NHS
Cheshire and Merseyside

Meeting of the Cheshire & Merseyside ICB System Primary Care Committee

Part B – Meeting held in Public
Thursday 25 June 2026
Venue: Meeting Room 1, No 1 Lakeside,
920 Centre Park Square, Warrington,
WA1 1QY (WA1 1QA for SatNav)
Timing: 10:15-12:30

Agenda
Chair: Erica Morriss

AGENDA NO & TIME	ITEM	LEAD	ACTION / PURPOSE	PAGE No
10:15am	**Preliminary Business**			
SPCC 25/06/B01	Welcome, Introductions and Apologies	Chair	Verbal	-
SPCC 25/06/B02	Declarations of Interest	Chair	Verbal	-
SPCC 25/06/B03	Questions from the public (TBC)	Chair	Verbal	-
10:20am	**Committee Management**			
SPCC 25/06/B04	Draft Minutes of the last meeting (Part B) – 26 April 2026	Chair	Paper To approve	Page 3
SPCC 25/06/B05	Action Log of last meeting (Part B) 26 April 2026	Chair	Paper To note	Page10
SPCC 25/06/B06	Forward Planner	Chris Leese	Paper To Note	Page11
10:30am	**Finance Assurance**			
SPCC 25/06/B07	Finance Update	Lorraine Weekes-Bailey	Paper To Note	Page 13
SPCC 25/06/B08	Prescribing Assurance /Update	Susanne Lynch/Chris Haigh	Verbal Update To note	
11.00AM	**Policy and Commissioning**			
SPCC 25/06/B09	Primary Care Action plan	Chris Leese/Tom Knight	Paper To note	Page 21
SPCC 25/06/B10	Primary Care Commissioning Update	Chris Leese/Tom Knight	Paper To note	Page 39
SPCC 25/06/B11	Community Pharmacy Contract Update	Tom Knight	Paper To note	Page 52
11.45AM	**Estates**			

AGENDA NO & TIME	ITEM	LEAD	ACTION / PURPOSE	PAGE No
SPCC 25/06/B12	Business Case approval of Neighbourhood Bespoke Layer in STRATA	Lucy Andrews	Paper For Approval	Page 60
SPCC 25/06/B13	Utilisation and Modernisation Fund 25/26 Programme Update	James Burchell	Update To note	Page 98
SPCC 25/06/B14	GP Practices Operating out of Lease	James Burchell	Proposal Paper For Approval	Page 110
12:30	**CLOSE OF MEETING**			

Date and time of next regular meeting:
Thursday 20 August 2026 (10.15-12:30)

F2F, Lakeside, Warrington, room tba

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

Thursday 16 April 2026 10:00-12:00
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
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
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
Ben Vinter	BVi	Executive Director of Corporate Services and Governance, C&M ICB
In attendance		
Cheryl Meaden	CMe	*Minute taker*, Executive Assistant, C&M ICB
Loraine Weekes-Bailey	LWB	Senior Primary Care Accountant
Lesley Kitchen		
Cathy Fox	CFo	Associate Director of Digital Operations, C&M ICB
James Burchell	JBu	Strategic Estates Manager (Cheshire East, Cheshire West & Wirral Places), C&M ICB
Rob Barnett	RBa	Association of LMC's
Apologies		
Name	**Initials**	**Role**
Tony Foy	TFo	Vice-Chair, Non-Executive Director, C&M ICB
Fionnuala Stott	FSt	LOC representative
Adam Irvine	AIr	Primary Care Partner Member
Anthony Leo	ALe	Place Director, Halton – NOW LEFT
Kevin Highfield	KHi	Head of Digital Operations, C&M ICB
Andrea McGee	AMc	Executive Director of Finance, C&M ICB
Daniel Harle	DHa	LMC representative
Stephen Hendry	SHe	Head of Business Support

Agenda Item, Discussion, Outcomes and Action Points
Preliminary Business
SPCC 26/04/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 26/04/B02 Declarations of Interest
The committee noted the standing declarations of interest. Members were invited to declare any additional specific interests.
SPCC 26/04/B03 Questions from the public
No public attended
Committee Management
SPCC 26/04/B04 DRAFT Minutes of the last meeting (Part B) 19 February 2026
The committee reviewed the minutes from the February 2026 meeting. No amendments were required and the minutes were **approved** as a true and accurate record of the meeting.
SPCC 26/04/B05 Committee Action Log (Part B) 19 February 2026
The Action Log was updated accordingly. Members discussed information-sharing arrangements, emphasising clarity of roles, responsibilities, and appropriate inclusion of Places, PCNs, and individual practices. It was noted that access, purpose, and communication at local level must be clearly understood and may vary appropriately between practices. Members recognised the limitations of a one-size-fits-all approach, reflecting differing populations and needs, and highlighted opportunities for GPs to further promote alternative roles within primary care.
SPCC 26/04/B06 Forward Planner **Presenter: Chris Leese**
The Forward Planner for 2026/27 was reviewed. Discussed no quality report, CLe to check with quality team and when to bring paper. **ACTION: Discussed no quality report, CLe to check with quality team and when to bring paper.**
Finance Assurance
SPCC 26/04/B07 Finance Update **Presenter: Lorraine Weekes-Bailey**
A verbal update was provided. The delegated medical budget was confirmed at month 12 as a £3.9m position, of which £1.8m related to Additional Roles, lower than anticipated. The GP practice budget deteriorated by £600k due to an unfavourable lease, not forecast earlier in the year, alongside additional pressures from GP locum costs. Practices have been asked to notify sickness absence. Overall, the position worsened by £1.1m between months 11 and 12. A full month-end report will be brought to the next meeting. Concerns were noted regarding the management and responsibility for backdated lease costs, particularly as the building has been identified as a potential Neighbourhood Health Centre and requires resolution. Areas of Discussion: - • Members discussed the prescribing position, noting that the month 10 spend was £14.1m, rising to a £14.8m overspend by year-end, driven primarily by increased use of tirzepatide. The month 12 position was also impacted by late invoices from I-Mersey, some dating back up to three years, with negotiated payment agreements contributing a further £0.5m pressure. • Demand for tirzepatide is expected to increase further from June as eligibility widens. While some additional funding has been allocated, this is not expected to significantly mitigate the impact. Significant work undertaken over the past year has placed the system in a stronger position than many other ICBs nationally; however, continued strict prescribing criteria, clear guidance, robust data collection, and close monitoring are essential. It was noted that prescribing decisions sit with individual practices rather than PCNs, creating challenges in

managing patient expectations. Ongoing engagement includes webinars (with further sessions planned) and continued challenge through NICE where appropriate. No prescribing paper was presented this month; a deep dive at FICC next week will inform a future paper to be brought to the Committee.

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The System Primary Care 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 DECISION** are required.

The System Primary Care Committee NOTED the finance update.

Policy and Commissioning

SPCC 26/04/B08 Dental, Community Pharmacy, Optometry and General Practice
Presenter: Tom Knight/Chris Leese

- **Enhanced Services Review – Presenter: Dr Jonathan Griffiths**

General Practice

- **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,** covers all 4 contractor groups.
- 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
- 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.
- The national **Neighbourhood health framework** has been released; 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.
- Ongoing dialogue is taking place between pharmacy, the ICB, and NHSE, with metrics and locally held information to be brought to SPCC, building on existing intelligence. The June plan will provide a springboard for further development of work in General Practice

Areas of Discussion: -

- Reporting requirements will be clearly defined and aligned to available resources. Reports will be reviewed at SPCC, with agreed items escalated to the Board and assurance provided via AAA.
- NHSE will review papers throughout the year, with updates incorporated into the plan as required. Work is underway to develop a dashboard, including practice-level use and resource implications; a proposal will return in June, with a pilot planned for August.

Enhanced Service Review –

- No report was presented this month due to shifting timelines. Originally planned for the new financial year, delivery is now proposed for the following year. A paper will be brought once there

is clarity on schemes for de-commissioning and associated communications, to reassure practices that funding is being reallocated rather than removed. The delay enables further engagement and clearer messaging, which has already been issued to primary care, LMCs, and GPs. It was agreed this is the right approach, with notice served in-year and implementation from next financial year, and a paper planned for June.

- Further discussion is required at SPCC prior to consideration at FICC, where challenge is anticipated regarding funding movement and discretionary budgets. It was emphasised this is about reinvesting funding appropriately, not reducing it, with LMC support noted. Some disquiet was reported regarding prescribing changes and values, and the need to present changes as a coherent, locally relevant package and avoid comparisons with other regions. It was noted that changes go live next April, with further GP reforms expected the following April, and an additional primary care item will be discussed under AOB.

The System Primary Care Committee is asked to:

- **NOTE the update.**

The System Primary Care Committee NOTED the updates on General Practice and Enhanced Services Review.

Key Strategic Delivery Areas

SPCC 26/04/B09 Patient Experience – Dental Access
Presenter: Louise Barry

- A slide presentation was noted. An email from a member of the public was discussed, describing their frustration with dental services, including long travel for treatment while in pain, cost, lengthy telephone or online waits, inability to register with an NHS dentist, and inability to afford private care. The experience highlighted wider public concern that the system is structurally unsafe and fundamentally unfair.
    - Discussed sharing information around a number of areas:-
    - Private care not affordable for many
    - Dentures – access to these are limited
    - Referrals made to speciality declined
    - No Commissioner pathway
- Access to NHS dental care remains extremely limited, with many patients—particularly vulnerable groups—unable to travel to available provision and presenting instead to GPs, pharmacies, and other services while in pain. Lack of access often results in reactive treatment, including tooth extraction, with little or no preventative care, and reasonable adjustments for patients are frequently not met. Refugees and asylum seekers, especially children, face additional barriers, further restricting access, while pharmacies continue to provide support where possible.
- Examples of good, consistent dental care were noted where services are established; however, ad hoc access and areas without dentists remain the most significant challenge. The “Find a Dentist” tool was described as not fit for purpose, with denture pathways posing particular difficulty. Increasing numbers of dentists moving to private practice, rising travel costs, and poor service availability were highlighted as national issues. It was noted that poor access to dental care can have wider health consequences, including preventable admissions to critical care, and without improvements in oral health provision, pressures across the system will continue to escalate.

Areas of Discussion: -

- The gap between intended action and operational reality was noted, with impacts on the wider system and on patient health. Dental problems were highlighted as contributing to serious, sometimes preventable conditions, including an example of cardiac issues linked to stress from unresolved dental care. While some improvement in urgent care was acknowledged, limited progress in oral health means pressures will continue to increase.
- Ongoing access challenges were recognised as real and compounded by poor or inconsistent patient information. Previous plans and recent patient case studies were referenced. National

contract reforms were noted to be six months behind schedule, with revised service targets adding challenge. A review of helpline abandoned calls and capacity against demand was discussed, noting only 44% of commissioned appointments are utilised, potentially due to transport barriers.

The System Primary Care Committee is asked to:

- **NOTE** the update on patient experience report on dental Access

The System Primary Care Committee NOTED the Patient Experience report on Dental Access.

SPCC 26/04/B10 Dental Improvement/Access Plan
Presenter: Tom Knight

- Highlights of the report: -
    - Maintaining existing local Quality and Access scheme with focus on vulnerable groups. 68 practices are signed up to the scheme.
    - 207 practices 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.
- Performance continues to improve, though challenges remain, particularly for vulnerable groups including asylum seekers and cancer patients, especially children. Contract reforms continue to impact commissioning intentions, with gaps in information on support and prevention noted; oral health and neighbourhood health approaches will inform future planning.
- Unscheduled dental care requires review to consider emerging findings and determine next steps. Domiciliary care remains limited and is delivered through four Community Dental Services, with a need to ensure domiciliary provision is included. The routine access scheme will continue within a constrained budget, noting uncertainty arising from planned contract reforms and the current transitional position.
- National dental recruitment schemes remain in place, although historic challenges persist. Of approximately 200 practices, seven are eligible and three have successfully recruited to date. Eligible practices are required to allocate 8.2% of appointments to urgent care, with around 270 contracts eligible; financial impacts, limitations on patient access, and implications for the dental ringfence require further consideration.
- Some issues are locally controllable, while others require escalation to NHSE and Government, with Board support. Capacity remains constrained, as increased activity risks affecting care quality. Engagement with the LMC was noted, and thanks were recorded to Healthwatch for their valuable contribution.

Areas of Discussion:-

- The overall quality of dental care remains high; however, dentists can safely manage only a finite number of patients, and exceeding this would compromise care. Capacity cannot be expanded without reducing quality. Some immediate improvements exist, such as translation services, though these are poorly publicised, presenting an opportunity for Healthwatch to work with LDCs to improve awareness.

- The ICB inherited a constrained and largely unfit-for-purpose dental system from NHSE. Urgent care reforms risk worsening access for some patients: while urgent care is funded at 8.2%, most practices currently deliver around 4.5%, improving practice viability but reducing routine care capacity by an estimated 1.5–2 weeks per dentist. With no additional NHS funding, there is concern activity may shift into private provision.
- Contract values are approximately £45k lower than last year, supporting viability but not access. The lack of funding for appraisal, peer review, and similar initiatives further reduces patient availability. Weak contracts, poor communication, limited monitoring, and absence of business intelligence mean the impact of reforms is unclear, with concern that deprived communities and patients unable to travel will be most affected.
- Capacity has not been aligned to population need for over 20 years, and short-term schemes are insufficient, indicating the need for wholesale service reform. Delivery is constrained by limited ICB resource, workforce shortages, and financial pressures. A dental improvement plan is in place, with clawbacks and underspends, but use of these requires Board consideration, including via AAA, with a stronger focus on health inequalities.
- It was noted that national funding covers only around 50% of the population, with implicit reliance on private care, and that use of dental underspend to support other services is inequitable and risks longer-term cost and inequality impacts. The role of the CDO and proposals to reduce routine check-ups were discussed; modelling shows this would generate minimal additional capacity. Persistent challenges around contracts, workforce, and in-year reallocation remain, requiring clearer commissioning intent, improved BI, workforce planning, and sustained Board oversight to avoid recurrence.

The System Primary Care Committee is asked to:

- **NOTE** the Dental Access Improvement Plan.

The System Primary Care Committee NOTED the update on the Dental Access Improvement plan.

Digital

SPCC 26/04/B11 Shared Care Update
Presenter: Lesley Kitchen

Discussed 4 contract groups, and recognition of organisational change and other challenges.

- Pharmacy - an intention to move to place and shared care record, now ready to progress with. And conversations ongoing.
- Dentistry - has a big blind spot from digital data point of view and need to do further work around this. Use cases, systems, landscape to work out next steps.
- Optometry - had national offer received early sight of 2 national tactical and immediate options. Access and use the NHS ERs web-based interface, with follow on support for optometrists to access NCRS. API integrated with existing electronic referral systems.
- GPs - Share information and not duplicate services. CM ShCR linked to GP connect for direct care purposes. GP read connection to CMCR o restarting.

A strategic approach is being taken to implement a sustainable digital care offer, supporting the development of new care models and more dynamic care management through digital enablement.

Areas of Discussion: -
No questions were raised. Further information is available on request.

The System Primary Care Committee is asked to:

- **NOTE** the update on Shared Care

The System Primary Care Committee NOTED the update on Shared Care.

Estates

SPCC 26/04/B12 Leasing Policy
Presenter: Lucy Andrews

- 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.
- 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.
- 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.

Areas of Discussion: -

- A process is in place and will be formalised internally and externally, with communication to GPs to ensure a robust and consistent approach. This work is welcomed, addressing historical inconsistency. The District Valuer remains a key risk due to delays and additional requirements; consideration should be given to establishing an MOU or SLA to improve performance.
- Government correspondence to trusts regarding taking over leases from NHS Property Services has caused concern about the future security of NHS practices. Ensuring leases are satisfactory remains essential. This is a national issue and is routinely escalated. Further discussions are planned with the LMC, including with William, regarding premises ownership, the management of a large and varied lease portfolio, and the wraparound processes required before any decisions are made. With multiple lease types, landlords, buildings, and several reviews imminent, it was agreed this should be considered at Board development to agree a future position. Close working with the LMC is required, recognising the ICB cannot act as the backstop and will need LMC support to take a firmer, consistent approach with GPs on leases.

The System Primary Care Committee is asked to:

- **APPROVE** the NHS Cheshire and Merseyside ICB Primary Care Lease Assessment and Approval policy.

The System Primary Care Committee APPROVED the NHS Cheshire and Merseyside ICB Primary Care Lease Assessment and Approval policy.

AOB

PRIMARY CARE

- In recent months, a national NHS England requirement to reduce waiting lists led some specialties to undertake large-scale validation and culling exercises, significantly impacting services, GPs, and patients, with Liverpool Women's services particularly affected. An external organisation was commissioned to triage referrals and determine approval, raising concerns about commissioning arrangements, governance, and a disconnect between reviewers, clinicians, and patients, despite GPs' clinical expertise. Although governance processes (including QIA and QEA) were in place, and patients were written to with safeguards allowing reinstatement if discharge was deemed inappropriate by the GP, there is widespread concern that some patients were not adequately informed and that the process generated substantial additional and often inappropriate workload for GPs. The issue has been raised through QPC and discussed with the provider collaborative, including with Sinead Clark, with further engagement planned with the LMC. While some trusts adopted this approach and regional funding in 2024/25 supported waiting list validation, the exercise has been poorly experienced in many cases, affecting patients' lives and prompting media interest. It was agreed that stronger oversight, clear communication, and system-wide learning are required to prevent recurrence.

ACTION: Conversations to be taken offline and Sinead Clark to discuss with LMC.

CLOSE OF MEETING

Date of Next Meeting: Thursday 25 June 2026 (09:00-12:30)
F2F, Lakeside, Warrington

CHESHIRE MERSEYSIDE
INTEGRATED CARE BOARD

Action Log 2026/27 *updated post April 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	17/04/25	Digital - Shared Care (Connected Care records)	ii) regular 6 monthly update to SPCC Committee	Kevin Highfield / Cathy Fox	June 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	June 2026 committee	*CW spoken with comms team, need to be progressed at March board (private) verbal update in April on progress made*	ONGOING
SPCC 26/04/B06	16/04/2026	Forward Planner	Discussed no quality report, CLe to check with quality team and when to bring paper.	Chris Leese	June 2026 committee	On June agenda	COMPLETED

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

Updated Jun 26 / Christopher Leese

Item	Who	Frequency	Part A/B	Oct-25	Dec-25	Feb-26	Apr-26	Jun-26	Aug-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	No	Yes
Self-Assessment of Committee Effectiveness	EM	Yearly	n/a	No	No	No	No	No	Yes
Forward Planner Annual Plan Review	EM / CL	Yearly		No	No	No	No	No	Yes
Key Business Items									
Minutes of any ExtraOrd SPCC Meetings	EM/CL	If held	A	Yes	Yes	Yes	No	No	No
Committee Risk Register for 4 contractor groups	SH	Every Other Meeting usually	B	No	Yes -progress	Yes - update	Yes - update	No	Yes
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	Yes
Patient Experience									
Deep Dive (s)				No	General Practice via Healthwatch and June Plan update	No	Dental	No	General Practice (as part of access update)
Assurance of progress of Primary Care Strategic Plans									
Estates Update	Estates	Alt	B	Yes	No	Yes	Yes	BC approval	tbc
Digital Strategy	JL	Alt	B	No	Yes	No	No	No	Yes
Workforce Strategy	JG	Alt	B	No	No	No	No	No	tbc
Priority Commissioning Area - Improving Access (Primary Medical)	CL	Alt	B	No	Yes	No	No	Yes as part of PCAP	Yes (detail including GPPS)
Priority Commissioing Area - Improving Access (Dental)	TK	Alt	B	Yes	No	No	Yes	Yes as part of PCAP	No
Priority Commissioning Area - Neighbourhood Health/Primary Care	CWA	Alt	B	Yes	Yes	Yes - paper (AL)	No	No	Yes
Commissioning , Quality and Performance									
Commissioning Update (All 4 contractor groups)	CL/TK	Every Meeting	B	Yes	Yes	Yes	Yes	Yes	Yes
Performance Issues (escalated from Place)	TBC	As required	A	Yes	Yes Part A	No	No	No	tbc
Quality - Report from PCQ plus any key performance metrics	LE/TK/CL	Every Meeting	B	Yes	Yes	Yes	No	metrics update part of PCAP paper and update in commissioning paper	Yes
Committee Budget SORD Delegations									
Capital bids across Estates and Digital	CF/LA/JB/KH	As required	A/B	Yes	Yes	Yes UMF inc digital	UMF part A	x1 bc approval	tbc
Improvement Grant Estates Bids	JA	As required	B	No	No	No	No	No	tbc
Primary Care Business cases / approvals required from Place	TBC	As required	A/B	Yes x 1	No	No	No	No	tbc
Ad Hoc Items for tracking/follow up									

Primary Care Governance	BV/CWA		A					Verbal/Part A	
Protected Learning Time - review	CL/JG		A						Yes - Part A
Enhanced Services Review and recommendations	JG/CL/LWB		B			No	part of policy update	Yes	tbc
Planning - Primary Care (March Board Submission)	CL/TK		B				part of policy update	Yes final plan (PCAP)	tbc
Other Escalations from Place	TBC		TBC		x1 Part A		x1 Part A	No	Liverpool BC approval
Dental Paper – Operational/Contract Part Year performance note	TK		A	Yes	No	Yes	No	No	Yes

NHS
Cheshire and Merseyside

Primary Care Finance Update

NHS Cheshire and Merseyside Primary Care Committee (System Level)

Date: 25th June 2026

NHS Cheshire and Merseyside
Primary Care Committee (System Level)

NHS Cheshire and Merseyside

Date of meeting:	25th June 2026
Agenda Item No:	07
Report title:	**2026/27 Primary Care Finance Update**
Report Author & Contact Details:	Lorraine Weekes-Bailey, Senior Finance Manager - Primary Care
Report approved by:	Clare Barrow, Director of Finance

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

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

N/A

Executive Summary and key points for discussion

The report provides the Primary Care Commissioning Committee of the Cheshire and Merseyside Integrated Care Board (ICB), with a detailed overview of the financial position related to primary care expenditure as at the end of May 2026 (M02).

The report covers seven areas of spend: -

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

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

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

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

NHS Cheshire and Merseyside
Primary Care Committee (System Level)

NHS Cheshire and Merseyside

Recommendation/ Action need:	**The Committee is asked to:** The Primary Care Committee is asked to: - 1. Note the combined financial summary position outlined in the financial report as at 31st May 2026. 2. Note the Additional Roles spend 3. Note the Capital position.

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

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

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

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

Primary Care Finance Update

1. Introduction and Background

1.1. The report provides the Primary Care Commissioning Committee of the Cheshire and Merseyside Integrated Care Board (ICB) with a detailed overview of the financial position in relation to primary care expenditure anticipated for 2026/27 as at 31st May 2026.

1.2. The financial positions for May 2026 (M02) are based on the historical recurrent expenditure for each service area, along with any in-year amendments notified to date. At this early stage, where information has been received at a national level, the report also incorporates any uplifts in line with national assumptions.

2. Financial Position

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

Table 1

Primary Care Position Summary - Month 2 ICB TOTAL	Year To Date			Forecast Outturn		
	Budget (£000's)	Actual (£000's)	Variance (£000's)	Annual Budget (£000's)	FOT (£000's)	Variance (£000's)
Delegated Medical Primary Care						
Core Contract	65,276	65,276	0	377,484	377,484	0
QOF	6,311	5,061	1,250	37,867	36,617	1,250
Premises Reimbursements	9,548	9,666	(118)	57,286	57,405	(118)
Other Premises	129	129	(0)	776	776	0
Direct Enhanced Schemes	808	351	457	4,849	4,392	457
Primary Care Network	7,413	7,413	0	44,479	44,479	0
Additional Roles Reimbursement Scheme	13,947	13,947	0	83,682	83,682	0
Fees	1,931	1,763	169	11,589	11,420	169
Other - GP Services	104	104	0	621	621	0
DELEGATED PRIMARY CARE TOTAL	**105,468**	**103,711**	**1,757**	**618,634**	**616,877**	**1,757**
Local Primary Care						
GP Local Enhanced Service Specification	6,240	6,240	0	37,437	37,437	0
Local Enhanced Services	3,257	3,256	2	19,545	19,543	2
Commissioning Schemes	188	188	0	1,131	1,131	0
Out Of Hours	5,043	5,044	(2)	30,256	30,257	(2)
GP IT	3,641	3,641	(0)	20,870	20,870	0
GP Investment	50	50	0	303	303	0
Primary Care SDF	525	525	0	3,149	3,149	0
Primary Care Other	407	407	0	2,444	2,444	0
QIPP	0	0	0	0	0	0
PC Local Pay Costs	0	0	0	0	0	0
Medicines Management - Clinical and Pay Costs	1,929	2,030	(101)	11,574	12,087	(513)
LOCAL PRIMARY CARE TOTAL	**21,281**	**21,382**	**(101)**	**126,707**	**127,220**	**(513)**
Prescribing						
Central Drugs	3,314	3,299	15	19,886	19,871	15
Oxygen	891	871	20	5,346	5,326	20
Prescribing BSA	81,428	81,428	(0)	504,070	504,070	(0)
Prescribing Local Schemes	824	716	108	4,944	4,835	108
PRESCRIBING TOTAL	**86,457**	**86,313**	**144**	**534,246**	**534,102**	**144**
Delegated Pharmacy Optoms Dental and Other						
Delegated Community Dental	2,194	2,141	53	13,162	13,162	0
Delegated Optomtery	4,956	4,819	137	29,737	29,737	0
Delegated Pharmacy	17,096	17,435	(339)	91,272	91,273	(1)
Delegated Primary Dental	24,600	20,951	3,649	156,148	146,238	9,910
Delegated Property Costs	87	93	(7)	520	520	0
Delegated Secondary Dental	7,208	7,205	4	47,218	47,218	0
PHARMACY, OPTOMS, DENTAL & OTHER TOTAL	**56,141**	**52,645**	**3,496**	**338,058**	**328,149**	**9,910**
TOTAL	**269,347**	**264,051**	**5,296**	**1,617,645**	**1,606,347**	**11,298**

3. Delegated Primary Care - Medical

3.1. The Month 2 financial forecast for Delegated Medical Primary Care indicates a projected underspend of £1.757 million, which primarily relates to prior-year benefits. As the financial year is still at an early stage, with only two months of activity recorded, current data and payment trends are not yet sufficiently developed to reliably identify emerging pressures or surpluses.

3.2. The section below outlines the variances across the individual service lines that contribute to the £1.757m prior year.

3.3. **Quality Outcomes Framework-** The QOF position currently shows a favourable variance of £1.250m. Achievement levels declared by GP practices are lower than anticipated, even when taking into account the protected QOF points included within the proposals. All but two GP practices have now submitted their achievement declarations for 2025/26.

3.4. **Premises Reimbursements-** There is a prior year pressure of £118k within the Premises Reimbursements service line, relating to reimbursements to GP practices for water rates. The finance team requested actual water rate expenditure from practices and, following reconciliation against previously estimated values, a prior year pressure has been identified.

3.5. **Direct Enhanced Services-** These services are activity-driven, and with all four quarters of data for 2025/26 now received, a prior year benefit of £457k has been identified. This predominantly relates to Advice and Guidance and minor surgery activity.

3.6. **Fees-** There is a prior year benefit of £169k, predominantly relating to the prescribing administration fee attributable to dispensing services. Costs accrued at year-end were higher than the amounts originally incorporated, resulting in a prior year benefit of £169k.

4. Local Primary Care

4.1. **Local Primary Care**- The Local Primary Care financial position for 2026/27 as at Month 2 is balanced across most service lines, except for Medicines Management clinical pay costs.

4.2. There is currently insufficient data to identify any emerging surplus or deficit trends. Other than Medicines management clinical pay costs, no prior year variances are reported at this stage, as reconciliation is ongoing and quarter four data, along with year-end achievement data, is still being received.

4.3. **Medicines Management -Clinical and Pay Costs**- Currently shows an in-year pressure of £513k. This is attributable to the former Sefton locality, where some staff were previously shared with Primary Care Networks (PCNs). However, these arrangements have changed, with some PCNs significantly reducing their requirements and, in one case, no longer contracting with the ICB for these roles. As a result, the associated recharge arrangements are no longer in place, creating a pressure for this financial year.

5. Prescribing

5.1. The prescribing budget is currently showing a small surplus relating to 2025/26. Due to the inherent data lag, no data for 2026/27 has yet been received, as prescribing information is typically reported with a two-month delay.

6. Delegated Pharmacy

6.1. Similarly to prescribing, pharmacy data is subject to a two-month reporting lag. The year-to-date variance reflects prior year adjustments following receipt of the February and March remuneration reports.

6.2. There may be further adjustments as additional items, such as clinical waste, are finalised. As this process is not yet complete, no adjustment has been made to the forecast outturn at this stage.

7. Delegated Optometry

7.1. The 2026/27 budget is £29.7m, is anticipated to be sufficient to cover the identified contracts and services funded from this allocation. Expenditure will continue to be monitored against the agreed budget throughout the year.

8. Delegated Other Costs

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

9. Delegated Dental

9.1. The dental allocation for 2026/27, covering Primary Care, Community, and Secondary Care dental services, is approximately £216.5m. This represents a ring-fenced allocation provided by NHSE. Based on detailed service costing, there is confidence that the allocation is sufficient to meet all anticipated dental commitments.

9.2. The DDRB uplift remains subject to ongoing negotiations, and it is anticipated that a further allocation will be received once these discussions are concluded.

9.3. The dental position reports a favourable £9.91m forecast variance. This is primarily driven by the contract allocation of approximately £186.5m, compared with currently commissioned and expected contracts totalling £176.6m. This position will continue to be closely monitored.

9.4. The ICB Primary Care senior leads and commissioners are planning to meet shortly to discuss how to ensure that dental services are commissioned in the most appropriate and effective way, with the aim of increasing the level of activity delivered to the population.

10. Additional Roles Reimbursement Scheme

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

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

10.3 At this early stage in the financial year, it is not yet possible to provide an accurate forecast. Therefore, the position is currently assumed to be balanced with full utilisation.

10.4 This will be closely monitored, and forecasts will be updated as more data becomes available.

Table 2

Additional Roles Reimbursement Scheme 2026/27							
Place	Total	Monthly Allocation	Forecast	YTD Allocation	YTD Spend fro	YTD Utilisati	FOT Utilisati
Cheshire East	12,052,803	1,004,400	12,052,803	2,008,800	1,968,376	98%	100%
Cheshire West	11,454,373	954,531	11,454,373	1,909,062	1,827,905	96%	100%
Halton	4,141,668	345,139	4,141,668	690,278	511,618	74%	100%
Knowsley	5,473,342	456,112	5,473,342	912,224	806,136	88%	100%
Liverpool	18,134,171	1,511,181	18,134,171	3,022,362	1,633,789	54%	100%
Sefton	8,718,525	726,544	8,718,525	1,453,088	616,702	42%	100%
St Helens	6,445,779	537,148	6,445,779	1,074,296	768,482	72%	100%
Warrington	6,490,264	540,855	6,490,264	1,081,711	748,323	69%	100%
Wirral	10,771,198	897,600	10,771,198	1,795,200	1,485,454	83%	100%
Total	**83,682,123**	**6,973,510**	**83,682,123**	**13,947,020**	**10,366,785**		

11. Recommendations

The Primary Care Committee is asked to:

11.1 Note the preliminary combined financial summary position outlined in the financial report as at 31st May 2026.

11.2 Note the Additional Roles spend.

12. Officer contact details for more information

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NHS
Cheshire and Merseyside

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

Primary Care Action Plan

Agenda Item No:09

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

Compassionate Inclusive Working Together Accountable

Leading integration through collaboration

1. Purpose of the Report

1.1 The purpose of the report is to:

(i) Present the draft primary care action plan (PCAP), which is a requirement of the medium-term planning framework. The plan covers all four primary care contractor groups and has been completed in line with the national template, and following meetings with NHS England regional colleagues. The plan was required to go through the ICB Board prior to submission to NHS England at the end of May.

(ii) Outline the future oversight and assurance arrangements for this plan, and highlight any additional feedback received that will need to be added (following the plan being taken through board and NHS England moderation)

2. Executive Summary

2.1 As part of the medium-term planning framework, ICBs were asked to complete a primary care action plan covering a three-to-five-year period, with a detailed Year 1 plan for 2026/27 – the action plan is attached to this paper as an Appendix (noting some areas have been abridged/summarised for this paper version and wider documents referred to have not been included).

2.2 The expectation for ICBs is that plans focus on practical, deliverable actions and draw on evidence-based approaches and proven best practice to improve access and outcomes. All PCAPs had to be submitted to NHS England by 27 May, following prior consideration by ICB Boards. The plans can be further developed and amended during the year and will be subject to ongoing NHS England monitoring.

2.3 An initial feedback meeting was held with NHS England before the draft was submitted to the Board. It was noted that, due to the ICB's ongoing reorganisation, some areas, timescales and governance arrangements would need to be clarified further as the ICB operating model develops.

2.4 The following areas are highlighted to the committee and reflect some of the national prompts within the template provided. Each area includes a series of supporting actions, metrics where available, and implementation timescales. Where existing agreed plans already cover relevant areas, these have been referenced in the return, for example the Population Health Improvement Plan and the June 2025 Access Improvement/Variation Plan for General Practice.

Community Pharmacy

- **Addressing unwarranted variation for community pharmacy advanced services** – By the end of Q2 2026, the ICB will complete a system-wide mapping of Pharmacy First, Pharmacy Contraception Service and Hypertension Case-Finding activity identifying high/low performers and unwarranted variation. By Q3, agree targeted improvement plans with the bottom quartile of sites.
- **Further support/actions to support increased referrals to Pharmacy First** - Majority of pharmacies are delivering Pharmacy First and we will be working with NHS 111 to maximise clinically appropriate referrals.
- **Actions to support the introduction of independent prescribing into community pharmacies during 26/27 –** We plan to incorporate learning from the 7 pilot schemes and integrate Community Pharmacy Independent Prescribing into the ICB's Medicines Optimisation governance and NMP oversight framework. There will also be structured PCN-level engagement sessions, targeted communications to practice teams and implementation of referral prompts within online consultation platforms.
- **Emergency contraception and HPV vaccination -** By Q2 2026, complete an audit of ongoing contraception supply lengths across all participating community pharmacies, identifying the proportion of supplies issued for 3, 6, and 9–12 months. We will also develop and implement ICB-level support plan to encourage increased use of 9–12-month supplies where clinically appropriate. Collaborative working between primary care and S7A teams and identify HPV eligible cohorts and target groups; develop local comms and outreach (Q1–Q2).
- **Interface between general practice and community pharmacy -** from Q1 2026, conduct monthly variation audits to identify significant increases or decreases in Pharmacy First referrals at practice, PCN and provider level. We will work to ensure all GP practices have enabled GP Connect Update Record and Access Record functionality in line with contractual requirements.
- **Use of the NHS app** - engage all community pharmacies to enable NHS App prescription-tracking functionality, providing targeted technical support to sites not yet activated. Achieve 50% of pharmacies enabled by March 2026 (national requirement) and reach 80% enablement by Q4 2026.

General Practice

- **Support delivery of the same day urgent appointments ICB target** - Currently delivering an average of 75 per cent of urgent coded appointments seen same day with a target of 90 per cent by March 2027 – plan in progress to focus this which will form part of the revised June 2025 variation plan. This will include surge/winter capacity planning.
- **Addressing unwarranted variation and contractual compliance** – The ICB will build on and refresh the June 2025 variation plan during Q3 2026/27. Where improvement plans were agreed by individual commissioners, progress against these will be reviewed during Q3 2026/27, one year on from the original plan. This will support

understanding any difference made at practice level from the plan's targeted approach. The GP Patient Survey results are due shortly which will also support any findings.

- **Digital development including use of the NHS app**
  Current NHS App registrations are in line with other North West ICBs (69%) but remain below the national average (74%). Other indicators are broadly in line with national expectations. Additional digital metrics are being developed and will be included in the overall refresh of the plan and this remains a focus area for 26/27.
- **Wider system transformation including estates.**
  These areas are already reflected in estates plans and emerging neighbourhood health plans, but they will require further refinement and confirmation as the work progresses.
- **Capacity and demand management.**
  During Q2 and Q3, the ICB will put in place a demand and capacity analysis plan using cloud-based telephony and other available data and drawing from existing best practice across the ICB.

Optometry

- **Implementation of the Special Education Settings national specification** – this is currently out to procurement.

Dental

- **Capacity and demand actions to support access to urgent dental care** – The ICB will complete demand–capacity modelling for urgent and unscheduled dental care and implement redistribution of capacity to reduce unutilised appointments. Strengthen 111/IUC pathways by reviewing Directory of Services (DoS) accuracy, improving referral routing.
- **Implementation of the new national contract reforms** – the ICB have rolled out the requirement for all practices to offer urgent care to their patients and will encourage the uptake of funded annual appraisal and participation in the dental Quality Improvement programme.
- **Improving overall access to dentistry** – continued investment in local Routine Access scheme and Dental Neighbourhood Pilot alongside national contract reforms relating to urgent care. Maintain historically commissioned out of hours and in hours capacity and Dental Helpline.
- **Maximising spend within the dental ringfence** - implement targeted interventions to address variation, including flexible commissioning, additional access sessions, and targeted schemes for high-inequality areas. Robust contract management working with Local Dental Committee.
- **Implementation of dental checks for Special Education Settings** – the ICB will develop and implement a procurement strategy for dental checks for CYP SEND pupils in residential and day special educational settings during Q1–Q3

2.5 It should also be noted that not all areas and metrics listed are contractual for providers; all relate to areas the ICB is expected to deliver as part of the

planning guidance. Some areas the ICB may expand/add to as the plan develops.

3. Next Steps

3.1 The action plan will be refined in response to the board and regional feedback and managed through primary care operational structures, which are currently being finalised. Board feedback centred around metrics around looked after children and further clarification/alignment of the urgent care metrics. We are currently awaiting NHS England feedback.

3.2 An updated progress report by exception, with data, will return to this Committee as part of the wider performance and delivery element of the commissioning update.

3.3 The risks and mitigations/support section of the PCAP are not contained with this paper - but will be summarised as part of a revised additional risk on the committee risk register as part of the risks to the delivery of the plan.

3.4 The ICB will be moving to a single overall integrated commissioning plan for primary care in due course which will incorporate this action plan and current plans under review for access to dentistry and general practice.

4 Ask of the Board and Recommendations

The Committee is asked to;

(i) **Discuss and note** the draft Primary Care Action Plan and proposed reporting/next steps.

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

- Tackling Health Inequalities in outcomes, experience and access (all 8 Marmot Principles)
- Improve population health and healthcare.

6 Link to meeting CQC ICS Themes and Quality Statements

- Supporting to People to live healthier lives
- Safe and effective staffing
- Equity in access
- Equity in experience and outcomes
- Care provision, integration and continuity
- How staff, teams and services work together.

7 Risks

No risks are detailed in the paper appendices, but risks to delivery will be captured through the System Primary Care Committee risk register going forward.

8 Finance

No financial decisions are required for this paper, although some investment considerations are highlighted in the PCAP.

9 Communication and Engagement

Communication and engagement requirements are reflected within the relevant PCAP actions where needed.

10 Equality, Diversity and Inclusion

Equality, diversity and inclusion considerations will be addressed where individual actions require this as part of PCAP implementation.

11 Officer contact details for more information

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Appendix – Primary Care Action Plan

Dental

ICB	0			
Theme	**Prompts**	**Practical Actions (Scope, Scale, Schedule)**	**Expected outcomes (Dates, Milestones)**	**Measurement (national, local indicators)**
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 Dental Helpline/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	Complete demand–capacity modelling for urgent and unscheduled dental care and implement redistribution of capacity to reduce unutilised appointments (Q1–Q2). • Strengthen 111/IUC pathways by reviewing Directory of Services (DoS) accuracy, improving referral routing, and implementing monthly quality checks (Q1–Q4). • Deliver targeted communications to improve public awareness of urgent dental access routes, including local campaigns and updates to NHS.uk (Q2–Q4). • Ensure comprehensive out-of-hours urgent dental provision through contract review, escalation of gaps, and commissioning of additional sessions where required (Q1–Q4). • Establish a monitoring framework for mandated urgent care capacity, including compliance checks, escalation routes, and breach notices where non-compliance is identified (Q1 onwards). • Implement a quarterly review process for flexibility in mandated unscheduled care proportions, ensuring adjustments reflect local need and inequalities (Q2–Q4).	Demand–capacity plan completed by end of Q2. • Improved utilisation of urgent dental appointments by Q4. • Full compliance with mandated urgent care capacity by Q4.	Utilisation rate of urgent dental appointments. • Dental Helpline referral conversion rates. • OOH session delivery vs commissioned levels. • Compliance with mandated urgent care capacity.

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	Strengthen collaborative working across commissioning teams to reduce duplication, streamline processes, and improve contract oversight (Q1–Q4). • Maintain focus on dental workforce development, including recruitment incentives, Golden Hello utilisation, and engagement with training providers (Q1–Q4). • Implement monthly financial monitoring to ensure full utilisation of the ring-fence and early identification of slippage (ongoing). Identify at Mid Year reviews practice performance and issuing of rectification plans if required. LPN to support practices in contract delivery. Build on existing network of practices that are able to take on additional UDAs.	Improved efficiency and reduced duplication across teams by Q3. • Increased uptake of recruitment incentives by Q4. • Full utilisation of the dental ring-fence by year-end.	- Monthly Golden Hello reporting. - Workforce vacancy rates. - Ring-fence utilisation percentage. Mid year UDA delivery and review process

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 - Provide support where required to establish peer groups for dental providers participating in QI and align these to local clinical leadership	Provide implementation support through webinars, guidance packs, and direct engagement with providers (Q2-Q4) Promote uptake of funded annual appraisal and participation in the dental QI programme (Q1–Q4). Establish peer groups for QI participants and align these with local clinical leadership structures (Q2–Q4).	100% of contract variations issued and signed by end of April Increased provider participation in QI and appraisal programmes. Peer groups established and operational by Q3	% contract variations signed. QI programme participation rates. Number of active peer groups.

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.	Use national datasets and local intelligence to identify unwarranted variation in access, recall intervals, UDA delivery, and patient experience (Q1–Q2). Implement targeted interventions to address variation, including flexible commissioning, additional access sessions, and targeted schemes for high-inequality areas (Q2–Q4). Work with providers to reduce inequalities in access for vulnerable groups, including those with low attendance or long recall intervals (Q2–Q4). Develop Local Dental Improvement Plan with focus on needs led acess to routine and urgent care. Align to ICB Commissioning Strategy and Population Health Plan. Review of Dental CDS with a view to shifting some activity to primary care /shared care. Evaluaiton of Dental Neighbourhood pilot and development of commmissioing intentions aligned to Neighbourhood Health Service developments in C+M.	Reduction in unwarranted variation by Q4. Improved access in high-inequality areas. Increased delivery of targeted access sessions.	Nationally provided QI datapacks will provide insights on variation in NICE recall. Local access metrics UDA delivery vs contracted levels. Adult and Child access levels

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.	Develop and implement a procurement strategy for dental checks for CYP SEND pupils in residential and day special educational settings (Q1–Q3). Engage with local authorities, schools, and providers to design a service model that meets statutory and safeguarding requirements (Q1–Q2). Commission providers with appropriate skills and capacity to deliver on-site dental checks (Q2–Q4). Establish monitoring and reporting mechanisms to track delivery and outcomes (Q3–Q4).	Procurement strategy completed by Q2. Contracts awarded by Q3. Service delivery commenced by Q4.	ICB returns via regions on progress to date - Number of CYP SEND pupils receiving dental checks. - Provider compliance with service specification

General Practice

ICB Theme	Prompts	Practical Actions (Scope, Scale, Schedule)	Expected outcomes (Dates, Milestones)	Measurement (national, local indicators, as applicable)
(1) Front door access, navigation & demand management (ending the 8am scramble)	**(a) Same day appointments for clinically urgent patients** in General Practice, including achievement of 90% ambition.	Continue to promote and support practices developing under modern general practice, including learning from PLS . Individual practice variation will be underpinned by the variation approach listed below. Further use and promotion of MGP assessment tool to support effective MGP models Using CBT data to understand patient flows and demand in line with contract ask and establishing a framework for this (also referenced below) Adding same-day appointment urgent requirements and reporting / monitoring to existing frameworks: Ensuring that all patients identified as clinically urgent receive an appointment on the same day,in line with the 2026/27 GP Contract and MTPFT. Utilisiing national category appointment slots: Supporting Practices to use national category appointment slots and the approach to measuring to support delivery of the ICB target Improving access to GP appointments overall as part of the June 2025 plan refresh: Investing in access-related support: exploring how existing funding steams can further support access-improvement a Further refine/develop a single set of performance measures to ensure equitable and safe access to general practice as part of June 2025 plan refresh and new ICB model Digital systems: supporting use of digital systems for GP appointment booking, such as online request systems, to ensure fairer access and quicker resolution of requests.	Achievement of 90 per cent of urgent appointments seen same day by March 2027. Improvements in key patient experience metrics via GP Patient Survey and ONS survey in relation to same day/appointments when required and overall experience	% of clinically urgent appointments seen on the same day (GPAD) (90 per cent by March 2027) Patient Experience - Ease of access (Health Insight Survey) (tracked, system level only) - continued improvement Patient Experience - National GP Patient Survey - access related / relevant questions (practice level) - continued improvement NHS111 data (via GP Dashboard as part of outlier work) - variation actions in June 2025 plan and 3(c) Data to understand operational capacity pressures in general practice fed into system-wide oversight arrangements approach/ measurements tbc as part of that work in section 1 (b) Data on the ICBs BIP
	(b) Supporting practices' understanding of demand/capacity optimisation. This should include further embedding of **modern general practice** and **population health management/risk stratification.**	The ICB will add/develop and approach to understanding and monitoring demand and capacity to support the new contract asks - *We will amend the GP Contract Regulations to align with existing cloud based telephony (CBT) requirements and to require practices to provide timely data and information related to online and video consultation services, enabling consistent monitoring of access, patient experience and system performance.* *This approach will include* using CBT dashboard to support demand/capacity analysis through an enhanced framework and ICB's BIP pulling through some levels of data from the national dashboard (work underway) ICB to support asks in relation to risk stratification in the PCN DES Continuity of care (risk-stratified cohorts) in preparation for contract changes to follow and to underpin/link to ongoing wider work in Neighbourhood Health/use of risk stratification tools, approach to be developed consistently as the ICB new operating model is finalised *We will make it a core requirement for PCNs to identify and prioritise cohorts for continuity of care using risk stratification tools as part of their core activities. This will make continuity a core expectation within primary care and support future work to embed more meaningful continuity models in subsequent contract reform.*	CBT capacity and demand using dashboard and other data approach agreed by mid Q2 26/27 to System Primary Care Committee in 08/26 - as part of this the ICB will develop an addition to the June 2025 plan developing a practice support overview for practices where demand/capacity variation is excessive, as part of the section (3) below Risk strat - ongoing ICB monitoring of PCN DES actions that underpin this area - ensure aligned to NH approaches and aims Q2 26/27 reported through as part of new ICB governance arrangements and linked to PHIP	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 (via GP Dashboard as part of outlier work) General - GPAD any additional Data to understand operational capacity pressures in general practice fed into system-wide oversight arrangements and support new contract asks approach tbc Cross reference to NH targets in terms of frailty, ltc and other areas outlined below / and PHIP
	(c) Resilience, 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	Pulling into the overall planning all primary care related capacity including out of hours and any additional surge planned areas timescales tbc Ensuring maximisation and usage of Enhanced Access contractual asks. Winter planning process/plans tbc Explore use of SDF to support winter resilience Use outputs from 1(b) above to support decisions on areas for action and to support any further variation work section 3 below Agreement for SDF use to support winter resilience	Surge and capacity planning actions as part of overall winter and surge plans - timescales tbc as part of winter planning SDF discussion at Execs/ agreement May 2026 and implementation /agreement of plans tbc	% of clinically urgent appointments seen on the same day (GPAD) Cloud Based Telephony Dataset - Calls, Abandoned, Callback per 1,000 pop - time of call and length of call (as part of demand and capacity approach) Analysis on walk ins NHS111 data (via GP Dashboard as part of outlier work) Data to understand operational capacity pressures in general practice fed into system-wide oversight arrangements approach tbc Enhanced access dashboard/usage Local indicators tbc
	(d) Monitoring, reporting and response of system pressures for general practice. This could include use of tools such as Operational Pressures Escalation Levels (OPEL) framework	The ICB is continuing with its current escalation approach but during Q2 26/27 this will be streamlined in line with the new structure and governance. DOS reporting and escalation process will be aligned. Adaptation and consideration of existing approaches will inform any new process, in discussion with LMCs. SDF support for practices re resilience discussion at Execs May 26 with timescales to follow	Any revised single approach in place by commence Q3 26/27	Will be developed and confirmed as part of revised approach
(2) Clinical capacity	(i) Promote recruitment of GPs or fund additional sessions through **Capacity and Access Payment reimbursement scheme** *and* (ii)Promote recruitment of GPs and other roles through **additional roles reimbursement scheme**.	Ongoing commissioning support for practices to maximise recruitment of additional GPs including targeted work with areas where recruitment is an issue/where highlighted as an outlier on the GPD as part of variation approach 3 (c) below Identify any funding for further support/resilience in this area Referral/support for targeted work in line with our approach to variation and support (below) Supportive measures such as awarness/follow up re accurate workforce returns submitted by PCNs for baseline assessments/improvement Ensuring aligned workforce plans/approaches are aligned across Neighhbourhood health deliverables and outcomes Promotion and maximisation of schemes such as national retention scheme and offers via the training hub A gap in this area is workforce planning and modelling which will need to be addressed in year tbc	Additional GPs TBC in target areas (local/individual target) as part of variation work Ongoing support and promotion of options for recruiting additional GPs (ongoing) ICB overall workforce planning approach (tbc) in line with new ICB operating model Process in place re caprs (tbc once further details are confirmed)	Fully qualified GPs (FTE) increase GPs recruited through Additional Roles Reimbursement Scheme (ARRS) and new national reimbursement scheme increase Overall GP WTE increase GPD workforce / access domains - outliers - in particular GP patient ratio - reduced as outlier overall in GPS where unwarranted Finance - amounts reimbursed/claimed under ARRS/caprs Individual practice measurements as part of variation actions plans as part of section 3 below (Target/measurement will be specific to the individual practice or PCN) General Practice staffing/numbers and expectations in NH workforce plans/modelling tbc Links to trainee targets and numbers through regional workforce tbc Number of GP retainer applications approved (NHS England approve)
(3) Unwarranted variation in access in different parts of the country	**(a) 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. **(b)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. reference gp to patient list ratio	The ICB has an approach in place previously outlined to NHSE in the June 2025 plan for contract oversight and management - this included data sets, escalation and support - specific new actions will centre around (see below for further information) -Refreshed clear single monitoring framework (already in place but will be refreshed as part of new operating model) -Governance review of decision making across ICB in progress but existing governance outlined in June 2025 plan is still in place (oversight and SPCC , Place level decision making forums) - Refreshed Intervention approach is still in place in line with June 2025 plan using basis of escalation approach outlined and shared by NHSE for contractual issues (for OLC) but contract compliance and intervention process review is underway as part of ICB operating model work/review For variation approach see variation box below (and June 2025 plan submitted)	Initial update re new contract changes to SPCC in April/onward communications and awareness (complete) Review plan as part of PCAP to return to SPCC June/onwards Use of dashboard/BIP to understand use of areas such as OLCs etc already in place and ongoing Refreshed single operating model in place timescales (noting existing June 2025 plan arrangements remain at present) TBC	Contract compliance in key areas 100 % Annual Edeclaration follow up 100% compliance reported General Practice Dashboard - areas that support contract compliance - reduction in outlier areas Health Insights Survey - questions around mode of access i increased positive scoring over during 26/27 ICB BIP dashboard - areas that support contract compliance General Practice Patient Survey - questions around mode of access - improvement year on year GPAD - on line consultations/balance of consultation's NHS111 calls in hours (GPD) reduction MGPAT - diagnostic tool outputs flagged by practices Same Day Urgent metric as outlined in 1(a) above

	(c) Use datasets and local intelligence to identify and address unwarranted variation and track practice progress. This should include the General Practice Dashboard and patient feedback from You and Your GP Practice.	**A plan for this already exists signed off by NHS England and System Primary Care Committee** - the ask is to further expand and review the June 2025 access improvement/ variation plan submitted to NHS England re variation which articulates a data driven/patient experience approach. This previously agreed approach includes data at a *system level* that is used to measure overall progress, but at a *practice level* there may be an individual set agreed to track progress over time on key areas to assess improvements in access. Support implementation of the contract asks *To support practices where unwarranted variation has been identified in contractor performance, we will require them to engage with support from their integrated care board (ICB).* Refreshed variation list in line with June 2025 plan refresh - Level 1 - outliers identified and agreed as unwarranted variation including practices identified not through data but resilience issues or where demand exceed capacity through identified process, for additional support/intervention Level 2 - practices as not requiring immediate intervention/support but ongoing watch Actions to measure/assess impact of practices identified in 25.26 to see improvements/outcomes The ICB will have additional practices added to this approach for capacity/demand support (1b) above An approach to variation in *quality and other performance data sets* will need to be agreed/confirmed - further work is also required to *map access/variation in deprived areas* - this is something we have also discussed as part of the national feedback on the GPD	Revision/Refresh of June 2025 plan by end Q1 26/27 Assessment of 12 months of intervention for practices assessed as outliers in June 25 end Q2 26/27 (noting GPD data sets have changed over the year) PCAP plan to SPCC System Primary Care Committee in June 2026 with initial data set Agreement on /final June 2025 Plan/new single sets of data for local performance at SPCC August 26 (this will include quality and other performance data sets) Refreshed single outlier / variation list from August 26 Feedback via You and Your GP is set up already to feed into our existing PALs process www.cheshireandmerseyside.nhs.uk/contact/complaints/you-and-your-gp-charter/ Reduction in overall number of practices identified as outliers (pre refresh) remains under review and ongoing	Please also refer to data sets and approaches outlined in the June 2025 plan, including Core base indicators - All GPD Indicators - Practices that are overall outliers in each domain will be worked through , supplemented by additional information from local data sets (tbc) and intelligence. GPD - GP/patient ratio practices - a particular focus on this area during 26/27 in line with NHSE enquiry - noting initial enquiries point to multiple factors which led to potential outlier practices being identified so will need additional analysis, in line with the June 2025 plan approach % of clinically urgent appointments seen on the same day (GPAD) Patient Experience - 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 (via GP Dashboard as part of outlier work) General - GPAD Patient Experience - GP Patient Survey Data to understand operational capacity pressures in general practice fed into system-wide oversight arrangements approach tbc Number of practices identified as outliers in the GPD overall changes over time for named practices identified Deprivation/access correlation and measurement tracking
	(d) 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.	Continue to promote the MGPAT for practices to determine support needs. Identify funding for any practice level support provision/working with training hub in relation to any other support available Continue to identify practices for support as part of the June 2025 plan variation work approach , with support targeted at the most challenged in terms of data and where capacity/demand variation is excessive tbc as part of 1(c) above Support/intervention approach remains as outlined in the June 2025 plan but is under review as part of model ICB blueprint Agree PLS support offer (If applicable) Agree any funding allocation for support	Agree any SDF funding support by Q2 26/27 Agree practices for any additional funded support by mid Q2 26/27	Number of practices identified as requiring support using variation data approach Number of practices self completed MGPAT Number of practices accessing PLS (TBC dependant on funding) Improvements detailed in individual practice plans tbc - note this is a continuation of existing approach Overall reduction in practices classed as outliers on the GPD /practices identified for support reduction in number of variation areas in GPD
	(e) Support general practice to 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.	**individual actions are detailed in the ICBs population health improvement plan** www.cheshireandmerseyside.nhs.uk/media/ac3j34h3/cm-population-health-improvement-plan-board-final.pdf. Examples include -Cancer: Early detection, screening, and referral. -CVD: Identification and management of risk factors. -Diabetes: Prevention, annual reviews, and structured education. -Respiratory: Annual reviews, vaccination, and smoking cessation. -Mental Health, Neurodiversity, Learning Disability & Autism: Early identification, shared care, and ongoing support. -Women's Health: Early diagnosis and management in community settings. In addition further specific asks will fall out of the **Enhanced Services review** with new specifications being developed during 26/27 and in place from 1.4.27 **Emerging Neighbourhood Health plans** would cover the asks for LTCs outlined in the Neighbourhood Health framework with further dates/details and deliverables cross referenced as part of this Maximisation of QOF and PCN DES related areas to support delivery of improved care for those patients	Individual milestones for specific areas are outlined in the ICBs population health improvement plan with dates and actions developed from those Current timeline - Enhanced Services review new' contract arrangements in place from 1.4.2027 Targets/achievements in NH documented as part of the ICB NH plan and timelines contained therein,	Some To be developed as part of enhanced services review Individual LTS areas measurements detailed in population health improvement plan 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 ICB targets and measurements as outlined in the Population Health Improvement plan which covers 3 year trajectory (cross reference) Growth in appointments and access within 2 weeks. Reduction in emergency admissions and waiting times. Improvement in continuity and patient experience measures. Other national targets and measurements outlined in the Neighbourhood Health framework (cross reference) Modern Service Frameworks will specify further metrics for cardiovascular disease and mental health in due course QOF targets maximisation improvement/realisation linked to specific conditions/areas
(4) Digital development and reform	(a) 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; - Use of **NHS Notify**, and use NHS App 'push' notifications	**Implement and optimise GPiT and digital tools** 1. Continue with rollout for digital triage, online consultations etc 2. Embed demand & capacity optimisation and population health / risk stratification tools 3. Improve data quality and integration across GPAD, telephony and online consultation datasets **Ambient Voice Technology (AVT)** 1. Pilot AVT in selected practices as part of C&M system wide AVT pilot 2. Complete generic DPIA/IG and clinical safety case with Practices responsible for adapting for local use; agree patient information/consent approach 3. Train clinicians and agree documentation standards 4 Evaluate impact (admin time, quality, staff experience) and assess affordability 5 Scale-up subject to evaluation, business case and governance approval **NHS App** 1. Maximise and promote the NHS App as the main digital front door to primary care (record access, health info, booking and messaging) 2. Support practices to enable appointment booking in line with the 95% target, with guidance and support from Digital Partners 3. Promote NHS App push notifications as the primary method of contacting patients (aligned to SMS optimisation/fragment capping) 4. Run local campaigns to encourage patients to enable notifications and use app features **NHS Notify** 1. Implement limit of ICB funded SMS fragments to 20 per registered patient per year. 2. Continue with training and awareness sessions for practices to support them to transition to the use of NHS App notifications and / or email as the primary methods of communicating with patients. 3. Provide practices with access to reports showing their current SMS and NHS notify usage on a quarterly basis 4. Continue with Digital inclusion work to enable patients to transition to digital communication methods should they wish / be able to do so	Improved takeup of digital tools for online consultation, booking and patient communication By end of 2026/27: demonstrable reduction in clinician admin burden and improved quality/consistency of consultation notes Improved clinician experience and increased patient-facing time No increase in clinical safety incidents attributable to AVT Increase in NHS App messages sent and read Increase the % of notifications enabled for the NHS App Decrease in SMS costs More appointment bookings completed through the NHS App Reduction in the use of SMS and associated costs Increase in NHS App messages sent and read Increase the % of notifications enabled for the NHS App Increased contact with practices via the NHS App and other digital communication methods	Cloud-based telephony dataset: calls, abandoned calls, queue/callback rates per 1,000 pop and by time of day Online consultation activity per 1,000 pop and response times % practices meeting agreed digital maturity baseline Demand/capacity tool adoption and reporting completeness Training completion rates for agreed digital workflows Number of practices live with AVT % clinicians trained and active users Indicative admin time saved per consultation (local evaluation) Quality audit of consultation documentation Clinical safety / incident reporting related to AVT Continue current NHS App usage reports, including appointment booking data Number of practices with booking enabled and being used % of patients with notifications enabled (where available) SMS volume/cost trend alongside App messaging volumes % of direct-to-patient communications sent via NHS Notify (vs legacy) Volume of messages by channel (Notify / SMS / email) and by service Delivery success rate, failure rate and time-to-deliver % communications using NHS App push notifications (where available) SMS spend

(5)System and broader transformation	(a) 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.	**Overall engagement of people and communities** is being worked through as part of Neighbourhood Health plans which include primary care service - and as part of the development of NH plans for approval at HWBB during 27/28. NHSE has already received updates in relation to this area. Plans will set out any further engagement with neighbourhood partners linking in coproduction and reducing health inequalities. PHIP sets out a framework for working with communities in key areas (link above in 3(e) **Estates** Development of Place Capital Pipelines - June 2026 Expansion of Core, Flex and Tail classifications into the Non Public Sector i.e Local Authority, VCSE etc - July 2026 Neighbourhood Health Centre System Plan - June 2026 Increased investment into Data/occupancy monitoring within Core Premises- July 2026 4 Year Capital Return for Strategic Primary Care Capital and Utilisation and Modernisation fund - April 2026 Commissioning Intentions 5 Year Framework (ICB) - March 2026 Development of disposal pipelines for not fit for purpose Estate and enahnced utilisation of Core premises - June 2026 **Staffing alignment to neighbourhood development** will also be set out in emerging plans as above, NHSE have details of current status of this via recent returns/status updates, with more detailed information from pioneer sites **Investment and resourcing** - the ICB is currently approaches to budgets and resources to this as part of the NH plans and the new ICB operating model, but the main areas for focus as outlined above are non core enhanced services spend for general practice, and allocation of SDF for 26/27.	Emerging NH Plans timetable tbc for 26/27 as part of NH response/reporting - ICB meeting 11th May to discuss Estates Identification of cohort of Neighbourhood Health Centres that are 'ready' to go live - June 26 Identification of cohort of Neighbourhood Health Centres that require investment or development - June 26 Enhanced prioritisation and assessment framework for Capital linked to critical success factors and system priorities - July 26 Enhanced One Public Estate approach to planning and strategic estates development - July 26 Establishing Combined Authority One Pulbic Estate Forums - September 2026 Estates Operating Model/Principles agreed by the Board - July 2026 SDF agreement / spend by end of May 2026	Measurements tbc as part of NH planning **Estates** Utilisation Rate: % of bookable and demised rooms used >60% of the time Occupancy Rates: % of total space actively used or booked Patient Access: Number of patients contact per month Service Integration: Number of co-located services aligned with the Neighbourhood Health Model Reduction in Negative Variation in access across the system, evidenced based review through General Practice Dashboard

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Theme	**Prompts**	**Practical Actions (Scope, Scale, Schedule)**	**Expected outcomes (Dates, Milestones)**	**Measurement (national, local indicators)**
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.	ICB executive agreement for the procurement confirmed - December 2025 and then System Primary Care Committee December 2025 The procurement is in collaboration with the other two NW ICBS with NECs	Key milestones and timescales for the provider selection process Procurement progressing currently	The service will be delivered in line with the national specification issued by NHS England and metrics associated

Pharmacy

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Theme	**Prompts**	**Practical Actions (Scope, Scale, Schedule)**	**Expected outcomes (Dates, Milestones)**	**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	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	**Reduce Unwarranted Variation -** By the end of Q2 2026, complete a system-wide mapping of Pharmacy First, Pharmacy Contraception Service and Hypertension Case-Finding activity across all community pharmacies, identifying high/low performers and unwarranted variation. By Q3, agree targeted improvement plans with the bottom quartile of sites. **Improve Data Quality -** From Q2 2026, implement a monthly data quality review cycle with LPC and contractors, producing a standardised report on missing/incorrect data fields for PF, PCS and HCFS. Achieve a 20% reduction in data quality errors by Q4 2026. **Improve PF Utilisation Rates Through NHS111 -** By Q2 2026, work with NWAS and DoS leads to review and update NHS111 algorithms to maximise clinically appropriate Pharmacy First referrals. ICB comms stragety to include promotion of Pharmacy First availability and work with Primary Care Forum/ LPCs LPN to promote services. From Q1–Q4 2026, monitor PF rejection data monthly and reduce inappropriate rejections by 15% by year-end. By Q4 2026, increase NHS111-initiated PF consultations by 10% through targeted engagement with IUC providers and GP practices. Ensure PF **Reduce Urgent Repeat Medicines (URM) Activity -** By Q2 2026, complete a structured review of URM activity to identify high-volume practices/pharmacies and the main drivers of inappropriate use. By Q3 2026, implement a joint GP–pharmacy communication plan (including the Interface Principle) and deliver patient-facing campaigns before each bank holiday. Reduce URM consultations as a proportion of PF activity by 10% by Q4 2026. **Monitor Antimicrobial Supplies - F**rom Q2 2026, produce a quarterly report on antimicrobial supplies issued under PF, identifying outlier pharmacies and conditions. By Q3 2026, implement targeted interventions for the top 10% of outlier sites and monitor impact through subsequent quarterly reports. **Improve ABPM Conversion Rates (HCFS Quality) -** From Q1 2026, monitor ABPM conversion rates monthly and identify pharmacies with conversion rates below the regional median. By Q3 2026, implement tailored improvement plans for all outlier sites. Increase overall ABPM conversion rates by 15% by Q4 2026.	**Reduce Unwarranted variation** TBC based on natonal dta stes and measurs. monitor refused referrals as immediate baseline fot potential capacity issues. **Improve Data quality** Reduction in PF consultations claimed outside specification by Q4. **Improve PF Utilisation rates through 111** PF minor illness referrals to community pharmacies increase Rejections of PF referrals by community pharmacies reduce **Reduce Urgent Meds** Reduction in URM claims as % of total PF consultations by Q4. **Monitor Antimicrobial Suppli**es Number of outliers identified reduces **Improve ABPM conversion** Increase in ABPM:clinic check ratio by Q4	Producing a plan for identifying capacity issues and addressing them locally PF - % of total consultations claimed outside of service specification + monitoring and management of claims relating to CD's supplied through the URM pathway) PCS - as per PF 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	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.	**GP Connect Update & Access Record -** By the end of Q2 2026, ensure 100% of GP practices have enabled GP Connect Update Record and Access Record functionality in line with contractual requirements. Provide targeted technical support to practices not yet compliant and publish a monthly compliance dashboard to monitor activation status and data-sharing performance. **Improve GP Referrals to PF** From Q1–Q4 2026, increase GP referrals into Pharmacy First by at least 15% through: • structured PCN-level engagement sessions, • implementation of referral prompts within online consultation platforms, and • targeted communications to practice teams. Monitor referral volumes monthly and provide feedback to PCNs on performance against baseline. **Identify & Investigate significant changes in referrals -** From Q1 2026, conduct monthly variation audits to identify significant increases or decreases in Pharmacy First referrals at practice, PCN and provider level. Investigate all changes greater than ±20% from baseline, including analysis of online consultation tool usage, and agree corrective actions with relevant practices within four weeks of identification.	GP Connect Update & Access Record 90% GP Connect enabled by Q2. Increased GP referral numbers by Q4. Improve GP Referrals to PF % rejected referrals from GP reduces Referrals from low/zero practices improves Identify & Investigate significant changes in referrals Occurrence of significant changes in referral numbers reduces, number of practices contacted regarding this matter reduces	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+A6:H6	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.	**Incorporate IP into existing MO governance & audit -** By the end of Q1 2026, establish a task-and-finish group to oversee the integration of Community Pharmacy Independent Prescribing into the ICB's Medicines Optimisation governance and NMP oversight framework. From Q2–Q4 2026, incorporate learning from the IP Pathfinder Programme into routine governance processes, including quarterly audits of prescribing activity outside scope or competence. Ensure Community Pharmacy IP is formally included in the 2026/27 MO governance work programme and associated assurance cycles. **Identify & review IP Rx inc formulary adherence, AMR, opioids -** By Q2 2026, develop and approve an ICB-wide plan for provider-led audits of Community Pharmacy IP prescribing against the local formulary, including targeted audits on antimicrobial stewardship and opioid prescribing. From Q3–Q4 2026, implement the audit programme and provide feedback to all participating contractors. For any contractor whose prescribing falls outside expected parameters, ensure an action plan is developed within 6 weeks and monitored through quarterly MO governance meetings.	**Incorporate IP into existing MO governance & audit** NMP governance and oversight includes CP IP **Identify & review IP Rx inc formulary adherence, AMR, opioids** Compliance to formulary improves from baseline >90% supplies made in line with formulary Quarterly IP prescribing report produced.	Reported as a % of CP's registered to deliver NHSE community pharmacy services includign IP services IP led 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	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.	**Plan to increase length of ongoing supplies made -** By Q2 2026, complete an audit of ongoing contraception supply lengths across all participating community pharmacies, identifying the proportion of supplies issued for 3, 6, and 9–12 months. By Q3 2026, develop and implement an ICB-level support plan (education, clinical updates, case studies, and feedback reports) to encourage increased use of 9–12-month supplies where clinically appropriate, recognising that final supply length remains a pharmacist-led clinical decision. Monitor changes in supply patterns quarterly through 2026/27. **Monitor conversion from EHC supply to OC initiation -** Subject to NHS England data availability, establish a data flow by Q2 2026 to monitor the proportion of patients receiving EHC who subsequently initiate ongoing contraception within community pharmacy. From Q2–Q4 2026, produce quarterly reports identifying conversion rates and variation between providers. Where conversion rates are low, work with contractors to co-design follow-up pathways (e.g., proactive signposting, appointment booking prompts) to support improved uptake of longer-term contraception options.	**Plan to increase length of ongoing supplies made** TBC dependent upon type and detail of data provided by NHSE to support this prompt **Monitor conversion from EHC supply to OC initiation** TBC dependent upon type and detail of data provided by NHSE to support this prompt	Report that describes the number of ongoing supplies made for a period of 9-12 months as a percentage of all ongoing supplies made EC → ongoing contraception conversion rate.
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.	From Q1–Q4 2026, work with all acute and community Trusts to increase DMS referrals by: • delivering quarterly training sessions for ward, pharmacy and discharge teams, • implementing referral prompts within electronic discharge systems, and • monitoring referral volumes monthly against Trust-level baselines. Aim to achieve a 15% increase in DMS referrals by Q4 2026. By Q2 2026, develop and implement Trust-level DMS dashboards showing referral volumes, conversion rates, and ward-level variation. Provide monthly feedback to Trust DMS leads and incorporate findings into quarterly stakeholder meetings. By Q3 2026, identify the bottom quartile of Trusts for DMS referral rates and work with them to expand the patient cohorts included in DMS (e.g., high-risk medicines, polypharmacy, frailty). Agree improvement plans with each Trust and monitor progress monthly. From Q2 2026, use DMS referral and completion data to identify practices with high levels of post-discharge discrepancies. Work with PCNs and practices to implement targeted improvements in medicines reconciliation processes, and monitor impact quarterly through reductions in discrepancies and follow-up queries. Produce a monthly ICB-wide DMS performance report covering referrals, completions, variation and outcomes. Hold quarterly DMS stakeholder meetings with all Trusts to review performance, share learning, and agree improvement actions.	Lowest referring Trusts identified Referral rates in lowest referring trusts improves Trust DMS referral numbers per 1000 discharges	Trust DMS referral numbers per 1000 discharges

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.	By Q2 2026, align ICB community pharmacy digital plans with the Cheshire & Merseyside primary care communications strategy to promote patient-led repeat ordering via the NHS App. From Q2–Q4 2026, deliver coordinated messaging across GP practices, PCNs and community pharmacies to increase patient uptake. Aim to increase the proportion of repeat prescriptions ordered via the NHS App by 20% by the end of 2026/27.	TBC Increase in adoption of used based on % of community pharmacies enabled by March 2026. Quarterly progress reports..	Reported as number of community pharmacy sites (and percentage of total estate) with prescription tracking functionality enabled.

NHS
Cheshire and Merseyside

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

Primary Care Commissioning Update

Agenda Item No: 10

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

1. Purpose of the Report

The Primary Care Policy and Contracting Update provides the Committee with information and assurance in respect of key national policy areas and commissioning/performance updates for all four primary care contractor groups.

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 Updates

3.1 **Completion of self declaration for primary care for 25/26 -** In accordance with the NHS Oversight Framework, NHS England remains accountable for those services it has delegated responsibility for the commissioning of, to ICBs. These include all primary care services and the handling of associated complaints. As part of this ICBs are asked to complete an annual self-declaration. The purpose of the self-declaration is to provide assurance that ICBs have the necessary processes and mechanisms in place to meet core commissioning and contracting standards, The self-declaration for 25/26 was requested by NHS England in May and is attached in **Appendix 1** for the committee's awareness.

3.2 **Performance measures –** at the last committee meeting it was requested that the commissioning update contains key performance metrics on a regular basis. These would include those reported as part of the planning guidance reporting, for example, to Board – and those highlighted as potential metrics in the population health improvement plan moving forward. This should also include quality metrics/processes where available, noting arrangements for each contractor group differ depending on the national contracting arrangements. Those current metrics are given in **Appendix 2** noting some are under review / in progress where indicated. It should be highlighted that we are still awaiting the reporting metrics expected by NHS England that support primary care commissioning /delivery of the primary care action plan - which will need reflecting in our performance measures list.

4. Primary Medical Services Update

4.1 NHS England recently released a clarification document in relation to the 26/27 contract changes, to support the delivery of the asks NHS England » Supplementary information to support changes to the 2026/27 GP contract. This includes explaining details of claim eligibility under the new GP salaried entitlement process and further explanation of contract changes around modes of access and narrative around the single point of access.

4.2 NHS England announced the Introduction of local flexibilities to the PCN DES (Primary Care Network Directed Enhanced Service) NHS England » Primary Care Networks: Network Contract Directed Enhanced Service from May 2026. This allows greater

flexibility to vary arrangements to local circumstances where existing local contractual routes may not be sufficient. The changes could support ICBs that are developing neighbourhood services by utilising the Network Contract DES framework. These amendments are separate from the proposed Multi Neighbourhood Provider (MNP) and Single Neighbourhood Provider (SNP) Contracts, which will be subject to a separate national consultation. Any proposal under these local variations has to be agreed by NHS England.

Part B of the non-clinical guidance (network-contract-des-part-b-guidance-non-clinical-26-27-2.pdf) also sets out the considerations to be undertaken by commissioners when presented with requests from PCNs. Annex B of that document contains the clear criteria against which those requests are to be reviewed relating to:

- Eligibility - sufficient scale/participation to be viable, total investment, NHS England regional team awareness, evidence of engagement
- Scope- aims and intended outcomes, patient population covered, interaction with any in-year national DES changes, parity of access, assessment of health inequalities
- Readiness- plan for reverting to standard DES, feasible and deliverable model, workforce implications, complete, clear, and workable proposal for initial discussion with region prior to submission for consideration.

Considerations around these variations form part of future contract approaches for commissioned models.

4.3 **Primary/Secondary Care Interface (PSCI) –** The Wave 4 Interface self-assessment tool, which was expanded in August 2025 to include community and mental health providers, has been released. The interface remains a priority within the Neighbourhood Health Framework, to support regions and ICBs and strengthen the primary–secondary care interface. A maturity matrix, aligned with the Interface Trust Self Assessment Tool and the GIRFT (getting it right first time) bridging the interface checklist, was included to support self assessment and continuous improvement. The deadline for trusts to complete is 24th June.

4.4 **Primary Care Quality -** Primary Care escalation and quality processes remain in place across the ICB. The Primary Care Quality group met in June to bring together current issues and continued oversight. For medical there is currently a review of the quality indicators used to support monitoring underway. Part of the review work covers future governance for primary care quality. An update on complaints will also be presented at the next meeting. In addition the group has been updated on the sexual safety charter work and communications around this have been shared with providers.

4.5 **Digital** – Commissioning support unit functions - The ICB Service Transition Group who oversee the transition are planning for a transfer of services in September 2026, there is a weekly review of all risks and mitigation plans to ensure a target completion date on or before 31 December 2026. As part of the ongoing reviews of current digital technologies and to ensure alignment across the ICB there is a plan to review the current network provision during 26/27 to ensure they align with future Primary Care and agreed NHC estate requirements. As part of the recently approved ADHD

scheme, digital has been working with ICB commissioning team and IT partners to ensure there is provision of additional support during 26/27.

5.0 Optometry - General Ophthalmic Services (GOS)

5.1 Service provision remains consistent within Cheshire and Merseyside ICB with 216 mandatory service (high street) contractors and 73 additional service (domiciliary) contractors. 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 The Special Education Settings procurement progressed in line with governance and due process during May, working with the two north west ICBs. This remains an area of keyreporting assurance and update to NHS England.

6.0 Dental

6.1 The Dental Operations Group most recent meeting was held on 20 May 2026 and the following issues were highlighted:

- There have been 2 partnership composition requests since the last meeting. Paperwork now fully received, Contract variations to be sent and Compass updated.
- There were no quality issues for escalation to the Primary Care Quality Group
- 1 partnership to individual request. Paperwork completed, awaiting CQC sales and transfer letter before issuing the Contract Variation.
- A number of recurrent and non-recurrent UDA changes were noted. Issues cited by practices were primarily in relation to recruitment and retention challenges faced by practices.
- The group discussed and issue relating to a request for second course of NHS orthodontic treatment. Dental commissioning team have been working with specialist Orthodontist and ICB Complaints Team in this respect.
- A safeguarding referral has been made to the CQC regarding a dental practice. The commissioning team was made aware and has informed the ICB safeguarding team. At this stage following review commissioners are not required to take any actions.
- The group reviewed a force majure request from a practice that has been under performing.
- Commissioners agreed to instruct the BSA to rescind the remedial notices relating to non-submission of a national workforce return by a local provider.
- Commissioners have reviewed a number of subcontracting requests. The NHS England policy book states that commissioners should agree and no contract variation is required, however there should be updates to Compass to reflect any additional premises and performers involved in the delivery of the subcontracting.
- Commissioners reported that a provider has lodged an appeal having been served a Termination Notice. In accordance with the Regulations, the contract will not terminate until the outcome of the appeal is known.

- Commissioners are requesting to withhold payments from another practice who had been served with a Remedial Notice in May following lengthy legal advice. The practice has been closed without prior notice and is not delivering NHS services.
- The Dental Clinical Advisor reported they are dealing with complaints that evidence poor record keeping and issues with referrals.

7.0 Community Pharmacy

7.1 The Pharmacy Operations Group most recent meeting was held on 29 April 2026 and the following issues were highlighted:

- There were no quality issues for escalation to the Primary Care Quality Group
- A number of Community Pharmacy Assurance Framework visits have been completed as part of national process and requirements placed on ICBs under the delegation agreement. There are 4 outstanding visits and 11 have been completed.
- Visits are being arranged in line with national requirements under the Dispensary Services Quality Scheme (DSQS) a voluntary annual NHS scheme designed to reward dispensing GP practices for providing high-quality, professional services to their dispensing patients. It aligns clinical governance standards closely with the broader Community Pharmacy Contractual Framework (CPCF).
- Directed Rotas for August have been distributed in line with the plan. In May the team started planning for the Christmas rota.
- Enhanced Commissioned Services - 84 Pharmacies are signed up to provide a new Palliative Care service across Cheshire and Merseyside.
- Recoveries & Expenses for Pharmacy Quality Scheme 2025/26 were made from 25 pharmacy contractors who did not meet requirements.

7.2 A separate paper on the 26/27 Community Pharmacy contractual measures will be presented at the Committee.

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
Clare.Watson@cheshireandmerseyside.nhs.uk

Appendix 1

Annex 2. Annual self-declaration form

ICB Assurance Framework

Delegated Primary Care Functions - Self-certification

For each question, please rate your response following the key provided below. Full details of what assurance is required for each domain is set out in Table 1 of the Framework.

Red	Non-compliant
Amber	Compliant but some risks identified
Green	Fully compliant

ICB Name	Cheshire and Merseyside
Year to which certification applies	25/26

General		
	R/A/G Rating	**Comments**

Compliance with the Delegation Agreement Has the ICB complied with the terms and associated responsibilities and measures required to ensure the effective and efficient exercise of the Delegated Functions?	green	If Red or Amber, please provide further details
Governance structures Does the ICB have the appropriate governance structures for the delegated functions in place to enable the commissioning and delivery of high quality care	green	If Red or Amber, please provide further details
Pharmaceutical Services		
	R/A/G Rating	**Comments**
Compliance with mandated Guidance issued by NHS England		
Has the ICB understood and complied with all nationally set operating procedures and policies (e.g. the Pharmacy Manual)?	green	If Red or Amber, please provide further details
Service provision and planning		
Has the ICB been actively involved with all Pharmaceutical Needs Assessments (PNA) in their area, as undertaken by HWBs in year?	green	If Red or Amber, please provide further details
Has the ICB assured itself that there are no material gaps (as defined by the PNA) in pharmaceutical provision and has it taken action to address any gaps identified?	green	If Red or Amber, please provide further details
Can the ICB confirm that all payments made to community pharmacy contractors, dispensing appliance contractors and dispensing doctors are as outlined in the Drug Tariff, in line with usual NHSBSA custom and practice or are made within other formal contractual routes (e.g. LPS contracts or NHS Standard Contract)?	green	If Red or Amber, please provide further details
Can the ICB confirm that all contracts put in place for local enhanced services are in line with The Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2013?	green	If Red or Amber, please provide further details
Has the ICB obtained written consent of NHS England prior to making any new LPS schemes?	green	If Red or Amber, please provide further details
Can the ICB confirm that all applications for the Pharmaceutical List received by the ICB related to community pharmacy contractors, dispensing appliance contractors and dispensing doctors have been decided within their regulatory timescales? Reasons should be provided where this is not the case.	green	If Red or Amber, please provide further details
Contractor/ Provider compliance and performance		
Can the ICB confirm that it has the necessary processes in place to comply with all guidance/regulations for contractor compliance	green	If Red or Amber, please provide further details

and has taken appropriate action where necessary.		
Can the ICB confirm that contractors have completed the Community Pharmacy Assurance Framework (CPAF) and it has taken appropriate action where this is not the case?	green	If Red or Amber, please provide further details
Primary Ophthalmic Services		
	R/A/G Rating	**Comments**
Compliance with mandated Guidance issued by NHS England		
Has the ICB understood and complied with all nationally set operating procedures and policies (e.g. the Eye Health Policy Book)?	green	If Red or Amber, please provide further details
Service provision and planning		
Can the ICB confirm that it has the necessary processes in place to plan and manage service provision.	green	If Red or Amber, please provide further details
Contracting		
Can the ICB confirm that it is managing the processes involved for new, varied and terminated contracts effectively and efficiently.	green	If Red or Amber, please provide further details
Contractor/ Provider compliance and performance		
Can the ICB confirm that it has the necessary processes in place to comply with all guidance/regulations for contractor compliance and has taken appropriate action where necessary.	green	If Red or Amber, please provide further details
Dental Services		
	R/A/G Rating	**Comments**
Compliance with mandated Guidance issued by NHS England		
Has the ICB understood and complied with all nationally set operating procedures and policies (e.g. the Policy Book for Primary Dental Services)?	green	If Red or Amber, please provide further details
Service provision and planning		
Can the ICB confirm that it has the necessary processes in place to plan and manage service provision.	green	If Red or Amber, please provide further details
Contracting		
Can the ICB confirm that it is managing the processes involved for new, varied and terminated contracts effectively and efficiently.	green	If Red or Amber, please provide further details
Does the ICB have local process mechanisms in place for the collection of data relating to decisions on Discretionary Payments or Support?	green	If Red or Amber, please provide further details
Contractor/ Provider compliance and performance		
Can the ICB confirm that it has the necessary processes in place to comply with all guidance/regulations for contractor compliance	green	If Red or Amber, please provide further details

and has taken appropriate action where necessary.		
Primary Medical Services		
	R/A/G Rating	
Compliance with mandated Guidance issued by NHS England		
Has the ICB understood and complied with all nationally set operating procedures and policies (e.g. the Primary Medical Care Policy and Guidance Manual?	green	If Red or Amber, please provide further details
Service provision and planning		
Can the ICB confirm that it has the necessary processes in place to plan and manage service provision	green	If Red or Amber, please provide further details
Contracting		
Does the ICB have local process mechanisms in place for the collection of data relating to decisions on Discretionary Payments or Support?	green	If Red or Amber, please provide further details
Does the ICB have processes to implement Premises Costs Directions Functions?	green	If Red or Amber, please provide further details
Contractor/ Provider compliance and performance		
Has the ICB got the appropriate systems and processes in place to manage quality and performance of providers? Has the ICB taken appropriate action where necessary.	green	If Red or Amber, please provide further details

Appendix 2

26/27 Current Performance and Quality Metrics (Draft) (cross reference with Primary Care Action Plan) *Note NHS England 'PCAP' measurables TBC will need to be added to this list/amend – currently awaited*				
Area	**Metric**	**Target**	**Current**	**Narrative**
Dental (cross reference with Dental Improvement Plan)				
Planning Guidance (PG)/Pop Health Improvement Plan (PHIP)	Units of dental activity delivered as a proportion of all units of dental activity contracted	85%	82% (April 26)	cm-population-health-improvement-plan-board-final.pdf
	Number of unique patients seen by an NHS Dentist – Adults (24 month)	Q1 = 963452, Q2 = 966320, Q3 = 969188 Q4 = 972056	954662 (April 26)	
	Number of unique patients seen by an NHS Dentist – Children (12 month)	Q1 = 337612, Q2 = 338408, Q3 = 339204, Q4 = 340000	342454 (April 26)	
	Unscheduled Care	Part of new contract reforms - mandated level of unscheduled CoTs, set at 8.2**%** of contract value.	tbc	NHS England » Confirmation of urgent/unscheduled care activity requirements for NHS dental contract holders for 2026/27
Other	Patient Experience Measure - Overall experience of Dental to meet england average and improve year on year (GPPS)	71 (av)	71	GP Patient Survey
	ONS Health Insights Survey	tbc	tbc	Health Insight Survey dashboard
	Access / deprivation measurement	tbc	tbc	
Community Pharmacy				
PG/PHIP **For PF there was an element of overperformance after the targets were*	Pharmacy First (PF) – Total Consultations	No target but Projected 2.9% growth in consultations Target 26/27 - 465,151	*Actual delivered 25/26 - 443,465 26/27 tbc	cm-population-health-improvement-plan-board-final.pdf
	PF – Clinical Pathways	5% growth Target 26/27 - 155,881	*Actual 25/26 - 148,459 26/27 tbc	https://www.gov.uk/government/publications/community-pharmacy-contractual-framework-financial-year-2026-to-2027/community-pharmacy-contractual-framework-financial-year-2026-to-2027
	PF – Oral contraception	10% growth Target 26/27 - 57,779	*Actual 25/26 - 52,526 26.27 tbc	https://www.gov.uk/government/publications/community-pharmacy-contractual-framework-financial-year-2026-to-2027/community-pharmacy-contractual-framework-financial-year-2026-to-2027
	PF – Blood Pressures	continued growth Target 26/27 - 242,490	Actual 25/26 - 242,490 Tbc 26/27	https://www.gov.uk/government/publications/community-pharmacy-contractual-framework-financial-year-2026-to-2027/community-pharmacy-contractual-framework-financial-year-2026-to-2027

Other	Patient Experience Measure – Overall experience of CP services to meet england average and improve year on year (GPPS)	88 (av)	88	GP Patient Survey
	ONS Health Insights Survey CP question	tbc	tbc	Health Insight Survey dashboard
Optometry				
PHIP	SES Education Settings – coverage and outcomes	tbc	tbc	cm-population-health-improvement-plan-board-final.pdf
	Proposed indicator Reduction in GP eye related consultations	tbc	tbc	
	Proposed indicator Reduction in acute presentations eye related issues	tbc	tbc	
	Proposed indicator Roll out of pathways	tbc	tbc	
General Practice (Medical) (Cross reference with Primary Care Access Improvement Plan / June 2025 variation plan)				
PG/PHIP	Increased % urgent care demand met same day in general practice	90 % March 2027	75.4	cm-population-health-improvement-plan-board-final.pdf
	Appointments in General Practice & Primary Care networks	2.3% inc. in 26/27 Full Year Target: 16,708,331 April: Plan: 1.29m Actual: 1.36m	Apr 26 shows a 7% growth vs 25/26. 1.36m appointments delivered	
	Proposed Indicator – Continuity Of Care	tbc	tbc	
Other	Patient Experience – GPPS – continued improvement in overall experience as good and meet England average	England average 75% 2024 C/M 76%	78% (note awaiting GPPS 26/27)	GP Patient Survey
	Patient Experience – ONS Health Insights data continued improvement in	Increase/meet England average	75.1%	Health Insight Survey dashboard

	overall experience good	(England average current 72)		
	Access/deprivation measurement	tbc	tbc	
	MGP – NHS App registered patients to meet England average	74%	69%	

Quality		
General Practice		
	CQC rating	**Under review**
	Overall QOF achievement	
	(CHD015) Secondary prevention of Coronary Heart Disease (CHD)	
	(DM020) Diabetes Mellitus % of patients with diabetes on the registers without moderate or severe frailty with Hba1c reading	
	(DM021) Diabetes % patients with diabetes without moderate or severe frailty with an Hba1c < 75T2DM	
	(DEM004) % patients diagnosed with dementia with care plan review	
	(COPD010) % patients with COPD on the register, who have had a review in the preceding 12 months	
	% patients (aged 14 years or over) who have received a learning disability health check by a GP Practice	
	% patients with Severe Mental Health Issues (SMI) to receive the complete list of physical health checks in the preceding 12 months	
	Cancer detection rates	
	Emergency Cancer admissions	
	Patients with GP recorded hypertension, whose last blood pressure reading is to the appropriate treatment threshold	
Optometry	Managed through https://www.qualityinoptometry.co.uk/ with compliance follow up by commissioners. Managed by NHSBSA,	
Community Pharmacy	PQS _ Managed through Pharmacy Quality Scheme (PQS) & the Community Pharmacy Assurance Framework (CPAF). NHS England » Pharmacy quality scheme Community Pharmacy Assurance Framework (CPAF) | NHSBSA. Managed by NHSBSA	

	• PQS target - No national target • PQS achieved 25/26 - 88.7% contracts claimed payment CPAF _ https://www.gov.uk/government/publications/community-pharmacy-contractual-framework-financial-year-2026-to-2027/community-pharmacy-contractual-framework-financial-year-2026-to-2027 NHS Business Services Authority (NHSBSA). *Community Pharmacy Assurance Framework (CPAF)* states that "it is anticipated that a total of 1–3% of pharmacies in a region will be visited throughout the course of the year." • CPAF target – 1-3% CP Contracts – national target for contract visits to be undertaken in year, selected from priority cohorts and full CPAF monitoring self assessment • CPAF achieved 25/26- 15 C&M CPs visited for full assessment = 3% C&M CP contracts
Dental	New national voluntary scheme NHS England Dental Quality Improvement (QI) 2026/27 | NHSBSA, ICB follow up

NHS
Cheshire and Merseyside

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

2026/27Community Pharmacy Contractual Settlement summary report.

Agenda Item No: 11

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

1. Purpose of the Report

1.1 The report provides an overview of recently agreed Community Pharmacy Contractual Settlement.

2. Ask of the Committee and Recommendations

The Committee is asked to ;

- ***Note*** the update in respect of the nationally agreed contract settlement.
- This report is for ***information*** and ***no decisions*** are required.

3. Executive Summary

3.1 Community Pharmacy England, the Department of Health and Social Care (DHSC) and NHS England have announced the 2026/27 funding settlement for community pharmacy.

3.2 An increase in funding of £340 million (10.3%) to £3.636 billion, alongside an agreement not to recover £239 million of historic over-delivered medicines margin funding from the sector, will be used to help stabilise medicine supply and build on the services that community pharmacy provide. Community pharmacy will be receiving the largest uplift in funding across the whole of the NHS.

3.3 Financial investment accompanies changes to service specifications and expansion of currently commissioned National Advanced services with the aim to expand Community Pharmacies offer of clinically based service to patients.

4. Annoucement summary

4.1 A funding settlement for community pharmacies in 2026/27 will be implemented from this month after Community Pharmacy England accepted the offer, on condition of a shared programme of reform with Government and NHS England

4.2 Community Pharmacy Contractual Framework (CPCF) and Pharmacy First funding will increase from £3.296 billion in 2025 to 2026 to £3.636 billion in the financial year of 2026 to 2027. There will be a write off up to £239 million of historic net contract over-delivery against the historic settlements.

Table 1: changes to available funding, 2025 to 2026 to 2026 to 2027

	2025 to 2026	**2026/2027**
CPCF (£ billion)	3.073	3.636
Pharmacy First (£ million)	215	Included in CPCF
Digital developments (£ million)	8	Included in CPCF
Total available (£ billion)	3.296	3.636

Funding growth (£ million) (%)	-	340 (10.3%)

4.3 The following changes have been agreed for the financial year 2026 to 2027:

- The Single Activity Fee (SAF) will increase from £1.46 to £1.52 (4.1%). This uplift will be backdated to take effect from May 2026, with early advanced payments from June to swiftly benefit contractors.

- Clinical service and other non-SAF fees - All other fees will be maintained at the 2025 to 2026 level to prioritise the uplift in SAF.

- The one-month claim window for Pharmacy First clinical pathways and the New Medicine Service (NMS) will be retained. However, a new late claims process will be introduced for these services to allow submissions up to 2 months after the window closes, recognising the operational pressures on contractors.

- Pharmacy First clinical pathway cap arrangements will be maintained in the financial year 2026 to 2027. For those contractors delivering independent prescribing (IP) clinical pathway consultations, there will be an additional allowance made to each capping band to support the increased delivery we anticipate through this expansion to the service.

- It has been agreed to implement high level caps for the hypertension case-finding service and Pharmacy First minor illness service to restrict highest volume outliers, with details to be agreed and implemented during the year.

- Medicine margin has been a central focus of this year's settlement, reflecting its importance in underpinning the supply of medicines and providing greater certainty for contractors. The value of retained medicine margin will increase by £200 million to £1.1 billion for financial year 2026 to 2027.

- From autumn 2026, a national NHS Independent Prescribing offer will be introduced as an extension of Pharmacy First and the pharmacy contraception service.

- A revised Pharmacy Quality Scheme (PQS) will be introduced for 2026 to 2027 with a value of £20 million.

- The Pharmacy Access Scheme (PhAS) will be retained with funding capped at £20 million for the financial year 2026 to 2027. We also commit to reviewing the scheme with a view to implementing updates from 2027 to 2028

- A number of regulatory changes will be progressed from autumn 2026 including enabling pharmacies to close for up to 4 hours in a day up to once a month for learning and development purposes.

- A maximum of 2 national health campaigns and 2 local campaigns led by integrated care boards will be required in 2026 to 2027.

4.4 Community Pharmacy England has stated that despite pharmacy being prioritised for a higher funding uplift than other parts of the NHS, and improvements to the final offer achieved during negotiations, they were very reluctant to accept the deal.

4.5 The view is that funding available will cover growth in activity and inflation in the coming year, but does not make further significant progress towards delivering sustainability to an increasingly unstable sector.

4.6 However it should be noted that Community Pharmacy England recognised that Ministers have treated pharmacy preferentially for the second year running – the pharmacy funding uplift is the highest across primary care, and higher than that of the overall NHS.

4.7 Community pharmacies continue to deliver for patients, demonstrating the vital role of the sector. Between April 2025 and January 2026, over 2.75 million Pharmacy First clinical pathways consultations were delivered, alongside nearly one million pharmacy contraception service consultations and 3 million hypertension case-finding service consultations, as well as dispensing around one billion prescription items to patients in the same 10-month period.

4.8 Additional information on the settlement is included in Appendix 1.

5.0 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

6.0 Link to meeting CQC ICS Themes and Quality Statements

QS4 Equity in access
QS8 Care provision, integration and continuity
QS9 How staff, teams and services work together
QS13 Governance, management and sustainability

7. Risks

Supports the mitigation following BAF risks – P4, P12, P15, P16

11 Finance

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

12 Communication and Engagement

No external formal consultation is required in respect of this update but Commissioners will be engaging with Local Pharmaceutical Representatives regarding implementation.

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.

14 Officer contact details for more information

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

CPCF SETTLEMENT 2026/27

OVERVIEW

- **Community pharmacy funding to increase by 10.3% (£340m).**
- One of the largest funding uplifts across the NHS – despite not being enough to close pharmacy's funding gap.
- Net excess contract funding (margin) of **up to £239m written off** to help stabilise medicines supply.
- Government commitment to work in partnership on reforms for the sector.

KEY COMMITMENTS

Joint programme of reform to help develop future community pharmacy strategy, including funding, contract and reimbursement models.

Introduction of Independent Prescribing (IP) into NHS community pharmacy services.

Community Pharmacy England

FUNDING, MARGIN & PAYMENTS

- **The total CPCF funding for 2026/27 will be £3.636bn**
- This is for both the CPCF and Pharmacy First budgets which are being combined
- This is up 10.3% (£340m) from the previous year
- And compares with an overall NHS funding increase of 3%
- Single Activity Fee increases by 6 pence from £1.46 to £1.52 per item

- As part of the settlement, margin allowance will increase to £1.1 billion annually
- Net excess contract funding (margin) write-off (up to £239m) to support supply chain stability
- There will be a £20m Pharmacy Quality Scheme with 80% Aspiration payment payable on 1st September
- Agreement to allow late payment claims for Pharmacy First and NMS

We have been clear with Government that the sector is in a critical position, and that we now need urgent work on a sustainable long-term solution, including reform of the contract, funding and reimbursement model. As part of this deal Government have committed to work with us on this programme of work. That work will be difficult and will take time, but refusing this deal would have put more pharmacies — and the services they provide at greater risk.

Janet Morrison
Chief Executive
Community Pharmacy England

SERVICES

- Introduction of Independent Prescribing as part of Pharmacy First and the Pharmacy Contraception Service
- Infrastructure funding to support delivery of IP services

REGULATORY

- Caps on selected services to prevent disproportionate use
- Action on branded generics, including NHS guidance to discourage use for financial gain
- Review of the Pharmacy Access Scheme (PhAS)
- Measures agreed to tackle violence in pharmacies
- Pharmacies to be able to close for training for up to 4 hours a month

WHAT THIS MEANS

Immediate funding uplift provides some short-term support for pharmacies

Progress towards a more clinical, service-led future for community pharmacy via strategically important Independent Prescribing

A clear commitment to longer-term reform and sustainability, though further investment will still be needed

Stabilisation measures for medicines supply chain

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

Business Case approval of Neighborhood Bespoke Layer in STRATA utilising Business as Usual Capital Funding 26/27

Agenda Item No:12

Responsible Director: *Clare Watson – Deputy Chief Executive*

1. Purpose of the Report

1.1 The purpose of the report is to seek approval on the use of an element of the 26/27 BAU Allocation for developing the Cheshire and Merseyside bespoke Neighbourhood layer within the STRATA planning tool.

2. Executive Summary

2.1 Strata is an online, interactive, data mapping, analysis and insight tool that supports service planning and estates strategy development. Further details have been provided in Appendix Two.

2.2 Following discussions between Digital, Business Intelligence and the Estates Team there is a clear benefit and desire to support the integration and intelligent use of data to inform planning and future decision-making requirements for Neighbourhood delivery.

2.3 The delivery model of STRATA (previously known as SHAPE) was originally free to use but has since shifted to a subscription model. It's hoped that the adoption of a Cheshire and Merseyside bespoke layer will generate efficiencies within our partner organisations i.e local authorities being able to utilise and access the NHS layer.

2.4 The ability to visually map neighbourhood boundaries, associated population health indicators such as deprivation or QOF indicators and NHS/ non NHS premises will support the adoption of a strategic approach to capital and resource planning in the future, in addition to enabling to review of existing service delivery models and care pathways as part of the redesign of neighbourhood health within the system.

2.5 The business case seeks to utilise BAU allocation and capitalise the recurrent revenue charge for a 2-year period, totalling £41,840. Capitalising the licenses would generate a net revenue consequence for the ICB.

2.6 Digital, Estates and Business Intelligence are supportive of the business case.

3. Ask of the System Primary Care Committee and Recommendations

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

- **APPROVE** – the use of Business-as-Usual Capital Allocation **(£41,840)** to develop a bespoke Neighbourhood layer in STRATA for Cheshire and Merseyside.

4. Appendices

- Appendix One – Business Case
- Appendix Two – STRATA Supporting Documents

STRATA

SHAPE's next chapter

Product evolution to better support place-based insight and analysis.

Making SHAPE fit for the future

Over the past 20 years, SHAPE has formed a core part of public sector service planning.

The application has evolved from a geospatial tool, used to understand population health needs, to a scenario planning and strategy tool rich in data and features to support a much wider variety of users and projects.

The makers of SHAPE, Parallel, has funded and delivered a free to access version of the platform for the public sector for many years, with organisations commissioning their own, bespoke versions of SHAPE to more closely align platform data to support specific pieces of work.

Recognising the pace of technological innovation and the importance of high-quality data for directing investment and prioritising resources effectively, we want to ensure the platform is continuously improving and at the cutting edge of technology.

Feedback from our user base tells us that there is a growing demand to tailor the tool to individual organisation needs, whilst remaining flexible enough to continue to support public sector collaboration.

In response to this, 2026 will see the introduction of a new subscription offer, with new features, new data and regular benefits introduced based on customer feedback.

A simpler version of the tool will still be made available for NHS users, with advanced versions available through new subscription tiers.

The new subscriptions will come into effect on 9 March 2026. This pack aims to explain the changes and what it means for you.

STRATA

The power of layered intelligence

Listening to user feedback, SHAPE will also have a new name - Strata.

The name SHAPE reflected our origins in the health sector, but the tool has evolved over the last two decades, now providing an all-inclusive view of what makes up the identity of a place, to support strategic planning. The application has developed its breadth of features and is now made up of a variety of analysis and visualisation tools to provide users with a range of ways to interrogate data; including maps, dashboards, charts and prepopulated reports.

Strata deepens your understanding of a place, be that at a local, regional or a national level, through the layering and comparisons of multiple factors; from population demographic data, to economic factors, assets and the environment.

The name Strata reflects the essence of what makes place planning powerful, a holistic understanding of all factors that contribute to the changing needs of communities, services and assets.

You'll see the new brand appearing in the application over the next few weeks, alongside a cleaner design. Functionality will remain, but a streamlined, clearer view will help you distinguish between layers more easily. Emails and URLs will be automatically redirected.

How will my access change?

CURRENT ACCESS

SHAPE Place

The current free version of SHAPE

- Enquire about a Strata subscription by emailing **help@stratasoftware.net**
- Our team needs to understand:
  1. How many users your organisation needs
  2. What tier you are considering based on your project needs

  (we can help you with both questions if you're unsure, based on your current activity)
- A proposal will follow for your consideration.
- If you go ahead, we'll work with you to set everything up.
- If not, NHS users will automatically transfer to Strata NHS Essentials on 9th March 2026.

SHAPE Local

SHAPE commissions with tailored data and tools

- Your SHAPE Local workspace will be rebranded to Strata Enterprise and all your existing permissions and functionality will remain.
- You may notice some design improvements and new features over the coming weeks and months.
- Within 12 weeks of your next renewal, your dedicated Account Manager will contact you to discuss the different subscriptions available and associated features and benefits.

ICS Strategy Atlas

NHS England's bespoke area of SHAPE supporting estates data and infrastructure strategies

- Access to the following tools will remain unchanged for NHS England and ICB users with ICS Strategy Atlas permissions:
  - Data management tool
  - Locations, boundaries and sites
  - KPI charts
  - Summary reports
  - Population projects
  - PCN toolkit
- NHS England and ICB users will have access to NHS England Essentials functionality, coupled with ICS Strategy Atlas specific tools.
- Advanced users will have access to all analysis tools.
- Permissions have been determined by NHS England and your ICB lead. For further details email help@stratasoftware.net.

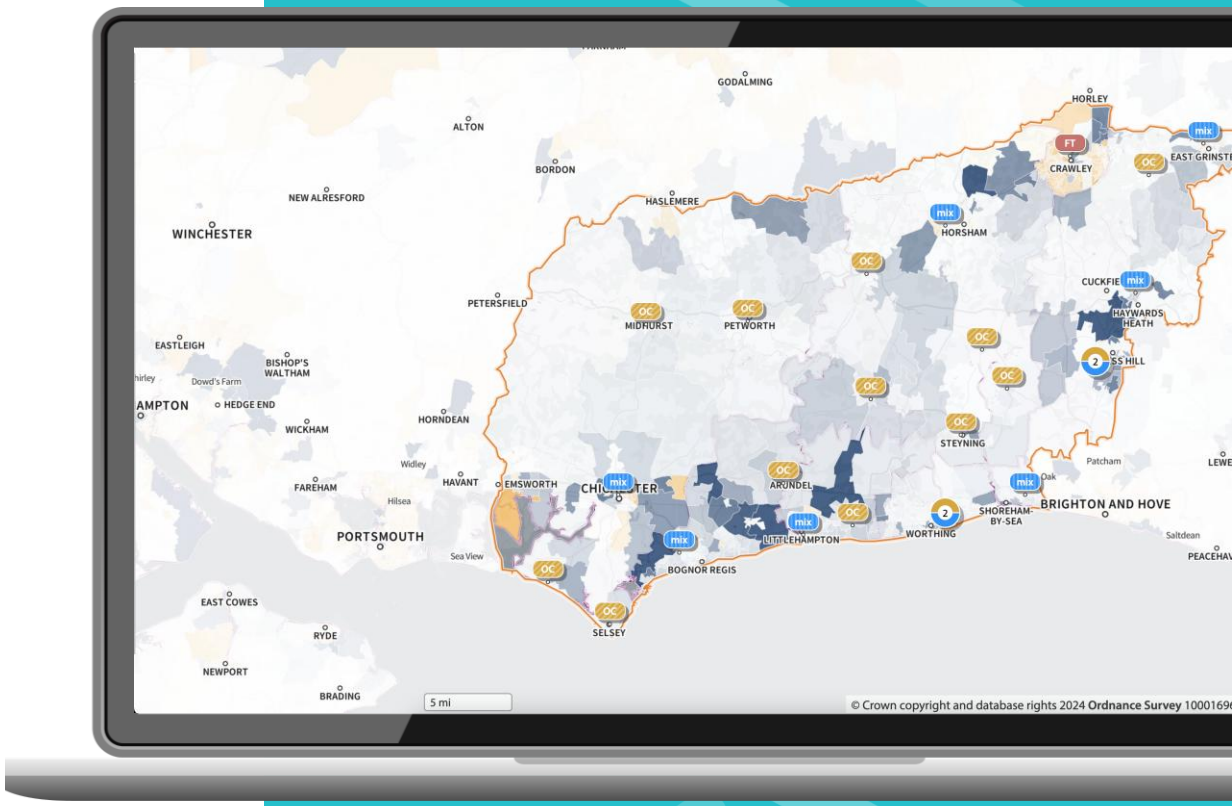
STRATA

For Health

Strata is the trusted, evidence-based platform designed to help the NHS plan services and estates with confidence.

Drawing on data from more than 40 trusted sources, including NHS Digital, ODS, DEFRA, Gov.uk and QOF, it brings essential information together into a single, reliable map-based view. This unified dataset enables NHS teams to make timely, informed decisions grounded in place-based evidence.

Proven at national scale, the tool has underpinned key NHS programmes, from mapping COVID-19 vaccination centres, to identifying community diagnostic centre locations and supporting the development of ICB infrastructure strategies and capital planning. Its role across these programmes demonstrates the platform's capability, accuracy and value in decision making.



At its core, Strata supports scenario planning and option appraisals, helping commissioners and planners understand the service configurations that offer the best access, value and outcomes for local populations. Its analytical and visualisation tools make it easier to compare options, test assumptions and build a robust case for change.

By combining demographic, activity and service data with detailed estates information, Strata also strengthens estates strategies and business case development. It provides a shared evidence base that improves collaboration across organisations, enabling partners to work together to design more effective, integrated solutions.

Strata offers an exclusive version of the platform, free of charge, to NHS users. Subscriptions are available to unlock enhanced features and more granular data, providing the insight required to support long term strategic planning.

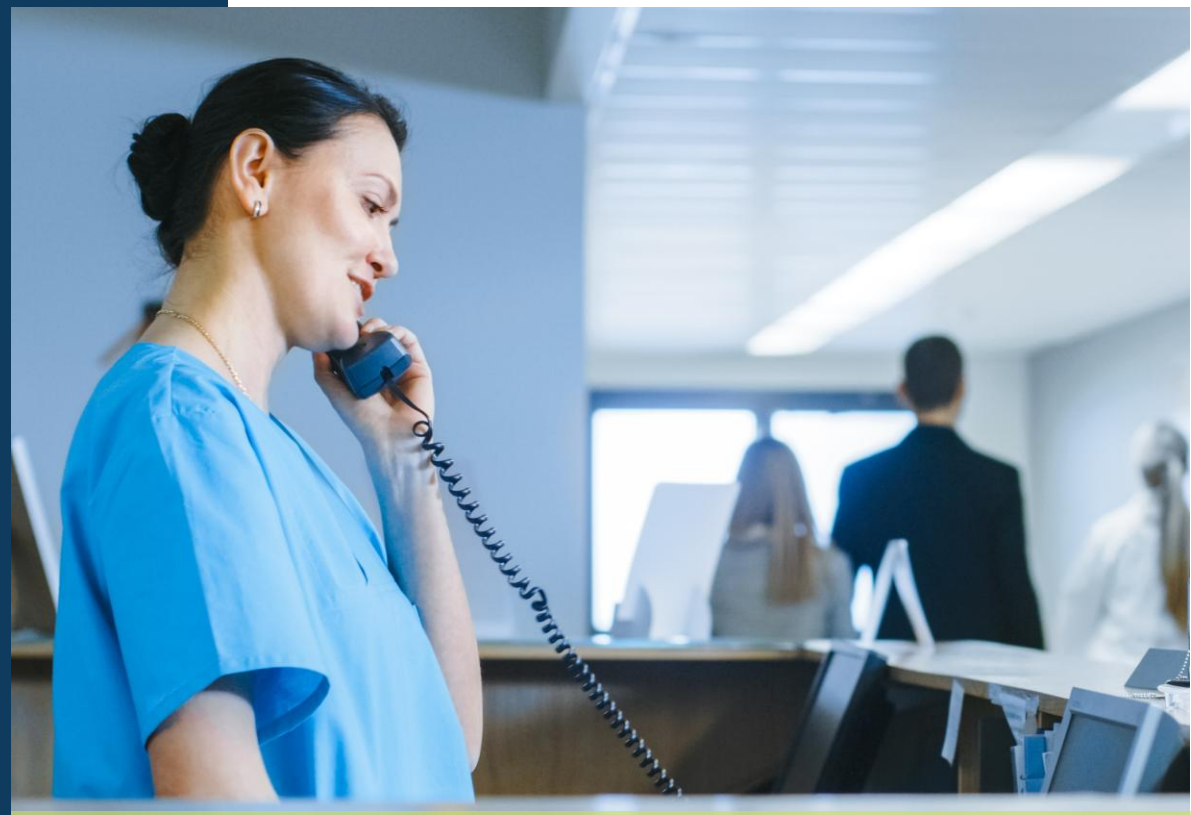
NHS England

Estates mapping tool for infrastructure strategies

Helps understand your place, people & services

Enables collaborative working

Streamlines decision making



Want to find out more?
Get in touch at help@stratasoftware.net

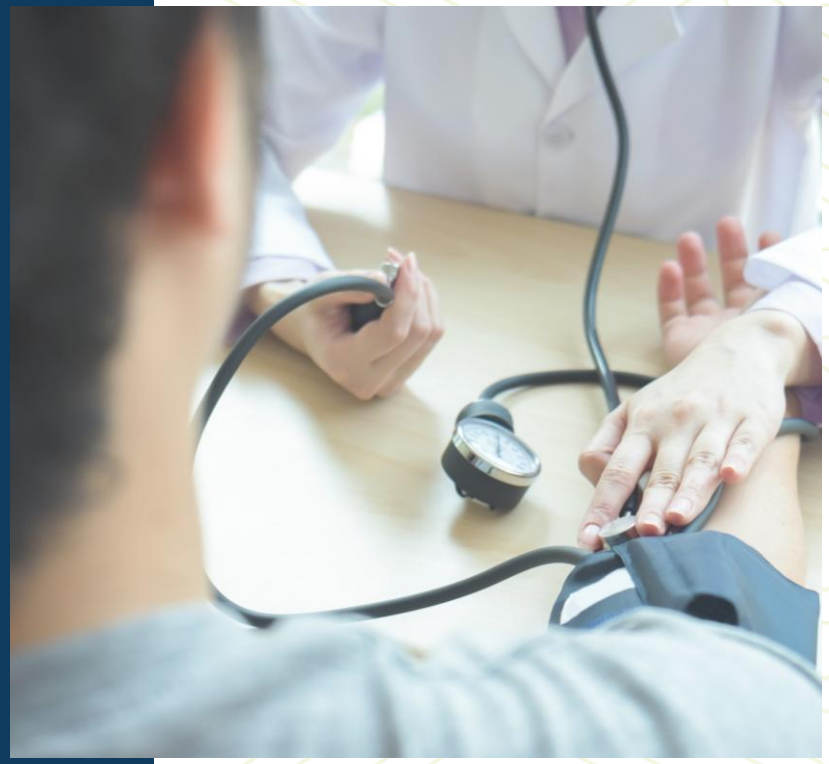
STRATA

NHS Essentials

The free version of Strata, available exclusively for NHS staff.

It provides an up-to-date overview of core NHS services mapped by Integrated Care Boards. NHS Essentials brings together primary and secondary care locations, including general practices, pharmacies, dental and optical services, primary care networks, acute and community hospitals, mental health, vaccination sites and diagnostic centres, overlaid with Core20 deprivation to highlight areas of greatest need.

Designed for users who need a simple snapshot rather than detailed analytics, this tier supports contextual understanding of how services align to Core20 population across Integrated Care Boards.



STRATA

Standard Subscription

A detailed view of services, estates and population need across health, local government and emergency services, helping organisations understand communities, how they are served, and where gaps or pressures may exist.

Strata Standard brings together core NHS services across primary and secondary care alongside wider social care, community and emergency services infrastructure. Users can overlay population characteristics, including deprivation, age, ethnicity, disease and intervention with service provision to support strategic decision-making, early options development and cross-sector planning.

Insights can be viewed and filtered by integrated care boards, local and combined authorities and emergency service boundaries, then exported for use in strategy papers, reports and business cases. By combining service data with contextual population datasets, the platform helps identify need, variation and alignment to place-based priorities.

Designed for organisations that require a detailed understanding of both services and population need, Strata Standard supports the NHS, local and central government and blue light services who need a shared evidence base for planning and service redesign.

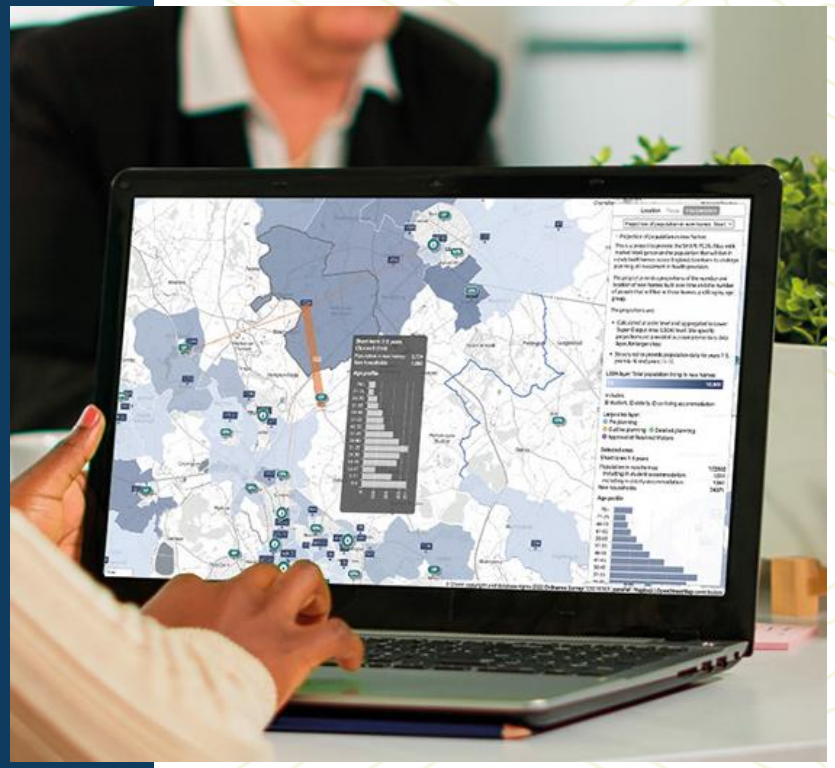
STRATA

Premium Subscription

Strata Premium enables powerful analytical and scenario-planning visualisations for organisations that need to model demand, test options, and make evidence-based strategic decisions across places and populations.

Building on the core data and cross-sector coverage of the Standard tier, Premium supports deeper analysis of access, geography, need and infrastructure. Users can model travel and access by walking, cycling, car or public transport, analyse catchments and distance radiuses, assess environmental and population factors, and define custom locations to evaluate future service configurations or estate proposals. Additional boundaries and functionality, including regional footprints and multi-area selection, support analysis across more complex geographies, enabling a clearer understanding of cross-system relationships and partnership working.

Designed for users leading strategic planning, business cases and service transformation, Premium supports scenario modelling, detailed options appraisal and data-driven decision making across the NHS, local and combined authorities, and emergency services. Strata Premium also benefits from enhanced support, including live agent assistance, a dedicated account manager, and bespoke training.



STRATA

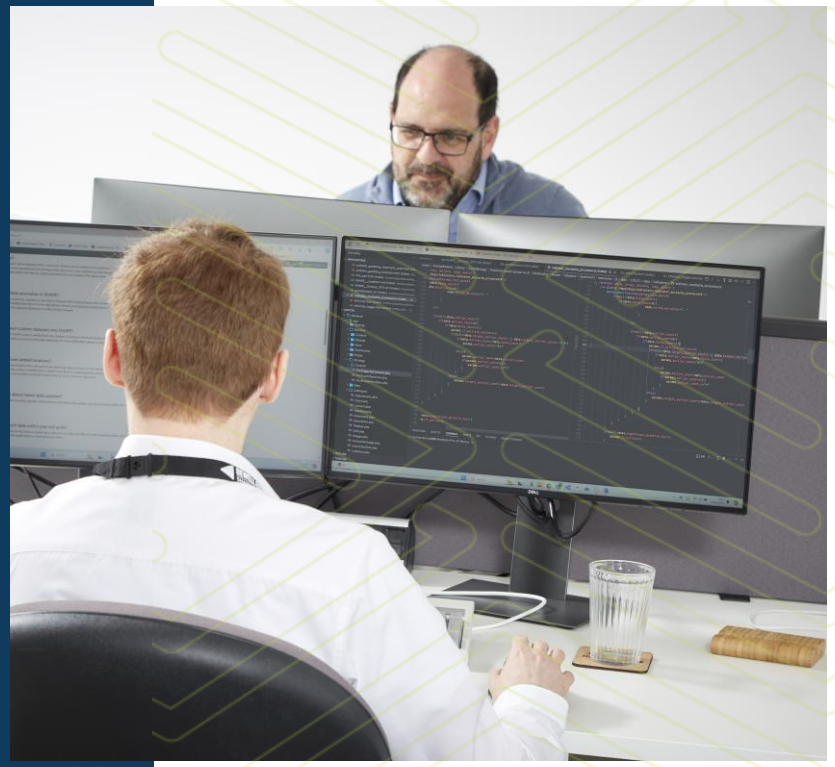
Enterprise Subscription

Strata Enterprise is a private, fully tailored Strata workspace, building on the power of Premium while enabling bespoke functionality, local datasets and dedicated expert support.

Enterprise offers a secure workspace with local data and tools aligned to organisational goals. Designed as a common evidence base, Enterprise enables multi-agency collaboration through a single platform and consistent insights.

By extending the capabilities of Premium, Enterprise allows organisations to tailor the platform to their own data models, workflows and decision-making requirements, from supporting estate transformation, service redesign, strategic investment programmes and future scenario planning. As a long-term solution, it enables Strata to be embedded into daily strategic and operational planning, providing a consistent, repeatable evidence base for decisions across programmes, teams and partners.

Enterprise also includes hands-on support from our in-house experts, helping teams interpret data, configure tools and turn insights into delivery. Enterprise includes a support allocation based on customisation needs, enhanced onboarding, live support, dedicated account management and bespoke training,



Which subscription is right for me?

Strata NHS Essentials

Core NHS services and organisational boundaries with the Core20 most deprived population.

Organisational Boundaries

- Integrated Care Board
- Sub Integrated Care Board

Locations

- Primary care sites – general practices, pharmacies, opticians and dental
- Primary care networks
- Secondary care sites – acute hospitals, community hospitals, mental health, non-inpatient support and other facilities
- COVID-19 and flu vaccination sites
- Community diagnostic centres

Functionality and Data

- NHS England pharmacy services – Pharmacy First, blood pressure check, stop smoking and contraception services
- Core20 deprived population map overlay

Support

- Email support via a helpdesk
- Frequently asked questions

Strata Standard

Overlay detailed location information with population and demographics to support high level options reviews.

Organisational Boundaries

- Integrated Care Board
- Sub Integrated Care Board
- Local Authorities
- Combined Authorities
- Fire & Rescue Authorities
- Police Force Areas

Locations

- Primary care sites – general practices, pharmacies, opticians and dental
- Primary care networks
- Secondary care sites – acute hospitals, community hospitals, mental health, non-inpatient support and other facilities
- COVID-19 and flu vaccination centres
- Community diagnostic centres
- Care homes
- Children's centres
- Independent hospitals
- Fire, police and ambulance stations
- Points of interest including supermarkets and open green space

Functionality and Data

- NHS England pharmacy services – Pharmacy First, blood pressure check, stop smoking and contraception services
- Core20 deprived population map overlay
- Tailored filters based on selected locations
- Detailed population factors including age, ethnicity, disease & intervention
- Export and download functionality

Support

- Email support via a helpdesk
- Frequently asked questions
- Full access to the resource centre
- Training via an online webinar programme

See the next page for our Premium and Enterprise subscriptions...

Which subscription is right for me?

Strata Premium

For users wanting a powerful analysis tool to support strategic decision making and scenario planning.

Organisational Boundaries

- Integrated Care Board
- Sub Integrated Care Board
- Local Authorities
- Combined Authorities
- Fire & Rescue Authorities
- Police Force Areas
- Regions
- Multiple area selection
- Ability to increase area radius

Locations

- Primary care sites – general practices, pharmacies, opticians and dental
- Primary care networks
- Secondary care sites – acute hospitals, community hospitals, mental health, non-inpatient support and other facilities
- COVID-19 and flu vaccination sites
- Community diagnostic centres
- Care homes
- Children's centres
- Independent hospitals
- Fire police and ambulance stations
- Points of interest including supermarkets and open green space
- User defined locations
- Educational establishments – nurseries, primary, secondary, further and higher

Functionality and Data

- NHS England pharmacy services – Pharmacy First, blood pressure check, stop smoking and contraception services
- Core20 deprived population map overlay
- Tailored filters based on selected locations
- Detailed population factors including age, ethnicity, disease & intervention
- Export and download functionality
- Travel and accessibility including walking, cycling, car, public transport with detailed population insight
- Driving routes including mileage and minutes
- Distance radiuses from locations
- Environmental factors including risk of flooding and air pollution
- Additional population factors including economic, education and spoken language

Support

- Email support via a helpdesk
- Frequently asked questions
- Full access to the resource centre
- Training via an online webinar programme
- 2 x 1 hour sessions of bespoke online training
- Live agent support 9am-5pm Monday-Friday (excluding bank holidays)
- Dedicated Account Manager

See the next page for our Enterprise subscription...

Which subscription is right for me?

Strata Enterprise

Your bespoke, private, fully tailored Strata workspace.

Includes enhanced data and tools, tailored to your project needs, in a private workspace.

Organisational Boundaries

- Integrated Care Board
- Sub Integrated Care Board
- Local Authorities
- Combined Authorities
- Fire & Rescue Authorities
- Police Force Areas
- Regions
- Multiple area selection
- Ability to increase area radius

Locations

- Primary care sites – general practices, pharmacies, opticians and dental
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- Care homes
- Children's centres
- Independent hospitals
- Fire, police and ambulance stations
- Points of interest including supermarkets and open green space
- User defined locations
- Educational establishments – nurseries, primary, secondary, further and higher

Enterprise enables organisations to build a private, tailored workspace, enhancing Strata with client specific data. Functionality is tailored to specific requirements to support comprehensive scenario planning and strategy development.

Each Enterprise will be provided with a number of credits based on the level of support required for the creation of your Strata Enterprise workspace.

Functionality and Data

- NHS England pharmacy services – Pharmacy First, blood pressure check, stop smoking and contraception services
- Core20 deprived population map overlay
- Tailored filters based on selected locations
- Detailed population factors including age, ethnicity, disease & intervention
- Export and download functionality
- Travel and accessibility including walking, cycling, car, public transport with detailed population insight
- Driving routes including mileage and minutes
- Distance radiuses from locations
- Environmental factors including risk of flooding and air pollution
- Advanced population factors including economic, education and spoken language

Support

- Email Support via helpdesk
- Frequently asked questions
- Full access to the resource centre
- Training via an online webinar programme
- 4 x 1 hour sessions of bespoke online training
- Live agent support 9am-5pm Monday-Friday (excluding bank holidays)
- Dedicated Account Manager

Not sure which subscription is right for your project or organisation? Drop us an email and the team will be more than happy to help: help@stratasoftware.net

Pricing

Standard

Overlay of detailed site information such as services, workforce and contract information with population and demographic data to support high level options reviews.

Max users	Cost per user, per month	Discount (%)	Per annum cost
10	£40.00	15.00%	£4,800
25	£26.00	35.00%	£7,800
50	£20.00	50.00%	£12,000
100	£12.00	70.00%	£14,400

Premium

For those wanting a powerful tool for strategic decision making and scenario planning. Includes travel and access functionality, more detailed population insights and environmental data.

Max users	Cost per user, per month	Discount (%)	Per annum cost
10	£65.00	15.0%	£6,630
25	£42.25	35.0%	£12,675
50	£26.00	60.0%	£15,600
100	£19.50	70.0%	£23,400

Enterprise

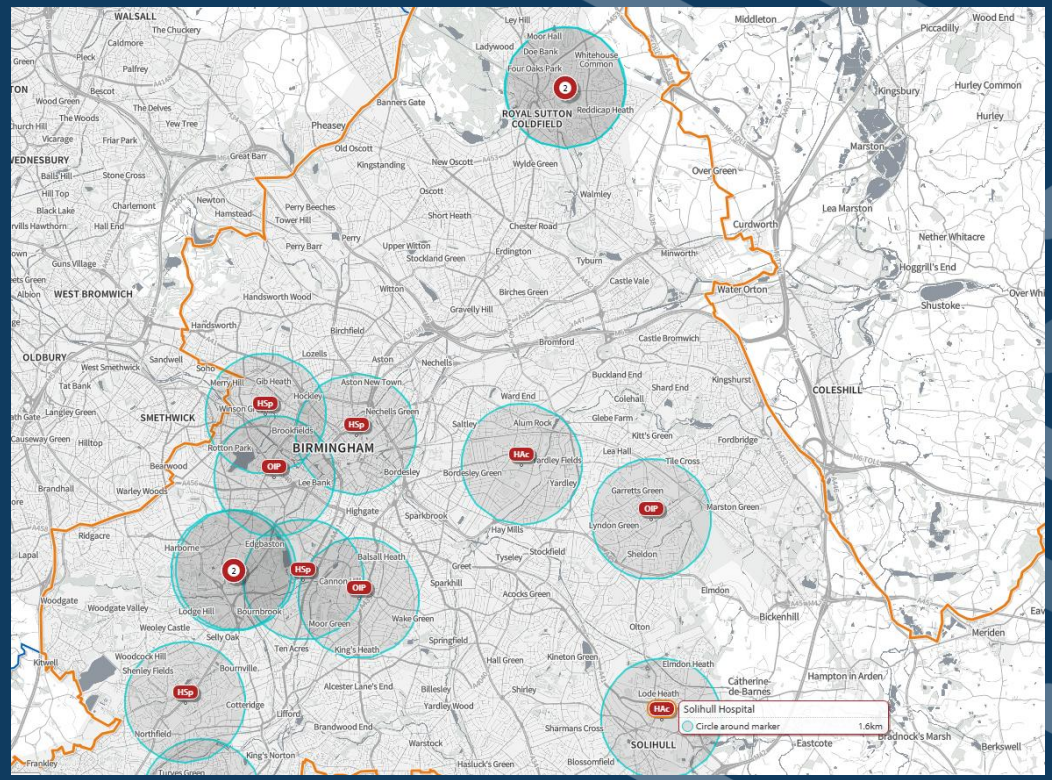
Your own bespoke data in a private, confidential workspace. Priced on enquiry.

Pricing as of date issued, subject to change. Discount based on private sector pricing

CASE STUDY: Understanding your neighbourhood

Goal: Birmingham and Solihull ICB serves a population of over 1.4 million people and with a focus on communities and health inequalities, the ICB wanted to understand their population by local areas.

Result: The ICB worked with Strata to define six localities across Birmingham and Solihull, with a focus on understanding the diverse population and health inequalities of each locality alongside their estate and services offered, allowing them to concentrate on relocating the most needed services from hospital to community.



"[Strata] is my go-to place for data. It saves us so much time and gives us the data we need for our ambitious plans for the future."

Phil Clark, Director of Estates (Primary Care), Birmingham and Solihull NHS

STRATA

CASE STUDY: Supporting future planning

Goal: Norfolk & Waveney ICB, responsible for planning health and care services across a large and diverse estate, aimed to create a reliable, system-wide 10-year infrastructure strategy.

Result: They adopted Strata to replace fragmented spreadsheets, centralise their estate data, and give them trusted mapping and scenario-planning tools. As a result, they now have a live, accurate digital estate picture that supports better decision-making, identifies opportunities for consolidation, and helps plan services around future population needs.

"Although we had a good handle on our estate data before, it has been a digital innovation for us."

Craig Boyles, Estates Programme Manager, Norfolk and Waveney ICB

STRATA

CASE STUDY: Mapping ideal locations for CDCs

Goal: NHS England wanted to provide more diagnostic capacity in England and needed their 170 new Community Diagnostic Centres to be in the right place to best meet the needs of local people.

Result: Strata enabled NHS England and ICBs to overlay information about where diagnostic units could be positioned, test whether population access would improve, assess demand and evaluate the suitability of different locations.

"[Strata] has significantly improved our understanding and decision making. This has informed next steps based on health inequalities ensuring as many people as possible have equal access to high-quality diagnostic services."

CDC Programme Team, NHS England

STRATA

CASE STUDY: Monitoring service take-up

Goal: South Yorkshire ICB wanted to better understand their primary care landscape to see how patients are accessing services and using digital tools available to them.

Result: Strata visualised registration and usage of online services at each practice, helping the ICB identify patterns of digital uptake and target support to areas with the lowest usage.

"Being able to bring everything together and visualise it on a map makes it much easier to understand and allows us to identify our innovators who are making the most of their resources, and those who need extra support. It really makes us confident that we can make decisions for the future that will really matter."

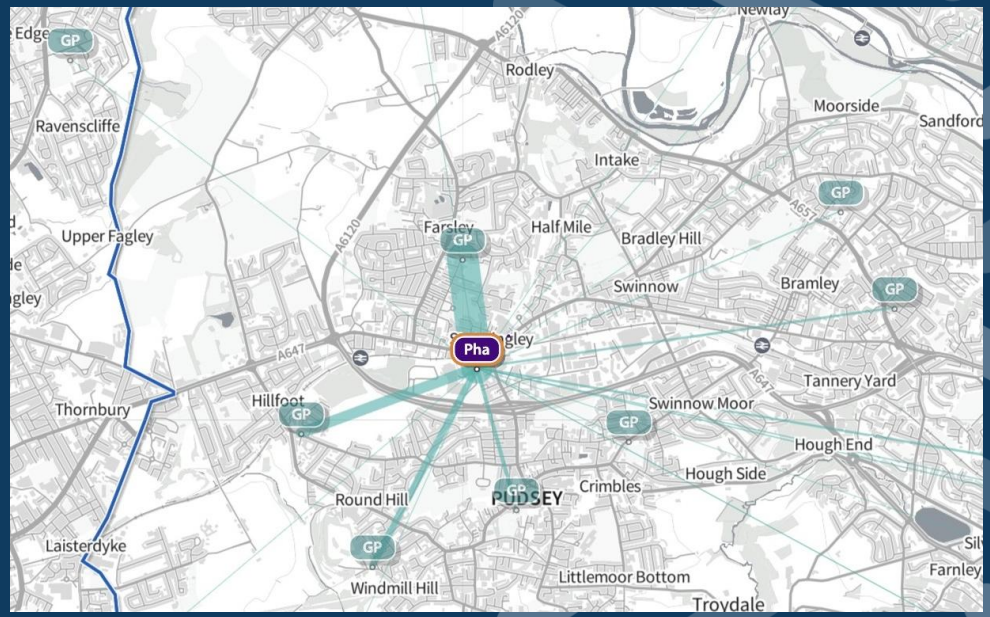
Nick Germain, Primary Care Manager, NHS South Yorkshire ICB

STRATA

CASE STUDY: Supporting the integration of community pharmacy services

Goal: West Yorkshire wanted to digitally map the provision of pharmaceutical services across the region, such as smoking cessation and blood pressure checks.

Result: Working with Strata, the ICB can now see at a glance where they have gaps in pharmacy service provision and visualise demand from each GP practice to ensure adequate coverage and uptake of services



"The development of [Strata] has been a great asset in the day-to-day management of pharmaceutical services. It has helped us support understanding of pharmaceutical services in the region."

Gillian Sealey, Primary Care Programme Manager, NHS West Yorkshire ICB

STRATA

CASE STUDY: Supporting primary care through population growth

Goal: York is growing rapidly, and the existing general practice estate doesn't have the capacity to absorb the population increase. York NHS, City of York Council and NHS Property Services used Strata to help develop an infrastructure delivery plan.

Result: Strata was used to map proposed housing growth and the geographic locations of practices, creating a map of the potential future estate. This informed proposals for investment and consolidation to respond to the new housing developments.

"Using the tool has supported our strategic thinking so we could recommend contributions from housing developers of £18m to provide general practice facilities for York residents."

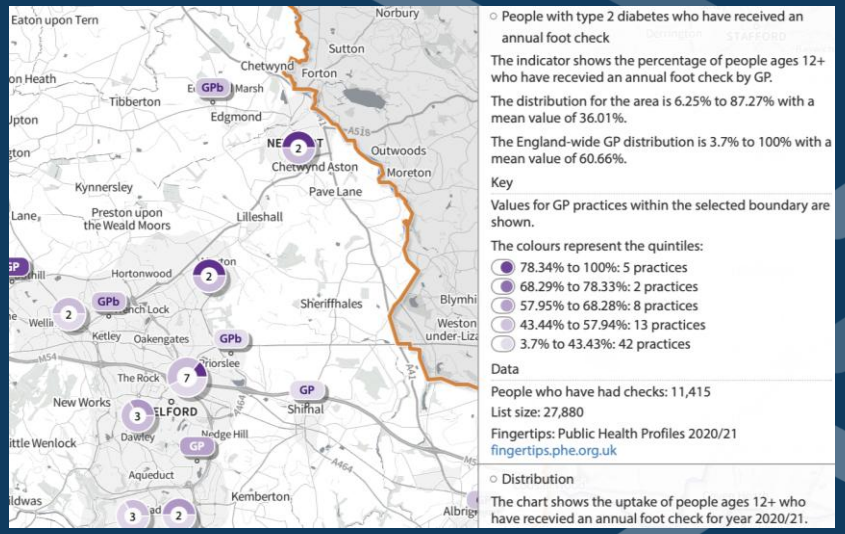
NHS Property Services

STRATA

CASE STUDY: Improving diabetes services

Goal: Shropshire Community Health NHS Trust wanted to understand their population, in order to make their diabetes prevention and treatment programmes more effective and improve health outcomes.

Result: Strata allowed the diabetes prevention team to identify areas with high risk factors for diabetes, so they could locate podiatry clinics in the most accessible places to support the avoidance of foot and lower leg complications.



"As well as improving health outcomes, using the tool for this project allowed me to demonstrate to our clinicians how it's essential that they look at populations before planning any outreach work. Now they are fully aware of the populations we have in the area, and they will proactively think about the best areas to target before starting a campaign, leading to more efficient, better directed campaigns and improved outcomes."

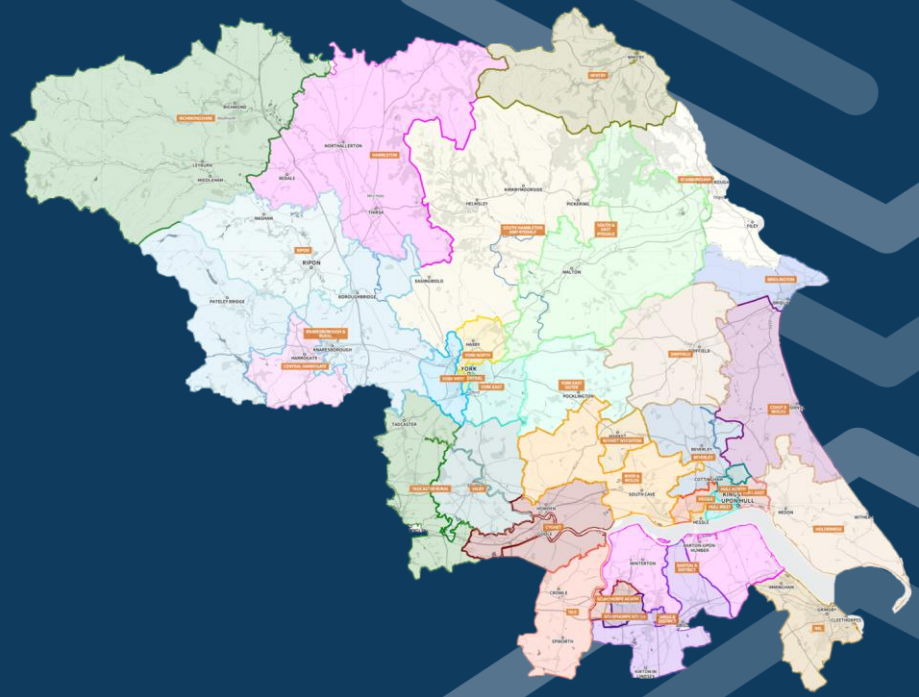
Helen Jones, Business Intelligence Lead, Shropshire Community NHS Trust

STRATA

CASE STUDY: Defining neighbourhoods

Goal: Humber and North Yorkshire ICB required a geospatial intelligence and analysis tool to support neighbourhood planning across estate, service, activity, and population. The objective was to support the places, PCNs, and wider partners with strategic planning to enable a consistent, data-driven strategic planning approach across the system.

Result: Humber and North Yorkshire ICB worked with Strata to develop bespoke neighbourhood boundaries to support strategic workspace, integrating estate data, anonymised hospital activity and population demographics planning. This enables partners to access consistent insights, assess population needs, profile neighbourhoods, and plan services more effectively.



> *"It is helping us get a much better understanding of the needs of our Places to develop our neighbourhood health services."*

Jake Abbas, Deputy Director – Insight and Analytics, Humber and North Yorkshire ICB

STRATA

REPORT TO:
AGENDA ITEM REF:12b

NHS
Cheshire and Merseyside

The Business Case is in Gateway 2 - design process. This should be done in conjunction with your impact assessments. This document should detail the options and outline plan for delivery.

Note: It may be that a project scoping document is more appropriate for your project/programme rather than a business case – this should be advised by the SRO.

Date of Meeting	
Report Title	**Development of the STRATA Tool for Neighbourhood Mapping and Delivery within Cheshire and Merseyside**
Presented by	**Lucy Andrews**
Prepared by	**Lucy Andrews**

PURPOSE OF THE REPORT:

Executive Summary	
Report purpose	Approval
Link to Strategic Priorities	**ICS Infrastructure Strategy/ 5 Year Commissioning Plan**
Recommendation/Required Action	The Board are requested to review the business case and approve the recommended preferred Option .

Contents

Executive Summary

Background

NHS Cheshire & Merseyside ICB requires a consistent, system-wide approach to understanding neighbourhood geographies, estate utilisation, and service delivery patterns to enable transformation aligned with the NHS "left shift" agenda. Current capability is fragmented across datasets, organisations and planning tools.

The STRATA Strategy ATLAS platform is already in use, but lacks a bespoke, tailored layer reflecting:

- Agreed neighbourhood boundaries
- Whole-system estate mapping
- Service utilisation aligned to population need
- Integrated BI outputs for decision-making

This business case **proposes the use of ring-fenced capital within BAU allocation to develop this bespoke layer.**

Scope

The scope of this business case covers the design, development and implementation of a bespoke Cheshire & Merseyside layer within the STRATA Strategy ATLAS platform, enabling a single, integrated view of neighbourhood geographies, estate utilisation, service activity and population need.

1. **Geographic & Neighbourhood Definition**

- Establishment of agreed, system-wide neighbourhood boundaries for our 58 Neighbourhoods
- Creation of a standardised geographic hierarchy (Neighbourhood → Place → System)
- Mapping of populations to neighbourhoods, including demographic and deprivation indicators
- Ability to flex boundaries (scenario modelling) for planning purposes

2. Estates Mapping and Utilisation

- Development of a comprehensive estate dataset, including:
    - Primary care estate
    - Community and mental health facilities
    - Acute estate
    - Where feasible, partner estate (local authority, VCSE)

- Attribution of:
    - Services delivered at each site
    - Utilisation levels (activity, capacity, occupancy where available)

- Integration of estate condition and suitability data (if available through ERIC or local sources)
- Visual mapping of estate against population need and service demand

3. Service Activity & Demand Integration

- Linking of activity data (e.g. outpatient, inpatient, community contacts) to:
  - Neighbourhood populations
  - Service locations (estate)

- Identification of:
  - Patient flows across localities and providers
  - Opportunities for care closer to home (left shift)
  - Mapping of inequalities in access, utilisation, and outcomes

4. User Access, Governance and Adoption

- Role-based access for:
  - ICB and partner organisation teams teams
  - locality-based partnerships
  - Provider organisations (as appropriate)
- Embedding within existing governance and decision-making forums
- Training and adoption support to ensure sustained use

5. Exclusions (Out of Scope)

- Replacement of existing operational BI systems
- Real-time operational performance management tools
- Large-scale infrastructure changes to core data platforms

Approach

The following high level approach will be undertaken:

- Phase 1: Discovery and Mobilisation
- Phase 2: Data Integration and Configuration
- Phase 3: Development of Analytical Outputs
- Phase 4: Implementation and Adoption
- Phase 5: Evaluation and Continuous Improvement

High level requirements

- Accurate neighbourhood-level geography mapping
- Fully attributed estate dataset
- Data integration (activity, workforce, population health)
- User-friendly BI outputs and dashboards

Strategic Context

The main objectives identified are:

Objective 1	
Objective	Enable neighbourhood-level planning across Cheshire & Merseyside
Current Arrangement	Inconsistent definitions and mapping of neighbourhoods and variance in system level access
Gap/Business Needs	Lack of standardised geography limits planning, reporting and investment decisions
Objective 2	
Objective	Optimise estate utilisation to support left shift
Current Arrangement	Estate data fragmented and not aligned to service demand
Gap/Business Needs	Inability to systematically identify opportunities to move care into community settings
Objective 3	
Objective	Strengthen BI for decision-making and reporting
Current Arrangement	Multiple disconnected BI tools and datasets
Gap/Business Needs	Lack of integrated insight to inform strategic and operational decisions

Benefits and Outcomes

Examples of benefits identified include:

- Improved strategic planning at neighbourhood level
- Identification of estate optimisation opportunities
- Enablement of left shift from acute to community settings
- Enhanced system-wide decision making
- Improved ability to meet national reporting requirements
- Reduced duplication of data and analytical effort
- Increased transparency across partners
- Support delivery of Return to Constitutional Standards

Risks, Constraints & Dependencies

The following risks, constraints and dependencies have been highlighted as part of the development of the case for change.

Risks

The following risks have been identified with the achievement of the programme outcomes:

Risk	Mitigating actions
Data quality issues	Data cleansing and governance controls
Stakeholder misalignment	Strong engagement and co-design of bespoke layer
Technical integration delays	Phased delivery and supplier support

Constraints

The following constraints have been identified:

- Availability and quality of partner datasets

Dependencies

The following dependencies have been identified as part of the programme:

- STRATA supplier capability and timelines
- Agreement on neighbourhood definitions
- Availability of estate and activity data
- Alignment with wider ICS digital strategy

Critical success factors

Critical success factors for the case for change are described below:

Critical Success Factor	Description
Strategic Fit	Alignment with NHS priorities (integration, left shift, population health)
Benefits Optimisation	Realisation of measurable estate and service improvements
Potential Achievability	Feasible delivery using existing STRATA platform
Affordability	Delivered within ring-fenced BAU capital

Options Appraisal

For completeness a range of options have been considered as part of the case for change, a brief description of full range of options is below:

Option 1: Do nothing

Pros	Cons
No cost	Continued fragmentation
No delivery risk	Missed transformation opportunity
	Inefficient estate optimisation

Option 2: Use Standard STRATA ATLAS Only

Pros	Cons
Lower cost associated with ATLAS in the interim period	Limited local relevance
	Does not meet neighbourhood planning needs
	NHSE Contract due to expire September 2026

Option 3: Develop Bespoke STRATA ATLAS Layer (Preferred Option)

Pros	Cons
Fully aligned to ICS needs	Associated cost and resource requirements
Enables neighbourhood planning and population health outcome measurement	
Supports national and local reporting requirements	
Integrates estate and BI planning tools	

Financial Case

Option 1	Description (*Committed costs)	Non-recurrent Year 1	Non-recurrent Year 2	Recurrent costs (Annual)	Comments
Do nothing	N/A	N/A	N/A	N/A	No benefit realisation
Option 2	**Description (*Committed costs)**	**Non-recurrent Year 1**	**Non-recurrent Year 2**	**Recurrent costs (Annual)**	**Comments**
Use Standard STRATA ATLAS Only	N/A	N/A	N/A	N/A	Limited capability
Option 3	**Description (*Committed costs)**	**Non-recurrent Year 1**	**Non-recurrent Year 2**	**Recurrent costs (Annual)**	**Comments**
Develop Bespoke STRATA ATLAS Layer	Initial Development and Hosting costs in addition to licenses to be capitalised to remove revenue consequence	£41,840		£0	Capital funded development

Summary Assessment of Options

The high level summary of the options against the investment objectives and critical success factors have enabled five options to be shortlisted for further evaluation, with a preferred option identified.

Key
Preferred
Possible
Discounted/Not Achievable

	Option 1 (Do nothing)	*Option 2*	*Option 3*
Investment Objectives / Business Needs			
Estate Optimisation	X	P	✓
Capability of Data Intelligence/Mapping	X	P	✓
Maturity of the System in decision making	X	P	✓
Critical Success Factors			
Strategic Fit			✓
Benefits Optimisation			✓
Potential Achievability			✓
Affordability			✓
Summary (Discounted/Preferred/Possible)	Discounted	Possible	Preferred

Following the initial options assessment, Options 1 has been discounted.

Preferred option

Option 3: Development of a bespoke STRATA Strategy ATLAS layer

This option provides the strongest alignment to strategic priorities, enabling:

- Neighbourhood-based planning
- Estate utilisation optimisation
- Integrated data-driven decision making
- Support for national and local reporting

The intention would be named individuals could also utilise the system from our partner organisations i.e Local Authority/VCSE. The proposal encompassed 25 users initially.

Potential Future Benefits

- Expansion to include wider partner estate (local authority, VCSE)
- Integration with workforce modelling tools
- Advanced predictive analytics
- Support for capital planning and investment prioritisation
- Replicability across other ICS region

Recommendation

- Approve the use of ring-fenced capital within the ICB BAU allocation
- Approve the development of a bespoke STRATA Strategy ATLAS layer
- Support system-wide adoption and data sharing to maximise benefits

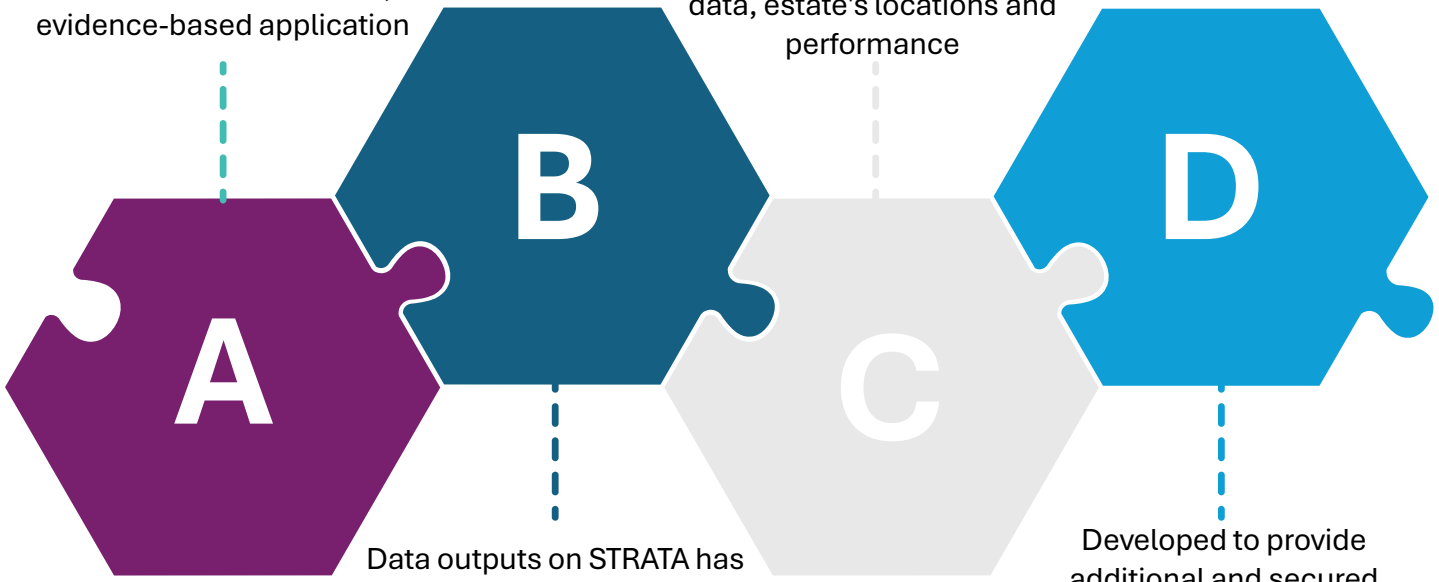
Appendix Two

NHS Cheshire and Merseyside

Estates - STRATA ICB Strategic Atlas

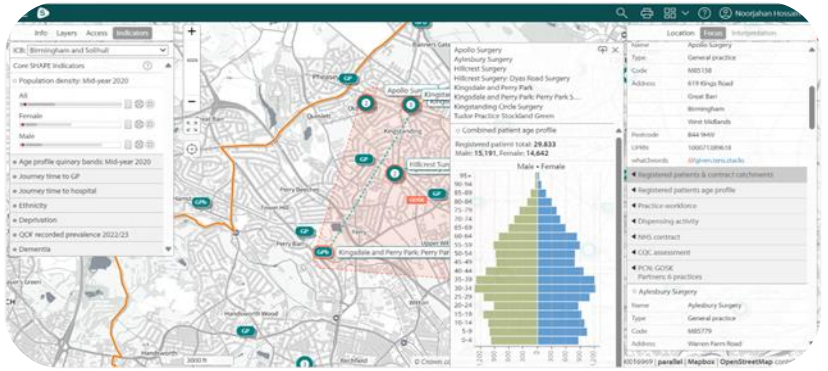
Supported by the **Department of Health and Social Care**, STRATA is a web enabled, evidence-based application

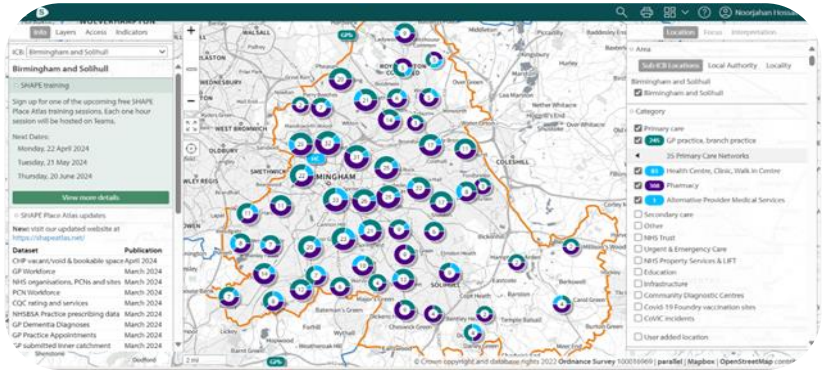
Contains the **most recent open source & national data sets**, e.g. public health data, primary care and demographic data, estate's locations and performance

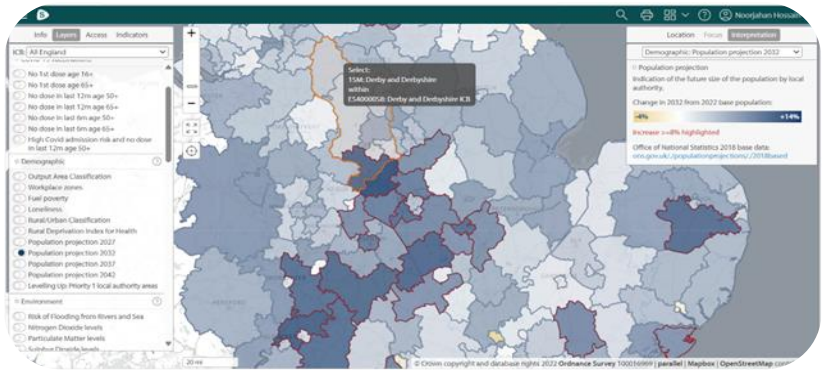


Data outputs on STRATA has helped to support joint **strategic needs assessments** and assist NHS **service reconfiguration**

Developed to provide additional and secured functionality to map the estates data to inform making best use of the asset base



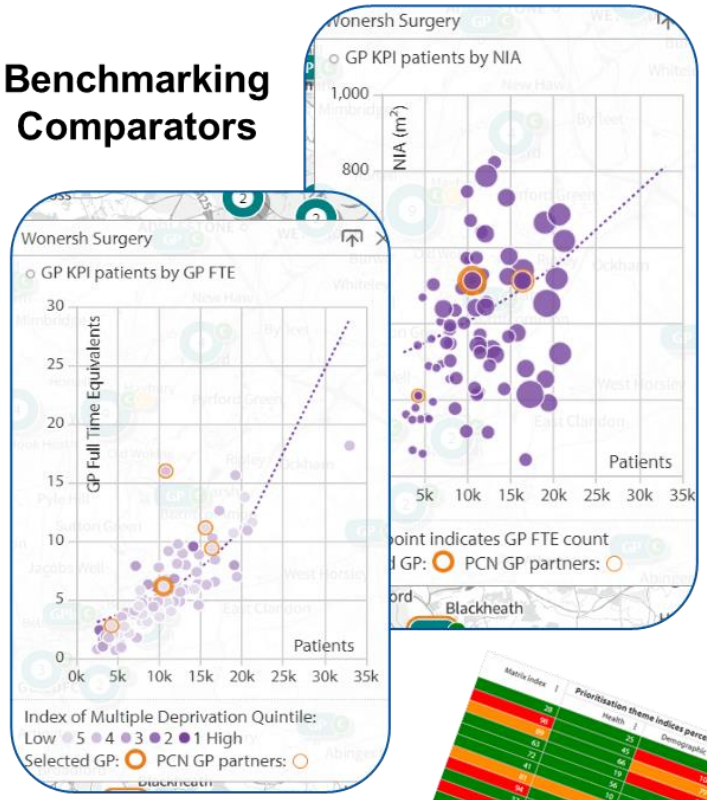




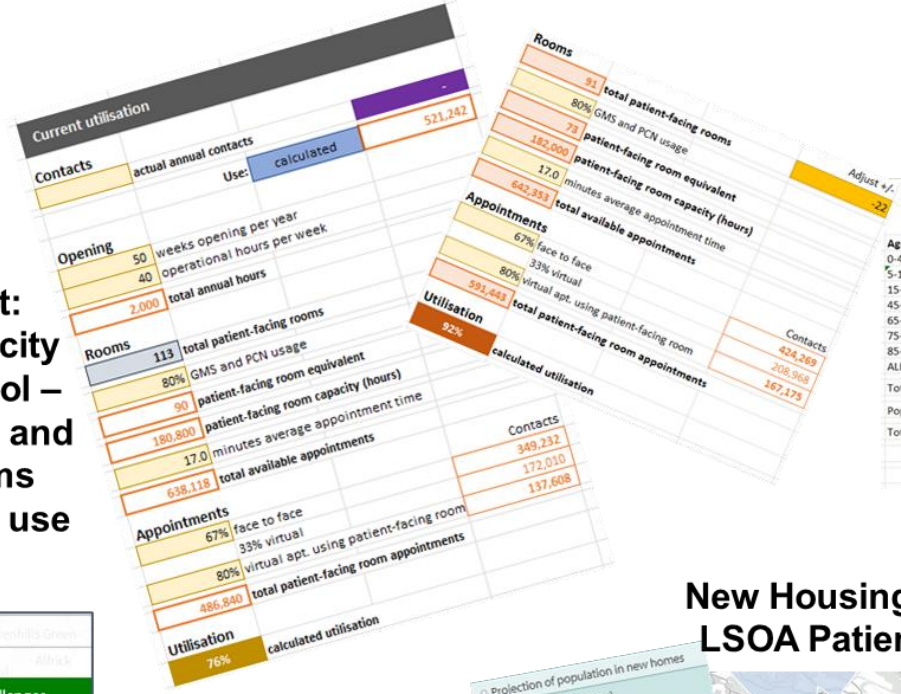
Examples of the Data Analysis & Planning Tools

NHS Cheshire and Merseyside

Benchmarking Comparators



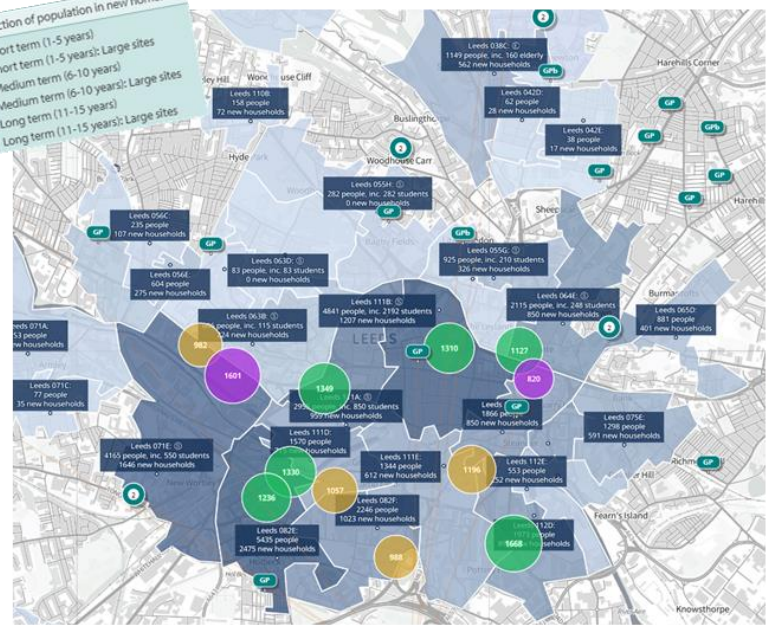
PCN Toolkit: Clinical Capacity Calculator Tool – Patient profile and patient rooms appointments use

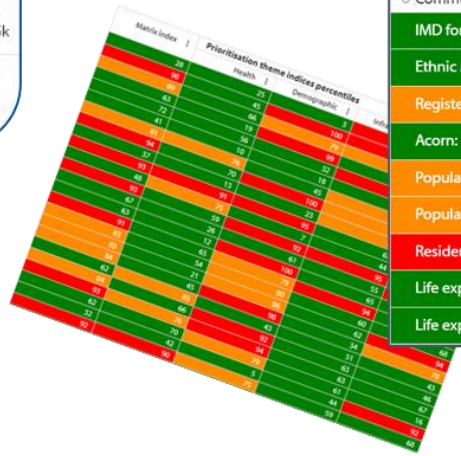


ONS demographic growth

	2032		
Ages	Change	Patients	Contacts
0-4	10.3%	4,825	28,276
5-14	-4.4%	10,097	21,810
15-44	8.5%	36,844	140,375
45-64	-0.2%	25,274	131,679
65-74	10.2%	11,377	90,785
75-84	10.4%	8,667	96,382
85+	19.4%	3,784	49,914
ALL	5.9%		
Total		100,869	559,221
Population in new housing		13,351	
Total		114,219	633,237
	Change	120%	121%
		Average contact rate	5.54

New Housing Population Analysis – LSOA Patient List Impact Analysis





PCN prioritisation matrix

Community Health Need

Wellbeing Acorn: Healthcare Challenges		
Cancer	CHD	COPD
Dementia	Depression	Diabetes
LD	MH	Obesity	STIA

Community Demographics

- IMD for GP contractual area
- Ethnic Minorities
- Registered patients ages 65+ proportion
- Acorn: Urban Adversity classification
- Population change next 5 years: all ages
- Population change next 5 years: ages 65+
- Residential population growth: 1-5 years
- Life expectancy at age 65: male
- Life expectancy at age 65: female

Supporting Infrastructure

- GP ages 60+ proportion
- GP single-handed practices
- Patients per GP FTE
- Patients per total clinical staff FTE

State of the Estate

- Patients per m² NIA
- Patients per clinical room
- Clinical staff FTE per clinical room
- Building age: >60 years
- Overall condition | Overall functionality

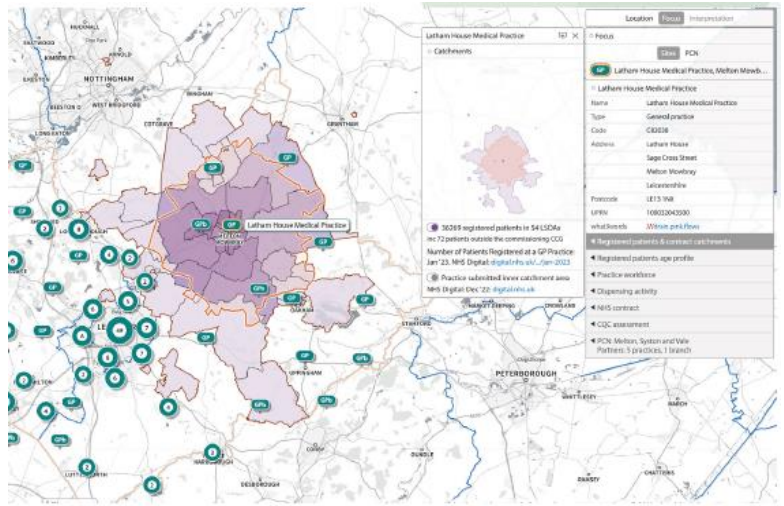
Prioritisation Matrix - National Indicator Tool

SHAPE Standard Datasets

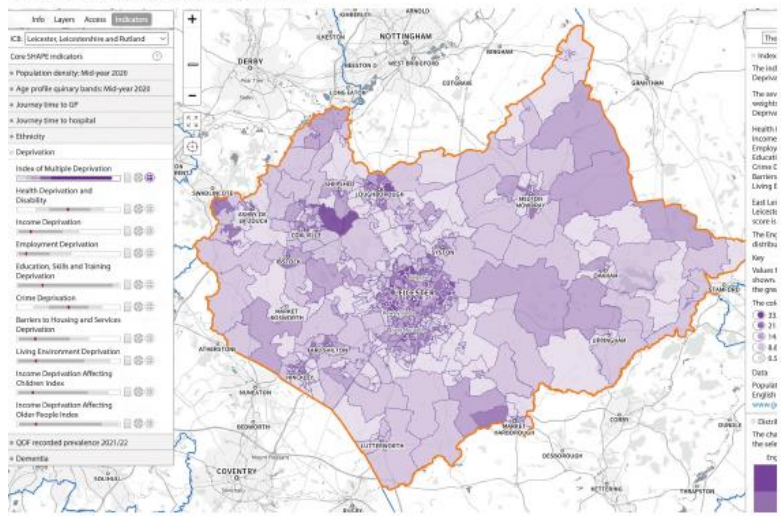
- Covid 19 unvaccinated date – by age group + high admission risk data
- Demographic information – IMD, Loneliness, fuel poverty, area classifications, rural/urban classifications, population projections
- Environment data eg: flood risk, air quality data, road traffic noise, air pollution, nitrogen dioxide, sulphur levels
- Dental access by age band
- Ambulance attendees and callouts in relation to alcohol and violence (data from 2015 – 2018)
- Crime records – Violence and sex offences (data from 2019)
- Hospital admissions
- Details IMD profile information – where people in top 10/20% are living and which practices fall within which bracket
- Travel distances
- Population & age profiles data – broken down by m/f & 5 year quinary age bands
- Journey times and main public transport routes
- Acorn & wellbeing classifications – Licensed dataset for viewing only
- GP Immunisation data
- Dementia diagnosis by age bands
- Ethnicity data
- Deprivation data – income, employment, IMD, education and skills deprivation, housing
- QOF Health prevalence indicators- asthma, af, kidney disease, copd, chd, dementia, depression, diabetes, epilepsy, heart failure, hypertension, mh, non diabetic hyperglycaemia, obesity, osteoporosis, palliative care, pad, arthritis, stroke – broken down by LSOA areas – and indicated where levels of certain diseases are above average
- Boundary information – CCG & LA areas, LSOS, MSOA, postcode, ward boundaries, parish & non civil parish areas, districts, acute trust catchments, police force areas, fire and rescue service authorities, ph regions, LIFT company coverage, cancer alliances

SHAPE Standard Location Information

- Primary Care – registered patients (inc age profile) & contract catchments, practice workforce, dispensing activity, CQC assessment data and NHS Contract info.
- Pharmacy locations
- Eric Site data – Acute, MH &Community
- Treatment/care centres
- Children's centres
- Carehomes
- Dental services – local and community
- Genito Medicine locations
- Hyper acute stroke units
- Private hospitals
- Mental health facilities
- Urgent and Emergency care properties by type eg Minor injuries, Sexual health
- NHSPS and LIFT sites
- Opticians
- Key supermarket sites
- Open Green spaces
- Education sites by category eg: nursery, primary, secondary
- Ambulance stations
- Prisons
- Railway stations
- Local prescribing service & catchment areas
- Licensed alcohol & gambling facilities
- Covid 19 vaccination sites



GP Registered Patients & Contract Catchment



Index of Multiple Deprivation

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

25th June 2026

General Practice Capital Funding – Utilisation and Modernisation Fund and IT related costs (BAU)

Agenda Item No:13

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

1. Purpose of the Report

1.1 To provide assurance to the System Primary Care Committee (SPCC) on delivery, governance, value for money, and sustainability of the 2025/26 Utilisation and Modernisation Fund (UMF) programme. Incorporating views from system leadership, delivery teams, partners, and practices.

2. Executive Summary

- £5.93m Capital programme delivered across 8 Places
- 50 schemes approved, delivered or progressing to schedule
- Plus 6 Schemes obtaining enabling support for future schemes.

2.1 **Appendix 1** - Provides 25/26 UMF Schemes, financial summary, tangible benefits, current deliverable position and UMF process BRAG rating.

3. Ask of the System Primary Care Committee and Recommendations

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

- **NOTE** delivery progress and achievement against a challenging National backdrop.
- **NOTE** proposed actions arising from lessons learned to strengthen future capital delivery. To engage with NHS E National and Regional Teams to address:
    - Inconsistent guidance
    - Changes to interpretation of guidance mid-way through year
    - Increase in legal and contingency costs
    - Levers for practice readiness
    - Reduced administrative and legal burden
    - Better alignment with estates strategy

4. Background and delivery

4.1 UMF was awarded to all ICB's in 2025/26 in to improve the Primary Care Estates. It was primarily focused on converting existing space within GP Practices into clinical space, at a minimum revenue impact.

4.2 As the scheme progressed in year, some of the original milestones were relaxed i.e. small extensions were allowed

4.3 As this was the 1st year, there was extensive policy change during delivery period

4.4 Some National processes still under review (Collateral Warranties, Guaranteed Period of Use).

4.5 Timescale deadline resulted in increased delivery and completion costs.

4.6 **Programme Delivery & Financial Management**

- A total of 50 schemes and 6 feasibility schemes are being progressed across 8 Places for 25/26 within an overall financial envelope of £5,928,350. Additional £901,350 funding successfully utilised (slippage from NW ICB)
- Reserve scheme planning enabled rapid response to funding opportunities
- Surplus reallocation maximised overall programme value.

4.7 **Legal Agreements & Governance**

- High proportion of schemes requiring extended legal agreements.
- Legal complexity significantly impacted timescales and resources.
- Increased legal and contingency costs not fully predictable at programme outset.

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

The UMF supports ICB objectives by:

- Supports ICB strategic commissioning objectives
- Strengthens integrated, partnership-based delivery
- Contributes to system digital priorities
- Aligns with broader Cheshire & Merseyside ambitions
    - Supporting population health, inequality reduction, and effective resource use.
    - Reinforces integrated working
    - Advances digital and data ambitions through improved estates and infrastructure

5.1 **Overall Assurance Statement**

Overall Programme BRAG Rating : Amber-Green (full details in appendix)

The UMF programme delivered strong outcomes for the ICB. However, this was a challenging year and early indications from NHS E are that future years will have less bureaucracy, and a simpler process.

6. Officer contact details for more information

- Pauline Underwood, Senior Primary Care Estates and Capital Manager

7. Appendices

- Appendix 1 - General Practice Capital Funding – Utilisation and Modernisation Fund and IT related costs (BAU)

Appendix 1 to
General Practice Capital Funding – Utilisation and Modernisation Fund and IT related costs (BAU)

Current Scheme Position (1)

BRAG Project Update	On-Scheule Delivery	Current Capital Splits	50 Schemes (Initial 25/26 UMF) Plus 2 NHSE Hill Dickinson Fees	6 Feasability Schemes (% of 2025/26 UMF Surplus)		33 with Digital Requirements	
Blue - In Delivery. Schemes delivery moving forward as scheduled	Very High (90-100%)	**£3,247,364.72**	**8**			**£110,197.48**	**6**
Percentages		55%	16%			19%	18%
Red - Issues / Risks : Legal Grant Agreement disputed unlikely to be signed within the next two months or withdrawn	Low (0-39%)	**£0.00**	**0**			**£0.00**	**0**
Percentages		0%	0%			0%	0%
Amber - Legal Grant Agreement with Tenant/Landlord Legals for final signing within the next month (Feasability iminant for NHSE signing)	Medium (40-69%)	**£251,689.79**	**1**	**£518,000.00**	**6**	**£8,672.95**	**1**
Percentages		4%	2%	9%		2%	3%
Green - Next Steps / Positives : Delivered	Very High (100%)	**£1,825,688.69**	**41**			**£131,283.12**	**26**
Percentages		31%	82%			23%	79%

TOTAL	£5,324,743.20	90%
6 Feasability Schemes(% of 2025/26 UMF Surplus)	£518,000.00	9%
Estates surplus to be utilisted on Firdale, Grosvenor and Woolton	£85,606.89	1%
TOTAL (Balance to C & M Budget)	**£5,928,350.09**	100%

TOTAL	£250,153.55	43%
Digital surplus (Fully Utilised -details page 11)	£325,846.45	57%
TOTAL (Balance to C & M Budget)	£576,000.00	100%

NHSE Regional and National teams have confirmed that the 2025/2026 UMF budget will be accrued, enabling all schemed approved by 31 March 2026 to progress through to full finalisation and ensuring committed projects are not disadvantaged by National timeline, legal delays or process variability experienced during this year's programme.

Appendix 1 to
General Practice Capital Funding – Utilisation and Modernisation Fund and IT related costs (BAU)

Current Scheme Position (2)

	Scheme Details					Financial Summary (as at 05/06/2026)				Digital Element	Tangible Benefits		Current Position	
	Place	UMF Tracker	Site name	ORIGINAL TOTAL AWARD (Incl Pro/Legal & Contingency)	OUTSTANDING SCHEMES TOTAL (includes NHSE Legal Charge)	FINISHED SCHEMES	INVOICED TO DATE FOR OUTSTANDING SCHEMES	NHSE ACCRUAL REQUIRED FOR OUTSTANDING SCHEMES	SURPLUS FROM FINALISED SCHEMES	Indicative IT Costs as per PID (BAU)	No of additional clinical rooms	Predicted number of additional GP appointments (based from clinical rooms/car parking etc)	Approval Status	Scheduled
1	Wirral	1656-UMF-NORTH WEST-N85022	Holmlands Medical Centre	£3,333.66		£2,700.00			£633.66	£1,953.60	2	16640	Delivered	
2	Wirral	1659-UMF-NORTH WEST-N85054	Kings Lane Medical Centre	£7,356.68		£6,620.40			£736.28	£12,311.82	1	8320	Delivered	
3	Wirral	1661-UMF-NORTH WEST-N85018	The Villa Medical Centre	£2,669.60		£2,874.00			-£204.40	£2,500.00	1	8320	Delivered	
4	Cheshire East	1663-UMF-NORTH WEST-N81002	Kenmore Medical Centre	£142,018.42		£137,104.49			£4,913.93	£9,000.00	6	49920	Delivered	
5	Cheshire West	1664-UMF-NORTH WEST-N81101	The Handbridge Medical Centre	£14,548.25		£13,926.00			£622.25	£2,432.00	2	16640	Delivered	
6	Liverpool	1665-UMF-NORTH WEST-N82059	Greenbank Drive Surgery	£127,984.82		£115,175.00			£12,809.82	£0.00	1	8320	Delivered	
7	Cheshire West	1667-UMF-NORTH WEST-N81102	Fountains Medical Practice	£32,123.16		£28,908.00			£3,215.16	£6,730.47	1	8320	Delivered	
8	Cheshire West	1668-UMF-NORTH WEST-N81079	The Elms Medical Practice	£39,406.10		£35,461.80			£3,944.30	£1,569.60	1	8320	Delivered	
9	Cheshire West	1669-UMF-NORTH WEST-N81080	Northgate Medical Centre	£6,703.55		£6,032.40			£671.15	£3,558.05	1	8320	Delivered	
10	Wirral	1670-UMF-NORTH WEST-N85005	Eastham Group Practice	£270,170.36	£273,986.36		£0.00	£273,986.36	-£3,816.00	£12,106.06	8	66560	In Deliverey	30/06/2026
11	Wirral	1671-UMF-NORTH WEST-N85006	Civic Medical Centre	£133,125.98		£121,289.59			£11,836.39	£4,653.21	3	24960	Delivered	
12	Wirral	1672-UMF-NORTH WEST-N85051	Allport Medical Centre (Sunlight Group)	£6,834.15		£6,000.00			£834.15	£0.00	1	8320	Delivered	
13	Wirral	1674-UMF-NORTH WEST-N85617	Spital Surgery	£36,768.06		£34,359.00			£2,409.06	£1,651.00	1	8320	Delivered	
14	Wirral	1675-UMF-NORTH WEST-N85007	Myrtle Group (Commonfield)	£15,901.57		£14,310.00			£1,591.57	£7,002.44	1	8320	Delivered	
15	Cheshire East	1676-UMF-NORTH WEST-N81632	Broken Cross	£41,338.02		£36,934.80			£4,403.22	£6,938.04	1	8320	Delivered	
16	Cheshire East	1677-UMF-NORTH WEST-N81062	Cumberland House Surgery	£46,251.15		£39,161.94			£7,089.21	£13,575.56	2	16640	Delivered	

	Scheme Details					Financial Summary (as at 05/06/2026)				Digital Element	Tangible Benefits		Current Position	
	Place	UMF Tracker	Site name	ORIGINAL TOTAL AWARD (Incl Pro/Legal & Contingency)	OUTSTANDING SCHEMES TOTAL (includes NHSE Legal Charge)	FINISHED SCHEMES	INVOICED TO DATE FOR OUTSTANDING SCHEMES	NHSE ACCRUAL REQUIRED FOR OUTSTANDING SCHEMES	SURPLUS FROM FINALISED SCHEMES	Indicative IT Costs as per PID (BAU)	No of additional clinical rooms	Predicted number of additional GP appointments (based from clinical rooms/car parking etc)	Approval Status	Scheduled
17	Wirral	1678-UMF-NORTH WEST-N85048	Moreton Medical Centre	£33,314.39		£29,979.91			£3,334.48	£2,579.52	1	8320	Delivered	
18	Cheshire West	1680-UMF-NORTH WEST-N81025	Firdale Medical Centre	£226,134.93	£251,689.79		£16,153.55	£235,536.24	-£25,554.86	£8,672.95	5	41600	Agreement Issued	Legal Grant/CW being finalised - 12 weeks from then (8 weeks contract period and 4 weeks mobilisation period)
19	Cheshire West	1681-UMF-NORTH WEST-N81067	Oakwood Medical Centre	£5,722.79		£5,150.00			£572.79	£3,558.00	2	16640	Delivered	
20	Cheshire West	1682-UMF-NORTH WEST-N81093	Whitby Health Partnership	£110,385.09		£104,106.84			£6,278.25	£5,845.30	5	41600	Delivered	
21	Cheshire West	1683-UMF-NORTH WEST-N81092	Hope Farm Medical Centre	£13,051.28		£11,577.00			£1,474.28	£2,996.85	2	16640	Delivered	
22	South Sefton	1686-UMF-NORTH WEST-N84003	High Pastures Surgery	£29,068.42		£25,484.13			£3,584.29	£0.00	0	49700	Delivered	
23	South Sefton	1687-UMF-NORTH WEST-N84007	Liverpool Road Medical Practice	£96,035.01		£86,423.00			£9,612.01	£0.00	0	49700	Delivered	
24	Warrington	1688-UMF-NORTH WEST-N81108	Grappenhall (Branch of Lakeside)	£77,107.59	£71,485.99		£48,474.91	£23,011.08	£5,621.60	£5,544.53	3	24960	In Deliverey	31/07/2026
25	St Helens	1689-UMF-NORTH WEST-N83053	Longton Medical Centre	£141,660.61		£134,564.40			£7,096.21	£6,417.66	1	8320	Delivered	
26	Liverpool	1691-UMF-NORTH WEST-N82073	The Ash Surgery	£59,719.21		£53,742.00			£5,977.21	£350.00	2	16440	Delivered	
27	Liverpool	1692-UMF-NORTH WEST-N82009	Grassendale Medical Practice	£14,352.52		£11,538.46			£2,814.06	£530.00	1	8320	Delivered	
28	Wirral	1694-UMF-NORTH WEST-N85027	Mill Lane Surgery	£44,568.83		£39,751.84			£4,816.99	£0.00	1	8320	Delivered	
29	Wirral	1695-UMF-NORTH WEST-N85025	St Hilary Group Practice	£5,311.63		£4,779.12			£532.51	£7,615.29	2	16640	Delivered	
30	Wirral	1696-UMF-NORTH WEST-N85629	Egremont Medical Centre	£31,930.92		£28,734.72			£3,196.20	£0.00	1	8320	Delivered	
31	Halton	1698-UMF-NORTH WEST-N81119	Hough Green Health Park	£82,491.61		£72,513.66			£9,977.95	£0.00	1	8320	Delivered	
32	Cheshire East	1699-UMF-NORTH WEST-N81614	Wrenbury Medical Practice	£55,665.48		£54,568.20			£1,097.28	£5,561.70	2	16640	Delivered	
33	Liverpool	1700-UMF-NORTH WEST-N82110	Long Lane Medical Centre	£13,330.68		£16,592.64			-£3,261.96	£1,830.80	0	0	Delivered	
34	Wirral	1701-UMF-NORTH WEST-N85016	Riverside Surgery	£59,596.98		£52,648.33			£6,948.65	£4,219.31	0	0	Delivered	

	Scheme Details					Financial Summary (as at 05/06/2026)				Digital Element	Tangible Benefits		Current Position	
	Place	UMF Tracker	Site name	ORIGINAL TOTAL AWARD (Incl Pro/Legal & Contingency)	OUTSTANDING SCHEMES TOTAL (includes NHSE Legal Charge)	FINISHED SCHEMES	INVOICED TO DATE FOR OUTSTANDING SCHEMES	NHSE ACCRUAL REQUIRED FOR OUTSTANDING SCHEMES	SURPLUS FROM FINALISED SCHEMES	Indicative IT Costs as per PID (BAU)	No of additional clinical rooms	Predicted number of additional GP appointments (based from clinical rooms/car parking etc)	Approval Status	Scheduled
35	Cheshire West	1702-UMF-NORTH WEST-N81082	City Walls Medical Centre	£68,698.98		£59,255.40			£9,443.58	£0.00	0	1000	Delivered	
36	Liverpool	1704-UMF-NORTH WEST-N82024	West Derby Medical Centre	£76,606.43		£71,938.57			£4,667.86	£0.00	0	2000	Delivered	
37	St Helens	1706-UMF-NORTH WEST-N83002	Patterdale Lodge Medical Centre	£19,204.49		£19,428.36			-£223.87	£1,777.32	2	16640	Delivered	
38	Liverpool	1707-UMF-NORTH WEST-N82083	Jubilee Medical Centre	£27,513.82		£26,656.00			£857.82	£0.00	0	0	Delivered	
39	South Sefton	1709-UMF-NORTH WEST-N84011	Eastview Surgery	£15,961.57	£20,620.35		£9,960.00	£10,660.35	-£4,658.78	£0.00	2	16640	In Deliverey	31/07/2026
40	Wirral	1710-UMF-NORTH WEST-N85012	St George's Medical Centre	£16,489.40		£15,895.84			£593.56	£0.00	3	24960	Delivered	
41	Liverpool	1711-UMF-NORTH WEST-N82066	Woolton House MC	£975,409.36	£964,765.77		£962,546.61	£2,219.16	£10,643.59	£35,000.00	5	41600	In Deliverey	31/08/2026
42	Warrington	449-UMF-NORTH WEST - N81075	Stockton Heath Medical Centre	£219,371.28	£222,340.28		£195,754.83	£26,585.45	-£2,969.00	£0.00	6	49920	In Deliverey	27/06/2026
43	Cheshire East	450-UMF-NORTHWEST-N81068	Grosvenor Medical Centre (Grersty)	£72,473.80		£70,884.00			£1,589.80	£0.00	0	0	Delivered	
44	Cheshire West	1993-UMF-NORTH WEST-N81060	Neston Surgery	£651,429.32	£662,645.32		£4,860.00	£657,785.32	-£11,216.00	£21,599.61	5	40000	In Deliverey	11/12/2026
45	South Sefton	1994-UMF-NORTH WEST-N84005	Cumberland House Surgery	£14,779.23		£13,500.00			£1,279.23	£0.00	0	0	Delivered	
46	Liverpool	443-UMF-NORTHWEST-N82117	Ropewalks General Practice	£377,664.61	£383,136.61		£0.00	£383,136.61	-£5,472.00	£15,947.28	3	24960	In Deliverey	10/07/2026
47	Warrington	446-UMF-NORTHWEST-N81048	Fearnhead Cross M.C.	£141,791.74		£123,753.85			£18,037.89	£0.00	1	8320	Delivered	
48	Cheshire East	453-UMF-NORTHWEST-N81068	Grosvenor Medical Centre (2nd BID)	£607,178.34	£641,869.04		£127,857.47	£514,011.57	-£34,690.70	£20,000.00	3	24960	In Deliverey	01/12/2026

	Scheme Details					Financial Summary (as at 05/06/2026)				Digital Element	Tangible Benefits		Current Position	
	Place	UMF Tracker	Site name	ORIGINAL TOTAL AWARD (Incl Pro/Legal & Contingency)	OUTSTANDING SCHEMES TOTAL (includes NHSE Legal Charge)	FINISHED SCHEMES	INVOICED TO DATE FOR OUTSTANDING SCHEMES	NHSE ACCRUAL REQUIRED FOR OUTSTANDING SCHEMES	SURPLUS FROM FINALISED SCHEMES	Indicative IT Costs as per PID (BAU)	No of additional clinical rooms	Predicted number of additional GP appointments (based from clinical rooms/car parking etc)	Approval Status	Scheduled
49	Cheshire East	1714-UMF-NORTHWEST-N81044	Hungerford Medical Centre	£67,723.15		£60,945.00			£6,778.15	£14,125.58	1	8320	Delivered	
50	Cheshire East	1715-UMF-NORTHWEST-N81068	Chelford Surgery	£25,558.07		£30,420.00			-£4,861.93	£0.00	0	2000	Delivered	
	Cheshire West	1712-UMF-NORTHWEST-N81081	Garden Lane	£4,942.00	£4,942.00	£0.00	£0.00	£4,942.00	£0.00	£0.00			Hill Dickinson legal Fees - Scheme withdrawn late in proceedings	
	St Helens	1716-UMF-NORTHWEST-N83019	Billinge Medical Centre	£1,573.00	£1,573.00	£0.00	£0.00	£1,573.00	£0.00	£0.00			Hill Dickinson legal Fees - Scheme withdrawn late in proceedings	
				£5,410,350.09	**£3,499,054.51**	**£1,825,688.69**	**£1,365,607.37**	**£2,133,447.14**	**£85,606.89**	**£250,153.55**	**93**	**876360**		
					(Incl 1 AMBER £251,689.79)	**£5,410,350.09**								
				TOTAL	£5,324,743.20	Dif Surplus	**£85,606.89**							

	FEASABILITY COSTS FOR FUTURE SCHEMES				
1	Liverpool	2627CMPC040	Aintree Neighbourhood Health Centre	£100,000.00	£100,000.00
2	South Sefton	2627CMPC039	Maghull Neighbourhood Health Centre	£100,000.00	£100,000.00
3	Cheshire West	2627CMPC043	Willaston Surgery Relocation	£143,000.00	£143,000.00
4	Cheshire West	2627CMPC037	Tattenhall Neighbourhood Health Centre	£100,000.00	£100,000.00
5	Cheshire East	2627CMPC035	Knutsford Neighbourhood Health Centre	£25,000.00	£25,000.00
6	St Helens	2627CMPC045	Billinge Health Centre	£50,000.00	£50,000.00
				£518,000.00	£518,000.00
				£5,928,350.09	**£5,842,743.20**

Appendix 1 to
General Practice Capital Funding – Utilisation and Modernisation Fund and IT related costs (BAU)

Financial Summary

SUMMARY			
No of Schemes	**Place**	**ESTATES Values £**	**DIGITAL Indicative Values £**
8 (1 over £144K and 1 Feasability)	Cheshire East	1,096,887.47	69,200.88
10 (2 over £144K, 2 Feasability 1 Hill Dickinson Fees NHSE fees only)	Cheshire West	1,426,694.55	56,962.83
1	Halton	72,513.66	0.00
8 (2 over £144k and 1 Feasability)	Liverpool	1,743,545.05	53,658.08
4 (1 Feasability)	Sefton	246,027.48	0.00
2 (1 Feasability & 1 Hill Dickinson NHSE fees only)	St Helens	205,565.76	8,194.98
3 (1 over £144k)	Warrington	417,580.12	5,544.53
14 (1 over £144k)	Wirral	633,929.11	56,592.25
50		**5,842,743.20**	**250,153.55**
C & M BUDGET		**5,928,350.09**	**576,000.00**
Variance after 25/26 UMF Schemes and Digital Costs		**85,606.89**	**325,846.45**

General Practice BAU Capital – DIGITAL APPROVAL SPCC (June 2025)	
BAU Capital Projects	**Digital**
Digital costs associated with U&M (P1+P2)	£ 576,000

Digital Values - BAU
For clarification, the digital costs currently presented remain indicative for the schemes. The apparent underspend reflects the position at the point these schemes were initially costed, approximately 12 months ago and does not account for any current contingency provisions.

Digital costs estimates are revisited and refined when practices receive their final scheme approval notifications and projects progress to the next stage of delivery. At this stage, site revisits may also identify additional requirements, which could further impact overall digital cost envelopes.

The Digital surplus generated by some of the larger schemes not proceeding, will be made available to fully support the Practices where there have been unforeseen increased costs and also schemes still awaiting completion due to issues with contractors or commercial changes, this will come from the original agreed 25/26 digital allocation.

The Estates surplus will be required to offset cost pressures associated with the larger outstanding schemes, many of which received approval at a later stage in the programme. In addition, allowance will need to be made for NHSE Hill Dickinson legal costs which haven't yet been confirmed. It is anticipated that the surplus will be fully utilised in supporting the delivery of these larger schemes.

Summary – Programme Position & Next Steps

NHSE Estates Programme – Board Summary

Status & Approvals

- All schemes have received NHSE approval (final approval: 30 March 2026), enabling transition into delivery.
- Delivery risk assessment is underway; All schemes are expected to meet their predicted schedules.
- Cross-year accruals have been approved where required and are reflected in NHSE reporting.

Financial Position & Controls

- Standard legal cost uplift applied: 4% (<£144k) and 5% (>£144k).
- NHSE has issued scheme-specific legal cost allocations; utilisation must be evidenced.
- Any uncommitted legal funding will be reallocated to reserve schemes to optimise use of the overall budget.

Delivery & Governance

- ICB Estates and Places teams are providing ongoing delivery support to practices and project teams.
- Strong alignment is maintained with Finance and Digital functions to ensure coordinated delivery and transparency.
- Monthly reimbursement claims are required by the 20th to ensure payment in the following month.

Oversight & Risk Management

- Joint oversight in place between ICB and NHSE.
- ICB responsible for monthly performance tracking and reporting.
- Formal change control required for scheme withdrawals or cost variances exceeding 20%.

Budget Optimisation & Forward Pipeline

- Approved prioritisation framework continues to guide investment decisions.
- Surplus funding is being redirected to feasibility and enabling activity to improve delivery readiness.
- Active pipeline development is underway to ensure future schemes are robust and deliverable.

Key Messages

- Programme is fully approved and progressing into delivery phase.
- Financial controls and governance arrangements are robust.
- Surplus funding is being actively managed to maximise programme impact and strengthen the future pipeline.

BRAG Rating Definitions

Rating	Colour	Definition	Interpretation
B	Blue	Exceeding expectations / best practice	Performance is significantly better than planned; no material issues and potential learning for wider system adoption.
R	Red	Significant concerns	Delivery is off track with material risks requiring urgent senior intervention or escalation.
A	Amber	Some concerns	Delivery broadly on track but with notable risks or issues that require active management to prevent deterioration.
G	Green	On track	Delivery is proceeding as planned with no significant issues requiring escalation.

Summary BRAG Dashboard – UMF Programme 2025/26 (with Trends)

Area of Assurance	BRAG	Trend	Overall Commentary
Overall Programme Delivery	Amber-Green	▲	Higher delivery volume and improved budget utilisation than previous programmes, despite increased complexity.
Strategic Alignment (ICB & C&M Priorities)	Green	►	Strong and consistent alignment-maintained year-on-year.
Financial Control & Budget Utilisation	Green	▲	Improved ability to maximise funding through reserve schemes and surplus reallocation compared to prior rounds.
Programme Governance & Oversight	Amber	►	Governance framework stable but operating under greater external pressure than in previous years.
Legal & Contractual Complexity	Red	▼	Increased legal burden and uncertainty compared with earlier programmes due to national policy changes.
Practice Readiness & Deliverability	Amber	▼	Greater variability than previously seen; readiness impacts more pronounced at scale.
Workforce Capacity & Sustainability	Red	▼	Delivery dependency on additional hours has worsened relative to previous programmes.
Feasibility & Pipeline Planning	Green	▲	Significant improvement with enabling funding secured and earlier feasibility embedded.
Integration & Partnership Working	Green	▲	Stronger cross-system collaboration than previous programmes, particularly across Places.
Quality, Safety & CQC Alignment	Amber	►	Consistent focus maintained; delays linked to external factors rather than quality regression.
Learning & Continuous Improvement	Green	▲	More structured and mature lessons-learned process than prior UMF cycles.

Interpretation of Trends (Optional for Board Pack)

- **Improving (▲):** Financial delivery, feasibility planning, integration, and learning maturity.
- **Stable (►):** Strategic alignment, governance fundamentals, and quality focus.
- **Deteriorating (▼):** Legal burden, workforce sustainability

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

25th June 2026

GP Premises Lease Compliance – Approval of Escalation Process for Practices Without NHS-Approved Leases

Agenda Item No: 14

1. Purpose of the Report

1.1 This paper seeks SPCC approval to implement a formal three-stage escalation process for GP practices receiving NHS rental reimbursement without an NHS-approved lease, in line with the NHS (General Medical Services – Premises Costs) Directions 2024 (PCDs).

The Estates Team is improving lease compliance through a proactive, collaborative approach. However, a small number of non-compliant practices remain. A formal escalation process is now required as a proportionate and necessary final step to enable consistent enforcement of the PCDs.

Executive Summary

1.2 The Estates Team has made progress with 12 compliant leases agreed in the past six months.

- All lease approvals are subject to Value For Money (VFM) and strategic estates assessment, ensuring alignment with the ICB's estate strategy and avoiding unnecessary long-term liabilities.
- 48 practices (excl NHSPS/CHP) currently receive rental reimbursement without an NHS-approved lease. Each will undergo individual pre-assessment to confirm whether a lease is strategically appropriate before escalation (i.e. is the GP Practice due to move to another site)
- Despite sustained engagement, some practices remain non-compliant. A formal escalation framework is therefore required to support consistent, legally robust enforcement.

The existing lease approval process is operating effectively and delivering NHS compliant, VFM outcomes. SPCC approval is now sought for the final and proportionate escalation step, enabling the ICB to fully enforce the PCDs and provide assurance of equitable, consistent and accountable estate governance.

2. Ask of the System Primary Care Committee and Recommendations

2.1 The System Primary Care Committee is asked to:

- **APPROVE** – The introduction of a formal three-stage escalation (breach) process for non-compliant practices.
- **ENDORSE** - The supporting governance framework to ensure a consistent, proportionate and legally defensible approach.
- **SUPPORT** – Continued collaborative working (Estates, Contracts and Finance) and development of a Standard Operating Procedure (SOP).

3. Reasons for Recommendations

3.1 The PCDs require confirmation of VFM and Current Market Rent (CMR) prior to reimbursement. This cannot be assured without an approved lease.

3.2 While the current approach is effective, lack of a formal escalation mechanism limits enforcement capability.

3.3 Non-compliance represents both an estates and contractual issue, requiring coordinated action with Contracts and Finance, enabling coordinated and equitable decision-making.

4. Background

4.1 Current Lease Approval Process

4.1.1 The Estates Team oversees lease approvals, including compliance checks, VFM assessments, and District Valuer property valuations. This will include:

- CMR-based rent reviews (avoiding RPI risk)
- Time of the Essence clause in all new leases - Financial protections against backdated liabilities.
- Clarity on VAT and repair obligations

4.2 Practices Without an Approved Lease – Scale and Assessment

4.2.1 Non-compliance arises from factors such as expired leases, historic gaps, or non-engagement. In some cases, sites may not be strategically viable (tail sites) and entering a lease would create unnecessary liability.

4.2.3 A mandatory pre-assessment stage will ensure escalation is only applied where a lease aligns with Strategic Estates objectives.

5. The Proposed Escalation Process – For Strategically Appropriate Practices only

5.1 Applicable only to practices confirmed as strategically suitable for a lease.

A three-stage process over a minimum 26 week period, with formal correspondence issued at eight-week intervals:

- STAGE 1: Initial Communication – Letter to be agreed with LMC's. Sets out requirements of the Premises Directions and the ICB ask.
- STAGE 2: Reminder letter and update on progress
- STAGE 3: Final Notice – Advises that continued non-compliance will result in suspension of reimbursement. A date will be agreed when rent will cease

5.3 Any decision to suspend reimbursement will be require a formal decision involving the Contracts and Finance Teams, ensuring compliance with GMS/PMS/APMS contractual requirements.

5.4 The process allows for mitigating circumstances (e.g. landlord disputes) and includes access to mediation support.

6. Governance and Cross-Team Dependencies

6.1 Implementation is subject to:

- Agreement with Contracts on enforcement authority.
- Agreement with Finance on arrears and reinstatement treatment.
- Development and approval of a cross-directorate Standard Operating Procedure (SOP), ensuring a consistent, transparent and auditable process.
- Engagement and agreement with LMC prior to implementation, to support transparency and system alignment.

7. Financial Implications

7.1 The current arrangements present a risk of non-compliant expenditure.

7.2 A clear approach to reimbursement, suspension and reinstatement is required to mitigate legal and financial risk.

7.3 Default position: reimbursement resumes from date of lease approval, not retrospectively (subject to finance agreement).

7.4 Impact on practice financial stability will be assessed case by case, with proportionate action where financial stability is at risk.

8. Risks

Risk	Mitigation / Action Required
Legal Challenge	Formal, contractually aligned escalation process, supported by PCDs and GMS Contract.
Inconsistent Application	SOP and cross-directorate governance
Financial Uncertainty	Finance to formally agree approach on arrears.
Practice Destabilisation	Impact assessments and proportionate application.
Strategic Misalignment	Mandatory pre-assessment

9. Link to Delivering on the ICB Strategic Objectives and the Cheshire and Merseyside Priorities

9.1 This proposal supports the ICB's strategic objectives by ensuring GP premises reimbursement is fully compliant with PCDs and GMS contractual requirements.

- Strong financial stewardship, governance and accountability across Primary Care.
- Reinforces VFM and consistent application of National policy
- Supports a sustainable and fit-for-purpose Primary Care estate.

- Introduction of a clear, governed escalation framework further demonstrates system leadership and regulatory assurance, enabling proportionate action where compliance is not achieved.

10. Next Steps and Responsible Person to Take Forward

Action	Responsible Person	Timescale
SPCC approval of the escalation process	Pauline Underwood	This meeting
Finalise governance arrangements with Contracts and Finance	Estates, Finance and Contracts colleagues.	TBC
Complete audit of practices in scope and pre-assessments	Estates Team	TBC
Develop and approve SOP	Estates Team	TBC
Engage the LMC prior	Estates Team	TBC
Begin phased issue of escalation letters	Estates Team	TBC
Provide assurance updates to SPCC	Estates Team	TBC

10.1 Conclusion – The ICB has demonstrated strong progress in lease compliance through a robust and effective process. A formal escalation mechanism is now required to address the remaining non-compliance.

10.2 SPCC approval will enable a consistent, proportionate and legally defensible approach, strengthening governance, protecting public funds and supporting a sustainable primary case estate.

11. Officer Contact Details for More Information

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