

Meeting of the Cheshire & Merseyside ICB System Primary Care Committee

Part B – Meeting held in Public

Thursday 15th October 2026

Venue: MS Teams

Timing: 09:45am-12.15pm

Agenda

Chair: Erica Morriss

AGENDA NO & TIME	ITEM	LEAD	ACTION / PURPOSE	PAGE No
09:45am	Preliminary Business			
SPCC 15/10/B01	Welcome, Introductions and Apologies	Chair	Verbal	-
SPCC 15/10/B02	Declarations of Interest	Chair	Verbal	-
SPCC 15/10/B03	Questions from the public (TBC)	Chair	Verbal	-
09:50am	Committee Management			
SPCC 15/10/B04	Draft Minutes of the last meeting (Part B) – 20 th August 2026	Chair	Paper	Page 3
			To approve	
SPCC 15/10/B05	Action Log of last meeting (Part B) 20 th August 2026	Chair	Paper	Page 8
			To note	
SPCC 15/10/B06	Forward Planner	Chris Leese	Paper	Page 9
			To Note	
SPCC 15/10/B07	SPCC Terms of Reference	Ben Vinter	Paper	Page 11
			To Approve	
SPCC 15/10/B08	Committee Review	Ben Vinter	Verbal	-
SPCC 15/10/B09	Sub- Committee Governance Update	Chris Leese	Paper	Page 34
			To Approve	
10:20am	Commissioning and Performance			
SPCC 15/10/B10	Integrated Primary Care Commissioning and Performance Update	Chris Leese	Paper	Page 57
			To Note	
SPCC 15/10/B11	Community Pharmacy – Independent Prescribing Update	Pam Soo Chris Haigh	Paper	Page 67
			To Note	
SPCC 15/10/B12	Referral Management Enhanced Service	Chris Rees Dr Eskander	Paper	Page 75

AGENDA NO & TIME	ITEM	LEAD	ACTION / PURPOSE	PAGE No
			To Approve	
10:50am	Key Strategic Delivery Area(s)			
SPCC 15/10/B13	Neighbourhood Health	Cheryl Mould/ Clare Watson	Verbal	-
SPCC 15/10/B14	'All Together Smiling' Update	Ian Ashworth	Paper	Page 91
			To Approve	
11:20am	Finance and Prescribing Assurance			
SPCC 15/10/B15	Finance Update	Lorraine Weekes	Paper	Page 110
			To Note	
SPCC 15/10/B16	Capital Allocation – BAU and UMF Update Paper	Cathy Fox Kev Highfield James Burchell Lucy Andrews	Paper	Page 118
			For Endorsement/ Noting	
11:50am	Estates Update			
SPCC 15/10/B17	Utilisation and Modernisation Fund 2025/26 Update	James Burchell/Lucy Andrews	Paper	Page 130
			For Endorsement/ Noting	
12:00pm	Digital Update			
SPCC 15/10/18	EMIS/Medicus Issue	Cathy Fox	Paper	Page 134
			For Information	
12:15pm	AOB CLOSE OF MEETING			
Date and time of next regular meeting: Thursday 17 th December 2026				

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

Thursday 20 August 2026 10:15-12:30
Meeting Room 1, No 1 Lakeside
920 Centre Park Square, Warrington, WA1 1QY

Unconfirmed Draft Minutes

ATTENDANCE - Membership		
Name	Initials	Role
Erica Morriss	EMo	<i>Chair</i> , Non-Executive Director
Clare Watson	CWa	Executive Director of Health and Integrated Care Commissioning, C&M ICB
Louise Barry	LBa	Chief Executive, Healthwatch Cheshire
Jonathan Griffiths	JGr	Associate Medical Director, C&M ICB
Rob Barnett	RBa	Secretary, Liverpool LMC
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
Fiona Lemmens	FLe	Executive Medical Director, C&M ICB
Kerry Lloyd	KLI	Deputy Director of Nursing & Care, C&M ICB
Matt Harvey	MHa	Pharmacy Rep from Local Pharmacy Committee (LPCs)
In attendance		
Cheryl Meaden	CMe	<i>Minute taker</i> , Executive Assistant, C&M ICB
Loraine Weekes-Bailey	LWB	Senior Primary Care Accountant
Rob Barnett	RBa	Association of LMC's
Paul Bishop	PB	Clinical Lead
Clare Barrow	Cba	Director of Finance Primary Care
Susanne Lynch	Sly	Chief Pharmacist, C&M ICB
Apologies		
Name	Initials	Role
Ben Vinter	BVi	Executive Director of Corporate Services and Governance, C&M ICB
Adam Irvine	Air	Primary Care Partner Member
Chris Haigh	CHa	Deputy Chief Pharmacist
Andrea McGee	AMc	Executive Director of Finance, C&M ICB
Daniel Harle	DHa	LMC representative
Tony Foy	TFo	Vice-Chair, Non-Executive Director C&M ICB
John Llewellyn	JLI	Chief Digital & Information Officer C&M ICB

Agenda Item, Discussion, Outcomes and Action Points

Preliminary Business

SPCC 20/08/B01 Welcome, Introductions and Apologies



The Chair welcomed member to the meeting and noted the attendance of a member of the public. Individual introductions were made by the committee members and officers representing primary care, finance, pharmacy, dentistry, optometry and nursing.

Apologies were noted.

SPCC 20/08/B02 Declarations of Interest

The Chair invited members to declare any interests relevant to the agenda items under consideration. No additional declarations of interest were raised.

SPCC 20/08/B03 Questions from the public

The committee noted that no questions had been received from the members of the public in advance of the meeting. The Chair thanked the member of the public in attendance for joining the meeting.

Committee Management

SPCC 20/08/B04 DRAFT Minutes of the last meeting (Part B) 25 June 2026

The minutes of the previous meeting held on 25th June 2026 were recorded as a true and accurate record.

SPCC 26/04/B05 Committee Action Log (Part B) 25 June 2026

The Chair reported that the two outstanding actions from the previous meeting had been completed.

Updates relating to primary care quality and the primary care action plan were included within papers presented to the committee. The committee agreed both actions could be closed.

SPCC 20/08/B06 Forward Planner

The Director of Integrated Primary Care provided an update on the Committee's forward work programme and the ongoing review of governance arrangements.

Members were advised that recommendations arising from the Committee effectiveness review were being incorporated into revised Terms of Reference. It was anticipated that the refreshed governance framework would strengthen strategic oversight and ensure alignment with wider Integrated Care Board governance structures.

Discussion took place regarding future agenda planning and the importance of ensuring that Committee business remained focused on strategic priorities, assurance and oversight responsibilities.

The Committee noted that the revised TOR for this Committee were being progressed and would return to this committee (BV)

SPCC 20/08/B07 Risk Update

The Committee received an update on the Primary Care Risk Register, including consideration of a proposed additional risk.

Members discussed the potential impact of proposed GP collective action and considered the consequences for primary care services and wider health system capacity. It was noted that any reduction in activity delivered within general practice could increase demand on urgent and secondary care services.

The Committee reviewed the current risk scoring and agreed that, whilst the situation required ongoing monitoring, the existing score remained appropriate at the present time.

Members agreed that detailed comments on individual risks would be submitted outside of the meeting to allow further refinement of the register.

Actions

1. CL and SH to collect member feedback on the risk register and bring back a revised version to the committee at a future meeting (December)
2. Monitor the impact of GP collective action and review risk scoring at a future meeting if required.

The Committee noted the report and supported retention of the current risk ratings, subject to ongoing review.



Finance & Prescribing Assurance

SPCC 26/05/B08 Finance Update

The Head of Primary Care Finance presented the Month 4 financial position.

GP Patient List Validation

Members were advised that ongoing patient list validation activity had identified a reduction of approximately 6,079 patients across Cheshire and Merseyside. This resulted in a corresponding reduction in General Medical Services funding of approximately £1.3 million.

The Committee discussed the implications for practices and noted that concerns had been raised nationally through NHS England and Local Medical Committee channels.

Prescribing Financial Position

The prescribing budget remained under pressure, with a £2.2 million year-to-date overspend reported. Members heard that National Concessionary Stock-Out costs continued to be a significant factor and that pressures could increase further during the remainder of the financial year.

Dental Financial Position

Members received an update on the dental budget and noted the availability of funding arising from previous-year allocations and in-year underperformance.

Discussion focused on opportunities to utilise available funding to improve access, address inequalities and maximise patient benefit. Members emphasised the importance of ensuring any additional investment was targeted towards areas demonstrating greatest need.

GP Reimbursement Scheme

The Committee reviewed uptake of the GP reimbursement scheme and noted that utilisation remained below expected levels.

Members acknowledged that practices had only recently completed recruitment activity and that implementation was still developing. Concerns were also raised regarding restrictions attached to the national scheme and their impact on local delivery.

Actions

1. Provide a future paper setting out available dental funding, commissioning options and opportunities for increased access activity.
2. Continue monitoring uptake of the GP reimbursement scheme and encourage practices to maximise use of available funding.

The committee noted the financial position and ongoing mitigation plans.

SPCC 20/08/B09 Prescribing Assurance Update

The Chief Pharmacist presented the prescribing assurance report.

Members heard that delivery of prescribing efficiency and cost reduction programmes remained on track and continued to contribute towards financial recovery objectives.

An update was provided regarding national medicine supply challenges and the impact of national pricing concessions on a number of commonly prescribed medicines in primary care. Members were advised that these pressures were affecting systems nationally and continued to create financial uncertainty of the primary care prescribing spend.

The Committee also received an update regarding work to support implementation of a national single formulary programme and the management of medication transitions following the discontinuation of Levemir insulin.



Discussion took place regarding medicines optimisation programmes, including therapeutic switching initiatives. Assurance was provided that clinical judgement along with individual patient consideration remained central to prescribing decisions and that alternative treatments.

Members highlighted concerns regarding practice understanding of prescribing budgets and recent funding changes.

Actions

1. Share prescribing deep-dive information considered by the Finance Committee.
2. Review communication arrangements to improve practice understanding of prescribing budgets and financial allocations.

The Committee noted the report and the assurances provided.

Commissioning and Performance

SPCC 20/08/B10 Integrated Primary Care Commissioning and Performance Update

The Director of Integrated Primary Care presented an update covering national developments, commissioning activity and performance monitoring arrangements.

Members received information regarding new NHS England requirements, commissioning developments and ongoing work to strengthen assurance arrangements across primary care services.

The Committee discussed proposals to streamline commissioning governance arrangements through the creation of larger commissioning groups out of the current 9 place based groups, and noted the ongoing arrangements for POD.

Discussion also took place regarding the balance between activity measures and quality outcomes within future performance reports. Members agreed that reporting should provide a comprehensive view of both service delivery and patient outcomes. It was noted that wider performance measurements that were reviewed at Board would form a standard part of this item in relation to primary care

Actions

1. Present revised commissioning governance arrangements and Terms of Reference for approval at the next meeting CL
2. Incorporate Quality from Committee members into future performance reports KL/FL
3. CL to speak to wider performance team in relation to including measurements as standard to reduce duplication and ensure committee is sited on the board reporti g.

The committee noted the report and supported the proposed direction of travel.

SPCC 20/08/B11 General Practice Patient Survey

The Committee reviewed findings from the latest GP Patient Survey.

Members noted that the survey methodology had remained consistent over a three-year period, allowing meaningful trend analysis to be undertaken.

The Committee discussed response rates and acknowledged that participation remained relatively low. Members agreed that survey findings should be considered alongside wider patient experience information, quality metrics and local intelligence.

Particular attention was drawn to ongoing concerns relating to access to GP appointments and NHS dental services, both of which continued to feature prominently within patient feedback.

Members recognised the value of the survey in highlighting areas requiring improvement and informing future quality and performance discussions.

The committee noted the survey findings.



Quality

SPCC 20/08/B12 Primary Care Quality Update

The Committee received a quality update covering developments in primary care quality assurance arrangements.

Members heard that work was underway to strengthen quality reporting through a more integrated approach combining patient experience, performance information, quality indicators and other intelligence sources.

The proposed model would support earlier identification of emerging concerns and enable targeted support for providers where required.

Members welcomed the development of a consistent system-wide approach to quality governance.

During the discussion, representatives highlighted the need to ensure appropriate engagement with the Local Dental Committee when developing future dental quality measures. It was noted that quality reporting within dentistry remained less mature than in some other sectors and that any future requirements would need to be proportionate and achievable.

Action

1. Ensure Local Dental Committee involvement in the development of future dental quality improvement initiatives. KL/FL/CL

The Committee noted the update and endorsed the proposed approach.

Any Other Business

The Chair advised members that the October meeting would be conducted virtually due to logistical considerations.

The Committee noted the update regarding future meeting arrangements.

CLOSE OF MEETING

Date of Next Meeting: Thursday 15 October 2026 (10.15-12:30) on teams



Action Log 2026/27

updated post August 2026 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 20/08/B11	20-Aug-26	Risk update	CL and SH to collect member feedback on the risk register and bring back a revised version to the committee	Chris Leese	17-Dec-26		New
SPCC 20/08/B16	20-Aug-26	Prescribing Assurance Update	Review communication arrangements to improve practice understanding of prescribing budgets and financial allocations.	Susanne Lynch	17-Oct-26		New
SPCC 20/08/B17	20-Aug-26	Integrated Primary Care Commissioning and Performance Update	Present revised commissioning governance arrangements and Terms of Reference for approval at the next meeting.	Chris Leese	17-Oct-26		Ongoing
SPCC 20/08/B18	20-Aug-26	Integrated Primary Care Commissioning and Performance Update	Incorporate quality from committee members into future performance reports.	Chris Leese	17-Dec-26		Ongoing
SPCC 20/08/B20	20-Aug-26	Primary Care Quality Update	Ensure Local Dental Committee involvement in the development of future dental quality improvement initiatives.	Kerry Lloyd/Fiona Lemmens/Chris Leese	17-Oct-26		New

Forward Planner 2025/26/27 : System Primary Care Committee

Updated October 2026

Item	Who	Frequency	Part A/B	Oct-25	Dec-25	Feb-26	Apr-26	Jun-26	Aug-26	Oct-26	Dec-26	Feb-27
Standing items												
Apologies	EM	Every meeting	Both	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Declarations of Interest	EM	Every meeting	Both	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Minutes of last meeting	EM	Every meeting	Both	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Action Log & Decision Log	EM	Every meeting	B	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Questions from the public (where received)	EM	Every meeting	B	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Forward Planner (pre meeting)	CL	Every meeting	B	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Governance & Performance of Committee												
Review of Terms of Reference	EM / MC	Yearly	n/a	No	No	No	No	No	No	tbc	tbc	tbc
Self-Assessment of Committee Effectiveness	EM	Yearly	n/a	No	No	No	No	No	Yes	No	tbc	tbc
Forward Planner Annual Plan Review	EM / CL	Yearly		No	No	No	No	No	Yes	No	tbc	tbc
Key Business Items												
Minutes of any ExtraOrd SPCC Meetings	EM/CL	If held	A	Yes	Yes	Yes	No	No	No	No	tbc	tbc
Committee Risk Register for 4 contractor groups	SH	Every Other Meeting usually	B	No	Yes -progress	Yes - update	Yes - update	No	Yes	no	Yes	no
Finance Update including Capital position	LWB	Every Meeting	A	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
PSRC Minutes/Update Minutes/Update from Pharmacy Operations Group and highlights	Contracting	Every Meeting	A	Yes	Yes	Yes	Yes	Yes	No	tbc	tbc	tbc
Prescribing position and risk	SL/CH	Every Meeting		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Patient Experience												
Deep Dive (s)				No	General Practice via Healthwatch and June Plan update	No	Dental	No	Yes GPPS	No	tbc	tbc
Assurance of progress of Primary Care Strategic Plans												
Estates Update	Estates	Alt	B	Yes	No	Yes	Yes	BC approval	No	General Update	tbc	tbc
Digital Strategy	JL	Alt	B	No	Yes	No	No	No	No	No	tbc	tbc
Workforce Strategy	JG	Alt	B	No	No	No	No	No	No	tbc	tbc	tbc
Priority Commissioning Area - Improving Access (Primary Medical)	CL	Alt	B	No	Yes	No	No	Yes as part of PCAP	Yes GPPS	Part of Commssioing Update	Sep Update	tbc
Priority Commissioning Area - Improving Access (Dental)	TK	Alt	B	Yes	No	No	Yes	Yes as part of PCAP	No	Part of Commssioing Update	Progress	Revised Plan
Priority Commissioning Area - Neighbourhood Health/Primary Care	CWA	Alt	B	Yes	Yes	Yes - paper (AL)	No	No	No	Yes	No	No
Commissioning , Quality and Performance												
Commissioning/Performance Update (All 4 contractor groups)	CL/TK	Every Meeting	B	Yes	Yes	Yes	Yes	Yes	Yes (includes governance update)	Yes - with new metrics from QP	Yes	Yes
Performance Issues (escalated from Place)	TBC	As required	A	Yes	Yes Part A	No	No	No	No	No	tbc	tbc
Quality - Report from PCQ plus any key performance metrics	LE/TK/CL	Every Meeting	B	Yes	Yes	Yes	No	metrics update part of PCAP paper and update in commissioning paper	Yes	No	tbc	tbc
Committee Budget SORD Delegations												
Capital bids across Estates and Digital	CF/LA/JB/KH	As required	A/B	Yes	Yes	Yes UMF inc digital	UMF part A	x1 bc approval	No	tbc	tbc	tbc
Improvement Grant Estates Bids	JA	As required	B	No	No	No	No	No	No	tbc	tbc	tbc
Primary Care Business cases / approvals required from Place	TBC	As required	A/B	Yes x 1	No	No	No	No	No	tbc	tbc	tbc
Ad Hoc Items for tracking/follow up												
Primary Care Governance	BV/CWA		A					Verbal/Part A	In commissioning update	Yes	progress	No
Enhanced Services Review and recommendations	JG/CL/LWB		B			No	part of policy update	Yes	Yes - decision	No	Yes update	No

Dental Paper – Operational/Contract Part Year performance note	TK		A	Yes	No	Yes	No	No	No	No	Yes Part A	No
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System Primary Care Committee (SPCC) Revised

Terms of Reference

Agenda item:	7.0
Date:	Thursday 15 th October 2026
Author:	Sallyanne Hunter
Responsible Director:	Ben Vinter Executive Director of corporate Services and Governance

1. Purpose

The purpose of this paper is to present the refreshed Terms of Reference (ToR) to System Primary Care Committee for approval.

2. Ask of the Committee and Recommendations

The Committee is asked to:

1. Endorse the approach taken to review and update all committee Terms of Reference.
2. Approve the revised Terms of Reference

3. Executive Summary

Following the recent review of the ICB governance structure, all committee Terms of Reference have been comprehensively reviewed and updated. This work has been undertaken to ensure that the governance framework remains fit for purpose, reflects the revised governance arrangements, and appropriately supports the delivery of the organisation's statutory responsibilities and strategic objectives.

The review has also considered the impact of organisational and management of change, ensuring that committee responsibilities, reporting arrangements, membership, and delegated authorities accurately reflect current operational and governance requirements.

In addition, the review provided an opportunity to incorporate learning and feedback from the recent Committee Effectiveness Survey. The findings from the survey have been used to strengthen and clarify the Terms of Reference, enhancing committee effectiveness, accountability, and oversight arrangements.

A key objective of the review was to achieve greater consistency across all committee Terms of Reference. A standardised template and format have therefore been adopted, together with harmonised wording where appropriate, to support clarity, transparency, and ease of reference while recognising the distinct purpose of each committee.

4. Background

A review of the governance structure has been undertaken. The outcome of this review has resulted in a refreshed committee architecture designed to support effective oversight, assurance, and decision-making across the ICB.

To support the implementation of these changes, all committee Terms of Reference have been reviewed against:

- The refreshed governance structure.
- Current statutory and regulatory requirements.
- Organisational and management of change impacts.
- Committee effectiveness survey findings and recommendations.
- Good governance practice.
- The need for consistency and alignment across all governance committees.

5. Key Changes

The revised Terms of Reference reflect the following key changes:

- Alignment to the refreshed ICB governance and committee structure.
- Updates to committee purpose, responsibilities, delegated authority, membership, and reporting arrangements where required.
- Incorporation of changes arising from management of change activity and organisational developments.
- Adoption of a standardised template and format across all committees.
- Strengthening of provisions informed by Committee Effectiveness Survey feedback.
- Greater consistency in governance language, terminology, and committee operating arrangements across all Terms of Reference.

6. Benefits

The review and refresh process provides a number of benefits, including:

- Clearer governance arrangements and accountability.
- Improved alignment between committees and organisational priorities.
- Enhanced committee effectiveness through the incorporation of survey feedback and learning.
- Greater consistency across committee documentation.
- Improved transparency and understanding of committee roles, responsibilities, and decision-making authority.
- A governance framework that is better equipped to support the organisation through ongoing change and development.

7. Appendices

Appendix 1: Revised Committee Structure

Appendix 2: Updated Committee Terms of Reference

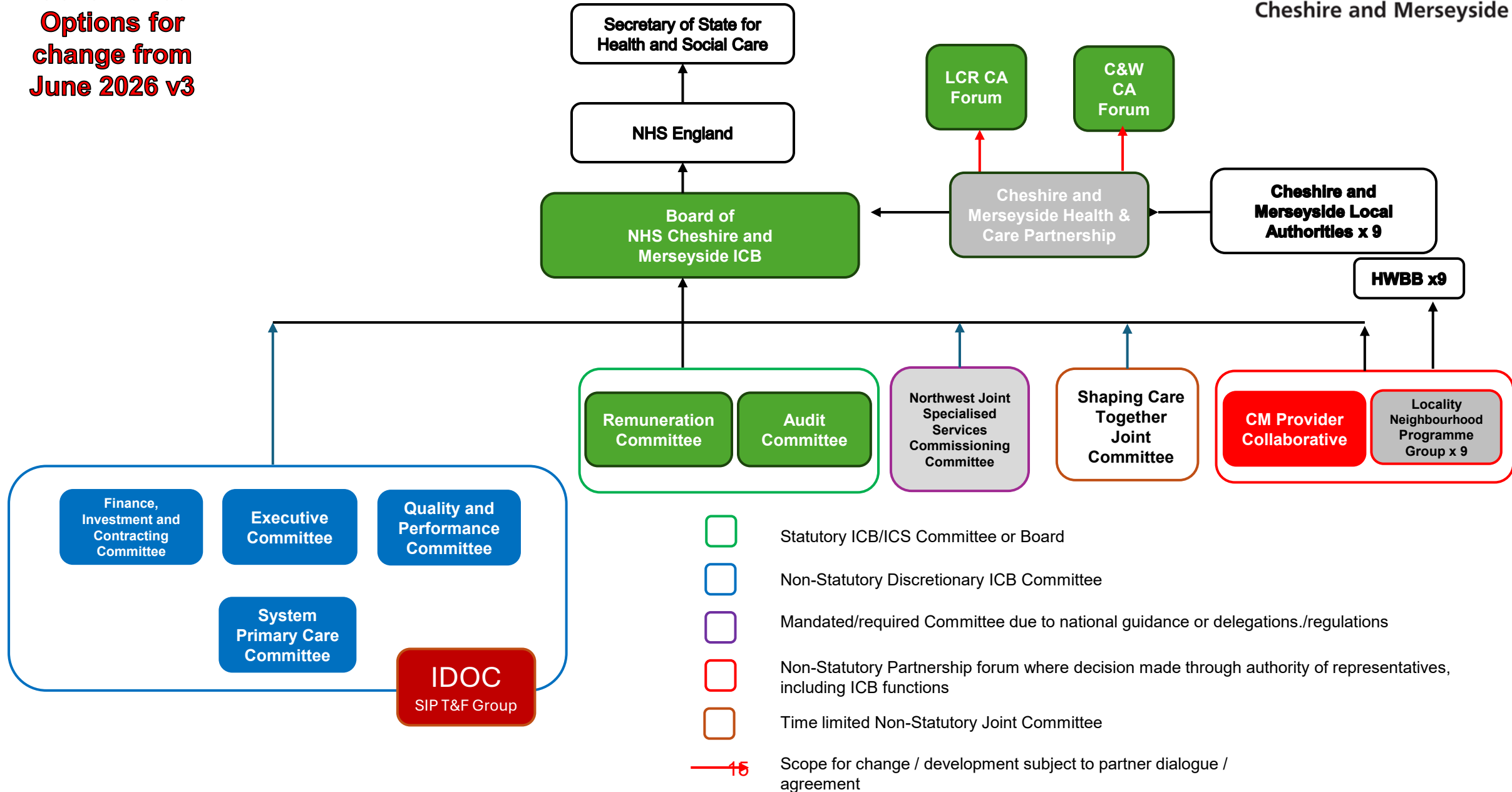
Appendix 3: Summary of Key Changes

Appendix 4: Executive Summary – SPCC Effectiveness Survey

**C&M ICB
Governance
Options for
change from
June 2026 v3**



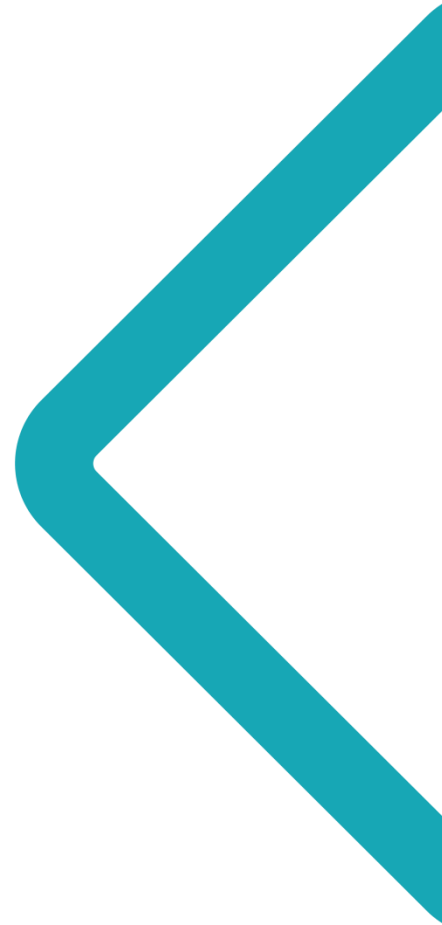
Cheshire and Merseyside



NHS Cheshire and Merseyside Integrated Care Board

System Primary Care Committee

Terms of Reference



Document revision history

Date Approved by Board	Version	Revision	Comment	Author / Editor
January 2022	V1.0	Initial ToRs		Ben Vinter
25.8.2022	V1.1		Revisions following first meeting of System Primary Care Committee	Christopher Leese
October 2023	V1.2		Revisions following October 2023 meeting of System Primary Care Committee	Matthew Cunningham
June 2026	V1.3		Updated ToR format, job titles following internal Management of Change and update of ICB Governance Structure	Sallyanne Hunter

Review due: September 2027
V1.0 approved by the ICB Board on **xx**

System Primary Care Committee

TERMS OF REFERENCE

Constitution	The System Primary Care Committee (the Committee) is established by the Board of NHS Cheshire and Merseyside Integrated Care Board (“the Board” or “ICB”) as a Committee of the Board and in accordance with its Constitution, Standing Orders, Standing Financial Instructions and its Scheme of Reservation and Delegation (SORD). The Committee has been established to enable collective decision-making on review, planning, procurement, commissioning and management of primary care services in relation to primary medical services, community pharmacy, primary dental and primary (General Practice) ophthalmic services in accordance with the ICB’s statutory commissioning responsibilities across Cheshire and Merseyside and its functions exercised under delegated authority from NHS England. In performing its role, the Committee will exercise its functions in accordance with the delegation agreement entered into between NHS Cheshire and Merseyside and NHS England (NHSE). ¹ The Committee will also provide oversight and assurance to the Board of the effective planning and provision of primary care services across Cheshire and Merseyside. In undertaking its responsibilities, the Committee will focus on strategic oversight, assurance and decision-making relating to the commissioning, quality, performance and transformation of primary care services. The Committee shall not routinely undertake operational management activities, except where specifically required under delegated commissioning arrangements or where assurance concerns necessitate detailed oversight. The Committee will seek to maintain an appropriate balance between: • strategic development of primary care services; • assurance regarding delivery, quality, finance and performance; • statutory commissioning responsibilities; and • operational decision-making required under delegated authority. Providing assurance involves: • Triangulating multiple sources of appropriate internal and external information, including: • Data analysis and contract performance intelligence • Patients’, service users’ and carers’ reports, surveys, complaints, and concerns
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	• Evidence from key system leaders • Other intelligence agreed to be important and reliable. • Remedial action: Where assurance cannot be provided in part or in full, to provide the Board with details of remedial actions being taken and or being recommended. • Considering efficacy and efficiency: Things are not only in place, but the right things are being done in the right way to achieve the right objectives, which support the ICS aims. The functions of the Committee are undertaken in line with NHS Cheshire and Merseyside desire to promote an increase quality, efficiency, productivity, and value for money and to remove administrative barriers. ¹ https://www.cheshireandmerseyside.nhs.uk/media/cyknidfl/cm-primary-care-and-dental-delegation-agreement-2023-final-version-issued-230323.pdf
Membership	The Committee members drawn from the Board of NHS Cheshire and Merseyside shall be appointed by the Board. Committee members drawn from outside of the Board of NHS Cheshire and Merseyside shall be appointed by the Committee, in line with the approved membership outlined within the TOR. The membership shall consist of the following voting members: • at least two ICB Non-Executive Members (Chair and Deputy Chair) • at least one ICB Partner Member • ICB Executive Director of Health & Integrated Care Commissioning (or Deputy) • ICB Chief Nursing Officer and/or ICB Clinical Director • ICB Director of Finance (Primary Care, MH and AACC) • Programme Director – Neighbourhood & Community Development • Chief Pharmacist (or appropriate deputy) In attendance by invitation (non-voting): • Head of Integrated Primary Care Commissioning (Cheshire and Warrington) • Head of Integrated Primary Care Commissioning (Liverpool City Region) • Associate Director of Integrated Primary Care • ICB Associate Medical Director for Primary Care & Neighbourhoods • Head of Primary Care Finance • Healthwatch nominated representative • Public Health representative • Local Medical Committee (LMC) representative • Pharmaceutical Services Regulations Committee (PSRC) representative • LOC (Local Optical Committee) representative • LDC (Local Dental Committee) representation • LPC (Local Pharmacy Committee) representation • Membership of other Professional Groups to be agreed/discussed further dependant on agenda item.

	All Committee members may appoint a deputy to represent them at meetings of the Committee. Committee members should inform the Chair of their intention to nominate a deputy to attend/act on their behalf and any such deputy should be suitably briefed and suitably qualified (in the case of clinical members). The Committee may also request attendance by appropriate individuals to present agenda items and/or advise the Committee on particular issues. The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these Terms of Reference. If the Chair or Deputy Chair, is unable to attend a meeting, they may designate an alternative ICB member to act as Chair. If the Chair is unable to chair an item of business due to a conflict of interest, another member of the committee will be asked to chair that item.
Attendance	The Committee will normally meet in private. However, where there is a requirement to undertake patient consultation in public, this will be taken into consideration when determining whether a meeting, or part of a meeting, should be held in public. Only members of the Committee have the right to attend Committee meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the Committee. Meetings of the Committee may, with the Chair's approval, also be attended by other individuals who are not committee members, for all or part of the meeting, where appropriate. The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters. The Committee shall be supported with a secretariat function. Duties will include: • ensuring the agenda and papers are distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant Director lead • ensure records of declarations of interest are maintained and made available to the Chair • ensure good quality minutes are taken in accordance with the ICBs standing orders and Corporate Standards Manual and agreed with the Chair • ensure minutes of the meeting will be circulated to all Committee members within 7 working days of the meeting,

	highlighting actions to be undertaken by individual members • keep a record of matters arising, action points and issues to be carried forward • keep a record of the decisions made under the authority of the Committee or made at Committee meetings • The Committee will promote the use of digital solutions, standardised reporting and continuous improvement approaches to support efficient governance and maximise the value derived from committee business.
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Quorum	A meeting of the Committee is quorate if the following are present: • at least four Committee members in total, including; • at least one ICB Non-Executive Member or ICB Partner Member • at least one Clinically qualified Member • at least two ICB Directors (or their nominated deputies). If the named Chair, or Deputy Chair, are both unable to attend a meeting, and the meeting is required to proceed on the agreed date, then an alternative suitably experienced ICB Non-Executive Member will be asked Chair the meeting. Where these quorum requirements are unable to be met the meeting date will be rearranged. If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum. If on an occasion a committee meeting is due to start but the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken. Alternatively, the meeting can be called to a halt and an agreement reached to rearrange an additional meeting.
Frequency/ Duration	The Committee will normally meet up to six times each year and arrangements and notice for calling meetings are set out in the ICB Standing Orders. Additional meetings may take place as required. The Board, ICB Chair, Committee Chair, or Chief Executive may ask the Committee to convene further meetings to discuss particular issues on which they want advice. In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.
Authority	The Committee will work collaboratively with other Board committees and governance groups to ensure clear accountability and avoid duplication.

Attention will be given to maintaining clarity of responsibility between the System Primary Care Committee and:

- Quality and Performance Committee;
- Finance, Investment and Contracting Committee;
- Neighbourhood Health Committee (or successor arrangements);
- Locality-based governance structures;
- Liverpool City Region and Cheshire & Warrington Primary Care Sub-Committees.

The Board of the ICB has delegated authority to the Committee as set out in these Terms of Reference and the ICB SORD, and which may be amended from time to time. Delegations are in line with the ICBs functions within the ICB Constitution and NHS Act 2006 (Annex One) and its delegated functions from NHSE (Annex Two). The Committee is also subject to any directions made by NHSE or by the Secretary of State for Health and Social Care.

The Committee is authorised by the Board to:

- investigate and approve any activity as outlined within its terms of reference
- seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these terms of reference
- commission any reports it deems necessary to help fulfil its obligations
- obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice
- establish sub-committees in order to undertake any of the functions of the Committee were considered appropriate and/or necessary by the Committee. The Committee has the authority to agree the Terms of Reference of these sub-committees, including approving any decision-making authority that is normally reserved to the Committee and that can be delegated to and undertaken by the sub-committee and its members, in accordance with the ICB's constitution, standing orders, standing financial instructions, SORD and OSORD. This authority will be outlined within a decision-making matrix, approved by and overseen by the Committee. Decisions undertaken by these sub- committees will be reported back to the Committee
- approve named positions within the ICB with the delegated authority to undertake any of the functions of the Committee were considered appropriate and/or necessary by the Committee, in

	accordance with the ICB's constitution, standing orders, standing financial instructions, SORD and OSORD. This authority will be outlined within a decision-making matrix, approved by and overseen by the Committee. Decisions undertaken by these individuals for and on behalf of the Committee will be reported back to the Committee • establish task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups • commission, review and approve policies where they are explicitly related to areas within the remit of the Committee as outlined within the TOR, or where specifically delegated to the Committee by the ICB Board. For the avoidance of doubt, in the event of any conflict, the ICB Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation will prevail over these terms of reference The Committee provides a report on its activities with financial consequences to the next appropriate FICC to support triangulation. Decision-making and voting: Decisions will be taken in accordance with the Standing Orders and within the authority as delegated to the Committee, and as outlined within the ICBs SORD and Standing Financial Instructions. The Committee will ordinarily make decisions by consensus. Where this is not possible, the Chair may call a vote. Only voting members, as identified in the "Membership" section of these terms of reference, may cast a vote. Each member is allowed one vote and a majority will be conclusive on any matter. A person attending a meeting as a deputy of a Committee member shall have the same right to vote as the Committee member they are representing. In accordance with ICB policy, no member (or deputy) with a conflict of interest in an item of business will be allowed to vote on that item. Where there is a split vote, with no clear majority, the Chair will have the casting vote. If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication. Decisions will be recorded and formally minuted and ratified at a subsequent formal meeting of the Committee.
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Duties	The duties of the Committee will be driven by the organisation's strategic objectives and the associated risks. An annual programme of business will be agreed before the start of the financial year; however, this will be flexible to new and emerging priorities and risks. In carrying out its role, the Committee will work alongside any of its established sub-committees where decision making authority has been delegated. These sub-committees will also provide regular reports to the Committee outlining what activity and decision have been undertaken. The Committee will provide regular assurance updates to the Board in relation to activities and items within its remit, as well as provide the Board with any items for escalation. Commissioning of Primary (GP) Medical Services: The Committee shall approve decisions on the review, planning, procurement, commissioning and management of primary medical (GP) services, subject to any decision-making authority that is delegated by the Committee to sub-committees. The Committee shall establish two sub-committees across the nine local authority footprints of Cheshire and Merseyside: the Liverpool City Region Primary Care Sub Committee and the Cheshire & Warrington Primary Care Sub Committee. These sub-committees will undertake any functions, responsibilities and decisions of the Committee relating to primary medical care services considered appropriate and/or necessary to be exercised at a local level. The Committee will agree the Terms of Reference of these sub-committees, including approval of any delegated decision-making authority. Such decision-making authority will be set out within a decision-making matrix approved by, and subject to oversight from, the Committee. The Committee shall oversee, coordinate and promote alignment of the functions exercised through the Liverpool City Region Primary Care Sub Committee and the Cheshire & Warrington Primary Care Sub Committee across the nine local authority footprints of Cheshire and Merseyside relating to the commissioning of primary medical (GP) services (the ICB's statutory functions under the NHS Act 2006 and the functions delegated from NHS England). This includes the following: • Develop a system-wide Primary Care Strategy including implementing the GP Forward View, or successor, through robust contractual arrangements with general practices and appropriate developmental support. • Review and consider the aggregate position of agreed service specifications and contractual proposals for all NHS C&M commissioned services from primary care providers • Develop outline framework/ expectations in regard to GMS, PMS
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	and APMS contracts (including the oversight and monitoring of contracts, approving material contractual action such as removing a contract) • Oversee the system obligations in relation to the Delegation Agreement with NHS England and the Policy and Guidance Manual and other-directed enhanced service type national regulatory frameworks as centrally mandated. • Oversee the strategic direction for newly designed enhanced services and agree new specifications where appropriate • Performance monitoring, oversight and assurance on agreed schemes and services, and compliance to NHSE; escalating issues on to NHSE in line with first level Delegation • Making recommendations related to alignment of decisions on 'discretionary' payment in • Local Authority Footprint (e.g., returner/retainer schemes). • Co-ordinate a common approach to the commissioning, contracting and delivery of primary care services • Manage the overall budget for commissioning of primary care services, including delegated rents and rates in line with Premises Directions. • Overseeing delivery of national primary medical services policy at system level and ensuring compliance at place level. Commissioning of Community Pharmacy. The Committee shall: • Develop outline framework/ expectations in regard to Community Pharmacy, essential, advanced and national enhanced services, including associated budgets, quality assurance and all existing NHSEI functions. • Develop and agree local discretionary/ non-core schemes. • Oversee national Community Pharmacy policy at system / local level. • Maintain oversight of the arrangement for pharmaceutical services commissioning, including receiving assurance on the work and decisions of the Pharmaceutical Services Regulations Committee (PSRC) where appropriate. Commissioning of Dental Services. The Committee shall: • Develop outline framework/ expectations regarding the national general dental, community, personal dental and orthodontic contracting, overseeing the central contracting function is discharged in line with the Dental Policy Book and national rules/frameworks • Responsible for overseeing national dental policy at ICB system and local level • Develop and agree local improvement schemes to support delivery of the national contract and policy asks. Commissioning of Optometry. The Committee shall: • Develop outline framework/ expectations regarding the national
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	general ophthalmic services (GOS) contractual regulations and policy • Responsible for overseeing national GOS policy at ICB system and local level • Develop and agree local improvement schemes to support delivery of the national contract and policy asks. Additional responsibilities. The Committees additional responsibilities include: • Support Primary Care development across Cheshire & Merseyside including oversight of: • Primary care networks (PCNs) ongoing development as the foundations of out-of-hospital care and building blocks of place-based partnerships • Workforce, resilience and sustainability • Maximisation of GP Contract opportunities such as ARRS (Additional roles) and QOF outcomes • Plan, including needs assessment, for primary care services across Cheshire & Merseyside and to support planning at scale for primary care • Have oversight of the development of an integrated Estates programme across Cheshire & Merseyside and at local level using flexibilities available through PCN arrangements, mixed estates with other partners, premises improvement grants and capital investment monies • To consolidate risk reviews of primary care services, aggregating findings and supporting solutions/ mitigations. • The Committee shall receive and review assurance relating to the quality and safety of primary care services, including information provided by the Quality and Performance Committee and other governance forums. • The Committee shall ensure there is clear oversight of quality risks relevant to primary care commissioning and shall escalate significant concerns to the Board where required. • To ensure contract proposals achieve health improvement and value for money • To oversee quality and safety of services delivered in primary care receiving regular reports from the ICB Quality and Performance Committee and Finance, Investment and Contracting Committee providing updates and assurance on primary care related quality, finance and performance issues • Ensure that conflicts of interest have been mitigated in line with the NHS C&M Conflicts of Interest Policy, and all actions/ decisions involving consultation with Committee members or GPs will record any declarations of interest. • Ratifying time limited recommendations made by the through locality specific decision making relating to this committee's remit or determining to 'call-in' such a recommendation and provide an alternative course of action.
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	Risk Management. The Committee will also ensure the appropriate management of risks in relation to primary care; receiving regular reporting of primary care related Corporate Risks, and relevant Board Assurance Framework (BAF) risk – these will include reference to relevant sub-committee Delivery Assurance risks – both strategic and corporate as per NHS C&M Risk Management Strategy.
Reporting	The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities. The Chair will provide assurance reports to the Board at the subsequent meeting of the Board following a meeting of the Committee and shall draw to the attention of the Board any issues that require disclosure to the Board or require action. Confirmed minutes of the Committee will be made available to the Board. The Committee Chair will ensure that there is an annual review of the effectiveness of the Committee, with key findings and improvements report as part of Committee Annual Report. The Committee will provide a key issues report to the Liverpool City Region Primary Care Sub Committee and the Cheshire & Warrington Primary Care Sub Committee and will receive a corresponding report from each sub-committee. The Committee will provide the Board with an Annual Report timed where possible to support finalisation of the ICB Annual Report and Accounts. The report will summarise its conclusions from the work it has done during the year. The outputs of the group may be reported to NHSE/supporting assurance, awareness and interaction.
Conduct	Members of the Committee will be expected to act consistently with existing statutory guidance, NHS Standards of Business Conduct and any other relevant organisational policies. Members should act in accordance with the Nolan Principles (the Seven Principles of Public Life). Committee Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB. Members are expected to actively contribute to discussion, scrutiny

	and constructive challenge and to prepare adequately for meetings through review of papers in advance. Members should refer to and act consistently with the ICBs Conflicts of Interest Policy and NHS England guidance: Managing Conflicts of Interest in the NHS: Guidance for staff and organisations. Where any member or regular attendee of the Committee has an actual or potential conflict of interest in relation to any matter under consideration by the Committee, that individual must raise this with the Chair of the meeting (in advance where possible to do so) or at the meeting before the agenda item is considered. The Chair will look to determine whether or not that individual participates in the meeting (or part of the meeting) in which the relevant matter is discussed, either by participating in discussion or by voting. A Committee Member or regular participant who is materially conflicted may secure that their appointed substitute attends the meeting (or part of meeting) in the place of that individual if it is to either support quoracy arrangements or the discussion to be undertaken regarding that item. All incidences of declarations made will be recorded and maintained within the ICBs declaration registers. Any breaches with regards to the management of conflicts of interest must also be recorded and reported to the Executive Director corporate Services & Governance. Members of, and those attending, the Committee shall behave in accordance with the Constitution, Standing Orders, and Standards of Business Conduct Policy of each of the partner ICBs. Members must demonstrably consider the equality, diversity, and inclusion implications of decisions they make.
Other Matters	Review The Committee will review its effectiveness at least annually. These terms of reference will be reviewed at least annually and earlier if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Review Date September 2027

Annex One: Statutory Framework

The Health and Care Act 2022 amends the NHS Act 2006 by inserting the following provisions:

13YB Directions in respect of functions relating to provision of services

- (1) NHS England may by direction provide for any of its relevant functions to be exercised by one or more integrated care boards.
- (2) In this section “relevant function” means—
 - (a) any function of NHS England under section 3B(1) (commissioning functions);
 - (b) any function of NHS England, not within paragraph (a), that relates to the provision of—
 - (i) primary medical services,
 - (ii) primary dental services,
 - (iii) primary ophthalmic services, or
 - (iv) services that may be provided as pharmaceutical services, or as local pharmaceutical services, under Part 7;
 - (c) any function of NHS England by virtue of section 7A or 7B (exercise of Secretary of State’s public health functions);
 - (d) any other functions of NHS England so far as exercisable in connection with any functions within paragraphs (a) to (c).

82B Duty of integrated care boards to arrange primary medical services

- (1) Each integrated care board must exercise its powers so as to secure the provision of primary medical services to such extent as it considers necessary to meet the reasonable requirements of the persons for whom it has responsibility.
- (2) For the purposes of this section an integrated care board has responsibility for— (a) the group of people for whom it has core responsibility (see section 14Z31), and (b) such other people as may be prescribed (whether generally or in relation to a prescribed service).

In exercising its functions, NHS C&M must comply with the statutory duties set out in NHS Act, as amended by the Health and Care Act 2022, including:

Having regard to and acting in a way that promotes the NHS Constitution (section 2 of the Health Act 1989 and section 14Z32 of the 2009 Act);

Exercising its functions effectively, efficiently, and economically (section 14Z33 of the 2006 Act);

- section 14Z34 (improvement in quality of services),
- section 14Z35 (reducing inequalities),
- section 14Z38 (obtaining appropriate advice),
- section 14Z40 (duty in respect of research),
- section 14Z43 (duty to have regard to effect of decisions)
- section 14Z44 (public involvement and consultation),
- sections 223GB to 223N (financial duties), and
- section 116B(1) of the Local Government and Public Involvement in Health Act 2007 (duty to have regard to assessments and strategies).

In addition, NHS C&M will follow the Procurement, Patient Choice and Competition (no2) Regulations 2013 and any subsequent procurement legislation that applies to the ICB.

Annex Two: Schedule 1 – Delegated Functions

- A. Decisions in relation to the commissioning, procurement, and management of Primary Medical Services Contracts, including but not limited to the following activities:
 - decisions in relation to Enhanced Services
 - decisions in relation to Local Incentive Schemes (including the design of such schemes)
 - decisions in relation to the establishment of new GP practices (including branch surgeries) and closure of GP practices
 - decisions about 'discretionary' payments
 - decisions about commissioning urgent care (including home visits as required) for out of area registered patients.
- B. The approval of practice mergers
- C. Planning primary medical care services in the Area, including carrying out needs assessments
- D. Undertaking reviews of primary medical care services in the Area
- E. Decisions in relation to the management of poorly performing GP practices and including, without limitation, decisions, and liaison with the CQC where the CQC has reported non- compliance with standards (but excluding any decisions in relation to the performers list)
- F. Management of the Delegated Funds in the Area
- G. Premises Costs Directions functions
- H. Co-ordinating a common approach to the commissioning of primary care services with other commissioners in the Area where appropriate; and
- I. Such other ancillary activities as are necessary in order to exercise the Delegated Functions.

SCHEDULE 2 – RESERVED FUNCTIONS OF NHSE

- A. Management of the national performers list
- B. Management of the revalidation and appraisal process
- C. Administration of payments in circumstances where a performer is suspended and related performers list management activities
- D. Capital Expenditure functions
- E. Public Health Section 7A functions under the NHS Act
- F. Functions in relation to complaints management
- G. Decisions in relation to the Prime Minister's Challenge Fund; and
- H. Such other ancillary activities that are necessary in order to exercise the Reserved Functions.

Appendix 3 - SPCC – Proposed Changes to the Terms of Reference:

Please note: Updated any reference to Places

Constitution:

- Additional paragraph following effectiveness survey:

In undertaking its responsibilities, the Committee will focus on strategic oversight, assurance and decision-making relating to the commissioning, quality, performance and transformation of primary care services. The Committee shall not routinely undertake operational management activities, except where specifically required under delegated commissioning arrangements or where assurance concerns necessitate detailed oversight.

The Committee will seek to maintain an appropriate balance between:

- strategic development of primary care services;
- assurance regarding delivery, quality, finance and performance;
- statutory commissioning responsibilities; and
- operational decision-making required under delegated authority.

Membership:

- Updated job titles and membership following MoC
- Removed Independent GP
- Added additional sentences for consistency across all terms of reference:
 - If the chair, or Deputy Chair, is unable to attend a meeting, they may designate an alternative ICB member to act as Chair.
 - If the chair is unable to chair an item of business due to a conflict of interest, another member of the committee will be asked to chair that item.

Attendance:

- Added additional sentence for consistency across all terms of reference:
- Paragraph has been refreshed:
 - The Committee will normally meet in private. However, where there is a requirement to undertake patient consultation in public, this will be taken into consideration when determining whether a meeting, or part of a meeting, should be held in public.
- Consistent paragraph replaced in all terms of reference with regard to the secretariat function.
- Additional bullet point following effectiveness survey:
 - The Committee will promote the use of digital solutions, standardised reporting and continuous improvement approaches to support efficient governance and maximise the value derived from committee business.

Authority:

- New paragraph following effectiveness survey:
 - The Committee will work collaboratively with other Board committees and governance groups to ensure clear accountability and avoid duplication.

Attention will be given to maintaining clarity of responsibility between the System Primary Care Committee and:

- Quality and Performance Committee;
 - Finance, Investment and Contracting Committee;
 - Neighbourhood Health Committee (or successor arrangements);
 - Locality-based governance structures;
 - Liverpool City Region and Cheshire & Warrington Primary Care Sub-Committees.
- Added a sentence for consistency across the terms of reference:
 - For the avoidance of doubt, in the event of any conflict, the ICB Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation will prevail over these terms of reference

Duties:

- Additional sentence following effectiveness survey:
 - The duties of the Committee will be driven by the organisation's strategic objectives and the associated risks. An annual programme of business will be agreed before the start of the financial year; however, this will be flexible to new and emerging priorities and risks.
- Paragraph updated following management of change:
 - The Committee shall establish two sub-committees across the nine local authority footprints of Cheshire and Merseyside: the Liverpool City Region Primary Care Sub Committee and the Cheshire & Warrington Primary Care Sub Committee. These sub-committees will undertake any functions, responsibilities and decisions of the Committee relating to primary medical care services considered appropriate and/or necessary to be exercised at a local level. The Committee will agree the Terms of Reference of these sub-committees, including approval of any delegated decision-making authority. Such decision-making authority will be set out within a decision making matrix approved by, and subject to oversight from, the Committee.

- Added paragraph under Commissioning of Community Pharmacy:
 - Maintain oversight of the arrangement for pharmaceutical services commissioning, including receiving assurance on the work and decisions of the Pharmaceutical Services Regulations Committee (PSRC) where appropriate.
- Additional bullet point following effectiveness review:
 - The Committee shall receive and review assurance relating to the quality and safety of primary care services, including information provided by the Quality and Performance Committee and other governance forums.
 - The Committee shall ensure there is clear oversight of quality risks relevant to primary care commissioning and shall escalate
- Updated paragraph in relation to Risk Management:
 - The Committee will also ensure the appropriate management of risks in relation to primary care; receiving regular reporting of primary care related Corporate Risks, and relevant Board Assurance Framework (BAF) risk – these will include reference to relevant sub-committee Delivery Assurance risks – both strategic and corporate as per NHS C&M Risk Management Strategy.

Reporting:

- Updated section in relation to consistency across all terms of reference.
- Updated reference to new sub committee structure:
 - The Committee will provide a key issues report to the Liverpool City Region Primary Care Sub Committee and the Cheshire & Warrington Primary Care Sub Committee and will receive a corresponding report from each sub-committee.

Conduct:

- Section extended for consistency across all terms of reference
- Additional sentence following effectiveness survey:
 - Members are expected to actively contribute to discussion, scrutiny and constructive challenge and to prepare adequately for meetings through review of papers in advance.

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

Primary Care Governance Update

Agenda Item No: 9.0

Responsible Director: Clare Watson
Executive Director of Health and Integrated Care Commissioning

1.0 Purpose of the Report

The purpose of this report is to provide the Committee with an update on changes to primary care governance, the overall direction of which was presented at the last meeting.

As requested, this paper includes the draft revised terms of reference for the two new primary care groups (Liverpool City Region and Cheshire and Warrington), which replace the previous nine place-based groups; a revised decision-making matrix for the new groups; and terms of reference for the new oversight and delivery group.

Attached with this paper are the following appendices

- Appendix 1 Terms of Reference for the new primary care groups
- Appendix 2 revised decision making matrix
- Appendix 3 Terms of reference – oversight and delivery group

2.0 Ask of the Committee and Recommendations

The Committee is asked to:

- **Note** the progress made to date on the governance arrangements.
- **Approve** the initial draft terms of reference and revised decision-making matrix for the new primary care groups.
- **Approve** the terms of reference for the new oversight and delivery group.
- **Note** that the terms of reference for the primary care groups will evolve further in line with the direction of travel for governance across all four contractor groups.
- **Note** that the terms of reference for the Pharmaceutical Services Regulatory Committee (PSRC) are currently being reviewed by the contracting team and will return for approval at a future meeting.

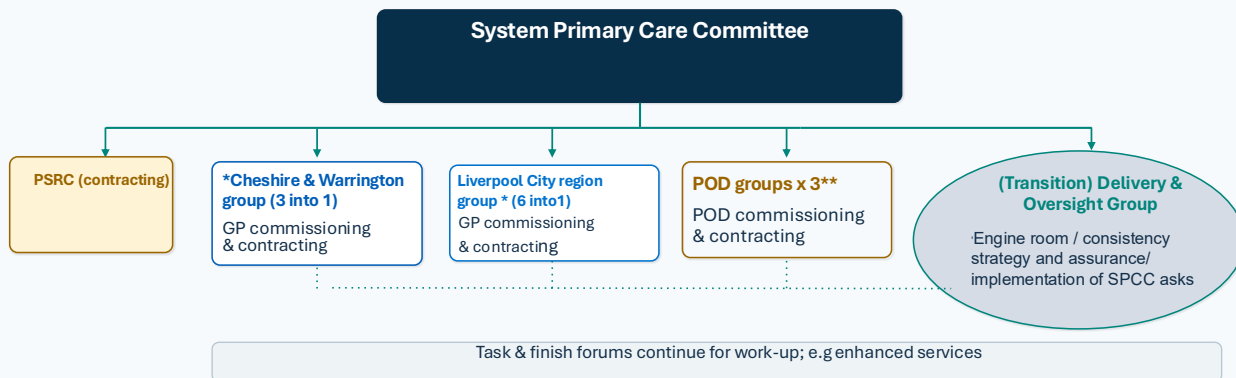
3.0 Executive Summary

3.1 During October, new governance arrangements were put in place to replace the previous nine primary care forums aligned to each place. Two primary care groups for medical commissioning and contracting decisions are now in place, aligned respectively to Cheshire and Warrington and the Liverpool City Region, and reporting to this Committee. These groups will be able to:

- agree and manage a range of decisions relating to areas such as the national medical Policy Book;
- manage variations, access issues and outliers;
- implement operational plans arising from the primary care action plan and related strategies;
- local contract and commissioning oversight;
- escalate matters and make recommendations on decisions that need to be taken by this Committee.
- triangulate issues with other teams within the ICB such as quality and estates.

- 3.2 To support these arrangements, revised terms of reference and a revised decision-making matrix, outlining which decisions can be taken at each forum, are attached to this paper. These documents do not override the Scheme of Delegation or Standing Financial Instructions. Some matters will therefore still need to be escalated to this Committee, with recommendations from the groups above, because of their financial value or for other reasons.
- 3.3 The membership and approach of the new groups differ from the previous arrangements, as the focus will be on the key decisions set out above. Outside these arrangements, there remains a need for wider engagement mechanisms and forums relating to, for example, neighbourhood health and primary care development across all four contractor groups, together with continued engagement with local representative committees.
- 3.4 The Pharmaceutical Services Regulatory Committee (PSRC) remains in place, as mandated. Its' membership and terms of reference are being reviewed to ensure that they reflect the new responsibilities of the commissioning and contracting teams. The Committee will be managed by the primary care contracting team, with commissioning representation.
- 3.5 A new primary care oversight and delivery group, comprising senior managers from primary care finance, contracting, medical and commissioning teams, is already in place to support the new governance approach. Having initially focused on transition issues, it will now operate as a senior delivery and oversight group that will:
- support strategic commissioning, consistency and delivery across the contractor groups, and strengthen cross-directorate working;
 - drive delivery of key strategies, including the primary care action plan, the dental improvement plan and the ICB's commissioning intentions;
 - oversee assurance returns and promote consistent, once-for-the-ICB approaches to primary care; and
 - drive action and delivery in key areas, supporting assurance to this Committee.
 - management / mitigation of risks to the above
- 3.6 For the time being, the POD (community pharmacy, optometry and dental) commissioning and operational decision groups will continue as they are. In due course, as relevant expertise is shared across the new teams, decisions currently taken by these groups will form part of the work of the two new primary care groups. A decision-making matrix will support escalation in line with the current arrangements for each contractor group. Operational groups may still be required beneath the new groups to support the development of key issues.
- 3.7 **Table 1** below illustrates the approach, including the planned transition of POD functions to the two new footprint groups over time.

Primary care governance structure:



*Decision remit: non-financial decisions Scheme of delegation / SFIs remain the formal authority via decision making matrix.

**Reviewed over time in respect of decisions made at the two new footprint groups and those at Delivery and Oversight, with operational groups below them. Some areas will still need to be escalated to System Primary Care Committee.

- 3.8 Due to necessity following officers assuming new roles and the need to ensure continuation of key areas and adhere timescales for certain areas, the new groups have already met but will develop further as outlined.

4.0 Next Steps

- 4.1 The groups will finalise membership and roles/responsibilities and areas as the ICB completes its management of change process and new operating model implementation. Working with the contracting team, a timeline for finalising movement of areas between the new groups will be agreed and an updated terms of reference and decision matrix will return to this committee in due course.

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

The paper supports delivery of the ICB's delegated duties in relation to primary care contracting. Effective and safe contracting supports the following wider themes:

- Tackling health inequalities in outcomes, experiences and access (including the eight Marmot principles);
- Improving population health and healthcare; and
- Enhancing productivity and value for money.

6.0 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

7.0 Risks

This paper supports the mitigation of the following BAF risks: P1, P4, P5, P6 and P8.

8.0 Finance

Any financial implications will be covered in the separate finance update to the Committee.

9.0 Communication and Engagement

No formal external consultation or further engagement is required in relation to this paper. Engagement duties are addressed in the national Policy Books for each contractor group and through nationally established duties on contractors. Any additional commissioner requirements would be outlined in this update.

10.0 Equality, Diversity and Inclusion

These duties are addressed in the national Policy Books for each contractor group and in nationally negotiated contract terms. Any additional commissioner requirements would be outlined in this update.

11.0 Officer contact details for more information

Clare Watson - Executive Director of Health and Integrated Care Commissioning

Clare.Watson@cheshireandmerseyside.nhs.uk

NHS Cheshire and Merseyside Integrated Care Board

Primary Care Group, (XXX Region)

Terms of Reference

-to be confirmed at meeting of System Primary Care Committee

Document revision history

Date Approved by Board	Version	Revision	Comment	Author / Editor
July 2026	V1.0	Initial ToRs		Caroline Lees
July 2026	V2.0	Revised TORs		Christopher Leese
September 2026	V3.0	Further revisions		Christopher Leese/Caroline Lees
October 2026	V4.0	Revision to frequency Consideration of quoracy to be discussed at SPCC		Christopher Leese

Review due: xx

Primary Care Group, XXX Region

TERMS OF REFERENCE

Constitution	The X Region Primary Care Group (PCG), the 'Group', is established by the Board of NHS Cheshire and Merseyside Integrated Care Board ("the Board" or "ICB") as a Sub-Group of the System Primary Care Committee (SPCC), and in accordance with its Constitution, Standing Orders, Standing Financial Instructions and its Scheme of Reservation and Delegation (SORD). The Group has been established as part of the new Operating Model for Cheshire and Merseyside. The Group replaces the previous Place Primary Care governance structures and will operate as a new combined group for Primary Medical Services across the footprint of : • X places The Group will support the delivery of system priorities across X region and provide advice, oversight and assurance to the System Primary Care Committee (SPCC) and Integrated Primary Care Oversight Delivery Forum. In performing its role, the Group will exercise its functions in accordance with the delegation agreement entered into between NHS Cheshire and Merseyside and NHS England (NHSE) with regards to Primary Medical Services. The Group will: • Make decisions where delegated to it by the System Primary Care Committee • Support the implementation of the Cheshire and Merseyside Primary Care Strategy • Oversee / operationalise delivery of agreed programmes across x region • Promote consistency of approach • Identifying emerging risks, opportunities and innovation • Provide recommendations to the SPCC • Support operational and contracted delivery and escalation The group has no delegated financial decision-making authority and does not approve expenditure, contracts or commissioning and procurement decisions where a value is attached. The Group has delegated authority to make decisions in relation to core primary care operations as outlined within Appendix A. The group will operate within the new financial governance arrangements
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	of the ICB. The functions of the Group are undertaken in line with NHS Cheshire and Merseyside desire to promote an increase quality, efficiency, productivity, and value for money and to remove administrative barriers.
Membership	Group members will be representative of the primary medical workforce, independent representatives and the ICB across the X footprint. All Group members may appoint a deputy to represent them at meetings. Members should inform the Chair of their intention to nominate a deputy to attend or act on their behalf, and any deputy should be suitably briefed and appropriately qualified where clinical input is required. The Group may also request attendance by appropriate individuals to present agenda items or advise on particular issues. The Chair will be responsible for agreeing the agenda and ensuring that matters discussed align with the objectives set out in these Terms of Reference. If the Chair or Vice Chair is unable to attend a meeting, they may designate an alternative ICB member to act as Chair. If the Chair is unable to chair an item of business due to a conflict of interest, another member of the Group will be asked to chair that item. Members Chair/Vice Chair Head of Integrated Primary Care Commissioning – Region footprint Associate Director of Integrated Primary Care/Head of Integrated Primary Care Commissioning Clinical Lead C and M Senior Primary Care Commissioning Manager Primary Care Contracting Lead Primary Care Finance Lead Primary Care Estates Lead Digital Representative Medicines Management Lead Nursing and Quality Representative Advisory Attendees Local Medical Committee representatives Healthwatch representative Other subject experts as required

	Administration provided by the Primary Care Commissioning Team Note there will be a Part A and Part B section, with the private section being ICB officers only
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Attendance

Quorum	A meeting of the Group is quorate if the following are present: at least 3 members in total If the named Chair and Vice Chair are both unable to attend a meeting, and the meeting is required to proceed on the agreed date, an alternative suitably experienced ICB member will be asked to chair the meeting. Where quorum requirements cannot be met, the meeting date will be rearranged. If any member of the Group has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum. If on an occasion a Group meeting is due to start but the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken. Alternatively, the meeting can be called to a halt and an agreement reached to rearrange an additional meeting.
Frequency/ Duration	The Group will normally meet monthly but may move to 6 weeks in due course. Additional meetings may take place as required. monthly The Group Chair may ask the Group to convene further meetings to discuss specific issues on which advice is required. In accordance with the Standing Orders, the Group may meet virtually when necessary, and members attending by electronic means will be counted towards the quorum.
Authority	The Group will work collaboratively with other groups and governance groups to ensure clear accountability and avoid duplication. Decision-making and voting The Group has delegated authority to the Committee as set out in these Terms of Reference and the ICB SORD, and which may be amended from time to time. The Group is authorised by the System Primary Care Committee to make decisions in line with all items listed in Appendix A .

	For the avoidance of doubt, in the event of any conflict, the ICB Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation will prevail over these Terms of Reference. Decisions will be taken in accordance with the Standing Orders and within the authority delegated to the Group, as outlined within the ICB Scheme of Reservation and Delegation and Standing Financial Instructions. The Group will ordinarily make decisions by consensus. Where this is not possible, the Chair may call a vote or refer to the SPCC.
Duties	• The duties of the X PCG will be driven by the organisation's strategic objectives and associated risks, as determined by the System Primary Care Committee. • In carrying out its role, the X PCG will work alongside any established sub-groups or committees where decision-making authority has been delegated. • The X PCG will provide regular assurance updates to the SPCC and Oversight Forum in relation to activities and items within its remit, and will escalate matters to the SPCC as required. • The X PCG shall approve decisions on the management of primary medical services, subject to the decision-making authority delegated by the SPCC, as set out in Appendix A. • The broader role of the Group shall be to oversee the functions relating to the commissioning of primary medical services • Supporting the delivery of relevant strategies and improvement plans • To review and propose service specifications and contractual proposals within a framework provided by the ICB for commissioned services from primary care providers within its area • Support PCNs to co-ordinate a common approach to the commissioning and delivery of primary care services and work with PCNs to understand their priorities and how they will deliver these priorities • To undertake reviews of General Practice services within X • To ensure contract proposals achieve health improvement and value for money in-line with C&M wider strategy • Support the design of Local Enhanced Services (LES) and Local Improvement Schemes and Quality Outcomes Framework (QOF) type frameworks as part of an overall strategic framework

	• Performance monitoring, providing assurance, on above schemes and services, and compliance to ICB (System PC Committee) and through the ICB System Primary Care Committee to NHSE/I; • Escalating issues to the ICB System Primary Care Committee as may be required • Any other contractual issues above not listed but detailed in the National Primary Medical Care Policy and Guidance Manual (link below) https://www.england.nhs.uk/publication/primary-medical-care-policy-and-guidance-manual-pgm/ • Workforce issues including ARRS utilisation and escalation of particular workforce challenges • Risk Management. - The Group will ensure the appropriate identification and management of risks in relation to primary care, including developing and maintaining a risk register for Liverpool City Region. • Escalation of quality issues to the relevant quality decision making groups
Reporting	The Group is accountable to the SPCC and shall report to the Committee on how it discharges its responsibilities. The Chair will provide assurance reports to the SPCC as required and will draw to the attention of the Committee any issues requiring escalation, action or decision. as required It will provide: - o Highlight report following to inform the relevant SPCC commissioning update including key decisions made - o Escalation of strategic risks - o Recommendations requiring SPCC decision - o Annual Review of effectiveness - o Escalation of issues as required
Conduct	Members of the Group will be expected to act consistently with existing statutory guidance, NHS Standards of Business Conduct and any other relevant organisational policies. Members should act in accordance with the Nolan Principles (the Seven Principles of Public Life). Group Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB.

	Members are expected to actively contribute to discussion, scrutiny and constructive challenge and to prepare adequately for meetings through review of papers in advance. Members should refer to and act consistently with the ICBs Conflicts of Interest Policy and NHS England guidance: Managing Conflicts of Interest in the NHS: Guidance for staff and organisations. Where any member or regular attendee of the Group has an actual or potential conflict of interest in relation to any matter under consideration by the Group, that individual must raise this with the Chair of the meeting (in advance where possible to do so) or at the meeting before the agenda item is considered. The Chair will look to determine whether or not that individual participates in the meeting (or part of the meeting) in which the relevant matter is discussed, either by participating in discussion or by voting. A Group Member or regular participant who is materially conflicted may secure that their appointed substitute attend the meeting (or part of meeting) in the place of that individual if it is to either support quoracy arrangements or the discussion to be undertaken regarding that item. All incidences of declarations made will be recorded and maintained within the ICBs declaration registers. Any breaches with regards to the management of conflicts of interest must also be recorded and reported to the Executive Director corporate Services & Governance. Members of, and those attending, the Group shall behave in accordance with the Constitution, Standing Orders, and Standards of Business Conduct Policy of each of the partner ICBs. Members must demonstrably consider the equality, diversity, and inclusion implications of decisions they make.
Other Matters	Review The Group will review its effectiveness at least annually, as determined by the SPCC. These Terms of Reference will be reviewed at least annually and earlier if required. Any proposed amendments will be submitted for approval through the appropriate governance route.

Area of Decision	Description	Officer/team role	PC Oversight/delivery Forum	Primary Care Group x 2	System PCC	Reference/notes
ASSURANCE, STRATEGY AND PERFORMANCE						
Assurance returns	note this return covers all four contractor groups		Will oversee and report to SPCC	day to day delivery	D on the plan and provide assurance to board	
PC strategic commissioning plan	High level IPC SCP fed from PCAP and access improvement plans		Will oversee and report to SPCC	day to day delivery	D on the plan and provide assurance to board	Note national reporting is still requirement on elements of MGP and transformation
Variation - Access Key strategic theme area	Follow June 2025 Plan framework using single data set		Will oversee and report to SPCC	day to day delivery	D - agree overall approach and recv assurance	variation overseen by oversight group
LOCAL ENHANCED SERVICES						
Approval of contract content/funding/repurposing	Approval of Schemes		Will oversee consistency	support development of schemes	D	reference scheme of delegated limits in terms of which level of agreement - factor in findings of ES review -
Day to day management of ES issues within existing specs and funding envelope			Will oversee consistency	D	D	Depending on total value system
Programme Management of ES review and decisions therein	Day to day management of the programme		Linking in with ES group			
CONTRACTOR/PARTIES TO CONTRACT ISSUES						
CVs	The signing of the CV	appropriate officer signature				
PCSE management	Liaison and process with PCSE for removals and performers team	officer led				SOP via oversight group/ Section 8 PGM as basis
24 hour retirement	Agreement and liaison with PCSE	officer led		D		SOP via oversight group/Section 8 PGM as basis =note any additional assurances required for SH 24hr
DECISIONS IN RELATION TO THE DIRECTED ENHANCED SERVICES						
PCN DES Primary Care Network specification changes	Changes to core practices / allocation/ disputes /network areas			D		https://www.england.nhs.uk/wp-content/uploads/2025/03/PRN02067v-network-contract-des-contract-specification-2526-pcn-requirements-and-entitlements.pdf https://www.england.nhs.uk/publication/network-contract-des-2025-26-part-b-guidance-non-clinical/
Changes to Enhanced Access Plans (PCN DES)	Should a PCN wish to change their enhanced access service plan from what has been previously agreed by the ICB. I.e. change in hours, clinic type, bases, provider - or arranging cover for practice populations outside of the DES			D		Section 8.6 https://www.england.nhs.uk/wp-content/uploads/2025/03/PRN02067v-network-contract-des-contract-specification-2526-pcn-requirements-and-entitlements.pdf
PCN DES Subcontracting	sub contracting PCN DES services where permitted under the DES			D		section 5.6 https://www.england.nhs.uk/wp-content/uploads/2025/03/PRN02067v-network-contract-des-contract-specification-2526-pcn-requirements-and-entitlements.pdf
IIF sign off	value needs formal sign off			D	depending on value	Depending on total value system
POLICY AND GUIDANCE MANUAL PROCESSES						
Open and closed lists	Application to close list			D		PGM 3.53 page 41 https://www.england.nhs.uk/long-read/primary-medical-services-policy-and-guidance-manual-pgm/
Boundary Change	Changes to a practice boundary- increasing or decreasing			D		Part B, section 8.14 https://www.england.nhs.uk/long-read/primary-medical-services-policy-and-guidance-manual-pgm/
Branch Surgery Closure				Work up	decision	8.17 https://www.england.nhs.uk/long-read/primary-medical-services-policy-and-guidance-manual-pgm/
change of opening hours branch surgery				D		
service opt outs				D		8.18 PGM https://www.england.nhs.uk/long-read/primary-medical-services-policy-and-guidance-manual-pgm/
Relocation / other change of premises				Work up/R	decision	Consultation and engagement in line with relevant duties of commissioners should be accounted for
Practice Contract Mergers (where new contract isnt created)	Merging of one of more contracts (note any creation of new contracts needs to be managed with reference to the procurement section)			Decision (noting if financial implications/asks they should be referred elsewhere)		Part B section 8.11 PGM and Scheme of delegation - note consideration of costs of merging clinical systems

Contract Novations and Incorporation/Dis-incorporation	Conversion of a partnership to body corporate			Decision		Section 7.1 Supporting documents Annex 7 to 12 https://www.england.nhs.uk/wp-content/uploads/2025/09/pgm-annex-42-part-b-8.10.12-the-common-assessment-framework-for-incorporation-requests-support-and-guide.pdf Part B, section 8.10 plus examples of previous approaches / SOP needs updating https://www.england.nhs.uk/long-read/primary-medical-services-policy-and-guidance-manual-pgm/
Sub Contracting of core contract	Sub-contracting of provisions within the core contract			Decision		Section 13 sub contracting PGM https://www.england.nhs.uk/long-read/primary-medical-services-policy-and-guidance-manual-pgm-2/ any contract for sub contracting needs to be check with procurement and value via scheme of delegation
In hours closure (PLTs) and requests for in hours closure				D (ad hoc in hours closures)	D on PLT policy	SPCC will agree PLT approach in terms of closures and hours/frequency, above sub contracting PGM will apply
List dispersal following options appraisal/termination (Non urgent)				R	D	in line with PGM scenarios (see relevant sections) https://www.england.nhs.uk/long-read/primary-medical-services-policy-and-guidance-manual-pgm/ and principles in section 2.5
Special Allocations - Patient Appeals and patient assignment issues	suggest a single appeals panel formed with quality colleagues			day to day oversight of local SAS schemes (usually by separate Panel) timing important/urgency		SOP and PGM Section 7 https://www.england.nhs.uk/long-read/primary-medical-services-policy-and-guidance-manual-pgm/ and special allocations scheme model specification which includes appeals process
Remedial notices	Agree to issue- after investigation of concerns			D		Part C https://www.england.nhs.uk/long-read/primary-medical-services-policy-and-guidance-manual-pgm/
Breach notice	Agree to issue following PGM Process			D		Part C https://www.england.nhs.uk/long-read/primary-medical-services-policy-and-guidance-manual-pgm/
Contract Sanctions	Agree to issue- after investigation of concerns			D		Part C https://www.england.nhs.uk/long-read/primary-medical-services-policy-and-guidance-manual-pgm/
Termination of contract	Agree to issue- after investigation of concerns			work up	D	Page 113 Part C https://www.england.nhs.uk/long-read/primary-medical-services-policy-and-guidance-manual-pgm/
Assurance framework for contract reviews	Should follow an agreed overall protocol/approach based on PGM approach			D - day to day management via ops and reporting		follow PGM Section 2 https://www.england.nhs.uk/long-read/primary-medical-services-policy-and-guidance-manual-pgm/ , Approach to be worked up through oversight
Managing disputes (core GMS)	The ICB currently has an disputes policy that will need to be reviewed in line with the new structures			D day to day management via ops and reporting	Escalation	Should be in line with Section 4 of the PGM https://www.england.nhs.uk/long-read/primary-medical-services-policy-and-guidance-manual-pgm/
PERFORMANCE						
Variation/performance - practice level	deep dives and performance areas agree by SPCC			Transact/accountable to SPCC via report, day to day management and decisions D	D - agree overall approach and recv assurance	variation overseen by oversight group
URGENT ACTIONS						
Urgent terminations/mergers or other actions such as emergency interim provider* outside of committee cycle (immediate) due to serious issue or patient safety including urgent interim providers				D - Managed initially at pcg level, an exo SPCC may be required	support and escalation/report	A local sop needs to be developed by oversight to accommodate these circumstances focusing on the relevant sections of the PGM - may need to to central execs due to SORDs

Escalation processes and DOS management	Practices escalation of issues (in hours)			The ICB has separate/different escalation routes these need to be reviewed		A sop needs to be developed by oversight and communicated to practices for escalation processes. This must align to the national New Standard Operating Procedure for GP Practice Capacity
temporary List closure (not informal)	criteria are explicit in PGM and is commissioner agreed			D		5.2 PGM https://www.england.nhs.uk/long-read/primary-medical-services-policy-and-guidance-manual-pgm/ note temporary not informal. Criteria section 5.5
OTHER RELATED ACTIONS						
PMS right to transfer to GMS	The transfer right is a process within the PGM			D		In line with agreed process and discussion with finance. Section 9 page 183 of the PGM https://www.england.nhs.uk/long-read/primary-medical-services-policy-and-guidance-manual-pgm/
Investigations ad hoc				day to day management and decisions	reporting to private section if escalation/outcomes required	PGM Process such as section 2.6.10 of PGM should be referenced as good practice
CQC contractual follow up	CQC inspections should always be mapped to contractual asks			day to day management and decisions		SOP to be updated in conjunction with quality team
QOF sign off	Total value sign off needs to be formally signed off and outlier/follow up issues managed			Day to Day decision(s)	D (total value)	would be signed off cumulatively at pcg level if within scheme of delegation
QOF/IIF appeals	Appeals in relation to the above - appeals are only in relation to exceptional circumstances and not in relation to unable to achieve target routinely			decision		review of appeals process via oversight group
Patient allocations	Where patients need assigning to a list	Officer decision				3.2 Part A: managing patient assignments PGM https://www.england.nhs.uk/long-read/primary-medical-services-policy-and-guidance-manual-pgm/
caretaker/interim providers (managed)*	Where an interim or caretaker provider is required due to contract termination or contractor issue/pending procurement			D (depending on value may be R)	D Note - costs of interim providers may need to be agreed/referred £	SOP to be developed at oversight and value of contract refer scheme of delegation and procurement processes
SFE claims/queries	Claims for sickness/mat leave currently go to central contracts team signed off via place - currently place agree any appeals	contracts team confirm meet criteria/officer led	consistency management			ICB SOP plus https://www.gov.uk/government/collections/nhs-primary-medical-service-directions
CQRS NHS Logo Calculating Quality Reporting Service		officer led actions also		claims signed off by local commissioners/final sign off approval via finance		
NHS ENGLAND NOTIFICATION DECISIONS *under delegated rules)						
Commissioners are also reminded the delegation agreement includes a requirement that they seek the relevant NHS England regional director's sign-off for a ny matter in relation to the delegated functions which is novel, contentious or repercussive .	In the context of PSR and primary medical care contracting, this would include any novel, contentious or repercussive use of the contract modification process (May need some further guidance from region on this aspect)			R	R to region	then to region for final agreement - refer to NHSE notification protocol, PGM and Delegation Agreement
proposed contract modifications that would lead to a cumulative change in the lifetime value of the contract since it was entered into of £500,000 or 25% or more now need NHS England regional director sign-off.	That is, contract modifications at or above these thresholds made under Regulation 13 of the Provider Selection Regime Regulations (file:///C:/Users/IIIX47Y86/AppData/Local/Microsoft/Windows/InetCache/Content.Outlook/HDK6LOF4/Provider%20Selection% that would require a commissioner to publish a transparency notice.			R	R to region	then to region for final agreement - refer to NHSE notification protocol, PGM and Delegation Agreement

the delegation agreement includes a requirement that ICBs seek the relevant NHS England regional director's sign off of all contracts whose term can exceed 5 years. Potential for this to be managed centrally with resources?	Commissioners should have systematic processes for confirming plans for such contracts, both before proceeding with any selection process and on confirmation of contract award. These processes will need to align with the relevant NHS England region's process for sign-off, including the provision of such information as may be requested to support sign-off decisions.			R	R to region	then to region for final agreement - refer to NHSE notification protocol, PGM and Delegation Agreement
PROCUREMENT DECISIONS (AND PSR IMPLICATIONS) CHECK WITH PROCUREMENT TEAM FOR ANY CLARIFICATIONS this needs clarifying in terms of FICC/Execs SPPC						
Recommendation of option to procure a new contract				R		
Approval of Recommended bidder report/award contract				R		
Contract Extension				R		
Contract Uplifts				R		
PSR implications for PGM actions such as modification notices etc				R		https://www.england.nhs.uk/long-read/the-provider-selection-regime-statutory-guidance/
DECISIONS ABOUT 'DISCRETIONARY' PAYMENTS						
Discretionary payments under Section 96 of the regulations	awards under s96 are also notifiable to NHS England and therefore would need SPPC approval			R	D	p94 section 11 PGM https://www.england.nhs.uk/long-read/primary-medical-services-policy-and-guidance-manual-pgm-2/ plus application template https://www.england.nhs.uk/publication/primary-medical-care-policy-and-guidance-manual-section-96-application-functional-excel-template/

NHS Cheshire and Merseyside Integrated Care Board

Integrated Primary Care (Transition) Delivery
& Oversight Group

Terms of Reference

Document revision history

Date Of Amendment	Version	Revision	Comment	Author / Editor
22.9.2026	1.0	First Draft		Christopher Leese

Review due: October 2027, or sooner if required

Integrated Primary Care (Transition) Delivery & Oversight Group

TERMS OF REFERENCE

Constitution	The Integrated Primary Care (Transition) Delivery & Oversight Group is established as an operational delivery, coordination and oversight forum within the primary care governance structure. It will support the transition from legacy place-based arrangements into agreed Cheshire and Warrington, Liverpool City Region and POD governance groups, and will provide the ongoing system-level engine room for implementation, consistency, assurance and escalation for primary care commissioning and associated strategy's and assurance pieces..
Membership	• Associate Director of Integrated Primary Care — Chair CL • Heads of Integrated Primary Care for Liverpool City and Cheshire and Warrington — Vice Chairs CL/TJM • Head of Primary Care Contracting KC • Associate Medical Director for Primary Care and Neighbourhoods JG • Programme Director for Community and Neighbourhood Health Development CM • Head of Finance – Primary Care LWB • Associate Director of Finance CB • Executive Director of Health and Integrated Care Commissioning CWA
Attendance	Other invitees will be invited as required, depending on the agenda items under consideration. This may include subject matter experts and colleagues from governance, quality, procurement, finance, transformation, programme support or other teams where their input is required.
Quorum	The meeting will be considered quorate when the Chair or nominated deputy is present, alongside sufficient representation from commissioning and contracting, governance or programme delivery, and at least one relevant subject matter lead for the agenda items under consideration. Formal quoracy should be confirmed once membership is agreed.
Frequency/ Duration	• The Group will meet for monthly from end of October • Additional meetings may be convened by the Chair where urgent delivery, risk or escalation matters arise.

Authority	The Group is not a formal decision-making committee for matters requiring delegated authority. Its remit is to coordinate, assure and recommend. Formal authority remains subject to the ICB Scheme of Delegation, Standing Financial Instructions and any relevant committee-approved decision-making framework. The Group may agree non-financial operational recommendations, standardised approaches and implementation actions where these sit within existing approved policies, strategies or committee decisions. Matters requiring formal approval, financial commitment, change to delegated authority, or material change in policy will be escalated through the agreed governance route.
Duties	• Coordinate transition activity across primary care governance arrangements and support movement from legacy place-based arrangements into the agreed governance model. • Provide system-level oversight of primary care strategy implementation, ensuring priorities are translated into coordinated delivery plans, milestones, dependencies and benefits tracking. • Drive consistent approaches across primary care commissioning, contracting, policy application, access, variation handling and operational planning where this supports equity, efficiency and strategic alignment. • Oversee delivery of agreed actions, operational plans and implementation requirements arising from the System Primary Care Committee. • Support development and application of core governance enablers, including terms of reference, decision-making matrices, membership models, roles and responsibilities, escalation routes and standard operating procedures. • Maintain a shared view of transition, delivery and implementation risks, identify mitigations, assign leads and escalate unresolved issues. • Coordinate matters requiring consistent interpretation across primary care contractor groups, ensuring formal contractual decisions are taken through the appropriate route. • Receive outputs from task and finish forums, ensure alignment to strategic priorities and support progression into formal governance where required. • Agenda items should focus on delivery oversight, implementation progress, risk, consistency, escalation and matters requiring recommendation to formal governance. • Programme support will maintain an action log, risk and issue log, decision and recommendation tracker, and forward plan. • Oversee key assurance returns across all four contractor groups and key system plans for example, primary care elements of the winter plan

Reporting	The Group will report recommendations, delivery updates, risks and escalations to the System Primary Care Committee as part of overall existing reports. Where issues require executive oversight, approval outside delegated authority, financial decision-making or resolution of material strategic risk, these will be escalated to the relevant Executive Committee route in line with agreed governance arrangements.
Conduct	Members of the Group will be expected to act consistently with existing statutory guidance, NHS Standards of Business Conduct and any other relevant organisational policies. Members should act in accordance with the Nolan Principles (the Seven Principles of Public Life). Group Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB. Members are expected to actively contribute to discussion, scrutiny and constructive challenge and to prepare adequately for meetings through review of papers in advance. Members should refer to and act consistently with the ICBs Conflicts of Interest Policy and NHS England guidance: Managing Conflicts of Interest in the NHS: Guidance for staff and organisations. Where any member or regular attendee of the Group has an actual or potential conflict of interest in relation to any matter under consideration by the Group, that individual must raise this with the Chair of the meeting (in advance where possible to do so) or at the meeting before the agenda item is considered. The Chair will look to determine whether or not that individual participates in the meeting (or part of the meeting) in which the relevant matter is discussed, either by participating in discussion or by voting. A Group Member or regular participant who is materially conflicted may secure that their appointed substitute attend the meeting (or part of meeting) in the place of that individual if it is to either support quoracy arrangements or the discussion to be undertaken regarding that item. All incidences of declarations made will be recorded and maintained within the ICBs declaration registers. Any breaches with regards to the management of conflicts of interest must also be recorded and reported to the Executive Director corporate Services & Governance. Members of, and those attending, the Group shall behave in accordance with the Constitution, Standing Orders, and Standards of Business Conduct Policy of each of the partner ICBs.

	Members must demonstrably consider the equality, diversity, and inclusion implications of decisions they make.
Other Matters	Review These Terms of Reference will be reviewed after the initial transition period and at least annually thereafter, or sooner if there are material changes to the primary care governance structure, Scheme of Delegation, Standing Financial Instructions or committee reporting arrangements. The Group will use the decision-making matrix to distinguish between officer-led activity, delivery oversight, recommendations and matters requiring formal decision through Primary Care Groups, the System Primary Care Committee, Executive Committee or NHS England regional routes.
Interdependencies	Estates. Quality. Contracting. Finance structures and governance.

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

Integrated Primary Care Commissioning and Performance Update (October)

Agenda Item No: 10.0

Responsible Director: Clare Watson

Executive Director of Health and Integrated Care Commissioning

1. Purpose of the Report

The purpose of this report is to provide the Committee with an update on primary care commissioning priorities and performance across general practice, dentistry, community pharmacy and optometry. The paper draws together the current delivery position against national and local planning priorities, with updates on key commissioning priority areas.

As highlighted at the last Committee meeting, this paper includes the primary care metrics agreed through the Quality and Performance Committee for reporting to this Committee, in **Appendix 1**.

2.0 Ask of the Committee and Recommendations

The Committee is asked to **note** the update, including the immediate actions planned, the current delivery position, areas of progress and areas where additional assurance actions are required.

3.0 Commissioning and Performance Update

- 3.1 **National Dental Data** – the NHS Business Services Authority (NHSBSA) patient-location datasets show increased NHS dental activity for Cheshire and Merseyside residents in 2025/26 [Dental statistics - England 2025/26 | NHSBSA](#). There are complexities in interpreting the data because patient location and contract location may differ. Dental practices do not operate on a geographically registered-list basis, and patients may receive care from a dentist located outside of Cheshire and Merseyside.

Key local findings are:

- 1,893,113 courses of treatment (COTs) were delivered for Cheshire and Merseyside residents in 2025/26.
- This was an increase of 88,834 COTs, or 4.9%, compared with 1,804,279 in 2024/25.
- Band 1 (examination, diagnosis and preventive care) activity accounted for 59.1% of local COTs in 2025/26, up from approximately 58.5% in 2024/25.
- Urgent activity represented 11.8% of local COTs, compared with 11.3% in 2024/25, and increased faster than overall activity.
- Band 1 (examination, diagnosis and preventive care) and urgent activity together accounted for around 90% of the year-on-year growth, while complex treatment activity was broadly flat or slightly lower.

The increase in activity is positive, although local growth was below the 6.2% increase reported for England, and the treatment mix remains more weighted towards urgent care. Further work is required to understand coverage, particularly in areas of deprivation, and dental workforce capacity.

- 3.2 The ICB continues to report monthly to NHS England on the following areas in relation to the **Primary Care Action Plan**:

Dental

- Increased contracted UDA delivery
- Increased unique patient access (adults)
- Improved clinically appropriate recall of low-risk patients
- Uptake of new care pathways
- Delivery of mandated unscheduled care requirements
- Improved contract rebasing

General Practice

- Same-Day Access for Clinically Urgent Patients

- Ease of Access to General Practice
- Continuity of Care
- GP-to-Patient Ratios and Workforce Capacity

Community Pharmacy

- Actions to increase Pharmacy First clinical pathway and minor illness consultation activity, including action with low-referring practices
- Actions to onboard prescribing pharmacies for the rollout of community pharmacy prescribing

NHS England has confirmed a range of related metrics to support the areas above. These are set out in **Table 1**. Further metrics may be added in due course.

Table 1: Key current reporting areas to NHS England

Reporting to/reference	Metric / Indicator	Target / Plan	Current Performance/Narrative
Dental			
Planning Guidance (PG) / Population Health Improvement Plan (PHIP) NHS England	Overall UDA delivery against target - Reported in Appendix 1		
PG / PHIP NHS England	Number of unique patients seen by an NHS dentist – adults (24 months)	May 2026 target – 954,715 National target 500,000 unique adult patients seen by the end of 2026/27 (adjusted for the ICB).	May = 956,239 (99.2% of plan) June = 957,646 (99.4% of plan) July = 958,040 (99.1% of plan)
NHS England	Unscheduled care	Mandated level of unscheduled courses of treatment set at 8.2% of contract value	To date, 110,546 unscheduled care COTs have been delivered against an overall target of 180,760 (61.16% delivered). Individual contract performance will vary.
Community Pharmacy			
PG / PHIP	Pharmacy First – total consultations	No target, but projected growth of 2.9% in consultations Target 26/27 - 456,151	YTD July 26/27 (FOT) 184,102 (552,306)

PG / PHIP	Pharmacy First – clinical pathways	5% growth; 2026/27 target: 155,881	YTD July 26/27 (FOT) 63,675 (191,025)
PG / PHIP	Pharmacy First – oral contraception	10% growth; 2026/27 target: 57,779	YTD July 26/27 36,534 (103,350)
PG / PHIP	Pharmacy First – blood pressure checks	Continued growth; 2026/27 target: 242,490	YTD July 26/27 83,893 (251,679)
General Practice			
PG / PHIP NHS England	Increased percentage of urgent care demand met same day in general practice	90% by March 2027	79.8% in August 2026 (vs. a plan of 80.7%).
PG / PHIP ICB	Appointments in PCNs and General Practice - Reported in Appendix 1		
NHS England	Population headcount per GP – Reporting in Appendix 1		

3.3 The Quality and Performance Committee agreed a set of measures to be reported to this Committee; these are set out in **Appendix 1**. Where these overlap with the metrics above, the figures in the Appendix should be used. This is the first month of reporting. At future meetings, a supporting narrative will be provided in conjunction with the planning team. The committee should note that further work is underway with some metrics marked in the appendix.

4.3 Delivery narrative: Q1 and Q2

- The required primary care elements of the **winter plan** were finalised as part of the required Board assurance. These covered areas including enhanced access in general practice, community pharmacy capacity and the delivery of same-day urgent appointments in general practice. PCNs are now also receiving SDF (System Development Funding) to support areas including winter pressures and neighbourhood health, which further supports the assured position.
- The **SES (Special Education Settings) Optometry** provider and service are progressing through operational and mobilisation planning, working with schools and a transition/handover planning with existing providers.
- Following the Committee's approval of the proposed way forward, the **Enhanced Services** Steering Group has met, drafted and agreed revised governance arrangements, and begun to structure the workstreams required to deliver the April 2028 specifications. An update on this area will be presented to the Committee in December.
- The ICB presented to NHS England for assurance on two key areas of priority delivery for general practice: **urgent same-day access and overall variation and outliers in access**. There is concern about the narrowing trajectory towards delivery. The ICB's current performance (August) is 79.8% against the same-day target of 90% by March 2027, which is slightly behind the planned position of 80.7%. The agreed actions were as follows:

- Practices where fewer than 60% of urgent appointments are seen on the same day will be followed up to understand further.
 - These enquiries will seek to support practices and understand the issues, which may relate to coding. Follow-up and monitoring will be undertaken by each new primary care group team, with assurance provided to this Committee by exception.
 - The ICB has already provided practices with the information required to support delivery in this area in terms of coding/webinar information and national FAQs, noting that the 90% target is an ICB expectation rather than a contractual requirement.
 - Ongoing assurance to NHS England.
- In relation to the **overall approach to variation**, at the recent NHS England assurance meeting, 19 practices were already on the ICB outlier list and were flagged by NHS England. The ICB was able to demonstrate the follow-up undertaken and the actions due, providing assurance on its approach to managing outlier practices.
 - **Dental** – the ICB has extended the existing quality and access scheme for a further six months. The scheme requires each practice to see a specified number of new patients, verified through BSA data and a local online return. A proportion of these new patients must be from the vulnerable groups identified in the SLA (service level agreement). 66 practices are currently signed up to the scheme.
 - **Community Pharmacy – Pharmacy First and independent prescribing:** This quarter, Pharmacy First clinical pathway delivery reached 17,521 consultations in July 2026, 1,975 above plan, with Cheshire and Merseyside recording 627.72 combined clinical pathway and minor illness referrals per 100,000 population compared with a national average of 563.45. Readiness work for independent prescribing has progressed, including pharmacy onboarding, cost-centre allocation, policy and assurance processes, contractual compliance arrangements, an established stakeholder group and an expression of interest to assess contractor interest.

4.4 Priorities for Q3 and Q4

- Embedding the **new governance arrangements** to support delivery across the new teams.
- **Revision of the Primary Care Action Plan** to reflect new arrangements and refocused priorities by end of Quarter 3, overseen by the new delivery and oversight group, via a delivery plan approach.
- **Dental** – UDA delivery remains below the ICB target and NHS England expectations. Access to dentistry also remains an area of focus and concern across the ICB and the wider system. Key priorities and actions to support a revised dental improvement plan are therefore set out below:
 - Explore the further expansion of the local quality and access scheme during the year to more dentists that meet the existing criteria (now/Q3). A review of the scheme outcomes is required as part of this.
 - Work with community dental services providers in respect of reducing waiting lists in year (now/Q3), this work has already commenced.
 - Maintaining an increased focus on access and delivery, noting continued patient experience and external feedback about access gaps across the ICB.
 - Improving UDA (units of dental activity) delivery in line with national expectations.
 - Reviewing existing contracts and underperformance, and the reasons for this, noting that recurrently underperforming contracts remain an area for action and assurance for NHS England as part of the monthly reporting. Further meetings with NHS England are planned around this.
 - As part of the 2027/28 commissioning intentions, to review wider commissioning and contracting approaches across all contracts, including community provision, to understand capacity.
 - Continue to support implementation of clinically appropriate recall intervals.
 - Delivery and analysis of the national contract requirement for 8.2% unscheduled care.

- Special Education Settings - there is an expectation from NHS England for immediate action to put in place the national contract specification via the relevant procurement route this year – this remains a priority action for Q3.
- Looking ahead to 2027/28, the ICB is required to maintain an increased focus on access and delivery, noting continued patient experience and external feedback regarding access gaps across the ICB.
- **General Practice**
 - Progress and delivery in respect of the enhanced services review (a separate paper has been presented to the committee on this in August and an update will return in December).
 - Sustaining and improving the same-day urgent access trajectory with additional focused actions on outliers and data segmentation (requested by NHS England) as outlined above – these actions are in progress overseen by the two new footprint primary care groups.
 - Continuing practice-level variation work and assessing any practice-level changes since the original work in June 2025, with a revised list of practices by the end of October.
 - Workforce – continued focus from NHS England on GP-to-patient ratio variation, ARRS (additional roles) utilisation and GP reimbursement scheme uptake, as supportive enablers.
- **Optometry**
 - Special Education Settings – complete implementation of the new service and provide assurance against national expectations and reporting requirements. The first performance report to this Committee is scheduled for December, in line with national expectations.
- **Community Pharmacy**
 - Continuing to prioritise **Pharmacy First** referrals and related actions, with a focus on outliers, low-referring practices and identified issues or challenges, while maintaining delivery across all areas.
 - **Independent prescribing:** Next quarter, the ICB will confirm national prescribing-data requirements, agree analytical and BI capacity for ePACT support, and establish a resourced implementation plan to align community pharmacy independent prescriber data access, analysis and reporting with wider ICB non-medical prescribing arrangements. Work will also continue to address workforce support, onboarding, assurance capacity and processes, while progressing contractor engagement and readiness for go-live. There will be a further update to this Committee in December.

5.0 Key Next Steps

- Continue monthly reporting and assurance submissions to NHS England on primary care, addressing areas of concern and underperformance.
- Revise the Primary Care Action Plan to reflect the most up-to-date position and risks as part of overall delivery approaches (end of Q3).
- Develop a draft revised Dental Improvement Plan (Q4), noting that further engagement with stakeholders is required to undertake this. This includes the immediate actions set out above regarding the local quality and access scheme and community dental services waiting lists.
- Put in place the revised governance arrangements to support delivery and continuity (October).
- Finalise primary care staffing and posts in line with the ICB's new operating model.

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

The paper supports delivery of the ICB's delegated duties in relation to primary care contracting. Effective and safe contracting supports the wider themes of:

- Tackling health inequalities in outcomes, experience 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 mitigation of the following BAF risks: P1, P4, P5, P6 and P8.

10. Finance

Any finance implications will be covered in the separate Finance update to the Committee.

11. Communication and Engagement

No external formal consultation or further engagement is required in relation to this paper. Engagement duties are addressed in the national Policy Books for each contractor group and through nationally determined duties on contractors. Any additional commissioner requirements would be outlined in this update.

12 Equality, Diversity and Inclusion

These duties are addressed in the national Policy Books for each contractor group and through nationally negotiated contract terms. Any additional commissioner requirements would be outlined in this update.

13 Officer contact details for more information

Clare Watson - Executive Director of Health and Integrated Care Commissioning
Clare.Watson@cheshireandmerseyside.nhs.uk

Performance Summary

Primary Care Committee

October 2026



Primary Care metrics

Primary Care metrics - Summary Icon Table

Metric	Latest Month	Actual	Plan/Target	Variation	Assurance	Plan Met	Region Value	National Value	ICB Rank
Reduction in the number of CYP attending A&E due to asthma exacerbations. (NEW) (SEE NOTE)	Aug-26	691	TBC			TBC	0.0%	0.0%	n/a
% of children aged 9 and under prescribed antibiotics (rolling 12 months) (NEW)	Jun-26	30.0%	25.0%				29.8%	28.4%	28/36
AHCs carried out for persons aged 14 years or over on the QOF Learning Disability Register	Jul-26	20.1%	10.0%				20.4%	20.1%	17/36
People with severe mental illness on the GP register receiving a full annual physical health check in the previous 12 months	Q1 26/27	53.0%	60.0%				57.0%	59.0%	29/36
Appointments in General Practice & Primary Care networks	Jul-26	1,448,405	1,276,544				-	-	n/a
Total volume of antibiotic prescribing in primary care	Jun-26	0.900	0.871				-	1.00	n/a
Units of dental activity delivered as a proportion of all units of dental activity contracted	Aug-26	79.0%	83.0%				85.0%	88.0%	30/36
Deprivation gap in early cancer diagnosis (NEW)	12 months to May-26	-13.1%	TBC			TBC	0.0%	0.0%	n/a
Deprivation gap in lipid management (NEW)	Q4 25/26	-6.4%	TBC			TBC	-6.8%	-5.4%	19/42
Deprivation gap in hypertension management (NEW)	Q4 25/26	-5.5%	TBC			TBC	-6.6%	-5.7%	13/42
% receiving all 8 diabetes care processes (Type 1 and 2) (NEW)	4 Quarters to Mar-26	48.5%	TBC			TBC	56.0%	57.9%	39/42
By 2031 60% of people who die to have had an have an Advance Care Plan or discussion. (NEW)	Q1 26/27	44.8%	TBC			TBC	0.0%	0.0%	n/a
Population headcount per GP (NEW)	Jul-26	1,426	TBC			TBC	1,494	1,673	1/36

ICB Aggregate Position - 13 month trend

Metric	Latest Month	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Target	Regional	National	Ranking
Reduction in the number of CYP attending A&E due to asthma exacerbations. (NEW) (SEE NOTE)	Aug-26	1325	1456	2111	2398	1451	1166	1401	1086	1026	781	768	691	TBC			n/a
% of children aged 9 and under prescribed antibiotics (rolling 12 months) (NEW)	Jun-26	29.8%	29.7%	29.5%	29.8%	29.7%	29.5%	29.5%	29.5%	29.7%	30.0%			25.0%	29.8%	28.4%	28/36
AHCs carried out for persons aged 14 years or over on the QOF Learning Disability Register	Jul-26	31.1%	38.3%	46.4%	52.8%	62.0%	70.9%	80.5%	3.5%	7.6%	13.4%	20.1%		10.0%	20.4%	20.1%	17/36
People with severe mental illness on the GP register receiving a full annual physical health check in the previous 12 months	Q1 26/27		54.0%			59.0%			53.0%					60.0%	57.0%	59.0%	29/36
Appointments in General Practice & Primary Care networks	Jul-26	1,364,319	1,688,291	1,337,024	1,326,865	1,425,232	1,322,413	1,462,024	1,320,066	1,244,741	1,434,782	1,448,405		1,276,544	-	-	n/a
Total volume of antibiotic prescribing in primary care	Jun-26	0.920	0.920	0.910	0.910	0.910	0.900	0.900	0.900	0.900	0.900			0.871	-	1.00	n/a
Units of dental activity delivered as a proportion of all units of dental activity contracted	Aug-26	82.0%	84.0%	87.0%	76.0%	84.0%	92.0%	90.0%	87.0%	88.0%	87.0%	83.0%	79.0%	83.0%	85.0%	88.0%	30/36
Deprivation gap in early cancer diagnosis (NEW)	12 months to May-26						-12.7%	-12.6%	-12.7%	-13.1%				TBC			n/a
Deprivation gap in lipid management (NEW)	Q4 25/26		-6.9%			-6.4%								0%	-6.8%	-5.4%	19/42
Deprivation gap in hypertension management (NEW)	Q4 25/26		-5.5%			-5.5%								0%	-6.6%	-5.7%	13/42
% receiving all 8 diabetes care processes (Type 1 and 2) (NEW)	4 Quarters to Mar-26		33.4%			48.5%								TBC	56.0%	57.9%	39/42
By 2031 60% of people who die to have had an have an Advance Care Plan or discussion. (NEW)	Q1 26/27		40.6%			44.0%			44.8%					TBC			n/a
Population headcount per GP (NEW)	Jul-26					1549	1383	1394	1445	1418	1420	1426		TBC	1494	1673	1/36

NHS Cheshire and Merseyside ICB – Briefing Paper -

2026/27 Community Pharmacy Prescribing Services – NHS Cheshire and Merseyside ICB Governance arrangements and Onboarding Oversight

October 2026



1. Executive Summary

- 1.1. This document outlines NHS Cheshire and Merseyside's governance approach to support the introduction of nationally commissioned Community Pharmacy Prescribing Services in community pharmacies across the ICB.
- 1.2. There are two stages to governance: approving a community pharmacy who has registered to provide Community Pharmacy Prescribing Services, therefore allowing them to commence prescribing activities (onboarding), and then ensuring the ongoing oversight and continuous improvement of the effectiveness, quality and safety of community pharmacy prescribing-based services. This paper focuses on onboarding and approval to prescribe; a further paper will be shared in due course covering ongoing oversight.
- 1.3. The service is included in the Community Pharmacy Contractual Framework 2026 as agreed by the Department of Health and Social Care (DHSC), NHS England and Community Pharmacy England (CPE) in the 2026/2027 funding settlement for Community Pharmacy.
- 1.4. An increase in funding of £40 million (10.3%) to £3.636 billion, alongside an agreement not to recover £239 million of historic over-delivered medicines margin funding from the sector, will be used to help stabilise medicine supply and build on the services that community pharmacy provide.
- 1.5. Financial investment accompanies changes to service specifications and expansion of currently commissioned National Advanced services with the aim to expand Community Pharmacies offer of clinically based service to patients in line with the NHS 10 Year Plan.

1.6. CPIP Fees for 26/27

The initial introduction of IP during 2026/27 will be funded via 3 main streams		
Description	Amount	
Set up fee	£500 (one off payment following confirmation of registration and assured EPS product)	- Eligible Prescribing Pharmacies must - Have a minimum prescriber availability 24 hours per week - Offer prescribing based national services as per CPCF - Offer Prescription Management processes in line with guidance and local ICB agreements - Open to all Community Pharmacies with Prescribing Pharmacists subject to ICB approval Terms of Service in PLPS that will come into force for clinical governance purposes.
Monthly infrastructure fee	£525 monthly (supporting ongoing costs of maintaining a prescribing service e.g. EPS costs, clinical supervision)	
Service fee	£17 for Pharmacy First Clinical Pathways £20 or £25 for Contraception services	

1.13 RAG Assessment (System Impact Overview)

Domain	Rating	Commentary
Financial Opportunity	Green	Strong uplift and shift to clinical service-based funding creates opportunity for system efficiencies and patient access
Workforce Readiness	Amber	Growth in prescribers and career progression for pharmacy clinicians but variation across localities
Digital Infrastructure	Amber	National direction clear; local integration still developing
Service Delivery Risk	Amber	Implementation burden and variability in contractor readiness
Service support / governance risk	Amber	ICB capability and capacity to support contractual changes within revised structure and ways of working

2. Introduction

2.1. From autumn 2026/27, a national Independent Prescribing offer will be introduced as an extension of the Pharmacy First and Contraception services, as part of the national Community Pharmacy Contractual Framework (CPCF). This includes prescribing within existing Pharmacy First Clinical Pathways and the Pharmacy Contraception Service, five new prescribing only pathways for Pharmacy First, and Prescription Management under appropriate circumstances, where the intention is to allow prescribing pharmacists to prescribe alternative items under certain criteria when dispensing a prescription.

3. Background

3.1. From 2023 to 2026, NHS C&M ICB participated in the national Independent Prescriber Pathfinder Programme, the aim of which was to establish a framework for the future

commissioning of NHS community pharmacy clinical services incorporating independent prescribing for patients in primary care.

- 3.2. Pathfinder sites were nationally coordinated with core requirements whilst allowing local variation in clinical design responding to local need and availability of competent IP community pharmacists.
- 3.3. The governance arrangements put in place by ICBs were agreed through a Northwest collaborative with IP Pathfinder leads across the 3 NW ICBs and supported by the Regional Deputy Chief Pharmacist, supported by NHSE documentation including an ICB readiness checklist and a contractor readiness checklist.
- 3.4. Oversight of the programme was managed through a programme steering group with multi-disciplinary membership which met monthly and regular reporting to the Primary Care Leadership via Heads of and Place Leads for Primary Care, MOP, SPCC and CEG.
- 3.5. NHS Cheshire and Merseyside ICB governance approach to the national Community Pharmacy Prescribing Services is built on the foundation of robust governance throughout the pathfinder programme, tempered with considerations around scalability and resource, and aligned to a range of documentation produced by NHS England in 2026/27 to support ICBs and community pharmacies with the introduction and implementation of national prescribing services (Appendix 1)

4. Proposed Arrangements for Governance

- 4.1. Whilst the introduction of prescribing services into community pharmacies is nationally determined, there are responsibilities for ICBs which have been clearly outlined in the Commissioning guidance for community pharmacy prescribing-based services by NHS England.
- 4.2. For NHS Cheshire and Merseyside ICB to comply with the requirements in the NHSE commissioning guidance, there is a need to clearly define the governance and assurance process of onboarding, oversight and continuous improvement of the effectiveness, quality and safety of community pharmacy prescribing-based services. Where possible, it is recommended that there should be integration with or, at least alignment to existing processes for prescribing in primary care. (see appendix 2)
- 4.3. These additional requirements set Community Pharmacy Prescribing Services apart from other nationally commissioned community pharmacy services such as Pharmacy First, Pharmacy Contraception Service and Hypertension Case-Finding Service; where registration to deliver the service is simply based on the pharmacy contractor completing a registration on the 'Manage Your Service (MYS)' portal and including a declaration that they will deliver the service as described in the service specification and other service-related documents such as pathways and Patient Group Directions (PGDs).
- 4.4. This local governance approach is in line with the prescribing onboarding process shared by NHSE, and sits in the '*ICB receives, reviews and approves request to become a Prescribing Pharmacy*' box (Appendix 3).
- 4.5. The introduction of Community Pharmacy Prescribing Services is a significant change in clinical service delivery in community pharmacy, with prescribers starting to operate in a completely new sector. NHS Cheshire and Merseyside ICB is therefore recommending

additional safeguards and controls to the implementation of this service. This will support community pharmacies with delivery in the short-medium term, with a planned transition to business-as-usual arrangements as prescribing in community pharmacy matures.

- 4.6. The committee should be aware that community pharmacies are not currently regulated by the Care Quality Commission (CQC) as other providers of clinical services are. Regulation of premises and standards is by the General Pharmaceutical Council. As such consideration needs to be given to safeguards and assurance that will be different to CQC regulated providers of clinical services.
- 4.7. The NHS Cheshire and Merseyside ICB Governance Approach to onboarding:
- 4.8. Step 1 - Each Contractor wishing to register for Community Pharmacy Prescribing Services should ensure readiness via completion of the National Readiness documents including the "Community Pharmacy Prescribing-based Service readiness checklist (contractor version)" and associated National Checklists as published by NHS England (See Appendix 4)
- 4.9. Step 2- Note this is a nationally controlled process.
Each Contractor wishing to register for Community Pharmacy Prescribing Services should complete the registration form in the "**Manage Your Services**" portal which includes confirmation or service readiness, operational and professional assurance. (See Appendix 5)
- 4.10. This assurance declaration will be copied to the ICB for further action and local assurance processes.
- 4.11. Step 3 - Each Contractor wishing to register for Community Pharmacy Prescribing Services should complete the "Community Pharmacy Contractor Non-Medical Prescriber (NMP) Assurance" form (Appendix 3 in NHS Cheshire and Merseyside ICB NMP Policy <https://www.cheshireandmerseyside.nhs.uk/media/ojbpb345/cm-icb-nmp-policy-final-v20-september-2026.pdf>). This NHS Cheshire and Merseyside ICB assurance document has been developed specifically for community pharmacy, based on existing GP NMP Assurance documentation, assurance declaration documentation developed for the CP Prescribing Pathfinder programme and now aligned to NHS England's Professional assurance framework for delivering NHS community pharmacy clinical services.
- 4.12. This NMP Assurance includes forms for the contractor, who takes responsibility for the NMPs providing NHS services through their contract, and from each NMP providing those services, and is refreshed annually in line with the ICB NMP Policy.
- 4.13. Step 4 - Local Governance Contractual Compliance check – the list of community pharmacies wishing to register for Community Pharmacy Prescribing Services having completed Steps 1 - 3 is submitted to Pharmaceutical Services Regulations Panel (PSRP) who reviews and identifies any areas of concern. PSRP to determine what actions must be taken in relation to the concern e.g., refusal to approve Community Pharmacy Prescribing Services, action plan to address concerns and further review, or acceptance.
- 4.14. Step 5 - Contractors will be requested to submit local assurance to the ICB, via a Microsoft Form, mirroring and complementing the NHS England Readiness Checklists

to ensure auditable ICB Assurance and Governance. This form will be finalised on publication of the National SLA.

- 4.15. A Cost Centre will only then be requested on successful completion and assessment of the ICB Assurance Steps 3-5 above).
- 4.16. ICB CPCL (or agreed appropriate Authorised Signatory) informs the appropriate Registration Authority (RA) team that all governance requirements are complete for the contractor and confirms which NMPs have completed the NMP assurance process and can have their smart cards updated to include appropriate prescribing role (RBAC roles defined nationally).
- 4.17. The Medicines Optimisation team (via support from the NMP Inbox) will compile and maintain a master spreadsheet which tracks the CP Contractor details, cost centres and linked NMPs.

5. Next Steps

- 5.1. Further development of a Community Pharmacy Prescribing Services NHS Cheshire and Merseyside ICB Governance Resource Pack which details all requirements as outlined in this document. This Resource Pack, supported and informed by LPC and stakeholder feedback and support, will be shared with all community pharmacy contractors.

6. Recommendation

- 6.1. The recommendation is to approve the governance arrangements in this document

7. NHS England Guidance

7.1.



CP%20Prescribing%20Implementation%20

8. Contact for further information –

 Cheshire and Merseyside	Pam Soo Clinical Lead for Community Pharmacy Integration
 07967302627	
 Pam.Soo@nhs.net	
	

Appendix 1 – Associated Policies for Information

NHS England » Preparing for prescribing in national community pharmacy services - <https://www.england.nhs.uk/long-read/preparing-for-prescribing-in-national-community-pharmacy-services/>

NHS England » Commissioning guidance for community pharmacy prescribing-based services - <https://www.england.nhs.uk/long-read/commissioning-guidance-for-community-pharmacy-prescribing-based-services/>

NHS England » Professional assurance framework for delivering NHS community pharmacy clinical services - <https://www.england.nhs.uk/long-read/professional-assurance-framework-for-delivering-nhs-community-pharmacy-clinical-services/>

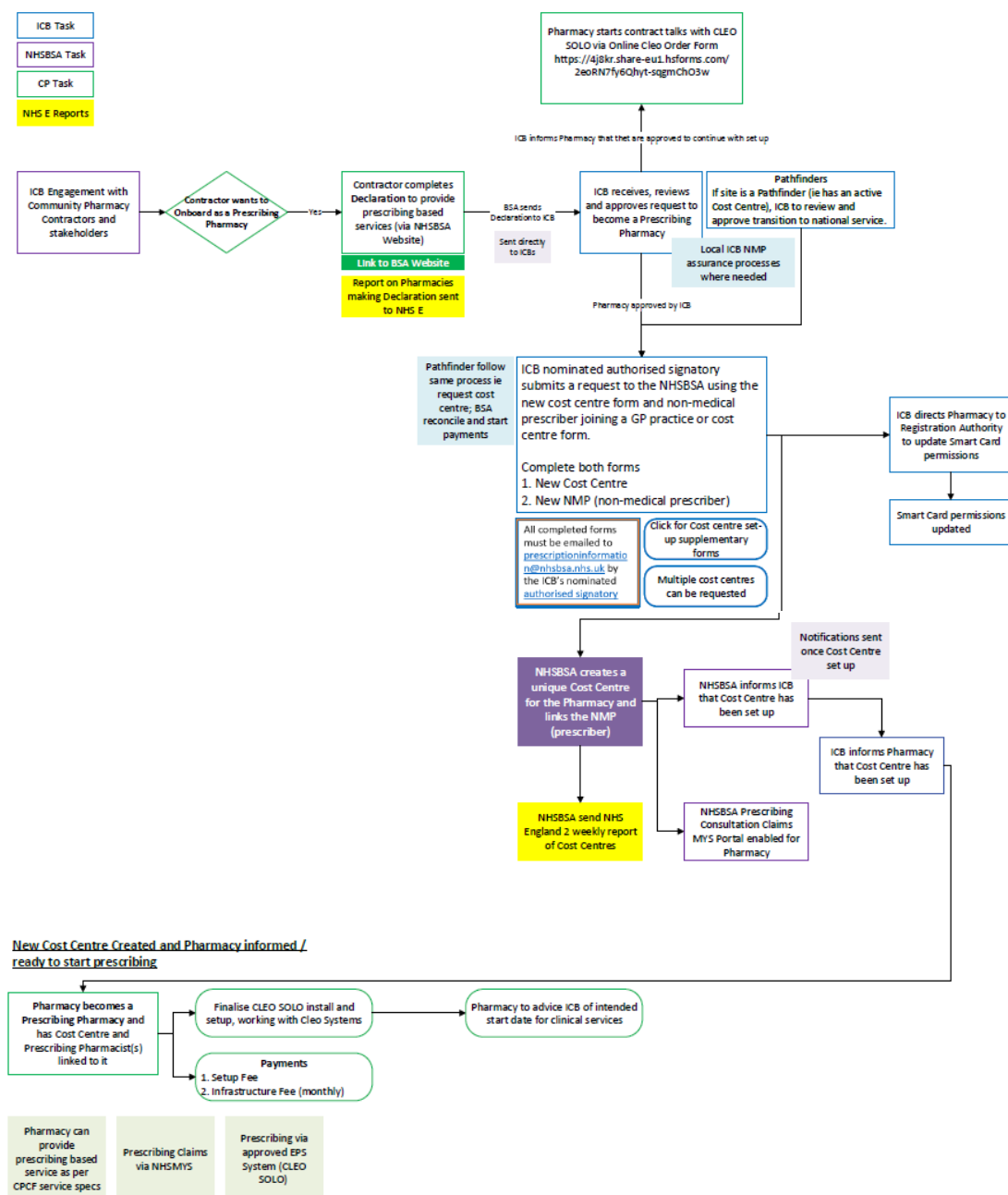
The governance approach is also aligned to NHS Cheshire and Merseyside ICB NMP Policies <https://www.cheshireandmerseyside.nhs.uk/media/ojbbp345/cm-icb-nmp-policy-final-v20-september-2026.pdf>

Appendix 2- ICB Assurance requirements as specified by NHS England

The components required by NHSE for ICBs to assure are:

- Independent prescribing pharmacist professional assurance
- Indemnity
- Prescribing oversight and audit
- Patient safety and incident reporting
- Premises standards, equipment and resources
- Safeguarding and consent
- Information Governance
- Digital clinical safety standards
- EPS
- Consultation records
- Access to patient clinical information
- Sharing consultation information with the primary healthcare provider e.g., patient's GP
- Smart cards
- Cost centres
- Risk assessment
- Infection prevention and control
- Clinical supervision

Appendix 3 – NHS England Onboarding Flowchart



Appendix 4 – NHS England Onboarding Information Including Readiness Checklists

1. [Information Pack](#) (v0.4) for ICBs -
2. [Detailed onboarding process](#) for ICBs
3. [Contractor Onboarding Instructions](#) - Requires future NHS access
4. [IT Webinar slides and recording](#) - Requires future NHS access

Appendix 5 – MYS declaration and Assurance

The MYS assurance declaration will include assurance that the contractor has read the service specifications, clinical pathway guardrail documents and completed the professional assurance framework and employer checklist as well as the following declarations (national process):

- a. I am authorised to make this declaration on behalf of the pharmacy contractor named in this application.
- b. The pharmacy intends to provide the prescribing element of the Pharmacy First Clinical Pathways service and/or the Pharmacy Contraception Service from X October 2026 and wishes to be considered for approval by the relevant Integrated Care Board (ICB).
- c. The pharmacy has completed the required preparatory work, reviewed the supporting documents in the section below and will deliver the service in accordance with their requirements.
- d. The pharmacy is located within the area of the ICB identified in this declaration and the contact details provided in this declaration are accurate and complete to the best of my knowledge.
- e. The pharmacy is already registered to provide the Pharmacy First Clinical Pathways service and/or the Pharmacy Contraception Service.
- f. The pharmacy understands that submission of this declaration does not itself confer approval to provide the service and that final approval is subject to confirmation by the relevant ICB.
- g. The pharmacy will have sufficient access to a prescriber, registered with the GPhC with the appropriate annotation, and understanding the expectation set by the commissioner to provide a minimum prescribing service level to the public.
- h. All prescribers that could issue prescriptions on behalf of this contractor are named as part of this declaration and the pharmacy will notify the NHS Business Services Authority (NHSBSA) and the relevant ICB if any information provided in this declaration changes before approval is granted.
- i. The pharmacy acknowledges that it must continue to meet all relevant service requirements and any applicable contractual, regulatory and clinical governance obligations in order to provide the service.
- j. The pharmacy is not subject to any investigation, restriction, suspension or enforcement action that could affect its ability to provide the service.

Appendix 6- Additional Information

NHS England Prescribing Implementation Pack v4



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

Date: **15 October 2026**

Implementation of a Local Enhanced Service (LES) to incentivise and accelerate adoption of the Referral Management System (RMS) across primary care

Agenda Item No:

Responsible Director: *Dr Goubran Eskander, Clinical Lead for Strategic Commissioning, NHS Cheshire and Merseyside ICB*

1. Purpose of the Report

1.1

- The proposal for the Implementation of a Local Enhanced Service (LES) with a value of £1.573 million to incentivise and accelerate adoption of the Referral Management System (RMS) across primary care has already been approved in principle by the ICB Executive Team as part of a wider business case to support the Integrated Referral Management and Expansion of Neighbourhood Care for Elective Services.
- To seek approval of the LES from the committee as this proposal sits outside the current general LES review process
- This Local Enhanced Service (LES) aims to streamline the referral journey, improve clinical triage accuracy, and ensure patients receive the right care in the right setting first time.
- Participating general practices will embed and utilise the Gateway referral platform across a variety of referral pathways, engage with ongoing feedback loops, and contribute operational data to enhance referral quality and service efficiency.
- The funding for the GP Referral Management System (RMS) Local Enhanced Service (LES) forms part of NHS Cheshire and Merseyside's ring-fenced "left shift" transformation programme. This investment has been made through a dedicated transformation fund, supplemented by System Development Funding and Better Care Funding, to support the delivery of the NHS 10-Year Health Plan through a shift towards proactive, neighbourhood-based care. The Executive Committee approved funding for the development of integrated referral management and Tier 2 outpatient services as one of five priority transformation schemes commencing in 2026/27. As part of this programme, funding has been allocated to implement a GP LES to incentivise and accelerate adoption of the Referral Management System across primary care, supporting the standardisation of referral management, expansion of community-based services, reduction of demand on hospital outpatient services, and delivery of system-wide transformation over the three-year period from 2026 to 2029. Neil Evans has confirmed this funding was approved as part of the Executive Committee approval of the Integrated Referral Management and Expansion of Neighbourhood Care for Elective Services Business Case outlined in appendix 1.

2. Executive Summary

2.1 Core Objectives

- **Standardise Triage & Pathways:** Drive consistent referral behaviour using standardized, dynamic clinical pathways and Decision Support built into Gateway.

- **Operational Integration:** Ensure all relevant practice staff (GPs, clinicians, administrative teams, allied health professionals) actively engage with and utilise the platform.
- **Quality Improvement:** Implement a structured feedback loop between primary care, triage leads, and secondary care to continuously refine pathways and template usability.
- **Integrate in Single Point Access Referrals:** Embed use of Single Point of Access (SPA) referral pathways so that eligible referrals are managed through a single entry point, enabling consistent triage and allocation to the most appropriate service.

2.2. Service Requirements

Year (2027/28)

- During the 2027/2028 year of the contract, practices will deepen adoption, demonstrate increased usage density, and expand across core clinical specialties.
- **Engagement:**
 - Fully integrate the Gateway platform into practice IT systems and getting the log ins for staff.
 - Fully operationalise and actively refer through all **5 Core Priority Clinical specialties** (MSK, Gynecology, ENT, Ophthalmology, Dermatology) configured on Gateway.
 - Route all eligible **2-Week-Wait (2WW) / Fast-Track Cancer** referrals through the designated Gateway pathways.
- **Demonstrable Volume Progression:**
 - Demonstrate a measurable increase in total referral volume processed via Gateway compared to the 2026/27 baseline.
- **Staff Engagement & Evidence of Use:**
 - Ensure relevant clinical and administrative staff are trained on platform workflows.
- **Feedback & Quality Improvement:**
 - Submit final-stage user feedback to support long-term commissioning decisions and system integration.

- **Continuation of the LES beyond FY27/28:**

- o This LES is intended as a time-limited incentive to support the onboarding and embedding of the Accenda Gateway Referral Management System. Funding has been approved to support adoption and sustained incentives sustained use throughout 2027/28. (Payments will only be made during FY 27 / 28). There are currently no plans to continue LES payments beyond 31 March 2028. The expectation is that, by the end of 2027/28, use of Accenda Gateway will be fully established within routine practice workflows, with the operational, clinical and administrative benefits realised by practices and patients providing sufficient incentives for continued use without the need for ongoing financial support. As such, the LES is intended to facilitate adoption and behavioural change rather than provide a permanent source of recurrent funding.

2.3 Payment Structure & Financial Schedule

Payment for this LES is calculated based on the practice's total registered population size (per patient list size).

Payment Component	Timing	Payment Rate	Verification Criteria
Year 27/28 Payment	Quarterly payments at end of each quarter of FY 27/28	£0.50 per weighted patient per financial year	Submission of staff usage logs, Gateway pathway activation, and completed Year 1 feedback log. Accenda/Gateway reports to support the usage data

2.4 Governance & Monitoring

- **Reporting:** Practices must submit annual self-declaration forms and usage evidence via the CQRS, or local portal as directed by the ICB.
- **De-registration:** Practices failing to demonstrate staff usage or submit required feedback within agreed timeframes may have payments pro-rated or withheld.
- **Payments:** Payments under this Local Enhanced Service (LES) will be made to participating GP practices quarterly in arrears. Practices will be required to submit claims and any associated evidence through the CQRS Local system, which is the established mechanism used across primary care for the administration and payment of a range of Local Enhanced Services and other commissioned schemes. Claims will be reviewed and validated in accordance with the requirements of this specification, with approved payments processed at the end of each quarter of the financial year. This approach provides a consistent and familiar process for practices, supports appropriate assurance of scheme delivery, and ensures that

payments are linked to the achievement of agreed activity and performance requirements.

3. Ask of the Committee and Recommendations

3.1 The Committee is asked to:

- Approve the implementation of a Local Enhanced Service (LES) valued at £1.573 million to incentivise and accelerate adoption of the Referral Management System (RMS) across primary care.

4. Reasons for Recommendations

4.1

- A targeted LES would recognise the additional effort required for practices to embed new digital pathways, adapt established referral practices, engage with training and system configuration, and contribute to the ongoing evaluation and development of services. By supporting primary care through a combination of financial incentives and structured implementation support, the LES would enable more consistent utilisation of the RMS across primary care. It also represents a collaborative and pragmatic approach to transformation, supporting practices while aligning incentives with system priorities. Over time, as adoption becomes embedded and sustainable, it is anticipated that reliance on incentives can be reduced.
- It is proposed that the LES is implemented on a price per weighted head of population basis, ensuring funding is aligned to underlying healthcare need through adjustments for factors such as age and deprivation. The proposed rate is £0.50 per weighted head.
- It is anticipated that, during this period, the introduction of a LES will significantly increase both the scope and pace of change associated with the RMS programme.

5. Background

5.1

- A business case from the Provider Collaborative 'Integrated Referral Management and expansion of Neighbourhood Care for Elective Services' which included the proposal for the GP LES has previously been approved at ICB Executive Level.

Implications and Comments

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

Objective One: Tackling Health Inequalities in access, outcomes and experience

The LES supports more equitable access to care by standardising referral pathways across all practices through the Gateway platform. Consistent triage criteria and clinical decision support reduce variation in referral quality and help ensure patients receive timely access to appropriate services regardless of where they live. The use of weighted population funding also recognises differing levels of need associated with deprivation and population demographics

Objective Two: Improving Population Health and Healthcare

The LES improves patient outcomes by ensuring patients are directed to the most appropriate service first time through structured referral pathways, clinical decision support and enhanced triage. Improved referral quality, greater use of community and neighbourhood services, and reduced delays in accessing specialist care support better population health outcomes and improved patient experience.

Objective Three: Enhancing Productivity and Value for Money

The Gateway platform reduces inappropriate referrals, administrative duplication and unnecessary outpatient activity through standardised referrals and integrated pathways. By increasing referral accuracy and supporting right-first-time decision-making, the LES helps optimise NHS resources, improve efficiency across the system and maximise the return on investment from the referral management programme

Objective Four: Helping to support broader social and economic

The LES supports workforce productivity by reducing delays in diagnosis and treatment, helping patients access care more efficiently and return to daily activities sooner where appropriate. It also promotes digital transformation within primary care and strengthens collaboration between primary, community and secondary care providers, supporting long-term system sustainability and service resilience

7. [Link to achieving the objectives of the Annual Delivery Plan](#)

The RMS GP LES directly supports the Annual Delivery Plan priorities relating to elective care recovery, digital transformation, neighbourhood care and improving access to services. By standardising referrals through the Gateway platform, improving referral quality, embedding clinical decision support and directing patients to the most appropriate care first time, the LES will help reduce variation, improve patient experience, support more effective use of NHS resources and contribute to sustainable reductions in elective care demand and waiting times across Cheshire and Merseyside.

8. [Link to meeting CQC ICS Themes and Quality Statements](#)

Theme One: Quality and Safety

The RMS GP LES supports quality and safety by embedding standardised referral pathways, clinical decision support and structured triage processes within Gateway. This helps reduce unwarranted variation in referral quality, improves referral accuracy, supports patients to access the right care first time and provides ongoing feedback mechanisms to drive continuous quality improvement and learning across primary and secondary care.

Theme Two: Integration

The RMS GP LES strengthens integration by creating a consistent referral process across primary, community and secondary care services. Gateway enables shared pathways, improved communication, coordinated triage and better continuity of care, supporting safer transitions between services and greater collaboration between clinical teams across the Cheshire and Merseyside system

Theme Three: Leadership

The RMS GP LES demonstrates leadership through system-wide adoption of digital transformation, clear governance arrangements, performance monitoring and continuous improvement. The LES promotes a shared strategic direction across organisations, encourages staff engagement and training, and supports evidence-based commissioning decisions through the collection of referral activity, feedback and outcome data.

9. Risks

9.1

- Failure to approve the LES may result in slower and less consistent adoption of the Gateway Referral Management System across primary care. This could limit the system's ability to standardise referral pathways, improve referral quality, support elective recovery and deliver planned productivity benefits. Reduced engagement from practices may diminish opportunities for pathway optimisation, clinical feedback and continuous improvement, resulting in lower return on existing programme investment. Inconsistent adoption may also increase variation in patient access and referral outcomes across Cheshire and Merseyside, potentially impacting the ICB's objectives relating to quality, efficiency and health inequalities

10. Finance

10.1

- Approval of the GP LES will release £1.573 million of funding to flow into General Practice to support and accelerate adoption of the Accenda Gateway Referral Management System (RMS). The LES forms part of the wider business case for Integrated Referral Management and Expansion of Neighbourhood Care for Elective Services and is intended to facilitate the delivery of the anticipated clinical, operational and financial benefits associated with that programme

- This is not a request for new funding. Funding for the LES was included within the business case approved by the Provider Collaborative in June 2026 and is therefore a deployment of previously approved investment to support implementation of the RMS programme.
- Approval of the recommendation is expected to have a positive financial impact through increased adoption of the RMS, supporting referral optimisation, pathway standardisation and delivery of the benefits identified within the approved business case. Conversely, non-approval may reduce practice engagement and uptake, delaying or limiting achievement of anticipated efficiencies and reducing the return on investment from the wider programme.
- The LES funding relates to Financial Year 2027/28 and is intended as a time-limited implementation incentive. It is anticipated that by the end of 2027/28 the use of Accenda Gateway RMS will be sufficiently embedded within practice workflows, reducing or removing the need for ongoing incentive payments. Funding will be met from existing commissioning resources already identified within the approved business case and is therefore considered a non-recurrent investment.
- The ICB has entered into a contract with Accenda for the provision of the Accenda Gateway Referral Management System, with an initial term of 15 months commencing on 1 January 2026 and ending on 31 March 2027. The value of the initial contract is £701,318.75 (excluding VAT). The contract includes an option to extend for a further 12 months, from 1 April 2027 to 31 March 2028, at a cost of £561,055.00 (excluding VAT), resulting in a total potential contract value of £1,262,373.75 (excluding VAT) over the full 27-month period. To facilitate continuation of the service during 2027/28, a formal contract variation will be required in March 2027 to enact the extension option. This variation will be managed through the ICB's Procurement Team and, due to the value of the extension, will be subject to oversight and approval through the Procurement Decision Review Group (PDRG) in accordance with the ICB's governance and procurement processes.
- To ensure that practices are treated fairly, no practice will be financially disadvantaged or deemed non-compliant where failure to meet scheme requirements is wholly attributable to circumstances beyond its reasonable control. This includes, but is not limited to, outages of the Referral Management System (RMS), wider NHS digital infrastructure failures, cyber security incidents such as ransomware attacks, network disruptions, or other significant technical failures affecting system availability. Where such events occur, the Commissioner will work with affected practices to agree appropriate mitigations and alternative arrangements, and performance against LES requirements will be assessed taking account of the impact and duration of the disruption. Practices will not be subject to payment recovery, withholding of payments, or contractual sanctions for activity that could not reasonably be completed as a result of these exceptional circumstances.

11. Communication and Engagement

11.1

- The RMS Programme Team has undertaken extensive engagement with system stakeholders throughout the development and implementation of the Referral Management System (RMS), including primary care, secondary care, clinical leads, operational teams and commissioning colleagues. Feedback has been consistently supportive of the need for a standardised referral management approach that improves referral quality, pathway compliance and patient access to the most appropriate care.
- The report is informed primarily by the views of clinicians, practice staff, provider organisations and system partners who have contributed to the development of the wider Integrated Referral Management and Expansion of Neighbourhood Care for Elective Services programme. The recommendations also reflect the objective of improving patient experience through reduced variation, more consistent referral processes and improved access to the right care first time.
- Further engagement will take place with General Practice following approval of the LES. As part of this, Dr Gouburan Eskander will undertake a series of engagement sessions with each Place's Local Medical Committee to socialise the LES, explain the requirements and benefits, and support successful implementation and adoption across practices.
- Formal consultation is not required as the proposal relates to a contractual incentive mechanism to support implementation of an approved service transformation programme and does not constitute a substantial change to patient services.
- Quality and patient experience considerations have been central to the development of this proposal. The LES is designed to support consistent use of standardised referral pathways, improve referral quality, reduce unwarranted variation and help ensure patients are directed to the most appropriate service first time. Increased adoption of the RMS is expected to improve the overall referral experience for patients whilst supporting safer, more efficient and integrated care pathways across Cheshire and Merseyside.

12. Equality, Diversity and Inclusion

12.1

- The RMS GP LES is expected to have a positive impact on equality, diversity and inclusion by promoting more consistent referral decision-making and reducing unwarranted variation in access to specialist services across Cheshire and Merseyside. Standardised referral pathways and clinical decision support will help ensure that patients are referred based on clinical need rather than local processes or differing practice behaviours.

- The proposal also supports the ICB's objective to reduce health inequalities by enabling equitable access to referral pathways regardless of a patient's location, ethnicity, age, disability, sex, religion, sexual orientation or socioeconomic circumstances. The use of weighted population funding recognises differing levels of population need, including deprivation and demographic factors, helping to ensure that practices serving more complex populations are appropriately supported during implementation.
- Improved referral quality and better signposting to the most appropriate service first time may particularly benefit groups who traditionally experience barriers to accessing care, reducing delays and improving patient experience and outcomes. No significant adverse equality impacts have been identified at this stage; however, these will continue to be monitored throughout implementation and mitigated through ongoing engagement, training and pathway review.

13. Climate Change / Sustainability

13.1

- NA

14. Next Steps and Responsible Person to take forward

14.1

- Following Approval of the LES, Dr Goubran Eskander will continue his LMC engagement. Once completed the LES will be issued by the Central Contracts Team to Practices.

15. Officer contact details for more information

15.1

- Ailsa Meakin – Project Support Officer
(Ailsa.Meakin@cheshireandmerseyside.nhs.uk)
- Chris Rees – Primary Care Development Support Manager and Referral Optimisation System Project Manager
(Christopher.Rees@cheshireandmerseyside.nhs.uk)

16. Appendices

Appendix One: Integrated Referral Management and Expansion of Neighbourhood Care for Elective Services Business Case



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Appendix Two: GMS GP LES



Gateway%20GP%20LES%20Final%201.0.doc

Appendix Three: Position Statement and Proposal for Wave 2



Position%20Statement%20and%20Proposal.doc

Appendix Four: Programme Communications



Provider Comms
Accenda Final August

Appendix Five: Latest referral data



Referral%20Data%20at%2029092026.xlsx

SERVICE SPECIFICATION NO:	
SERVICE:	Optimising Referral Pathways via the Gateway Referral Support Platform
PROVIDER:	Accenda
Commissioner Lead	Chris Rees
Provider Lead	Ian Cooper
Period	01/04/2027 – 31/03/2028
Date of Review	01/10/2027

Version Control:

Version No:	Section Edited:	Editing Author:	Date:
0.1	Original document produced	Dr G Eskander	15/08/2026
0.2	Format of document updated to use standard LES template	Chris Rees	11/09/2026
0.3	Multiple changes following review with Lorraine Weekes and Kevin Highfield	Chris Rees	05/10/2026

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Mandatory headings 1 – 4: mandatory but detail for local determination and agreement
Optional headings 5-7: optional to use, detail for local determination and agreement.

All subheadings for local determination and agreement

Service Specification No.	
Service	Optimising Referral Pathways via the Gateway Referral Support Platform
Commissioner Lead	Chris Rees
Provider Lead	Accenda Gateway
Period	01/04/2027 – 31/03/2028
Date of Review	01/10/2027

1. Population Needs

1.1 National/local context and evidence base

Health services across England continue to experience significant pressure from rising demand for elective and outpatient care, resulting in extended waiting times for many patients. At the same time, variation in referral quality and pathway selection can lead to referrals being directed to services that are not the most appropriate for a patient's needs, creating avoidable delays, duplication and additional administrative burden for providers and referrers. A key strategic priority for NHS Cheshire and Merseyside Integrated Care Board is to ensure that patients receive the right care, in the right place, at the right time, with greater utilisation of community-based services where clinically appropriate. Supporting patients to access care closer to home can improve patient experience, reduce pressure on acute hospitals and make better use of available healthcare resources.

In July 2025, the ICB approved the implementation of a single digital Referral Management System (RMS) across Cheshire and Merseyside to standardise referral processes, improve referral quality, support elective recovery, and ensure consistent application of patient choice principles. The Accenda

Gateway platform provides structured referral pathways, decision-support functionality and enhanced triage processes that help referrers identify the most appropriate service at the point of referral. By increasing adoption of Gateway across primary care, the ICB aims to reduce unwarranted variation, increase referrals to appropriate community and specialist services, improve referral accuracy and support more timely access to care for patients

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	
Domain 2	Enhancing quality of life for people with long-term conditions	X
Domain 3	Helping people to recover from episodes of ill-health or following injury	X
Domain 4	Ensuring people have a positive experience of care	X
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	X

2.2 Local defined outcomes

- **Standardise Triage & Pathways:** Drive consistent referral behaviour using standardized, dynamic clinical pathways and Decision Support built into Gateway.
- **Operational Integration:** Ensure all relevant practice staff (GPs, clinicians, administrative teams, allied health professionals) actively engage with and utilise the platform.
- **Quality Improvement:** Implement a structured feedback loop between primary care, triage leads, and secondary care to continuously refine pathways and template usability.

3. Payment Structure & Financial Schedule

Payment for this LES is calculated based on the practice's total registered population size (per patient list size).

Payment Component	Timing	Payment Rate	Verification Criteria
Year 27/28 Payment	Paid quarterly at	£0.50 per weighted	Submission of staff usage logs, Gateway

	the end of each quarter	patient per financial year	pathway activation, and completed Year 1 feedback log. Accenda/Gateway reports to support the usage data
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4. Governance & Monitoring

- **Reporting:** Practices must submit annual self-declaration forms and usage evidence via the CQRS, or local portal as directed by the ICB.
- **De-registration:** Practices failing to demonstrate staff usage or submit required feedback within agreed timeframes may have payments pro-rated or withheld.
- **Payments:** Payments under this Local Enhanced Service (LES) will be made to participating GP practices quarterly in arrears. Practices will be required to submit claims and any associated evidence through the CQRS Local system, which is the established mechanism used across primary care for the administration and payment of a range of Local Enhanced Services and other commissioned schemes. Claims will be reviewed and validated in accordance with the requirements of this specification, with approved payments processed at the end of each quarter of the financial year. This approach provides a consistent and familiar process for practices, supports appropriate assurance of scheme delivery, and ensures that payments are linked to the achievement of agreed activity and performance requirements.
- **Duration:** The LES funding relates to Financial Year 2026/27 and is intended as a time-limited implementation incentive. It is anticipated that by the end of 2026/27 the use of Accenda Gateway RMS will be sufficiently embedded within practice workflows, reducing or removing the need for ongoing incentive payments. Funding will be met from existing commissioning resources already identified within the approved business case and is therefore considered a non-recurrent investment.
- **Availability:** To ensure that practices are treated fairly, no practice will be financially disadvantaged or deemed non-compliant where failure to meet scheme requirements is wholly attributable to circumstances beyond its reasonable control. This includes, but is not limited to, outages of the Referral Management System (RMS), wider

NHS digital infrastructure failures, cyber security incidents such as ransomware attacks, network disruptions, or other significant technical failures affecting system availability. Where such events occur, the Commissioner will work with affected practices to agree appropriate mitigations and alternative arrangements, and performance against LES requirements will be assessed taking account of the impact and duration of the disruption. Practices will not be subject to payment recovery, withholding of payments, or contractual sanctions for activity that could not reasonably be completed as a result of these exceptional circumstances

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

Date: 15 October 2026

All Together Smiling and Mini Mouth Care Matters: Improving Children's Oral Health across Cheshire and Merseyside

Agenda Item No: 14.0

Responsible Director: *Prof. Ian Ashworth, Director of Population Health, NHS Cheshire and Merseyside*

Prepared By: *Jordan Brown, Programme Manager, Beyond CYP Transformation Programme & Dr. Susana Dominguez-Gonzalez, Consultant Orthodontist, Alder Hey Children's NHS Foundation Trust*

1. Executive Summary

- 1.1 Cheshire & Merseyside's 5-year Population Health Improvement Plan (PHIP) prioritises children and young people (CYP) as a population, increasingly building a 'one CYP system' approach. The PHIP also identifies a specific priority on improving the oral health of CYP.
- 1.2 All Together Smiling (ATS) is C&M ICB's population health strategic approach for oral health. This initially supported the implementation of ATS Supervised toothbrushing in community childcare settings, and the distribution of oral health packs to CORE 20+ populations, deployed through the Beyond programme. This business case outlines (depicted in Figure 1 below) the extension of the approach to oral health prevention for children in inpatient beds, across every paediatric inpatient hospital site in Cheshire & Merseyside, through the system-wide roll out of the Alder Hey Children's NHS Foundation Trust's Mini Mouthcare Matters (MMCM) - and extend to deliver a universal offer to all Special Educational Needs education settings. The Alder Hey Mini Mouthcare Matters team will work in a delivery partnership with Beyond to help scale the programme across all sites.

Figure 1: All Together Smiling Programme Overview



- 1.3 The three-year implementation of 'All Together Smiling' (ATS), Cheshire and Merseyside's evidence-based oral health improvement programme, approved by the System Primary Care Committee (SPCC) in October 2023, was established to enable upstream prevention at scale, addressing high levels of dental decay among children aged 2-7, with a particular focus on those living in the most deprived CORE20+ populations. This ambition is strengthened in the business case, proposing universal extension of supervised toothbrushing into SEND settings and the development of MMCM.
- 1.4 Since mobilisation in April 2024, ATS has delivered a structured, region-wide supervised toothbrushing (STB) programme and coordinated distribution of targeted toothbrush and fluoride toothpaste packs to CORE 20+ populations

alongside oral health promotion and engagement activity. Delivery is aligned with national guidance and supported by Dental Public Health, NHS England (NHSE) Northwest.

- 1.5 Tooth decay remains a significant system challenge, with 31.2% of 5-year-olds in Cheshire and Merseyside living with dental decay, substantially higher than the England average of 22.4%¹. Dental extractions under general anaesthesia continue to be the leading cause of hospital admissions for 5-9-year-olds with 2,645 extraction episodes recorded across Cheshire and Merseyside in 2025, a rate of 455.8 episodes per 100,000 children (England 413.9 per 100,000 children), of which 1,795 (71%) were due to tooth decay² - an increase of ~200 decay-related cases compared with 2024 data. Based on national data, the cost of decay-related tooth extractions in Cheshire and Merseyside is estimated to have been £2.7 million in 25/26.
- 1.6 Evidence shows that, to achieve meaningful improvements in oral health outcomes, STB programmes must reach a participation rate of 50% of eligible settings and be sustained for a minimum of three years, while population-level outcomes are typically observed after five years.³.
- 1.7 ATS exceeds the evidence-based recommendation with 341 early years and primary school settings (58% of those eligible) participating in STB, and 18,267 children taking part. The programme has distributed over 450,000 targeted oral health packs to CORE20PLUS communities, the children most at risk of decay.
- 1.8 Sustained investment is required to ensure the return on investment in ATS is maximised through the achievement of long-term oral health outcomes that are delivered with evidence-based STB programmes.
- 1.9 This business case seeks funding to sustain existing ATS programme delivery, with an expansion to provide a universal offer for children and young people with Special Educational Needs and Disabilities (SEND). Efficiencies in delivery have been made during mobilisation and this is reflected in a reduced annual cost. It is recommended that the ICB commits to a three-plus-two-year contract maintaining the at-scale delivery through the established central model, governance and quality assurance.
- 1.10 Cost for delivery of the supervised toothbrushing (including expansion into SEND settings) and oral health pack elements of ATS 2027-30 is: £364,280 in

¹ Office of Health Improvement and Disparities (2024). Oral health survey of 5-year-old schoolchildren.

² Office for Health Improvement and Disparities (2025). Hospital-based tooth extractions in 0- to 19-year-olds.

³ Macpherson, L. M. D., Anopa, Y., Conway, D. I., & MC&Mahon, a D. (2013). National supervised toothbrushing program and dental decay in Scotland. *Journal of Dental Research*, 92(2), 109–13. <http://doi.org/10.1177/0022034512470690>

27/28 (consumables partially covered within existing contract delivery), £523,147 in 28/29, and £539,269 in 29/30.

- 1.11 It is also recommended to expand the reach of Mini Mouth Care Matters (MMCM), currently delivered successfully within Alder Hey Children's NHS Foundation, across all district general hospitals (DGH) in Cheshire and Merseyside with dedicated children's wards. Hospital admission represents a unique opportunity to identify unmet oral health needs, deliver preventative interventions and connect children and families to dental services through an established and evaluated model developed locally at our Trust.
- 1.12 Since implementation at Alder Hey, MMCM has supported 4,499 children and young people, delivered training to over 900 healthcare professionals and embedded structured oral health assessment and mouth care within routine inpatient care. The programme has demonstrated that oral health assessment and mouth care can be successfully embedded within routine paediatric inpatient care when supported by appropriate training, resources and governance arrangements.
- 1.13 Expansion of MMCM across DGHs in Cheshire and Merseyside through a three-plus-two-year contract would cost £294,284 in 2027/28, £292,860 in 2028/29 and £308,967 in 2029/30.
- 1.14 Total costs to deliver ATS and MMCM over the next 3 (+2) years would be: £658,564 in 27/28, £816,007 in 28/29, and £848,036 in 29/30.

2. Ask of the Committee and Recommendations

The Committee is asked to:

- 2.1 Approve the recommendation to sustain ATS and approve the expansion of MMCM across all DGHs with children's wards, on a three-plus-two-year contract.

3. Reasons for Recommendations

- 3.1 The recommendation to sustain ATS is based on clear evidence that the current participation rate must be maintained for a minimum of three years to demonstrate the intended improved outcomes. Delivery through a three-plus-two-year contract will ensure outcomes are achieved for current cohorts while also supporting additional cohorts in the coming years. Due to high rates of tooth decay and extractions due to decay in Cheshire and Merseyside, an enhanced offer that is sustained long-term is required to improve population-level outcomes.

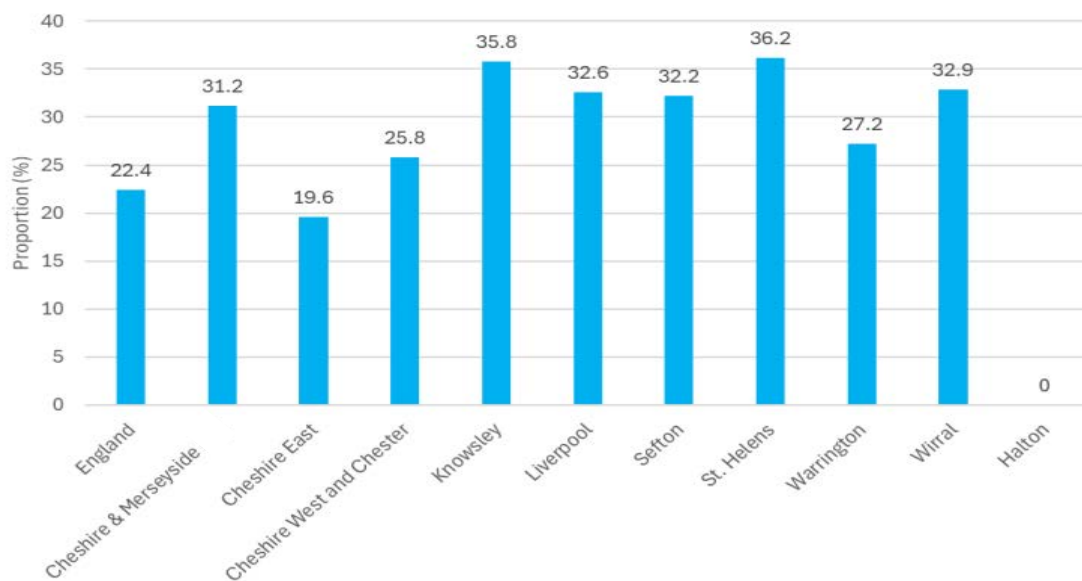
- 3.2 The recommendation to expand MMCM is based on the recognition that hospital admission represents a unique opportunity to identify and address unmet oral health needs among children and young people. Expanding MMCM will enable oral health assessment, prevention and intervention to be embedded within routine inpatient care, helping to prevent avoidable harm, reduce health inequalities and improve outcomes through a proven model already established within Alder Hey.

4. Introduction/ Background

- 4.1 This paper provides updates on ATS programme achievements since approval of the initial proposal in October 2023 (Appendix One) to implement a consistent, evidence-based oral health improvement programme across Cheshire and Merseyside. It sets out a proposal for sustained commissioning of ATS, and expansion of MMCM, ensuring that improved oral health outcomes are evidenced.
- 4.2 Oral health is a core component of overall health, wellbeing, and development for children affecting speech development, school readiness and attendance, confidence, self-esteem, sleep, and more.
- 4.3 Despite being largely preventable, Cheshire and Merseyside continues to have some of the highest rates of childhood dental decay, highlighting an ongoing and urgent need for action. This challenge is further exacerbated by oral health inequalities disproportionately affecting disadvantaged children.
- 4.4 Figure 2 presents the latest findings from the latest National Dental Epidemiology Programme (NDEP) oral health survey of 5-year-olds from 2024, highlighting the scale of the challenge and the need for a continued system-wide, evidence-based approach. This data shows that in Cheshire and Merseyside, 31.2% of 5-year-olds are living with tooth decay, with St Helens recording the highest rate locally of 36.2%, which is 8.8% above the regional average and 13.8% above the England average of 22.4⁴.

⁴ Office of Health Improvement and Disparities (2024). Oral health survey of 5-year-old schoolchildren.

Figure 2 – NDEP: Oral health survey of 5-year-olds (2024) - Cheshire and Merseyside findings⁵:



- 4.5 Children are continuing to experience poor oral health, with seven of the eight Local Authority areas participating in the 2024 survey reporting rates worse than the England average. This pattern contributes to high levels of dental extractions under general anaesthesia (GA) and highlights both the significant variation and the continued oral health inequalities across the system.
- 4.6 Tooth decay remains the leading cause of hospital admission for 5-9-year-olds, exceeding admissions for other common childhood conditions such as asthma, epilepsy, and diabetes. Data on hospital-based tooth extractions in 0-19-year-olds data shown Cheshire and Merseyside recorded 2,645 extraction episodes, a rate of 455.8 episodes per 100,000 children (England 413.9 per 100,000 children), of which 1,795 (71%) were due to tooth decay, an increase of ~200 decay-related cases compared with 2024 data. Decay-related tooth extractions cost the NHS £51.2 million in 25/26⁶ and based on these figures, the estimated cost of decay-related tooth extractions in Cheshire and Merseyside was approximately £2.7 million in 2025/26.
- 4.7 These figures demonstrate both the scale and largely preventable nature of childhood dental disease. Children living in the most deprived communities experience some of the poorest oral health outcomes, with rates of decay-related hospital tooth extraction more than three times higher than those seen among children living in the most affluent communities. This reinforces the

⁵ Halton did not participate in the 2024 survey.

⁶ Office for Health Improvement and Disparities (2025). Hospital-based tooth extractions in 0- to 19-year-olds.

need for sustained action that prioritises prevention, early identification and targeted support for those most at risk.

- 4.8 Oral health improvement programmes provide an important opportunity to intervene earlier, before children require urgent or hospital-based treatment. Embedding prevention, education and behaviour change support within settings that children and families routinely access can improve outcomes, reduce inequalities and reduce avoidable demand on NHS services. Continued upstream investment is therefore essential to improve oral health outcomes and reduce the significant costs currently associated with dental decay.
- 4.9 Hospital admission represents a valuable opportunity to identify unmet oral health needs. Evidence from the implementation of MMCM at Alder Hey has demonstrated gaps in routine oral health assessment and staff training, alongside opportunities to improve oral healthcare during hospital stays. Incorporating oral health assessment, effective mouth care and signposting into routine paediatric care can help prevent deterioration in oral health, support wider general health and wellbeing and promote positive oral health behaviours. Good mouth care is also an important component of infection prevention and may contribute to reducing the risk of respiratory complications, including hospital-acquired pneumonia, particularly in vulnerable patients. The MMCM approach also provides an opportunity to connect children and families with primary dental services, supporting continuity of care following discharge.

Alignment to ICB strategies

- 4.10 ATS directly supports the Cheshire and Merseyside Primary Care Dental Improvement Strategy by taking a preventative, upstream approach that will reduce future demand for dental services. The programme is delivered in line with All Together Fairer and the Strategic Commissioning Plan and Population Health Improvement Plan, with a focus on CORE20PLUS communities, contributing to improved population health outcomes through prevention, tackling health inequalities, and ensuring children have the best start in life.
- 4.11 The expansion of MMCM complements this approach by embedding oral health prevention and early intervention within paediatric inpatient settings, strengthening links between hospital and primary care services, identifying unmet need and improving access to oral health support for children and families.

5. Section 1: All Together Smiling

- 5.1 Since April 2024, Beyond, the children and young people's transformation programme on behalf of NHS Cheshire and Merseyside, has mobilised ATS, enabling structured, evidence-based delivery at scale across the sub-region. All nine Local Authority areas are fully engaged in and committed to the programme, with participation formalised through Memorandums of Understanding.
- 5.2 The programme team have provided central governance, co-ordination, resources, monitoring and support, underpinned by clinical advice from Dental Public Health NHS England Northwest.

Place	Before All Together Smiling Delivery		Current Delivery	
	Delivery of STB Programmes	Distribution of Oral Health Packs	Delivery of STB Programmes	Distribution of Oral Health Packs
Cheshire East	No	No	Yes	Yes
Cheshire West and Chester	No	Yes	Yes	Yes
Halton	Yes (limited self-funded settings)	Yes	Yes	Yes
Knowsley	No	Yes	Yes	Yes
Liverpool	No	No	Yes	Yes
Sefton	No	No	Yes	Yes
St Helens	No	No	Yes	Yes
Warrington	Yes	Yes	Yes	Yes
Wirral	No	Yes	Yes	Yes

- 5.3 Pre-programme scoping identified that five Local Authorities distributed oral health packs in their communities, mostly limited in the provisions available, and only one had an established STB offer.
- 5.4 ATS has worked in partnership with public health and provider colleagues to establish STB programmes and enhance existing oral health improvement activity. As a result, consistent, evidence-based STB programmes, and the distribution of large quantities of oral health packs to children most at risk of decay, are being delivered across all nine Local Authority areas.

Programme reach to date

- 5.5 Evidence from Scotland's Childsmile programme shows that meaningful improvements in oral health outcomes require a setting participation rate of over

50%, delivered consistently for a minimum of three years to begin evidencing outcomes, and sustained for over five years to achieve population-level impact⁷.

- 5.6 ATS is fully mobilised and, since Q4 2025/26, has achieved more than 50% coverage of eligible early years, childminder, and primary school settings. 341 settings are currently participating (58% of those eligible), with 18,267 children taking part, establishing positive lifelong oral health habits. In total, over 450,000 oral health packs have been distributed, targeting CORE20PLUS communities in partnership with public health teams, health visitors, dental services, DGHs, and community and voluntary organisations⁸.
- 5.7 ATS has provided enhanced support for children with SEND, supplying adapted toothbrushing products, ensuring inclusive STB, and delivering targeted activity across specialist SEND settings, alternative provisions, Speech and Language teams, Family Hubs, community hubs, and 0-19 services. The programme is piloting a universal supervised toothbrushing (STB) offer for children with SEND and delivery to date indicates that, with continued investment and resource availability, the programme could scale this approach to provide a fully inclusive universal SEND offer.
- 5.8 Targeted oral health pack distribution has also focused on CORE20PLUS communities, ensuring packs reach faith and cultural groups, children supported by social care, home-educated children, SEND and alternative provision settings, refugee and asylum-seeking families, and traveler communities.

National supervised toothbrushing programme

- 5.9 Structured, system-wide collaboration has ensured that national STB programme resources, including those provided at part of the national government partnership with Colgate, allocated to Local Authorities complement rather than duplicate ATS delivery. An options appraisal process, supported by Dental Public Health NHSE Northwest, has been undertaken to maintain strategic alignment, avoid duplication, and maximise return on investment.
- 5.10 Due to the scale of oral health inequalities across Cheshire and Merseyside, sustained delivery is required to improve population-level outcomes.
- 5.11 Local Authority use of national resources varies, but these inputs are further strengthening the local offer by enabling universal provision, additional distribution of oral health packs, increased public health capacity, and expanded community-based oral health support.

⁷ Macpherson, L. M. D., Anopa, Y., Conway, D. I., & MC&Mahon, a D. (2013). National supervised toothbrushing program and dental decay in Scotland. *Journal of Dental Research*, 92(2), 109–13. <http://doi.org/10.1177/0022034512470690>

⁸ Programme reach data reflects the position at quarter one 26/27 end.

Expected outcomes

5.12 It is expected this programme will deliver the following outcomes:

- Reduced oral health inequalities - demonstrated through reductions in the severity of tooth decay at age 5 (dmft) by deprivation quintile.
- Reduced prevalence and severity of tooth decay - evidenced by a decrease in the proportion of 5-year-olds with dental decay (%) and reductions in average severity (dmft).
- Improved health, wellbeing and development - measurable improvements in overall health, wellbeing and early childhood development among 2-7-year-olds in the most deprived communities, evidenced through changes in oral-health-related wellbeing and developmental indicators.
- Reduced cost within urgent and acute services – evidenced by reductions in hospital admissions for dental extractions under general anaesthetic, lower demand for urgent dental care, and a reduction in NHS expenditure associated with dental treatment.

5.13 To achieve these outcomes, the current scale of delivery must be sustained over a minimum of three years, in line with established evidence on population-level oral health improvement.

Case for continuing investment

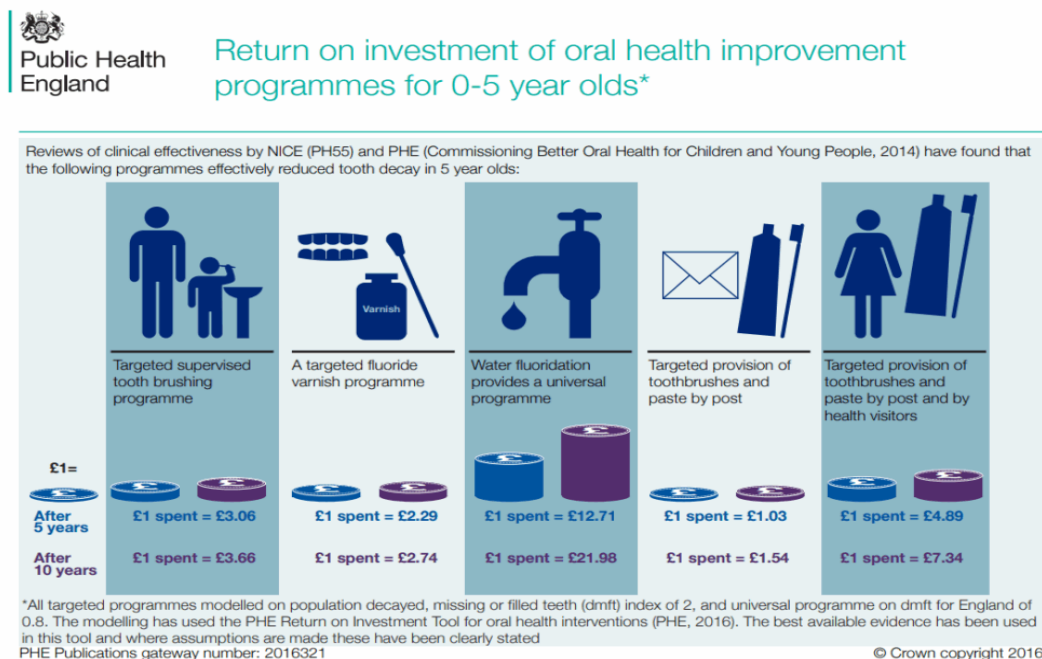
5.14 Further investment will safeguard the progress already made, enable the current cohorts of children to receive the full benefit of the intervention, and ensure Cheshire and Merseyside can realise measurable improvements in oral health outcomes

Return on investment

5.15 STB programmes deliver the greatest return on investment of £3.06 for every £1 spent after five years and increasing further over ten years (figure 3). Targeted distribution of toothbrush and toothpaste packs provides the second-strongest ROI⁹. Measurable reductions in tooth decay reduce demand in acute services for extractions under GA, in turn presenting significant cost savings within urgent and acute dental care services.

⁹ Public Health England (2016): Return on investment of oral health improvement programmes for 0–5-year-olds: https://assets.publishing.service.gov.uk/media/5a80ee0bed915d74e6231403/ROI_oral_health_interventions.pdf

Figure 3: Return on Investment of Oral Health improvement programmes



Finance

- 5.16 The initial programme, before uplifts, was commissioned at a total value of £1,610,590 over three years of delivery. The agreed delivery model against this investment includes £199,126 in pay costs and £370,069 non-pay costs a total of £569,195 per annum.
- 5.17 Delivery of ATS since 2024 has enabled the programme model to be tested and efficiencies identified through: streamlined staffing, an established delivery model, competitive consumables pricing¹⁰, reduced communications requirements achieved through a focus on low-cost methods, and the transition of epidemiology functions to Local Authorities via CHAMPS.
- 5.18 The average annual programme costs outlined below would reduce from ~£569k per annum currently to ~£476k per annum in line with identified efficiencies while also expanding the programme's existing offer.

Business Case Proposal

- 5.19 Programme extension maintains at-scale delivery to children aged 2-7 within CORE20PLUS communities through the established central model, governance and quality assurance (QA), delivered via a **three-plus-two-year contract**. It includes the roll out of a universal offer to primary and secondary-aged children attending specialist SEND settings (107).

¹⁰ Ongoing costs will be subject to re-tendering.

- 5.20 Inflation has been applied to staffing costs, with other elements assumed to remain on fixed contract values but recognising this activity may adjust if costs increase.
- 5.21 Costs cover core programme staffing, training and QA, consumables for participating settings, termly take-home packs for children taking part in STB, and sustained oral health promotion.
- 5.22 Local Authorities, supported through the national programme, will be responsible for distributing oral health packs within local communities. As a result, this element of the previous delivery model has been excluded from the business case.
- 5.23 Competitive tendering secured lower unit costs (Table 1) for consumables compared with the estimates in the original October 2023 proposal, while market and business uplifts will need to be factored into future tendering cycles.

Table 1: Overview of Unit Costs

Product	Estimated Unit Cost	Current Agreed Unit Costs
Toothpaste	£1	54p
Toothbrush	£1	25p
Toothbrush storage racks	£14	£7.95
Take-home packs	£1.25	70p

- 5.24 Table 2 below sets out the ongoing annual cost of this proposal, broken down by pay and non-pay:

Table 2: Proposed Costs between 2027 to 2030

	Agreed Delivery Model in existing contract		Proposed ongoing cost per year		
	Description	Cost per year based on 25/26	27/28	28/29	29/30
Pay*	Programme Manager Band 8A	£75,213	£83,568	£86,576	£89,687
	Project Support Officer Band 5	£42,744	£50,079	£51,879	£53,744
	Project Support Officer Band 5	£42,744	£50,079	£51,879	£53,744
	Project Adminsitrator Band 4	£38,425			
	Sub-total	£199,126	£183,726	£190,334	£197,175
Non-pay	Consumables (in-setting stock and take-home packs)**	£265,806	£105,554	£257,813	£267,094
	Training and Quality Assurance	£50,000	£50,000	£50,000	£50,000
	Communications/ OH Promotion	£50,000	£20,000	£20,000	£20,000
	Printing/ travel/ resources/ other	£4,263	£5,000	£5,000	£5,000
	Sub-total	£370,069	£180,554	£332,813	£342,094
	Total	£569,195	£364,280	£523,147	£539,269

**annual inflation added at 3.6%. Staffing cost uplifts required in addition each year.

***27/28 at a reduced cost due to carry over of remaining committed consumables resource at 26/27-year end into 27/28.

6. Section Two: Mini Mouth Care Matters

Programme development to date^{11, 12}

- 6.1 MMCM is a national training initiative designed to improve the oral health of children and young people during hospital admission by embedding oral health assessment, prevention and mouth care within routine inpatient care.
- 6.2 The programme has been successfully implemented and developed at Alder Hey since February 2024 with support from Liverpool City Council, Alder Hey Charity and NHS Cheshire and Merseyside.
- 6.3 Delivery at Alder Hey has included staff education and e-learning, ward-based training and drop-in sessions, development of ward champions, structured mouth-care assessment, oral health resources for children and families, and the provision of appropriate mouth-care products.
- 6.4 The programme is supported by a multidisciplinary team including paediatric dentists, dental therapists, dental nurses, nursing staff and volunteers, enabling oral health to be embedded within holistic inpatient care.
- 6.5 Published evaluations of the Alder Hey model have demonstrated previously unmet oral health needs among hospitalised children and identified gaps in healthcare professionals' training and confidence in delivering oral care.

Hospital admission as an opportunity for intervention

- 6.6 Children admitted to hospital may be particularly vulnerable to deterioration in their oral health as a result of acute or chronic illness, medication, altered diet, reduced oral intake, dependence on others for personal care and disruption to routine toothbrushing.
- 6.7 Hospital admission represents a unique opportunity to reach children and young people who may otherwise miss out on oral health support. Despite this increased risk, oral health assessment and mouth care are not consistently

¹¹ Shuter, L., Morgan, E., Albadri, S. and Dominguez-Gonzalez, S. (2022) 'Mini Mouth Care Matters: A baseline evaluation within Alder Hey Children's Hospital', *International Journal of Paediatric Dentistry* [British Society of Paediatric Dentistry Conference Abstracts]

¹² Al-Hafidh, N.N., Dominguez-Gonzalez, S., Albadri, S. and Moore, D. (2026) 'Mini mouth care matters: A response to unheeded oral health needs in Alder Hey Children's Hospital', *Community Dental Health*, 43(1), pp. 83–86. doi: 10.1177/0265539X251385346.

embedded within routine paediatric inpatient care, creating an important opportunity for prevention, education and early intervention^{13, 14, 15, 16}.

- 6.8 Embedding MMCM into routine paediatric nursing care enables the early identification of oral health needs, supports good oral health behaviours during admission, provides appropriate mouth-care interventions and creates opportunities to connect children and families with NHS dental services where required¹⁷.

MMCM reach to date

- 6.9 Since implementation at Alder Hey, MMCM has demonstrated successful delivery at scale within the inpatient environment. To date, 556 healthcare professionals have received face-to-face training and a further 367 staff have completed the MMCM e-learning programme. The programme has directly supported 4,499 children and young people, with 4,878 toothbrush packs distributed across participating inpatient wards.
- 6.10 Between September 2025 and March 2026 alone, ward teams completed 16,350 daily toothbrushing checks and 7,780 comprehensive weekly mouth assessments, demonstrating that oral health assessment, prevention and mouth care can be successfully embedded within routine paediatric inpatient care when supported by appropriate training, resources and governance.

Expected outcomes

- 6.11 The expected outcomes of expanding MMCM would be:
- Earlier identification and management of oral health needs among paediatric inpatients.
 - Improved provision and documentation of mouth care during hospital admission.
 - Increased knowledge, skills and confidence among paediatric nursing and healthcare staff.
 - Improved oral health education for children and families.
 - Increased identification of children without access to primary dental care, alongside improved signposting to NHS dental services.

¹³ Royal College of Surgeons of England, Faculty of Dental Surgery (2015) The state of children's oral health in England. London: Royal College of Surgeons of England.

¹⁴ Office for Health Improvement and Disparities (2026) *Hospital tooth extractions in 0- to 19-year-olds: 2025*. Department of Health and Social Care.

¹⁵ Capurro, C., Romanelli, G., Telini, G., Casali, V., Parodi, S. et al. (2026) Oral health status and care among hospitalised children: a prospective cohort study comparing admission and discharge', *BMC Oral Health*, 26, 799. doi: 10.1186/s12903-026-08166-0.

¹⁶ Fletcher, A., Hachey, S. and Doyle, T. (2024) Oral health knowledge, attitudes, and practices of paediatric nurses caring for hospitalized children', *Frontiers in Dental Medicine*, 5, 1426697. doi: 10.3389/fdmed.2024.1426697.

¹⁷ Office for Health Improvement and Disparities (2021) *Delivering better oral health: an evidence-based toolkit for prevention*. 4th edn. London: Department of Health and Social Care.

- Reduced oral health inequalities through improved access to prevention and support.
- Improved patient experience and greater integration of oral health within holistic paediatric care.

Case for and return on investment

- 6.12 The recommendation to expand MMCM is based on the unique opportunity that hospital admission provides to reach children and young people who may otherwise miss out on oral health support. Expanding MMCM will enable the NHS to use this important point of contact to identify unmet oral health needs, prevent avoidable harm, reduce health inequalities and improve outcomes through a proven model already established within Cheshire and Merseyside.
- 6.13 Regional implementation will build upon the clinical expertise, educational resources, governance arrangements and implementation experience already established at Alder Hey, avoiding unnecessary duplication of effort across organisations and providing a consistent approach across Cheshire and Merseyside.
- 6.14 Expansion of MMCM is also aligned with national NHS priorities to improve standards of inpatient mouth care. National NHS communications from the Chief Nursing Officer for England have highlighted mouth care as a fundamental component of safe, high-quality inpatient care and identified evidence demonstrating a return of £2.66 in inpatient healthcare benefits and £17 in wider social benefits for every £1 invested in Mouth Care Matters programmes.

Finance

- 6.15 The figures below are illustrative planning estimates based on typical UK acute paediatric ward costs and admission volumes; each Trust should validate against its own admission numbers, pay scales and existing training capacity before final sign-off.
- 6.16 The MMCM model has been developed using the implementation experience, workforce model, educational resources and delivery approach established at Alder Hey. This has enabled a scalable regional model to be developed while avoiding duplication of training development, clinical resources, governance processes and implementation activity across participating organisations.
- 6.17 Table 3 estimates the consumables costs to expand the programme. It is recognised that through alignment with ATS, these costs could be reduced through the competitive tendering process.

Table 3: Estimated Unit Costs for Mini Mouth Care Matters Expansion

Product	Estimated unit cost (exc VAT)
Baby dental packs	£0.90
Junior dental packs	£1.35
Special dental packs	£3.17
Unflavoured toothpaste	£1.99
360 degree tooth & mouth brush	£2.40
Q4 packs	£137 (15 units)
Suction toothbrushes	£115.50 (100 units)

Business Case Proposal

- 6.18 The proposal includes the rollout of MMCM across all DGHs with children's wards and High Dependency Unit (HDU) provision across Cheshire and Merseyside: Whiston Hospital, Leighton Hospital, Countess of Chester Hospital, Warrington Hospital, Ormskirk Hospital and Arrowe Park Hospital.
- 6.19 The expansion would be a be a partnership between Alder Hey Children's NHS Foundation Trust, All Together Smiling / Beyond, and NHS Cheshire and Merseyside. This partnership approach is in line with cross system working and the move towards a "One Children's Health System"
- 6.20 Table 4 sets out the implementation costs across additional sites.

Table 4: Implementation Costs

Cost category	Cost item / resource	2027-28	2028-29	2029-30
Workforce	Programme Lead (0.1 WTE)	£19,481	£20,182	£20,909
	Programme Manager (Band 7; 0.4 WTE Year 1, 0.2 WTE Years 2-3)	£29,061	£15,053	£15,595
	Project Support Officer (1 WTE; Band 6)	£54,020	£55,965	£57,979
	Project Dental Officers (Band 6; 0.6 WTE)	£32,412	£33,579	£34,788
	Project Dental Officers (Band 5; 0.6 WTE)	£26,507	£27,461	£28,450
	Ward Champions (6 x Band 7; 3 hrs/wk)	£32,016	£33,168	£34,362
	Subtotal	£193,497	£185,408	£192,083
Programme delivery	Training and quality assurance	£20,000	£20,000	£20,000
	Mouthcare packs and other consumables	£30,000	£40,000	£40,000
	Printed signposting materials, travel and other resources	£5,000	£5,000	£5,000
	Evaluation and audit	£8,500	£8,500	£8,500
	Statistical analysis and communication	£10,534	£7,328	£15,114
	Subtotal	£74,034	£80,828	£88,614
Contingency	Contingency (10%)	£26,753	£26,624	£28,070
TOTAL		£294,284	£292,860	£308,767

The rollout of MMCM across all district general hospitals with children's wards in Cheshire and Merseyside would complement, and work in a delivery partnership with the broader 'All Together Smiling' population health programme, working collaboratively as part of a joined-up oral health pathway. MMCM and All Together Smiling will require differential inputs / resources – for example, MCMM is a dental-qualified clinically-led delivery model. As such, core MMCM roles are required to operate directly to MCMM, and wherever non-clinical or coordinating roles are required, these have been considered as part of the delivery partnership with Beyond to optimise shared resource and coordination.

Alder Hey MMCM Team will continue to provide clinical leadership and oversight for MMCM, reflecting Alder Hey's role in developing, evaluating and leading the initiative locally. The programme team within Beyond will work in close partnership with the MMCM team to facilitate engagement with local paediatric teams, identify opportunities for shared learning and coordination and support governance requirements within the ICB. This collaborative approach will support consistent delivery across all DGH hospital sites with paediatric inpatient wards.

7. Section 3: Combined Business Case

- 7.1 This business case maintains the delivery of supervised toothbrushing at scale to children aged 2 to 7 years living in CORE20PLUS communities, expands a universal offer to primary and secondary-aged children attending specialist

SEND settings, and expands MMCM across to all DGHs with children's wards in Cheshire and Merseyside, delivered through a three-plus-two-year contract.

Combined Finance

- 7.2 Total costs to deliver ATS and MMCM over the next 3 (+2) years would be: £658,564 in 27/28, £816,007 in 28/29, and £848,036 in 29/30.

8. Recommendation

- 8.1 It is recommended that the Committee approves the proposal to sustain ATS, including the expansion of a universal offer for children and young people attending specialist SEND settings, and the expansion of MMCM across all DGHs through a three-plus-two-year contract.

9. Next steps

If the recommendation above is approved, the next steps would be as follows:

- 9.1 Communicate the decision to stakeholders at the earliest opportunity to ensure uninterrupted delivery of ATS and commence planning for the expansion of MMCM.
- 9.2 Engage programme leadership to support ongoing engagement with area leadership and providers, ensuring continued strategic alignment across ATS, MMCM and national oral health improvement initiatives.
- 9.3 Update Local Authority Memorandums of Understanding to reflect ongoing responsibilities in relation to ATS delivery.
- 9.4 Work collaboratively with Procurement to re-tender ATS consumables, training and quality assurance contracts, while identifying MMCM-specific mouth-care products and resources for all DGHs with children's wards, maximising procurement efficiencies while retaining flexibility to use specialist products that meet the needs of hospitalised children.
- 9.5 Refresh the ATS monitoring and quality assurance framework, focusing Key Performance Indicators on supervised toothbrushing delivery and oral health pack distribution via take-home packs only.
- 9.6 Confirm governance and reporting arrangements for the extended contract period, ensuring performance, finance and risk updates continue to flow through agreed NHS Cheshire and Merseyside assurance routes.

- 9.7 Establish governance, reporting and evaluation arrangements for MMCM across participating providers, including the identification of executive sponsors, programme leads and ward champions at each hospital site. This will include measures relating to oral health assessment completion, staff training, mouth-care provision, dental signposting and patient experience to inform ongoing programme development and future impact assessment, including confirmation of MMCM mouth care leads within each participating Trust.
- 9.8 Undertake baseline assessments across participating hospitals to understand current oral health assessment practices, staff knowledge and confidence, access to mouth-care products, and existing referral pathways.
- 9.9 Agree standardised oral health assessment, escalation and referral pathways across participating hospitals, including links with primary dental care and community dental services.
- 9.10 Commence a phased MMCM training programme for relevant paediatric inpatient staff across participating DGHs, followed by phased implementation supported by ongoing quality assurance, evaluation and shared learning between sites.

10. Officer contact details for more information

Jordan Brown, Programme Manager, Beyond CYP Transformation Programme on behalf of NHS Cheshire and Merseyside: Jordan.brown2@alderhey.nhs.uk

Dr Susana Dominguez-Gonzalez, Mini Mouth Care Matters Lead, Alder Hey Children's NHS Foundation Trust: Susana.Dominguez-Gonzalez@alderhey.nhs.uk

11. Appendices

Appendix One: *Initial approved proposal to establish a consistent oral health improvement programme across C&M.*



SPCC - Agenda &
Papers - Part B (Publ

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

Date: 15th October 2026

Finance Report

Agenda Item No: 15.0

Responsible Director: Clare Barrow -Director of Finance-Primary Care
Presented by Lorraine Weekes-Bailey Head of Finance-Primary Care

Primary Care Finance Update

1. Purpose of the report

- 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 2026/27 as at 31st July 2026.
- 1.2. The financial position for July 2026 (M04) is based on the historical recurrent expenditure for each service area, along with any in-year amendments notified to date. Where information has been received at a national level, the report also incorporates any uplifts in line with national assumptions.

2. Executive Summary

- 2.1. 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 related to primary care expenditure as at the end of August 2026 (M05).
- 2.2. 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
- 2.3. The paper will highlight any key variances within the financial position, in respect of the forecast outturn, compared to the allocated budgets.
- 2.4. Also provided is an overview of any reserves and flexibilities available.
- 2.5. It also provides the most up to date breakdown of the Additional Roles Reimbursement Scheme (ARRS) allocation. And the GP Reimbursement scheme.
- 2.6. Table 1, as shown below, illustrates the detailed financial position of the Primary Care and Prescribing services across Cheshire and Merseyside ICB.

3. Ask of the Committee and Recommendations

The Primary Care Committee is asked to:

- 3.1. Note the preliminary combined financial summary position outlined in the financial report as at 31st August 2026 (M05).
- 3.2. Note the Additional Roles and GP Reimbursement spend.

4. Financial Position

4.1. Table 1 below presents the detailed financial position of Primary Care and Prescribing services across Cheshire and Merseyside ICB.

4.2. As at Month 5, the year-to-date financial position for Primary Care shows a projected underspend of £14.71 million, resulting in a forecast year-end outturn of £19.82 million.

Primary Care Position Summary - Month 5		Year To Date			Forecast Outturn		
ICB TOTAL		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		163,786	163,446	341	393,586	392,269	1,317
QOF		15,778	13,716	2,062	37,867	34,668	3,199
Premises Reimbursements		23,928	24,320	(391)	59,898	60,254	(356)
Other Premises		323	323	0	776	776	0
Direct Enhanced Schemes		2,020	1,635	385	4,849	4,464	385
Primary Care Network		18,575	18,652	(78)	44,579	44,654	(75)
Additional Roles Reimbursement Scheme		34,868	34,868	0	83,682	83,682	0
Fees		4,854	5,013	(159)	11,649	12,244	(595)
Other - GP Services		259	259	0	621	621	0
DELEGATED PRIMARY CARE TOTAL		264,391	262,231	2,160	637,508	633,632	3,876
Local Primary Care							
GP Local Enhanced Service Specification		15,599	15,484	115	37,437	37,421	16
Local Enhanced Services		9,372	9,583	(211)	25,683	25,866	(183)
Commissioning Schemes		209	194	16	869	855	14
Out Of Hours		12,609	12,761	(152)	30,261	30,466	(205)
GP IT		9,384	9,442	(58)	21,550	22,513	(964)
GP Investment		126	126	(0)	303	303	(0)
Primary Care SDF		1,312	1,312	0	3,149	3,149	0
Primary Care Other		1,020	978	42	2,449	2,362	87
QIPP		0	0	0	0	0	0
PC Local Pay Costs		0	0	0	0	0	0
Medicines Management - Clinical and Pay Costs		5,272	5,404	(132)	12,024	12,163	(139)
LOCAL PRIMARY CARE TOTAL		54,903	55,283	(380)	133,723	135,096	(1,373)
Prescribing							
Central Drugs		8,286	8,985	(700)	19,886	20,888	(1,002)
Oxygen		2,228	2,132	95	5,346	5,308	38
Prescribing BSA		218,611	223,926	(5,315)	524,720	532,757	(8,037)
Prescribing Local Schemes		2,060	2,001	59	4,944	4,863	81
PRESCRIBING TOTAL		231,184	237,046	(5,861)	554,896	563,816	(8,920)
Delegated Pharmacy Optoms Dental and Other							
Delegated Community Dental		5,666	5,540	126	13,598	13,296	302
Delegated Optometry		12,390	11,635	755	29,737	28,507	1,230
Delegated Pharmacy		43,097	43,139	(43)	107,853	107,853	(0)
Delegated Primary Dental		66,118	48,262	17,856	158,707	134,192	24,515
Delegated Property Costs		217	139	78	520	332	188
Delegated Secondary Dental		18,394	18,376	18	47,218	47,215	3
PHARMACY, OPTOMS, DENTAL & OTHER TOTAL		145,882	127,091	18,791	357,634	331,396	26,238
TOTAL		696,361	681,650	14,710	1,683,761	1,663,940	19,821

5. Delegated Primary Care - Medical

5.1. As at Month 5, the year-to-date financial position for Delegated Medical Primary Care indicates a projected underspend of £14.71 million, with a forecast outturn of £19.82 million at year-end.

5.2. As we are now in Month 5 of the financial year and have received payment data covering the first 5 months, we have increased confidence in our ability to forecast the year-end financial position. The forecast is based on actual expenditure data received to date, providing a more robust basis for assessing the expected outturn position

5.3. The section below outlines the variances across the individual service lines that contribute to the £3.876m forecast benefit.

- 5.4. **Core-** The original Core Global Sum budget assumptions were developed during the planning phase and were based on projected patient list sizes. Since then, the National Patient List Validation (FP69) process has been implemented and remains ongoing.
- 5.5. Early outcomes from the validation exercise have identified reductions in registered patient numbers across a number of GP practices, which has impacted the forecast outturn position for the Core Global Sum, as funding is linked to validated patient lists.
- 5.6. The current forecast reflects the information available from Quarter 1 and Quarter 2 validation data. However, as the FP69 process has not yet concluded, the forecast position remains subject to change as further validation outcomes become available.
- 5.7. **Quality Outcomes Framework-** The current QOF position is forecasting a favourable outturn variance of £3.199m, of which £1.250m relates to prior-year adjustments.
- 5.8. Achievement levels reported by GP practices were lower than originally anticipated, even after allowing for the protected QOF points included within the national arrangements.
- 5.9. For the 2026/27 forecast, the projected position has been based on the 2025/26 outturn, adjusted for growth and incorporating a 1% increase in achievement levels compared to 2025/26. The forecast also includes an anticipated £278k potential achievement against the new obesity indicator, which has replaced the Weight Management DES.
- 5.10. The forecast position will continue to be monitored throughout the year and will be reviewed and updated as further performance information becomes available.
- 5.11. **Premises Reimbursements-** The Premises Reimbursements service line is forecasting an adverse variance of £356k. This comprises a £77k prior-year pressure relating to reimbursements paid to GP practices for water rates, together with a £279k pressure arising from rent revaluations undertaken during the current financial year.
- 5.12. These additional costs were not reflected in the original budget assumptions developed during the planning process and have therefore resulted in an increase to the forecast outturn position.
- 5.13. **Direct Enhanced Services-** These services are activity-driven, and with all four quarters of data for 2025/26 now received, a prior year benefit of £385k has been identified. This predominantly relates to Advice and Guidance and Minor Surgery activity.
- 5.14. **Primary Care Networks-** Similar to QoF, these services are achievement based. Following receipt of the 2025/26 PCN achievement data, a £75k overspend is now shown within the forecast. This reflects higher than anticipated achievement levels by PCNs compared with the assumptions used in year-end outturn projections.
- 5.15. **Fees-** The Fees budget is currently forecast to overspend against plan by £0.595m. This adverse variance is primarily due to maternity and sickness locum reimbursement costs, with a number of claims having been received recently that were not reflected in the original forecast assumptions.

- 5.16. Following receipt of these claims, the forecast has been recalculated using the latest available information and actual expenditure trends. The position will continue to be monitored throughout the year, with further adjustments made to the forecast as additional claims data becomes available.

6. Local Primary Care

- 6.1. **Local Primary Care-** As at Month 5, the Local Primary Care financial position is reporting an anticipated forecast overspend of £1.373m. The variances contributing to this position are detailed in the sections below.
- 6.2. **Local Enhanced Services-** The Local Enhanced Service payments for the former locality areas have now been finalised, resulting in an overall prior year pressure of £183k. This is due to activity levels being higher than estimated in the year end position, which was based on Quarter 1 to Quarter 3 data for 2025/26.
- 6.3. **Out of Hours-** The Paediatric Clinical Assessment Service, hosted by PC24 within the former Liverpool locality, is reporting an anticipated forecast overspend of £136k.
- 6.4. In addition, there is a budget-setting pressure of £69k, this relates to the former Knowsley Out of Hours service. The available budget was insufficient to meet the agreed level of growth when the budget was set during planning.
- 6.5. **GPIT-** The forecast pressure within GPIT is £0.964m, largely attributable to the costs associated with the continuation of Blinx Solutions service, to which GP practices are currently subscribed, together with an additional £80k pressure relating to Ardens Plus licences.

7. Prescribing

- 7.1. As at Month 5, the overall financial position for Prescribing reflects an overspend of £8.920m. The key variances across the prescribing categories are explained below.
- 7.2. **Central Drugs-** This expenditure relates to costs that cannot be directly attributed to a specific ICB or cost centre. Such costs typically include unidentified prescribing, VAT adjustments and some cross-border prescribing. These are initially accumulated nationally by the NHS Business Services Authority (BSA) and subsequently apportioned across ICBs based on their relative prescribing expenditure.
- 7.3. The expenditure also includes dental prescribing costs, which cannot be attributed to a patient's home ICB as this information is not captured within BSA data. As a result, these costs are distributed using prescribing expenditure shares. Cheshire and Merseyside ICB currently receive approximately 5.7% of the national dental prescribing costs.
- 7.4. The ICB has limited ability to influence the expenditure within the Central Drugs budget and is currently showing a forecast outturn overspend of £1.002m.
- 7.5. **Prescribing BSA-** The Prescribing BSA position is reporting a year-to-date adverse variance of £5.315m, with a projected forecast outturn overspend of £8.037m.
- 7.6. The main driver of this overspend is NCSO (No Cheaper Stock Obtainable) expenditure which is currently estimated at £11.2m year to date, resulting in a projected full-year cost of £26.7m.

- 7.7. This creates a forecast pressure of approximately £14.7m against the prescribing budget and represents a significant increase when compared with the equivalent period in 2025/26.
- 7.8. During the 2026/27 planning process, a horizon-scanning provision of £11.9m was included within the prescribing budget to reflect anticipated cost pressures.
- 7.9. However, current expenditure trends indicate that NCSO costs are significantly exceeding these planning assumptions.
- 7.10. As a result, an additional pressure of approximately £14.7m is now forecast, which continues to place considerable strain on the overall prescribing position.
- 7.11. The NCSO position will continue to be closely monitored throughout the remainder of the financial year given the volatility of medicine supply issues and the associated impact on drug pricing.
- 7.12. Prescribing costs associated with Pneumococcal and Influenza vaccinations administered through GP practices are recharged to NHS England, and the associated income is incorporated within the prescribing budget plan. However, lower than anticipated vaccination uptake has resulted in reduced recharge income being recovered. This is currently forecast to generate an adverse variance of approximately £0.7m against plan.
- 7.13. In addition, the forecast includes prior-year cost pressures of £0.242m.
- 7.14. The above in year pressures have been partially offset by lower expenditure than anticipated on several prescribing categories, including SGLT2 inhibitors, GLP-1 medicines (predominantly Tirzepatide), and Continuous Glucose Monitoring (CGM) devices.
- 7.15. The prescribing plan includes a £37.6m CRES target. However, as at Month 5, a £1.083m shortfall in delivery has been forecast against the Oral Nutritional Supplements workstream. This is primarily due to delays in implementation of the programme. The prescribing team continues to work closely with stakeholders to recover the programme and maximise savings opportunities during the remainder of the financial year.
- 7.16. The position will continue to be closely monitored throughout the year, with forecasts updated to reflect emerging prescribing trends and delivery of planned savings initiatives.

8. Delegated Community Dental

- 8.1. The Community Dental service is currently reporting a favourable forecast outturn variance of £302k. This underspend is primarily attributable to patient charge revenue being higher than originally budgeted, resulting in increased income being received during the year.

9. Delegated Optometry

9.1. The current position reflects a forecast benefit of £1.029m, of which £0.600m relates to prior year spend. A further projected underspend of £0.429m is attributable to lower than anticipated expenditure on Sight Tests and Optical Vouchers.

9.2. The finance team will continue to monitor expenditure closely, as these figures remain projections and may be subject to change as commissioning plans are finalised and implemented.

10. Delegated Pharmacy

10.1. The Pharmacy budget is currently forecasting a breakeven position, with the allocation considered sufficient to support planned Pharmacy initiatives during 2026/27.

10.2. However, a number of new nationally mandated investments are scheduled to commence from 1 October 2026. As these schemes are implemented and activity levels become clearer, the financial position will be reviewed at month 6, which will include an update to the forecasts to reflect emerging costs and any changes to commissioning plans.

11. Delegated Other Costs

11.1. The budget line "Delegated Property Costs" comprises budgets relating to Transformation Team staffing, NHS Mail, remote access costs for POD contractors, and sterile products.

11.2. The budget is currently forecasting a favourable variance of £188k, primarily as a result of prior year adjustments, where actual expenditure was lower than originally anticipated.

12. Delegated Primary Care Dental

12.1. The dental allocation for 2026/27, covering Primary Care, Community Dental and Secondary Care Dental services, totals approximately £219.5m. This represents a ring-fenced allocation provided by NHS England.

12.2. Primary Care Dental Services are currently forecasting an underspend of £24.515m against the planned outturn position, of which £11.917m relates to prior year spend, predominantly associated with contract underperformance.

12.3. The remaining variance reflects early indications of contract under-delivery during 2026/27. The forecast is based on month 3 data, extrapolated to year-end.

12.4. At this stage, the forecast remains indicative and is subject to change as commissioning intentions are further developed and contract performance throughout the year becomes clearer. The financial position will continue to be closely monitored and updated as additional information becomes available.

10. Additional Roles Reimbursement Scheme

10.1 For the 2026/27 financial year, the total ARRS allocation is £83.6 million.

10.2 Table 2, illustrates the ARRS allocation for 2026/27, including year-to-date and utilisation rate.

- 10.3 At this early stage in the financial year, it is not yet possible to provide an accurate forecast. Therefore, the position is currently assumed to be balanced with full utilisation.
- 10.4 This will be closely monitored, and forecasts will be updated as more data becomes available.

Table 2

Additional Roles Reimbursement Scheme 2026/27								
Region	Total	Monthly Allocation	Forecast	YTD Allocation	YTD Spend from	YTD Utilisation	FOT Utilisation	
Cheshire & Warrington	29,997,440	2,499,787	29,997,440	12,498,933	11,799,751	94%	100%	
Liverpool City Region	53,684,683	4,473,724	53,684,683	22,368,618	19,781,345	88%	100%	
Total	83,682,123	6,973,510	83,682,123	34,867,551	31,581,096			

11. GP Reimbursement Scheme

- 11.1 The GP Reimbursement allocation for 2026/27 is £13.7m. Year to date expenditure remains lower than anticipated.
- 11.2 However, this is largely due to delays in the implementation of the payment system, with training for practices only being completed in June. As a result, year to date actuals is currently below the expected level.
- 11.3 We have received assurance from a number of practices that, as this is an annual allocation, they intend to fully utilise 100% of their budget by the end of the financial year. We will continue to monitor this allocation and spend.

Table 3

GP Reimbursement Scheme 2026/27							
Region	Annual Budget	YTD Budget	YTD Reimbursement	Forecast Annual Reimbursement	Variance	YTD Utilisation	FOT Utilisation
	£000	£000	£000	£000	£000	%	%
Cheshire & Warrington	4,749,840	1,979,100	231,236	4,749,840	-	12%	100%
Liverpool City Region	9,022,077	3,759,199	584,794	9,022,077	-	16%	100%
Total	13,771,917	5,738,299	816,030	13,771,917	-		

12. Officer contact details for more information

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

Utilisation and Modernisation Fund and Business as Usual 2026/27 Capital Update

1. Purpose of the Report

- 1.1 The report is being presented to the Committee to update on the 26/27 Capital Plan for Business as Usual (BAU) and Utilisation and Modernisation Fund (UMF).

2. Executive Summary

- 2.1 NHS England Capital Planning Guidance for 2026/27 to 2029/30 established a four-year planning horizon and required capital investment to support the strategic shifts from hospital to community, analogue to digital and sickness to prevention. In response, the ICB developed coordinated four-year plans for UMF and BAU capital, recognising the interdependencies between estates, digital infrastructure and the emerging Strategic Primary Care Capital programme.
- 2.2 The four-year UMF and BAU plans were approved and endorsed by the Committee on 9 February 2026. Approval in principle for the UMF programme was subsequently received through the regional and national process, enabling individual projects to progress through Project Initiation Document (PID), due diligence and scheme approval gateways.
- 2.3 For 2026/27, the revised BAU resource available is £6.341m, comprising a £5.693m core allocation and £0.648m of additional ARRS development funding. The refreshed plan balances essential GP IT replacement, network and infrastructure requirements, break-fix provision, support for ARRS and strategic estates development.
- 2.4 Provision has also been identified for initial investment for digital infrastructure and hardware to support the delivery of neighbourhoods, this will be prioritised and allocation agreed via the neighbourhood programme governance.
- 2.5 The 2026/27 UMF allocation is £2.500m. Eight premises schemes with a current aggregate value of £1.968m are progressing through approval and delivery gateways, leaving a current planning variance of £0.532m. Further schemes are being developed from the pipeline so that the available allocation can be fully committed, subject to assurance, affordability and deliverability.
- 2.6 The programme remains subject to active cost and delivery management. Material increases in hardware pricing since the original planning assumptions have required the Digital and Estates components of the BAU plan to be refreshed. Digital PIDs will be progressed following the Committee's consideration of this updated plan.

3. Ask of the System Primary Care Committee and Recommendations

3.1 The System Primary Care Committee is asked to:

- **NOTE** The updates on the Utilisation and Modernisation Fund 26/27 Capital Plan
- **APPROVE** the refreshed Business as Usual Capital Plan for 26/27

4. Reasons for Recommendations

4.1 The recommendations are line with the Scheme of Reservation and Delegation (SORD) and delegated decision making of the Committee.

5. Background

5.1 The national capital framework places greater emphasis on multi-year planning, measurable productivity, value for money and the optimisation of existing estate. Primary care investment is expected to support neighbourhood delivery, improved access, digital resilience and the use of existing assets before additional capacity is created.

5.2 The ICB has therefore planned BAU, UMF and Strategic Primary Care Capital as connected programmes rather than as isolated funding streams.

5.3 The coordinated approach is intended to ensure that estates investment is supported by the necessary digital infrastructure, that capital schemes are affordable in both capital and revenue terms, and that limited funding is targeted towards schemes with the strongest evidence of need, readiness and impact.

5.4 The four-year UMF and BAU capital plans were approved and endorsed by the System Primary Care Committee on 9 February 2026.

5.5 The February approval established the programme direction and enabled the ICB to progress national and regional submissions and detailed scheme development.

5.6 Individual schemes remain subject to the appropriate PID, due diligence, affordability, procurement and approval requirements before commitment or drawdown.

5.7 The reserve pipeline remains dynamic. Schemes may move into delivery where hurdle criteria are met and capacity becomes available, while schemes that are no longer deliverable may be replaced through change control.

6. Business as Usual Capital Allocation

- 6.1 The refreshed approach applies hurdle and weighted scoring criteria so that funding is directed towards essential and strategically justified investment. BAU proposals are expected to demonstrate a clear link to critical infrastructure risk, cost avoidance or cost improvement, transformation and patient experience, and an activity- and data-led case for investment.
- 6.2 Hurdle considerations include committed digital consequences of estates schemes, critical infrastructure and cyber risk, GP IT operating model requirements, IFRS16 implications, analogue-to-digital requirements and transformation projects that cannot reasonably be funded through another route.
- 6.3 Priority has been given to evidence-led proposals that reduce material service or infrastructure risk, avoid greater financial pressure, improve service resilience and support population health outcomes
- 6.4 A breakdown of current schemes is included in Appendix One.

7. Utilisation and Modernisation Fund 2026/2027

- 7.1 The 2026/27 UMF allocation is £2.500m. Pre-endorsed schemes were identified through the four-year planning process and agreed by the Committee in February 2026. Following regional and national agreement in principle, GP practices have progressed individual PIDs with support from ICB Primary Care and Estates teams.
- 7.2 The programme is intended to increase primary care capacity through the better use, refurbishment and reconfiguration of existing premises.
- 7.3 Current prioritisation focuses on value for money, reduction of negative variation in access, optimisation of the existing estate, and an activity- and data-driven response to under-provision and deprivation. Schemes must also meet minimum due diligence, tenure, affordability and deliverability requirements.
- 7.4 A breakdown of current schemes is included in Appendix One.

8. Benefits of the Programme (UMF and BAU)

- 8.1 The intended outcomes are:
- Additional patient-facing capacity through extensions, room conversions and better utilisation of existing primary care premises.
 - Improved access and a reduction in unwarranted variation, particularly where estate constraints contribute to under-provision.

- Support for Modern General Practice, ARRS and neighbourhood models through fit-for-purpose premises and digital infrastructure.
- Improved digital resilience and continuity through planned hardware, network, contract and break-fix investments
- Avoidance of service disruption and greater future cost by replacing or strengthening infrastructure before failure.
- Better value from existing estate and alignment of investment with the ICB Infrastructure Strategy and population health priorities.
- A more mature, multi-year pipeline that enables the ICB to respond quickly where schemes slip or additional capital becomes available.

9. Key Risks and Mitigations

Risk	Potential impact	Mitigation
Hardware price inflation and supplier movement	Reduced purchasing power or pressure on planned refresh volumes	Refresh costs before commitment; use compliant procurement routes; maintain prioritised and scalable deployment plans.
Delay in PID approval or due diligence	Slippage, inability to commit allocation, or loss of delivery time	Gateway tracking, early escalation, standard evidence requirements and use of a ready reserve pipeline.
Construction cost movement or scope development	Scheme values exceed planning assumptions	Confirm scope and quotations, apply appropriate contingency, and subject material changes to change control.
Insufficient revenue affordability	Capital asset cannot be safely or sustainably operated	Require explicit RDEL, lifecycle and premises-cost assessment before approval.
Practice or landlord dependencies	Delay to consent, legal documentation, tenure assurance or delivery	Early legal and landlord engagement; evidence valid lease or agreement for lease; do not commit until conditions are satisfied.
Uncommitted UMF balance	Risk that available capital is not fully and effectively deployed	Progress additional PIDs from the reserve list and prioritise schemes with clear readiness and in-year deliverability.
Delivery concentration late in the financial year	Heightened risk of slippage, rushed procurement or weak assurance	Maintain critical paths and monthly reporting, with early intervention and substitution where milestones are missed.

10. Programme Controls

10.1 A programme tracker will monitor scheme value, approval gateway, due diligence, procurement, delivery milestones, forecast spend, risk and benefits.

10.2 Material scope, cost, deliverability or benefit changes will be managed through formal change control and escalated through the appropriate governance route.

10.3 Further updates will be provided to the Committee on financial performance, delivery confidence, risks, reserve pipeline activation and benefits realisation.

10.4 Digital and Estates leads will continue joint review of the BAU plan to manage interdependencies and ensure that investment remains within the approved envelope.

11. Next Steps

11.1 Progress the Digital PIDs and procurement activity following Committee approval of the refreshed BAU plan.

11.2 Complete ICB and NHS England approval of the outstanding UMF PIDs and confirm final scheme values and delivery profiles

11.3 Develop additional UMF schemes to address the current £0.532m variance, applying the agreed hurdle and scoring criteria

11.4 Maintain monthly programme assurance and escalate schemes at risk of missing approval, procurement or delivery milestones

11.5 Report material changes and the next programme position to the Committee through the established capital governance cycle.

12. Officer contact details for more information

- James Burchell – Head of Estates
- Cathy Fox – Associate Director of Digital Operations
- Kevin Highfield – Head of Digital Operations
- Lucy Andrews – Estates and Infrastructure Project Manager

13. Appendices

- Appendix One – Estates and Digital Capital Update 26/27

Estates and Digital – Capital Update October 2026

Background

- The NHS England Capital Planning Guidance for 2026/27 to 2029/30 was published mid November 2025. There was an overarching ask to develop a strategic capital plan for the Utilisation and Modernisation Fund and Strategic Primary Care Capital.
- Whilst not a requirement for NHSE the ICB also in parallel produced a 4-year Business as Usual strategic capital plan due to the dependencies and interoperability with these funding streams and the newly established Strategic Primary Care Capital.
- This was approved and endorsed at System Primary Care Committee on 9th February 2026.
- Given the significant impact of the changes on IT providers, the associated Digital PIDs will be submitted following the October meeting of the System Primary Care Committee.

Programme	26/2(£m)	27/28 (£m)	28/29 (£m)	29/30 (£m)	TOTAL (£m)
BAU	5.7	5.7	5.7	5.7	22.8
UMF	2.5	2.75	2.75	3.0	11.0

BAU Capital Scoring Criteria

Hurdle criteria: Bids must meet hurdle criteria to pass through to scoring

- Digital implications because of schemes committed to within Estates SPC or UMF allocations
- Critical infrastructure investment i.e BAU, cyber security, risk of failure, fragile services
- Digital transformation i.e neighbourhood delivery and GP IT Operating Model requirements
- Corporate IFRS16 CDEL implications
- Analog to Digital
- Transformation projects for Estates and Digital not otherwise able to be funded due to restrictive allocation criteria

Business as Usual Capital schemes will be prioritised where evidence-based and data-driven projects have demonstrable evidence of reducing otherwise significant financial pressures and critical infrastructure risks.

Score	Critical Infrastructure Investment – risk of imminent failure or impact on fragile services (30%)	Cost Improvement–in line with National guidance; reduction in potential financial pressures for provision of leasing, software, equipment (30%)	Transformation, Innovation & Patient Experience (25%) - Digital Front Door	Activity and Data Driven Approach (15%) – evidenced based targeted information and tools consolidation
0	No evidence that the investment will reduce or mitigate risk stratified critical infrastructure issues	No evidence that the investment will mitigate perceived financial pressures via provision of hardware or software	No evidence that the investment will demonstrate efficiency, service improvement and service resilience	No evidence that the investment will enhance clinicals models and deliver improvement in population health outcomes
2	Some evidence that the investment will reduce or mitigate risk stratified critical infrastructure issues	Some evidence that the investment will mitigate perceived financial pressures via provision of hardware or software	Some evidence that the investment will demonstrate efficiency, service improvement and service resilience	Some evidence that the investment will enhance clinicals models and deliver improvement in population health outcomes
4	Strong evidence that the investment will reduce or mitigate risk stratified critical infrastructure issues	Strong evidence that the investment will mitigate perceived financial pressures via provision of hardware or software	Strong evidence that the investment will demonstrate efficiency, service improvement and service resilience	Strong evidence that the investment will enhance clinicals models and deliver improvement in population health outcomes
6	Meets GP IT Operational Model (v5), ICB Digital Strategy and ICS Infrastructure Strategy aims and objectives	Meets GP IT Operational Model (v5), ICB Digital Strategy and ICS Infrastructure Strategy aims and objectives	Meets GP IT Operational Model (v5), ICB Digital Strategy and ICS Infrastructure Strategy aims and objectives	Meets GP IT Operational Model (v5), ICB Digital Strategy and ICS Infrastructure Strategy aims and objectives

Score	Investment projects bring service improvement via maintaining or transforming existing provision , aligned 10 Year Plam
0	No evidence investment will bring service improvement via enhancement or maintenance
2	Some evidence investment will bring service improvement via enhancement or maintenance
4	Strong evidence investment will bring service improvement via enhancement or maintenance
6	Meets GP IT Operational Model (v5), ICB Digital Strategy and ICS Infrastructure Strategy aims and objectives

UMF Capital Scoring Criteria

Hurdle criteria: Bids must meet hurdle criteria to pass through to scoring

- **Must be value for money and revenue neutral (by mitigation or another factor)**
- **Must reduce negative variation in Access**
- **Must meet minimum standard criteria i.e no debt and valid lease or agreement for lease**
- **Must target areas of under-provision and deprivation**
- **Must increase capacity in Primary Care**

UMF capital schemes will be prioritised where there is clear demonstrable contributions to Modern General Practice, % reduction in negative variation and with clear alignment to the ICS Infrastructure Strategy

Score	Value for Money (30%) – delivers a quantifiable benefit in return for investment being proposed	Reduce Negative Variation in Access (30%) – supporting the development of Modern General Practice	Optimisation– By utilising and optimising the existing estate it will support more provision of clinical services in local settings (15%)	Activity and Data Driven Approach (25%) - target areas of under provision and deprivation
0	No evidence that the capital investment will produce a tangible return on investment on activity and efficiency within General Practice (£ invested per additional appointment)	No evidence that the capital investment will contribute to a marked improvement in access	No evidence that the capital investment will enhance the existing clinical models and drive transformational change.	No evidence that the project will reduce the level of under-provision of access to services for the population where deprivation is identified as a key contributing factor
2	Some evidence that the capital investment will produce a tangible return on investment on activity and efficiency within General Practice (£ invested per additional appointment)	Some evidence of that the capital investment will contribute to a marked improvement in access	Some evidence that the capital investment will enhance the existing clinical models and drive transformational change.	Some evidence that the project will reduce the level of under-provision of access to services for the population where deprivation is identified as a key contributing factor
4	Strong evidence that the capital investment will produce a tangible return on investment on activity and efficiency within General Practice (£ invested per additional appointment)	Strong evidence that the capital investment will contribute to a marked improvement in access	Strong evidence that the capital investment will enhance the existing clinical models and drive transformational change.	Strong evidence that the project will reduce the level of under-provision of access to services for the population where deprivation is identified as a key contributing factor
6	Significant contribution to the ICB's Primary Care Access Recovery Plan	Significant contribution to the ICB's Primary Care Access Recovery Plan	Meets the aims and objectives of the Utilisation and Optimisation Programme	Meets the ICS Objectives of reducing health inequalities, improving outcomes, and enhancing service sustainability

Business as Usual 2026/2027

- Additional provision has been identified to support the strategic estates development requirements associated within Neighbourhoods and major development projects i.e business case production
- Significant consideration of the split between Estates and Digital has taken place due to the strategic pressures in both programmes
- The increase in PC and laptop prices since December 2025 reflects significant market-wide increases in hardware component costs, particularly memory and storage, together with supplier price rises and the move to new device specifications required to support Windows 11, enhanced security standards, and future digital services

	Dec 2025 Pricing	Sept 2026 Pricing	% Increase
DESKTOP TC M75Q GEN5	£535.50	£ 1,034.26	93%
NOTEBOOK THINKPAD L14 GEN6	£ 768.97	£ 1,276.65	66%

Allocation		£	
Core 26/27 Allocation		£	5,693,000.00
Additional ARRS Development Monies – NHSE awarded		£	648,000.00
Sub Total		£	6,341,000.00
Type	Scheme Description	£	
GPIT	Hardware Refresh - Cheshire, Warrington and Wirral	£	941,059
GPIT	Hardware Refresh - Liverpool, Sefton and Knowsley	£	910,736
GPIT	Hardware Refresh - St Helens, Halton	£	917,524
GPIT	Network Refresh AP & Switch – All Localities	£	986,346
GPIT	Contract and Infrastructure – All Localities	£	795,231
GPIT	Breakfix/BAU – All Localities	£	458,305
GPIT	ARRS - All Localities	£	406,578
Estates	IFRS16 Capitalisation of Corporate Leases	£	200,000
Estates	Strategic Estates Development - Neighbourhoods and Major Development Projects	£	648,000
GP IT	UMF Estates Schemes	£	77,221
		£	6,341,000

Utilisation and Modernisation Fund (UMF) 2026/2027

Cheshire and Merseyside

- Pre-endorsed schemes were identified and agreed at System Primary Care Committee in February 2026
- The Project Initiation Document (i.e Capital Bidding process) has been ongoing since August 2026, when Regional and National agreement in principle was received for the capital plan
- PIDs are continuing to be developed for 26/27 by GP Practices with support from ICB Primary Care and Estates Teams
- GP Practices who didn't initially express an interest have also been invited to continue to build the reserve list of projects for 26/27 and future years
- An update on the 26/27 programme delivery plan for these schemes is included for assurance
- Further schemes are underway for PID Development to support the remaining variance

GP Practice	Locality	GP Dashboard – Access Variation requiring support	Additional Clinical Capacity	£ Value	Delivery Milestone	RAG
Rainbow Medical Centre	St Helens	Yes	Extension – 4 Clinical Rooms	£484,083	Gateway 2 – PID Approved by NHSE	
Castlefields Health Centre	Halton	Yes	Waiting Room Conversion – 2 Clinical Rooms	£147,261	Gateway 2 – PID Approved by NHSE	
Kelsall Medical Centre	Cheshire West	No – but vacant space as a result of closed dispensary	Room Conversion – 1 Clinical Room	£19,897	Gateway 1 – PID being approved by ICB	
Hunferford Medical Centre	Cheshire East	Yes	Extension – 3 Clinical Rooms	£498,757	Gateway 1 – PID being approved by ICB	
Haslington Surgery	Cheshire East	Yes	Loft Conversion – 2 Clinical Rooms	£ 540,219	Gateway 1 – PID being approved by ICB	
Northgate Village Surgery	Cheshire West	Neighbourhood Health Centre identified	Room Conversion – 1 Clinical Room	£108,639	Gateway 1 – PID being approved by ICB	
Elms Medical Centre	Cheshire West	Neighbourhood Health Centre identified	Room Conversion – 3 Clinical Rooms	£ 58,830	Gateway 1 – PID being approved by ICB	
Northgate Medical Centre	Cheshire West	Neighbourhood Health Centre identified	Room Conversion – 1 Clinical Room	£ 110,791	Gateway 1 – PID being approved by ICB	

Total	£	1,968,477.39
Allocation 26/27	£	2,500,000.00
Variance	£	531,522.61

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

Utilisation and Modernisation Fund 2025/26 Update

1. Purpose of the Report

- 1.1 To provide assurance to the System Primary Care Committee (SPCC) on the delivery, governance, value for money and sustainability of the 2025/26 Utilisation and Modernisation Fund (UMF) programme.

2. Executive Summary

- 2.1 The Utilisation and Modernisation Fund (UMF) was allocated to all ICBs in 2025/26 to improve access to, and increase capacity within, general practice.
- 2.2 The programme was primarily focused on converting existing space within GP practices into additional clinical capacity, with minimal ongoing revenue impact.
- 2.3 A total of 50 schemes were approved. The current delivery position for the outstanding schemes is set out in Appendix One.
- 2.4 This paper provides an update on the delivery of the remaining schemes within the 2025/26 programme.

3. Ask of the System Primary Care Committee and Recommendations

3.1 The System Primary Care Committee is asked to:

- **NOTE** the delivery update for the 2025/26 Utilisation and Modernisation Fund programme, including the position of the outstanding schemes set out in Appendix One.

4. Reasons for Recommendations

- 4.1 The recommendation is consistent with the Scheme of Reservation and Delegation (SoRD) and the delegated decision-making responsibilities of the Committee.

5. Appendices

- Appendix One – UMF 2025/26 Position Update

Utilisation and Modernisation Fund 25/26

Position Update

- 50 Schemes were approved in 2025/2026
- Focus on improving Modern General Practice and access requirements across Cheshire and Merseyside
- Vast majority of schemes have successfully delivered and benefits realisation is expected from Quarter 3 26/27
- Oversight and assurance has previously been received by the Committee on the 42 delivered schemes for 25/26
- Remaining schemes and their indicative completion date are included below:

GP Practice	Locality	Additional Clinical Capacity	£ Value	Delivery Milestone	RAG
Firdale Medical Practice	Cheshire West	5 Clinical Rooms	£235,536	Completion Date – 31 st December 2026	
Neston Surgery	Cheshire West	5 Clinical Rooms	£651,429	Completion Date – 31 st December 2026	
Grosvenor Medical Centre	Cheshire East	3 Clinical Rooms	£641,869	Completion Date – 24 th December 2026	
Stockton Heath Medical Centre	Warrington	6 Clinical Rooms	£219,371	Completion Date – 30 th September 2026	
Grappenhall Surgery	Warrington	3 Clinical Rooms	£77,107	Completion Date – 30 th September 2026	
Woolton House	Liverpool	5 Clinical Rooms	£964,765	Completion Date – 30 th November 2026	
Eastview Surgery	Sefton	2 Clinical Rooms	£20,620	Completion Date – 30 th September 2026	
Eastham Medical Practice	Wirral	8 Clinical Rooms	£273,986	Completion Date – 5 th October 2026	

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

Date: 15th October 2026

Update on practices migrating to the Medicus General practice Electronic Patient Record (EPR) system

Responsible Directors:

Dr Fiona Lemmens, Executive Clinical Director
John Llewellyn, Director of Digital Innovation and System
Chief Digital Information Officer

Medicus GP Clinical System: Practice Migrations, Funding and Delivery Arrangements

Purpose of the Report

The purpose of this report is to update the System Primary Care Committee on requests from general practices to migrate to the Medicus GP primary care foundation clinical system; the procurement, integration, funding and delivery implications; and the proposed approach to supporting migrations. The ICB has received confirmed requests from five practices to migrate from EMIS to Medicus, with further practices and PCNs expressing interest but not yet formally confirmed. Wilmslow Health Centre is already live.

The Committee is asked to note the position and support a controlled and appropriately governed / assured migration programme.

Executive Summary

All but one general practice in Cheshire and Merseyside currently uses either EMIS or TPP SystmOne as its foundation clinical system. Medicus is a new market entrant assured by NHS England.

Interest in Medicus across Cheshire and Merseyside has increased, creating a need for a coordinated ICB response covering procurement, digital clinical safety, integration and implementation. One practice, Merepark Medical Centre, is currently scheduled to migrate before Christmas 2026. The remaining practices are discussing potential go-live dates, which are anticipated to be after April 2027.

In terms of costs Medicus has offered transition support for Cheshire and Merseyside practices migrating by 30 June 2027 in the form of waiver of the £5,000 data migration fee.

Key dependencies include written confirmation of the extension to NHS England's Tech Innovation Framework, completion of a compliant procurement process, availability of Informatics Merseyside project management capacity, and completion of digital clinical safety and business continuity assurance.

Ask of the System Primary Care Committee and Recommendations

The System Primary Care Committee is asked to:

1. Note the confirmed and emerging demand for migration to Medicus;
2. Support the go live for Merepark Medical Centre;
3. Support the principle of a phased migration programme, with dates dependent on NHSE procurement completion, practice preference, supplier capacity, digital resource capacity and digital clinical safety assurance;

4. Receive a further update on delivery, costs, risks and benefits in due course once the risks described below are further understood.
5. Note that the programme will be overseen by the new Digital, Data and Analytics Programme Board, which is being established.
6. Note the key risks relating to the procurement framework, delivery capacity, clinical safety and business continuity, and integration with Graphnet.
 - The first risk relates to the expiry of the NHS England procurement framework used to purchase Medicus which would mean that the ICB could be responsible for the licence costs for both the existing practices that are live with Medicus (Wilmslow) and Merepark. The cost of this risk is currently circa £45,000 per annum. It should be noted that Medicus is already live in 10 practices nationally and a further 90 practices are in the process of migrating, therefore there is significant pressure on NHS England to establish a compliant procurement route.
 - The second risk relates to the current lack of integration with Graphnet, which means that affected practices will not share data with the Shared Care Record or CIPHA. Graphnet has committed to developing this integration, but a firm completion date has not yet been confirmed. The practice that is currently employing Medicus can access and contribute to the Shared Care Record for direct-care purposes through the existing GP Connect arrangements. However, the separate secondary-use feed required to populate the CIPHA population health dataset has not yet been delivered. Consequently, other practices migrating before the feed is implemented would be absent from, or materially under-represented within, CIPHA population health datasets, dashboards and analytical outputs. This would reduce the completeness and comparability of system, Place, neighbourhood, PCN and practice-level intelligence used for population health management, inequalities analysis, risk stratification, cohort identification, service planning and strategic commissioning. The key reports, tools and dashboards affected include: Enhanced Casefinding, Core20plus, Fuel Poverty, Frailty, and segmentation reporting.
7. Note that approval of further practice migrations before the CIPHA secondary-use feed is operational would involve knowingly accepting incomplete population health coverage for the affected populations, potentially until September 2027 or later. The Committee is therefore asked to support a pause after the approved Merepark migration unless and until the ICB has received an assured integration timetable, quantified the affected population and reporting impacts, and approved adequate interim controls.

Reasons for Recommendations

A coordinated approach enables the ICB to meet its GPIT commissioning responsibilities, maintain supplier choice and competition, manage clinical and operational risk, and avoid unplanned costs falling to the ICB or individual practices. A phased programme also allows Digital clinical safety and project management capacity to be aligned and prioritised.

Background

Wilmslow Health Centre is already live on Medicus and provides local implementation experience. During recent months practices notified the ICB of further interest and formal migration intentions. The ICB has received confirmed requests from

- Merepark Medical Centre, Sandbach
- Princeway Surgeries, Frodsham
- Rope Green Medical Centre, Crewe
- Oaklands Medical Centre, Middlewich
- SSP Health (8 Practices - Atlas Medical Practice, The Bowery Medical Centre, Newton Practice, Orrell Park Medical Centre , Rawson Road Medical Centre, Upton Rocks Primary Care, Waters Edge Medical Centre, Windermere Medical Centre)

The ICB has received confirmed requests from the practices listed to migrate from EMIS to Medicus. Further practices and PCNs have expressed interest but have not yet formally confirmed their intentions.

The original Merepark migration date was deferred because of the transfer of CSU services to iMerseyside, associated workforce and operational pressures, and the need for a stabilisation and change-freeze period. A revised go-live date of 16 November 2026 has subsequently been agreed.

The national Tech Innovation Framework was due to expire on 6 November 2026. An extension has been indicated, but written confirmation of the revised expiry date remains a dependency. NHS England has advised that GPIT notional funding covers foundation clinical systems, while migration and change costs require separate consideration. The ICB has also submitted a bid for Frontline Productivity funding to support these costs.

The table below summarises the roles and responsibilities for this work as defined in NHS England's Primary Care GP Digital Services Operating Model v6.02.

Roles and responsibilities at a glance

Party	Primary role	Key responsibility
ICB	Framework, specialist support and assurance	Provide advice, CSO access, oversight and escalation support.
GP practice	Local clinical safety accountability	Manage local risks, comply with DCB0160 and implement the system safely.
Migration project	Delivery of project-specific safety work	Resource, produce and maintain the required clinical safety artefacts.

[Link to delivering on the ICB Strategic Objectives and the Cheshire and Merseyside Priorities](#)

Objective One: Tackling Health Inequalities in access, outcomes and experience

A broader choice of assured clinical systems can support equitable access and experience, provided migrations are phased safely and the risk relating to the Shared Care Record and CIPHA reporting gap is actively managed.

Objective Two: Improving Population Health and Healthcare

Safe implementation of a modern GP clinical system supports effective primary care delivery, continuity of care and improved digital capability.

Objective Three: Enhancing Productivity and Value for Money

The approach supports competition and value for money because the foundation clinical system is funded through NHS England pass-through funding. Migration and change costs require separate consideration. Whole-life costs, decommissioning savings, internal resource requirements and recurrent pricing must therefore be assessed through procurement and benefits tracking.

Objective Four: Helping to support broader social and economic development

The programme may contribute indirectly by expanding digital supplier diversity.

[Link to meeting CQC ICS Themes and Quality Statements](#)

Theme One: Quality and Safety

Supports safe deployment, continuity of care, clinical risk management and equitable access. Each migration must maintain DCB0160 assurance, data validation, incident escalation and business continuity controls.

Theme Two: Integration

Supports integration through the Shared Care Record and GP Connect. The temporary absence of the CIPHA secondary-use feed must be clearly controlled, monitored and resolved through the Graphnet development plan.

Theme Three: Leadership

Requires clear commissioner leadership, transparent procurement, defined accountabilities, effective partnership working with practices, NHS England, Informatics Merseyside, Medicus and Graphnet, and routine reporting of delivery, risk and benefits.

Risks

9.1 Key risks and controls are:

- **Framework risk:** uncertainty over the extension NHS England's procurement framework (Tech Innovation Framework or TIF) could delay call-offs. This procurement framework is used to purchase Medicus which would mean that the ICB could be responsible for the licence costs for both the existing practice that are live with Medicus (Wilmslow) and Merepark. The cost of this risk is currently just under £30,000 per annum. It should be noted that Medicus is already live in 10 practices nationally and a further 90 practices are in the process of migrating, therefore there is significant pressure on NHS England to establish a compliant procurement route.
Mitigation: obtain written national confirmation and maintain contingency dates.
- **Capacity and delivery risk:** limited iMerseyside engineering and ICB specialist capacity may make the proposed sequence unachievable.
Mitigation: confirm resources before dates are offered and phase the cohort.
- **Clinical safety and business continuity risk:** unsafe configuration, incomplete data validation or inadequate local readiness could affect care.
Mitigation: apply DCB0160 controls, named CSO support, hazard management, go-live criteria and rollback/business continuity arrangements.
- **Data completeness, population health and strategic commissioning risk:**
The secondary-use data feed required for Medicus data to populate the CIPHA population health dataset is not currently available. Correspondence from Medicus indicates that the Graphnet development is presently penciled in for September 2027 and may be delayed further; Graphnet has not yet provided the ICB with a confirmed delivery date. Any practice migrating before successful implementation and validation of the feed would therefore be excluded from or under-represented within CIPHA population health data. This would affect the completeness of Enhanced Case Finding, risk stratification and segmentation, neighbourhood and proactive-care cohorts, Core20PLUS5 and inequalities analysis, CVD and respiratory reporting, mental health intelligence, fuel-poverty analysis, and approved analytical access to linked primary care data. The reports would remain accessible, but their coverage would no longer represent the whole registered population. The consequence is a risk of biased comparisons between practices, PCNs, neighbourhoods and Places; under-identification of risk and unmet need; reduced ability to target interventions and resources; incomplete monitoring of inequalities and outcomes; and reduced confidence in intelligence supporting strategic commissioning, service redesign and evaluation. The scale of this risk would increase with each additional migrating practice and could persist until the feed is delivered, tested, reconciled and formally accepted by the ICB.

Mitigation : Obtain a jointly agreed and contractually supported delivery plan from Graphnet and Medicus, including committed milestones, technical specification, testing, data-quality reconciliation, acceptance criteria and a target production date.

- o Treat successful delivery and ICB acceptance of the secondary-use feed as a formal dependency for any migration beyond the specifically approved initial practice or cohort.
- o Complete an impact assessment before each migration, covering registered population size, affected Place, PCN and neighbourhood, deprivation and protected-characteristic profile, and the CIPHA products and strategic programmes that rely on that practice's data.
- o Clearly flag affected practices and populations within CIPHA outputs and analytical products so users do not interpret incomplete results as complete system coverage.
- o Establish an interim reporting arrangement for essential cohorts and indicators, with a named owner, defined data specification, frequency, quality assurance and end date.
- o Report the number and registered population of non-flowing practices, duration of the gap, affected products, delivery milestones and unresolved issues routinely to the Digital, Data and Analytics Programme Board.
- o Require successful historic-data loading and reconciliation following implementation so that trend reporting does not contain an unexplained discontinuity.

Finance

Medicus has offered to waive the £5,000 data migration fee for Cheshire and Merseyside practices migrating by 30 June 2027. The Digital team has submitted a bid for annual NHS England Frontline Productivity programme funding up to 2030 to cover future migration-related costs. The outcome of the bid is expected imminently; until it is confirmed, the funding available for migration and change costs remains uncertain.

Communication and Engagement

The position has been informed by direct engagement with interested practices, Medicus, NHS England, procurement colleagues, iMerseyside and Graphnet. Practices must formally notify the ICB of their intention to migrate and agree achievable dates.

Equality, Diversity and Inclusion

Equality Impact Assessments will be developed as part of the implementation process. The Shared Records / CIPHA reporting gap should be monitored for disproportionate impact.

Next Steps and Responsible Person to take forward

- Commence implementation planning for each confirmed migration, aligned with the agreed go-live dates and subject to completion of procurement, resource, clinical safety and business continuity requirements.
- Monitor progress with NHS England procurement framework to ensure there is a continued compliant procurement process for Medicus.
- Work with Graphnet and Medicus to progress a comprehensive safe integration process as quickly as possible.

Officer contact details for more information

- Cathy Fox, Associate Director of Digital Operations
- Kevin Highfield, Head of Digital Operations

Appendices

Appendix One: Extract from Securing excellence Primary Care (GP) Digital Services: The Primary Care (GP) Digital Services Operating model v 6.02

Appendix 1 - System Migration Responsibilities

Source: PRN00408 – NHS England GP Digital Services Operating Model v6.02

Core principle: The ICB provides the framework, assurance and specialist support for a safe migration. The GP practice retains accountability for safe local implementation and compliance with DCB0160 NHS clinical safety standard that applies to organisations deploying, implementing, using, maintaining or decommissioning health IT systems.

ICB responsibilities

- Provide access to clinical safety assurance advice and support.
- Provide access to a qualified Clinical Safety Officer (CSO) or CSO support function.
- Advise on DCB0160 and DCB0129 during procurement, deployment, configuration, migration and decommissioning.
- Support the management and escalation of digital patient safety incidents.
- Provide oversight and assurance that appropriate clinical safety, cyber security, information governance and business continuity arrangements are in place.
- Ensure practices can access appropriate specialist support throughout the migration programme.

GP practice responsibilities

- Retain accountability for clinical safety and DCB0160 compliance within the practice.
- Apply clinical risk management processes during implementation and go-live.
- Identify, assess and manage local hazards and clinical risks associated with the migration.
- Maintain safe local operational processes and business continuity during and after migration.
- Report and manage patient safety incidents through the appropriate reporting routes.
- Ensure the new system is used safely in the practice environment.

Migration project responsibilities

Migration-specific clinical safety work should be explicitly included and resourced within the project. This may include:

- Clinical Risk Management Plan
- Hazard Log
- Clinical Safety Case
- Detailed implementation and migration risk assessments

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