

- Primary Care Networks (PCNs)
- GP Confederations
- Alliance of Pharmacies
- Optician Practice Partnerships
- Dental Networks

Structure:

- **Resources Combined:**

- A group of practices (or other providers) combine resources to support the introduction of a Freedom to Speak Up Guardian role and processes.

- **Internal Escalation Routes:**

    - The development of more integrated working also emphasizes the need for cross-organizational processes to be clear and well-understood by workers, Freedom to Speak Up Guardians, and leaders. FTSU Guardians should have an escalation route map provided, which includes but is not limited to:
        - Line Manager
        - Partner Board/Practice Leadership Team
        - HR, Quality and Safety, Safeguarding

    - **External Escalation Routes:**

    - Professional Bodies
    - Regulatory Bodies
    - Commissioning Body

- **Additional Route:**

    - A Freedom to Speak Up Guardian provides a further route for speaking up to workers across the group of practices (or other providers).

- **Reporting:**

- The Freedom to Speak Up Guardian reports to:

    - Practices' Joint Leadership Team
    - PCN Leadership Team
    - General Practice Transformation Board

- **Funding Considerations:**

    - No specific consideration is given to how the Freedom to Speak Up Guardian role is funded, other than operating by virtue of a goodwill arrangement.
    - It would be advisable to have a coordinator arrangement, and there might need to be a budget if this post is introduced.

8.6 Benefits and challenges of Partnership Model

Benefits:

- Provides practices or other providers (regardless of discipline) with speaking up routes for workers, which can be either internal or separate from their organization.
- May help foster more collegiate working between organizations within the network.
- Providing network-level speaking up data may help overcome barriers to sharing organizational intelligence, leading to wider learning and improvement.
- For theme triangulation, assurance, and reporting at a local level, FTSU review groups can be established for patient safety concerns, resolution, and oversight depending on the discipline and expertise. For example, in GP practices, an FTSU review group can be established as outlined below.

Advantages:

- **Resource Efficiency**: Combining resources from multiple practices or providers can lead to more efficient use of funding and staffing.
- **Shared Learning**: Sharing themes and insights across the network promotes collective learning and continuous improvement.
- **Unified Standards**: Establishing consistent standards and processes across the network ensures a uniform approach to addressing concerns.
- **Expanded Support**: Workers have access to multiple routes for speaking up, increasing the likelihood of their concerns being addressed.

Disadvantages:

- **Coordination Complexity:** Managing and coordinating multiple organizations within the network can be complex and require significant administrative effort.
- **Resource Allocation**: Ensuring fair and effective distribution of resources across the network can be challenging.
- **Varied Priorities**: Different organizations within the network may have varying priorities and approaches, potentially leading to conflicts or inconsistencies.
- **Dependency on Collaboration**: The success of the partnership model relies heavily on the willingness and ability of individual organizations to collaborate and share information openly.

Considerations:

- For theme triangulation, assurance, and reporting at a local level, FTSU review groups can be established for patient safety concerns, resolution, and oversight depending on the discipline and expertise. For example, in GP practices, an FTSU review group can be established as outlined below.

  - Chief Medical Officer
  - Head of Quality Primary and Local Care, Urgent and Emergency Care and Planned Care
  - Primary Care Engagement & Contract Officer
  - Primary Care Transformation Programme Director
  - Senior Designated Nurse, Safeguarding Adults
  - Director Primary Care

  A networked model like this will require support either via the provider board, through disciplines, or places.

- **Consistency in Protected Time**: Ensuring Freedom to Speak Up Guardians have dedicated time to fulfil their role.

- **Balancing Act**: Balancing being distanced from and working within a setting may be challenging in terms of visibility, relationship building, reporting routes, and partnership working.

- **Provider Placement**: The Freedom to Speak Up function should sit within providers. This could be organised through the System Primary Care Committee (SPCC)/Primary Care Provider Board (PCPB) and potentially through the chairs of each primary care discipline or by locality/place.

- There needs to be a coordinating function in the SPCC/PCPB, with potential for this to be located and funded within the Health and Wellbeing Infrastructure, to coordinate access, recording, and training effectively.

- **Funding Streams**: Funding streams need to be considered to support this function, or roles should be realigned as appropriate across the SPCC/PCPB and/or ICS Primary Care Commissioning Team into SPCC/PCPB, in recognition that this is an essential development and function.

9. The Role of the ICB

- The NHS Cheshire and Merseyside Freedom to Speak Up Guardian Lead will be a facilitator of a community of practice for Freedom to Speak Up Guardians and a professional advisor.
- The ICB will also seek assurance from providers as part of its role in Quality and Performance and People and Culture across the Health and Care system. Currently, NHSE provides the escalation route for cases that cannot be handled sufficiently in Primary Care. New guidance is expected to outline whether this will continue or if ICBs will also form part of the escalation chain.

10. Benefits of Freedom to Speak Up

Quality and Safety:

- **Enhanced Patient Care:** Encouraging staff to speak up about concerns helps identify and address issues that may impact patient care, leading to improved patient outcomes.
- **Early Detection of Issues:** Regular reporting and raising concerns allow for early detection of potential problems, preventing them from escalating.
- **Learning and Improvement:** FTSU promotes a culture of continuous learning, where feedback from staff is used to make improvements in processes and practices.
- **Transparency:** Creating an environment where concerns can be openly discussed fosters transparency and accountability within the organisation.

Fraud Prevention:

- **Increased Vigilance:** A culture of speaking up empowers employees to report any suspicious activities, helping to detect and prevent fraud.
- **Ethical Conduct:** Promoting FTSU reinforces the importance of ethical conduct and integrity, discouraging fraudulent behaviour.
- **Safeguarding Resources:** By identifying and addressing fraudulent activities early, organisations can safeguard their resources and ensure they are used appropriately.

Workplace Culture:

- **Empowerment**: FTSU gives employees a voice, making them feel valued and empowered to contribute to the organisation's success.
- **Trust and Confidence:** Encouraging open communication builds trust and confidence among staff, leading to a more collaborative and supportive work environment.

- **Conflict Resolution:** Providing a structured way for employees to raise concerns helps resolve conflicts and issues promptly, reducing workplace tensions.
  Inclusivity and Diversity: FTSU promotes an inclusive culture where all voices are heard, regardless of background or position, fostering diversity and equality.

11. Officer contact details for more information:

Temitayo Roberts FTSU Guardian Lead C&M ICB
Temitayo.Roberts@cheshireandmerseyside.nhs.uk

12. Further information


PCN FTSU checklist.pptx


Wording to introduce the toolkit.docx


FTSU Implementation toolkit for PCNs.pptx


PAR1245i-Freedom-to-speak-up-policy-for


B1245_iii_Freedom-to-speak-up-a-reflectic


Guidance-on-Champions-and-Ambassador


Exploring-Freedom-to-Speak-Up-Primary-

NHS
Cheshire and Merseyside

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

April 2025

Update – Primary Care Workforce Steering Group

Agenda Item No: SPCC 25/04/B16

1. Purpose of the Report

1.1 The purpose of the report is to provide an update to the Committee from the Primary Care Workforce Steering Group, which met in March 2025.

2. Ask of the Committee and Recommendations

2.1 The Committee are asked to ***note*** the update which is for information/assurance purposes

3. Update

- Terms of Reference/Role of the Group - Amendments to the terms of reference were drafted prior to the meeting and comments were invited from members, for discussion/finalisation at the next meeting – the revised Terms of Reference are given in **Appendix 1.** It was noted that the group had no financial authority but could recommend/offer support to areas for consideration for funding.

- NHS England presented an overview of latest national primary care workforce issues including a discussion on how PCNs can be supported in terms of the revised additional roles (ARRS) funding from 1st April and supporting GPs qualifying in August.

- An update was given regarding the Community Pharmacy Technician Apprenticeship Programme.

- Workforce planning – an update on workforce planning was given - It was noted that the agenda / data was primarily around primary medical and further work was required to look at consistency around this – but the main challenge was lack of data for the other three contractor groups. The lack of 'SDF' system development funding for the other three contractor groups was also raised.

- A discussion on how the 9 Place Workforce Groups would feed into this meeting via the place representatives on the group took place – collated views from place would feed into this meeting, but it was noted that most asks from NHS England were for an overall ICB position especially in light of the new planning guidance asks.

- A presentation/update on dental workforce was given and it was agreed that regular updates on this area were needed.

- The training hub presented an update on their work programme for 24/25 and proposals for 25/26, subject to agreed funding.

- At the next meeting the following items were prioritised for discussion
    - An analysis /update on the Pharmacy workforce survey
    - An update on the Optometry workforce project which was funded through ICB transformation funding.
    - Clarity on any SDF funding for workforce and agreed priorities for primary medical workforce for 25/26

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

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

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

5 Link to meeting CQC ICS Themes and Quality Statements

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

6 Risks

Supports the mitigation following BAF risks - P1, P4, P5, P6, P8, P9 – Workforce Planning

7 Finance

There are no additional finance risks or asks associated with this paper outside of those in the finance update (for example in relation to ARRS additional roles)

8 Communication and Engagement

No external formal consultation or further engagement is required in respect of this paper.

9 Equality, Diversity and Inclusion

As part of any workforce strategy work and related workstreams.

10 Next Steps and Responsible Person to take forward

Christopher Leese, Associate Director Of Primary Care
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11 Officer contact details for more information

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NHS
Cheshire and Merseyside

Appendix 1 – (Amended) Terms of Reference Primary Care Workforce Steering Group

Cheshire and Merseyside ICB

Primary Care Workforce Steering Group

Terms of Reference v1.5

Document revision history

Date	Version	Revision	Comment	Author / Editor
30.3.2023	1.0	Initial ToRs		Christopher Leese Emma Hood
8.6.2023	1.1	Revisions following PCWSG meeting		Christopher Leese
1.10.2023	1.2	Revised ToRs going to People Board for agreement in November / SPCC in October	Awaiting comments from People Board to agree TORs - incorporated	Christopher Leese
March 2025	1.3 1.4 1.5	Review to reflect current operating model and decision making processes	Discuss at March meeting – awaiting comments	Christopher Leese

Review due
Underway

NHS Cheshire and Merseyside ICB

Terms of Reference Primary Care Workforce Steering Group

1.0 Background

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

2.0 Purpose

- To manage and/or make recommendations for funding streams relating to primary care workforce under SDF funding and other sources, in line with delegated authority from the People Board
- To support the development of a wider Workforce Strategy (Primary Care elements)
- To ensure that there is a credible and agreed baseline profile for the general practice and primary care workforce within Cheshire and Merseyside, to aid effective workforce planning and modelling across Primary Care Networks (PCN).
- That critical workforce gaps and risks are clearly identified with an informed and appropriate prioritised plan developed to address the gaps & risks identified.
- To support the future development of any workforce action plans/workforce planning ensure it reflects the level of local progress within the context of any other emerging priorities or risks within PCNs.
- To consider and plan how the utilisation of any national and local workforce development and education initiatives, including access to available funding relevant to general practice and primary care, might be connected and presented to enable their best application and adoption within Cheshire and Merseyside through the Primary Care Training Hubs across C&M.
- To monitor and report progress on the workforce aspects of the Operational Planning Guidance and other national policy,
- To connect place, corporate and other primary care workforce leads and stakeholders to achieve common aims of improving workforce retention, recruitment and maximisation of workforce resources
- To ensure wider workforce needs such as health, wellbeing, training, support and OD are factored into planning at all levels
- To facilitate partnership working with the training hub including overview of delivery of work programme and other key partners.
- Supports the role of the People Board and the Boards responsibilities.
- Supports Place in relation to it's workforce responsibilities and place level primary care workforce plans.
- To receive and assess national workforce policy, guidance and contractual requirements in relation to Primary care, ensuring implications are identified
- To support the triangulation of information and updates from Place based Primary Care Workforce Groups

- To support and underpin the ICB's Primary Care Strategic Framework

3.0 Membership

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

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

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

4.0 Frequency of Meetings:

4 meetings per year will be held

5.0 Administration:

To be supported by the primary care contracts team for an interim period

- providing facilities to support the effective operation of the steering group
- coordinate meeting agendas and papers, distributed in advance of any meeting
- providing a record of discussions and agreed actions following each meeting within a reasonable timeframe

6.0 Governance and Reporting

Primary Care Workforce Steering Group will report directly to:

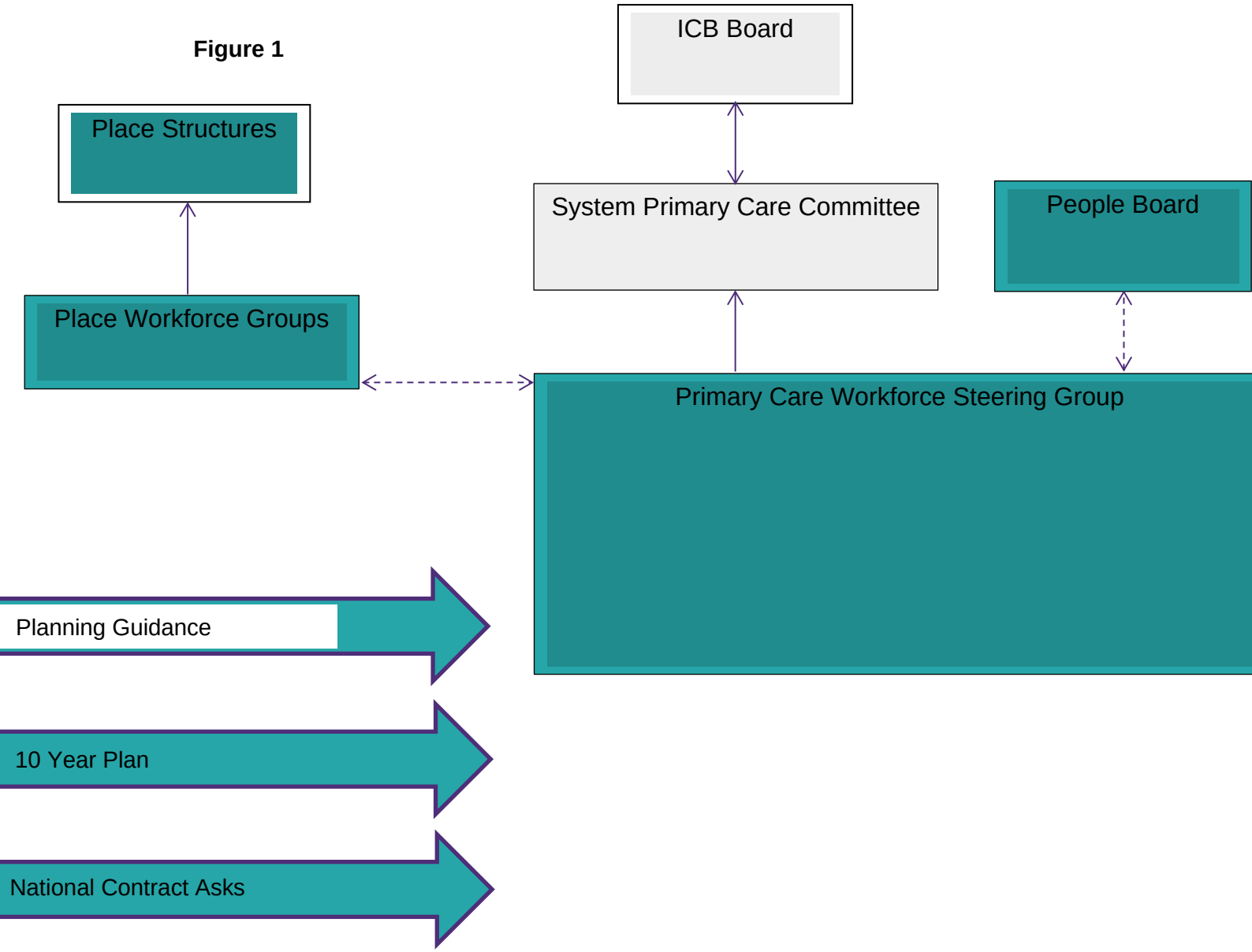
Cheshire Merseyside People Board and Cheshire and Merseyside System Primary Care Committee via a regular update/paper of key items and recommendations

Figure 1 below captures the proposed governance (tbc)

7.0 Review

The terms of reference will be reviewed annually

Figure 1


ICB Board
Place Structures
System Primary Care Committee
People Board
Place Workforce Groups
Primary Care Workforce Steering Group
Planning Guidance
10 Year Plan
National Contract Asks