NHS
Cheshire and Merseyside

Meeting of the Cheshire & Merseyside ICB System Primary Care Committee

Part B – Meeting held in Public

Thursday 16 April 2026
Venue: Meeting Room 1, No 1 Lakeside,
920 Centre Park Square, Warrington,
WA1 1QY (WA1 1QA for SatNav)

Timing: 10:00-12:00

Agenda

Chair: Erica Morriss

AGENDA NO & TIME	ITEM	LEAD	ACTION / PURPOSE	PAGE No
10:00am	**Preliminary Business**			
SPCC 26/04/B01	**Welcome, Introductions and Apologies**	Chair	Verbal	-
SPCC 26/04/B02	**Declarations of Interest**	Chair	Verbal	-
SPCC 26/04/B03	**Questions from the public (TBC)**	Chair	Verbal	-
10:05am	**Committee Management**			
SPCC 26/04/B04	**Draft Minutes of the last meeting (Part B) –** 19 February 2026	Chair	Paper To approve	Page 3 *Click here for link to page*
SPCC 26/04/B05	**Action Log of last meeting (Part B)** 19 February 2026	Chair	Paper To note	Page17 *Click here for link to page*
SPCC 26/04/B06	**Forward Planner**	Chris Leese	Paper To Note and Approve	Page 18 *Click here for link to page*

AGENDA NO & TIME	ITEM	LEAD	ACTION / PURPOSE	PAGE No
10:10am	**Finance Assurance**			
SPCC 26/04/B07	**Finance Update**	Lorraine Weekes-Bailey	Verbal To Note	-
10:25am	**Policy and Commissioning**			
SPCC 26/04/B08	**Policy and Commissioning Update: Dental, Community Pharmacy, Optemetry and General Practice** • **Enhanced Services Review**	Chris Leese/Tom Knight Dr Jonathan Griffiths	Paper To note	Page 20 *Click here for link to page*
10:40am	**Key Strategic Delivery Areas**			
SPCC 26/04/B09	**Patient Experience – Dental Access**	Louise Barry	Verbal To Note	-
SPCC 26/04/B10	**Dental Improvement/Access Plan**	Tom Knight	Paper To Note	Page 32 *Click here for link to page*
11:25am	**Digital**			
SPCC 26/04/B11	**Shared Care Update**	Lesley Kitchen	Presentation on day To note	-
11:45	**Estates**			
SPCC 26/04/B12	**Leasing Policy**	Lucy Andrews	Paper For Agreement	Page 40 *Click here for link to page*
12:00	**CLOSE OF MEETING**			

Date and time of next regular meeting:
Thursday 25 June 2026 (09:00-12:30)

F2F, Lakeside, Warrington, room tba

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

Thursday 19 February 2026 09:45-12:00
Meeting Room 1, No 1 Lakeside
920 Centre Park Square, Warrington, WA1 1QY

Unconfirmed Draft Minutes

ATTENDANCE - Membership		
Name	**Initials**	**Role**
Erica Morriss	EMo	*Chair*, Non-Executive Director
Clare Watson	CWa	Executive Director of Health and Integrated Care Commissioning, C&M ICB
Louise Barry	LBa	Chief Executive, Healthwatch Cheshire
Fionnuala Stott	FSt	LOC representative
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
Adam Irvine	AIr	Primary Care Partner Member
Daniel Harle	DHa	LMC representative
Tom Knight	TKo	Head of Primary Care, C&M ICB
Kerry Lloyd	KLl	Interim Director of Nursing & Care, C&M ICB
Susanne Lynch	SLy	Chief Pharmacist, C&M ICB
In attendance		
Zoe Rubotham	ZRu	*Minute taker*, Executive Assistant, C&M ICB
Loraine Weekes-Bailey	LWB	Senior Primary Care Accountant
Kevin Highfield	KHi	Head of Digital Operations, C&M ICB
Cathy Fox	CFo	Associate Director of Digital Operations, C&M ICB
Stephen Hendry	SHe	Head of Business Support
James Burchell	JBu	Strategic Estates Manager (Cheshire East, Cheshire West & Wirral Places), C&M ICB
Pam Soo	PSo	Community Pharmacy Clinical Lead, C&M ICB
Susanne Question		External

Apologies		
Name	**Initials**	**Role**
Anthony Leo	Ale	Place Director, Halton
Susanne Lynch	SLy	Chief Pharmacist, C&M ICB
Tony Foy	TFo	Vice-Chair, Non-Executive Director, C&M ICB

Agenda Item, Discussion, Outcomes and Action Points
Preliminary Business
SPCC 26/02/B01 Welcome, Introductions and Apologies
The Chair, formally opened the public meeting, welcomed attendees and thanked members of the public for joining. The Committee began with introductions to ensure everyone was clear on who was present. Apologies were noted as received.
SPCC 26/02/B02 Declarations of Interest
The committee noted the standing declarations of interest. Members were invited to declare any additional specific interests. One member declared undertaking limited work for another organisation; no further declarations were made.
SPCC 26/02/B03 Questions from the public
The member of the public read out their submitted question regarding how industry could partner with the Committee to support effective delivery of the **Oral Nutritional Supplement (ONS) programme**, seeking improved patient outcomes and measurable cost efficiencies. The Chair confirmed the question had been formally received but unfortunately later than the deadline to provide an answer on the day and confirmed that we would be responded within the required SLA. The question was responded to 20/2/26 and acknowledged by the member of public.
Committee Management
SPCC 26/02/B04 DRAFT Minutes of the last meeting (Part B) 18 December 2025
The committee reviewed the minutes from the December meeting. No amendments were required and the minutes were **approved** as a true and accurate record of the meeting.
SPCC 26/02/B05 Committee Action Log (Part B) 18 December 2025
The Action Log was updated accordingly.
SPCC 26/02/B06 Primary Care Risks – Update **Presenter: Stephen Hendry**
The Committee received a comprehensive update on the Primary Care risk register. The risk lead explained that a structured review had been undertaken since the previous meeting, focusing particularly on risks currently rated extreme or critical. The purpose of this work was to ensure that all risk scores, controls, and assurances accurately reflected the current operational and governance environment. The Committee was advised that review sessions had taken place with relevant operational leads, including those responsible for estates-related risks. As a result of these discussions, it was recommended that two estates-focused risks should now be reduced in score, as the associated controls and oversight arrangements were judged to be more robust than previously assessed. The Committee noted that although wider governance structures remain subject to change, the assurance mechanisms for estates now provide a stronger level of confidence in risk management. In relation to finance-related risks, the Committee heard that an initial assessment had been undertaken, but a fuller review will be completed following the meeting. Members were informed that early indications suggest some of these risks may also warrant reduction in score; however, this requires more detailed analysis before formal recommendations can be made. The Committee was reminded that any risk shifting between “red” and “black” categories has wider implications for corporate reporting, as such risks are subject to additional scrutiny at ICB level. The Committee was further informed that digital-related risks have not yet been fully reviewed. However, a broader digital risk review is underway within the digital team, and Primary Care-specific

digital risks will be incorporated into that exercise. A joint discussion has taken place to ensure alignment between the wider digital risk profile and the Primary Care elements, and the Committee will receive updates once this work is complete.

The risk lead reported significant progress in rationalising risks that had previously been logged at place level. Following discussions with place-based teams and primary care operational leads, most place-level risks relating to primary care have now been closed in favour of central oversight at system level. The next stage of work will focus on defining how assurance from place level will feed into the Committee going forward. It was noted that this work is complicated by ongoing organisational and governance changes, although the ICB will continue to require a clear understanding of risk at local level irrespective of future structures.

During discussion, Committee members emphasised the importance of ensuring that quality considerations—including potential impacts on patient harm, safety, and experience—are clearly reflected in the scoring rationale for relevant risks, particularly those relating to financial pressure. It was noted that some risks currently carry a scoring profile associated with "significant harm", and the Committee explored the need for greater alignment between the risk register, the Primary Care Quality Group, and any patient safety intelligence submitted to the Committee.

Members also noted the opportunity for a broader review of the risk impact scoring framework across the ICB as part of the forthcoming governance work, which may result in improvements to consistency and clarity in how risks are assessed.

After reviewing the information provided, the Committee agreed to:

- **Approve the recommendation to reduce the scores of the relevant estates-related risks;**
- **Note the ongoing review of digital and finance risks and expect further updates;**
- **Accept the introduction of a new risk PG9, reflecting changes within the Primary Care risk landscape.**

Finance Assurance

SPCC 26/02/B07 Finance Update
Presenter: Lorraine Weekes-Bailey

The Committee received a comprehensive update on the financial position across the delegated primary care budget, prescribing expenditure, and the independent contractor groups. The financial report highlighted several areas of variance, pressures, and emerging risks.

The Committee was informed that the overall delegated primary care budget is currently underspent by approximately £5 million. The finance team explained that this variance is driven primarily by a significant underspend in Additional Roles Reimbursement Scheme (ARRS) funding.

ARRS position - showing a £2.1 million underspend, which is now expected to increase further based on the most recent data returns. Places have been working actively with Primary Care Networks (PCNs) to reconcile forecasts and understand the reasons for reduced uptake. Despite earlier expectations that ARRS allocations would be fully utilised, recruitment challenges—particularly in GP-based ARRS roles—have resulted in practices failing to draw down their full entitlements.

The Committee discussed the reasons for this, which include increasing difficulty in recruiting and retaining ARRS-funded staff. Concerns that remuneration levels within ARRS roles are becoming uncompetitive compared to other GP or non-GP roles. A shift in the behaviour of newly-qualified GPs, with some choosing alternative work patterns or not entering the traditional general practice workforce. Limited flexibility within national ARRS rules, which restricts the range of roles that PCNs can appoint.

Committee members noted that ARRS underspends are a sensitive issue given the wider pressures on primary care capacity and the political focus on access. It was acknowledged that, while the ICB must

remain compliant with national funding rules, there is an intention to review whether greater flexibility could be applied locally within those constraints for future financial years.

The Committee also reflected on the perception risk if ARRS underspends continue, particularly at a time when GP appointments, access pressures and patient demand are under national scrutiny.

Accuracy of PCN Forecasting - Finance colleagues reported that some PCNs continue to forecast 100% ARRS expenditure despite historic underspends and limited recruitment in-year. Committee members noted that earlier visibility of realistic forecasts would support better planning, reduce the need for reactive measures late in the year, and avoid inflated expectations. The Committee discussed the need for stronger forecasting discipline, earlier escalation where plans are unlikely to be met, and more open dialogue between PCNs, Place teams and the ICB.

The Committee noted a forecast underspend of £959,000 within fees and premises budgets. This variance is due primarily to lower-than-expected maternity, locum and sickness reimbursement claims compared with the previous financial year, and reduced sickness levels amongst GPs compared with the prior reporting period.

The Committee recognised this as a favourable variance but emphasised the importance of ongoing monitoring, given the volatility of these budgets.

The Committee received an update on prescribing expenditure, which continues to represent a significant system financial pressure.

Year-to-date GP prescribing costs stand at £13.9 million, with a forecast outturn of £14.1 million. December prescribing data has now been received but is still subject to detailed analysis. December is typically a high-volume month, with an expected seasonal uplift of around 10%, and therefore has a major impact on the year-end forecast. The Committee was advised that the final December analysis will determine whether the current forecast remains achievable.

It was reported that a number of planned prescribing mitigation measures began to take effect from November, including interventions around high-cost areas and targeted medicines optimisation activity. These measures are expected to yield further reductions in prescribing expenditure, though there remains uncertainty about whether they can fully offset earlier year pressures. A key savings initiative previously planned was not implemented due to issues in gaining approval but is expected to form part of next year's programme.

The Committee acknowledged that prescribing remains a highly sensitive and challenging area, with limited flexibility due to clinical safety requirements and patient need.

Community Pharmacy and Dental Financial Position - The budget shows a £3 million underspend, although this is now expected to reduce to approximately £2.5 million, due to higher than anticipated uptake of the national Pharmacy First service. The Committee discussed the importance of ensuring that the financial impact of Pharmacy First is monitored throughout the remainder of the year, given the potential for further volatility.

Dental budgets show a £6.2 million underspend, with approximately £5 million relating to prior-year adjustments. The Committee noted that this underspend cannot be assumed to continue into future years, given the ongoing pressures and upcoming contractual changes within NHS dental services.

The Chair requested further clarity on demonstrating improvements in access across all four contractor groups. The Committee agreed that current reporting is too limited, there is a need for clearer, more

coherent dashboards covering GP, dental, pharmacy and optical activity, and improved reporting will support better public accountability when meetings are held in public.

The Committee noted the following ongoing concerns:

- **Risk of ARRS underspends continuing into 2026/27 unless structural, workforce and national contractual issues are addressed.**
- **Potential for increased prescribing pressures in the final months of the year once December data is fully analysed.**
- **Uncertainty regarding national funding streams, including future financial support for schemes such as Pharmacy First and technology-enabled care.**
- **The wider ICB financial recovery context, which may require further efficiencies across primary care budgets.**

The Committee acknowledged that the financial environment remains highly constrained, with limited capacity for discretionary investment.

SPCC 26/02/B08 Prescribing Assurance
Presenter Susanne Lynch

The Committee received a detailed update on prescribing expenditure and the associated assurance framework. The prescribing team outlined current performance against plan, key drivers of variance, and the assurances in place to manage financial, clinical and operational risks. The Committee noted that prescribing remains one of the most significant and volatile areas of spend across the system, requiring ongoing scrutiny.

The Committee was advised that although prescribing expenditure continues to exceed planned levels, there are early indications of stabilisation following the implementation of targeted mitigation measures. These actions began to take effect from November onwards, and early data suggests emerging downward trends in some of the highest-cost categories.

Members were reminded that the December prescribing dataset is critical in determining the year-end forecast, as December typically generates a seasonal uplift in prescribing volumes of around 10%. While this data has been received, a full analytical review has not yet been completed, and therefore the formal forecast remains provisional.

The Committee recognised that fluctuations in prescribing expenditure are driven by high-cost drug categories, national shortages, therapeutic switching delays, variations in primary care behaviour, and underlying increases in patient demand and disease burden.

The Committee sought assurance that the prescribing overspend is being actively managed. The prescribing team provided an update on the key mitigation actions underway, with assurance that a number of high-impact interventions began implementation in November. Early indicators from November and December show downward movement in several targeted areas. While the full impact cannot yet be quantified, the prescribing team is confident that these measures will contribute to cost containment over the final quarter.

Medicines optimisation teams are working directly with practices and PCNs to address variation and support best-value prescribing. Specific programmes include therapeutic switching in appropriate categories, deprescribing in line with clinical safety guidance, and reviewing high-cost drug usage.

The Committee was assured that all prescribing intervention plans undergo clinical scrutiny, safety considerations override financial targets, and medicines optimisation work is framed around evidence-based practice rather than cost-saving alone. Members took assurance that although the financial pressures are significant, there is no lowering of clinical governance standards.

The Committee was reminded that one major mitigation programme originally planned for the current year did not progress due to external factors. However preparation for re-launch is underway, it will form part of the next financial year's prescribing improvement plan and will be introduced earlier in-year to maximise benefit and reduce in-year slippage.

The Committee discussed the inherent challenges in forecasting prescribing expenditure, given the unpredictability of medicine price concessions, supply chain disruption, national policy changes, and population demand. To support assurance, the team outlined the strengthened processes now in place, including

- Monthly prescribing performance reviews,
- Exception reporting for high-impact cost categories,
- Detailed place-level scrutiny meetings,
- Closer alignment with Primary Care operational leads,
- And further analysis of PCN variation to identify targeted areas for intervention.

Members acknowledged that prescribing pressures are a recognised national issue, and assurance was provided that local processes are in line with national expectations for financial governance.

Committee members emphasised the need for improved visibility of the impact of mitigation actions over time, clear reporting that distinguishes between volume-driven pressures and price-driven pressures, assurance that practices are receiving timely support to address areas of unwarranted variation and continued clinical oversight to ensure that any savings initiatives remain safe and appropriate.

Members recognised the significant operational burden on primary care and requested that future updates include qualitative feedback on implementation challenges at practice level.

The Committee also highlighted that prescribing will remain a key focus area as part of the wider ICB financial recovery programme and reinforced the need for a consistent and transparent assurance framework.

The committee noted the report and endorsed the action being undertaken to manage the primary care prescribing spend.

Policy and Commissioning

SPCC 26/02/B09 Dental, Community Pharmacy, Optometry and General Practice
Presenter: Tom Knight

The committee received an update on developments in national primary care policy, including the emerging NHS England Primary Care Operating Model, and the implications for local contracting arrangements. The update also outlined ongoing work within the ICB to develop a new internal operating model and future governance structure for primary care.

National Operating Model

- NHS England will continue to work with ICBs on a shared approach to oversight and assurance of primary care.
- The new national model provides updated expectations around commissioning responsibilities, escalation routes and reporting.
- A more detailed presentation is planned for a future committee meeting to ensure clarity on the national framework.

ICB Operating Model Development

- The ICB is finalising its own operating model, aiming to clarify directorate responsibilities and integrated ways of working.
- This includes how primary care, digital, quality, contracting and strategy functions will coordinate to support delivery.
- A future update will present the structure, roles and interfaces, including how primary care governance will operate under the new model.

Contractual and Policy Implications

- National policy increasingly emphasises general practice access, neighbourhood health, digital transformation and integration across primary care.
- Requirements for other contractor groups, including dentistry and community pharmacy, are expected to evolve as part of emerging national reforms.
- Policy implications include potential changes to:
    - Protected Learning Time arrangements
    - Online consultation and access standards
    - Digital enablement expectations
    - Contract monitoring and assurance processes

The committee emphasised the importance of early, clear communication with primary care providers as both national and local operating models develop. Members welcomed the plan for a combined update on NHS England's model and the ICB's internal arrangements.

The committee noted that the future operating model may require updates to:

- Committee terms of reference
- Escalation and assurance routes
- Pathways for decision-making and oversight
- Integration with neighbourhood health and strategic commissioning programmes

Members emphasised the importance of aligning contracting decisions and commissioning functions with wider system priorities, particularly neighbourhood health, population health management, workforce and digital transformation.

Next steps: CW/FL to provide a combined update at the next meeting covering:

- NHS England's Primary Care Operating Model
- The ICB's new internal operating model
- Expected implications for commissioning, oversight and governance.

Updated structural information, diagrams and governance materials will be shared once the operating model is finalised.

No formal decisions were required for this item. The committee noted the update.

SPCC 26/02/B10 Enhanced Services Review
Presenter: Dr Jonathan Griffiths

The committee received a progress update on the system-wide review of local enhanced services (LES) for General Practice. The item aimed to outline the emerging commissioning approach, explain how historic variation is being addressed, and set expectations around timelines for formal decision-making.
The transition from nine legacy CCGs to a single ICB footprint has resulted in significant variation in the type, scope and value of LES schemes across the system. Many schemes have existed for years and now function as core income for practices, leading to understandable provider anxiety about changes. The review is therefore designed to bring coherence, equity and clarity while maintaining service
A longlist of around 150 schemes has been compiled. A multidisciplinary review group—including clinical, finance, prescribing and representative bodies—has completed stage one of the assessment
Each scheme has been assigned to one of the following categories:

- Basket 1: Schemes recommended for commissioning consistently across all practices within the ICB. These represent priority or baseline services
- Basket 2: Schemes available for optional local adoption at place level, subject to funding capacity and local priorities
- Basket 3: Schemes recommended for decommissioning because they are outdated, duplicated by national contractual requirements or PCN DES commitments, or are more appropriately delivered by community diagnostic or specialist services.
- Out of Scope: Schemes deemed inappropriate for inclusion due to specialist nature or misalignment with the review's remit

- Identified Gaps: Areas of unfunded workload carried by General Practice, which will require decision-making on whether they are commissioned in future or explicitly closed

Analysis has highlighted system-wide funding variation, ranging from approximately £7 per head in some places to £25 per head in others. The committee acknowledged that harmonisation cannot be achieved through a single-year uplift and will require a phased approach and potential future investment.

At this stage, there is no intention to remove funding from the overall LES envelope or redirect money between places during the review phase, though final decisions remain pending.

The committee emphasised that significant mid-year change during 2026/27 is undesirable because of the operational and financial disruption this would create for practices.

2026/27:

- Serve formal notice on schemes proposed for decommissioning or redesign.
- Maintain stability for practices by providing extended notice periods beyond minimum requirements.
- Continue co-design of specifications and tariffs.

April 2027/28:

- Full implementation of the unified Basket 1 scheme set.
- Adoption of the Basket 2 optional local scheme framework

Prescribing leads advised that a small number of aligned metrics—particularly around medicines safety and antimicrobial stewardship—need accelerated implementation during 2026/27. These will be delivered through local contracts this year and later absorbed into the final LES structure

Members expressed strong concerns about destabilising practice income and workforce planning. The committee agreed that major changes should not take effect mid-year and that any decommissioning must be managed through early notice and clear communication

The need for transparent, early communication with practices, representative bodies and place-based partners was highlighted. The review methodology was commended for involving clinical and representative voices and should be replicated in future contractor-group reviews

The review for General Practice is the first phase. Enhanced services for dental, community pharmacy and optometry will be reviewed during 2026/27 using a similar methodology.

Executives emphasised the need for the future LES portfolio to demonstrate measurable return on investment, aligned with system financial recovery and the emerging Neighbourhood Health model.

- Agreement to proceed with the development of the Basket 1 and Basket 2 model, with standard pricing and specifications for Basket 1 schemes
- Agreement to the “notice served in-year, changes implemented from April 2027/28” approach.
- Support for delivering interim prescribing metrics via local contracts in 2026/27.

Next steps: JG to provide full proposal—including recommended Basket 1 schemes, decommissioning proposals, impact analysis and transition plan—will return to the committee in April

SPCC 25/02/B11 National Community Pharmacy Independent Prescribing (CPIP) Pathfinder Programme
Presenter: Pam Soo

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

The committee noted that the national CPIP Pathfinder Programme officially ends on 31 December 2025, meaning ICBs must put exit and transition plans in place. A short transition window to the end of March 2026 is supported by NHS England, but only with limited financial assistance per site. This national timeline shaped local decisions about whether continuation was feasible.

Operating CPIP sites is resource-intensive, with the cost of a single site significantly exceeding the small amount of residual local funding available. The committee was advised that maintaining all seven

sites was not financially viable, given the remaining local budget would not support them even for one full month of activity

A major factor influencing the local decision was loss of key pharmacist prescribers, including the departure of experienced independent prescribers from at least one site. This created uncertainty in continuity and sustainability of safe clinical delivery. Nationally, workforce utilisation remains low, with around 93% of pharmacists who hold an IP qualification not currently using it in community pharmacy settings, highlighting systemic barriers.

The committee acknowledged strong national evidence showing the impact of CPIP:

- **33,000+ consultations** delivered across England.
- **59%** included prescribing interventions that previously required GP or hospital involvement.
- **97%** were managed without onward referral, demonstrating a major potential reduction in GP workload.

These data strengthened recognition of the programme's clinical value even though it was not financially sustainable locally.

The committee discussed the wider national direction: From September 2026, all new pharmacists will register as independent prescribers. NHS England will use CPIP learning to shape future national pharmacy clinical services under potential new contractual arrangements from 2026/27 onwards.

Members expressed concern that local closure may appear to conflict with national ambition, though the financial constraints locally were unavoidable.

While local sites could not continue, there was consensus that residual funds should support preparation for a future national prescribing-enabled service, including training, engagement and system readiness. This was seen as essential to avoid losing the progress already made.

National evaluation shows very positive patient feedback, with **over 90% of patients** at some sites wanting more pharmacy-based clinics. Pharmacists reported increased job satisfaction and improved use of clinical skills. The committee acknowledged that these findings demonstrate the long-term potential value of community pharmacy prescribing within neighbourhood teams.

The discussion highlighted the importance of robust clinical governance, consistent digital access (e.g., records integration), strong two-way pathways with general practice, appropriate supervision and oversight structures

These needs are emphasised nationally and will shape future commissioning models.

Given the national end date, the limited transition funding and local financial and workforce constraints, the committee agreed to the recommendation to close all seven CPIP sites locally at the end of March.

Consideration to be given through active dialogue with Finance to retain remaining funds to support mobilisation of a future national model. Continue monitoring national developments and prepare for reintegration once new commissioning frameworks are released

Key Strategic Delivery Areas

SPCC 26/02/B12 Neighbourhood Health Update
Presenter: Clare Watson

The Committee received a comprehensive update on the development and implementation of Neighbourhood Health across the system. This forms one of the ICB's core priorities and is central to the future delivery model for primary and community care. The update provided clarity on progress to

date, emerging expectations from national bodies, interdependencies with wider ICB transformation, and the implications for all contractor groups.

The Committee noted that Neighbourhood Health is positioned nationally as the foundation for integrated, place-based care. The model is intended to bring together multiple partners at a population footprint of approximately 30,000–50,000 residents, enabling:

- more proactive, personalised care,
- earlier intervention and prevention,
- improved population-health outcomes,
- better use of local assets including voluntary and community sector,
- and reduced pressure on hospital and crisis services through coordinated neighbourhood-level working.

Although the national policy direction is firm, members noted that detailed expectations and contractual links—particularly relating to general practice—remain in flux, with formal consultation on future contractual arrangements anticipated but not yet issued.

The Committee was informed that the system has now formally confirmed 61 neighbourhood footprints across all places. These footprints have been developed in collaboration with local leaders, taking into account: population size and demographics, existing PCN geographies, community identity, relationships between practices, and alignment with local authority locality structures where feasible.

Members noted that in most areas, neighbourhoods are broadly co-terminus with PCNs. In some places—particularly urban geographies—footprints differ from PCN boundaries, reflecting practical considerations or longstanding local configurations. Local areas consider the agreed footprints workable, even where structures differ.

The Committee acknowledged the importance of avoiding “donut configurations” (where a neighbourhood sits geographically within another) or “orphan practices”. However, members also recognised that relational dynamics and neighbourhood maturity must be considered before forcing structural changes.

Assurance meetings have been held with each place, revealing mixed levels of readiness. The system will continue to support consistent development while recognising that variation in maturity is expected at this early stage.

Two neighbourhoods within the system are designated as national Pioneer Sites. The update highlighted that Pioneer Sites receive supportive oversight (e.g., coaching) but do not receive additional funding, which is a common misunderstanding. In return, they must undertake a significant level of reporting, including baseline data collection, structured plans, and national evaluation participation. The workload associated with Pioneer status includes substantial deadlines before the end of March.

The system has approved a governance structure that includes: a system-level Neighbourhood Health Programme Board, neighbourhood-level coordination groups in each place, and direct links into the forthcoming Strategic Commissioning Programme Board, which will sit above the Committee. Members heard that these structures ensure neighbourhoods are linked to decisions about population-health priorities, resource planning, primary care development, and community transformation programmes.

The Committee emphasised that neighbourhood health must incorporate all four primary care contractor groups. However, members observed that current national policy and operational pressure remain heavily weighted toward general practice access, dental urgent-care pathways are undergoing major change, creating uncertainty, community pharmacy’s role is expanding (e.g., Pharmacy First,

independent prescribing), yet funding and capacity pressures persist. Optical services support urgent eye-care pathways but require clearer inclusion in neighbourhood governance and communication.

The Committee agreed that neighbourhood health will only succeed if all sectors are visible and valued within the transformation.

The Committee agreed the following:

- **Today's slides will be circulated to all members.**
- **A future update will include the emerging metrics framework and reporting pathway.**
- **The Committee will receive periodic updates as part of its ongoing work programme, with substantial items aligned to the Strategic Commissioning Programme Board's development**.

Quality

SPCC 26/02/B13 Primary Care Quality Update
Presenter: Dr Jonathan Griffiths

The Committee received an extensive update on the wider primary care landscape, covering modern general practice, workforce pressures, neighbourhood health development, contractor-group alignment, financial challenges, and national policy influences. The discussion highlighted the increasing complexity across all four contractor groups and the interdependencies between access, workforce sustainability, digital transformation, and local commissioning reform.

The Committee noted that primary care continues to operate in a period of significant transition, driven by new national guidance on modern general practice, continued political and public scrutiny of access, workforce instability across multiple disciplines, financial constraints affecting all primary care contractors, timely but often resource-intensive digital transformation programmes, and the emerging national direction on Neighbourhood Health as an organising model.

Members reflected that this environment places pressure on practices, PCNs, pharmacy contractors, dental providers and optical practices simultaneously, with interlocking consequences for demand, staffing, and patient expectations.

The Committee discussed in detail the persistent challenges in recruitment and retention across general practice, including for ARRS roles. Members noted:

- difficulties in attracting newly-qualified GPs into partnership or salaried roles,
- an increasing trend of GPs choosing portfolio work or locum opportunities,
- structural pay disparities that reduce the attractiveness of some ARRS roles,
- and reported cases of qualified clinicians preferring not to work within the ARRS framework due to pay or workload constraints.

Members expressed concern that workforce inflexibility across the national contract may be contributing to reduced utilisation of available funding and undermining local resilience. The Committee agreed that these issues need to be raised consistently at system level and reflected within primary care strategy development.

The Committee acknowledged ongoing public concern about access to primary care appointments. It was noted that public attendees at system committees often seek tangible evidence of improvement, and therefore the system has a responsibility to present clear, understandable access data for all four contractor groups.

Work is underway with business intelligence teams to develop improved metrics covering:

- appointment supply and utilisation,
- face-to-face vs remote delivery,
- response times for online requests,
- access to urgent dental care,
- uptake and impact of Pharmacy First,

- and metrics for optical urgent care pathways.

The Committee emphasised the need for simple communication tools that help residents understand the range of roles in modern general practice, the rationale for multi-disciplinary models, the benefits of alternative access routes (e.g., pharmacy), and the limits of what primary care can provide within current national frameworks.

The Committee received further narrative on the ongoing development of Neighbourhood Health, which continues to form one of the system's key priorities. Members noted 61 neighbourhood footprints have now been confirmed across the system, these do not always align perfectly with PCN boundaries, though local consensus suggests arrangements are workable. Early assurance meetings with places have shown mixed maturity but consistent willingness to progress. Pioneer sites are facing substantial reporting requirements, including baselining, population-health metrics, and delivery plan submissions.

Members emphasised the importance of avoiding "donut" configurations where practices sit outside local neighbourhood structures. However, it was also recognised that longstanding local relationships and dynamics mean decisions need to be handled sensitively to avoid destabilising existing partnerships. There was recognition that future national GP contract reforms are expected to align with the neighbourhood health model, although consultation timelines remain uncertain. This creates a need for the system to plan proactively while remaining adaptable to national direction.

The Committee considered the implications of the emerging review of local enhanced services and how they relate to broader primary care transformation. Members acknowledged the scale of historical variation inherited from former CCGs, the importance of not destabilising practices through mid-year financial changes and the need to ensure that any future commissioning model is transparent, fair, and aligned to neighbourhood health priorities.

The Committee noted the intention to introduce standardised specifications across the system, with local flexibility where funding allows. Members raised concerns about uncertainty within general practice and emphasised the need for clear communication, adequate notice periods, and an evidence-based approach to future decommissioning or redesign.

In summarising the update, the Committee agreed that:

- Primary care remains in a challenging transition period that requires sustained system support.
- All four contractor groups must be included in transformation planning, rather than a GP-only focus.
- Neighbourhood health provides a long-term organising framework but requires careful groundwork.
- Communications to practices and the public must be strengthened.
- Workforce and access pressures remain priority risks.
- Financial decisions must avoid destabilising practices or undermining resilience.
- Digital change must be paced and coordinated across programmes.

The Committee welcomed continued updates as part of its forward programme.

SPCC 26/02/B14 Digital Update
Presenter: Cathy Fox/ Keving Highfield

The Committee received a consolidated digital update covering: (a) the cessation of CSU-provided GP IT services and transition planning; (b) the system-wide ambient voice technology pilot for primary care; (c) an SMS messaging funding review; and (d) funding arrangements for clinical system mergers associated with practice mergers.

GP IT Service Transition CSU Closure - Members were advised that the national closure of Commissioning Support Unit (CSU) GP IT services means the current support model ends on 31 December 2026. GP IT services currently delivered by the CSU will transfer to a single provider model within the system footprint. Planning assumptions are to transition services to the existing NHS

informatics service already operating at scale in parts of the footprint, with a view to standardising service levels and tooling across all practices.

A dedicated transition governance forum is meeting fortnightly to oversee scope, due diligence, risk, resourcing and timeline. A structured communications plan is being prepared for practices and PCNs, including FAQs, service catalogues, contact routes, and key milestone dates. The transition will include TUPE or equivalent staff transfer activity where applicable. Members noted the risk of staff attrition due to voluntary exit schemes operating within legacy organisations and requested that this be kept under active review.

Key risks discussed.

- Service continuity risk during parallel running and cutover, particularly for practices currently reliant on CSU field services and remote support.
- Capacity risk for the receiving provider if staff do not transfer in the expected numbers, or if concurrent programmes (e.g., operating model changes, national cyber tasks) draw on the same specialist staff.
- Change saturation risk for practices if transition work coincides with other local or national initiatives (e.g., system upgrades, premises moves, telephony migrations).

Ambient Voice Technology Pilot (Primary Care. The system has secured 12 months' time-limited funding to pilot an ambient voice documentation solution in general practice. Eighty-six practices have expressed interest; the final participating cohort will be confirmed following readiness checks and scheduling. The pilot offer includes implementation support, onboarding, role-based training, and helpdesk coverage. The Committee noted the aim is to test across a representative spread of practice sizes, clinical systems, and patient demographics.

Beyond month 12, ongoing licence costs are not guaranteed from local budgets. The system intends to bid into the next national digital funding round for continuation at scale if the pilot demonstrates value for money and safety. The Committee recognised the bid route is highly competitive and requested transparent messaging to practices to avoid any implied commitment beyond the pilot period.

SMS Messaging Funding – Review in Progress. The Committee noted significant feedback from practices regarding SMS costs, patient reach, and the absence of like-for-like alternatives for time-critical, push-based messaging. Members observed that patient portal/app and email channels currently do not match SMS for immediacy and open rates in many cohorts.

A paper will be submitted to the ICB Executive Committee within two weeks setting out options, costs, activity benchmarks, and equity considerations (including impacts on digitally excluded groups). The review will also consider standardisation opportunities (e.g., approved vendors, pricing tiers, message templates, inclusive safeguarding use cases) to leverage economies of scale and reduce unwarranted variation.

Clinical System Mergers Funding Approach (linked to Practice Mergers) Context - Where practices merge, clinical system data must be safely merged to ensure a single, accurate patient record and preserve continuity of care. The typical one-off cost per merger is up to c.£10,000, varying by list size, data quality, and technical complexity. Historic national funding for these activities has ceased. No dedicated ICB budget line currently exists.

Members agreed the system needs a single, consistent policy. The Committee supported a principle of "no routine ICB funding" for clinical system mergers, with an exceptions process where the ICB has requested or brokered the merger primarily for quality, safety, or service-continuity reasons (e.g., to avert list dispersal or address material quality concerns). For business-led mergers, practices should plan and fund merger-related costs as part of their due diligence. For exception cases, the Committee asked that the business case template explicitly sets out system benefit (e.g., avoided costs of list

dispersal, safeguarding of patient access, consolidation of fragile workforce/estates), clinical risk reduction, and value for money.

Next steps - A recommendation reflecting the above principle will be submitted to the ICB Executive for decision. Until Executive confirmation, existing local arrangements will apply to imminent in-flight mergers to avoid retrospective policy changes impacting patient safety or practice continuity.

The committee

- **Noted: CSU closure timetable, approach to transition governance, and the need for robust continuity planning.**
- **Noted: Ambient voice pilot funding is time-limited; continuation is contingent on a successful national bid and demonstrable benefits.**
- **Noted: SMS funding paper to be considered by the ICB Executive within two weeks.**
- **Endorsed (for Executive recommendation): Principle of no routine ICB funding for clinical system merger costs, with an exceptions policy for ICB-requested or safety-critical mergers.**

CLOSE OF MEETING

Date of Next Meeting: Thursday 16 April 2026 (09:00-12:30)
F2F, Lakeside, Warrington

CHESHIRE MERSEYSIDE
INTEGRATED CARE BOARD

Action Log 2025/26 *updated post Feb 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 25/04/B15	17-Apr-25	Digital - Shared Care (Connected Care records)	ii) regular 6 monthly update to SPCC Committee	Kevin Highfield / Cathy Fox	April 2026 committee		ONGOING
SPCC 25/12/B14	18/12/25	Access to General Practice – June 2025 Plan update	CWa will pick up ways to share information regarding specialist roles within GP's with the public and core NHS staff with Comms.	Clare Watson	April 2026 committee	*CW spoken with comms team, need to be progressed at March board (private) verbal update in April on progress made*	ONGOING
SPCC 26/02/B10	19/02/2026	Enhanced Services Review	JG to provide full proposal—including recommended Basket 1 schemes, decommissioning proposals, impact analysis and transition plan	Jonathan Griffiths	April 2026 committee		NEW

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

Updated Mar 26 / Christopher Leese

Item	Who	Frequency	Part A/B	Aug-25	Oct-25	Dec-25	Feb-26	Apr-26	Jun-26
Standing items									
Apologies	EM	Every meeting	Both	Yes	Yes	Yes	Yes	Yes	Yes
Declarations of Interest	EM	Every meeting	Both	Yes	Yes	Yes	Yes	Yes	Yes
Minutes of last meeting	EM	Every meeting	Both	Yes	Yes	Yes	Yes	Yes	Yes
Action Log & Decision Log	EM	Every meeting	B	Yes	Yes	Yes	Yes	Yes	Yes
Questions from the public (where received)	EM	Every meeting	B	Yes	Yes	Yes	Yes	Yes	Yes
Forward Planner (pre meeting)	CL	Every meeting	B	Yes	Yes	Yes	Yes	Yes	Yes
Governance & Performance of Committee									
Review of Terms of Reference	EM / MC	Yearly	n/a	No	No	No	No	Yes	Yes
Self-Assessment of Committee Effectiveness	EM	Yearly	n/a	No	No	No	No	Yes	Yes
Forward Planner Annual Plan Review	EM / CL	Yearly		No	No	No	No	Yes	Yes
Key Business Items									
Minutes of any ExtraOrd SPCC Meetings	EM/CL	If held	A	Yes	Yes	Yes	Yes	tbc	tbc
Committee Risk Register for 4 contractor groups	SH	Every Other Meeting usually	B	Yes	No	Yes -progress	Yes - update	No	Yes (final)
Finance Update including Capital position	LWB	Every Meeting	A	Yes	Yes	Yes	Yes	Yes	Yes
PSRC Minutes/Update Minutes/Update from Pharmacy Operations Group and highlights	TK	Every Meeting	A	Yes	Yes	Yes	Yes	Yes	Yes
Prescribing position and risk	SL/CH	Every Meeting			Yes	Yes	Yes	Yes	Yes
Patient Experience									
Deep Dive (s)				Yes - HW survey (Final) and GPPS (General Practice)	No	General Practice via Healthwatch and June Plan update	No	Dental	Digital and Estates? TBC
Assurance of progress of Primary Care Strategic Plans									
Estates Update	Estates	Alt	B	No	Yes	No	Yes	Yes	tbc
Digital Strategy	JL	Alt	B	Yes	No	Yes	No	tbc	tbc
Workforce Strategy	JG	Alt	B	No	No	No	tbc	tbc	tbc
Priority Commissioning Area - Improving Access (Primary Medical)	CL	Alt	B	Yes	No	Yes	No	No	Yes
Priority Commissioing Area - Improving Access (Dental)	TK	Alt	B	No	Yes	No	No	Yes	No
Priority Commissioning Area - Neighbourhood Health/Primary Care	CWA	Every meeting TBC	B	Yes	Yes	Yes	Yes - paper (AL)	No	Yes
Commissioning , Quality and Performance									
Policy BAU Update – Primary Care Contracting and Commissioning (All 4 contractor groups)	CL/TK	Every Meeting	B	Yes	Yes	Yes	Yes	Yes	Yes
Performance Issues (escalated from Place)	TBC	As required	A	No	Yes	Yes Part A	tbc	tbc	tbc
Quality - Report from PCQ plus any key performance metrics	LE/TK/CL	Every Meeting	B	Yes	Yes	Yes	Yes	No	No
Committee Budget SORD Delegations									
Capital bids across Estates and Digital	CF/LA/JB/KH	As required	A/B	No	Yes	Yes	Yes UMF inc digital	UMF part A	tbc
Improvement Grant Estates Bids	JA	As required	B	No	No	No	tbc	tbc	tbc
Primary Care Business cases / approvals required from Place	TBC	As required	A/B	Yes	Yes x 1	No	tbc	tbc	tbc
Ad Hoc Items for tracking/follow up									
Beyond/Oral health	IA		B	No	No	No	tbc	Yes	Yes
Shared Care	LK							Yes	
Primary Care Governance	BV		B						Yes
Protected Learning Time - review	CL/JG		B					No	tbc

Enhanced Services Review and recommendations	JG/CL/LWB		B				No	part of policy update	Yes
Planning - Primary Care (March Board Submission)	CWA		B					part of policy update	Yes final plan
Escalations from Place	TBC		TBC			x1 Part A		x1 Part A	
Dental Paper – Operational/Contract Part Year performance note	TK		A	No	Yes	No	Yes	No	tbc

NHS
Cheshire and Merseyside

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

Primary Care Policy and Commissioning Update

Agenda Item No: SPCC 26/04/B08

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

1. Purpose of the Report

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

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

2. Ask of the Committee and Recommendations

The Committee is asked to ;

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

3. General Policy Update

3.1 **Primary Care Action Plan** - The Primary Care Action Plan (PCAP) template and information for ICBs, with confirming timescales was released, which covers a three-to-five-year period – with a requirement for a detailed Year 1 plan for 2026/27. Plans will focus on practical, deliverable actions, building on the feedback provided on Integrated Strategic Commissioning Plans and draw on evidence-based approaches and proven best practice to improve access and outcomes. All PCAPs have to be completed and approved by regional teams by **COP 27th May 2026.**

3.2 Updated plans for subsequent years are expected to be requested in the quarter preceding each year, with the process to be agreed in partnership with regions and ICBs. ICB plans must meet the following requirements:

- Outcomes Focused
- Accountability and Transparency
- Collaborative
- Evidence Based

3.3 The template for completion is given in **Appendix 1** – in addition, the minimum expected metrics are outlined which can be enhanced to reflect locally agreed approaches. These metrics, combined with other planning guidance asks, will form the basis of performance reports received by this committee in 26/27 – and to then provide onward assurance to the Board.

3.4 The national **Neighbourhood health framework** has been released, Neighbourhood health framework - GOV.UK – this outlines key actions and ambitions, including, for primary care, access to general practice as a key area (Goal 2) and strengthening the role of community pharmacy. Ambitions laid out in the framework will also be developed/enhanced with local measurements and outcomes.

4. Primary Medical Services Update

4.1 Changes to the **national GP contract** were announced in February , a full summary is given here NHS England » Changes to the GP Contract in 2026/27. Some of the key changes are given below ;

- Requirement that patients identified as clinically urgent will be dealt with on the same day, noting it is for the GP practice to determine which patients are clinically urgent. Guidance has also been issued to practices on recording of these appointments, to support the contract ask NHS England » Recording same day appointments for all clinically urgent patients
- For patients whose needs are assessed as non-urgent, practices will be required to provide an appropriate response by the end of the next core hours period. For non-urgent cases, this does not necessarily mean an appointment, but it does mean patients will know how their presenting issue will be managed and what the next steps are.
- To support practices where unwarranted variation has been identified in contractor performance, there will be a requirement for those practices to engage with support from the integrated care board (ICB).
- A practice-level GP reimbursement scheme, to recruit additional GPs or fund additional sessions from existing GPs to support clinical same day urgent access in general practice.
- Embed the previous advice and guidance enhanced service funding within core practice funding. Practices will be required to use advice and guidance prior to or in place of a planned care referral where clinically appropriate and to follow locally agreed referral pathways, including single point of access models, once introduced
- Changes to QOF (Qualities and Outcomes Framework) to support childhood vaccinations and obesity.

4.2 NHS England also released contractual information in relation to the **Network Contract Directed Enhanced Service** NHS England » Network Contract Directed Enhanced Service (DES)(PCN DES). Some of the key areas are given below ;

- Removal of the restriction that ARRS (additional roles reimbursement scheme) funding can only be claimed for recently qualified GPs.
- A core requirement for PCNs to identify and prioritise cohorts for continuity of care using risk stratification tools as part of their core activities.
- PCNs to work with their ICB to achieve greater alignment between the PCN registered list and the neighbourhood boundary.

4.3 NHS England have confirmed the **planning guidance** objective to ICBs for 90% of clinically urgent patients to be seen by their GP practice on the same day. Information on measurements and trajectories are currently being worked through and an initial numerical plan is required by end of April. ICBs will be asked to report regularly on this area, and as part of the plan referenced in 3.1 above.

4.3 **Local Enhanced Services Review** – schemes for 26/27 will roll on for a full year, some of which have been reviewed and amended locally, prior to being re-issued. Any notice will be served in-year for commencement of new schemes from 1.4.27, subject to ICB processes and agreement. Leads for areas for specification development will need to be confirmed as part of this.

4.4 **Primary/Secondary Care Interface (PSCI)–** The ICB have recently completed two PSCI surveys and the results/reports from these are linked below ;

- pcsi-summary-february-2026.pdf This report details the summary results from the recent survey of clinicians where the ICB sought their views on the interface and the advice and guidance system. This is a repeat of the survey undertaken a few years ago, with questions added regarding advice and guidance.
- developing-a-system-level-case-for-change-around-the-interface.pdf .This report summarises a spot survey undertaken in General Practice seeking to quantify the impact of interface issues in terms of appointments - and gives narrative around the system level issues and case for change.

The interface work is also a key part of reform agenda 1 area of the **neighbourhood health framework** (3.4 above). This area will be rolled into the overall action PCAP (3.1 above.

4.5 **Practice Level Support (PLS)** – over the last 12 months, practices have been able to access the latest practice level support programme, which completed at the end of March 2026. 36 practices were supported over 6 cohorts during the year - which included 297 site visits - with 16 practice requesting additional sessions. The programme was funded by NHS England but the ICB supported recruitment and interest from practices to generate the cohorts. The support providers are collating learning and themes for onward sharing, to support cross learning. The current arrangements for PLS for 26/27 are being confirmed.

5.0 Optometry - General Ophthalmic Services (GOS)

5.1 Service provision is consistent within Cheshire and Merseyside ICB with currently 218 Mandatory (high street) services contractors and 73 Additional (domiciliary) providers currently operating. GOS activity is periodically monitored and any practices without activity over 12 months and potentially classed as “dormant” will be contacted to see if they wish to maintain their GOS contract - this work is ongoing.

5.2 Following previous agreement via the Executive Committee and update to this Committee, the **Special Education Settings** Eyecare Procurement tender has gone live through the Atamis portal to receive bids from interested providers, as part of 3 lots with all north west ICBs. The provider response deadline for the tender is 30 April 2026. An ongoing timeline, in terms of scoring/evaluation as well as governance to support/agree contracting actions that may result, should be highlighted to the committee – and the need for any additional support required to manage this by the ICB within those timelines.

5.3 Sight testing of patients with **LD/Autism** and patients who are **homeless** are progressing. A report covering provision of homeless eyecare for 2022/2024 is available and work will be undertaken later this year on a further 2-year report for 2024/2026

6.0 Dental

6.1 From the last set of **Dental Operational Group** minutes on 25th February the following actions were being taken:

- A number of recurrent and non-recurrent UDA changes were noted
- Force Majeure application from one practice regarding software issue
- Ongoing issue regarding an orthodontic provider and spoke site arrangements.
- A number of subcontracting requests were received from providers with multiple contracts.
- A request from a provider to increase their UDA rate.
- A review of a request for a second course of orthodontic treatment.
- Query regarding orthodontic payments to a contractor requiring manual payment on system.
- Provider attending hearing that may result in eviction notice served by CHP.
- Drafting of termination notice as approved at previous SPCC in Feb 2026 with support from ICB legal service provider.

6.2 **NHS dental quality and payment contract reforms** in England aim to improve access to care, particularly for urgent and complex cases. Key changes include a new £75 payment for urgent treatment, incentives for complex care, and increased utilization of dental nurses. These changes aim to support patients with higher needs while addressing dentists' concerns over the current UDA rates.

Key Changes to GDS and PDS contracts from April 2026:

- Urgent Care Focus: The payment structure for urgent care will increase, with a £15 automatic payment to help with capacity and a total of £75 for completed urgent treatments.
- Complex Care Pathways: Three new pathways for patients with advanced periodontal disease or extensive decay, providing better remuneration.

- Skill Mix Expansion: Dental care professionals, such as dental nurses, will be enabled to work to their full scope of practice, including applying fluoride varnish.
- Mandated Procedures: Increased support for preventive measures.
- Payments & Audits: New payments for dental practices undertaking peer reviews and clinical audits.
- 207 contracts (GDS/PDS) are now mandated to provide urgent care as of April 1st 2026
- It should be noted that alongside contract reforms patients will pay increased fee charges of 2.7% from April 1st.
- The commissioning team have been very busy implementing the contract reforms and working with NHSE NW to ensure all requirements have been met under the current delegation agreement.

6.3 Luci Devenport and Mike Williams opted to take voluntary redundancy at the end of March after many combined years of service. Their contribution, expertise and commitment to improving dental services across Cheshire and Merseyside should be noted and they will be missed.

7.0 Community Pharmacy

7.1 From the last set of **Pharmacy Operational Group** minutes on 26th January the following actions were being taken:

- A number of CPAF visits had been arranged for February and March
- Easter Rota arrangements agreed as per usual process and with LPC colleagues. The team have been implementing the changes previously approved at SPCC regarding payment and coverage.
- The team have been working with Meds Mgt colleagues to implement new Palliative Care service.

7.2 A number of updates were received from the **Local Pharmacy Network**:

- Temporary suspensions – The national team are continuing to work with CPE to make MYS the mandatory reporting system.
- Hub and Spoke module is currently being built into MYS. Teams will be asked for the details of any approvals granted to date.
- Pharmaceutical list validation is due imminently, along with historical discrepancy checks.
- No update re 2026-27 contractual framework negotiations.
- Free NHS services are to be offered to care leavers. Care leavers are defined as “a person raised in care”. They are eligible for free prescriptions up to 25 years of age. No clarity as yet from DH re how or where services are accessed.
- EPS nominations – A number of issues reported re bulk nomination switching, mainly re former Jhoots branches

7.3 Jackie Jasper and Nicola Dickenson opted to take voluntary redundancy at the end of March after many combined years of service. Their contribution, expertise and commitment to improving community pharmacy services across Cheshire and Merseyside should be noted and they will be missed.

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

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

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

9.0 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

10 Risks

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

11 Finance

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

12 Communication and Engagement

No external formal consultation or further engagement is required in respect of this paper. Duties for engagement are accounted for accounted for in each of the national Policy Book's for the contractor groups and duties on contractors nationally set. Any additional commissioner requirements would be outlined in this update.

13 Equality, Diversity and Inclusion

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

14 Officer contact details for more information

Clare Watson - Executive Director of Health and Integrated Care Commissioning
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Appendix 1 – PCAP Template

Contents

General Practice

Theme	Prompts
Front door access, navigation & demand management (ending the 8am scramble)	Plan should highlight practical steps the ICB is undertaking to support: - Same day appointments for clinically urgent patients in General Practice, including achievement of 90% ambition. - Supporting practices understanding of demand/capacity optimisation. This should include further embedding of modern general practice and population health management/risk stratification. - Resiliency, winter planning and surge capacity, ensuring sufficient capacity is commissioned. This should include additional commissioned activity for out-of-hours and surge periods, such as bank holidays and weekends. - Monitoring, reporting and response of system pressures for general practice. This could include use of tools such as Operational Pressures Escalation Levels (OPEL) framework
Clinical capacity	Plan should highlight practical steps the ICB is undertaking to support: -Promote recruitment of GPs or fund additional sessions through Capacity and Access Payment reimbursement scheme -Promote recruitment of GPs and other roles through additional roles reimbursement scheme.
ICB performance and improvement support	Plans should set out the practical steps the ICB will take to: - Develop priorities and plans across the system by using support tools (CATS tool or equivalent) -Support, monitor and ensure compliance with the GP contract. This should include the GP contract changes introduced in October 2025 as well as the new 2026/27 GP contract requirements. Plans would benefit from specific reference to the governance mechanisms that will be used to monitor compliance. -Outline interventions, either already in place or to be introduced, to support struggling practices in meeting requirements around core hours opening, equity of access (e.g., telephone and online consultation routes), implementation of You and Your GP Practice feedback, and delivery of prospective records access. -Identify practices requiring additional support, using the Support Level Framework (SLF) or the Modern General Practice Assessment Tool (MGPAT) to determine their support needs. Plans would benefit from specific reference to the number of practices the ICB expects to offer targeted support. -Provide improvement and transformation support, already in place or planned, for practices. This may include Practice-Level Support, Peer Ambassadors, or local Quality Improvement (QI) support. -Use datasets and local intelligence to identify and address unwarranted variation and health inequalities; and track practice progress. This should include the General Practice Dashboard patient feedback from You and Your GP Practice. -Support general practice to deliver deliver better diagnosis, more effective treatment, and improved continuity of care for patients with long-term conditions such as CVD, diabetes, COPD, mental health conditions, and dementia.
Digital development and reform	Plans should set out the practical steps the ICB will take to: - Support general practice implement and optimise GPIT and digital tools. This could include online consultation, messaging, online booking, digital telephony, population health management and demand and capacity planning tools. - Support implementation of new technologies, including ambient voice technology (AVT) - Promote utilisation of NHS App capabilities; including ensuring that at least 95% of appointments across all care settings are made available through the NHS App following appropriate triage. - Transition all direct-to-patient communications to NHS Notify, retiring local communication systems, and use NHS App ‘push’ notifications as the primary method of contacting patients. Transitions should begin in 2026/27, with all providers completing migration by the end of 2028/29.
System and broader transformation	Plan should set out strategic approach for: - Engagement of people and communities to understand needs and co-design services - Utilisation and planning of estates to support alignment and integration supported across PCNs, neighbourhoods and Primary/Secondary/Community Care. - Staffing and alignment to neighbourhood development. - Investment and resourcing, specifically how this compares to previous years.

Community Pharmacy

Theme	Prompts
Embedding pharmacy clinical services, ensuring that local commissioning discussions utilise Pharmacy First and other pharmacy clinical services to support local system, primary care/ urgent demand pressures	Plans should set out the practical steps the ICB will take to: -Address unwarranted variation in delivery of community pharmacy advanced services and improve system confidence, e.g. identify pharmacies where service demand is above capacity and create a plan to help decompress or support to improve access and reduce unwarranted variation -Support community pharmacies to improve the quality of data shared and captured through the pharmacy clinical services -Improve Pharmacy First utilisation rates. Including through Integrated Urgent Care providers (NHS111 telephony). -Reduce utilisation of the urgent repeat medicines pathway e.g. monitoring activity, identifying patterns, addressing issues and promoting good prescription re-ordering practice -Monitor antimicrobial supplies made under the Pharmacy First service and address outliers -Improve the quality of the Hypertension Case Finding Service, e.g. monitor ABPM conversion rates, identify and address outliers
Continue developing the relationships between general practice and community pharmacy to support access to pharmacy services	Plans should set out the practical steps the ICB will take to: - Ensure GP Connect Update and Access Record are enabled and being utilised. - Improve GP referral numbers in Pharmacy First service. - Identify and investigate significant changes in referral numbers. This could included auditing variation linked to use of GP online consultation tools.
Introduce prescribing-based services into community pharmacies during 2026/27	Plans should set out the practical steps the ICB will take to: - Incorporate Independent Prescribing into existing medicine optimisation governance processes and audit of provider reports / audits of activity outside the scope of the service specification or defined clinical competence and action plan to address any identified issues. - Identify and review independent prescriber prescribing that includes local formulary adherence, antimicrobials and opioids. This will be possible through analysis of ePACT2 data.
Monitor community pharmacy contraception service, focussing on ongoing supply length and emergency contraception	Plans should set out the practical steps the ICB will take to: -Audit ongoing contraception supplies and produce an action plan for increasing the length of ongoing supplies made under the service. - Monitor patient level outcomes to identify patients who through the Emergency Contraception service then go on to be initiated on longer term contraception.
Maximise use of the Discharge Medicines Service to reduce medicines harm and reduce readmissions	Plans should set out the practical steps the ICB will take to monitor and increase NHS trust referrals into the Discharge Medicines Service.
Make HPV vaccination available at pharmacies for women and young people who missed out on vaccination at school	Plans should set out the practical steps the ICB will take to allocate support and resource to optimise uptake of the HPV vaccine by utilising access benefits of community pharmacy.
Ensure all community pharmacies have fully enabled the capability for patients to track their prescription status using the NHS App	Plans should set out the practical steps the ICB will take to support full adoption and integration of the NHS App into community pharmacies to support operations and patient communication. This could include support for more local engagement with pharmacy sites and support for funding or implementation of technologies such as scan-to-shelf.

Dental

Theme	Prompts - Draft
Urgent and unscheduled care	Plans should set out the practical steps the ICB will take to:

	- Better match capacity to demand and reduce unutilised appointments - Optimise 111/unscheduled care pathways to support access to urgent and unscheduled care - Utilise comms to improve patient awareness of and access to urgent and unscheduled dental care appointments - Provide comprehensive out of hours urgent and unscheduled dental care provision - Ensure sufficient capacity and resources to monitor use of mandated urgent care capacity and ensure this capacity is accessible to all patients. This should include plans to escalate concerns and implement breach notices as needed in the event of non-compliance - Ensure processes in place for the review and implementation of flexibility of the mandated proportion of unscheduled care
Maximising and optimising the spend of the dental ring-fence	Plans should set out the practical steps the ICB will take to: - Ensure collaborative working to improve efficient and reduce duplication across their commissioning teams - Ensure continued focus on developing the dental workforce with plans to include consideration of dental recruitment incentives
Implementing the 2026 dental payment and quality contract reforms	Plans should set out the practical steps the ICB will take to: - Ensure contract variations for the 2026 reform package are issued and signed by providers ahead of April 2026 - Support dental providers with implementation of the new changes - Encourage the uptake of funded annual appraisal and participation in the dental QI programme - Establish peer groups for dental providers participating in QI and align these to local clinical leadership
Improving access to NHS dental services	Plans should set out the practical steps the ICB will take to: -Identify unwarranted variation identified using national datasets and local intelligence - Identify and implement intervention to address unwarranted variation and reduce health inequalities. Plans will benefit from referencing specific interventions.
Procurement of dental checks for CYP SEND pupils	Plan should provide strategy for the procurement of dental checks for CYP SEND pupils within residential and day special educational settings.

Optometry

Theme	Prompts
Procurement of sight tests for CYP SEND pupils	Plan should provide strategy for the procurement of sight tests for CYP SEND pupils within residential and day special educational settings.

Measurements

General Practice

Theme	Measurement (national, local indicators, as applicable)
Front door access, navigation & demand management (ending the 8am scramble)	% of clinically urgent appointments seen on the same day Ease of access (Health Insight Survey) Online Consultation Rates/1,000 pop, volumes and hour of day Cloud Based Telephony Dataset - Calls, Abandoned, Callback per 1,000 pop - time of call and length of call Analysis on walk ins NHS111 data GPAD Data to understand operational capacity pressures in general practice fed into system-wide oversight arrangements
Clinical capacity	Fully qualified GPs (FTE) GPs recruited through Additional Roles Reimbursement Scheme (ARRS) ARRS roles
ICB performance and improvement support	General Practice Dashboard Health Insights Survey General Practice Patient Survey

	GPAD NHS111 Local data sources and experience measures SLF outcomes (Spider Diagram) MGPAT - diagnostic tool Same Day Urgent metric Reduction in variation in Quality and Outcomes Framework standards for CVD, diabetes, COPD, mental health conditions and dementia Increase the percentage of patients with diabetes who received all 8 elements of the diabetes care process bundle as reported in National Diabetes Audit Modern Service Frameworks will specify further metrics for cardiovascular disease and mental health in due course
Digital development and reform	# practices with AVT NHS app usage % of patient registrations integrated with GPIT
System and broader transformation	

Community Pharmacy

Theme	Measurement (national, local indicators)
Embedding pharmacy clinical services, ensuring that local commissioning discussions utilise Pharmacy First and other pharmacy clinical services to support local system, primary care/ urgent demand pressures	Producing a plan for identifying capacity issues and addressing them locally PF - % of total consultations claimed outside of service specification (limit to outside terms of PGD + CD's supplied in quantities greater than 5 days through the URM pathway) PCS - PGD as above HCFS - Reduce numbers of returning patients to the hypertension case finding service within a defined time period (5 year) Audit report - outliers identified as a % of consultations where an antimicrobial was supplied # of URM consultation claims as a % of total Pharmacy First consultation claims % of ABPMs vs clinic check claims
Continue developing the relationships between general practice and community pharmacy to support access to pharmacy services	GPs to report in to ICB on status. KPI >90% enabled % of practice population Review % of rejected referrals Production of audit report shared with NHSE
Introduce prescribing-based services into community pharmacies during 2026/27	Reported as a % of IP's registered to deliver NHSE community pharmacy services KPI >90%. Consultation numbers as a % of total site level PF consultations. Generation of IP prescribing report
Monitor community pharmacy contraception service, focussing on ongoing supply length and emergency contraception	Report that describes the number of ongoing supplies made for a period of 9-12 months as a percentage of all ongoing supplies made
Maximise use of the Discharge Medicines Service to reduce medicines harm and reduce readmissions	Trust DMS referral numbers per 1000 discharges

Make HPV vaccination available at pharmacies for women and young people who missed out on vaccination at school	Monitoring and identifying target cohort and reporting against vaccination numbers delivered by community pharmacy
Ensure all community pharmacies have fully enabled the capability for patients to track their prescription status using the NHS App	Reported as number of community pharmacy sites (and percentage of total estate) with prescription tracking functionality enabled. 50% of community pharmacies have tracking enabled by March 2026

Dental

Theme	Measurement (national, local indicators)
Urgent and unscheduled care	
Maximising and optimising the spend of the dental ring-fence	Monthly Golden Hello reporting
Implementing the 2026 dental payment and quality contract reforms	
Improving access to NHS dental services	Nationally provided QI datapacks will provide insights on variation in NICE recall
Procurement of dental checks for CYP SEND pupils	ICB returns via regions on progress to date

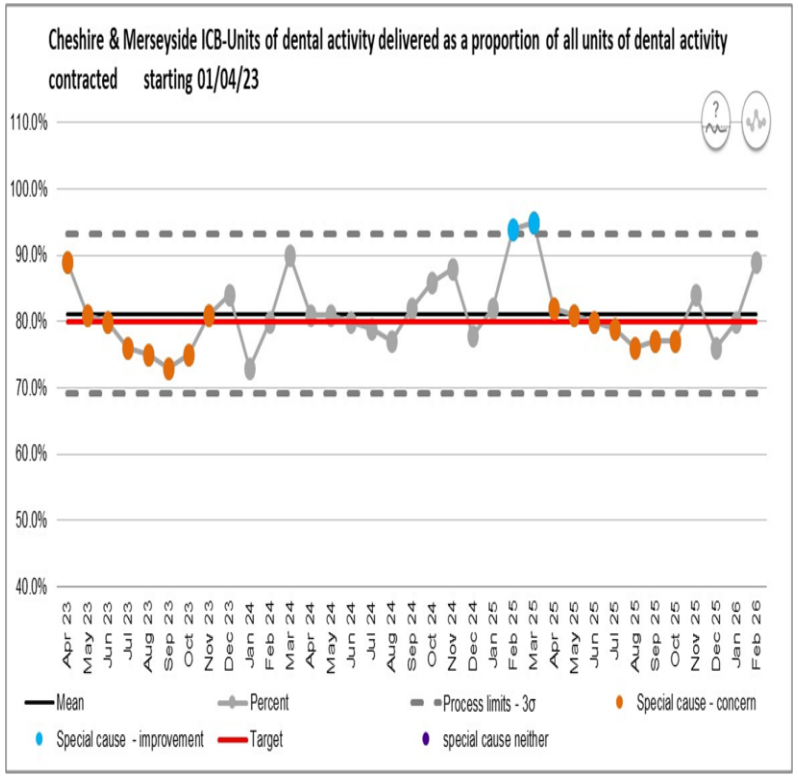
NHS
Cheshire and Merseyside

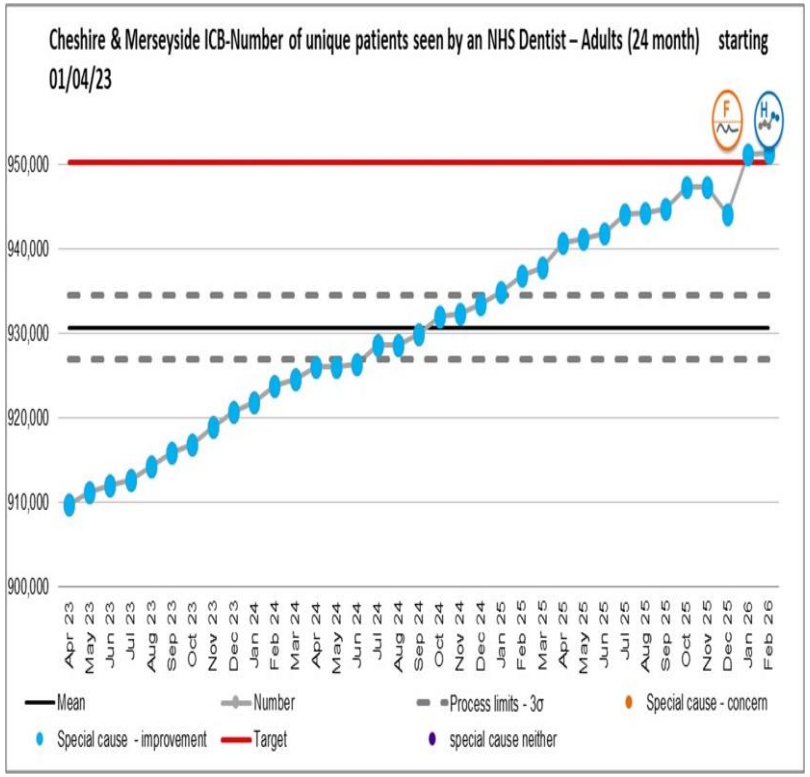
DENTAL COMMISSIONING UPDATE AND PLANNED ACTIONS

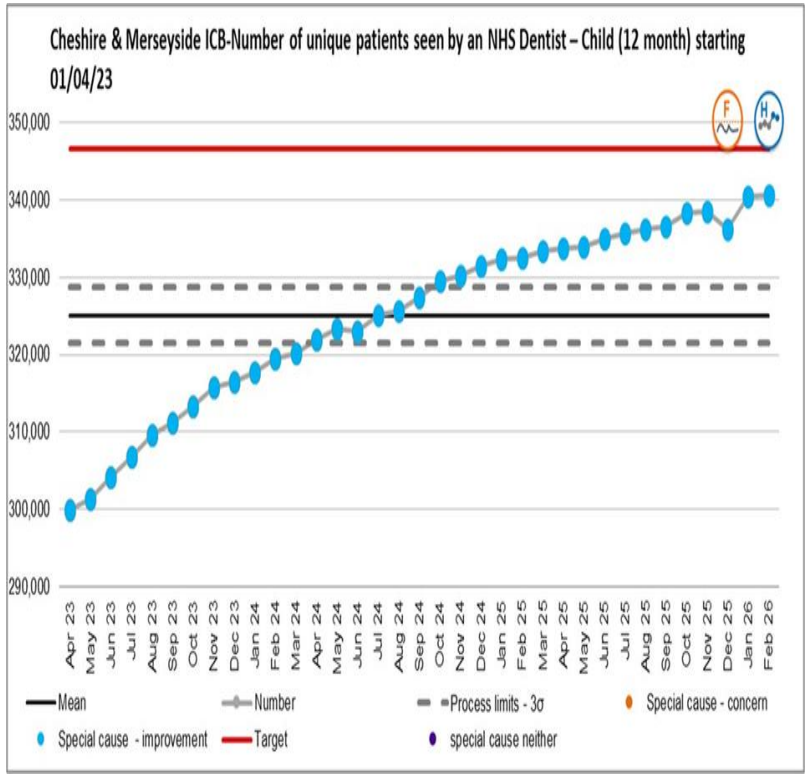
APRIL 2026

Increasing capacity, improving access and addressing oral health inequalities

PERFORMANCE OVERVIEW – POSITION AS AT FEB 2026







COMMISSIONING CONSIDERATIONS

NHS
Cheshire and Merseyside

- Dental contract reform implementation 2026/2027 consequences/impact still unclear at this stage.
- Listening to concerns so focussed on continuing locally commissioned access scheme during transitional period.
- ICB's 5-Year Clinical and Strategic Commissioning Plan 2026/2031 incorporating Population Health Improvement Plan.
- Shift to commissioning for outcomes focussed on Starting Well; Growing Well; Living Healthy Lives; Ageing Well.
- Contributing to the application of Strategic Commissioning Framework and developing the Neighbourhood Health Model.
- National Planning Process 2026-2031 (Multi Year Planning) and targets for UDA Delivery, Adult and Child Access rates.

Phase	Timeframe	Key Activities	Outcome Framework Role
Needs Assessment & Planning	Mar–Jun 2026	Workshops with commissioners, public health, Healthwatch, and LA partners; review JSNAs; population oral health analysis; agree baseline data.	Establish baseline metrics for access, efficiency, and equity.
Prioritisation & Strategy Development	Jul–Sep 2026	Multi-stakeholder sessions; align proposals with NHS 10 Year Plan & Planning Guidance; option appraisal of PoC and prevention programmes; embed Neighbourhood Health Services priorities.	Assess impact potential against outcome framework.
Contract Design & Procurement	Oct–Dec 2026	Co-design contracts with providers; embed quality-linked payments; prevention metrics; capitation pilots; align to reform proposals; ensure integration with Neighbourhood Health Services Framework.	Embed outcome measures directly into contracts.
Implementation & Monitoring	Jan–Mar 2027	Mobilise delivery; launch reporting dashboard; establish	Use framework as monitoring and assurance tool.

DENTAL COMMISSIONING INTENTIONS

NHS
Cheshire and Merseyside

- Ensure routine access focussed on vulnerable groups and underpinned by population health management approach. Develop Dental as a Neighbourhood frontline provider.
- Integrate Dentistry into the Neighbourhood MDT model in relation to urgent / unscheduled care.
- Move away from UDA driven contracting, develop a local PDS contract with local core outcome framework focussed on prevention OR include in a Neighbourhood Integrated Primary Care Locally Enhanced Service.
- Use dental as the Neighbourhood's proactive outreach engine with a focus on prevention and linking with local authority public health responsibilities.
- Dental to contribute to Neighbourhood level inequalities reduction.
- Early detection of oral cancer, targeted in high-risk groups. Single point of access for follow up care following urgent appts and vulnerable patients.

RAPID REVIEW OF UNSCHEDULED DENTAL CARE FEB 2026

NHS
Cheshire and Merseyside

- Consider streamlining existing dental access pathways by delivering unscheduled care through dental contract reform requirements, supported by an additional pathway for pre-identified priority groups (with eRMS referral pathways)
- Hold a stakeholder engagement event to ensure dental providers, commissioners, Healthwatch, patient, public health perspectives are considered in future strategic commissioning
- Opportunities for embedment of unscheduled dental care provision (additional pathway in key recommendation 1) across NHS priority initiative(s) (e.g. Neighbourhood Health Service) to ensure strategic alignment with organisational priorities
- Review current data-collection processes across different pathways and identify opportunities to streamline them, ensuring consistent capture of patient demographics (e.g. socioeconomic status, ethnicity etc), key clinical activity data, and patient-reported outcome measures.
- Develop ICS unscheduled dental care community of practice(s) for pathway providers which incorporate peer review, shared learning etc
- Review the current service specification for C&M Dental Helpline triage and strategically consider how it can be expanded to include non-urgent dental care, with additional consideration to appointment allocation for both urgent and non-urgent unscheduled care to ensure optimal use of available appointments

LOCAL ACCESS QUALITY SCHEME 2026/27

NHS
Cheshire and Merseyside

- Continuation of scheme up until Q2 2026 has been approved with caveat that this may change due to national policy, further contractual guidance/financial modelling and impact assessment of national urgent care contract mandation.
- The national contract reform amendments, particularly the mandated urgent care appointments, may cause patients without a regular dentist challenges in accessing substantive care.
- Head and Neck Cancer patients can be referred to practices for ongoing monitoring post treatment. New electronic referral form implementation this year.
- Practices signed up offer appointments as appropriate to the meet the needs of patients seeking care. They free up capacity to take on new patients including those with high need.
- Practices engage with local vulnerable group/third sector organisation/charity (e.g. Homeless Centre/Family Hub) to provide dental services for vulnerable groups.
- Provide added quality by completion of dementia friendly toolkit training, AMR audit and oral cancer toolkit training.
- Practices accept new patients calling the practice, on their waiting list and those from vulnerable groups, these include those triaged by the Dental Team and also accept patients from the Looked After Children portal which can be extended to include care leavers as is due to be mandated nationally.
- Total cost of the Quality & Access Scheme for 2025/26 for 68 practices was £5,828,937.

Number of Practices undertaking Q&A	Number of Adult patients seen	Number of Child patients seen
68	39 436	19 006

CONTRACTUAL REFORMS - URGENT CARE ACCESS 2026/27

NHS
Cheshire and Merseyside

- 270 contracts in Cheshire and Merseyside now mandated to provide urgent care from April 1st
- Equates to 180,523 unscheduled Courses of Treatment. There's no requirement to see new patients, so they can fulfil the 8.2% with existing patient list and potentially deliver more.
- Urgent Care should be of high quality, and individuals with urgent dental needs should be seen in the right place, by the right person delivering the right care at the right time.
- In addition we have maintained existing commissioned Advice Triage Helpline and In Hours/Out of Hours Urgent Care for 12 months to allow time to assess impact of contract reforms.

HEADLINES

NHS
Cheshire and Merseyside

- Maintaining existing local Quality and Access scheme with focus on vulnerable groups. 68 practices are signed up to the scheme.
- 207 practice across Cheshire and Merseyside now contractually obliged to provide urgent care from April 1st.
- Continue to support practices seeking to recruit via the national Dental Recruitment Incentive Scheme. 3 out of 7 identified practices have recruited so far in Cheshire and Merseyside.
- Undertake Quarter 1/2 to review impact of national urgent care contract reforms.
- By end of Q1 complete full evaluation of Neighbourhood Dental Health pilot and consider commissioning recommendations.
- Implementation of Practice Sustainability Framework – used when practices request UDA review/contract hand back.
- Continue with Dental commissioning intentions - developed as part of the NHS planning process and proposals regarding Shift Left / Neighbourhood Health Framework.
- Consider a review of UDA rates across Cheshire and Merseyside aligned to the commissioning strategy/population health plan.

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

TBC April 2026

NHS Cheshire & Merseyside ICB Primary Care Lease Assessment and Approval Policy

Agenda Item No: SPCC 26/04/B12

Responsible Director: *Clare Watson – Deputy Chief Executive*

1. Purpose of the Report

1.1 The purpose of this report is to present the NHS Cheshire & Merseyside ICB Primary Care Lease Assessment and Approval Policy for approval by the System Primary Care Committee.

2. Executive Summary

2.1 The ICB has statutory responsibility under the Premises Cost Directions 2024 to assess GP practice lease applications for value for money before approving rental reimbursement.

2.2 This policy provides a consistent framework for assessing lease applications across all nine Places in Cheshire & Merseyside, ensuring transparent decision-making, reducing variation, and protecting public funds.

2.3 The policy incorporates the Core, Flex, Tail framework from the ICS Infrastructure Strategy to align lease approvals with strategic estate planning and value for money principles.

3. Ask of the System Primary Care Committee and Recommendations

3.1 **The System Primary Care Committee is asked to:**

- **APPROVE** – the NHS Cheshire & Merseyside ICB Primary Care Lease Assessment and Approval Policy.

4. Reasons for Recommendations

4.1 The policy ensures compliance with the National Health Service (General Medical Services – Premises Costs) Directions 2024, which requires NHS England to be satisfied that lease terms represent value for money before approving rental reimbursement.

4.2 The policy provides consistent assessment criteria across all nine Places, reducing variation in decision-making and supporting equitable treatment of GP practices.

4.3 The incorporation of the Core, Flex, Tail framework aligns lease approvals with the ICB's strategic estate planning and the ICS Infrastructure Strategy agreed in November 2024.

4.4 Clear criteria and transparent processes protect public funds while supporting sustainable primary care infrastructure.

5. Background

5.1 Under Direction 32 of the 2024 Premises Cost Directions, the ICB must be satisfied that lease terms represent value for money before agreeing to reimburse rental costs for GP practice premises.

5.2 Prior to this policy, lease assessments were conducted on a case-by-case basis without a unified framework, leading to variation in decision-making across Places.

5.3 The policy has been developed by the Central Estates Team in consultation with Place teams and reflects national guidance, the Premises Cost Directions 2024, and local strategic priorities.

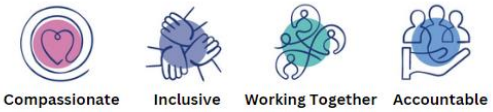
5.4 The policy includes specific provisions for emerging contracting models including Single Neighbourhood Providers and Neighbourhood Health Contracts, ensuring the framework remains fit for purpose as primary care delivery evolves.

6. Appendices

- Appendix One – NHS Cheshire & Merseyside ICB Primary Care Lease Assessment and Approval Policy

NHS
Cheshire and Merseyside

ICB GP Premises Lease Policy Framework and Approval Criteria



Leading integration through collaboration

Version Control

Version Number	Author(s)	Date	Purpose/Change	Date Ratified	Committee	Next Review Date
1.0	Michaela Good	29.12.25	Creation of Document			
1.1	Michaela Good	22.01.25	Amendments			
1.2	Michaela Good	09.02.25	Amendments			

Document Owner:	Approval date:	
	Approved by:	
	First published:	
	Where published:	
	Next review date:	

This policy is subject to change in line with updates to national policy, including the Premises Cost Directions, NHS England guidance, and the introduction of new contractual models for neighborhood health services. Any amendments will be approved through the ICB's established governance processes and communicated to all relevant stakeholders.

Contents

1. **Introduction and Purpose**

1.1 Background

NHS Cheshire & Merseyside Integrated Care Board (ICB) has statutory responsibility for the commissioning of Primary Medical Services across the Cheshire & Merseyside region, covering nine Places: Warrington, Halton, St Helens, Cheshire East, Cheshire West, Wirral, Knowsley, Sefton, and Liverpool.

Under the National Health Service (General Medical Services – Premises Costs) Directions 2024, '*a contractor which rents its practice premises makes an application to NHS England for financial assistance towards its rental costs; and (b) NHS England is satisfied (before the lease is agreed or varied), where appropriate in consultation with the district valuer or appointed valuer, that the terms on which the new or varied lease is to take effect represent value for money, NHS England must consider that application and, in appropriate cases (having regard, amongst other matters, to the budgetary targets it has set for itself), grant that application.'*

1.2 Purpose

This policy sets out the ICB's framework for assessing lease applications from GP contractors holding GMS, PMS, or APMS contracts. The purpose of this policy is to:

- Reduce variation in decision-making across the nine Places
- Enhance value for money for the taxpayer through consistent assessment
- Align lease approvals to national and local strategic drivers
- Provide clear criteria for assessing value for money
- Ensure transparent decision-making processes
- Protect public funds while supporting sustainable primary care infrastructure

1.3 Role of the District Valuer

The District Valuer Services of the Valuation Office Agency provides professional property valuation services to the NHS. The District Valuer's role is to:

- Assess the Current Market Rent (CMR) for leasehold premises in accordance with Schedule 2 of the 2024 Directions
- Provide professional opinion on whether proposed lease terms represent value for money
- Consider market comparables and lease provisions in their assessment
- Recommend appropriate amendments to achieve value for money where necessary

The District Valuer acts as an independent professional advisor to the ICB. The ICB instructs the District Valuer and receives their reports, which inform (but do not solely determine) approval decisions. The ICB maintains responsibility for final decisions on lease approvals, taking into account the District Valuer's advice alongside strategic, service delivery, and financial considerations.

2. **Scope**

This policy applies to all lease applications from GP contractors for Primary Care premises, lease variations, assignments, or renewals requiring ICB approval, sale and leaseback proposals, all contract types (GMS, PMS, and APMS), main practice sites and branch surgeries.

3. **Key Policy Principles**

3.1 Value for Money

NHS Cheshire & Merseyside ICB will only approve lease arrangements where the lease terms represent value for money for the taxpayer, the premises are suitable for the delivery of Primary Medical Services, the lease complies with the requirements of the Premises Cost Directions 2024, the lease term and conditions provide adequate security of tenure for service provision, the lease tenants mirror the GMS/PMS/APMS contract holders, and financial risk to the ICB is appropriately mitigated through lease provisions.

3.2 Core, Flex and Tail Assessment

The ICB will assess all premises using a Core, Flex, Tail framework to ensure that rental reimbursement is focused on space required for service delivery.

The Core, Flex, Tail framework was established in the ICS Infrastructure Strategy (published and agreed November 2024). This framework is a key recommendation to understand and classify the estate across the ICS. Whilst primary care has enhanced management requirements within the ICB, the rest of the NHS provider estate uses the same classification. This delivers the following benefits:

- Consistency in estate assessment across the ICS
- Development of ICB disposal and investment plans based on evidence
- Support for an activity-driven assessment of the provision of estate
- Alignment with system-wide strategic priorities

The ICB will assess all premises using a Core, Flex, Tail framework to ensure that rental reimbursement is focused on space required for service delivery.

Core Premises

Core premises are essential buildings that are critical for delivering services in the long term (at least the next 10 years). They are:

- Good quality, fit for purpose and future-proofed
- Aim to eliminate voids and maximise use, including for other health care/local authority services

Investment in Core premises would: (i) support more patients, including mixed delivery model (telephone/digital pods/etc), (ii) support PCNs, (iii) support integration of services, and (iv) deliver on Net Zero Carbon delivery targets.

Investment in maintenance and upgrades is a high priority for Core facilities, which align with the ICS's clinical strategy and the NHS Long Term Plan.

Flex Premises

Flex premises are of acceptable quality and are currently providing services, but they may not be needed in the longer term (e.g., beyond five years) as the clinical model evolves. They offer flexibility for future growth or temporary needs but do not fully enable the long-term ambitions of the ICS.

Flex 1 Premises

Flex 1 premises have potential to become Core premises with appropriate investment. Investment would: (i) support more patients, including in mixed delivery model (telephone/digital pods/etc), (ii) support PCNs, (iii) support integration of services - likely to be more limited than core, and (iv) deliver on Net Zero Carbon delivery targets.

Flex 2 Premises

Flex 2 premises would not become Core premises even with investment. Limited investment may be justified in the short/medium term, for example maximising space from existing patient records where there are no alternative estate options. Disinvestment could be considered if there is sufficient capacity in the area.

Tail Premises

Tail premises are sub-optimal buildings considered poor quality or unfit for their intended purpose. They often have high maintenance costs and are not suitable for future models of care. These buildings should be phased out and considered for disposal when alternative core or flex estate becomes available, with capital proceeds reinvested into the health system.

Tail 1 Premises

Tail 1 premises are patient-facing sites that are poor quality and not fit for services. Significant and major investment would be required to raise them to Flex standard. Investment should be limited to core IT (wi-fi) and compliance works for patient safety only. The strategy should be to disinvest and relocate services to Core or Flex 1 facilities.

Tail 2 Premises

Tail 2 premises are non-patient-facing sites that are poor quality and not fit for purpose. Significant and major investment would be required to raise them to Flex standard. Investment should be limited to core IT (wi-fi) and compliance works for staff safety only. The strategy should be to disinvest and relocate services to Core or Flex 1 facilities.

3.3 Security of Tenure

Leases must provide adequate security of tenure for the expected duration of service provision. The standard hypothetical lease term used by the District Valuer for CMR assessment is 15 years. This standard is set out in Schedule 2 Part 3 of the Premises Cost Directions 2024 and reflects the typical term required to balance security of tenure with flexibility for service transformation.

Actual lease terms will be determined based on:

- Service needs and expected duration of requirement
- Contract type (GMS/PMS indefinite, APMS fixed term)
- Strategic considerations and Core, Flex, Tail classification
- Building condition and suitability

Different assessment criteria apply depending on building classification:

- Core premises: Longer lease terms (15-25 years) appropriate given long-term strategic importance
- Flex premises: Moderate terms (10-15 years) with consideration of break clauses to allow service model evolution
- Tail premises: Shorter terms strongly preferred (5-10 years) with break clauses, reflecting sub-optimal nature and disposal/replacement strategy

For sale and leaseback arrangements involving GP-owned premises moving to leasehold status, the assessment considers the age and condition of the building, with different parameters applied if the building is classified as Core, Flex, or Tail.

APMS contract leases must not exceed contract duration without appropriate break clauses.

3.4 VAT Considerations

Contractors should use reasonable endeavors to secure VAT-free lease arrangements, reducing the financial impact to the NHS. The ICB will consider VAT-inclusive leases on a case-by-case basis, with discretion exercised for sale and leaseback arrangements (Direction 33(6) and (8) apply).

Special considerations apply for dispensing practices, which may have different VAT recovery positions than non-dispensing practices. VAT status must be clearly stated and any changes during the lease term require ICB approval.

Connected Parties and VAT

Where the contractor and landlord are connected parties (e.g., same individuals, family members, or related entities), additional scrutiny applies to VAT arrangements. If the ICB agrees a sale and leaseback with connected parties on a VAT-free basis, and the property is subsequently sold to a third party who opts to tax, the ICB's position is that:

- The original VAT-free arrangement reflected the connected party relationship
- A change in landlord triggering VAT election requires fresh ICB assessment and approval
- The ICB is not obligated to continue reimbursement at a VAT-inclusive rate without reassessing value for money

- The contractor should ensure any sale agreement addresses the VAT position with the ICB

3.5 Break Clauses

Break clauses are strongly encouraged for:

- Leases exceeding 15 years
- Branch surgeries with leases over 10 years
- APMS contracts (mandatory – see section 3.7)
- Tail premises (to enable disposal/replacement strategy)
- Sale and leaseback arrangements where the property will not meet strategic aspirations of being core premises

The ICB has significant influence over break clause inclusion through its approval role. While the ICB cannot dictate commercial terms between landlord and tenant, the ICB can:

- Refuse to approve leases without appropriate break clauses where required by this policy
- Consider the presence and terms of break clauses in overall value for money assessment
- Require demonstration that contractors have negotiated for break clauses in good faith

What is reasonable for the Commissioner: The ICB considers it reasonable to require break clauses for APMS contracts (to align with fixed-term contracts), Tail premises (to support disposal strategies), leases exceeding 15 years (to provide long-term flexibility), and sale and leaseback of sub-optimal premises (to avoid long-term commitment to buildings that don't meet future needs). The ICB acknowledges that mutual break clauses are more achievable in negotiations than tenant-only breaks.

3.6 Branch Surgery Considerations

Branch surgery leases require additional strategic assessment including service need, utilisation, viability, and alignment with estate rationalisation plans. Enhanced break clause requirements may apply to branch surgeries.

3.7 APMS Contract Requirements

APMS lease terms must not exceed contract duration. Break clauses must align with contract expiry or review dates. Where APMS leases exceed contract terms, mutual break clauses at contract expiry are mandatory. Additional flexibility provisions are required to protect the ICB from post-contract termination liabilities.

3.8 Sale and Leaseback

The ICB has a right to refuse to approve sale and leaseback arrangements that do not represent value for money. Whilst the ICB cannot prevent a contractor from entering into a commercial arrangement with a third party, the ICB is not obligated to provide rental reimbursement unless the lease meets the requirements of the Premises Cost Directions 2024 and represents value for money.

The overall suitability of a sale and leaseback approach is assessed in the context of wider system priorities. Sale and leaseback proposals require careful assessment of value for money, considering that the contractor benefits financially from the sale. The ICB therefore scrutinises whether the leaseback rent represents fair value or whether it reflects an attempt to extract additional value from premises funding.

Strategic considerations must be explicitly assessed when determining the appropriateness of any sale and leaseback arrangement. This includes alignment with SHAPE (Strategic Health Asset Planning and Evaluation) analysis considering:

- Population demographics and projected changes
- Population health needs and service requirements
- Nearby NHS assets that could be better utilised or support consolidation
- Accessibility and transport links
- Capacity and utilisation of existing provision in the area
- Strategic fit with ICS Infrastructure Strategy and Place plans

Sale and leaseback proposals must secure Central Estates Team and Place endorsement before proceeding to District Valuer assessment. The endorsement process considers the strategic factors above alongside Core, Flex, Tail classification and long-term service viability.

The District Valuer scrutinises whether the proposed leaseback rent represents value for money, considering market comparables for similar properties and whether the rent reflects the building's age, condition, and suitability for modern primary care delivery. The District Valuer's assessment takes into account that the same parties negotiating the sale price are also setting the lease rent, which may not represent arms-length market terms.

4. **Single Neighbourhood Providers and Neighbourhood Health Contracts**

The NHS 10 Year Health Plan (July 2025) introduced new contractual models for neighbourhood-level care delivery, including Single Neighbourhood Provider (SNP) contracts serving populations of approximately 30,000 to 50,000 patients, and Multi-Neighbourhood Provider (MNP) contracts covering populations of 250,000 or more. These contracts are expected to roll out from 2026 and will have significant implications for the primary care estate and how the ICB assesses and approves lease arrangements.

The introduction of neighbourhood provider contracts does not replace or override the requirements of the Premises Cost Directions 2024. All lease applications will continue to be assessed against the PCDs regardless of the contractual model under which primary medical services are delivered. The fundamental principles of this policy, including value for money, tenant alignment with contract holders, and the lease approval process, remain in full effect.

Where a practice or PCN transitions to an SNP contract, the following considerations will apply to lease assessments.

4.1 Tenant and Contract Holder Alignment

The Premises Cost Directions require that lease tenants mirror the holders of the contract under which primary medical services are delivered. Where an SNP contract is held by a corporate vehicle (such as a PCN limited company, GP federation, or other legal entity), any new lease or lease variation must name the SNP contract holder as tenant. Existing leases naming individual GMS or PMS contract holders will need to be reviewed and, where necessary, assigned or replaced to reflect the new contracting arrangements. The ICB will not approve rental reimbursement where there is a mismatch between the lease tenant and the neighbourhood provider contract holder.

Practices transitioning to SNP contracts should engage with the Central Estates Team at the earliest opportunity to discuss the implications for their existing lease arrangements. Any lease assignment or new lease will need to follow the standard approval process set out in this policy, including District Valuer assessment and value for money determination.

4.2 Lease Terms and Contract Alignment

Lease terms must be appropriate to the duration and nature of the neighbourhood provider contract. Where an SNP contract has a defined term, break clauses should be aligned with the contract period to avoid the ICB being committed to rental reimbursement beyond the life of the contract. This mirrors the existing approach for APMS contracts set out elsewhere in this policy.

Where the duration of the SNP contract is not yet confirmed or is subject to renewal, the ICB will consider lease terms on a case-by-case basis, taking into account the strategic classification of the premises under the Core, Flex, Tail framework and the long-term service need for the site. Longer lease terms will generally only be supported for premises classified as Core or Flex 1 where there is clear evidence of ongoing strategic need.

4.3 Multi-Site Arrangements

SNP contracts may involve the delivery of services across multiple sites within a neighbourhood footprint. The ICB will assess each premises individually against the requirements of the PCDs and this policy. The existence of an SNP contract covering multiple sites does not create an automatic entitlement to rental reimbursement for all sites within the neighbourhood. Each premises must demonstrate value for money, meet minimum standards, and have an NHS-approved lease in place.

Where an SNP contract holder proposes to consolidate services into fewer, larger sites (such as neighbourhood health centres), the ICB will work with the contractor and Place teams to manage the transition, including supporting applications for lease surrender grants under Direction 29 where appropriate and in line with this policy.

4.4 Estate Strategy Alignment

The introduction of neighbourhood provider contracts reinforces the importance of the Core, Flex, Tail assessment framework. The ICB will use this framework alongside SHAPE analysis and Place-level estate strategies to inform decisions about which premises should be supported through the transition to neighbourhood-based delivery models.

Premises classified as Tail that are not aligned with the neighbourhood health service model will not be supported for long-term lease commitments. The ICB expects that the shift to neighbourhood-based delivery will, over time, support the rationalisation of the primary care estate towards fewer, better-quality premises that are fit for modern, integrated service delivery.

4.5 Interim Arrangements

Due to the ongoing changes in national policy and strategic drivers, this policy will therefore be subject to review in line with section 11.

5. **Essential Lease Provisions**

Table 1: Essential Lease Provisions – All Lease Types

Provision	Requirement	Rationale
Lease Tenants	Must exactly mirror GMS/PMS/APMS contract holders	Compliance with Direction 32 - only contract holders eligible for reimbursement
'Time is of the Essence'	Landlord must trigger rent reviews within specified period or review is lost	Protects ICB financial position from retrospective rent increases
Rent Reviews	Upwards and downwards, never below initial rent, every 3 years (standard)	Ensures market alignment and protects against excessive increases
VAT Status	Must clearly state whether VAT applies and will be charged	Enables accurate financial assessment and prevents disputes
Repairing Obligations	Clearly state FRI or TIR with rent reflecting obligations	FRI should result in lower rent; ensures cost-appropriate arrangement
Assignment Rights	Right to assign with landlord consent (not unreasonably withheld)	Enables transfer to successor contractors or NHS England/nominee
License to Alter	Must include if future Capital Grant applications anticipated	Enables premises improvements funded by ICB grants

Table 2: New Build vs Existing Lease Considerations

Aspect	New Build	Existing/Re-gear
Rent Reviews	CPI cap and collar arrangements may be acceptable for initial period	Open market rent reviews required (RPI not acceptable)
Process	Post-build VFM report, lease completion, Stamp Duty Land Tax considerations (see section 8)	Standard lease approval process (see section 5)
Lease Term	20-25 years may be appropriate to support capital investment	15 years standard, shorter for Tail premises
Professional Fees	May be eligible for reimbursement (Direction 15) - see section 8.4	Generally not reimbursable unless significant refurbishment

Prohibited Provisions: The ICB will not approve leases containing RPI-linked rent increases, rent review clauses without 'time is of the essence', restrictions on use preventing primary medical services, or prohibition on assignment to NHS England or nominee.

6. **Approval Process**

6.1 GP Contractor Responsibilities

A process flowchart is provided in Appendix 1 for quick reference.

- Present an agreed unsigned final draft lease for ICB assessment
- Seek independent legal and professional advice before agreeing lease terms
- Ensure lease tenants match GMS/PMS/APMS contract holders exactly
- Provide all information reasonably requested by ICB or District Valuer
- Respond to amendment requests in timely manner
- Not sign lease until written ICB approval is received
- Notify ICB immediately of any amendments to lease or property for additional approval

6.2 ICB Process

Central Estates Team conducts initial assessment for compliance with Premises Cost Directions 2024 (or subsequent future legislation). Place teams review application in context of local estates strategy and alignment to ICS Infrastructure Strategy, budgetary constraints, SHAPE Atlas data, and longevity of regional health requirement needs. Places provide written evidence of approval in principle after thorough due diligence.

The GP Estates Operational Oversight Group (GPOOG) receives system summaries by Place of outstanding leases and recommendations on sale and leasebacks going to Executive level. GPOOG provides a forum for system oversight and consistency.

If compliant in principle, lease is submitted to District Valuer for CMR assessment and value for money report. District Valuer provides recommendation (Value for Money, Not Value for Money, or Value for Money with recommendations). Central Estates Team provides recommendation to Place team based on all factors. Place team makes final approval decision, which may override Estates Team recommendations in exceptional circumstances with documented rationale. Place teams cannot approve leases that the District Valuer has assessed as Not Value for Money without addressing the specified concerns.

6.3 Timeframes

The lease approval process typically takes 8-16 weeks from submission of a compliant final draft lease, depending on District Valuer workload and case complexity.

Compliant means: The draft lease contains all required provisions, lease tenants match contract holders, VAT status is clearly stated, no prohibited provisions are included, and all requested information has been provided. The ICB may accept minor concessions on preferred terms where there is clear justification, but cannot accept leases with prohibited provisions (e.g., RPI increases, no 'time is of the essence').

NHS England advises that negotiations for a new lease should commence 18-24 months prior to lease expiry. Locally, the ICB monitors leases approaching expiry (within 5 years) and contacts practices to advise on timelines. The ICB begins actively chasing practices when leases have less

than 18 months to run. This process is working reasonably well, though some practices delay due to uncertainty about future plans or difficulty negotiating with landlords.

6.4 Interim Arrangements

Where a contractor is already in occupation and paying rent pending lease approval, the ICB may, at its discretion, make interim payments at the equivalent of notional rent.

Notional rent vs Actual rent: Notional rent is the payment made to owner-occupiers based on the current market rental value of their premises. Actual rent is the payment made to tenants based on the lower of their lease rent or the current market rent. Interim payments at 'equivalent of notional rent' means the ICB assesses what the notional rent would be if the property were owner-occupied, and pays this amount pending finalisation of the actual lease terms.

The current process requires written confirmation from Place teams to continue interim reimbursement. The GPOOG will review and approve the policy on interim arrangements to ensure consistency. Arrangements will be reviewed periodically and may be reduced or withdrawn if the approval process is unduly delayed by the contractor. Full reconciliation occurs once final approval is granted.

7. Monitoring

The ICB Estates Team monitors compliance with approved lease terms and rental reimbursement arrangements through continuous collaborative working between departments (Places, Digital, Finance, Contracts).

7.1 Minimum Standards

Contractors are responsible for ensuring premises meet minimum standards under Schedule 1 of the Premises Cost Directions 2024. The ICB's responsibility is to ensure rental reimbursement is only provided for premises that meet these standards. The ICB may arrange survey visits where there is risk that standards are not being met (Direction 51(2)).

The ICB does not mandate specific fixtures, changes, or quality improvements beyond minimum standards. However, premises that fail to meet minimum standards may result in the ICB serving a remedial notice requiring improvements within a specified timeframe. Infection prevention and control requirements form part of the minimum standards that contractors must meet.

7.2 Core, Flex, Tail Utilisation

Place teams are responsible for monitoring utilisation of premises, particularly for branch surgeries and premises classified as Flex or Tail. Where premises are underutilised, the Place team will:

- Engage with the practice to understand reasons for underutilisation
- Consider whether the space could be better used for other services
- Review whether continued rental reimbursement represents value for money
- Consider service reconfiguration options if underutilisation persists

The ICB may exercise its discretion under Direction 49 to reduce rental reimbursement for unused space where appropriate.

7.3 Lease Compliance

The ICB monitors:

- Rental payments in accordance with Premises Cost Directions
- Regular reconciliation of rental payments to alleviate significant arrears
- Rent review processes and outcomes
- Capital grant abatements
- APMS lease arrangements approaching contract expiry
- Changes in VAT status
- Break clause exercise where relevant

7.4 Contracting Links

The Estates Team works collaboratively with the Contracting Team to monitor:

- Assignment of leases when contract holders change
- Partners varying off contracts and corresponding lease changes required
- Contract termination clauses and lease implications

The Contracting Team provides variation summaries to the Estates Team for assessment of partner changes. Where a partner comes off the GMS/PMS contract but remains on the lease, the Estates Team will contact the practice to request lease variation to mirror the contract. Rental reimbursement may be affected if the lease tenants no longer match contract holders, as Direction 32 requires alignment.

Consequences of not having an NHS-approved lease: Contractors without NHS-approved leases may face restricted access to capital grants (as lease term must cover abatement periods), potential contract breach if premises do not meet requirements, rental reimbursement paid at ICB discretion (typically at notional rent equivalent) rather than as contractual entitlement, and inability to claim reimbursement for actual rent if it exceeds notional rent equivalent.

8. New Build Premises

8.1 Agreement for Lease Stage

During the development phase, contractors typically enter into an Agreement for Lease (AFL) setting out the terms on which the lease will be granted upon practical completion. The ICB's approval process for AFLs includes:

- Initial strategic approval and premises development proposal (Direction 7)
- Assessment of AFL terms for compliance with ICB requirements
- Confirmation that final lease will meet all essential provisions (section 4)
- Agreement on rent basis (may include cap and collar for initial period)

The AFL should make clear that ICB approval is required before the final lease is completed and that the terms must remain compliant with ICB requirements.

8.2 Post-Build Process

Upon practical completion of the new build:

1. Contractor notifies ICB of practical completion
2. District Valuer conducts post-build valuation and VFM assessment
3. ICB reviews final lease documentation for compliance with AFL and ICB requirements
4. ICB provides written approval for lease completion
5. Lease is completed and registered
6. Rental reimbursement commences from lease commencement date

8.3 Variations Between AFL and Final Lease

Variations between the Agreement for Lease and the final lease document are common due to:

- Changes in floor area following completion
- Amendments negotiated during construction
- Updated specifications or fit-out requirements
- Final construction costs differing from estimates

Where variations occur:

- Minor variations (e.g., floor area within 5%, no change to key terms) can typically be accommodated with updated District Valuer assessment
- Material variations (e.g., significant rent changes, changes to repairing obligations, changes to review mechanisms) require fresh ICB approval
- Contractors must notify ICB immediately of any proposed variations
- ICB will not approve variations that introduce prohibited provisions or undermine value for money

Timescales: The process from practical completion to lease completion typically takes 8-12 weeks, comprising District Valuer post-build assessment (4-6 weeks), ICB review and approval (2-3 weeks), and lease completion formalities (2-3 weeks). Delays often occur where there are material variations requiring additional assessment or where documentation is not provided promptly.

8.4 Stamp Duty Land Tax

Stamp Duty Land Tax (SDLT) is payable by the tenant (contractor) when entering into a lease if the consideration exceeds the relevant threshold. SDLT liability depends on the Net Present Value (NPV) of rent payable over the lease term.

Under Direction 31, the ICB must consider applications for financial assistance to cover SDLT costs where:

- The contractor agrees to acquire land or lease premises approved by ICB
- The acquisition/lease will improve range and quality of services

- The contractor makes an application for SDLT cost assistance

The ICB's position: SDLT assistance is considered on a case-by-case basis, primarily for new builds where SDLT costs are substantial. The ICB will consider whether the SDLT cost was foreseeable and should have been factored into the commercial arrangement, the overall value for money of the premises arrangement including SDLT, and whether providing SDLT assistance supports strategic objectives. SDLT assistance is less likely to be approved for straightforward lease renewals or assignments where SDLT costs are typically minimal.

8.5 Professional Fees for New Builds

Direction 15 allows the ICB to reimburse certain professional fees for contractors occupying new or significantly refurbished premises. Reimbursable expenses include:

- Project manager costs: up to 1% of construction contract sum
- Surveyors', architects' and engineers' fees: up to 12% of construction contract sum (or higher if ICB agrees)
- Reasonable legal costs for site purchase and construction
- ICB Position: Professional fee reimbursement for new builds is provided subject to:
- Evidence that fees are reasonable and represent value for money
- Confirmation that contractor has undertaken competitive tendering for professional services
- Fees being within the maximum reimbursable amounts under Direction 15
- Application being made in accordance with Direction 14

Professional fees for ordinary lease negotiations (existing buildings, lease renewals, or re-gearing) are not reimbursable. The contractor is expected to cover legal and professional costs for routine lease transactions. Reimbursement under Direction 15 is intended for substantial development or refurbishment projects where professional input is necessary for the project to proceed.

Process for seeking professional fee reimbursement: Contractor submits application under Direction 14 providing details of the project, breakdown of professional fees incurred or anticipated, evidence of competitive tendering for professional services, and confirmation of fee reasonableness. ICB assesses application considering whether fees are within Direction 15 limits, fees represent value for money, and the project justifies professional fee support. Approval is provided before fees are incurred where possible, or retrospectively where fees have already been paid (subject to evidence of reasonableness).

9. **NHS Property Services and Community Health Partnership Leases**

NHS Property Services (NHSPS) and Community Health Partnerships (CHP) are wholly owned by the Department of Health and Social Care and manage property on behalf of the NHS. Leases with these organisations require specific consideration.

9.1 General Approach

While NHSPS and CHP are part of the Department of Health and Social Care, the ICB still applies value for money assessment to proposed lease terms. Being part of the same overall NHS family does not automatically mean leases represent VFM, as NHSPS and CHP operate with commercial objectives and must generate returns.

9.2 Assessment Criteria

NHSPS and CHP leases are assessed using the same criteria as private landlord leases:

- District Valuer CMR assessment
- Compliance with essential lease provisions (section 4)
- Suitable lease term and break clause provisions
- VAT status clearly stated

However, there are some specific considerations:

- NHSPS leases often include rent floor provisions preventing rent falling below initial level (Direction 33(3) – the ICB must reimburse at least the initial rent in these cases
- NHSPS and CHP may have standardised lease templates that differ from ICB preferred terms – the ICB assesses whether variations are acceptable
- Service charges are common in NHSPS/CHP buildings and require careful scrutiny to ensure they represent value for money

9.3 Head Lease and Sublease Arrangements

Where NHSPS holds a head lease from a third-party landlord and proposes to grant a sublease to a GP contractor:

- The ICB is not involved in head lease negotiations between NHSPS and the landlord
- Once the head lease is finalised, the ICB will move forward with joint instruction to the District Valuer for the sublease assessment
- The ICB only approves the sublease between NHSPS and the contractor
- The sublease must meet ICB requirements for value for money

This approach ensures the ICB assesses the sublease terms that will determine rental reimbursement, while recognising that NHSPS has commercial freedom in its head lease negotiations.

10. References

National Health Service (General Medical Services – Premises Costs) Directions 2024. National Health Service Act 2006. The National Health Service (General Medical Services Contracts) Regulations 2015. NHS England Premises Directions Guidance (published May 2024). Primary Care Capital Grant Policy (published July 2024)

11. Policy Review

This policy will be reviewed per annum or sooner if required by changes to legislation, national guidance, or local circumstances.

APPENDIX 1: LEASE APPROVAL PROCESS FLOWCHART

CONTRACTOR SUBMITS UNSIGNED FINAL DRAFT LEASE

To: EstatesTeam@cheshireandmerseyside.nhs.uk and Place Team

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CENTRAL ESTATES TEAM - INITIAL ASSESSMENT

Check for:

- Lease tenants match contract holders
- 'Time is of the essence' clause included
- No prohibited provisions (RPI, upwards-only reviews)
- VAT status clearly stated
- Compliance with Premises Cost Directions 2024

Timeframe: 1-2 weeks

↓

COMPLIANT?

NO - NON-COMPLIANT	**YES - COMPLIANT**
Estates Team contacts contractor Lists required amendments → Return to INITIAL ASSESMENT with amended draft	Proceed to Place Team Review ↓

↓

PLACE TEAM REVIEW

Strategic Assessment:

- Alignment to local estates strategy & ICS Infrastructure Strategy
- SHAPE Atlas data review
- Budgetary constraints
- Core, Flex, Tail classification
- Longevity of regional health requirement

Timeframe: 2-3 weeks

↓

APPROVAL IN PRINCIPLE?

NO - NOT APPROVED IN PRINCIPLE	YES - APPROVED IN PRINCIPLE
Place provides written rationale Application refused → END	Place provides written approval Proceed to District Valuer ↓

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DISTRICT VALUER ASSESSMENT

Estates Team instructs District Valuer for:

- Current Market Rent (CMR) assessment
- Value for Money report
- Lease terms review

Timeframe: 4-8 weeks

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DISTRICT VALUER RECOMMENDATION

NOT VALUE FOR MONEY	VFM WITH RECOMMENDATIONS	VALUE FOR MONEY
DV specifies: • Max acceptable rent • Required amendments Estates contacts contractor → Return to INITIAL ASSESMENT	Acceptable but could improve Estates & Place review Proceed or seek amendments ↓	Rent and terms acceptable Proceed to final approval ↓

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FINAL APPROVAL DECISION

Place Team makes final decision based on:

- District Valuer recommendation
- Estates Team recommendation
- Strategic considerations

ICB issues written approval to contractor

Timeframe: 1-2 weeks

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CONTRACTOR SIGNS LEASE

Contractor returns signed lease copy to ICB

Estates Team validates against approved draft

Timeframe: Variable (contractor dependent)

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RENTAL REIMBURSEMENT COMMENCES

Full reconciliation completed

Arrears paid or overpayments recovered as appropriate

Ongoing monitoring begins

KEY INFORMATION

Total Typical Timeframe: 8-16 weeks

Common Delay Factors:

- Incomplete draft lease (add 2-4 weeks)
- Prohibited provisions (add 2-4 weeks)
- Not Value for Money (add 4-8 weeks)
- Slow contractor response (variable)

Contact: EstatesTeam@cheshireandmerseyside.nhs.uk

APPENDIX 2: GLOSSARY OF TERMS

This glossary defines key terms and acronyms used throughout the Primary Care Lease Assessment and Approval Policy. Terms are listed alphabetically.

TERM	DEFINITION
APMS Contract	Alternative Provider Medical Services contract - a fixed-term contract for the provision of primary medical services, typically with a specific end date (unlike GMS/PMS contracts which are indefinite).
Actual Rent	The rent actually specified in the lease agreement between the landlord and tenant. For rental reimbursement purposes, the ICB pays the lower of actual rent or Current Market Rent.
Break Clause	A provision in a lease allowing either party (or both) to terminate the lease before the end of the full term, subject to giving specified notice and meeting certain conditions.
CHP (Community Health Partnerships)	A company wholly owned by the Department of Health and Social Care that manages NHS property. Part of the DHSC Group.
CPI (Consumer Price Index)	A measure of inflation tracking changes in the price of consumer goods and services. Sometimes used in lease rent review clauses (particularly for new builds) with cap and collar arrangements.
CMR (Current Market Rent)	The rent that would reasonably be expected to be paid for premises in the open market, as assessed by the District Valuer in accordance with Schedule 2 of the Premises Cost Directions 2024. This is based on a hypothetical 15-year lease with specific assumptions about repairing obligations and other terms.
Core Premises	Essential buildings critical for delivering services in the long term (at least 10 years). High-quality, fit-for-purpose, future-proofed premises that align with ICS clinical strategy. Investment priority for maintenance and upgrades.

Direction / Directions	Refers to the National Health Service (General Medical Services – Premises Costs) Directions 2024, which set out the regulatory framework for NHS rental reimbursement and premises funding. Individual provisions are referred to by number (e.g., Direction 32, Direction 33).
District Valuer (DV)	District Valuer Services of the Valuation Office Agency - professional valuers who provide independent assessment of property values and rental levels for the NHS. The DV assesses Current Market Rent and provides Value for Money reports on lease proposals.
Flex Premises	Buildings of acceptable quality currently providing services but may not be needed longer term (beyond 5 years) as clinical models evolve. Offer flexibility for future growth or temporary needs but don't fully enable long-term ICS ambitions.
FRI (Full Repairing and Insuring)	A lease type where the tenant is responsible for all repairs (internal and external), maintenance, and building insurance. FRI leases should have lower rents than TIR leases to reflect the tenant's greater obligations.
GMS Contract	General Medical Services contract - the standard NHS contract for the provision of primary medical services. GMS contracts are indefinite (no fixed end date) unless terminated by either party.
GPOOG (GP Estates Operational Oversight Group)	A forum providing system-level oversight of GP estates matters across Cheshire & Merseyside, reviewing summaries of outstanding leases and ensuring consistency in approach across Places.
ICS (Integrated Care System)	The partnership of NHS organizations, local authorities and others in Cheshire & Merseyside working together to plan and deliver joined-up health and care services.
ICS Infrastructure Strategy	The strategy published November 2024 setting out how the ICS will prioritize investment in estate and infrastructure, including the Core, Flex, Tail classification framework.

Notional Rent	A payment made to GP contractors who own their practice premises (owner-occupiers), based on the current market rental value of the premises. Notional rent is assessed every 3 years and represents what the premises would rent for if leased to a third party.
NHS Property Services (NHSPS)	A company wholly owned by the Department of Health and Social Care that manages NHS property across England. Part of the DHSC Group.
PCD / PCDs (Premises Cost Directions)	Short form reference to the National Health Service (General Medical Services – Premises Costs) Directions 2024. Sets out the regulatory requirements for NHS rental reimbursement and premises funding.
Place	One of the nine geographic areas within Cheshire & Merseyside ICB: Warrington, Halton, St Helens, Cheshire East, Cheshire West, Wirral, Knowsley, Sefton, or Liverpool. Each Place has responsibility for commissioning primary care services in their area.
PMS Contract	Personal Medical Services contract - an alternative to GMS contracts with locally negotiated terms. Like GMS contracts, PMS contracts are indefinite unless terminated.
RPI (Retail Price Index)	A measure of inflation tracking changes in retail prices. RPI-linked rent increases are NOT accepted by the ICB as they do not represent value for money and are prohibited in the policy.
Sale and Leaseback	An arrangement where a GP contractor sells their premises to a third party (often a property investor or developer) and then leases the same premises back from the new owner
SHAPE (Strategic Health Asset Planning and Evaluation)	NHS planning tool providing data on demographics, population health, existing NHS assets, accessibility, and service capacity. Used by the ICB to assess strategic fit of premises proposals including sale and leasebacks.
Tail Premises	Sub-optimal buildings considered poor quality or unfit for patient-facing services. Often have high maintenance costs and are not

	suitable for future care models. Should be phased out and considered for disposal when alternatives become available.
Time is of the Essence	A lease clause requiring strict adherence to time limits for triggering rent reviews. If the landlord does not trigger a rent review within the specified review period, that review is missed and cannot be actioned retrospectively. This protects the ICB from backdated rent increases.
TIR (Tenant Internal Repairing)	A lease type where the tenant is responsible for internal repairs and maintenance, while the landlord remains responsible for external repairs, structural maintenance, and building insurance. TIR leases should have higher rents than FRI leases to reflect the landlord's obligations.
Value for Money (VFM)	The District Valuer's assessment that proposed lease rent and terms represent fair value compared to market rates and do not expose the ICB to unreasonable costs or risks. A lease can be assessed as 'Value for Money', 'Not Value for Money', or 'Value for Money with recommendations'.
VAT (Value Added Tax)	A consumption tax charged on most goods and services. Landlords may choose to 'opt to tax' their property rental, making it subject to VAT. The ICB prefers VAT-free lease arrangements and has discretion about whether to reimburse VAT, particularly for sale and leaseback arrangements.