NHS
Cheshire and Merseyside

Meeting of the Cheshire & Merseyside ICB System Primary Care Committee

Part B – Meeting held in Public

Thursday 19 February 2026
Venue: Meeting Room 1, No 1 Lakeside,
920 Centre Park Square, Warrington,
WA1 1QY (WA1 1QA for SatNav)

Timing: 09:45-12:00

Agenda (V1)

Chair: Erica Morriss

AGENDA NO & TIME	ITEM	LEAD	ACTION / PURPOSE	PAGE No
09:45am	**Preliminary Business**			
SPCC 26/02/B01	**Welcome, Introductions and Apologies**	Chair	Verbal	-
SPCC 26/02/B02	**Declarations of Interest**	Chair	Verbal	-
SPCC 26/02/B03	**Questions from the public (TBC)**	Chair	Verbal	-
09:55am	**Committee Management**			
SPCC 26/02/B04	**Draft Minutes of the last meeting (Part B) –** 18 December 2025	Chair	Paper To approve	Page 3 *Click here for link to page*
SPCC 26/02/B05	**Action Log of last meeting (Part B)** 18 December 2025	Chair	Paper To note	Page12 *Click here for link to page*
(10:00) **SPCC 26/02/B06**	**Primary Care Risks - Update**	Stephen Hendry	Paper To Note and Approve	Page 14 *Click here for link to page*

AGENDA NO & TIME	ITEM	LEAD	ACTION / PURPOSE	PAGE No
10:05am	**Finance Assurance**			
SPCC 26/02/B07	**Finance Update**	John Adams / Lorraine Weekes-Bailey	Paper To Note	Page 27 *Click here for link to page*
(10:20) **SPCC 26/02/B08**	**Prescribing Assurance**	Susanne Lynch	Paper To Note	Page 39 *Click here for link to page*
10:35am	**Policy and Commissioning**			
SPCC 26/02/B09	**Policy and Commissioning Update: Dental, Community Pharmacy, Optemetry and General Practice**	Tom Knight	Paper To note	Page 47 *Click here for link to page*
(10:50) **SPCC 26/02/B10**	**Enhanced Services Review**	Jonathan Griffiths	Verbal To Note	-
(11:00) **SPCC 26/02/B11**	**National Community Pharmacy Independent Prescribing (CPIPP) Pathfinder Programme**	Pam Soo	Paper For Decision	Page 55 *Click here for link to page*
11:15am	**Key Strategic Delivery Areas**			
SPCC 26/02/B12	**Neighbourhood Health Update**	Clare Watson	slides in meeting To Note	-
11:30pm	**Quality**			
SPCC 26/02/B13	**Primary Care Quality Update**	Jonathan Griffiths/	Paper To note	Page 95 *Click here for link to page*
(11:45) **SPCC 26/02/B14**	**Digital Update**	John Llewellyn/ Kevin Highfield	Paper To note and Decision	Page 112 *Click here for link to page*
12:00pm	**CLOSE OF MEETING**			

Date and time of next regular meeting:
Thursday 16 April 2026 (09:00-12:30)

F2F, Lakeside, Warrington, room tba

NHS
Cheshire and Merseyside

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

Thursday 18 December 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**
Tony Foy	TFo	*Vice-Chair*, Non-Executive Director, C&M ICB
Clare Watson	CWa	Assistant Chief Executive, C&M ICB
Louise Barry	LBa	Chief Executive, Healthwatch Cheshire
Fionnuala Stott	FSt	LOC representative
Jonathan Griffiths	JGr	Associate Medical Director, C&M ICB
Mark Woodger	MWo	LDC representative
Naomi Rankin	NRa	Primary Care Member for C&M ICB
Chris Leese	CLe	Associate Director of Primary Care, C&M ICB
Anthony Leo	Ale	Place Director, Halton
Rowan Pritchard-Jones	RPJ	Executive Medical Director, C&M ICB
Daniel Harle	DHa	LMC representative
Tom Knight	TKo	Head of Primary Care, C&M ICB
Matt Harvey	MHa	LPC representative
Christine Douglas	CDo	Director of Nursing & Care, C&M ICB
In attendance		
Cheryl Meaden	CMe	*Minute taker*, Executive Assistant, C&M ICB
Loraine Weekes-Bailey	LWB	Senior Primary Care Accountant
Kevin Highfield	KHi	Head of Digital Operations, C&M ICB
Cathy Fox	CFo	Associate Director of Digital Operations, C&M ICB
John Llewellyn	JLl	Chief Digital Information Officer, C&M ICB
Stephen Hendry	SHe	Head of Business Support (Liverpool Place)
Chris Haigh	CHa	Deputy Chief Pharmacist
James Burchell	JBu	Strategic Estates Manager (Cheshire East, Cheshire West & Wirral Places), C&M ICB
John Adams	JAd	Head of Primary Care Finance, C&M ICB
Pam Soo	PSoo	Clinical Lead for Community Pharmacy Integration
Apologies		
Name	**Initials**	**Role**
Erica Morriss	EMo	*Chair*, Non-Executive Director
Susanne Lynch	SLy	Chief Pharmacist, C&M ICB
Adam Irvine	AIr	Primary Care Partner Member
Andrea McGee	AMcG	Interim Director of Finance, C&M ICB

Agenda Item, Discussion, Outcomes and Action Points

Preliminary Business

SPCC 25/12/B01 Welcome, Introductions and Apologies

The Chair opened the meeting and welcomed everyone, confirmed attendance and apologies were noted as received.

SPCC 25/12/B02 Declarations of Interest

Standing DoI were noted and there were no new declarations pertinent to the meeting.

SPCC 25/12/B03 Questions from the public (TBC)

There were no questions raised.

Committee Management

SPCC 25/12/B04 DRAFT Minutes of the last meeting (Part B) 16 October 2025

Minutes from the previous meeting were reviewed and approved with no amendments.

The Minutes were APPROVED as a true and accurate record of the meeting

SPCC 25/12/B05 Committee Action Log (Part B) 16 October 2025

Action log: Two outstanding actions discussed.

- Prescribing action was marked as completed
- Healthwatch/GP access comms action : CWa proposed integrating this with winter comms to avoid multiple campaigns; will coordinate with colleagues as appropriate

The Action Log was updated accordingly

SPCC 25/12/B06 Forward Planner

The forward planner was reviewed.

The Forward Planner was NOTED for information

SPCC 25/12/B07 Primary Care Risks - Update

At the August 2025 meeting, the Committee agreed to the inclusion of 15 new primary care related risks on its risk register. These risks were applied across all four contractor groups and included key strategic themes of improving access, national and regional financial constraints, workforce capacity and estates planning.

- GP primary care – 8 risks including access & demand, financial constraints at national and local level, workforce, estates and neighbourhood development
- Dental services – 3 risks including access & demand and financial constraints at both national and local level
- Community pharmacy – 3 risks including access & demand and financial constraints at a national and local level
- Ophthalmology – 1 risk relating to workforce

One principal risk from the ICB's 2024/25 Board Assurance framework (P6) was delegated to committee level for management and oversight, although the Committee determined that the risk would essentially duplicate the new 'access and demand' themed risk which was more aligned with the ICB's current organisational context, objectives and the NHS 'Ten Year Plan'. The Committee therefore recommended that risk P6 be stood down given that the newer risk was more reflective of the current context and environment that the ICB was operating in.

- Work began and risk leads were nominated; the work is still ongoing with risk summaries expected to be completed by January 2026.

Areas of Discussion: -

- Discussed industrial action risk for GPs previously stood down as managed centrally; no primary care escalations, so cannot escalate to Committee unless added to risk register. Public health colleagues developing medical access roadmap (due June) to mitigate risk. Need process and confidence for GPs to raise concerns on online consultations.
- ADHD tables reviewed: PG7B and PP5B appear identical—likely a typo relating to GPs. Appendix 1 shows corporate-level risks; individual place reporting will cease. Risk strategy includes local scoring; governance work ongoing. Discussed escalation to NHSE—Board Assurance Framework (Levels 1–3) outlines reporting. Risks shared with region and NHSE regularly, not in risk register format. Transparency occurs via Board meetings; papers published online but not routinely shared externally.

System Primary Care Committee was asked to:

- **NOTE** the contents of report in regard to progress and proposed actions/arrangements for the continued reporting of risks and assurance to the Committee.

The SPCC NOTED the contents of report in regard to progress and proposed actions/arrangements for the continued reporting of risks and assurance to the Committee

Finance Assurance

SPCC 25/12/B08 Finance Update

The report provided a detailed overview of the preliminary financial position related to primary care expenditure as at the end of November 2025 (M08).

- The report covered seven areas of spend: -
    - Local Place Primary Care
    - Primary Care Delegated Medical
    - Prescribing
    - Primary Care Delegated -Pharmacy
    - Primary Care Delegated -Dental
    - Primary Care Delegated -Optometry
    - Primary Care Delegated Other Services
- The paper highlighted any key variances within the financial position, in respect of the forecast outturn, compared to the allocated budgets. Also provided was an overview of any reserves and flexibilities available. It also provided the most up to date breakdown of the Additional Roles Reimbursement Scheme (ARRS) allocation.

Areas of Discussion: -

- The budget remains on track with additional roles expected in Q4, though no further NHSE funding is anticipated. Guidance is needed on flexibility between GPRs and additional roles, with LW to confirm. PCN contract restrictions can be managed to address underspend and support winter pressures. Locum fees have decreased and figures revised. An OOH uplift of 2.5% has been agreed, bringing PC24 into alignment. The GP prescribing budget has reduced, and CRES delivery is progressing well.
- GPIT is likely to overspend due to increased activity beyond the original plan. Mitigation options were discussed, but the savings target will not be raised given the current stretch. A small surplus was noted earlier in the year, though overall funding remains lower across PCNs.

System Primary Care Committee was asked to:

- **NOTE** the preliminary combined financial summary position outlined in the financial report as at 30th November 2025.

- **NOTE** the Additional Roles spend by Place
- **NOTE** the capital position.

The SPCC NOTED the financial summary position as outlined in the report, and noted additional roles spend by place, and also the capital position

SPCC 25/12/B09 Prescribing Position – risk and mitigations

Summary of Month 6 position:

- Month 6 BSA data for primary care prescribing shows an actual spend greater than planned spend. This equates to around £1.9m higher planned in month 6 (+4.2%) and £10.5m higher than planned year to date (+3.9%).
- Items per dispensing day have increased by 2.5% and BSA cost per dispensing day by 2.9% compared to the same point in the previous year. Weighted population has increased by 4.6% and registered population by 2.4%. This is a greater increase than seen nationally (+2.73%) and the Northwest has the largest Weighted population increase in England.
- BSA Cost per weighted person has reduced by £1.42 (-1.65%), meaning that despite cost increases, the population's rising health needs (as measured by the index) are being met with better cost efficiency
- The overspend above plan reflects several factors: non-delivery or step-down of CRES programmes, faster growth in weighted population compared to registered population, increased costs for Tirzepatide and ADHD treatments, and national drug shortages. A monitoring system is being implemented, with anticipated benefits expected in the coming months.

Areas of Discussion: -

- The original plan remains the benchmark for measurement, though its accuracy was questioned. Data collection is highly time-consuming and creates a continuous cycle of activity, particularly with medicines management teams under pressure. Finance reports an overspend of £30M on PC prescribing, compared to £10.5M in received data. It is critical to resolve these discrepancies and ensure reliance on accurate information.

System Primary Care Committee was asked to:

- **NOTE** the report and endorse the actions being undertaken to manage the primary care prescribing spend.

The SPCC NOTED the report and endorsed the action being undertaken to manage the primary care prescribing spend

Policy and Commissioning

SPCC 25/12/B10 Dental, Community Pharmacy, Optometry and General Practice

- The Primary Care Policy and Contracting Update provides the Committee with information and assurance in respect of key national policy and commissioning actions in respect of:-
  - GMS/PMS (General Medical Services/Personal Medical Services) and APMS (Alternative Providers of Medical Services) including DES (Directed Enhanced Services)
  - General Ophthalmic Services (GOS)
  - General Dental Services (GDS)
  - Community Pharmacy

Areas of Discussion: -

- The return to NHSE now required monthly, was noted in Appendix 1 – this version was for the committee and not the version to be submitted. It was noted that for Optometry GOS fees had been announced since the paper was completed. GDS results on dental contracts and future expectations were noted, with ongoing work to assess the impact of contract reform from 2026/27. Additional guidance issued yesterday is being incorporated into financial modelling for the new year. Key risks include the absence of confirmed reform details for 2026 and the impracticality of

delivering within a three-month notice period. Urgent Care viability is also at risk due to reduced funding, compounded by limited planning time and uncertainty around impacts. Contractors and LDCs have been alerted to potential implications. Christmas rota plans have been communicated, and pharmacies have been directed for Easter, with flexibility to stand down if necessary for cost control. Information has been shared with places and providers. Concerns remain over low GOS fees, with some providers considering reducing hours or returning NHS contracts.

System Primary Care Committee is asked to:

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

The SPCC NOTED the updates in respect of the commissioning, contracting and policy of the four contractor groups, and were assured of all actions being taken in respect of any issues

SPCC 25/12/B11 Advice and Guidance Update

- The paper provided an update, seeking approval for year-end funding arrangements. NHS England have introduced a national Enhanced Service for General Practice Advice and Guidance (A&G), commissioned locally by the ICB, paying £20 per request to secondary care. The service aims to reduce outpatient appointments by enabling GPs to seek timely consultant advice. Although funding was allocated, there is an underspend; the cap has now been raised, and it is recommended that the Committee align with national guidance. NHSE is scrutinising uptake and has set targets, with principles shared with practices. RAS activity does not count toward the £20 payment.
- NHSE guidance also requires ICBs to monitor A&G through Primary Secondary Care Interface (PSCI) Groups. The ICB will use local PSCI groups for operational management, overseen by a system-wide group, whose Terms of Reference require Committee approval. The expectation is that A&G will reduce outpatient referrals, though some cases will still convert. A self-assessment of system capability is underway, and an initial steering group chaired by Dr Sinead Clarke has been established.

Areas of Discussion: -

- Finance discussions confirmed that the cap increase applies only for this year, with 2026/27 spend still unknown pending national guidance. The risk of overspend is minimal given current low activity, and claims are not retrospective. Approvals occur monthly, with checks planned for areas showing no activity. Any overspend will be covered by NHSE. Maximising use of the cap this year could help offset future pressures. Advice and Guidance funding is non-recurrent, and its position for next year remains unclear.

System Primary Care Committee was asked to:

- **NOTE** the updates in respect of Advice and Guidance
- **NOTE and DISCUSS** the changed financial arrangements outlined in 2.8 above which may impact on the need for the original capped approach, once confirmed via Andrea McGee.
- **AGREE** the terms of reference in Appendix one for the system level primary/secondary care interface group

The SPCC NOTED AND DISCUSSED the updates in respect of advice and guidance, and the changed financial arrangements and the potential impact. It also AGREED the Terms of Reference for the system level primary/secondary care interface group

SPCC 25/02/B12 National Community Pharmacy Independent Prescribing (CPIP) Pathfinder Programme

- C&M currently commission 7 CPIP sites as part of the National Community Pharmacy Independent Prescribing (CPIP) Pathfinder Programme. The aim of the community pharmacy independent prescribing (IP) pathfinder programme was to establish a framework for the future commissioning of NHS community pharmacy clinical services incorporating independent prescribing for patients in primary care.

Areas of Discussion: -

- The two-year pilot across C&M and the Northwest is progressing well, with two sites showing strong referral activity. From 2026, all pharmacy graduates will qualify with prescribing education, supporting the development of prescribing pharmacists in both primary and secondary care. National commissioning is expected to include some independent prescribing in local pharmacies, though details remain unclear, and a national solution is unlikely by April 2026. Current funding ends then, but there is sufficient budget to maintain seven CPIP sites until 31 March 2026. The main risk is reputational and patient understanding if services are decommissioned; providers have been briefed.
- The pilot has delivered positive results, and a further paper will be presented in February 2026. Continuing services beyond March would cost approximately £38K per month, requiring risk-based plans aligned with the national framework. Opportunities for neighbourhood integration were discussed, alongside the need to share learnings from the seven sites. National contract details are not expected before March, creating uncertainty for transition planning. Sites have been advised of potential decommissioning, and evaluation of impact and savings is underway. Strengthening behavioural change and cross-provider links remains a priority and will feed into the five-year strategy.

System Primary Care Committee was asked to:

- **NOTE** the programme end date of 31st March 2026 and use of residual funding.
- **NOTE** paper will be submitted for Committee in January 2026 to consider:
    - The impact of the discontinuation of the existing CPIP service provision and access in the period from 1st April 2026 to such time as national arrangements are in place to further support local commissioning.
    - Options for local commissioning of CPIP services in this interim period during 2026/27.
    - Funding potential arrangements and impact on ICB budgets to support any local arrangements for commissioning CPIP service in the interim period
    - The development of clear risk-based plans to commission future CPIP services in C&M to support access to clinical services as a part of the ICB integrated Primary Care arrangements and offer to patients.

The SPCC NOTED the programme end date and the need to use residual funding, and that the papers will be submitted to the Committee in February 2026

Key Strategic Delivery Areas

SPCC 25/12/B13 Access to General Practice – Patient Experience update

- Building on the GP Healthwatch survey, work continues across nine Healthwatch organisations. Challenges remain, particularly around securing appointments, telephone pressures, and uncertainty in triage decisions. Online requests receive mixed feedback, with confusion when alternative routes are offered instead of GP access. Positive feedback highlights good listening and clinical outcomes.
- A single access model does not suit all; flexibility is needed. While some practices have made effective adjustments, these vary widely. Long callback windows create difficulties for those working or with caring responsibilities. Feedback reflects familiar themes, including

understanding of service pressures and variation across places. This intelligence, gathered through feedback centres and surveys, suggests improvements will follow as patients gain awareness of different roles and how they support care.

Areas of Discussion: -

- Attendance at TOSC was positive, and feedback will be triangulated. Healthwatch intelligence is continually reviewed, with the Liverpool report providing a balanced view of strengths and challenges. Key themes include the need for better education on additional roles and improved communication. Current Place-level communications are weak, and options discussed include sharing CNN posts in pharmacies, dental practices, and GP surgeries, as well as posters in A&E. Social media engagement remains low in some areas. Suggestions included scripts for receptionists to explain triage and roles, and visible role lists in practices. The Committee agreed to work with the communications team to strengthen messaging.

System Primary Care Committee is asked to:

- **NOTE** the update on Patient Experience regarding Access to General practice.

The SPCC NOTED the update on Patient Experience regarding Access to General practice

SPCC 25/12/B14 Access to General Practice – June 2025 Plan update

CL presented an update on access to general practice services, which is a key strategic priority for the ICB.

In January 2025, NHS England published the operational planning guidance NHS England » 2025/26 priorities and operational planning guidance and for primary medical services, there was a focus on assurance of actions expected by ICBs to support improved access following two years of investment and policy measures. By June 2025, the ICB was required to expand on this response, and produce a single agreed action plan which sets out practical actions to improve contract oversight, commissioning and transformation for general practice - and address unwarranted variation. Collectively, these actions would support delivery of the overall planning guidance priority to enable patients to access general practice in a timelier way and improve patient experience

- In June this Committee signed off the agreed plan which centred around specific actions to support ;
    - Tackling Unwarranted Variation
    - Improving Contract Oversight
    - Improving Commissioning and Transformation Which was to be achieved by key enablers, including ;
        - Supporting delivery of modern general practice including maximisation of digital tools and other services to improve access
        - Implementing the 2025/2026 GP contract and maximising available commissioning and contracting levers
        - Use of key data sets and patient experience feedback, to inform progress
- In line with NHS England expectations, and as part of the governance and overview in line with the plan submitted, regular updates to the committee on improving access to primary medical services are expected. It was agreed that this would be combined with an update from Healthwatch's in relation to current patient experience and feedback on access.
- Key progress areas made to date were presented and discussed, including use of consistent data sets to understand variation and applying a framework to identify further actions with practices, practice level support, Data and patient experience and contracting and governance.
- An ICB Scorecard on position of key areas of access has been developed by NHS England and shared in draft with ICB's, which will form part of the ongoing ICB assurance.
- It was noted that some individual practice level improvements and strategic indicators will need to be reviewed after a full year effect to understand meaningful measured increases.

Areas of Discussion: -

- Discussion focused on outlier practices, their input, and available support, with dashboards used for monitoring. Halton demonstrates good pharmacy use, though complaints persist via the Health and Wellbeing Board re misunderstanding of roles within GP surgeries. Improved communications could help address these issues, but a large-scale campaign would require funding. Around 50–60,000 appointments are offered monthly, with strong attendance avoidance, yet greater community engagement is needed.
- Education for carers and district nurses on GP services was highlighted, alongside improving patient understanding of appointment systems and countering negative national media narratives. Neighbourhood digital solutions present significant opportunities, though clarity is needed on what constitutes a digital appointment. Funding balance remains a concern.

ACTION: CWa will pick up ways to share information regarding specialist roles within GP's with the public and core NHS staff with Comms

System Primary Care Committee is asked to:

- **DISCUSS** and **NOTE** the update on actions to support improving access to general practice, as part of the 'June Plan' submission - which is for assurance purposes.

The SPCC DISCUSSED and NOTED the update on action to support improving access to general practice as part of the 'June Plan' submission

SPCC 25/12/B15 Neighbourhood Health

The pilot now covers 49 neighbourhoods, with Warrington the last to confirm boundaries. The ICB neighbourhood framework, signed off in July, will return for review in February alongside an update from Alison. A national blueprint, still in draft, is expected to align with the 10-year health plan. Progress depends on national guidance to ensure consistency, but in the meantime, good practice will be shared more widely while working within existing resources.

ACTION: CWa Will ask Alison to attend next meeting to provide more detailed update

Areas of Discussion:-

- No further discussion.

System Primary Care Committee was asked to:

- **NOTE** the update given and take reassurance on Neighbourhood Health.

The SPCC NOTED the verbal update on Neighbourhood Health

Quality

SPCC 25/12/B16 Primary Care Quality Update

The Committee were provided with assurance and information on how to effectively deliver Quality in Primary Care Services contracted by NHS Cheshire and Merseyside at a system level relating to:

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

An update on quality assurance across Cheshire and Merseyside was given highlighting:

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

Areas of Discussion: -

- The Committee discussed 900 ultrasound results not returned to GPs, assessing whether issues were identified and any patient harm occurred; Tony Leo will confirm with Liverpool and share findings with RPJ. Four to five serious diagnoses were missed, and auditing continues to ensure full understanding before reporting back. Persistent digital system changes are causing escalation challenges; GPs should raise concerns to Place PCQG, which will escalate to SPCC and Quality Committees. Clear escalation pathways and timely action are essential to prevent safety risks and should be considered in upcoming organisational changes.

ACTION: ALe to check on Liverpool statistics regarding Ultrasounds and those not shared with GPs and any patient harm that occurred and share with RPJ

System Primary Care Committee is asked to:

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

The SPCC NOTED the updates relating to the Quality Primary Care Services for the four contractor groups and were assured of actions raised in support and quality issues

AOB – Fst raised concerns re the communication of referrals from primary care to independent sector providers, and how this information was disseminated. There was assurance this had been raised at Execs who were sighted.

CLOSE OF MEETING

Date of Next Meeting: Thursday 19 February 2026 (09:00-12:30)
F2F, Lakeside, Warrington

CHESHIRE MERSEYSIDE
INTEGRATED CARE BOARD

Action Log 2025/26 *updated post Dec 2025 meeting*

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 25/02/B08		Contractor Operations Updates	Optometry : qualification of FP10 starting in Jan 2026, placement requirement within a Trust - requesting support from the Trusts and the ICB for their commitment to this programme - has been agreed in principle but ideally would like a formal agreement	Clare Watson & Rowan Pritchard Jones & Fionnuala Scott	ASAP	*suggestion for RPJ to write out to Trust MDs asking for commitment to support - Clarify who is picking this up with chnages in structure*	ONGOING
SPCC 25/04/B15	17-Apr-25	Digital - Shared Care (Connected Care records)	ii) regular 6 monthly update to SPCC Committee	Kevin Highfield / Cathy Fox	01-Feb-26	*Request response in Feb SPCC*	ONGOING
SPCC 25/06/B12	19-Jun-25	Advice and Guidance	Pilot in place, for a period of 6 months to allow for review, to come back to SPCC with a report and update (sooner than 6 months if necessary)	Jonathan Griffiths	December 2025	*Verbal request for response in Feb*	NEW
SPCC 25/10/B10	16 Oct 2025	Governance changes	To share the July Board NH papers with the SPCC members for comment and feedback in December	Committee Admin	December 2025		ONGOING
SPCC 25/10/B12	16 Oct 2025	Finance Update	Request for a detailed financial and contractor input paper between Estates and Digital to come to the Public meeting of SPCC in December *(unless anything changes or there are any concerns to do quicker)*	Estates & Digital	December 2025	*Verbal update to be given in Feb SPCC*	ONGOING
SPCC 25/10/B12	16 Oct 2025	Qualty Update	to escalate to Execs for SRO assignment (clinical waste contracts, covering general practice and community pharmacy)	Clare Watson	ASAP	*This was completed but will ask for verbal update in Feb SPCC*	ONGOING

Action Log No.	Original Meeting Date	Description	Action Requirements from the Meetings	By Whom	By When	Comments/ Updates Outside of the Meetings	Status
SPCC 25/12/B14	18/12/25	Access to General Practice – June 2025 Plan update	CWa will pick up ways to share information regarding specialist roles within GP's with the public and core NHS staff with Comms.	Clare Watson	19-Feb-25	*Verbal update in Feb SPCC*	NEW
SPCC 25/12/B15	18/12/25	Neighbourhood Health	CWa Will ask Alison to attend next meeting to provide more detailed update.	Clare Watson	19-Feb-25	*Included in Feb agenda*	NEW
SPCC 25/12/b16	18/12/25	Primary Care Quality Update	ALe to check on Liverpool statistics regarding Ultrasounds and those not shared with GPs and any patient harm that occurred and share with RPJ.	Anthony Leo	19-Feb-25	*Verbal request in Feb SPCC*	NEW

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

Date: 19th February 2026

Committee Risk Report

Agenda Item No: SPCC 26/02/B07

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

NHS
Cheshire and Merseyside

Committee Risk Report

1. Purpose of the Report

The purpose of this report is to present an update on the risk management activity undertaken for those risks which relate to the business of the Primary Care Commissioning Committee (PCCC) since the last report presented in December 2025.

2. Executive Summary

2.1 The ICB Risk Management Strategy sets out committee and sub-committee responsibilities for risk and assurance.

Risks held on the ICB's Board Assurance Framework (BAF) are those which have the potential to impact on the delivery of the ICB's Strategic Objectives. There are currently no risks held on the BAF relating to the business of the Primary Care Commissioning Committee (PCCC).

Risks held on the Corporate Risk Register (CRR) are those which have been assessed as having the potential to significantly impact on the delivery of the ICB's plans or priorities. Risks categorised as 'extreme' to 'critical' (i.e. those risks which are scored between 15 and 25) receive additional corporate oversight through the Executive Committee and the relevant committees, ultimately providing assurance upwards to the Board.

The Committee currently has a total of 14 risks across three contractor areas:

- GP primary care (7)
- General dental services (4)
- Community pharmacy (3)

Discussions are continuing at Operational Group level with the aim of identifying optometry risks relating to national funding and service provision.

2.2 There are currently three risks on the SPCCC Risk Register that meet the threshold for escalation to the ICB's Corporate Risk Register:

Risk ID	Risk Description	Current Score	Target score
PG7b	ICB financial constraints / pressures may limit funding available to deliver strategic aims for GP primary care impacting on quality and trust and confidence in the ICB	**16**	**8**
PD5b	ICB financial constraints may limit funding available to deliver strategic aims for dental services, impacting upon quality and trust and confidence in the ICB	**16**	**8**
PP5b	ICB financial constraints may limit funding available to deliver strategic aims for community pharmacy, impacting on quality and trust and confidence in the ICB	**16**	**8**

A table summarising ***all*** SPCCC related risks can be found in Appendix 1 of this report.

Since the December 2025 Committee meeting, discussions with risk leads from the finance team have taken place to assess the current level of risk/risk score and to map out the necessary controls, assurances and mitigating actions.

Similarly, discussions with estates colleagues during January and February 2026 have resulted in a recommendation that the risk scores for PG6 and PG8 be reduced to 10 and 12 (moderate) respectively. As the risk scores were initially assessed as 'extreme' (16) fully worked up summary documents for both are provided in Appendix 2 to provide more contextual information for the recommendation. All other risk scores remain unchanged.

2.3 Following the desktop review of primary care related risks at place level, further conversations with appropriate leads at place have taken place with the aim of closing any primary care medical risks which potentially duplicate those now overseen by the Committee (the eventual outcome of this review is, however very much dependent on the future ICB Target Operating Model).

3. Ask of the Committee and Recommendations

3.1 **The Committee is asked to:**

3.1.1 **NOTE** the contents of report detailing the risk management activity undertaken during the reporting period.
3.1.3 **REVIEW** all risks relating to the business of the SPCCC (Appendix 1)
3.1.4 **NOTE** for information the 'extreme' and 'critical' risks which require escalation to the Corporate Risk Register (CRR).
3.1.5 **NOTE** the recommendation to reduce risk scores for estates related risks PG6 and PG8.
3.1.5 **APPROVE** the inclusion of new risk (PG9) on the Committee risk register.

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 August 2025 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.

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 scored as 15 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 national ICB Core Purposes / Priorities

- **Improve population health outcomes**
- **Tackle health inequalities**
- **Enhancing Productivity and Value for Money**
- **Helping to support broader social and economic development within the local area**

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. Risk Overview

9.1 All primary care related risks have been reviewed within the context of the key strategic objectives of the ICB 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 operating environment.

9.2 All risks have been reviewed in the period with two reportable changes to current risk scores. There are four risks with a current score of 15+ (but none currently scored at 20+).

Risk ID	Risk Description	Current Score
PG7b	ICB financial constraints / pressures may limit funding available to deliver strategic aims for GP primary care impacting on quality and trust and confidence in the ICB	16
PG9 **NEW**	End of Concession in CHP Premises (expiration of long-term building lease arrangements)	16
PD5b	ICB financial constraints may limit funding available to deliver strategic aims for dental services, impacting upon quality and trust and confidence in the ICB	16
PP5b	ICB financial constraints / pressures may limit funding available to deliver strategic aims for GP primary care impacting on quality and trust and confidence in the ICB	16

A summary table of all risks attached to the Committee (and their application to each contractor group) can be found in Appendix 1 of this report.

9.3 Responsibility for dental services, community pharmacy and ophthalmology continue to align with the corporate Primary Care Team. Responsibilities for GP primary care are split between corporate and place teams.

9.4 Engagement will continue with place primary care leads and business support colleagues to ensure a more streamlined, coordinated and consistent approach to the reporting and management of risks relating to primary care for 2026/27. In the December 2025 Committee report, a total of 19 primary care risks were reported as 'active', with three of these place risks scored at 15+. Following review meetings with the respective leads, all three risks have subsequently been closed/removed during the reporting period:

Risk	Score	Place	Status
Increased demand, funding and workforce pressures preventing delivery of high quality Primary Care Services resulting in poor care and potential provider failure	16	St Helens	**CLOSED**
ADHD (Adults) waiting times	20	Wirral	**CLOSED**
Impact of increased employer national insurance costs on independent contractors	20	Wirral	**CLOSED**

Conversations are continuing in relation to the remaining 16 place-based risks, with the likelihood of most (if not all) closing before the end of this financial year.

9.6 The Committee will continue to be 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 *current* 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.

9.7 The approved BAF risks for 2025-2028 include a strategic risk relating to the ICB's delivery and implementation of a neighbourhood / community health service. This risk has initially been delegated to the ICB's Executive Committee for oversight and management but may transfer ownership to the System Primary Care Committee. The Committee will, of course be kept informed of any plans to transfer ownership of risks in which it has an interest in.

10. Finance

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

11. Communication and Engagement

11.1 No patient and public engagement has been undertaken.

12. Equality, Diversity and Inclusion

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

13. Climate Change / Sustainability

13.1 No identified impacts.

14. Next Steps and Responsible Person to take forward

14.1 The nominated operational lead for each risk will be asked to complete a risk assessment using a new format of the ICB's risk summary template. Support will be made available to leads from the Corporate Affairs and Governance team.

14.2 The completed risk assessments (in the new corporate format), together with proposals for a reporting schedule of 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

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

16. Appendices

Appendix1: Primary Care Committee Corporate Risk Register Summary – February 2026
Appendix 2: Risk Summary – PG6 (Estates capital investment)
Appendix 3: Risk Summary **–** PG8 (Primary Care GP estates capacity)
Appendix 4: Risk Summary – PG9 (proposed new risk – end of CHP estate concessions)

Appendix 1 - System Primary Care Commissioning Committee Risk Register Summary (February 2026)

Risk ID	Risk Title	Senior Responsible Owner	Inherent Risk Score	Current Risk Score	Previous Risk Score	Target Score	Risk Proximity
All Contractor Groups							
GP Primary Care							
PG1	Access to general practice services will not meet demand, impacting negatively on patient experience and outcomes and delivery of the access improvement plan.	Chris Leese	**4x4=16**	**12**	**12**	**8**	B – within financial year
PG4	Inability to recruit and retain GP primary care workforce may curtail or delay access improvement plan success, impacting on quality and increasing pressure on remaining staff	Chris Leese	**4x4 = 16**	**12**	**12**	**8**	B – within financial year
PG6	Reduction in capital development funding for estates may curtail or delay GP primary care access improvement plans, impacting on quality and trust and confidence in the ICB	James Burchell	**3x5=15**	**10** ▼	**15**	**10**	B – within financial year
PG7a	National financial constraints / pressures may limit funding available to deliver strategic aims for GP primary care impacting on quality and trust and confidence in the ICB	John Adams	**4x4 = 16**	**12**	**12**	**8**	B – within financial year
PG7b	ICB financial constraints / pressures may limit funding available to deliver strategic aims for GP primary care impacting on quality and trust and confidence in the ICB	John Adams	**5x4=20**	**16**	**16**	**8**	B – within financial year
PG8	GP primary care estates capacity constraints may curtail or delay access improvement plans, impacting on quality and trust and confidence in the ICB	David Cooper/Chris Leese	**3x5=15**	**12** ▼	**15**	**10**	B – within financial year
PG9	End of Concession in CHP Premises (expiration of long-term building lease arrangements)	James Burchell	**16**	**16**	**NEW RISK**	**10**	C- beyond financial year
13DR	There is a risk that the introduction of new core clinical system suppliers through the GP IT Futures Tech Innovation Framework Early Adopter Programme results in a more fragmented infrastructure and has a negative impact on record sharing	John Llewelyn	**4x4 = 16**	**12**	**12**	**4**	A – within Quarter
Dental Services							
PD1	Access to dental services will not meet demand, impacting negatively on patient experience and outcomes	Tom Knight	**4x4 = 16**	**12**	**12**	**8**	B – within financial year

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

NHS Cheshire & Merseyside Risk Summary

NHS Cheshire and Merseyside

Risk Title	Reduction in capital investment for primary care estates

Risk Ref	Risk Description
PG6	Reduction in capital development funding for estates may curtail or delay GP primary care access improvement plans, impacting on quality and trust and confidence in the ICB. Without sufficient 'long-term' capital funding commitments, the ICB may struggle to plan and invest in the transformation of services needed to deliver the objectives of the NHS Long Term Plan

Risk Scoring and Tolerance

	Inherent risk score	Current Risk Score	Previous Risk Score	Target Risk Score	Target Date	Risk Appetite
Likelihood	3	2	3	2	April 2026	Cautious-open
Impact	5	5	5	5		
Risk Level	15	10	15	10		

Links to BAF (include BAF Risk Ref)	Risk Proximity
	B - within Financial Year

ICB Core Purpose	Improve population health outcomes
ICB Strategic Goal	Improve access to primary and community care
Directorate	Primary Care
Risk Lead	Head of Estates
Lead Committee	System Primary Care Commissioning Committee
Date Raised	14th August 2025
Date last reviewed	February 2026

Lines of Defence	Sources of Assurance	Assurance Level
1st Line	Places Estates Groups established for initial issue escalation and management of local priorities	Acceptable
2nd Line	Estates Development Framework and System Capital Investment Plan	Acceptable
3rd Line	System Primary Care Committee for approval and oversight	Acceptable

Rationale for score and progress made in the quarter

Following the publication of the Capital Planning Guidance in November 2025, the ICB is required to submit a 4 Year Capital Plan to NHS England on 12th February 2026. Whilst further refine management and overall programme management will be required this will see major investment being direct to primary care.

Key Controls

- Place Capital Investment Plans developed for short,medium and long term priorities
- 4 Year Capital Plan for Strategic Primary Care Developed
- 4 Year Capital Plan for Utilisation and Modernisation Fund Developed
- Robust Capital Bidding Process, Hurdle Criteria and Prioritisation Toolkit to be developed
- GP Estates Operational Group in place for thematic review of issues/escalation
- NHSPS and CHP Capital Plans to be developed in conjunction with the ICB

Gaps in Control or Assurance

- Estates Programme Board needs to be re-established
- NHS England process changes which may curtail project start or completion timescales
- Requirement to understand clinical drivers in relation to Neighbourhood Health to develop an estates enablement plan

Action

No	Action Required	Due Date	Update on Actions	Action Owner	BRAG Rating
1	Refresh of System Capital Investment Plan (Primary Care)	Mar 26		JB	On track
2	Submission of 4 Year Strategic Capital Investment Plan	Feb 26		JB	On track
3	Submission of 4 Year Utilisation and Modernisation Fund Plan	Feb-26		JB	On track
4					
5					

Next review date: April 2026

NHS Cheshire & Merseyside Risk Summary

NHS Cheshire and Merseyside

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Risk Ref	Risk Description
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NHS
Cheshire and Merseyside

Primary Care Finance Update

NHS Cheshire and Merseyside Primary Care Committee (System Level)

Date: 19th February 2026

NHS Cheshire and Merseyside
Primary Care Committee (System Level)

NHS Cheshire and Merseyside

Date of meeting:	19th February 2026
Agenda Item No:	
Report title:	**2025/26 Primary Care Finance Update**
Report Author & Contact Details:	Lorraine Weekes-Bailey, Senior Finance Manager - Primary Care John Adams, Assistant Director of Finance (Primary Care)
Report approved by:	Andrea McGee, 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 financial position related to primary care expenditure as at the end of January 2026 (M10).

The report covers seven areas of spend: -

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

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

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

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

NHS Cheshire and Merseyside
Primary Care Committee (System Level)

NHS Cheshire and Merseyside

Recommendation/ Action need:	**The Committee is asked to:** The Primary Care Committee is asked to: - 1. Note the combined financial summary position outlined in the financial report as at 31st January 2026. 2. Note the Additional Roles spend by Place 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 financial position in relation to primary care expenditure anticipated for 2025/26 as at 31st January 2026.

1.2. The financial positions for January 2026 (M10) are based on the historical recurrent expenditure at each Place plus in-year amendments, including any uplifts for national assumptions.

2. Financial Position

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

Table 1

Primary Care Position Summary - Month 10 ICB TOTAL	Year To Date			Forecast Outturn		
	Budget (£000's)	Actual (£000's)	Variance (£000's)	Annual Budget (£000's)	FOT (£000's)	Variance (£000's)
Delegated Medical Primary Care						
Core Contract	299,048	298,972	76	359,399	358,834	565
QOF	31,270	31,270	0	37,401	37,175	226
Premises Reimbursements	47,210	45,905	1,306	56,618	55,272	1,346
Other Premises	620	655	(35)	744	786	(42)
Direct Enhanced Schemes	5,593	5,909	(316)	6,385	6,753	(368)
Primary Care Network	46,980	46,960	20	56,421	56,308	113
Additional Roles Reimbursement Scheme	67,331	65,535	1,796	80,812	78,656	2,156
Fees	10,274	9,354	920	12,305	11,346	959
Other - GP Services	732	619	113	878	833	45
DELEGATED PRIMARY CARE TOTAL	**509,059**	**505,179**	**3,880**	**610,964**	**605,963**	**5,001**
Local Primary Care						
GP Local Enhanced Service Specification	31,044	30,148	896	37,253	36,170	1,084
Local Enhanced Services	16,322	16,455	(133)	19,621	19,638	(17)
Commissioning Schemes	1,791	1,734	58	2,095	2,024	71
Out Of Hours	25,020	25,183	(163)	30,024	30,220	(196)
GP IT	16,354	16,480	(126)	19,035	19,176	(141)
GP Investment	94	240	(146)	113	291	(178)
Primary Care SDF	3,754	3,760	(7)	5,036	5,043	(7)
Primary Care Other	1,142	1,113	29	2,272	1,476	796
QIPP	0	0	0	0	0	0
PC Local Pay Costs	367	414	(47)	441	487	(46)
Medicines Management - Clinical and Pay Costs	10,499	9,982	517	12,623	11,918	705
LOCAL PRIMARY CARE TOTAL	**106,389**	**105,510**	**879**	**128,513**	**126,441**	**2,072**
Prescribing						
Central Drugs	15,405	16,647	(1,243)	18,475	19,858	(1,383)
Oxygen	4,607	4,059	548	5,564	5,019	545
Prescribing BSA	432,987	446,952	(13,964)	514,699	528,807	(14,108)
Prescribing Local Schemes	3,460	3,643	(183)	4,153	4,564	(412)
PRESCRIBING TOTAL	**456,459**	**471,301**	**(14,842)**	**542,890**	**558,248**	**(15,358)**
Delegated Pharmacy Optoms Dental and Other						
Delegated Community Dental	11,119	10,745	374	13,343	12,903	440
Delegated Ophthalmic	24,232	23,235	998	29,079	29,043	36
Delegated Pharmacy	84,182	81,382	2,800	101,140	98,128	3,012
Delegated Primary Dental	119,782	113,886	5,895	151,626	145,774	5,852
Delegated Property Costs	682	657	25	818	826	(8)
Delegated Secondary Dental	32,514	31,223	1,291	41,352	41,352	0
PHARMACY, OPTOMS, DENTAL & OTHER TOTAL	**272,511**	**261,128**	**11,383**	**337,358**	**328,026**	**9,332**
TOTAL	**1,344,418**	**1,343,119**	**1,299**	**1,619,725**	**1,618,678**	**1,047**

3. Delegated Primary Care - Medical

3.1. The Month 10 financial forecast for Delegated Medical Primary Care indicates a projected underspend of £5m, based on current data and payment trends.

3.2. **Core Contracts** — The current underspend of £0.565m within the core contracts budget is primarily driven by a prior-year benefit, where forecasted costs were higher than the actual expenditure incurred. In addition, list size growth has been lower than projected, further contributing to the favourable variance.

3.3. **Quality Outcomes Framework-** The QoF currently shows a favourable variance of £0.226m. This has been adjusted based on the data received to date. However, the position remains provisional, as the final QoF data will not be concluded until 31 March 2026. As such, this variance may be subject to change.

3.4. **Premises Reimbursements-** The Premises Reimbursement budget is currently reporting an underspend of £1.346m. Of this, £0.330m relates specifically to the delay in the move to the new Great Sutton premises within Cheshire West Place.

3.5. The remaining underspend is attributable to adjustments in Business Rates, as well as updated forecasts for NHS Property Services and Community Health Partnership building invoices, which are now aligned to the latest billing schedules.

3.6. **Direct Enhanced Services-** These services are activity-driven, and we now have three quarters of data, enabling a more meaningful, up-to-date, and accurate forecast outturn. The financial position has deteriorated and is now showing a pressure of £0.368m against the outturn.

3.7. **Additional Roles Reimbursement Scheme-** We have now received ten months of ARRS portal data. In December, a review of ARRS expenditure was undertaken to assess the extent to which PCN allocations are expected to be utilised. Places have discussed the financial position with their PCNs, and despite the steps taken to maximise use of the available funding, we anticipate an underspend of approximately £2.156m. Please refer to Section 10 for a more detailed analysis.

3.8. **Fees-** All sickness and maternity claims have now been reviewed, and there is a significant reduction in activity compared to last year. Following this review, £0.504m has been removed from the forecast outturn for maternity-related claims, and £0.455m has been removed for sickness-related claims. This has resulted in a total reduction to the forecast outturn of £0.959m.

4. Local Primary Care

4.1. **Local Primary Care**- The Local Medical Primary Care forecast for Month 10 is an expected underspend of £2.072m.

4.2. **GP Local Enhanced Service Specification-** This budget line is reporting an underspend of £1.084m. The majority of this relates to Wirral Place, where the 2024/25 achievement data has now been finalised. The confirmed figures are significantly lower than anticipated, resulting in a £0.5m variance against the original projections. As we begin to finalise the values for 2025/26, Places are forecasting lower achievement than was provisionally budgeted.

4.3. **GP Out of Hours-** The GP Out of Hours service line is currently showing an overspend of £0.196m. This pressure has arisen due to a discrepancy between the budget planning assumptions and the actual contract uplift. During planning, a 2.15% increase was applied to certain GP Out of Hours contracts based on 2024/25 values. However, the actual uplift payable is 4.15%, resulting in a significant variance and contributing to the current overspend.

4.4. **GPIT-**There has been an increase in charges for Docman Connect and Enterprise Search & Reports over the last few months. In addition, the GPIT SLA charges with MLCSU are now higher than the available funding following a recent contract revision by the Contracting Finance Team. This has resulted in a deterioration in the forecast position of £0.141m.

4.5. **GP Investment-** Within this service line, there is a Physiotherapy First contract that sits within Cheshire West Place. Cheshire and Wirral Partnership Trust have advised a shortfall in funding, arising from a recent contract revision. This has resulted in a deterioration in the forecast position of £0.178m.

4.6. **Primary Care Other-** There is currently an underspend of £0.796m against this service line. This is primarily due to a timing issue between budget planning and actual expenditure requirements when budgets were allocated in April 2025.

4.7. The funding is no longer expected to be utilised. Budget planning is typically based on Month 8 financial forecasts. However, by Month 12, the forecast had reduced, resulting in the additional budget being unnecessary.

4.8. **Pay Costs Prescribing-** There is currently a projected underspend of £0.705m against the Pay Cost Prescribing budget. This variance is primarily due to unfilled vacancies within the team.

5. Prescribing

5.1. **Central Drugs-** This expenditure relates to costs that cannot be directly attributed to a specific ICB or cost center. These costs, often relate to unidentified prescribing or VAT, that are accumulated nationally by the NHS Business Services Authority (BSA) and then shared out fairly among all ICB's based on their respective prescribing percentages, as well as some cross border prescribing.

5.2. This also includes Dental Prescribing; this is not allocated to the dental patient's own ICB as this is not recorded in BSA data, so the cost is allocated on a Prescribing spend %. For Cheshire and Merseyside ICB, this is approximately 5.7%, thus meaning we receive 5.7% of all Dental Prescribing across England.

5.3. The ICB cannot control the costs incurred within the Central Drugs budget. Recent data for April through to September 2025 indicates a notable increase in daily expenditure.

5.4. Our current financial position reflects the cost pressures of £1.243m in our year-to-date expenditure and have been incorporated into our financial forecast with a projection of £1.383m.

5.5. **Prescribing BSA- GP Prescribing Data –** The average daily cost per dispensing day from April through to November has been used to inform both the year-to-date and forecast positions, including CRES achievements to date.

5.6. Analysis indicates that, although the 2025/26 prescribing budget was set using recognised assumptions, current data suggests a projected financial pressure of approximately £13.9m.

5.7. To mitigate the in-year prescribing pressure, a number of actions have been aligned to deliver the required savings, and several programmes of work have been established with defined savings targets.

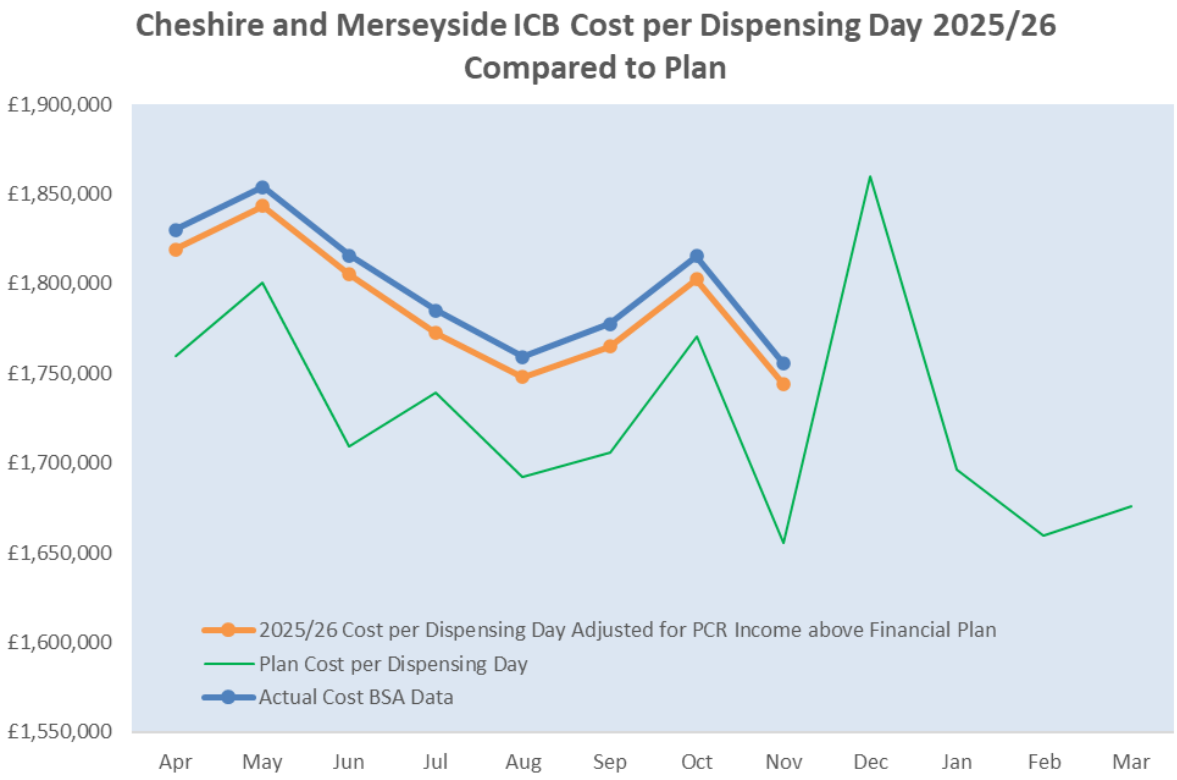
5.8. The forecast incorporates the projected CRES assumptions and anticipated spend mitigations, which we expect to be fully delivered.

5.9. As shown in Table 2 below, in the latest data the cost per dispensing day is significantly higher than planned. While part of this variance can be attributed to known cost pressures particularly from Tirzepatide and Lidocaine, there is also a marked increase in prescribing activity.

Prescribing Cost per Dispensing Day Comparison

Table 2-This table comparison highlights current cost pressures relative to both 2025/26 planned expectations and the 2024/25 monthly trends.

Table 2



6. Delegated Pharmacy

6.1. The 2024/25 out-turn position on the Pharmacy contract was an underspend of £3m. This was based on a recurrent allocation of £70m and non-recurrent allocations of £10m (incl Pharmacy first).

6.2. Pharmacy fee rates have been increased by approximately 15% for 2025/26 and patient charges have been held at the 24/25 rate. The fee increase follows a five-year agreement with the profession where total Pharmacy Contract remuneration remained static.

6.3. In month 4 the ICB received an allocation increase of £17.4m for services covered by the Community Pharmacy Contractual Framework (CPCF), together with confirmation that services within the Pharmacy First programme will be funded in-year at 100% of cost incurred. Since month 4 we have received a further £3.3m for Pharmacy Contract Advanced Services and £8.1m for Pharmacy First.

6.4. Based on current activity growth, it is likely that the pharmacy budget will underspend by £2.5m in 2025/26.

7. Delegated Optometry

7.1. In December, the ICB was notified of an increase in sight test fees of 2.55% and Domiciliary fees of roughly 1%, the increase to be backdated to April 2025. Arrears for the period April to [mid] December will be paid in March. The service is expected to deliver a balanced position at the end of the year. The current surplus reflects the benefit of 2024/25 accrual balances.

8. Delegated Other Costs

8.1. The budget line “Delegated Property Costs” consists of budgets for Transformation Team staff, NHS Mail and Remote Access costs for POD contractors and Sterile Product costs. This budget is expected to break even.

9. Delegated Dental

9.1. The utilisation of Pharmacy, Optometry & Dental (POD) allocation is subject to the principles set out in the ICB and system finance business rules – namely the duty to break even within the resource limit. It is also subject to the additional rule that dental budgets are ringfenced and NHS England reserves the right to direct that any unused resource is used to improve dental access, or exceptionally, the unspent allocation may be returned to NHS England.

9.2. Published guidance for 2025/26 says that NHS England may agree to relax the dental ringfence (so that any underspends are retained locally) for ICBs which (i) deliver additional urgent care in line with the manifesto commitment, and (ii) improve dental access more broadly. Additional guidance is expected to be issued on the opportunities for the ringfence to be relaxed in 2025/26.

9.3. Narrative received in early October describing the funding of the new national incentive payment for dentists (subsequently amended at the end of November) reaching a

target level of additional urgent activity, contradicted the published guidance and suggested that there would be no flexibility to earn the right to re-direct unused dental funding. This has since been confirmed by NHSE and consequently, the ICB has agreed to pay for over-performance of up to 10% on UDA and UOA contracts.

9.4. Expenditure on the local dental investment plan utilises funds from anticipated primary care dental contract under-performance to improve dental access, improving population health whilst reducing the likelihood of funds being returned to NHSE.

9.5. The Dental Investment Plan targets those patients most in need of treatment and expenditure has broadly been in line with plan. The ICB's share of the government's manifesto commitment to provide 700,000 additional urgent appointments, and the new Urgent Care Initiative announced in October also need to be funded from dental under-performance.

9.6. Workforce capacity limitations may affect the ability of dentists to deliver the level of additional service envisioned in the Dental Investment Plan in addition to the required national increase in urgent appointments, and to over-perform on their UDA and UOA contracts, which is likely to result in further underspend.

9.7. Assessment of the likely cost of 2024/25 superannuation payments and debt recovery suggested that there could be a benefit of £6.1m in 2025/26.

10. Additional Roles Reimbursement Scheme

10.1 For the 2025/26 financial year, the total ARRS allocation is £80.886 million. Unlike in previous years, this funding is no longer split between GP-specific roles and traditional ARRS roles. Instead, it is provided as a single unified allocation to support all eligible roles under the scheme.

10.2 A key change for 2025/26 is that the ICB will no longer be required to draw down funds from NHS England (NHSE). The full ARRS allocation is now included within the ICB's delegated base allocation.

10.3 Table 3 illustrates the ARRS allocation at Place level for 2025/26, the year to date spend, forecast outturn and utlisation rate.

Table 3

Additional Roles Reimbursement Scheme 2025/26								
Place	Total	Monthly Allocation	Forecast	YTD Allocation	YTD Spend from Portal	YTD Utilisation	Annual Utilisation	FOT Utilisation
Cheshire East Total	11,618,253	968,188	11,196,765	9,681,878	9,146,813	94%	79%	96%
Cheshire West Total	11,072,012	922,668	10,910,524	9,226,677	9,025,340	98%	82%	99%
Halton Total	4,037,946	336,495	3,924,657	3,364,955	3,283,253	98%	81%	97%
Knowsley Total	5,307,342	442,279	5,291,538	4,422,785	4,088,853	92%	77%	100%
Liverpool Total	17,513,147	1,459,429	17,321,804	14,594,289	14,049,491	96%	80%	99%
Sefton Total	8,396,865	699,739	7,711,387	6,997,387	5,571,037	80%	66%	92%
St Helens Total	6,237,405	519,784	6,033,631	5,197,838	4,584,809	88%	74%	97%
Warrington Total	6,282,651	523,554	6,055,719	5,235,543	4,523,387	86%	72%	96%
Wirral Total	10,420,283	868,357	10,280,364	8,683,569	7,804,166	90%	75%	99%
Total	**80,885,904**	**6,740,492**	**78,726,389**	**67,404,920**	**62,077,149**			

11. Capital

11.1 There are two capital funding streams available to Primary Care in 2025/26. £5.027m was made available for GP premises improvement grants through the Utilisation and Modernisation Fund (U&M). £6.012m is available from the Business-as-Usual Primary Care capital fund (BAU). NHSE also provided an additional £0.700m for the purchase of IT kit for ARRS staff.

11.2 It is anticipated that the ICB will fully utilise its U&M funding. At the beginning of the financial year NHSE endorsed a full list of projects plus reserve schemes (to replace any projects that are withdrawn).

11.3 As other ICBs were unable to spend their U&M fund in full, a further £2.1m was made available to Cheshire and Merseyside (C&M) for U&M schemes being held in reserve.

11.4 The ICB Estates team manages the collection of documentation to enable U&M schemes to begin. Some of the schemes are still unable to proceed due to delays in NHSE's legal team producing the grant agreements that need to be in place before a scheme starts. This remains the greatest risk to completion of schemes and utilisation of the funding.

11.5 Separate reports have been brought to this committee describing the requirements for premises improvement grants (both BAU and U&M) and BAU GPIT equipment & systems.

11.6 In June, SPCC gave in principal approval for £4.7m of BAU funding to be utilised as follows:-

General Practice BAU Capital								
BAU Capital Projects	Allocation		Digital		Estates		Expenditure to be approved by Committee	
Allocation	£	4,700,000					£	4,700,000
Estates C&M schemes			£	80,000				
Digital costs associated with U&M (P1+P2)			£	576,000				
ICB Corporate office re-alignment					£	100,000		
Informatics Merseyside - Priority 1 C&M Investment			£	1,371,843				
Mid Mersey Digital Alliance - Priority 1 C&M Investment			£	844,932				
Midlands and Lancashire CSU - Priority 1 C&M Investment			£	1,700,000				
C&M pool of Digital kit for break/fix			£	27,225				
Totals	**£**	**4,700,000**	**£**	**4,600,000**	**£**	**100,000**	**£**	**4,700,000**

PIDs for the GPIT projects have now been signed off by NHSE (North West) and the ICB's delivery partners are proceeding with the purchase of equipment.

11.7 IFRS16 cover for ICB lease costs also needs to be funded from BAU capital, but there will be no costs in 2025/26. Instead, disposal of administration buildings will generate an additional capital resource in 2025/26 and SPCC agreed that this should be spent on GPIT. PIDs are in the process of being signed off by NHSE.

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 30th January 2026.

12.2 Note the Additional Roles spend at Place.

12.3 Note the Capital position.

13. Officer contact details for more information

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

19th February 2026

Primary Care Prescribing

Agenda Item No: SPCC 26/02/B09

Responsible Director: Dr Fiona Lemmens

NHS
Cheshire and Merseyside

Primary Care Prescribing

1. Purpose of the Report

1.1 The report provides the committee with an update on primary care prescribing based on month 8 NHS Business Service Authority (BSA) data and delivery of Cash Releasing Efficiency Savings (CRES) up to the end of December 2025.

2. Executive Summary

2.1 Summary of Month 8 position:

- Month 8 BSA data for primary care prescribing shows an actual spend greater than planned spend. This equates to around £2.5m higher planned in month 8 (+5.3%) and £11.8m higher than planned year to date (+3.3%).
- Items per dispensing day have increased by 2.4% and BSA cost per dispensing day by 3.0% compared to the same point in the previous year. Weighted population has increased by 4.6% and registered population by 2.4%. This is a greater increase than seen nationally (+2.73%) and the Northwest has the largest Weighted population increase in England.
- BSA Cost per weighted person has reduced by £2.75 (-2.45%), meaning that despite cost increases, the population's rising health needs (as measured by the index) are being met with better cost efficiency.

The spend above plan is due to several factors including:

- Non delivery/step down of CRES programmes of work in financial plan with gap in time until mitigation plan delivery.
- The weighted population has grown faster than the registered population, indicating greater relative healthcare needs in the ICB.
- Local Tirzepatide spend higher than financial planning assumption, £6.4M increase on previous year.
- Local SGLT-2 Inhibitors (Dapagliflozin/Empagiflozin) usage and associated costs have increased by £2.3M, however a price reduction began in September for Dapagliflozin and switches are underway now to optimise the savings.
- Local Lidocaine spend has increased by £1.1m on the previous year
- Local ADHD prescribing has increased in items and costs - an additional £849k.
- National drug shortages with associated national advice on alternatives to use
- CRES plans span across a wide range of medicines prescribed. There is targeted word underway on the review and deprescribing of Tirzepatide and Lidocaine patch prescribing outside of guidance. Monitoring via GP practice system data across C&M is undertaken every 2 weeks.

Analysis of month 8 prescribing data is currently underway to assess delivery of mitigation plans. Prescribing data and monitoring of GP practice systems demonstrates a significant reduction in lidocaine and Tirzepatide and Lidocaine prescribing outside of NICE Technology Appraisal/APG criteria.
The work undertaken has been acknowledged outside of Cheshire and Merseyside. Our approach and resources have been shared with other ICBs.

3. Ask of the Committee and Recommendations

3.1 **The Committee is asked to n**ote the report and endorse the actions being undertaken to manage the primary care prescribing spend.

4. Reasons for Recommendations

4.1 Previously the ICS Chief Pharmacist has shared the extensive analysis of prescribing data that is undertaken to interpret the primary care prescribing spend, trends and pressures. The ICS Chief Pharmacist works closely with experienced BI colleagues and finance colleagues to agree a monthly prescribing forecast position as detailed in the System Primary Care Committee finance paper.

4.2 Analysis of multiple data sources along with knowledge and understanding of national and local influences on prescribing inform the monthly analysis undertaken by the ICB.

4.3 A subsequent summary for the overall position of the ICB, as well consistent analysis at place level informs actions, escalations (local and national) and ensures medicines management colleagues, clinical directors and place directors can work with and support primary care colleagues to optimise the use of the primary care prescribing budget.

4.4 Information and required actions are communicated at a place level and from the ICB centrally.

4.5 Monthly reporting of CRES by the ICB medicines management team ensures the ICS Chief Pharmacist and ICB have oversight and assurance relating to the delivery of CRES plans and can manage/mitigate any potential under delivery.

4.6 Additional oversight of CRES and prescribing spend is provided to the ICB Financial Control and Oversight Programme by the ICS Chief Pharmacist as the Senior Responsible Officer (SRO) for prescribing.

4.7 The oversight of CRES and understanding of the primary care prescribing spend ensures the ICB and Chief Pharmacist can proactively manage and forecast this significant area of spend.

4.8 Horizon scanning for expected primary care prescribing spend has been undertaken and included in ICB financial plans. CRES plans for primary care prescribing have also been finalised and incorporated into the ICB financial plans.

5. Background

5.1 The 2025/26 primary care prescribing budget for NHS Cheshire and Merseyside is £526.8m. The budget assumes delivery of CRES of £21.8m within the primary care prescribing spend.

5.2 Including December 2025 delivery, the forecast of CRES for primary care prescribing is £18.7m with a further £9.2m in planned spend mitigation.

5.3 The main driver for the under delivery of the original CRES plan relates to a decision to pause a programme of work planned to review oral nutritional supplements (ONS) prescribed. This programme of work has now been approved. Savings will be realised in 2026/27.

5.4 Prescribing spend is affected by many factors including changing population, clinical need, change in clinical guidance, prescriber behaviours/engagement, national price changes, medicines shortages and management of profit margins into community pharmacy (which is managed via national changes to medicines reimbursements).

5.5 The size and volatility of the primary care prescribing spend means the budget is a significant risk to the ICB. It does however offer opportunities for significant cash releasing cost savings.

5.6 Appendix One details the primary care spend against plan for NHS C&M based on BSA data.

5.7 Appendix Two details the spend by place compared to their statistical neighbours across England.

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

Optimised prescribing including management of resources consistently across NHS C&M supports tackling health inequalities in access, outcomes and experience.

Objective Two: Improving Population Health and Healthcare

Optimised prescribing including best use of resources across NHS C&M supports the improvement of population health and outcomes.

Objective Three: Enhancing Productivity and Value for Money

The primary care prescribing spend offers significant opportunities for increasing value for money.

Objective Four: Helping to support broader social and economic development

Consideration of primary care prescribing spend in relation to patient outcomes and impact on relevant stakeholders e.g. community pharmacy supports broader social and economic development.

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

Prescribing is the most common intervention in healthcare. Optimised prescribing and appropriate use of resources is therefore essential to the delivery of the annual plan.

8. Link to meeting CQC ICS Themes and Quality Statements

Theme One: Quality and Safety
Optimised primary care prescribing and spend supports quality and safety.

Theme Two: Integration
Optimised prescribing including use of resources is most likely to be achieved if there is an integrated approach across C&M via providers and local authorities.

Theme Three: Leadership
Leadership within pharmacy and across prescribers is essential to the delivery of optimised prescribing and management of resources.

9. Risks

9.1 The size and volatility of the primary care prescribing spend means the budget is a significant risk to the ICB. It does however offer opportunities for significant cash releasing cost savings.

9.2 ICB medicines management team and general practice capacity and stability are essential for the optimised spend of the primary care prescribing budget. Capacity and stability in both are challenged at present which represents a risk.

10. Finance

10.1 The agreed month 10 financial position (based on month 8 BSA data) is detailed in the SPCC finance paper.

11. Communication and Engagement

11.1 ICB colleagues at place including Heads of Medicines Management, Place Directors, Clinical Directors and finance colleagues are fully sighted on the in-

year position relating to spend and CRES delivery via monthly communication and regular meetings.

11.2 The ICB communications team has recently rerun the Only Order What You Need campaign with the public to reduce medicines waste. A campaign relating to switching to cost effective medicines will be going live in February 2026.

11.3 All work within the primary care prescribing CRES plans is supported by parallel work in our trusts to ensure a system approach is taken. The ICS Chief Pharmacist has monthly meetings with all provider Chief Pharmacists and is a member of the C&M Provider Collaborative Efficiency at Scale Programme Board.

12. Equality, Diversity and Inclusion

12.1 Weighted population growth indicates higher healthcare need among specific communities; optimisation actions will be implemented with due regard to health inequalities and access, ensuring clinically appropriate prescribing and support across Places.

13. Climate Change / Sustainability

13.1 No direct environmental impact identified; optimisation programmes will seek to minimise waste and unnecessary prescribing in line with the Green Plan.

14. Next Steps and Responsible Person to take forward

14.1 The ICS Chief Pharmacist will update the committee on the targeted work around Tirzepatide and Lidocaine at the next committee meeting as well as providing further context of system prescribing spend influencing primary care prescribing spend.

15. Officer contact details for more information

Mrs Susanne Lynch MBE, ICS Chief Pharmacist
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16. Appendices

Appendix One: Primary Care in Year Spend against Plan

In-Year Actual Vs Plan 2025/26 Month 8

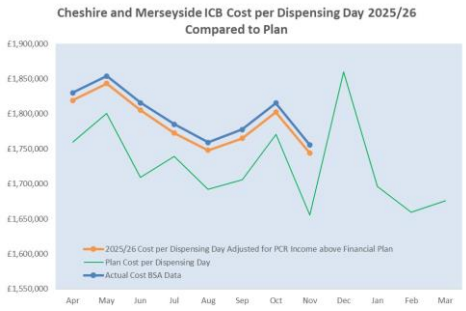
(Actual – including Flus/Pneumos)

NHS
Cheshire and Merseyside

As of Month 8, Cheshire and Merseyside is £14.2M above plan, based on BSA Actual Cost.

BSA Actual Cost has been adjusted to include income received for Primary Care Rebates (PCR) which are additional to the Financial Plan assumptions to enable tracking of delivery of place level plans.

A further adjustment has been made for Tirzepatide costs from Sept-25 onwards due to the list price increase and nationally handled rebate price adjustment



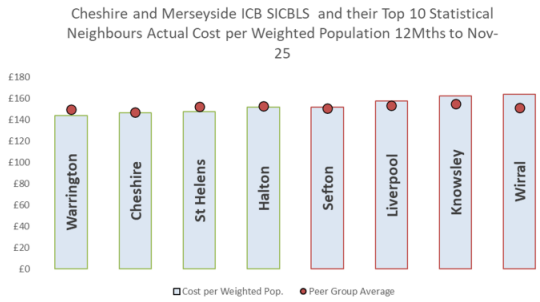
	Actual Cost BSA Data Inc. Tirzepatide Adjustment	Actual Cost Adjusted for PCR Income Above Financial Plan	Cost per Dispensing Day BSA Data: Actual	Plan	Variance	%	Variance to Planned Cost	Cost per Dispensing Day (Adjusted for PCR Income above Financial Plan): Actual	Plan	Variance	%	Variance to Planned Cost
Apr-25	£43,917,160	£43,661,249	£1,829,882	£1,759,894	£69,987	4.0%	£1,679,696	£1,819,219	£1,759,894	£59,324	3.4%	£1,423,785
May-25	£46,343,328	£46,082,760	£1,853,733	£1,800,272	£53,461	3.0%	£1,336,518	£1,843,310	£1,800,272	£43,038	2.4%	£1,075,949
Jun-25	£45,389,583	£45,130,885	£1,815,583	£1,709,348	£106,235	6.2%	£2,655,882	£1,805,235	£1,709,348	£95,887	5.6%	£2,397,184
Jul-25	£48,197,904	£47,855,527	£1,785,108	£1,739,086	£46,021	2.6%	£1,242,575	£1,772,427	£1,739,086	£33,341	1.9%	£900,197
Aug-25	£43,983,684	£43,694,689	£1,759,347	£1,692,214	£67,133	4.0%	£1,678,337	£1,747,788	£1,692,214	£55,574	3.3%	£1,389,342
Sep-25	£46,216,852	£45,887,978	£1,777,571	£1,706,106	£71,465	4.2%	£1,858,089	£1,764,922	£1,706,106	£58,816	3.4%	£1,529,215
Oct-25	£49,017,778	£48,661,226	£1,815,473	£1,770,580	£44,893	2.5%	£1,212,108	£1,802,268	£1,770,580	£31,687	1.8%	£855,556
Nov-25	£43,897,683	£43,605,057	£1,755,907	£1,655,575	£100,332	6.1%	£2,508,298	£1,744,202	£1,655,575	£88,627	5.4%	£2,215,672
Dec-25			DNA	£1,859,506					£1,859,506			
Jan-26			DNA	£1,696,207					£1,696,207			
Feb-26			DNA	£1,659,397					£1,659,397			
Mar-26			DNA	£1,675,965					£1,675,965			
	£366,963,972	£364,579,370	£1,819,299	£1,727,155	£92,144	5.3%	£14,171,502	£1,787,154	£1,729,375	£57,779	3.3%	£11,786,900

Appendix Two: Spend by C&M Place Compared to Statistical Neighbours

SICBLs Primary Care Stat Neighbours

NHS
Cheshire and Merseyside

GP Practices Only (Exc. Flus/Pneumos, Stoma, Catheters, Dressings and *Tirzepatide*)



SICBL	Cost per Weighted Pop.	Peer Group Average	Variance from Average	Improved (^) or Worsened (v) on Previous Mon	Saving if at Group Average	% Saving	75th percentile	Saving if at 75th Percentile	% Saving
02E00 Warrington	£143.89	£149.90	-4.2%	↑			£143.74	£37,778	0.1%
27D00 Cheshire	£146.49	£147.09	-0.4%	↑			£141.86	£4,163,450	3.2%
01X00 St Helens	£147.55	£152.24	-3.2%	↑			£146.24	£337,229	0.9%
01F00 Halton	£151.70	£152.70	-0.7%	↑			£146.24	£940,803	3.6%
Sefton	£151.97	£150.93	0.7%	↔			£145.24	£1,622,418	3.0%
99A00 Liverpool	£157.41	£153.41	2.5%	↑	£2,499,838	2.5%	£147.98	£5,892,809	6.0%
01J00 Knowsley	£162.54	£154.85	4.7%	↑	£1,645,258	4.7%	£150.74	£2,525,579	7.3%
12F00 Wirral	£163.96	£151.37	7.7%	↑	£5,614,646	7.7%	£145.62	£8,175,254	11.2%
Cheshire and Merseyside	**£157.55**				**£9,759,742**			**£19,156,863**	

NHS
Cheshire and Merseyside

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

Primary Care Policy and Commissioning Update

Agenda Item No: SPCC 26/02/B10

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 commissioning actions in respect of;

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

2. Ask of the Committee and Recommendations

The Committee is asked to ;

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

3. Primary Medical Services Update

3.1 The 2025 **e-declaration** (edec) for general practice closed on the 21st November General Practice Annual Electronic Self-Declaration (eDEC) - NHS England Digital. A small number of practices who did not submit on time were asked to undertake a manual completion of the required information. NHS England have followed up assurance on those practices and asked for further information in relation to on line consultations responses.

3.2 There remains a continued national focus on **areas of the national contract implemented from 1.10**, covered here https://www.england.nhs.uk/long-read/changes-to-the-gp-contract-in-2025-26/.

- In relation to 'On Line Consultations' the ICB is reporting 100 per cent compliance with some further ongoing follow up.
- For GP connect, November 2025 Figures are as at below, but it should be noted a number of practice's data is not pulling through to the reporting and this has been advised to NHS England:
  - HTML Activated: 334/336 (99%)
  - Meds & Allergies Activated: 328/336 (98%)
  - Remainder Activated: 311/336 (93%)
  - All 3 Activated: 311/336 (93%)
- 'You and Your GP' is reported at 100% compliance but is being followed up as part of the edec submissions.

3.3 **Protected Learning Time (PLTs) and On Line Consultations (OLCs)** – NHS England has revised it's FAQs for OLCs NHS England » Online consultations – frequently asked questions and support resources, with further information in respect of PLTs. The ICB had previously agreed that PLTs would remain as is until any further clarifications were received – the ICB will now need to work through this as part of a wider review of PLTs as part of the operating model discussions - a paper will return to this committee in April.

3.4 **Prospective records access -**practices have been contractually obliged to enable this and following some data anomalies reported in terms of compliance, the ICB is following up with NHS England to deep dive the data further. Information on this area can be found here Prospective record access manually enabling patient access - NHS England Digital

3.5 The **Enhanced Services review** is continuing and a next steps full paper update will return to this committee in April, with a verbal update at this meeting.

3.6 The **commissioning oversight group** has met monthly since July to oversee areas of medical commissioning across the ICB, supporting assurance, compliance and consistency. Most recent actions include ;

- Supporting development of the workforce planning submission
- Reviews and updates on practice variation lists including deep dives on the national GP dashboard, as requested by NHS England, in January.
- Updates on contract areas (post 1.10 implementation areas) and consistency in modes of access approach and monitoring.
- Advice and guidance uptake/ referrals and follow on actions
- Focus on ARRS (additional roles) maximisation
- Approach to capacity and access payments and approvals in line with NHS England expectations and data sources.

3.7 **Advice and Guidance –** following the last committee update, the cap on practice claims was lifted. NHS England have now received a requested recovery plan including actions to maximise referrals under the enhanced service. As part of this, actions for understanding variation across the ICB are being worked through. Assurance is overseen through the advice and guidance steering group and primary/secondary care interface groups.

4.0 Optometry - General Ophthalmic Services

4.1 There are currently 220 mandatory and 72 domiciliary (additional) contracts in place with service provision remaining as expected.

4.2 There are a number of live issues that the optometry operations group are working through including.

- post payment verification

- contracts with no activity
- Contract termination notice
- non submission of annual complaints data by some contractors.

Contractual action that may fall out of this will be agreed by the Assistant Chief Executive and reported to the next Committee meeting.

4.3 A QIO (Quality in Optometry) follow-up contract assurance programme of visits has commenced with randomly selected Cheshire and Merseyside opticians with one visit undertaken in Liverpool and one in Tarporley, Cheshire, to date. A third visit is scheduled for this month, noting that future visits are dependent on capacity within the small central team.

4.4 The 2022/2024 Homeless Project report outlining eyecare for hard-to-reach groups has now been completed - and the service is still being received well, with women's shelters and traveller sites being added to the programme. A further report looking at these new areas will be completed during 26/27

4.5 Special Education Settings – work is progressing to go out to procurement following agreement at the Executive Committee.

5.0 Dental

5.1 Summary of contract management activities from the most recent Dental Operational Group held on 14/1/26:

5.2 Practice in Warrington requesting non recurrent reduction 25/26 due to recruitment difficulties and one member of staff on maternity leave. The contract target has been reduced from 11,880 UDAs to 8,915 UDAs.

5.3 As the contract has had a non-recurrent reduction in year for consecutive years, it was agreed that performance against the contract should be monitored for the first few months of 26/27, to determine whether an earlier non-recurrent reduction or permanent reduction is required.

5.4 Novation agreement discussed regarding a Wirral practice. The previous partnership had incorporated to a Limited company. CQC has been updated to reflect this change. The original Novation Agreement was signed, and it was the intention for the current providers to be removed as Directors, however no formal notification was received. A solicitor was approached and emailed in to contest the guarantee clause and the "current contractors" being all 3 partners to the original Novation Agreement.

5.5 After discussion at an operational meeting, an updated Novation Agreement was agreed to use as a standard template going forward and this was amended and sent to the solicitor and current contractors, so it is fair and consistent with all incorporation requests going forward, whereby the current contractor(s) can be

released from the guarantee clause, should they find suitable alternative(s) to agree to it.

5.6 Company to Company Request - Annex 5.2 received to transfer received from a provider in Macclesfield 13,705 UDAs at £35.37 per UDA. Performs well, 24/25: 107.66%, 23/24: 108.26%. Companies House up to date. GDC and Performers List have been checked. Benefits to patients were noted: The practice will maintain and improve access through increased clinical capacity, enhanced operational efficiency and continued investment in infrastructure.

5.7 Appointment availability will continue to be actively monitored to ensure timely access for NHS patients and the provision of additional in-house specialist services will reduce the need for external referrals, improving continuity of care and overall patient experience. The practice has recently benefited from over £200,000 of investment, including the addition of three new surgeries and ongoing upgrades to improve accessibility, including planned DDA-compliant improvements.

5.8 These developments will increase clinical capacity, enhance the patient experience, and support the continued delivery of high-quality NHS dental care.

5.9 Request for reallocation of 8,000 UDA's from Liverpool site to Sandbach. Commissioners discussed the request and although it was agreed that the UDAs were unlikely to be able to be performed at the Liverpool site and that significant investment had been made into new premises in Sandbach which has the potential to deliver more UDAs, a transfer of the UDAs to Sandbach could not be supported for the following reasons:

- Distance between the two practice is 43 miles (c. an hour by car). Therefore, it could not be suggested that patients could travel to continue to access NHS dental care.

- Inequalities created by moving UDAs from a high need/more deprived area. This view is supported by Healthwatch, who regularly highlight that patients in Liverpool report that dental access is one of their biggest health concerns, unlike patients in Cheshire.

5.10 The request was therefore refused.

5.11 The Managed Clinical Network for Special Care met on 7 January 2026 to review pathways for future proofing. It was noted that the landscape has changed for this. The current needs assessment and service evaluation will need to be reviewed, as they are outdated. Commissioners will be supported by NHSE NW Dental Public Health Team. Challenges remain with waiting times and the Network is exploring the possibility of opening up a non-dental referral form, which has been used in Manchester. However, there are concerns regarding inappropriate referrals, capacity to manage an influx of new referrals and the difficulties in providing a shared care arrangement, if the patient is not referred by a GDP.

5.12 Analysis of Friends and Family Test (FFT) reveal excluding orthodontic practices and other specialist services, there were 53 nil returns on the latest FFT report. The ICB is performing well with submission rates compared to other ICBs.

5.13 In relation to Oliver McGown training it was reported that no clear level 2 training route had yet been identified for dental practices and that level 2 training would remain challenging in the current climate where practices were not being renumerated/compensated to undertake this, as well as the challenges facing practices with contract reform.

5.14 Commissioners continue to support practices regarding the completion of de-contamination audits and liaison with local authority colleagues has been undertaken via the Oral Health Strategic Partnership.

5.15 2 out 7 practices who were awarded funding via the national Dental Recruitment Incentive Scheme (DRIS) in C&M have recruited. The remaining 5 have been contacted. 1 has handed back the DRIS offer and we have recently given practices a new opportunity to submit an EOI application. The applications will be reviewed and the DRIS offer given to a different provider.

5.16 To support the remaining 4 practices who have yet to recruit, we have reviewed the terms of the DRIS and intend to reduce the annual UDA commitment outlined in the national offer. After consultation with our LDC colleagues, we believe that our revised figures will make the DRIS offer more attractive, as it will mean that dentists recruited under the scheme have the flexibility to deliver some private work, as feedback shows that very few dentists want to deliver NHS dentistry for 100% of their time.

5.17 Urgent Care data from the Dental Helpline provider in C&M shows that there are an adequate number of appointments available for patients. In some areas the capacity outweighs the demand and appointments are left vacant. A rapid review of the Dental Helpline has identified some concerns in relation to its capacity and response and this is being reviewed.

5.18 There are many unknowns as part of the contract reform measures and it is not clear how the mandated 8.2% urgent care delivery in every contract will impact the number of calls to the Dental Helpline.

5.19 Overall performance delivering our share of the national 700k urgent care appointments remains under planned trajectory and commissioners continue to review performance, support providers and ensure communications are clear and widespread across the ICB about how patients can access appointments.

5.20 Monthly progress reports relating to DRIS and Urgent Care are submitted to NHSE NW by commissioners. In January additional feedback to the monthly returns was requested by NHSE of all ICBs and submitted by commissioners.

6.0 Community Pharmacy

6.1 Summary of contract management activities from the most recent Pharmacy Operational Group ratified minutes held on 4/11/25:

6.2 The Community Pharmacy Assurance Framework (CPAF) questionnaire closed on 31/10/25 and commissioners are awaiting results from BSA for non-responders to go forward for CPAF visits.

6.3 48 submissions were received from pharmacies regarding Temporary Suspension of Services

6.4 Jhoots Pharmacy entered administration in early 2026 following severe financial, operational, and staffing issues, leading to over 129 branches being acquired by Allied Pharmacies to secure their future. The company faced allegations of failing to pay staff and numerous branch closures.

6.5 The ICB commissioning team have been working closely with national colleagues and in C+M three Jhoots sites were affected. Work is ongoing to protect services to patients and maintain access working within the regulatory framework. Stakeholders have been updated and monitoring is ongoing.

6.6 Commissioners are currently planning for Easter and working with LPC's regarding the choice of localities to be open for patients. The rota is being renewed, SLAs are to be updated in line with new payment rate as agreed previously by SPCC.

6.7 Commissioners reviewed Antiviral stockholding provision and annual payments are due soon. Reminder to all contractors to report any stock issues immediately.

6.8 There will be a ICB wide launch of Palliative Care service in April 2026and EOIs have gone out to all contractors. Selections to be made based on geographical spread & need to reduce duplication. LPCs have been engaged in the process.

7.0 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

8.0 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

9.0 Risks

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

10.0 Finance

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

11.0 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 national Policy Book's for the contractor groups and duties on contractors nationally set. Any additional commissioner requirements would be outlined in this update.

11 Equality, Diversity and Inclusion

Duties for these are accounted for in each of the national Policy Book's for the contractor groups and nationally negotiated contract terms. Any additional commissioner requirements would be outlined in this update.

12 Officer contact details for more information

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

18th February 2026

National Community Pharmacy Independent Prescribing (CPIP) Pathfinder Programme

Agenda Item No: SPCC 26/02/B12

NHS
Cheshire and Merseyside

National Community Pharmacy Independent Prescribing (CPIP) Pathfinder Programme

1. Purpose of the Report

1.1 To provide an update regarding the delivery of the National Community Pharmacy Independent Prescribing Pathfinder (CPIP) programme in Cheshire & Merseyside. The programme will conclude on 31st March 2026.

2. Executive Summary

2.1 C&M currently commission 7 CPIP sites as part of the National Community Pharmacy Independent Prescribing (CPIP) Pathfinder Programme. The aim of the community pharmacy independent prescribing (IP) pathfinder programme was to establish a framework for the future commissioning of NHS community pharmacy clinical services incorporating independent prescribing for patients in primary care.

3. Background

3.1 C&M currently commission 7 CPIP sites as part of the National Community Pharmacy Independent Prescribing (CPIP) Pathfinder Programme.

3.2 The aim of the community pharmacy independent prescribing (IP) pathfinder programme was to establish a framework for the future commissioning of NHS community pharmacy clinical services incorporating independent prescribing for patients in primary care.

3.3 The NHS 10 Year Plan clearly describes future commissioning, development and integration of CPIP services within the NHS Primary Care offer. Further mandated by the recently published Medium Term Planning Guidance.

3.4 The seven sites below have provided CPIP services from April 2025.

Pharmacy ODS Code	Pharmacy Name	ICB Place
FKJ00	Kensington Health Centre Pharmacy, 155 Edge lane, Liverpool L7 2PF	Liverpool
FTW03	Allied pharmacy (Upton Rocks), Fir Park Health Centre, Lanark Gardens, Widnes, Cheshire, WA89DT	Halton
FRG94	Daveys Chemist, 99 Holt Road, Liverpool, L7 2PN	Liverpool
FK172	Daveys Chemist, 253 Kensington, Liverpool, L7 2RG	Liverpool
FFW97	Allied Pharmacy (Crosby Road), 77a Crosby Road North, Waterloo, Liverpool L22 4QD	**Sefton**
FVK97	West Bank Pharmacy, 8a Mersey Road, West Bank, Widnes, Cheshire, WA8 0DG	Halton
FHH35	Allied Pharmacy (Knowsley Road), 290 Knowsley Road, Bootle L20 5DQ	**Sefton**

3.5 The sites deliver CPIP clinical modules and prescribe to patients over two specific clinical models:

- Minor Illness Service
- Respiratory Review Service

3.6 A “Transitional Period” has been agreed between 1st January 2026 and 31st March 2026 where the C&M programme is funded via residual budget from the NHS England original allocation.(No financial burden to ICB via utilisation of residual NHS England provided funding allocation from 25/26.)

3.11 The NHS 10 Year plan and Medium-Term Planning Framework mandates that ICBs must commission CPIP services from 2026.

3.12 Currently the NHS England, the DHSC and Community Pharmacy England are in national negotiations regarding plans for commissioning and funding of the National Community Pharmacy Framework (National Contract) for 2026/27. This framework agreement is anticipated to describe and inform the commissioning of CPIP services by ICBs from 2026 onwards.

3.13 National agreement and arrangements, including operational deliverables and service design, is not anticipated to be in place and available to start operational commissioning or service roll out and delivery from 1st April 2026.

3.14 The C&M CPIP Pathfinder Programme will cease form 31st March 2026 unless locally commissioned by ICB.

4. Funding Review

4.1 A finding review has been undertaken regarding the cost of continuation of the C&M programme.

4.2 It is projected that a residual balance of £36,600 will remain after the closedown of the existing programme 31st March 2026.

Balance 24/25	£ 83,345.00	as conformed carried forward by finance team
Received 25/26	£ 286,000.00	from NHS England allocations at end of year
	£369,345.00	
Spent	£ 38,083.00	programme expenses
Spent	£ 294,662.00	sessional fees
	£ 332,745.00	
Leaving -		
Balance 25/26 programme end	£ 36,600.00	

This position should be "worst case scenario" as based it is on Jan Feb March sessional claims being submitted as maximum available for providers and they have not to date claimed maximum sessions each month.

4.3 Forecast for **Monthly** Cost of continuing programme –

Number of sites	Number of monthly sessions (£197.76/session)	Sessional cost at max number of 24 sessions	Cost of CLEO licence	Clinical mentor	Total site cost
7	24	£ 33,223.68	£650.00	£1,536.00	£35,409.68
1	24	£ 4,746.24	£650.00	£1,536.00	£ 6,932.24
2	24	£ 9,492.48	£650.00	£1,536.00	£11,678.48

4.4 The residual budget, as forecast (£36,000), **would not** cover one month costs for all 7 sites.

4.5 The residual budget, as forecast (£36,000), **would potentially** cover three months costs for 2 sites.

4.6 If the ICB were to prioritise two sites we would look to prioritise the Sefton sites which are co located within the Neighbourhood Pioneer Programme.

4.7 Unless otherwise agreed, the C&M CPIP Pathfinder Programme will cease form 31st March 2026 and all C&M CPIP NHS delivery will cease until such times as a national solution is available- potentially as a result of the outcome of the 2026/27 Contractual Framework negotiations.

4.8 It is not known, if the negotiations do result in an agreement regarding a nationally agreed service specification including CPIP functions, at what point this agreement will be enacted. Service design and SLA, IT infrastructure and other enablers will have to be agreed and in place before any national go live for CPIP services.

5. Options Appraisal

5.1

Option	Description	Cost	Appraisal
1	Current service discontinued 31st March 2026 and hiatus in all CPIP NHS IP Activity until nationally agrees solution in place (unknown date 2026/2027)	No further cost to ICB. Any residual funding (projected £36,000.00) is retained for future work to promote IP services once	• Reputational cost to CP services • Relationship cost to GP /CP relationships at all sites • Loss of patient engagement at current sites • Residual budget accrued for 26/27 to support launch of national arrangements for IP services as part of the national contract settlement later in 26/27 • Mitigation of identified Risk – comms plan to ensure briefing of all stakeholders to include – ➢ Successes of Pathfinder programme- nationally and locally ➢ Current delivery and achievements in C&M ➢ Future arrangements and national commissioning intensions
2	Residual budget post 31st March 2026 used to continue CPIP services at 2 priority sites (Sefton) for up to three months	No further cost to ICB (Use of residual NHS England funding estimated £36,600)	• The provider would be required to confirm they wish to continue to deliver this programme at these 2 sites • Provider has confirmed loss of “resident” IP so service is less stable than would be otherwise due to loss of recognised lead pharmacist. • We would be required to secure a Cleo Licence at this late stage to support continued service delivery (EPS). • It is unknown how the Neighbourhood Pioneer Site would wish to / has plans to engage with this programme as they are still in planning and development. • Identified misalignment of clinical focus between Neighbourhood pioneer Site (Frailty) and CPIP Pathfinder site (Minor Illness and Respiratory Review) so services not best matched in focus. • 3 months extension may not be long enough for the Neighbourhood Pioneer Site to actively use or engage with the CPIP Pathfinder programme. • Programme facilitators e.g programme manager or commissioned reporting enablers would no longer be in place to support this programme so all operational support and administration would have to be brought "in house". • Same risks as option 1 after three month interim solution ended.
3	Commissioning of Locally Funded CPIP service by ICB	£35,409.68 per month for all 7 sites ongoing	• Commissioning of Locally Funded CPIP service by ICB to “bridge” between the end of the National CPIP Pathfinder until the start of a nationally agreed and supported CPIP service as part of 26/27 service developments and contract settlement. • Mitigates all risks of Option 1 and some risks of Option 2 • Timeframe for any Nationally Commissioned Service to be announced, designed and launched is unknown • Due to lack of clarity regarding design or implementation plan for any subsequent National CPIP service it is unknown if the current CPIP Pathfinder service, as currently commissioned, will align with the design or arrangement of the future national service. • **Not financially viable due to lack of identified ongoing budget and unknown time frame involved**

6 Ask of the Committee and Recommendations

6.1 The Committee is asked to:

6.1.1. Consider:

6.1.2. The impact of Option 1 -the discontinuation of the existing CPIP service provision and access in the period from 1st April 2026 to such time as national arrangements are in place to further support local commissioning via a nationally agreed and developed service.

6.1.3. Limited benefit of Options 2 - Local commissioning of CPIP services from current programme end (31st March 2026) in two sites only for a limited timeframe as dictated by available budget (nominally 3 months extension) delivers limited benefit and once discharged, same risks as Option 1.

6.1.4. Option 3- Local commissioning of services for an unknown period to "bridge" between the existing service 31st March 2026 until the implementation of a Nationally agreed and supported CPIP Service (at unknown date) in 26/27. This option is considered not financially viable due to lack of identified budget and unknown time frame involved.

6.1.5. **Recommendation – Option 1** – closure of all current sites. The concerns re misalignment in service arrangements for the CPIP sites and clinical focus for the Neighbourhood Pioneer Site, the timeframes available and lack of maturity for the Neighbourhood Pioneer Site do not allow a cohesive working relationship to be established within the timeframe proposed. The continuation of the CPIP sites by three months would not allow working practices between the Neighbourhood Pioneer programme and the CPIP programme to be established, used and tested to deliver outcomes. The benefit for continuation of this service in this limited way (2 sites) for a limited time (3 months) is minimal.

6.1.6. The development of clear risk-based plans to commission future CPIP services in C&M to support access to clinical services as a part of the ICB integrated Primary Care arrangements and offer to patients.

7. Reasons for Recommendations

7.1 Further work is required to confirm the ICB approach prior to any nationally agreed way forward post April 2026.

7.2 The outcomes of the Community Pharmacy National Contract Consultations for 26/27 are yet to be agreed and published. As such the plans for CPIP programmes, other than the clear intensions to commission stated in the NHS 10 year plan and Medium Term Planning Guidance are yet to be established or confirmed.

7.3 National direction regarding inclusion of CPIP services as part of the National Community Pharmacy Contractual Framework are anticipated post April 2026.

7.4 Lack of identified local budget, limited available residual budget from NHS Englanfd allocation do not allow a cohesive or comprehensive extension to current arrangements.

7.5 Option 1 – Closure of all current sites until such time as national arrangements are in place for CPIP Services as part of the National Community Pharmacy Contract Framework is the only viable option.

7.6 Mitigation to risk identified with Option1 can be discharged via a comprehensive communication plan and Local Engagement with stakeholders and the public.

7.7 Use of the accrued residual budget from 25/26 can support these comms and engagement specifically at such time as we support contractors and the public to engage with new CPIP services as they become commissioned later in 26/27.

Implications and Comments

8. 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**

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

The national delivery plan for recovering access to primary care has a focus on improving access and reducing demand on GP appointments. Every CPIP appointment represents an additional GP practice appointment capacity. Equivalent to almost 1000 additional GP practice appointments between April and October 2025.

10. Link to meeting CQC ICS Themes and Quality Statements

Theme One: **Quality and Safety**

Theme Two: **Integration**

Theme Three: **Leadership**

11. Communication and Engagement

There are no communication or engagement requirements at this stage.

12. Equality, Diversity and Inclusion

At this stage health inequalities related impacts to ensure the ICB has given regard to the need to reduce / tackle inequalities (ICB Priority One) have not been considered.

13. Climate Change / Sustainability

No issues to consider at this stage.

14. Next Steps and Responsible Person to take forward

12.1 Consider the commissioning requirements post April 1, 2026, and align with national policy and negotiations regarding plans for commissioning and funding of the National Community Pharmacy Framework (National Contract) for 2026/27.

15. Officer contact details for more information

13.1 Pam Soo – Clinical Lead for Community Pharmacy

16. Appendices

Appendix One: National Community Pharmacy Independent Prescribing (CPIP) Pathfinder Programme: Cheshire and Merseyside Programme Review 20026.

NHS
Cheshire and Merseyside

National Community Pharmacy Independent Prescribing (CPIP) Pathfinder Programme

Cheshire and Merseyside Programme Review 2026

NHS
Cheshire and Merseyside

1. Executive Summary

1.1. The aim of the community pharmacy independent prescribing (IP) pathfinder programme was to establish a framework for the future commissioning of NHS community pharmacy clinical services incorporating independent prescribing for patients in primary care.

1.2. From September 2026 newly qualified pharmacists will be joining community pharmacy ready to work as independent prescribers. The development of IP as part of clinical services in community pharmacy is expected to have key benefits including:

1.2.1. Improved patient access to healthcare across the system
1.2.2. Ensuring community pharmacists are working to their full potential
1.2.3. Supporting General Practice
1.2.4. Enabling better Integrated Care System (ICS)/Integrated Care Board (ICB)1 service delivery planning
1.2.5. Creating the opportunity for placed based training for Foundation pharmacists and newly registered pharmacists to expand their clinical practice and create career pathways for a sustainable workforce in primary care.

1.3. Enabling community pharmacy clinical services to offer IP needs to be robustly tested and developed. In order to do this ICBs are being asked to establish Pathfinder sites to identify and test the delivery of IP across all NHSE regions.

1.4. Pathfinder sites were designed as nationally coordinated with core requirements whilst allowing local variation in clinical design responding to local need and availability of competent IP community pharmacists.

1.4.1. ICBs were asked to design service delivery models that will align with the following objectives for the programme:
1.4.2. Identify the optimum processes including governance, reimbursement and IT requirements required to enable independent prescribing in community pharmacy.
1.4.3. Help address the risks and identify the benefits for the NHS and patients:
1.4.4. Inform the development of assurance processes for professional and clinical service standards that support IP activities in the context of NHS community pharmacy services.
1.4.5. Inform the professional development needs of community pharmacists and wider workforce strategy for pharmacy professionals in primary care.
1.4.6. Inform the post 2019- 2024 community pharmacy contractual framework clinical strategy.

2. Introduction / Background

2.1. The Pharmacist Independent Prescriber (PIP) pathfinder model proposed by NHS Cheshire and Merseyside Integrated Care Board was determined following extensive local and regional consultation with stakeholders. The model was designed to fully utilise the existing competencies of the PIPs working within our constituent pharmacies and enhance the clinical services provided to meet the present-day needs of our citizens.

2.2. The commissioned service delivered CPIP supported clinical sessions from existing pharmacy contracts. The service allows a clinical service offer via a flexible hybrid solution, stratified to the local needs via three key care components.

2.3. A primary care core component with a minimum number of weekly appointments dedicated to minor ailments from 111, general practices and urgent care, linked to the NHS Community Pharmacy Consultation Service (CPCS).

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

2.4.1. Respiratory Disease, to take referrals from Primary Care to initiate or manage inhaler therapy, supporting the green agenda and managing over/under usage of inhalers.

2.4.2. Originally, a third clinical model was proposed which was anticipated to deliver Antidepressant Therapy Review to support patients who have not had their Antidepressant therapy reviewed in the last year and who may wish to step down therapy or address concerns relating to this therapy.

2.5. This third model module was withdrawn from consideration and development due to delays in the National rollout of this pilot. The delays would have resulted in the length of the national pilot not being appropriate to deliver the timelines required for patients to effectively be recruited on to these pathways and adequate time for the CPIPs to support and manage these patients to an appropriate clinical resolution and outcome. As such, it was deemed inappropriate to commission a service that patients could start on via one service delivery model, however would have to transition to another provider to conclude their episode of care.

3. Programme development and initiation –

3.1. In conjunction with the Cheshire and Merseyside LPCs, Independent prescriber resource employed in Community Pharmacies in Cheshire and Merseyside was mapped to describe capacity and opportunity within this sector of workforce. An EOI was submitted, based on this, as part of the national process detailing a plans to undertake a comprehensive and ambitious scheme to deliver a consistent service across 20 pharmacies over the Cheshire and Merseyside footprint. The financial allocation resulting from that EOI was equivalent to delivery of 7 pathfinder sites across Cheshire and Merseyside.

3.2. C&M CPIP Worforce Survey - 148 responses were received from a PharmOutcomes CPIP survey;

- 23 CPs employ pharmacists who have a prescribing qualification,
- 10 have pharmacists who are currently in training and
- 10 have pharmacists who are about the begin training
- (these responses represent 37 unique pharmacies).

3.3. We engaged with the CP multiples who also have declared that they have CPIPs employed in Cheshire and Merseyside and mapped (where possible) this resource.

3.4. The CPIP Pathfinder service Specification was developed to utilise and comply with locally approved formularies and guidelines for the specific conditions within scope of the pathfinder initiative, initially; minor illness, respiratory care and antidepressant prescribing. The ICB ensured that this programme complied with Cheshire and Merseyside Area prescribing Group (APG) Formulary in line with all Cheshire and Merseyside prescribers and utilises national guidance/resources (including but not exclusive to):

- ICB Self Care Policy
- British National Formulary (BNF)
- Summary of Product Characteristics (SPC)
- ICB Prescribing Guidance
- NICE Clinical Knowledge Summaries (CKS)

3.5. The Cheshire and Merseyside PIP pathfinder service model was based on each community pharmacy contractor providing a CPIP led primary service (minor ailments) for a minimum of 16 hours per week. They can increase sessions beyond this and also offer a secondary service; focused on respiratory disease or SSRI deprescribing.

3.6. These areas have been chosen in order to maximise existing areas of primary care and prioritise areas where there is demand form patients for access to service.

3.7. The Minor Ailments aspect was designed to capitalise on referrals into the nationally commissioned Community Pharmacy Consultation Service (CPCS) and enhance the existing offer to patients with regard to the treatment and management of Minor Ailments and minimise instances where referral to a secondary service is required in order to access a POM medication to resolve the patient's therapeutic journey.

3.8. Respiratory Review was selected as an additional clinical service module as we understood from the local workforce survey that this was a clinical area where a number of Community Pharmacy IPs had clinical specialism. We were aware of a range of respiratory review models currently delivered across Cheshire and Merseyside, managed via a range of IPs in different roles and professional background including Nursing Staff and PCN Pharmacists.

3.9. The deprescribing of Antidepressant Therapy, originally considered, was led by current work in Sefton due to patent demand identified locally. This work was being developed for and delivered by Sefton PCN pharmacists. This programme of clinical work has also been supported by professional input from the Maudsley Hospital, London whose expertise in this area is nationally recognised.

3.10. All three selected clinical areas were identified as contributing to the Recovery and Access agenda.

3.11. The national funding allocation allows each commissioned site to claim up to 24 sessions per month. An allowance is given to consider activities post consultation, e.g. record keeping, participation in peer support activities, review with clinical leads, training and PCN engagement etc.

3.12. The commissioned pathfinder service model was based on a combination of both referrals and a walk-in service to maximise CPIP sessional utilisation. This model allows CPIP services to prioritise primary care and urgent care referrals.

3.13. Sites also explored and will evaluate the use of appointment booking and referral systems

3.14. The service model was based on face to face however the option of remote access could be delivered as part of the providers service model in line with the

restrictions and guidance for national commissioned CP clinical services. Remote access would be via NHS approved care processes with the PIP situated at the pharmacy premises. Arrangements for remote consultations included a requirement for recall if a face-to-face assessment was required.

3.15. As NHS Virtual Wards develop, we may in future explore how home / offsite CPIP visits could be developed within the scope of the initial pathfinder.

3.16. Effective working partnership working between pharmacists and general practice/PCNs was identified from the offset as key to the success of the initiative. This requires clear communication, inter-professional collaboration on the design and ongoing development of the service model via joint working and stakeholder groups, and CPIP participation in PCN meetings and other relevant forums.

3.17. The following were also incorporated into the service model;

- Our service models were based on the best use of clinical systems and designed to help CPIPs fully consider existing patient medication.

- IT provision was designed to create a digital pathway for communication between CPIPs and general practices regarding the care provided, including integration of care provision into practice medical record systems.

- Within the sessions commissioned time will be allocated so that CPIPs can participate in PCN forums to aid collaboration, peer networking and information sharing on the pathfinder initiative. This will involve regular audit to identify model enhancements and opportunities and improve patient care.

- Governance pathways were established through the ICB with oversight of this programme by the ICB NMP group.

3.18. Programme development established a model for ICB clinical support via set up of a programme steering group to both establish this programme and ongoing to ensure clinical governance

3.19. Processes and data flow mapping were established to ensure there is sufficient the clinical governance oversight, supporting quality improvement risk and incident management.

3.20. Development of and implementation of comprehensive clinical governance policies and procedures were undertaken to ensure that the service model operates in a safe, effective, and appropriate manner. These policiesl covered

the management of risks and incidents within the service model and the development of mitigation strategies to address identified risks. This involved incorporation of the PIPs and CPIPs into existing governance and oversight processes and policies regarding management of NMPs in the ICB

3.21. Resources were allocated to allow CPIPs to undertake and share regular clinical audits to monitor the quality of care provided and to identify areas for improvement.

3.22. Implementation of a robust incident reporting and management system to ensure that incidents are reported, investigated, and acted upon in a timely manner. This included processes for the prompt reporting of incidents, investigation and analysis of root causes, and the implementation of corrective actions to prevent similar incidents from occurring in the future.

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

3.24. Full consideration was given to the possible commercial conflicts of interest faced by CPIPs to mitigate against potential financial incentives, sponsorship or funding, industry relationships, and dispensing arrangements that may impact on prescribing in line with ICB policies.

3.25. CPIPs were required to comply with the ICB policy in relation to Working with the Pharmaceutical Industry (PI), Dispensing Appliance Contractors (DACs) and Prescribing Associated Product Suppliers Policy.

3.26. Place Clinical Leads and Medicines Optimisation Leads were engaged with to support the IPs with clinical mentorship and ensure that they are incorporated in to existing clinical support systems e.g. peer mentorship groups for IPs in PCNs, communities of practice, PCN training programmes for existing PCN pharmacists

3.27. The ICB worked, via a prescribing monitoring process, to provide oversight of prescribing activity to ensure that this programme's prescribing complies with the Cheshire and Merseyside Area prescribing Group (APG) Formulary in line with all Cheshire and Merseyside prescribers. Programme governance processes including EPACT data review was established monitor prescribing patters and formulary compliance.

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

3.29. In collaboration with other pathfinder ICBs, development of clear ethical and clinical guidelines was undertaken to allow CPIPs demonstrate that their professional judgement was not compromised and that all dispensing arrangements were transparent in relation to ensuring;

- There was no prescription direction or restricting a person's choice of dispenser.
- Any prescribing errors detected at dispensing were reported through an agreed ICB process in line with other IPs

3.30. Contractors and CPIPs delivered assurance process in line with the current ICB NMP processes before they were registered as a pathfinder site or as a CPIP practicing within the ICB.
This covered:

- Site appropriateness and readiness
- Processes and policies to support CPIPs and the process of prescribing
- Risk assessment specific to service
- Risk assessment specific to prescribing and dispensing on same site
- CPIP professional assurance and documentation re training and current competence
- CPIP areas of clinical competence

3.31. The service model was designed to ensure that a second Pharmacist was involved in carrying out the final accuracy check and the check for clinical appropriateness where any CPIP prescription was dispensed "in house". The assurance process was designed to ensure that the service provided declared that they there were robust procedures and arrangements in place to ensure this, and to consider any risks of supplying against not supplying any prescribed medication. Processes and documentation (IT modules) were designed to ensure and record that Patients were always given the choice to take their prescription to another pharmacy for supply.

3.32. The CPIP service model was developed to offer the greatest support to our population. It has a primary, core component dedicated to minor illnesses. Contractors can supplement this with extra appointments for a second tier service of respiratory disease. Service design ensured that the initiative delivered a model for high-quality care that was inclusive and accessible to all sections of the local population.

3.33. Pathfinder sites ensured, and provided assurance, that the initiative was inclusive and accessible to all sections of the local population, including marginalized and disadvantaged groups.

3.34. The pathfinder sites worked to establish provision that met the recommendations of the Fuller Stocktake report, “Next steps in integrating primary care” by using PIPs to;

- Streamline access to care and advice for people, where and when they need it.
- Provide more proactive, personalised care.
- Help people to stay well for longer as part of a more ambitious and joined-up approach to prevention.
- Improve the health of children and young people.
- Support people to stay well and independent, acting sooner to help those with preventable conditions.
- Support those with long-term conditions and those with multiple needs as populations age get the best care as quickly as possible.

3.35. To achieve this, the CPIP programme;

- Collaborated with local stakeholders, including general practices, PCNs, community organisations, and patient groups, to ensure that the initiative was tailored to meet the specific needs of the local population and to ensure that it was delivered in a way that is accessible and acceptable to patients.
- Monitored and evaluated the progress of the initiative regularly to ensure that it was achieving its intended outcomes and to identify areas for improvement.
- The final evaluation established, collecting data on patient outcomes, patient satisfaction, and health inequalities, providing this data to make informed decisions about the future direction of national and local commissioning.

3.36. Future work will be required to resolve the requirements of the digital agenda for this programme. Work was undertaken with digital partners and regional colleagues to procure an IT platform that provided pharmacists with the clinical access to data required to safely prescribe e.g. patient histories, previous test results and care plans.

3.37. This system allowed access to IT provision to facilitate prescriptions via the NHS Electronic Prescription Service and ensured that CPIP prescribing, advice and interventions were communicated to GP Partners to allow incorporated into medical records for safe and effective prescribing and collaboration among healthcare providers.

3.38. The programme was developed to ensure that providers had access to IT resources such as remote consultations, electronic prescribing, and prescribing support systems, to improve prescribing safety and effectiveness, and support better and safer patient pathways. The National IT Team provided access for Pathfinder sites to GP Connect, Cleo and supporting Pharmacy System providers to provide referral system compliant with the Booking and referral standards.

3.39. IT resources such as decision support tools, drug information databases, and drug interaction checkers were linked where possible to support CPIPs to prescribe based on informed decisions, avoid errors, and provide the best possible care.

3.40. The key project management elements required in this initiative included:

- Project planning to define project goals, objectives, scope, timeline, budget, and resources required to achieve the desired outcomes.

- Stakeholder engagement to understand their needs and expectations to ensure the project is aligned with their interests.

- Risk and quality management to Identify potential risks to patient safety, regulatory compliance, privacy and security of patient data and implement measures to manage these, ensuring the project remains on track and achieve programme goals.

- Quality assurance processes to ensure quality aspects were paramount and included all relevant elements of clinical governance and guidance e.g. Infection Control policies

- Communication processes and mechanisms, ensuring regular and effective communication between project team members, stakeholders, and relevant parties.

- Continuous monitoring of progress, identifying issues, and making necessary adjustments to keep the project on track.

- Evaluation and review to assess the performance of the programme including regular evaluations to identify areas for improvement, and making necessary changes to ensure programme outcomes and inform future developments or commissioning intentions and patient pathways.

3.41. Budget was pooled Regionally to ensure adequate programme support and to maximise efficient use of funding.

3.42. Programme Support has been Provided via a contract funded via shared costs by each of the three NW Region ICBs pro rata based on site numbers

3.43. This contract is held by CPMG and delivers support for programme set up and development support, development , maintenance and management of Pharmoutcomes clinical and operational modules to support the programme, support to manage and facilitate national reporting for the programme as per national audit and evaluation requirements and employment and management of an operational programme manager (shared cost across the NW Region three ICBs).

3.44. The input of our CPIPs in the planned evaluation process was crucial to develop the programme and will inform the final review of the service model, outcomes and delivery, key governance requirements and standards, the digital and clinical system functionality and considerations, assurance framework development and the core KPIs of the programme.

3.45. The following steps have been taken as part of established national evaluation processes to create a supportive environment for participants in the evaluation process;

- Clearly communicate the purpose and benefits of the evaluation to explain why the evaluation is being conducted and what benefits it will bring as a whole.

- Provide training and resources to participants with the necessary training and resources to help them understand the evaluation process, and how they can contribute effectively.

- Ensure confidentiality and anonymity and reassure participants that their responses will be confidential and anonymous, to encourage honest and open feedback.

- Foster open communication and actively listen to participants' feedback, concerns, and suggestions. Respond to their questions and provide clarification as needed so that they can see the impact of their contributions and feel valued.

3.46. In order to prioritise the EOIs received by the ICB in relation to this programme we have considered the following aspects:

- Clinical governance including clinical mentorship and integration in to communities of practice and peer review groups
- Premises specifications
- Infection Control and adherence to IC policy
- Assurances regarding processes and policies in relation to Independent prescribers
- Geography – including potential impact on access to services and areas of multiple depravation
- Feedback form Interested Parties e.g. LPC, GPhC, Community Pharmacy Commissioning Teams, Place Based Heads of Medicines Optimisation, Regional CDAO Team
- Community Pharmacy provider history of service provision including provision of COVID services and other Innovative or Transformational services
- Place bases historic collaboration and levels of innovative and transformational working with Community Pharmacy and Community Pharmacy Stakeholders e.g. LPC

3.47. As a result of this analysis we identified the Following Places where EOIs would be actively considered and have been working with providers in these areas to identify potential priority providers:

- Liverpool
- Halton
- Sefton

3.48. This would allow each place between 2-3 Pathfinder sites to work with across their system

3.49. Based on the available funding allocation from NHS England we commissioned seven CPIP Pathfinder sites as following:

Pharmacy ODS Code	Pharmacy Name	ICB Place
FKJ00	Kensington Health Centre Pharmacy 155 Edge lane Liverpool L7 2PF	Liverpool
FTW03	Allied pharmacy (Upton Rocks) Fir Park Health centre, Lanark gardens, Widnes, Cheshire, WA89DT	Halton
FRG94	Daveys Chemist, 99 holt road, Liverpool, I7 2PN	Liverpool
FK172	Daveys Chemist, 253 Kensington, Liverpool, L7 2RG	Liverpool
FFW97	Allied Pharmacy Crosby Road 77a Crosby Road North Waterloo Liverpool L22 4QD	**Sefton**
FVK97	West Bank Pharmacy, 8a Mersey Road, West Bank, Widnes, Cheshire, WA8 0DG	Halton
FHH35	North Park HC 290 Knowsley Road Bootle L20 5DQ	**Sefton**

3.50. For context - NHS Lancashire and South Cumbria ICB were allocated 7 Sites and NHS Greater Manchester ICB 10 sites.

3.51. The selection of the sites and providers ensured that, for programme evaluation purposes, we had considered the following

- Local support from Place / key clinical leads within place
- Local relationships between CP sites and local surgeries
- Patient demographics
- Areas of deprivation and defined need
- Pharmacy set up and site in relation to GP Practice – some co-located with GP Practices, others not including High St locations, proximity to residential areas and local communities etc
- Size and throughput of pharmacy provision and dispensing
- Participation in and delivery of National and Local commissioned services
- Pharmacies were in “good standing” with commissioners and professional regulatory bodies
- Support from stakeholders including LPCs

4 Engagement

4.1 Initial engagement was facilitated during weekly briefing meetings with a Range of stakeholders including LPC, GPhC Regional Colleagues including Regional Pharmacy and Clinical Leads

4.2 The Medicines Optimisation Leads were briefed at monthly ICB Quality Medicines Optimisation and Pharmacy meetings to ensure that they were informed and could inform the programme development.

4.3 Programme initiation meetings with Leads from Place including Place Directors, Place Clinical Leads, Heads of Medicines Optimisation and any other interested party identified by Place to introduce the specifics of the programme to Sefton Place, Halton Place and Liverpool Place as the three geographies initially identified via the EOI process to as having potential viable sites for development into pathfinder status.

4.4 Clinical leads from ICB Places and Medicines Optimisation Leads from Place along with other interested parties including ICB Primary Care leads and external Stakeholders formed an ICB Steering Group to shape and develop this programme. This group had a mandate to ensure key deliverables were optimised including patient pathways, quality and safety governance arrangements, clinical supervision and mentorship, IT arrangements, AMR agendas delivered, IP policies were delivered and supported.

4.5 Under this steering group each place had arrangements in place to ensure this programme reported to and had oversight by an appropriate local operational group with Key Place representation and Stakeholders local to Place. This was supported by the ICB Steering group to ensure that the Place has an opportunity to, where appropriate, localise these services, patient pathways, referral arrangements and to facilitate cross professional working between the pathfinder sites and local PCNs and other clinicians

.

4.6 The SLA was subject to a consultation process within Cheshire and Merseyside ICB. The initial SLA included the minor Ailments / Low Acuity Conditions service with further appendices for the Respiratory Service being added as this service was developed and clinically launched.

5 Quality and Safety

5.1 Work was undertaken to begin to work with Quality and Care team and the Community Pharmacy Commissioning Team to ensure that suitable arrangements are in place for both contract management and clinical and quality support for the Pathfinder sites.

5.2 This work mapped and appropriate pathways agreed to facilitate the reporting, Clinical management and support for any concerns, complaints or issues raised concerning this programme or the delivery thereof.

5.3 This work covered any concerns, complaints or issues raised by the sites

themselves, clinicians, or the public.

5.4 This work supported and underpinned the nationally agreed and supported Evaluation process for this programme.

5.5 An ICB Clinical Mentor was appointed @one session per week to provide additional senior clinical oversight to this programme. The Clinical Mentor delivered one clinical session per week to support the CPIPs, has oversight of prescribing and any feedback concerns or incidents.

5.6 All prescribing (in an anonymised format) was detailed in a report for the Stakeholder Group's review on a monthly basis. This allowed transparency of the programme and allows professional review by the programme clinical lead, and at Place via the Heads of Medicines Optimisation (and their teams) for local review and intelligence. Review and feedback was provided back to the programme and shared with all CPIPs regarding quality and prescribing safety. This included formulary and AMR guidance adherence, clinical feedback and insight which is shared across the programme CPIPs.

5.7 Personal prescribing data was shared with each individual CPIP monthly to allow personal review and audit of prescribing. This supported the CPIPs personal development, programme quality and facilitated their prescribing development programme with their personal Clinical Supervisor.

5.8 Prescribing data is accessed via the PharmOutcomes Modules that have been developed to support the programme and is available in "real-time" in comparison with the NHSBSA Epact data that is available to the programme The NHS Epact data set has a time lag in the data provision in line with all prescribing data provided by NHSBSA.

5.9 An AMR clinical audit has been undertaken by all IPs on their personal prescribing of antibiotics over December 2025 and January2026 to support and inform the AMR agenda. This data will be shared locally and regionally with the relevant AMR groups.

6 Equality, Diversity and Inclusion

6.1 Any change in provision that impacts on access was reviewed in the context of health inequalities and more vulnerable population in C+M.

6.2 Completed programme QIA

CM%20ICB%20QIA%20Template%20-%20(

6.3 Completed programme EIA

EIA%20CP%20Pharmacy%20independent%

7 Health Inequalities

7.1 The development of IP as part of clinical services in community pharmacy was designed to have key benefits including:

- Improved patient access to healthcare across the system
- Ensuring community pharmacists are working to their full potential
- Supporting General Practice
- Enabling Integrated patient pathways

7.2 Capitalising on these benefits and ensuring that the Pathfinder Sites are integrated fully into Place and PCN systems was designed to enable sites to deliver services out with that already commissioned including (though not exclusively) late night and weekends. This increased access to services will support delivery of services generally however would also support addressing inequality of access.

7.3 The programme findings were, as the service developed, that the vast majority of clinical sessional provided by sites were in “normal working hours” Monday to Friday. This is attributed to the availability of IPs and additional Pharmacist cover at these times.

7.4 The addition of prescribing to support the nationally commissioned Community Pharmacy, Pharmacy 1st Clinical Service would also support inequality by supporting patients who may not be able to pay for self-care OTC medications and would at the point of counselling leave the Pharmacy 1st service to access their GP for a “free” prescription. This created an additional step in a patient pathway and a barrier to them accessing self-care support or accessing self-care support in a timely manner. As such the CPIP pathfinder sites could support such vulnerable patients.

7.5 Independent prescribing in Community pharmacy would enhance the clinical offer of Community pharmacy services building on national prioritisation of clinical services e.g the Common Conditions Service (commissioned as part of the Recovery and Access agenda) to deliver seamless point of access clinical care to patients.

7.6 The pathfinder programme findings and experience is being used to support the ICB and Pharmacy in meeting the recommendations of the Fuller Stocktake report, “Next steps in integrating primary care” by using CPIPs to;

- Streamline access to care and advice for people, where and when they need it.
- Provide more proactive, personalised care.
- Help people to stay well for longer as part of a more ambitious and joined-up approach to prevention.
- Improve the health of children and young people.
- Support people to stay well and independent, acting sooner to help those with preventable conditions.
- Support those with long-term conditions and those with multiple needs as populations age get the best care as quickly as possible.

8 Climate Change / Sustainability

8.1 The overall programme supports the Climate Change and Sustainability agenda in line with existing primary care services and arrangements e.g. arrangements for waste management and provision for patient education programmes with regard to waste and sustainability.

8.2 The commissioned clinical model for Respiratory Review included specific commissioned content regarding the “green agenda” with regard to inhaler supply, choice and use and a focus on sustainability.

9 Digital

9.1 Work was undertaken with the ICB Digital Leads to ensure that the National digital plans for this programme were visible to the ICB Digital leads. This also allows feedback to the National programme and local influence for the programme digital arrangements and inclusion in local digital strategic plans where appropriate.

9.2 The National Digital implementation plan included provision of GP Connect to allow access to clinical information and the national commissioning of Cleo to allow production of EPS prescriptions.

9.3 The Cleo System to facilitate access for EPS prescribing for CPs was procured nationally to support this programme with associated support for ICBs to adopt use of this system as part of the CPIP programme. This support included Guidance documents for DPIA development etc.

9.4 Nationally there is no programme to support CPs with IT infrastructure of clinical systems or Digital Programmes. All existing nationally commissioned services are designed and commissioned nationally using a “Provider Pays” model. This is restrictive for commissioners in terms to access to both service provision detailed data and clinical data. This arrangement is also not in line with standing equivalent funding arrangements for other parts of primary care including GP contractual arrangements. There are no current national intentions for “provider pays” arrangements to change. ICBs are requested to include IT costs and costs for digital enablers and support for contractors when commissioning any local services and asked to ensure this is included in any service fees structure to supp0ort contractors in procuring such enablers.

9.3 Pharmacy System providers are working with NHS England and NHS Digital to develop solutions for recording clinical sessions and supporting reporting of CP Prescribing intervention outcomes to GP Clinical Systems in an integrated manner. These solutions were not yet available to support the go live, or current programme of ongoing development, of this programme.

9.4 To address the gap in availability of digital solutions and clinical systems to support the CPIP programme, the North West regional ICB programme leads collaborated to commission a provider to develop and support a Pharmoutcomes solution to provide a -

- clinical record recording and reporting model for the commissioned clinical modules and
- service delivery recording and reporting module.

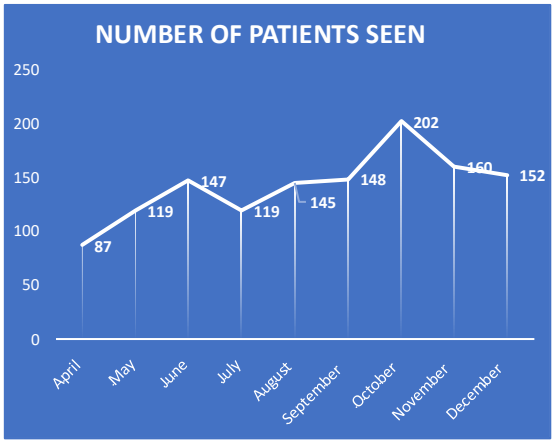
These modules included-

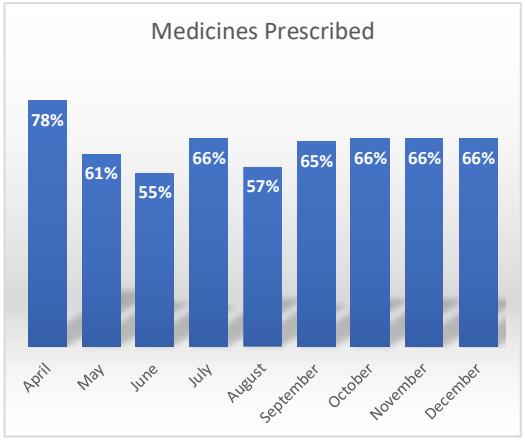
- Clinical consultation recording
- Collation of and recording of QOF data
- Collation of and recording of clinical and diagnostic records and data sets - Including clinical test results
- Links to appropriate diagnostic tools
- Collation and recording of clinical intervention outcomes including prescribing, amendment to existing mediation, advice, safety netting, escalation or future follow up
- Communication of consultation outcome and follow up including any prescribing QOF data sets, and relevant clinical findings and outcomes to the Patients GP for inclusion in Patient Clinical Records.
- Collation of and recording of data sets required to inform national and local evaluation
- Collation of sessional provision data sets and remuneration claims
- Recording and reporting of Prescribing data sets to inform prescribing analysis and clinical evaluation and oversight

10 Service Outcomes to Date

Total Number of Patients seen within C&M service – April – December = 1279

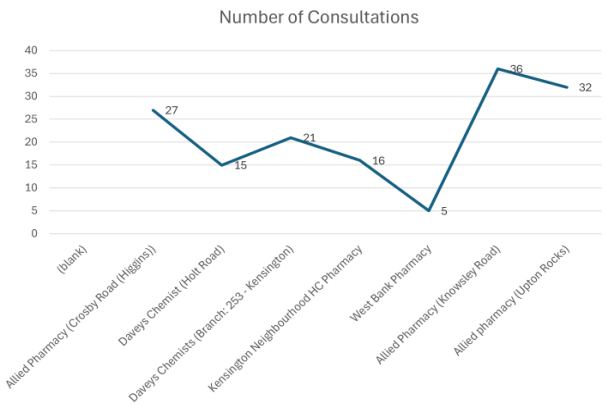
Minor Illness IP Pathfinder Activity Summary: April – December 2025

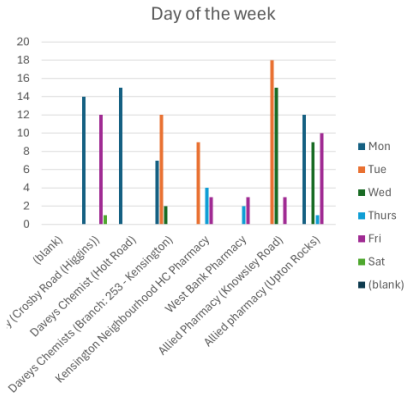




- Steady uptake of patients since go live in April. October saw the highest number of patients since go live.
- The number of medicines prescribed remains steady over 55%.

Minor Illness IP Consultations: December 2025

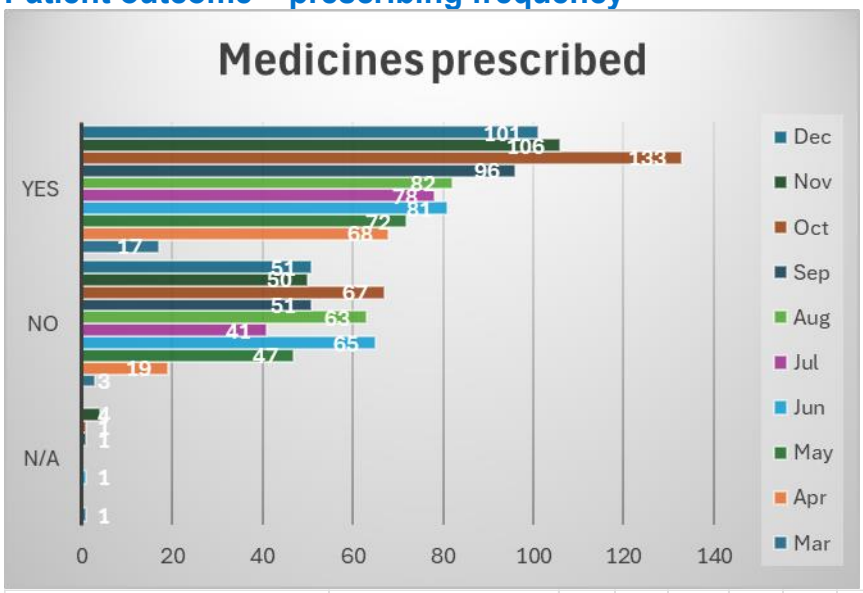




- Service activity remains consistent across the weekdays.
- Busy periods vary across pathfinder sites.

NHS
Cheshire and Merseyside

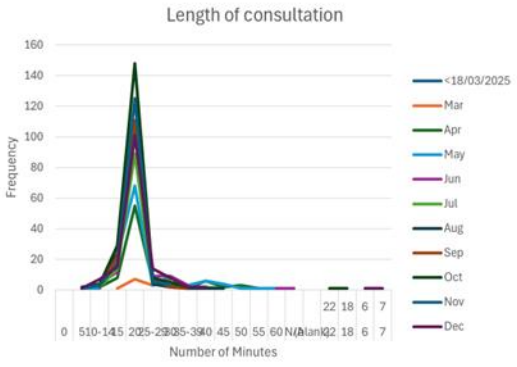
Patient outcome – prescribing frequency –

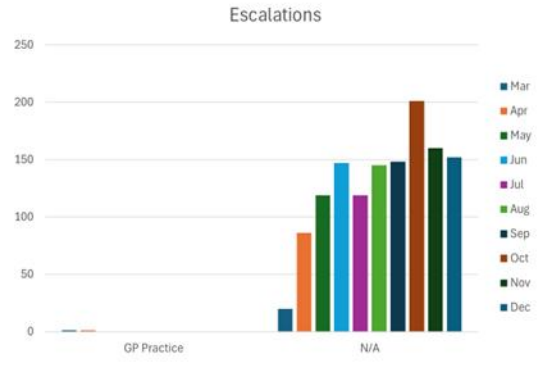


Count of Did you prescribe	Column Labels										
Row Labels	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Grand Total
N/A	1			1			1	1	4		8
No	3	19	47	65	41	63	51	67	50	51	457
Yes	17	68	72	81	78	82	96	133	106	101	834
Grand Total	**21**	**87**	**119**	**147**	**119**	**145**	**148**	**201**	**160**	**152**	**1299**

NHS
Cheshire and Merseyside

Minor Illness IP Pathfinder Activity Summary: April – December 2025



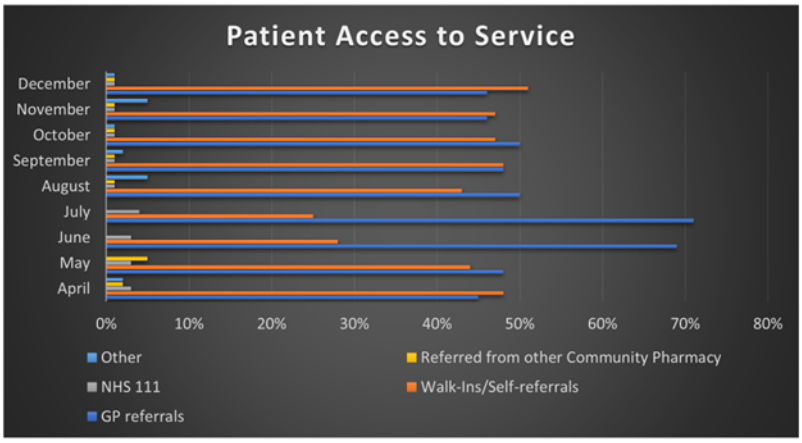


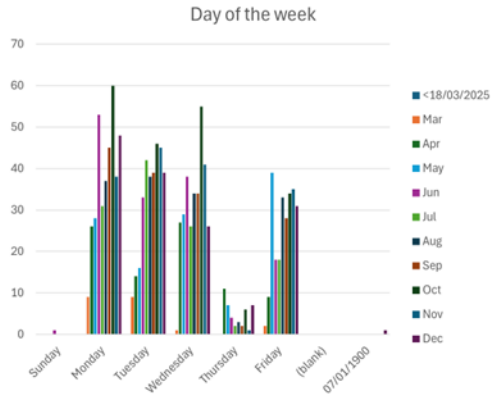
- The average length of consultations are 20-25 minutes which shows a consistency in how pathfinder sites are managing consultations.
- There have only been two escalations to the GP Practice between April and December

Access Routes into service –

Cheshire and Merseyside

Minor Illness IP Pathfinder Activity Summary: April – December 2025





- Most patients in Cheshire and Merseyside accessed the service via Walk-Ins/Self-referrals in December compared to previous months.
- There is a consistent level of service activity during the week which shows a positive level of engagement from patients.

11 Finance

11.1 This programme did not require any financial input from the ICB in that all funding was provided via the National Integration Fund programme allocation. The ICB provided support to the programme via staff and clinical oversight as part of their day-to-day roles and responsibilities. Any additional programme or clinical support, e.g. ICB Clinical mentorship was funded by the national allocation.

11.2 Nationally, an overall budget of up to £12m was allocated to the Pathfinder programme. Funding was provided to ICBs to support the operational delivery and provide support for the Pathfinder sites including:

• Project management, including the local commissioning of the Pathfinder sites using a Local Enhanced Service contractual agreement.

• Clinical mentoring, peer networks, supporting prescribing pharmacists.

• Evaluation. A portion of the funding was made available to ICBs will be available to pharmacies involved in delivery of the programme.

Sites were able to claim for:
• Set up costs, including support to enable IT for prescribing activity, participation in evaluation and operational readiness.

• Sessional time for prescribing pharmacist(s); up to six sessions per week. No additional funding was be made available for medicines costs, which continued to be attributed to ICBs and funded from existing allocations as usual.

11.3 For NHS Cheshire and Merseyside ICB the following finances have been allocated

National Programme Allocation for C&M 25/26= £63,804	
ICB Funding for C&M 25/26- National allocation via SDF	**Allocated Funding**
General Programme	50,952.00
Non Pharmacy Evaluation @426/site	1,750.00
Clinical Support @£1,586/site	11,102.00
TOTAL (from original 25/26 funding)	**£63,804.00**
Additional nationally agreed allocation – payable for "Transition Period" commissioning = 500/site/month for 7 sites Jan -Mar- Transition Period)	10,500.00
Residual Budget from2024/25)	83,345.00
Total Current balance available 25/26	**£157,649.00**

Cost pressure (cost incurred 25/26	**Cost(£)**
Project Manager (CHL) (21695.2 + 1810.8 = 23506)	14,380.60
CPPE clinical training for URTI 30th April / 9th May 2025	2,232.00
Printing (apt.creative) Patient survey/evaluation	419.00
Evaluation Work	1,750.00
Clinical Mentor £320 (+20% on costs) = £384.00	
• AW April-June 25 (13 weeks)	4,992.00
• RR July 25 -March 26 (40 weeks)	15,360.00
Total programme costs incurred 25/26 to date -	£39,133.60
Current balance available to facilitate programme extension over "transition Period" 1st Jan 2026 to 31st March 2026	**£118,515.40**
Current Balance equated to clinical sessions (@£197.60 per session)	560 sessions = **28.5** sessions per month per site (Jan-March 2026)

11.5 There was also additional complex service funding is to support models that may require additional support and greater level of clinical mentorship or additional set up support. This additional £500.00 can be claimed by sites as appropriate.

11.6 6 sessions a week was the maximum that sites can deliver / claim for payment. The pharmacies claim monthly for sessional fees as undertaken. Claims were reviewed by the Programme and submitted for payment via existing “local payment scheme” national funding payment mechanisms by NHS BSA and are charged to the ICB. The ICB recharged NHS England for the cost of the sessional fees monthly as part of the programme operational processes to recover this cost.

11.8 Annual Programme costs were transferred to the ICB the SDF funding route. The finance team were able to give assurance that this funding was received.

11.9 This programme funding has been actively managed and reviewed to ensure that this has fully cover the costs associated with this programme.

11.10 Any residual allocations unused by the ICB at the close of this programme could be recovered by NHS England. This funding may, where appropriate, be redistributed to ICBs where extension of their programme has been agreed. However, all effort has been made to maximise the utilisation of programme funds in C&M with minimal residual budgets retained subsequent to the agreed contract extension period covering 1st Jan 2026 to 31st March 2026.

11.11 It was anticipated that any prescribing undertaken in this programme would not be over and above prescribing that would happen under current primary care arrangements and would seek to instead provide the same prescribing provision in an alternative location. Monthly review of prescribing has given additional assurance that this is the case.

11.12 Arrangements for financial governance within the agreed contract extension 1st Jan 2026 to 31st March 2026 (the “Transition Period”) has ensured that costs remain within the current allocated budget.

11.13 The C&M Programme continuance for the nationally proposed “Transition Period” 1st Jan – 31st March 2026 @24 sessions per site per month for all seven sites will result in a Maximum Spend of £106,229.04

11,14 Note that this will leave a residual funding of £36,600.00 (minimum residual budge based on all 7 sites claiming and delivering maximum allocation of 24 clinical sessions per month for 3 months Transitional Period activity)

11.15 This residual budget will ensure that any unforeseen additional programme closedown costs or evaluation costs will be funded from existing national programme allocation and will not result in any cost pressures to the ICB.

11.18 Any immediate future commissioning of current service is anticipated to cost-

- £197.60 per clinical session (in line with existing arrangements)
- Equates to £4,742.40 per site per month for 24 clinical sessions per month (in line with existing arrangements)
- IT costs – to facilitate access to EPS arrangements – if commissioned via Cleo (existing provider) this is anticipated to be £650.00 per site per month (TBC)
- Clinical Mentor @(£320=20% on costs = £384/week) = £1,536.00
- Total cost per site /month = £6,932.24 per month
- Total cost for all seven sites / month = £35,409.68per month

11.19 Any further future commissioned services will require identification of ICB funding.

12.Funding Review post transition period –

12.1 A finding review has been undertaken regarding the cost of continuation of the C&M programme.

12.2 It is projected that a residual balance of £36,600 will remain after the closedown of the existing programme 31st March 2026.

Balance 24/25	£ 83,345.00	as conformed carried forward by finance team
Received 25/26	£ 286,000.00	from NHS England allocations at end of year
	.....	
	£369,345.00	
	.....	
Spent	£ 38,083.00	programme expenses
Spent	£ 294,662.00	sessional fees
	.....	
	£ 332,745.00	
	.....	
Leaving -	.....	
Balance 25/26	£ 36,600.00	
programme end	.....	

This position should be "worst case scenario" as based it is on Jan Feb March sessional claims being submitted as maximum available for providers and they have not to date claimed maximum sessions each month.

12.3 Forecast for **Monthly** Cost of continuing programme –

Number of sites	Number of monthly sessions (£197.76/session)	Sessional cost at max number of 24 sessions	Cost of CLEO licence	Clinical mentor (£320=20% on costs = £384/week)	Total site cost
7	24	£ 33,223.68	£650.00	£1,536.00	£35,409.68
1	24	£ 4,746.24	£650.00	£1,536.00	£ 6,932.24
2	24	£ 9,492.48	£650.00	£1,536.00	£11,678.48

12.4 The residual budget, as forecast (£36,000), **would not** cover one month costs for all 7 sites.

12.5 The residual budget, as forecast (£36,000), **would potentially** cover three months costs for 2 sites.

12.6 If the ICB were to prioritise two sites we would look to prioritise the Sefton sites which are co located within the Neighbourhood Pioneer Programme.

12.7 Unless otherwise agreed, the C&M CPIP Pathfinder Programme will cease form 31st March 2026 and all C&M CPIP NHS delivery will cease until such times as a national solution is available- potentially as a result of the outcome of the 2026/27 Contractual Framework negotiations.

12.8 It is not known, if the negotiations do result in an agreement regarding a nationally agreed service specification including CPIP functions, at what point this agreement will be enacted. Service design and SLA, IT infrastructure and other enablers will have to be agreed and in place before any national go live for CPIP services.

13.Options Appraisal

Option	Description	Cost	Appraisal
1	Current service discontinued	No further cost to ICB.	• Reputational cost to CP services • Relationship cost to GP /CP relationships at all sites

	31st March 2026 and hiatus in all CPIP NHS IP Activity until nationally agrees solution in place (unknown date 2026/2027)	Any residual funding (projected £36,000.00) is retained for future work to promote IP services once	• Loss of patient engagement at current sites • Residual budget accrued for 26/27 to support launch of national arrangements for IP services as part of the national contract settlement later in 26/27 • Mitigation of identified Risk – comms plan to ensure briefing of all stakeholders to include – ➢ Successes of Pathfinder programme- nationally and locally ➢ Current delivery and achievements in C&M ➢ Future arrangements and national commissioning intensions
2	Residual budget post 31st March 2026 used to continue CPIP services at 2 priority sites (Sefton) for up to three months	No further cost to ICB (Use of residual NHS England funding estimated £36,600)	• The provider would be required to confirm they wish to continue to deliver this programme at these 2 sites • Provider has confirmed loss of "resident" IP so service is less stable than would be otherwise due to loss of recognised lead pharmacist. • We would be required to secure a Cleo Licence at this late stage to support continued service delivery (EPS). • It is unknown how the Neighbourhood Pioneer Site would wish to / has plans to engage with this programme as they are still in planning and development. • Identified misalignment of clinical focus between Neighbourhood pioneer Site (Frailty) and CPIP Pathfinder site (Minor Illness and Respiratory Review) so services not best matched in focus. • 3 months extension may not be long enough for the Neighbourhood Pioneer Site to actively use or engage with the CPIP Pathfinder programme. • Programme facilitators e.g programme manager or commissioned reporting enablers would no longer be in place to support this programme so all operational support and administration would have to be brought "in house". • Same risks as option 1 after three month interim solution ended.
3	Commissioning of Locally Funded CPIP service by ICB	£35,409.68 per month for all 7 sites ongoing	• Commissioning of Locally Funded CPIP service by ICB to "bridge" between the end of the National CPIP Pathfinder until the start of a nationally agreed and supported CPIP service as part of 26/27 service developments and contract settlement. • Mitigates all risks of Option 1 and some risks of Option 2 • Timeframe for any Nationally Commissioned Service to be announced, designed and launched is unknown • Due to lack of clarity regarding design or implementation plan for any subsequent National CPIP service it is unknown if the current CPIP Pathfinder service, as currently commissioned, will align with the design or arrangement of the future national service. • **Not financially viable due to lack of identified ongoing budget and unknown time frame involved**

14. Ask of the SPCC Committee and Recommendations (Feb 2026)

14.1 The Committee is asked to:

- Consider:

➢ The impact of Option 1 -the discontinuation of the existing CPIP service provision and access in the period from 1st April 2026 to such time as national arrangements are in place to further support local commissioning via a nationally agreed and developed service.
➢ Limited benefit of Options 2 - Local commissioning of CPIP services from current programme end (31st March 2026) in two sites only for a limited timeframe as dictated by available budget (nominally 3 months extension) delivers limited benefit and once discharged, same risks as Option 1.
➢ Option 3- Local commissioning of services for an unknown period to "bridge" between the existing service 31st March 2026 until the implementation of a Nationally agreed and supported CPIP Service (at unknown date) in 26/27. This option is considered not financially viable due to lack of identified budget and unknown time frame involved.
➢ **Recommendation – Option 1** – closure of all current sites. The concerns re misalignment in service arrangements for the CPIP sites and clinical focus for the Neighbourhood Pioneer Site, the timeframes available and lack of maturity for the Neighbourhood Pioneer Site do not allow a cohesive working relationship to be established within the timeframe proposed. The continuation of the CPIP sites by three months would not allow working practices between the Neighbourhood Pioneer programme and the CPIP programme to be established, used and tested to deliver outcomes. The benefit for continuation of this service in this limited way (2 sites) for a limited time (3 months) is minimal.
➢ The development of clear risk-based plans to commission future CPIP services in C&M to support access to clinical services as a part of the ICB integrated Primary Care arrangements and offer to patients.

14. Reasons for Recommendations

15.1 Further work is required to confirm the ICB approach prior to any nationally agreed way forward post April 2026.

15.2 The outcomes of the Community Pharmacy National Contract Consultations for 26/27 are yet to be agreed and published. As such the plans for CPIP programmes, other than the clear intensions to commission stated in the NHS 10 year plan and Medium Term Planning Guidance are yet to be established or confirmed.

15.3 National direction regarding inclusion of CPIP services as part of the National Community Pharmacy Contractual Framework are anticipated post April 2026.

15.4 Lack of identified local budget, limited available residual budget from NHS England allocation do not allow a cohesive or comprehensive extension to current arrangements.

a. Option 1 – Closure of all current sites until such time as national arrangements are in place for CPIP Services as part of the National Community Pharmacy Contract Framework is the only viable option.

b. Mitigation to risk identified with Option1 can be discharged via a comprehensive communication plan and Local Engagement with stakeholders and the public.

c. Use of the accrued residual budget from 25/26 can support these comms and engagement specifically at such time as we support contractors and the public to engage with new CPIP services as they become commissioned later in 26/27.

15.5 Post Transition Period propositions and arrangements –

15.6 The existing Pathfinder Programme will be closed down from 31st March 2026

15.7 It is anticipated that options for a further National CPIP programme will be in place, subject to National negotiations, as part of the National Community Contractual Framework consultation for 2026 /27 as part of the NHS England 10 Year Plan.

15.8 There is no assurance (and it is not generally anticipated) that a contractual agreement will be in place to start 1st April 2026.

15.9 Any future commissioning in 2026/27 will be on a phased roll out (yet to be established)

15.10 This will result in the requirement, for any delivery of CPIP prescribing services post 31st March 2026, to be locally commissioned by ICBs as part of their primary care delivery strategic commissioning intentions.

15.11 National Guidance and support documents will be made available to ICBs to support any commissioning intensions in this arena as part of learnings developed from this programme.

15.12 The ICB will be required to consider further commissioning intensions regarding Community Pharmacy Independent prescribing as part of the 10 year

plan and the indication that these services must be commissioned by ICBs in 2026 as outlined in the Medium Term Planning Framework Medium term planning framework - delivering change together 2026/27 to 2028/29

15.13 Consideration should be made as to potential for future any collaboration and integration opportunities for this programme with existing Transformation Programmes e.g. Neighbourhood Pioneer Sites – Specifically relevant to the two Sefton CPIP Sites which sit within the Sefton Neighbourhood Model for Neighbourhood Health

15.14 Consideration should be taken as to any Risks which may be identified due to the closure of this Programme –

- Impact of withdrawal of this additional prescribing capacity and access within local systems.
- Potential negative impact on perception of public and local professions for discontinuation of this service
- Potential negative impact on engagement of local professional with CPIP services in the future – discontinuation and then "restarting" of services may give an appearance of short term commissioning intensions/ transient programme delivery for CPIP future programmes
- Potential loss of engagement from Local Pharmacy Providers / Local Pharmacy stakeholders regarding CPIP future programmes.
- Potential loss of local resources – e.g. CPIPs lost from local workforce system as IP employed positions are lost as part of programme discontinuation and IPs move elsewhere for employed positions. CPIPs lost to CP workforce and / or from C&M workforce

16.Officer contact details for more information

Pamela Soo
Clinical Lead for Community Pharmacy Integration for Cheshire and Merseyside ICB

t: 07967302627
e: Pam.Soo@nhs.net
w: www.england.nhs.uk
Regatta Place Summers Road Brunswick Business Park **Liverpool** Merseyside L3 4BL

NHS
Cheshire and Merseyside

17. Appendices

Appendix 1: National Strategy

NHS England – Medium Term Planning Framework delivering change together 2026/27 to 2028/29 -

https://www.england.nhs.uk/wp-content/uploads/2025/10/medium-term-planning-framework-delivering-change-together-2026-27-to-2028-29.pdf

NHS Long Term Workforce Plan –

https://www.google.com/search?q=NHS+Long+Term+Workforce+Plan&mstk=AUtExfAYicfKprsEhBIBXK6KBoZWTyRpJLXX0a1BjYtw3FGJV3OwsXLBZ6pFOR8TD8930nIGvJazhLudF2di-EwfkLjL1SMQg02O_yygxC09wRVXq9xCbEMICIMTK2kjuKdCWEuiLHfDCLFI74dCgeq_86aFhASIM7DI_TmLAkEurrxm4q8&csui=3&ved=2ahUKEwjDvO_dg8mQAxUHUkEAHZaqEIQQgK4QegQIBhAC

NHS 10 Year Plan -

NHS%2010%20Year%20Plan%20Commu

Referenced%20Summary%20Pharmacy%

Summary%20Pharmacy%20and%20Pharn

Medium term planning framework - delivering change together 2026/27 to 2028/29

Appendix 2: National Comms

IP Funding Model August 2023 0.3 ICB Aug 2023

PRN02171_Letter_Independent Prescribin Oct 2025

Appendix 2: letter to ICB Chief Executives / Chief Pharmacist/ Director of Medicines and Pharmacy and Medical Director from Ali Sparke Director of

NHS
Cheshire and Merseyside

Pharmacy, Dental and Optometry – NHS England ref PR00641 – 14th August 2023.


PRN00641_Indepen
dent Prescribing in

Appendix 3: MOU


Cheshire and
Merseyside ICB.docx

Appendix 4: SLA template


IP Pathfinder
Programme – Suppl


20230912 IP
Pathfinder program

Appendix 5 – Local Presentations used with Stakeholder groups to support this programme


NW SMT CP IP
Pathfinder Program


20230725 IP
Pathfinder Slides v0.

Appendix 6- CPMG contracts for Service development /


CM-CHL SLA IP
Pathfinder PharmOut


Signed Contract- RA.
PS signature.rtf

October Stakeholder Data sets –

NHS
Cheshire and Merseyside


Oct%20Minor%20Illness%20dashboard%2


Oct%20Resp%20dashboard%20CPMG.xls›0


03112025%20V2%20redacted%20report9

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

Date: 19th February 2026

Primary Care Services - Quality Report

Agenda Item No: SPCC 26/02/B14

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

NHS
Cheshire and Merseyside

Primary Care Services - Quality Report

1. Purpose of the Report

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

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

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

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

2. Ask of the Committee and Recommendations

2.1 The Committee is asked to:

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

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

3.1 **General Practice**

No items to Alert

3.2 **Dental Services**

- A provider of two practices; one in North Huyton and one in St Helens, has been served notice by CHP to vacate both premises. This is a CHP rather than ICB decision and follows a prolonged period where a large debt has occurred in relation to rent payments. Both contracts are delivering on their NHS activity. It is likely that the activity for both contracts will have to be redistributed to other local providers to ensure continuity of care for patients, unless the provider is able to secure viable, alternative premises. Commissioners have contingency plans prepared and are liaising with the ICB's Communications Team and ICB Place Leads in readiness.

3.3 General Ophthalmic Services

- Advise of a contract termination following a previous update to the group.
- Advise of breaches issued included due to non-submission of complaints information despite reminders

3.4 Community Pharmacy Services

No items to Alert

4. Quality Issues for Advising (ongoing monitoring)

4.1 General Practice

- Cheshire West GP Practice - During early 2025, Concerns were raised regarding Professional relationships at a Surgery that could potentially affect patient safety. The ICB implemented a period of enhanced surveillance to ensure that GP partners worked together to ensure the safe delivery of the GMS contract and to ensure that patients received appropriate and continuity of care.

  The ICB set out expectations of the GP Partners in a formal letter during July 2025 informing of an enhanced surveillance period. One of the stated recommendations were not met, therefore the ICB notified the surgery that a period of enhanced surveillance would be reinstated from 1st December to 31st January 2026, with ICB Cheshire West Place Head of Quality & Safety Improvement and Primary Care Development Manager visiting the Practice and attending Practice meetings. November and December Practice Clinical meetings have been attended, with positive feedback. A further assurance update will be provided as the process progresses.

4.2 Dental Services

- Provider in breach of contract in Liverpool for having no dentists available during core hours. This is an ongoing situation, previously reported on. We are currently seeking approval from SPCC to terminate the contract. If approved, we are seeking support from solicitors to draft a robust termination notice, based on the breach notices served and evidence gathered to date.

4.3 General Ophthalmic Services

- Updates on post payment verification actions ongoing

4.4 Community Pharmacy Services

No items to Advise

5. Quality Issues for Assurance (assurance received)

5.1 General Practice

- **Cheshire West – Reported at November meeting as an Alert.** Availability of Chlamydia Testing kits (male and female) for over 25s. Ongoing supply challenges relating to Liverpool University Foundation Trust who co-ordinate shipments. The financial challenges have now been resolved, with the only outstanding action to ensure transportation of the testing kits. Countess of Chester Hospital have agreed to utilise existing transport links to transport testing kits to West Practices. Cheshire West primary care team have reached out to another Provider to transport testing kits to Northwich and Winsford practices. Assurance received.

- **Cheshire West – Reported at November meeting as an Alert.** Communications were received from a Practice in Cheshire West regarding the adaption of the Sexual Safety Charter and Sexual Misconduct Policy framework. Within the framework it states that ICBs are asked to ensure primary care providers receive the support needed to focus on the sexual safety of staff (in particular from third parties i.e. patients), and that providers notify their commissioner of any allegations of sexual misconduct involving a member of their team especially healthcare registered with General Medical Council and Royal College of Nursing. Support was provided from C&M Associate Director of Safeguarding. C&M ICB Domestic Violence and Sexual Safety Coordinator will be attending the Cheshire West Practice Managers forum to provide support to Practices to support implementation. Assurance received.

- **Liverpool Place – Whistleblowing -** Whistle blowing concerns received by CQC at a practice in Liverpool. CQC has prioritised for urgent visit, however unable to visit in Q3. Liverpool Place has scheduled a quality visit for 17th December 2025. Open and transparent visit taken place with KLOE in relation to concerns. No evidence to substantiate the claims. Action plan implemented. CQC advised of outcome. Assurance received.

5.2 Dental Services

No items to update

5.3 General Ophthalmic Services

- As per Eye Health Policy Book instruction, there have been 2 face to face quarterly quality cycle follow up contractual visits where the ICB and a clinical adviser have

conducted a store visit to ensure that contractual obligations are met and to answer any queries from the contractor and their staff.

5.4 **Community Pharmacy Services**

- All 3 J Hoots contracts which had gone into administration have been bought by Allied Pharmacies. They are currently operating under a management agreement whilst waiting for the change of ownership to be processed. This allows the branch provide services without further delay. Assurance

6. Complaints

6.1 Q3 Report due next meeting

7 Reasons for Recommendations

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

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

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

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

9 Link to meeting CQC ICS Themes and Quality Statements

9.1 Quality & Safety - QS2, QS3, QS5
9.2 Integration – QS7, QS8
9.3 Leadership – QS10, QS13, QS15

10 Risks

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

11 Finance

11.1 Will be covered in separate Finance update.

12 Communication and Engagement

12.1 Not required in respect of this paper.

13 Equality, Diversity and Inclusion

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

14 Next Steps and Responsible Person to take forward

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

15 Appendices

Appendix One: *General Practice Quality Indicators & Process*

General Practice - Quality Indicators &

Appendix Two: *Optometry Quality Oversight Process*

OPTOMETRY QUALITY OVERSIGHT

Appendix Three: *Dental National Assurance Process*

NHS England » Policy book for primary dental services

Appendix Four: *Community Pharmacy Quality Scheme*

Acrobat Document

NHS
Cheshire and Merseyside

Primary Care – General Practice - Quality Assurance & Improvement Process

Primary Care in Cheshire & Merseyside

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

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

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

Clinical Outcomes and Care Quality Indicators

NHS
Cheshire and Merseyside

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

Clinical Outcomes and Care Quality Indicators

NHS
Cheshire and Merseyside

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

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

General Practice Contractual, Quality & Performance

Escalation Pathways

Contractual Concerns

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

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

Quality & Safety Issues & Concerns

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

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

Professional Concerns

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

For urgent matters outside of these hours contact

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

General Practice Quality Assurance - Target Operating Model

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

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

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

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

Reporting requirements

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

General Practice Quality - Risk Categorisation

Low risk issue examples (for management at Place) :

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

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

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

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

Reporting and Escalation Governance

Primary Care Quality issue identified

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

Place level reporting

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

C&M level reporting

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

Key issues arising from the ICB Place meeting held ……

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

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

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

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

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

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

OPTOMETRY QUALITY OVERSIGHT PROCESS

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

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

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

QIO follow up visits

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

OPTOMETRY – indicators

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

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

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

PPV (Post Payment Verification)

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

NHS
Cheshire and Merseyside

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

19th February 2026

Digital Updates

Agenda Item No	SPCC 26/02/B15
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Report Approved by (Sponsoring Director)	John Llewellyn, Chief Digital Information Officer
Responsible Officer to take actions forward.	Cathy Fox, Associate Director of Digital Operations

Digital workstream updates

Executive Summary	The purpose of this paper is twofold: 1. To request approval for an agreed mechanism to fund clinical system costs associated with practice mergers. These costs were previously covered by notional NHSE funding, which was reduced nationally by 10% in 2024/25. Prior to the ICB, former CCGs took inconsistent approaches to supporting this funding when national options were unavailable. 2. To provide updates on a number of key workstreams for information: - Closure of CSU – plans for transition of service (closure date for GPIT: 31 December 2026). - Opportunity for practices to participate in a 12-month pilot of ambient voice technologies in general practice. - Progress with planning for GPIT cost savings including implementation of a cap on ICB funded SMS fragments from 1 April 2026. .

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

Recommendation	**The System Primary Care Committee is asked to:-** **1. Consider the options below in given that notional funding not being available, for all future practice mergers: -** **a. ICB to fund all costs** **b. ICB to fund 50% of costs, Practice to fund 50%** **c. Practice to fund 100% of costs** **d. Primary Care teams to apply to resilience funding stream to support costs (assuming this exists going forward)** **The recommended option** 2. **Note the updates provided on closure of the CSU, contract for network links, pilot for Lyrebird and progress with cost savings**

Impact (x) (further detail to be provided in body of paper)	**Financial**	**IM &T**	**Workforce**	**Estate**
	X	X	X	X
	Legal	**Health Inequalities**	**EDI**	**Sustainability**
Route to this meeting	This paper was developed by the ICB Digital team.			
Management of Conflicts of Interest	None reported			

Purpose of this paper

The purpose of this paper is to provide an update on current digital workstreams and funding elements associated with 2025/26 GPIT investments.

A decision is requested on funding for clinical system changes to enable GP practice mergers. Updates are also provided on:

- Closure of the CSU (GPIT services ending 31 December 2026).
- Opportunity for practices to participate in a 12-month pilot on ambient voice technology in general practice.
- Progress with planning for implementation of GPIT cost-saving measures, including the SMS cap.

Funding for General Practice Mergers

There are two standard processes for practice mergers across Cheshire and Merseyside:
- A full business merger, where two practices become one; or
- A practice moving from one system to another.

Both scenarios require the merging or alteration of patient information within the electronic patient record (EPR) system (EMIS, TPP, or Medicus). This may also include Docman10 clinical correspondence where applicable.

Currently, all EPR funding is centrally held by the NHS England finance team, with each ICB receiving an annual notional allocation based on patient population. This previously covered all licence costs and supported mergers. In 2024/25, this fund was reduced nationally by 10%, resulting in insufficient allocation to support mergers. Requests for additional funding have been repeatedly rejected.

The table below highlights the current need for a consistent model across C&M to support planning in General Practice.

The current costs for merging systems ranges between £3k-£10k depending on services involved and costs from IT Partners to support migration.

Place	Funding Approach
Cheshire East	Previously fully CCG funded if notional funding not available
Cheshire West	Previously fully CCG funded if notional funding not available
Halton	No mergers for 7-8 years, notional funding previously
Knowsley	Funded by SDF

Liverpool	No practice mergers in recent years, previously would have been funded out of local Digital budget (CCG days). Place have submitted an SDF resilience application in anticipation of this merger with a proposal to cover these costs
Sefton	Previously fully CCG funded if notional funding not available
St Helens	Previously funded from the local resilience monies 24/25 financial year
Warrington	Previously part CCG funded, part practice funded, if notional funding not available
Wirral	Previously merger costs 50/50 between CCG and the practice

Consider the options below in the event of notional funding not being available, for all future practice mergers: -

a. ICB to fund all costs

b. ICB to fund 50% of costs, Practice to fund 50%

c. Practice to fund 100% of costs

d. Primary Care teams to apply to resilience funding stream to support costs (assuming this funding exists going forward)

Closure of Commissioning Support Units (CSUs)

National reforms include the closure of CSUs as part of wider restructuring, including the transfer of NHS England services into the Department of Health and Social Care (DHSC).

The ICB commissions both corporate digital services and GPIT support in Warrington, Wirral, and Cheshire; therefore, these areas will see significant impact.

Following system-wide discussions:

- Informatics Merseyside (IM) will take on ICB corporate and GPIT services previously delivered by MLCSU across Cheshire, Warrington, and Wirral.

- Mid Mersey Digital Alliance (MMDA) will continue delivering services for St Helens, Knowsley, and Halton, and will also onboard services currently provided by MLCSU to East Cheshire NHS Trust.

A new ICB CSU Service Transition Group has been established to oversee the transition, with a target completion date of on or before 31 December 2026.

This approach provides a clear and structured route to maintain safe, reliable digital services for health and care colleagues and patients across Cheshire, Warrington and Wirral, while ensuring ongoing stability in other places.

Opportunity for practices to participate in a pilot the use of ambient voice (AI) technologies in General practice

The Cheshire and Merseyside Provider Collaborative (CMPC) were successful in bidding for NHSE North West Regional Transformation Funding (RTF) which was established to identify and support sustainable innovations and collaborative initiatives which will drive the 'three shifts' outlined in the NHS 10 Year Plan or particularly impact on Urgent and Emergency Care (UEC) and/or elective waits and/or productivity.

Alder Hey Children's NHS Foundation Trust, on behalf of the Cheshire and Merseyside Provider Collaborative, led a successful bid focused on the use of Ambient Voice Technology (AVT) across the whole of Cheshire and Merseyside ICB. The bid has secured funding to support:

- Licences for an AVT system (Lyrebird) for use across all NHS organisations in Cheshire and Merseyside that wish to take part, including Primary Care, until the end of May 2027

- Implementation resource to support participating sites (details of which are still being confirmed).

This opportunity has been offered to all General practices across Cheshire and Merseyside that are interested in exploring how the Lyrebird AVT solution could support local service delivery, enhance productivity, and improve both patient and clinician experience.

Participation will be entirely voluntary, with the programme designed to capture shared learning and evidence to inform future approaches to AVT deployment and adoption.

The deadline for responses of an initial expression of interest is Friday 20th February 2026. Funding for the solution post evaluation has not been confirmed or discussed.

Progress with planning for the implementation of GPIT Cost savings including SMS cap with a start date of 1st April 2026

Non mandatory GPIT solutions

As discussed previously, a decision was taken by the Executive Committee to cease funding non mandatory solutions (as defined by NHS England's GP IT Operating model). For historic reasons some Places (CCGs) invested in additional solutions for General Practice. Notice has been given on these contracts and Places / Practices have been offered the opportunity to meet with relevant suppliers should they wish to do so.

Solution	Annual cost	Places impacted

Redaction software (IGPR)	£37,312	Cheshire East & Cheshire West
Digital Dictation (Lexacom)	£42,880	Cheshire East & Cheshire West
GP Teamnet	£21,285	Warrington
Bluestream	£15,420	Warrington
GP Telephony (MMDA)	£86,725	St Helens, Knowsley, Halton
Apex	£235,710	Cheshire East, Cheshire West, St Helens, Warrington, Knowsley, Marine Lake Wirral
Automated arrivals & Patient calling screens	£306,699	All
Schappitt (Footfall)	£31,481	St Helens

Cap on ICB funding for SMS fragments for communication with patients in General practice

As discussed previously, the Executive Committee took the decision to restrict the funded allocation of SMS fragments, with a limit of 16 fragments per registered patient per financial year.

Work is now underway to plan the implementation of this. Full details will be communicated over the next few weeks. This has been delayed slightly by national delays issuing details of the national framework for SMS that will be in place from April 2026.

Informatics Merseyside have held 3 webinars for all practices to discuss opportunities to optimise their use of SMS and these are planned to continue during February and March. Recordings of these sessions have been circulated to Practices and Place leads along with frequently asked question documents.