Primary Care Action Plan Template for the Medium Term Planning Framework

ICB	NHS NORTH EAST AND NORTH CUMBRIA INTEGRATED CARE BOARD

Introduction

Primary Care is critical to delivering overall NHS transformation and reform, including the 'three shifts' in the 10 Year Health Plan. As part of the Medium Term Planning Framework (MTPF), ICBs are asked to prepare and submit an action plan for Primary Care.

This document provides a template to support consistency for the ICB Primary Care Action Plans (PCAPs). To join up strategic and operational planning, PCAPs should align with and build upon the ICB Integrated Strategic Commissioning Plan submissions made in February 2026. The Action Plans are an opportunity to provide further detail on how the Integrated Strategic Commissioning Plans (ISCPs) will be delivered in relation to primary care, and can also be used to provide information and actions to cover any gaps in ISCPs or provide any other clarification required.

The plan should cover primary care work across a three to five-year period at a high level, in line with the ISCP, but with a detailed focus on 2026/27 (Year 1). Please note refreshed plans for future years are expected to be requested in the quarter preceding each year and the process for this would be determined in partnership with regions and ICBs nearer to the time.

Key guiding principles for plan development

Plans submitted by ICBs must meet the following requirements:

Outcomes focused

Plans must deliver measurable improvements in outcomes for patients and the public, and improved value for money. Outcomes, baselines, milestones and metrics must be clearly defined, with evidence of engagement with patients, carers and communities to ensure services respond to local population needs and address inequalities.

Accountability and transparency

ICBs must have clear governance arrangements to support plan development, oversight and delivery. Roles, decision making authority and escalation routes must be explicit, enabling transparent decision making and regular oversight. There should be alignment with system and national priorities and targets set out in the MTPF, and support for delivery of the three shifts outlined 10- year plan .

Collaborative

Plans must be co developed with system partners and relevant functions, including finance, workforce, clinical and operational leaders. Plans must demonstrate joint ownership and coordinated delivery across organisations.

Evidence based

Plans must be underpinned by robust analysis, including population health, demand and capacity, workforce and financial modelling. Plans should apply insights and learning from the current year's General Practice Action plans and approaches across wider primary care work that have already improved access / best practice that has achieved results locally. Assumptions must be explicit and informed by benchmarking and best practice.

Credible and deliverable

Plans must be stretching but realistic, affordable within agreed financial envelopes, and achievable within workforce and delivery constraints. Key risks, dependencies and mitigations must be clearly set out.

Template structure

Each tab includes:

Theme – MTPF priority area.
Prompts – Specific elements to deliver the theme.
Actions – Detailed steps, scope, timescale and resources needed to deliver the theme.
Outcomes – Expected results of delivering the theme and timelines.
Measurement – National/local indicators to track progress of the theme, including health inequalities.
Delivery Confidence – Assessment of likelihood of successful delivery (High, Medium, Low).
Key Risks & Mitigations – Risks, mitigation measures and escalation needs.
Support Requirements – Areas requiring regional/national support.

Oversight arrangements

Progress against this action plan will be monitored by [**Governance and frequency TBA following transition into new organisation**]

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Lead for GP Dashboard
Please note that ICBs/Regions will be providing updates on the delivery of plans through the year as part of regular reporting (specifically through ICB summaries for General Practice).

Return Instructions

The action plan must be approved by the ICB Governance Board and submitted to the central planning team via regional planning contacts at [insert email address] by [insert regionally agreed date].
Date of Board Sign-off: [Insert date of formal governance approval]

PCT Feedback	General Practice ICS Theme	NHS NORTH EAST AND NORTH CUMBRIA INTEGRATED CARE BOARD Prompts	Practical Actions (Scope, Scale, Schedule)	Expected outcomes (Dates, Milestones)	Measurement (national, local indicators, as applicable)	Delivery confidence (High, Medium or	Key risks and mitigation	Support requirements
NI - Significant improvement with clear system approach to OPEL and escalation. To strengthen: -define specific interventions and response times at each OPEL level -clarify link between actions and trajectory to 90% access -strengthen link to continuity for high-risk cohorts	**Front door access, navigation & demand management (ending the 8am scramble)**	Plan should highlight practical steps the ICB is undertaking to support: - **Same day appointments for clinically urgent patients** in General Practice including achievement of 90% ambition; - Supporting practices' understanding of **demand/capacity optimisation**. This should include further embedding of modern general practice and population health management/risk stratification, - **Resiliency, winter planning and surge capacity**, ensuring sufficient capacity is commissioned. This should include additional commissioned activity for out-of-hours and surge periods, such as bank holidays and weekends, - Monitoring, reporting and response of **system pressures** for general practice. This could include use of tools such as Operational Pressures Escalation Levels (OPEL) framework	**Same Day appointments for clinical urgent patients:** - Central communication to GP practices, to refresh requirements on GPAD categorisations of appointments linked to capacity access plan in 2023. To be issued to practices by the end of May, with quarterly reminders. Improvements in coding of appointment data is expected to support an increase in the trajectory in the first 2 quarters. - Explore AI support to assist in collating and analysing relevant data sources such as GPAD, to understand variation across the ICB and where to focus support - Use C&V process to ensure standard and consistent approach to addressing variation in performance. Same day appt data to be incorporated into the Q&V process, alongside the GP dashboard metrics that will be used to triangulate access such as online consultation use, number of appts per 1k population, % appts not seen in 14 days to ensure visibility of access metrics to practices and appropriate VLOE to understand variation and determine areas of improvement support required - Contract term to support where practices not engaging and contract management sanctions may need to be considered. **Demand/Capacity Optimisation:** -Explore opportunities to fund further GPIPSLF as part of frontline productivity? Awaiting to hear the outcome of the NHSE regional funding approach through frontline productivity bid to cover (Peer Ambassadors, GPIP and Ambient Voice Technology). + Continue to support practices to embed MGPA through digital support hub + Continue to triangulate through C&V process opportunities to support practices to improve operational processes that may improve patient satisfaction/continuity of care + Ensure general practice is a key partner in neighbourhood health plan developments to strengthen opportunities for risk stratification linked to priority cohorts to improve access and outcomes building on the risk stratification and continuity of care process already in place via PCNs and evidenced through recent CAIP plans **Resilience, winter planning and surge capacity:** -Additional AV capacity in place for Easter and May; with further commissioning intention to be submitted to Exec to cover all BH in 26/27 and to seek recurrent support for BH capacity. This will predominantly be via integrated urgent care, for rise of Bhrs per BH. **System Pressures:** - OPEL framework for GP practices already in place across NENC which includes suggested practical measures that practices can consider linked to business continuity and other suggestions where system resilience response may be required e.g. liaison with SCC to facilitate discussion with providers; prepare urgent care/111 for potential increased demand; facilitate additional capacity through GP Federations, PCNs, GP-led Integrated Urgent Care; DoS management. - attached framework for further details. Local teams are instantly notified of OPEL changes and will reach out to practices the same day to understand the situation and offer support using the framework prompts. OPEL is linked to the DoS in the North East allowing instant system visibility to ensure patients can be directed elsewhere if needed. Practices reporting OPEL 3/4 are reviewed mid-week to ensure the OPEL remains accurate (and if lowered then the DoS will be informed). OPEL automatically re-sets to level 1 on a Sunday. - System Approach: UEC-RADR provides a system overview of all operational pressures, including acute, community, mental health, primary care and ambulance providers. This application has an automated real time update and when the OPEL levels change, SCC receive notifications and can drill down into the reasons for change, when this notification is received SCC would notify the relevant neighbourhood team, and the local hospitals nearby as this may affect the ED attendances at any collocated UTC. In total at present there are over 2500 users of the UEC-RADR application from acute providers to on call colleagues who can immediately see the system pressures across NENC. The SCC team are part of the wider Emergency Preparedness Resilience and Response (EPRR) team and would be the first tactical officer to be notified of a critical or major incident via NEAS, NWAS or YAS, , and any business-critical incident at an acute trust site or primary care facility. -GP OPEL reporting and trends are also included as part of C&V process and data sources to ensure triangulation with access metrics or other areas of variation to determine if the pressures are short-term impact or longer-term for which additional support will then be considered e.g. in terms of operating model support, promoting MGPA, linking in with digital hub etc. **Local A&E Delivery Boards:** Primary care (general practice) is a key partner in LAEDB across NENC where system pressures are monitored and reported to enable potential system support and winter planning opportunities to be identified	To achieve 90% by March 2027 in line with national ambition. As per planning trajectory submitted: ~ 90% by March 2027 (currently 72% with Q2 ambition 82% and Q3 ambition 84%) ~ maintain 90% for 27/28 and 28/29 80% of people reporting that it was easy or very easy to contact their GP practice by March 2027 as per national ambition (HIS wave 21 data 74.2%)	% of clinically urgent appointments seen on the same day (GPAD) Ease of access (Health Insight Survey) Online Consultation Rates/1,000 pop, volumes and hour of day Cloud Based Telephony Dataset - Calls, Abandoned, Callback per 1,000 pop - time of call and length of call Analysis on walk ins NHS111 data GPAD % patients finding it easy to contact their GP practice % patients reporting overall experience of GP practice as good Data to understand operational capacity pressures in general practice fed into system-wide oversight arrangements	Medium	ICB is going through significant restructure as part of transition to strategic commissioner, resulting in 35% reduction in staff capacity. Over the next 3 months, the ICB will be mobilising staff and teams into new ICB operating model. Local CSUs are also closing, which may impact on access to some current system used to support monitoring, tracking etc. The ICB will review priorities on a regular basis, which may result in reprioritisation or adjusting/redirecting capacity as needed. Number of practices signed up to/completed GPIP/PLS In addition there is a threat of providers resurrecting GP Collective action. Potential financial pressures and rationalisation of priorities and must do, may stall/delay some areas of work as full detail of costs materialise.	- Local BI support to collate and consolidate relevant data to support performance and variation across the ICB, such as GPAD, OPEL, workforce, ARRS, OC, Patient Survey etc
NI - Clearer workforce approach and system collaboration. To strengthen: -link workforce deployment to access and variation outcomes -identify priority geographies/practices for investment -quantify expected impact on capacity (appointments/access)	**Clinical capacity**	Plan should highlight practical steps the ICB is undertaking to: -Promote recruitment of GPs or fund additional sessions through **Capacity and Access Payment reimbursement scheme** -Promote recruitment of GPs and other roles through **additional roles reimbursement scheme.**	**GP Reimbursement Scheme and Additional Roles** - Central communication to GP Practices to outline claim parameters/mechanism and to encourage maximum recruitment and use of funding for both GP reimbursement and new flexibilities within ARRS - will be issued by end of May/ early June -Use C&V process - along with review of workforce analysis to identify unwarranted variation and focus targeted promotion to maximise recruitment. Along with access metrics to triangulate greatest unwarranted variation to determine and prioritise which localities and practices need additional investment and support such as MGPA/GPIP to get the best out of and maximise any additional clinical capacity. Priority localities/practices will be indentified as part of reviewed Q&V process under new ICB operating model. - Continue to promote the use of ARRS, working with PCNs and system partners to maximise opportunities of role deployment and use of the ARRS budget e.g. through brokering arrangements to support rotational working across PCNs and acute/ community providers, whilst ensuring consideration of how roles can support in the delivery of neighbourhood health models. - Explore through neighbourhood health plan developments with partners, how workforce and any investment opportunities could be maximised to support the improvement of outcomes for priority cohorts - Promote the inclusion in 26/27 DES contract of 'other non-direct patient care roles' to identify new and innovative roles that will support in PCN and neighbourhood working. - Continue to support MGPA and ensure practices have sufficient clinical capacity to meet the reasonable needs of patients. Variation in workforce (e.g. **GP to patient ratios**) will continue to be reviewed as part of the Q&V process and triangulated against access and experience measures to identify what further support practices may require where this is necessary. + Central communications to practices to refresh requirements of the NWRS and to highlight importance of data quality and accuracy, especially for GP roles + Work with the Primary Care Collaborative and Local Medical Committees to explore and strengthen opportunities to promote GP recruitment opportunities + Explore through Primary Care Training Hubs and Deanery additional opportunities to maximise GP recruitment and retention -Work with PCNs who want to explore the new local flexibility with ARRS, where GP/Nurse staff may have been previously employed under CAIP and those interested in exploring developing neighbourhood services using PCN DES.	which will increase access capacity, either directly through more GP or telephone appointments with a trajectory of 1.9% and more in line with planning appointment trajectory. Or indirectly through increased OC outcomes, in addition supporting/increasing same day urgent access to meet 90% target. Increase the total current ARRS spend across NENC ICB, providing increase in staffing skill mix and clinical workforce capacity in line with workforce planning trajectory. Increase in GP workforce will reduce the number of practices identified as outliers for unwarranted variation in relation to GP/patient ratios NENC ICB positive variation for access and patient experience has always been below England average, it is expected that increase clinical capacity and access will increase and narrow the current gap. (England average is 8.9%, NENC ICB average is 4.2%) Maintain current levels of continuity of care (HIS wave 21 data 70%)	Fully qualified GPs (FTE) GPs recruited through Additional Roles Reimbursement Scheme (ARRS) ARRS roles deployed at PCN and neighbourhood level Maximised use of ARRS budgets- all PCNs to submit a timely workforce plan indicating their recruitment intentions 4X number of practices signed up to Care Navigation Training Appointments in general practice and PCNs % patients able to see preferred healthcare professional	Medium	ICB is going through significant restructure as part of transition to strategic commissioner, resulting in 35% reduction in staff capacity. Over the next 3 months, the ICB will be mobilising staff and teams into new ICB operating model. The ICB will review priorities on a regular basis, which may result in reprioritisation or adjusting/redirecting capacity as needed. In addition there is a threat of providers resurrecting GP Collective action. Delays in national systems and guidance regarding funding and claim parameters. Local CQRS is a new system to the GP contracting team - training is being access and SOPs being developed If pushing to maximise ARRS spend, this will add financial pressure to ICB due to ARRS shortfall in funding compared to actual maximum spend. Potential financial pressures and rationalisation of priorities and must do, may stall/delay some areas of work as full detail of costs materialise.	- Awaiting further information nationally on GP reimbursement scheme - Local BI support to collate and consolidate relevant data to support performance and variation across the ICB, such as GPAD, OPEL, workforce, ARRS, OC, Patient Survey etc - Support regionally/ nationally to address shortfall in ARRS allocated funding compared to actual maximum spend allowance
PT - previous comments appear to be mostly addressed. NI - Strong and well-evidenced Q&V framework with clear support offer. To finalise: -define thresholds for identifying outliers -set expected improvement trajectories -indicate scale of practices requiring support	**Unwarranted variation in access in different parts of the country**	Plans should set out the practical steps the ICB will take to: -Support, monitor and ensure **compliance with the GP contract**. This should include the GP contract changes introduced in October 2023 as well as the new 2026/27 GP contract requirements. Plans would benefit from specific reference to the governance mechanisms that will be used to monitor compliance. -Outline interventions, either already in place or to be introduced, to **support struggling practices** in meeting requirements around core hours opening, equity of access (e.g., telephone and online consultation routes), implementation of You and Your GP Practice feedback, and delivery of prospective records access. -**Identify practices requiring additional support**, using the Support Level Framework (SLF) or the Modern General Practice Assessment Tool (MGPAT) to determine their support needs. Plans would benefit from specific reference to the number of practices the ICB expects to offer targeted support. -Provide **improvement and transformation support**, already in place or planned, for practices. This may include Practice Level Support, Peer Ambassadors, or local Quality Improvement (QI) support. -Use datasets and local intelligence to identify and address unwarranted variation and track practice progress. This should include the **General Practice Dashboard** and patient feedback from You and Your GP Practice. -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.	**Contract compliance:** + Continue to monitor practice compliance with core hour access (telephone, attendance and CC) - Explore BI support to measure and track contract compliance metrics, such as OC, GP Connect, and provide an overview of priority areas, to address through joint Q&V process. + NENC wide SOP in place to manage in- hours closure requests and sub-contracting/alternative arrangements -Undertake full audit of all sub-contract 6 to 6.30 arrangements. + Parameters document developed and shared with practices to aid understanding of contract requirements (Oct 25 changes) which will be updated to reflect 26/27 contract changes, once guidance and contract documents are published - General oversight and governance of contract compliance is detailed within the Q&V process, including reporting progress through appropriate sub-committees. Due to ICB restructure, the governance routes are being reviewed and will be updated in the amended SOP. - The Q&V SOP will also need to reflect the new contract changes on non-engagement with identified variation, including non-compliance. The arrangement on agreeing contract sanctions (e.g. remedial notices, breach notices) will also be reviewed given the ICB transition and new governance arrangements over the coming months. **Support to struggling practices/additional support:** + Continue to take a supportive approach to practices who may be struggling to meet new contract requirements, taking a proportional and progressive approach to contract sanctions where deemed necessary as outlined in the Q&V SOP + Peer ambassador programme in place with Primary Care Collaborative to support with best practice learning + Continue to facilitate the relevant subject matter experts to liaise with practices depending on need (e.g. FTSU, digital, CQC, meds optimisation, estates etc) + Continue to facilitate identification of 'buddying' arrangements with practices who require operational discussions with peers to learn best practice + You and Your GP practice feedback shared with practices through Q&V process to help facilitate future improvements - or to share good news stories + Continue to promote digital support hub to help practices with MGPA requirements **Quality and Variation:** - The ICB already has a well respected Q&V process which was established in 25/26, which has undertaken 60 rolling reviews and 95 risk reviews over the last 12 months. + From Sept 25 to March 26, the number of practices identified on the GP Dashboard as having 3 or more areas of negative variation reduced from 150 to 134. Overall negative variation scores in the same period also decreased from 939 to 895. As of 21st May, this has further reduced to 126 practices with 3 or more negative indicators. + From Sept 25 to March 26, the number of practices identified on the GP Dashboard as having 3 or more areas of positive variation increased from 240 to 258. Overall positive variation scores in the same period also increased from 1696 to 1827. As of 21st May, the position is stable with 259 practices having 3 or more positive indicators. + The SOP contains the data sources (page 9 of the SOP but examples include GP dashboard (PDF) identification of negative variation; eDec 'non-compliance' flags; You and Your GP Practice feedback; GP patient survey results) - The Q&V SOP will need to be reviewed in light of the ICB transition to a strategic commissioner to further streamline the process and ensure consistency as well continuing to address contract compliance. The SOP will also be refined to ensure neighbourhood health themes are included as core component of the process to identify opportunities to support practices to work at scale/ allow practice level, and sharing best practice amongst their peers. This will include focusing on those patients that are most vulnerable who are using avoidable health and care services, and utilising improved population health management data to identify high risk cohorts -The SOP already identifies and addresses key themes and support for struggling practices - Explore BI support to assist in collating and analysing relevant data sources such as GPAD, to understand variation across the ICB and where to focus support - Contract team to issue statutory instruments to inact the contract changes and support where practices not engaging, where contract management sanctions may need to be considered. - including making use of the new contract clause requiring practices to engage with ICBs where variation has been identified. -Explore opportunities to fund further GPIP/SLF as part of frontline productivity? Regional team have confirmed support for GPIP, of £175K, we are now awaiting outcome of national panel. - Need to consider actions, identification, allocation etc -Continue to provide a 'deep and network' for practices who have 50% or more of the registered population in the 15% most deprived neighbourhoods.	~ Q&V process is currently monthly; on average 17 practices are reviewed per month + Practices identified as to be 'sustained' as a result of the Q&V deep dive will be routinely re-reviewed as part of the 2 year rolling review cycle unless new information prompts a risk-based deep dive approach + Practices identified as to be 'improved' will be re-reviewed from 6-12mths (depending on the improvement task identified) + Practices requiring to be 'stabilised' will be reviewed more frequently to ensure support is in place to enable improvement ~ Increase % of practices with significant overall positive variation score (April 14.8%) by March 2027. Sept -March saw a 6% improvement, however recognising 77% of practices already identified as having positive variation, a relatic trajectory would be between 258-273 practices identified with 3 or more positive outliers by March 2027 ~ Maintain or reduce % of practices with significant overall negative variation score (April 6.9%) by March 2027. Sept - March saw a 4% reduction, however as some of the negative variation scores are influenced by CQC ratings and CQC timeframes, a relatic trajectory would be between 126-138 practices identified with 3 or more negative outliers by March 2027	General Practice Dashboard Health Insights Survey General Practice Patient Survey GPAD NHS111 Local data sources and experience measures SLF outcomes (Spider Diagram) MGPAT - diagnostic tool Same Day Urgent metric Reduction in variation in Quality and Outcomes Framework standards for CVD, diabetes, COPD, mental health conditions and dementia Increase the percentage of patients with diabetes who received all 8 elements of the diabetes care process bundle as reported in National Diabetes Audit Modern Service Frameworks will specify further metrics for cardiovascular disease and mental health in due course 4X Peer Ambassador roles in place, number of practices receiving support Deep and network practices support identification of neighbourhood health models that better meet their population needs	Medium	ICB is going through significant restructure as part of transition to strategic commissioner, resulting in 35% reduction in staff capacity. Over the next 3 months, the ICB will be mobilising staff and teams into new ICB operating model. The ICB will review priorities on a regular basis, which may result in reprioritisation or adjusting/redirecting capacity as needed. In addition there is a threat of providers resurrecting GP Collective action. Potential financial pressures and rationalisation of priorities and must do, may stall/delay some areas of work as full detail of costs materialise.	- Awaiting further information nationally on contract changes guidance as well as contract variations - Local BI support to collate and consolidate relevant data to support performance and variation across the ICB, such as GPAD, OPEL, workforce, ARRS, OC, Patient Survey etc - Awaiting update on NHSE funding to support Peer Ambassador programme, GPIP/SLF etc
NI - Strong digital plan with improved risk stratification and support offer. The addition of risk stratification through RADR and strengthened articulation of CSU transition risks and mitigations are welcome improvements from the first draft. To strengthen: -link digital adoption to access/productivity outcomes -clarify how insight triggers specific improvement actions -ensure consistent embedding of PHM tools across practices	**Digital development and reform**	Plans should set out the practical steps the ICB will take to: - Support general practice **implement and optimise GPIT and digital tools**. This could include online consultation, messaging, online booking, digital telephony, population health management and demand and capacity planning tools. - Support implementation of new technologies, including **ambient voice technology (AVT)** - Promote utilisation of **NHS App** capabilities; including ensuring that at least 95% of appointments across all care settings are made available through the NHS App following appropriate triage. - Transition all direct-to-patient communications to **NHS Notify**, retiring local communication systems, and use NHS App 'push' notifications as the primary method of contacting patients -Use primary method of contacting patients. Transitions should begin in 2026/27, with all providers completing migration by the end of 2028/29.	1. Implement and optimise GPIT and digital tools. NECS as ICB Delivery partner in collaboration with the Digital Team will throughout 2026/2027 carry out the following: GP Connect Integration: - Monitor national reporting and actively engage with practices not meeting requirements supporting the continued rollout, configuration and troubleshooting of GP Connect features in the GP clinical systems. Register with a GP: - Tracking the successful integration of the digital registration service across all sites. Online Consultations (OC): - Monitoring and supporting "Core Hours Enablement" to ensure OCs is on and not switched off during the day. Prospective Records Access: - Ensuring 100% of practices provide full record access to patients subject to ICB Contractual team direction once identified practices have been escalated as non-compliant. 2. Support implementation of new technologies, including ambient voice technology (AVT) The Digital team will work in collaboration with regional NHSE partners (and allocated delivery partner) to implement AVT technology across all GP practices within the NENC region. This will be dependant upon funding expected, should the regional AVT bid be successful through the Frontline Productivity Programme. If successful, this will include providing a framework of providers for practices to select a solution/supplier from, implementation, integration and roll-out, this will also include raising any appropriate risks and challenges. The ICB Digital team are continuing to publish guidelines and best practice around AVT usage via the Teamnet portal, ensuring this is in line with national NHS process and guidance. 3. Promote utilisation of NHS App capabilities; including ensuring that at least 95% of appointments across all care settings are made available through the NHS App following appropriate triage. -The ICB Digital team in partnership with delivery partner NECS will support this aim in the following ways. - Monitoring of NHS App 6 Core Metrics: Through regular regional reporting, identify outliers and provide targeted support to maintain Practice uptake. - Conducting practice-level "Digital Maturity" audits to identify barriers to the 6 core metrics. - Delivery of support sessions for Practice Managers on streamlining "Digital First" messaging. - Promote NHS App 6 core metrics and provide targeted support to practices. -Linking in with regional and national promotion campaigns to provide tailored webinars covering the key use cases for NHS App. - Design and delivery of a webinar series focusing on high-impact use cases like record views, repeat prescription ordering and or booking and cancelling appointments. - Creation of "Quick Start" video guides for practice staff to show patients in the waiting room the benefits of using NHS App. -Updating and maintaining ICB's TeamNet page with latest and relevant guidance. -Utilising national data to track and monitor patient usage. - Development of monthly performance dashboards for each practice/PCN. -Link in and support NHS App ambassador network to ensure they have access to latest and most up to date guidance. - Provide targeted support to practices and patient groups with low utilisation of NHS App functionalities to improve engagement and adoption rates. - Collaborate with national teams escalating issues and enhancements 4. Transition all direct-to-patient communications to NHS Notify, retiring local communication systems, and use NHS App 'push' notifications as the primary method of contacting patients The ICB will work with national and national partners to carry out all relevant work and activities to support practices to migrate to NHS notify and to share best practice and knowledge of the system and its requirements. Timelines and associated plans will be dependant upon national direction and progress. 5. Risk stratification The RADR tool is available to all practices which contains a Risk Stratification Tool that can generates relevant cohorts for practices to risk stratify, a frailty guidance document has been developed and shared with practices as a guide. We will ensure that all practices understand that they have access to this tool and where to go to get support to use this effectively and how to create actionable outcomes as a result. Continue to provide dedicated hands on support through the digital support hub to practices to support them to implement and optimise GPIT and digital tools. Practices will be identified through the Q&V process or through local relationships which identify support requirements. This will include support to reduce SMS useage and increase the use of the NHS app, along with maximising the use of booking links, total triage implementation and better understanding capacity and demand through use of data sources which inform practice plans. Continue to maintain digital information hub on GPTeamnet to provide self directed support to practices and PCNs Use GP Connect, NHS App, and OC dta to identify outliers. Apply defined thresholds (e.g. low NHS App use, OC non-compliance, high call abandonment) to trigger targeted support and improvement plans. Standardise use of PHM tools (RAIDR) across all practices with support and training on how to use to best advantage and hpw to risk stratify. Embed PHM into neighbourhood planning and demand/capacity management.	1. GPIT - Throughout 2026/27 Optimisation support to practices, with improved compliance with key NHSE metrics. Beyond 31st March 2027, plans to be confirmed and will be dependent upon confirmation of GPIT supplier, following closedown of CSUs. 2. AVT – (Dependant upon national funding via the Frontline Productivity Programme) - work is expected to commence in October 2026 2026 Q4 – Baselining and planning 2027/28 Q1 – Q4 – AVT Implementation 2028/29 Q1 – Q4 – Review outcomes and benefits to date Expected outcomes to include AVT being used by the majority of practices within the region, with the associated time benefits being realised over time. 3.NHS App - Throughout 2026/27 - Optimisation support to practices. - Targeted communications campaign, to promote the use of the NHS App. - Monitoring of uptake and usage. Beyond 31st March 2027, plans to be confirmed and will be dependent upon confirmation of GPIT supplier, following closedown of CSUs. Anticipated outcomes include increased uptake and usage of the NHSe across the region. 4.NHS Notify - Throughout 2026/27 - Work with NHSE team, to understand rollout plans, timescales and implications. - Where possible and appropriate practices are utilising NHS notify. Practices supported to implement GPIT and digital tools- Ongoing Case studies developed which can support practices to adopt new ways of working- Throughout 2026/27 - Improved access through increased digital access routes. - Increased clinical capacity and productivity through reduced admin burden through implementation adn increased use of AVT. - Consistent use of PHM to support proactive care and demand reduction. (Deliverables embedded throughout 2026/27 with ongoing improvement)	AVT Regular measurement of the number of practices with AVT, its benefits and impact moving forward into future years NHS App NHS App Support Measurements / Indicators •NHS App uptake - Measured against a baseline for NENC ICB, regional and nationally % of practices meeting NHS App core requirements •NHS App usage - Regular reports produced on usage trends •Reporting dashboard available - Provides uptake and usage data for authorised users •Engagement via the NHS App Ambassador Forum - Supported through webinars, drop-ins and 1: 1s (activity measure) Type: National digital adoption metrics + local reporting NHS App Core Metrics Measurements / Indicators •Compliance with the 6 NHS App Core Metrics - Tracked in a live compliance tracker •Variation in performance - Highlighted in routine performance reports •Use of implementation support - Counts practices receiving regional/local support (process measure) GPIT & Digital Tools Prospective Record Access (PRA) •PRA compliance: % of practices •Non-compliant practices: number needing optimisation support Online Consultation (OC) •OC utilisation and compliance: % of practices (including time compliance where applicable). •Practices by status: number non-compliant, time non-compliant, switched off, or using caps. •Availability and use: system availability and utilisation measures (national/supplier data). Digital Patient Registration •Onboarded: % of practices using the "Register with a GP surgery" service. •Uptake: number and/or % of registrations completed digitally. GP Connect •Use and compliance: utilisation and compliance rates (national reporting). •Support to reach compliance: number of non-compliant practices supported Number and % of practices accessing support through the digital support hub Number & % of practices utilising NHS Notify Number & % of practices and Neighbourhoods using RAIDR and other risk stratification tools Number of practices with a risk stratification plan for targetting support	Medium	Risk - Plans are only able to be firm for year one 2026/2027 currently Risk - Suppliers may not be able to provide information & data for some metrics. Risk - National team may not be able to provide information & data Risk - GP connect/OC can be activated and deactivated 'at will' by practices, meaning a practice is only compliant at 'a point in time' Risk - There could be insufficient digital staff within ICB and NHSe to support this programme of work Mitigation - Continue to work closely with regional and national teams to monitor and where possible find resolution. Risk - AVT funding may not be guaranteed at the point. Risk - CSU Closure and Migration of delivery Mitigation - Fully controlled transfer of delivery work currently carried out by CSU underway. TUPE of staff to alternative provider as impact on practices should be minimal. A recent ICB Executive Committee agreed to move existing GPIT services, currently delivered by NECS, to one of the constituent provider organisations within NENC ICS. The selected receiving organisation will already be proficient with IT delivery, have an existing IT service team, and the model will be to 'left and shift' current provided GPIT products, services, and teams from NECS to the new host organisation. NHS England has approved this approach, and we will now expediently work with relevant stakeholders, focusing on the delivery of a smooth transition where key performance indicators for core GPIT services are maintained throughout the change.	Require national supplier data to monitor compliance. Practices which are not compliant will require support from NECS training team support. Require understanding the expectations of ICB's where a practice is non-compliant.

NI - Improved strategic alignment to neighbourhood model and system transformation. So strengthen: -clarify operational delivery model for general practice -define governance and decision-making across system levels -set out how learning will scale across neighbourhoods	System and broader transformation	Plan should set out strategic approach for: - **Engagement of people and communities** to understand needs and co-design services - Utilisation and planning of **estates** to support alignment and integration supported across PCNs, neighbourhoods and Primary/Secondary/Community Care. - **Staffing** and alignment to neighbourhood development. - **Investment and resourcing**, specifically how this compares to previous years.	The ICB is re-establishing a patient experience assurance group, (previously patient voice - prior to transition to new ICB model), which includes representation from Health Watch, voluntary sector and key ICB leads, this will triangulate what is being raised and key themes from the different sectors and communities. This will include key patient issues across primary care and community, including access to primary care. The ICB also has a dedicated 'here to help' programme that is a behaviour change campaign that provides information on how to access services such as pharamcy first and primary care etc. The ICB also has a 'tell us what you think campaign' which provides opportunity for patients to feedback any issues to the ICB - Promotional resources continue to promote access to NHS App, Pharmacy First, and Enhanced Access through Healthwatch involvement activity - this follows on from a focused piece of involvement where the report has been shared with the primary care team - QR code on promotional materials which links to regularly update information and give an opportunity for communities to provide feedback on access/services. - Rollout of the General Practice Staff Survey (GPSS) and identify areas for improvement directly benefitting patients - Patient charter process in place - You and Your General Practice - where people can feedback their GP experiences Work with communication and involvement team and Healthwatch to continue to communicate access to primary care services, engage with the public and design services to meet the needs of patients, and receive experience / intel. Work with local authority in initiatives such as Area Action Partnerships. When practices are considering making changes to the way they work they are required to engage with their patients and stakeholders to ensure their views and concerns are considered. The ICB has an involvement team who support practices with this activity to ensure that their engagement activity is relevant and meaningful. You and your GP survey feedback to be used to inform themes and trends within general practice. You and Your GP information is collected and collated by the involvement team, information is cascaded to local delivery/neighbourhood teams to share with their practices and request a response to the information shared. Responses are logged and shared back with the involvement team and discussed at the NENC ICB Quality, Safety and Risk Committee. Utilising the Primary Care Estates Capital to create increased clinical capacity through the creation of additional clinical rooms, extensions and new builds to enable the delivery of services, which can include neighbourhood health services and other services providing care closer to home. ARRS workforce plans submitted in October 2026 to be mapped across with community staffing to identify opportunities for further collaboration across pathways Continue to spread and share learning from national neighbourhood health implementation programme so that early learning can help inform the development of the ICBs neighbourhood health commissioning framework The ICB's approach also focuses on optimising national funding streams and targeting investment to agreed priority areas, ensuring resources are aligned to service transformation and system objectives. Delivery will be supported through: -Maximised use of national funding mechanisms, including GP contractual funding, ARRS, Capacity and Access Payments, GPIT and Frontline Productivity Programme funding, alongside targeted Primary Care Estates Capital. -Time-limited, targeted investment, aligned to access recovery, productivity, digital optimisation and neighbourhood models of care, informed by Quality & Variation intelligence and population health data. -Improved alignment of capital investment, with multi-year estates allocations enabling phasing of schemes that deliver sustainable increases in clinical capacity. Compared with previous years: -Non-recurrent national funding has reduced, including the cessation of PCARP funding linked to digital tools and the baselining of the Primary Care SDF funding with removal of enghence. -Despite these changes, the ICB remains committed to delivery of core digital, productivity and transformation programmes and has continued to invest in primary care by prioritising available resources, repurposing funding where appropriate and embedding these programmes within core commissioning and delivery arrangements. -ICB internal commissioning and management capacity has reduced, reflecting the transition to a strategic commissioning model. Delivery therefore relies more heavily on system partners, delivery organisations A Senior Head of Commissioning group has been established to bring together senior leaders across the new commissioning operating model, including Neighbourhood locality leads, GPOD, Secondary Care Alliance, MHLD, Strategy, Contracting and Improvement to collectively work together, share local learning and drive solutions The ICB is still in the process of transitioning to a new operational model, with renewed governance for decision making. A primary care steering group has been established which will act as an assurance group and central hub of primary care discussion, which recommendations will be fed into the Neighbourhood Health sub-committee for any decisions. Decision making will take place in accordance with the ICB scheme of reservation and delegation (SORD) and the standing financial instructions (SFIs). In line with the revised and simplified governance structure, responsibility for each contract, associated budget and any programme funding will be aligned to appropriate commissioning sub-committees, such as the Neighbourhood Health sub-committee. Decision will be escalated depending on value, or where this is novel, contentious or repercursive, including escalting to NHS England as needed. As part of the new ICB operating model, key themes and leads have been identified across NENC, including Neighbourhood Health, General Practice/Primary Care, Children and Young people etc. The thematic leads will support cordination of learning and scalability across the ICB.	All contractual changes are backed up by clear patient engagement to assist decision making [Ongoing] Refresh of communication and engagement plan for both internal and external use Production of work plan key m llestones to understand patient experience and identify areas for targeted pieces of work. Continued roll out of promotional materials The Capital funding will need to be allocated and building work complete by the 31st March 2027. Due to receiving 4 year capital allocations larger schemes can be phased over multiple financial years. **Finance caveat and assurance** Delivery of the investment approach is dependent on confirmation and timing of national allocations. Financial assumptions will be reviewed as allocations are finalised, with plans adjusted accordingly where required.	Involvement team to continue to monitor YYGP website to collect and collate themes and share with local delivery/neighbourhood teams where engagement with practices is made to share feedback, requesting actions/response to inform improvement /inform action and outcomes Improved feedback from GPSS Increased uptake in Pharmacy First Services and access of NHSApp The number of increased clinical rooms and the additional appointments that can be delivered. All PCNs to submit timely workforce plans by October 2026, with ICB teams coordinating efforts to better understand staffing models in community that can work collaboratively to deliver practice and preventative care pathways **Investment and impact** will be measured and assured through established national and local mechanisms, including: Capital investment tracked against approved business cases, delivery milestones and year-end spend profiles. Financial reporting through existing ICB governance and NHSE regional assurance routes.	Medium	Capacity within the workforce due to organisational restructures **Estates:** 1) GP Practices committing to the works, including having lease arrangements in place and identifying contractors to carry out the works. - Confirm GP Practice agreement as soon as possible, ensure the tenure arrangements are up to date and ensure the GP Practice have identified contractors can complete works prior to the end of the financial year. If a GP Practice pulls their scheme, use the prioritised pipeline of schemes to reuse the funds allocated. 2) Legal requirements for the funding to be allocated. Legal holds on GP-owned premises can take up 20 weeks. - As part of ensuring deliverability within the financial year, build in the timescales required for the legal processes to be followed. 3) Works taking longer than the financial year to be complete - The 4-year capital allocations allows the opportunity to phase works over multiple financial years and to be assured the funding is available in each year **Investment and Resourcing** 1) NHS financial constraints and reduced national funding, Ongoing financial pressures across the NHS. -Prioritisation of available funding, optimisation of national funding streams. 2) Inability to sustain transformation programmes, removal of enghencing increases risk that digital and transformation activity cannot be sustained alongside wider financial pressures. - Alignment of programmes with contractual, access and productivity requirements and prioritisation. 3) Reduced ICB commissioning and management capacity, Transition to a strategic commissioning model and reduced internal capacity. - Focus on system priorities, use of delivery partners, PCNs and system collaboration, and streamlined governance and escalation.	
General comment: NI - Strong improvement from draft 1, particularly in operational clarity and system coordination (e.g. OPEL, QNV). Also, the inclusion of supporting annexes (specifically the OPEL Framework and Quality & Variation SOP) significantly strengthens the operational credibility of the plan. To finalise: -strengthen quantification of outcomes (baselines, trajectories, milestones) -clarify what will be delivered in-year vs longer term -ensure clear line of sight from actions + measurable impact at practice level								

Dental

ICB : NENC	NHS NORTH EAST AND NORTH CUMBRIA INTEGRATED CARE BOARD

PCT Feedback:	Theme	Prompts	Practical Actions (Scope, Scale, Schedule)	Expected outcomes (Dates, Milestones)	Measurement (national, local indicators)	Delivery confidence (High, Medium or Low)	Key risks and mitigation	Support requirements
Response to previous comments: ICB have responded in part **Missing detail:** ICBs plan would benefit from detail which covers practical steps on: . Matching capacity and demand . Reducing unused appointments . Management of contracts i.e. monitoring and escalation	**Urgent and unscheduled care** Priority 2	Plans should set out the practical steps the ICB will take to: - Better match **capacity to demand** and reduce unutilised appointments - Optimise **111/unscheduled care pathways** to support access to urgent and unscheduled care - **Utilise comms** to improve patient awareness of and access to urgent and unscheduled dental care appointments - Provide comprehensive **out of hours urgent and unscheduled dental care** provision - Ensure sufficient capacity and resources to monitor use of **mandated urgent care capacity** and ensure this capacity is accessible to all patients. This should include plans to escalate concerns and implement breach notices as needed in the event of non-compliance - Ensure processes in place for the review and implementation of **flexibility of the mandated proportion** of unscheduled care	We will work within the 2026-27 new financial, regulatory, policy and reform guidance and constraints to deliver a structured network of urgent and unscheduled care as follows: 1. Implement National Reform Tier 1 GDP UDC 8.2% Mandate including application of national flexibilities, where available 2. Maintain our pre-existing Tier 2 in hours UDAC Structured safety net of provision (24 sites) at least for the transitionary year 2026-27 until National Reform mandated urgent care access take up can be evidenced. We will maintain these arrangements whilst we evidence levels of National Reform 'take up' from Tier 1 GDP services to ensure that Reforms have the capability to meet local unscheduled urgent care demand safely into the future without the need for local safety net provisions to be maintaned. NHS England national and regional teams have previously agreed continuation of this local scheme for at least the transitionary reform period. We will also review the operational impact that the national NHS Pathways, and Dental DoS reform changes will have upon pre-existing local systems in readiness for the national software launch as at June 2026. 3. Maintain our pre-existing and long standing Tier 2 out of hours DCAS & UDTC Structured Network capacity, which includes 1 x OOHs DCAS provider and 5 x OOHs Treatment providers. 4. Further develop our local 111 & DoS Team Relationships to optimise sign-posting of patients into available levels of accepting and reformed unscheduled urgent care GDP high street service provision. This will be undertaken alongside national improvements to the Find a Dentist, NHS Website portal to raise visibility of urgent care mandated Reform access. 5. Continue to locally explore and pilot UDC online self service patient booking innovations via NHS 111, Dental Direct (North Cumbria) and our local ICB Web Portal. 6. Continue to invest in our local Dental Communications Strategy & Plans to ensure consistent public, patient and media messaging is undertaken and a local communications toolkit is made available to local professional stakeholders. 7. Set up local unscheduled urgent care monitoring and governance arrangements working in partnership with LDN professional leads, where we will seek to: a) Set up quantitive systems to confirm capacity v demand patterns and trends across the whole system of urgent care. To do this we will use National BSA contract and ICB wide Datasets, NHS 111 disposal data from third party provider and locally drawn ICB Portal datasets supplemented by qualitative feedback from services and on site visits where necessary. b) We will track and manage unused appointments with a view to trying to minimise these through adjustment of capacity v demand or more likely the higher risk management issue of patient DNA/FTA/Late Cancellations, we will do this through review of capacity and demand information as previously outlined and for patient waste work as an urgent care MCN to attempt to try to find best case local practice/service strategies, comms and processes that seek to improve patient reliability of attendance and change patient attendance behaviours although this will prove difficult without being able to apply financial penalties to patients similar to the BSA approach to penalty charges for non evidencing of exemptions etc. c) Manage contracts through active review of COMPASS, EDEN datasets and performance of contracts on a regular and on-going basis applying contract sanctions available to the ICB via the National Regulatory and Policy Frameworks.	National Reform implementation for 2026-27 will be completed in accordance with NHS England technical guidance expectations and mandated deadlines: - Mandated Urgent Care Targets Issued - 15 March 2026 - Mid Year Performance Review - October 2026 - End of Year Performance Review - June 2027 Issue of NHS Reform Re-enforcement and GDP Expectations Letter - April 2026 Secure funding to support Local Dental Comms & Engagement Plan - April 2026 Review collaboratively with local partners unscheduled urgent care mandated Reform impacts and unintended consequences across our local 'whole system' throughout the Transitionary 2026-27 year: - Q1 June 2026 - Q2 Sep 2026 - Q3 Dec 2026 - Q4 Mar 2027	As we rely upon national clinical datasets being collected, analysed and reported through national NHS BSA systems we will rely primarily upon receipt and review of nationally published datasets and data packs made available to ICBs in order to secure a pre-Reform baseline position and then track unscheduled urgent care reform impacts on a quarterly basis to review take up, activity, delivery pattern and patient access trends and set realistic future targets. This will include accessing and reviewing: - NHS England, Futures: National Dental Data Packs & Dashboard (Success will be an increasing FP17 B1U trend that satisfies demand and channel shifts urgent care demand away from NHS 111 and Tier 2 Safety Net Services) - NHS BSA: COMPASS, EDEN contract based and ICB aggregated data packs (Success will be an increasing FP17 B1U trend that satisfies demand and channel shifts urgent care demand away from NHS 111 and Tier 2 Safety Net Services) Alongside national datasets we will also secure and review (where available) external and internal local whole system stakeholder quantative and qualatitive information from the following sources to supplement national core datasets, these are likely to include: - MP letters indicating issues and complaints in relation to unscheduled urgent care access (Success would be a reducing trend) - NHS 111 contacts for urgent care and ease of and reliability of disposal into GDP Reform high street services (Success will be a reducing trend and channel shift away from NHS 111 into GDP including reducing repeat call volumes) - Local ICB Portal contacts and online booking, self service pilot take up (Success would be a reducing trend as demand begins to be met by GDP urgent care reform incentives)	**Medium**	Confidence must at this point be no higher than **Medium** as the National UDC Reforms are new, untried and tested operationally and as such it is not yet possible to determine the impact of change and potential unintended consequences that may arise from the following risk management perspectives: - Professional engagement, buy in to a more open door policy of access. To achieve success nationally and reliably meet unscheduled urgent care demand via the high street this will need NHS providers to go beyond the minimum mandated expectations set, shifting finite capacity from general access 'recall activity patterns' towards a more balanced open door policy of overall new and recall patient access. This is a significant cultural change for the profession. - The change in patient and public expectations that is likely to arise from the National Reform media campaigns are likely to create an increased pressure that national and local unscheduled urgent care systems will need to try to meet within existing finite resources. This will prove difficult if professional buy in and engagement with the new reforms is not fully achieved. - Conversely, where new overall quality and payment reforms prove to be wholly successful this will result in the availability of dental contract under-performance significantly reducing or being removed. This positive outcome would then require National additional funding to be provided to local ICB commissioners in order to expand and extend local dental service provision in order to continue to meet locally increasing need and capacity gaps as the local Dental ring fence and finite budget at this point would be fully allocated. Our risk mitigation plans will therefore include: - Close monitoring of the NHS Reform implementation throughout the transitionary 2026-27 period to evidence and confirm postive impacts and unintended consequences that arise, raising these into the National and Regional NHS England teams as necessary. - Use National Reform and Regulatory contract sanctions available at mid and end of year to drive at least minimum unscheduled urgent care delivery compliance across local GDP Mandatory Service general access contractors - Consider the development of alternative local schemes out-with the Reform arrangements to address any evidenced NHS Urgent Care Reform unintended consequences or delivery gaps that might arise. This could include; UDAC extension and expansion, GDP urgent care extended hours operation, OOHs capacity increases where feasible.	NHS England & NHS BSA reliable and regular publication of ICB and Contract level FP17 B1U delivery patterns. In order to help set local ICB meaningful targets that are aligned with national reform expectations be provided with NHS England's national leading and lag performance measurements of unscheduled urgent care success that they have agreed with DHSC/Government. These key performance metrics set between NHS England and the DHSC/Goverment including forecast professional uptake expectations from national baselines can then be replicated directly at a local level to ensure local and national data collection, reporting and success is being judged consistently via NHS BSA and Futures provided national reporting. Provision of a list of acceptable national alternative unscheduled urgent care solutions that local ICBs can seek to quickly implement should the National Reform urgent care GDP high street actual delivery and take up not meet public and patient demand expectations that are newly created.
Resonse to previous comments: ICB have responded in part. However, there is an opportunity to strengthen further **Missing detail:** . Examples of actions to be taken to support efficiency . Examples of actions to be taken to reduce duplication across commissioning teams	**Maximising and optimising the spend of the dental ring-fence** Priority 4	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	To support delivery of this theme we will locally seek to optimise the spend of the dental ring fence by: 1. Driving forward proactively the implementation of National Reform Quality & Payment Reforms. A primary aim of the national reforms being to improve dental budget spend through a reduction in under-performance. This being achieved by the national introduction of a range of new quality and payment claiming arrangements. If these National Reforms are successful this will in itself optimise dental budget spend, remove financial under-performance and through the increased national payment arrangements potentially help to retain and attract new NHS Dentistry providers and workforce. 2. Implementing our local and evidenced true cost of care UDA uplift to all mandatory services contract holders. This will alongside the National Reform quality and payment additions further improve the financial viability of NHS Dentistry contracts and the potential to retain and recruit local dental workforce through improved remuneration. 3. NHS Dentistry workforce development is not a direct responsibility of the ICB, it is a national, regional and local responsibility held by NHS England. Locally as an ICB we will continue to engage with our local NHS England, Workforce Training & Education 'Deanery' leads, the Local Dental Network and Regional Local Dental Committee's to ensure that we can we can provide regulatory dental contracting and collaborative whole system support wherever possible. This will include support into the local Dental Hospital to support student development (SIFT), NHS England Deanery leads to explore Foundation Dentist placement expansion, EU and overseas entry programmes and broader dental team development through their local specialist and skill mix training programmes. 4. National Golden Hello Scheme - Prior to the implementation of the National Golden Hello scheme the NENC ICB as a trail blazer had trialled the Golden Hello concept locally with limited success. As part of this work the Golden Hello created an unintented consequence which was conflict and discontent across the long standing dental workforce who felt the scheme was unfair to the established NHS Dentistry workforce. As a result the ICB shifted emphasis away from the Golden Hello Scheme to create a local loyalty bonus scheme to try to rebuild trust and retain the existing dental workforce. This scheme has been operated successfully and non recurrently for two years with positive feedback received from the local profession. This however will now stand down for 2026-27 with the introduction of the new NHS Quality & Payment Reforms coming into place and our local true cost of care UDA uplift coming into place for 2026-27. The new reforms if successful should resolve the remuneration issues that have seen dental workforce losses continue nationally and locally over recent years. The ICB will review the impact of the NHS Quality and Payment Reform impacts on workforce over the coming months and as part of that review determine whether finite resource would be best placed towards re-instatement of the Golden Hello Scheme at any future point. 5. To improve efficiency and remove duplication we will engage in regular financial and whole system delivery review processes across the year working with our partners as necessary to track both recurrent and non recurrent spend patterns and identify where opportunities might exist to remove unwarranted or inefficient spend (waste) through active non recurrent and/or recurrent financial rebasing, undertaking active performance case investigations to recover inappropriate claiming activity and identify potential duplication of funding areas across commissioning partners (Local Authorities, NHS WTE, ICB Secondary Dental Care), for example through the implementation of our new Referral Management System during 2026-27 with the outcome of all of these activities being the redirection of any financial inefficiencies released towards local pressures and areas of prioritised need. These regular review processes will also link into more formal mid-year and end of year regulatory processes to ensure that release of inefficiencies can be secured at the earliest opportunity for re-distribution.	Full implementation of National Quality & Payment Reforms 2026-27 in accordance with NHS England technical guidance expectations and mandated deadlines: - Mandated Urgent Care Targets Issued - 15 March 2026 - Mid Year Performance Review - October 2026 - End of Year Performance Review - June 2027 Issue of NHS Reform Re-enforcement and GDP Expectations Letter to all providers - April 2026 Secure funding to support Local Dental Comms & Engagement Plan implementation for 2026-27 - April 2026 Complete the implementation of the local True Cost of care UDA uplift to all Mandatory Services GDPs excluding Child Only - April 2026 Dental Budget Monitoring Meetings with ICB Finance Leads to review recurrent spend patterns, forecast under-performance and non recurrent budget release - April 2026 onwards Quarterly collaboration meetings with the local NHS England, Dental Dean as the local NHS workforce commissioning lead to ensure that the ICB can provide appropriate support to ensure their workforce development plan is supported appropriately at a local level with the shared aim of improving primary care dental workforce skill mix, recruitment and retention - April 2026 onwards	Monthly Dental Ring Fence Budget meetings and monitoring with Primary Care Finance Leads to track spend v budget for 26-27 and any change in spend patterns compared to pre-Reform years 25-26. Monthly Review of national clinical datasets being collected, analysed and reported through national systems to monitor, compare and contrast patterns of delivered care, UDA burn rate and unique patient access changes in year to determine impacts upon contract delivery and as such potential forecast underspends. We will rely primarily upon receipt and review of nationally published datasets and data packs to secure a pre-Reform baseline position and then track new Reform impacts on UDA burn rates and subsequently dental ring fence budget spend: - NHS England, Futures: National Dental Data Packs & Dashboard (Success will be an increasing UDA burn rate and improved delivery position across contracts to 96% or above) - NHS BSA: COMPASS, EDEN contract based and ICB aggregated data packs (Success will be an increasing UDA burn rate and improved delivery position across contracts to 96% or above) The above review of dental budget spend alongside review of national delivery clinical datasets will also provide a 'leading proxy indication' of whether there is sufficient dental workforce within the local area to deliver the commissioned NHS Dental capacity in place. In addition to the above proxy metric we will also secure qualitative data from our collaborative work with LDN and LDC local leaders and through our quarterly collaboration meetings with the local NHS England, Dental Dean as the local NHS workforce commissioning lead.	**Medium**	Confidence must at this point be no higher than **Medium** as the National UDC Reforms are new, untried and tested operationally and as such it is not yet possible to determine the degree of professional workforce and provider engagement and buy in to optimising the new claiming and financial viability benefits offered through the new national quality and payment reforms. However, based on local engagement over recent years the major driver for workforce loss and under performance has been confirmed as: 1. Non viability of UDA rates 2. The need for contract reform and move away from the UDA system. Therefore the combination of a more viable UDA rate locally and the new Reform claiming and re-targeting of the NHS contract towards more viable urgent, complex and preventative care provision should if supported by the local profession address those root cause problems and lead to the Dental Ring Fence budget spend locally becoming optimised and the local dental market becoming re-stimulated. In summary therefore the risks are: - National Quality & Payment Reforms do not impact positively upon practice viability and workforce remuneration to such a degree that dental workforce continues to move away from NHS Dentistry to Private Dentistry provision in the short term. - Step change, long term national further reforms outlined as part of the 10 year plan do not come forward with an acceptable solution acceptable to the dental profession Our risk mitigation plans will therefore include: - Close monitoring of the NHS Reform implementation throughout the transitionary 2026-27 period to evidence and confirm postive impacts and unintended consequences that arise in relation to budget spend, dental delivery and by poxy workforce retention, responding accordingly. - Use National Reform and Regulatory contract mid and end of year sanctions to drive and lever delivery in support of both mandated and discetionary reform change benefits across local GDP Mandatory Service general access contractors - Pro-actively seek ways to successfully re-commission any released contract capacity that occurs through active rebasing or contract handback. - Providing 'flow through' funding to the NHS England Workforce Training and Education Team (Deanery) to fund a range of programmes aimed at recruitment and retention of dentists and the wider dental workforce.	NHS England & NHS BSA reliable and regular publication of ICB and Contract level FP17 CoT, Pattern of Care and Patient treated data. In order to help set local ICB meaningful targets that are aligned with national reform expectations be provided with NHS England's national leading and lag performance measurements of unscheduled urgent care success that they have agreed with DHSC/Government. These key performance metrics set between NHS England and the DHSC/Goverment including forecast professional uptake expectations from national baselines can then be replicated directly at a local level to ensure local and national data collection, reporting and success is being judged consistently via NHS BSA and Futures provided national reporting. Clarification as to where the commissioning responsibility for dental workforce development and funding sits within the newly reformed systems being developed and implemented from 2026-27 onwards and what the specific expectations upon local ICB Regulatory, Primary Care Contracting teams should be including workforce metrics that local ICBs are to be directly held accountable for.
Response to previous comments: ICB have responded	**Implementing the 2026 dental payment and quality contract reforms** Priority 1	Plans should set out the practical steps the ICB will take to: - Ensure **contract variations for the 2026 reform package are issued** and signed by providers ahead of April 2026 - **Support dental providers** with implementation of the new changes - Encourage the uptake of **funded annual appraisal** and participation in the **dental QI programme** - Establish peer groups for dental providers participating in QI and **align these to local clinical leadership**	We will work within the 2026-27 new financial, regulatory, policy and reform technical guidance to optimise Quality and Reform implementation as follows: 1. Implement National Reforms as per the recently issued stage 1 technical guidance and then beyond that stage 2 once launched and published nationally later in 2026. 2. As part of those reforms implement each separate element of the new reform package pro-actively to ensure providers receive appropriate communication, instruction and the ability to engage with both Mandated and Discretionary reform initiatives including QI and Appraisal wherever possible, all of which being achieved within the nationally set deadlines associated with each. 3. We will ensure that our LDN Chairs and Regional LDC clinical leads engage within and provide support where necessary to promote the benefits of practice engagement within the QI initiative, support the establishment of peer groups, and offer clinical support to practices where needed to complete peer review QI initiatives. We will also engage NHS England Deanery leads where appropriate. Please note this is a discretionary initiative and as such there are no levers to force practice enrollment or engagement within the QI scheme. 4. Continue to invest in our local Dental Communications Strategy & Plans to ensure consistent public, patient and media messaging is in place to raise awareness of and secure reasonable management of expectations across all staheholders regarding the change of NHS Dentistry focus that the Quality & Performance Reforms will introduce from April 2026-27.	National Reform implementation for 2026-27 completed in accordance with NHS England technical guidance expectations and mandated deadlines: - Mandated Urgent Care Targets Issued & CVs signed - 15 March 2026 - Standard Reform CVs Issued & CVs signed - May 2026 - QI & Appraisal Enrolment Conclusion - May 2026 - Mid Year Performance Review - October 2026 - End of Year Performance Review - June 2027 Issue of NHS Reform Re-enforcement and GDP Expectations Letter - April 2026 Secure funding to support Local Dental Comms & Engagement Plan - April 2026 Review National Dental Q&P changes in patient focus, pattern of care delivery, UDA burn and Unique Patient impacts across our local 'whole system' throughout the Transitionary 2026-27 year: - Q1 June 2026 - Q2 Sep 2026 - Q3 Dec 2026 - Q4 Mar 2027	Monthly Review of national clinical datasets being collected, analysed and reported through national systems to monitor, compare and contrast patterns of delivery, UDA burn rate and unique patient access using: - NHS England, Futures: National Dental Data Packs & Dashboard (Success will be an increasing UDA burn rate and improved delivery position across contracts) - NHS BSA: COMPASS, EDEN contract based and ICB aggregated data packs (Success will be an increasing UDA burn rate and improved delivery position across contracts) In addition we will: - Secure 100% successful issue and formal signature of CV's by nationally set deadlines - Secure baseline positions for No/% of providers taking up QI and Peer Group review initiative	**High**	Confidence in completing these Reform based contracting actions is **High** as they are predominently internal ICB Dental Team process management and contract performance management core tasks.	NHS England & NHS BSA reliable and regular publication of ICB and Contract level FP17 CoT, Pattern of Care and Patient treated data. In order to help set local ICB meaningful targets that are aligned with national reform expectations be provided with NHS England's national leading and lag performance measurements of unscheduled urgent care success that they have agreed with DHSC/Government. These key performance metrics set between NHS England and the DHSC/Goverment including forecast professional uptake expectations from national baselines can then be replicated directly at a local level to ensure local and national data collection, reporting and success is being judged consistently via NHS BSA and Futures provided national reporting.
Response to previous comments: Response needs strengthening **Missing detail:** ICBs plan is linked to reform intent. It doesn't give strong enough reference to specific actions which will be taken to address unwarrented variation and reduce health inequalities. Throughout, the plan would benefit from some detail around addressing unwarrented variation and reducing health inequalities. The plan could be strengthend by including specific reference to particular cohorts or areas where there is an opportunity i.e. vulnerable groups, target coastal or rural gaps	**Improving access to NHS dental services** Priority 3	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.	We will work within the 2026-27 new financial, regulatory, policy and reform guidance to optimise Quality and Payment Reform impacts as follows: 1. Implement National Reforms as per the recently issued stage 1 technical guidance and then beyond that stage 2 once launched and published nationally. The primary intention of the new national reforms being to improve the financial viability of contract and workforce remuneration, whilst shifting the focus of NHS Delivery towards reducing oral health inequalities through a more preventative, urgent and complex needs provision of access and care. 2. Set up local NHS Dentistry mandatory service performance management and governance arrangements that will allow us to track local Reform uptake of mandatory and discretionary changes and the subsequent impact that the new Reforms generate on NHS Dentistry delivery patterns and UDA burn rates compared with pre-reform periods. As this national claiming data becomes available and is reviewed the local performance management and governance group will identify risk management and mitigation actions using nationally available contracting and reform leverage or sanctions alongside any local interventions that are deemed reasonable and compliant to monitor and remove unwarranted variation and inequality. 3. Any recommissioning of access needed moving forward will be based upon an assessment of local need and health inequalities with prioritisation of allocation of contracts and activity being given to those dental contracts that can evidence full engagement within and compliance with the new delivery patterns and access expectations that are outlined within the National Quality & Payment Reform regulatory and policy based changes. As part of these recommissioning arrangements we will: a) Be developing a local dental re-commissioning policy linked to the wider Integrated Care Partnership, Health & Wellbeing for All strategy that seeks following a partner wide needs assessment to target improved quality of services and targeting finite resources towards addressing health, economic, social and both rural and coastal deprivation and inequalities. This will necessitate difficult decisions to be made by the ICB Board regarding striking an appropriate balance as to when re-commissioning of activity is re-directed back into the immediate locality it has been released from with the political and public pressures associated versus moving capacity away from those areas to re-direct into areas of the ICB where NHS Dentistry access inequality exists. b) We recognise that our priority currently remains attempting to recover general access for all to a point where dental ring fence budget is spent and in doing so ensure that National Reform mandates are met. However, we also recognise the National shift being requested for available, finite and limited NHS Denstistry funding to be moved from general access for the worried well and orally fit patient base more towards vulnerable higher needs groups. As part of the reform implementation some of our local targeted vulnerable group initiatives were asked to stand down due to reform conflicts. Recognising this we plan to commence reviews of Community Dental Services and Domicilliary care to identify opportunities where general access funding can be better directed towards supporting our most vulnerable young, elderly and disabled populations although this work will be constrained by available dental ring fence funding until further reforms and increased national funding becomes available.	National Reform implementation for 2026-27 completed in accordance with NHS England technical guidance expectations and mandated deadlines: - Mandated Urgent Care Targets Issued - 15 March 2026 - Standard Reform CVs Issued - April 2026 - QI & Appraisal - May 2026 - Mid Year Performance Review - October 2026 - End of Year Performance Review - June 2027 Issue of NHS Reform Re-enforcement and GDP Expectations Letter - April 2026 Secure funding to support Local Dental Comms & Engagement Plan - April 2026 Review National Dental Q&P changes in patient focus, pattern of care delivery and UDA burn Impacts across our local 'whole system' throughout the Transitionary 2026-27 year: - Q1 June 2026 - Q2 Sep 2026 - Q3 Dec 2026 - Q4 Mar 2027	Monthly Review of national clinical datasets being collected, analysed and reported through national systems to monitor, compare and contrast UDA burn rate, unique patient access and unintended inequality of access to care changes that impact as part of the transitionary year 2026-27, with a particular focus on unwarranted variation from Reform expectations. We will rely primarily upon receipt and review of nationally published datasets and data packs to secure a pre-Reform baseline position and then track new Reform impacts on UDA burn rates, changes in delivered patterns of care and patient access including: - NHS England, Futures: National Dental Data Packs & Dashboard (Success will be an increasing UDA burn rate and improved delivery position across contracts) - NHS BSA: COMPASS, EDEN contract based and ICB aggregated data packs (Success will be an increasing UDA burn rate and improved delivery position across contracts) We will particularly focus our attention on how unique patient numbers are impacted by the Reform changes as we expect that unique patients numbers are likely to reduce (or ability to access), whilst more high needs, complex patients are treated (as such increased oral health gain / inequality reduction) if the reforms prove successful. This key monitoring risk is based on analysis of previous reforms to Band 2's, which had similar intentions that has seen a reduction in Band 2 CoT or patients treated reduce by circa 100k for the same UDAs delivered?	**Medium**	Confidence must at this point be no higher than **Medium** as the National Q&P Reforms are new, untried and tested operationally and as such it is not yet possible to determine the impact of change and potential unintended consequences that may arise from the following risk management perspectives: - Professional engagement, buy in to a more open door policy of access and going beyond the minimum expectation in order to priority urgent care access from a patient safety, contract delivery and financial viability perspective. - The change in patient and public expectations that may arise, creating a new and potentially increased spike in unscheduled urgent care access with a new expectation regarding ability to reliably access provision and how this may change patterns of future demand, patterns of access and management of new patient expectations and demand levels. Our risk mitigation plans will therefore include: - Close monitoring of the NHS Reform implementation throughout the transitionary 2026-27 period to evidence and confirm postive impacts and unintended consequences that arise, responding accordingly to unwarranted reform variation or inequality pressures. - Use National Reform and Regulatory contract sanctions to drive optimised National Reform compliance wherever possible, rewarding and setting new contract or re-commissioning criteria for award to include conditions of reform compliance and demonstrable pro-active compliance where pre-existing contract activity is held - Begin to consider and develop a range of possible local actions that could be locally commissioned where needed and whilst remaining compliant with Reform expectations.	NHS England & NHS BSA reliable and regular publication of ICB and Contract level FP17 CoT, Pattern of Care and Patient treated data. In order to help set local ICB meaningful targets that are aligned with national reform expectations be provided with NHS England's national leading and lag performance measurements of unscheduled urgent care success that they have agreed with DHSC/Government. These key performance metrics set between NHS England and the DHSC/Goverment including forecast professional uptake expectations from national baselines can then be replicated directly at a local level to ensure local and national data collection, reporting and success is being judged consistently via NHS BSA and Futures provided national reporting.
Response to previous comments: ICB have responded well	**Procurement of dental checks for CYP SEND pupils** Priority 5	Plan should provide strategy for the procurement of dental checks for CYP SEND pupils within residential and day special educational settings.	Local CDS services currently do screening with risk assessment and provide treatment to CPY in special educational residential settings but currently don't deliver the rest of the elements outlined in the national SES service specification. To avoid any duplication and ensure full complaince the ICB plan is as follows: 1 Map current service delivery against clinical and non-clinical spec to identify any gaps in provision (completed mid April 2026) 2. Engagement with SES staff to complete a baseline questionnaire to determine: preventive mouth care being delivered by the setting staff; whether mouth care plans are in place, the proportion of children receiving dental care provision; and setting staff training needs to support residents with their daily mouth care (to be completed by end June 2026) 3. Negotiate with current CDS providers and where gaps have been identified vary the existing service specification so that it reflects the requirements of the national service specification. rement has not taken place (timescales to be confirmed following review of workload priorities following implementation of the new ICB structure which is expected to be in place by end of May 2026)	1 Understanding of the gaps between current CDS specification/service provision and the national SES specification requirements (completed mid April 2026) 2. Completion of baseline questionnaire for each residential setting to provide an understanding of the current positon with regard to delivery of the national specification ie whether mouth care plans are in place , understand the proportion of children receiving dental care provision; and setting staff training needs to support residents with their daily mouth care (to be completed by end June 2026) 3. Conclude the negotiations with the current CDS providers inclusion of the national specification into their contracts (timescales to be confirmed following review of workload priorities following implementation of the new ICB structure which is expected to be in place by end of May 2026) Meanwhile the current OHP teams supplemented by the Dental Public Health Foundation Therapist will be working with setting staff to ensure every CYP has a mouthcare plan in place by end of June 2026.	CDS quarterly reporting on numbers of CYP receiving an oral health check per residential setting Bimonthly reporting of progress to Regional NHSE Team.	**Medium**	**Situation:** Potential duplication with the service already commissioned from the Community Dental Services has been highlighted and therefore review required to understand any gaps. **Issue:** - current CDS specs only reference screening and provisin of treatment not the full oral health checks as per national SES spec. - As highlighted in relation to other national schemes, team capacity to full progress the work required is an issue. The focus of work in the limited Dental Team has been on implementing our plans to deliver increased urgent dental access in line with the national targets , stabilisation of current dental provision. and implementation of the new dental contract reforms. Resources have therefore focused on these priorities. **Mitigation plan:** - obtained support of Dental Public Health consultant to inform initial mapping and co-ordinate engagement with SES staff to complete baseline questionnaire and mouthcare plans for CYP residents. - The ICB's position with regard to taking forward the outstanding actions required for this national initiative will be reviewed once the new operating model and structure has been implemented which we expect to by the end of May 2026. We are therefore unable to give a timescale at this stage on when the full plan as outlined will be implemented until the new structure is fully implemented and we have had the opportunity to assess the impact on other work priorities including the national dental reforms. - utilise the funding available to address any potential barriers to delivery fo the full service specification/workforce constraints highlighted by providers. **Timeline:** - completion of baseline question and mouthcare plans by end of June 2026. - agree and implement commissioning plan (timescale to be confirmed following review of workload and priorities once the new ICB structure is in place.	NHS England Dental Public Health support to undertake key elements of the action plan including baseline mapping and to support the discussions with the CDS providers to negotiate expansion of current services to include full national SES specification.

Practical Actions (Scope, Scale, Schedule) ■	Expected outcomes (Dates, Milestones)	Measurement (national, local indicators)	Delivery confidence (*High, Medium or Low*)	Key risks and mitigation	Support requirements
Understanding current provision and need: Identify relevant data sets available and local level to which these are available eg. Pharmacy First Utilisation Rates, number of urgent repeat medicines issued by Neighbourhood area. Review data on current provision, uptake and population health needs, starting with cardiovascular disease (hypertension, access, capacity), contraception (access/ capacity) and antimicrobial stewardship (Pharmacy First, access/ capacity). Use detailed data to inform ICB team and local coaches of needs and uptake to focus local conversations. Share relevant data and analysis externally to partners to make decisions and target efforts eg. via governance routes, LPCs, 111 Embedding community pharmacy in Neighbourhood conversations within the ICB: All ICB Neighbourhood Commissioning teams to have a linked named member of the MO NC team, to advise on: medicines strategy, community pharmacy clinical strategy, draw on community pharmacy clinical lead, and GPOD processes. Set up a communication method for community pharmacies to be able to share ongoing service updates eg. GP Teamnet. Embedding community pharmacy in Neighbourhood conversations in wider work: Continuation of local coaches for pharmacy first and PCN engagement work - to attend local Neighbourhood forums. Monitor impact of local coaches and, if beneficial, seek funding for continuation via ICB investment panel. Encourage local networking and education opportunities for Pharmacy and practice staff to promote the use of electronic pharmacy referrals and discuss any barriers/issues with current systems Set up a communication method for community pharmacies to be able to share ongoing service updates eg. GP Teamnet. Ensure wider healthcare teams are aware of how to use NHS Service Finder to signpost people to local services. Maximising uptake and focusing impact of existing advanced services: Champion Pharmacy First conditions across the wider health network utilising the coaches and system advocates. Monitor uptake versus population health needs, starting with cardiovascular disease, contraception and antimicrobial stewardship. Using the data to understand exceptional performance and support poor performance, not least at neighbourhood level. Report out results and potential actions via for outliers relevant planning and governance routes. Urgent repeat medicines - encourage patients to order medication in time, promote use of NHS App. Monitor supplies delivered, identifying inappropriate supplies, along with relevant governance intervention. Monitor antimicrobial supplies - data will be made available to facilitate AMR as appropriate, identify outliers and relevant networks for support and governance routes for management. For those practices highlighted via the Q&V process, include local coach support for signposting to pharmacy servuces in the action plan. Explore how coordinated offsite clinics can identify the "walking unwell" (patients who would not receive services at Pharmacy or GP). Continue the 'here to help' communications line, signposting to community pharmacy services and reminding of prescription ordering, especially where affected by system pressure eg. bank holidays and in tourist areas. Ensure wider healthcare teams are aware of how to use NHS Service Finder to signpost people to local services. Standardising and focusing impact of existing enhanced services: Monitor uptake versus population health needs, starting with antivirals and palliative care medication. Report out results and potential actions via relevant planning and governance routes. Maximising uptake and focusing impact of independent prescribing services: Monitor uptake versus population health needs, starting with covid medicines and minor ailments. Report out results and potential actions via relevant planning and governance routes. Monitor supplies delivered, identifying inappropriate supplies, along with relevant governance intervention.	Producing baseline benchmarking datapacks for neighbourhood teams highlighting unwarranted variations to enable neighbourhood leadership to deliver data led interventions. Primary Care Strategy Delivery Group/Investment panel to make a determination re funding of Pharmacy First projects. Increased usage of all the pharmacy first services, using data to inform progression. Enhanced relationships between Pharmacy Critical Coaches/PNC Leads and General Practice Increased electronic referrals from General Practice to Pharmacy On receipt of the national dataset this will enable us to be able to frame our quarterly ambitions.	To work with national team towards: Producing a plan for identifying capacity issues and addressing them locally PF - % of total consultations claimed outside of service specification (limit to outside terms of PGD + CD's supplied in quantities greater than 5 days through the URM pathway) PCS - PGD as above HCFS - Reduce numbers of returning patients to the hypertension case finding service within a defined time period (5 year) Audit report - outliers identified as a % of consultations where an antimicrobial was supplied # of URM consultation claims as a % of total Pharmacy First consultation claims % of ABPMs vs clinic check claims ePACT 2 reporting can also be used to monitor PF	**Medium**	Need to consider ongoing funding for PCN Lead/Coaches. Consider representation from Community Pharmacy in early neighbourhood discussions/planning - community pharmacy need to be seen as a key stakeholder. There is work to be undertaken to understand the reasons for variation in referrals from GP practice to community pharmacy. NHS England suppling relevant data in a timely fashion. An auditing approach will be necessary at ICB level. Pending NHS England providing datasets. Potential financial pressures and rationalisation of priorities and must do, may stall/delay some areas of work as full detail of costs materilise.	ICB to champion the pharmacy first mission and actively encourage GP practices to engage/utilise. Funding for PCN Lead/Coaches. Ongoing Community Pharmacy development group with on the ground community pharmacist expertise. NHS England support at national and regional level, specifically in relation to data and guidance. ICB to adopt an enabling and auditing approach. In addition, the contracting team will do internal auditing at neighbourhood level. ICB insights team need to review data and work with national colleagues to ensure appropriate reporting can be produced (is aligned to measurements). Continue with LPC support and engagement. National team to provide reporting including a dashboard to support ICBs understand which of their pharmacies require action.
Improve understanding of population need and current uptake through review of data: GP Connect Update and Access Record - monitored by GP contract team within the community pharmacy delivery group governance, reporting outliers through relevant governance routes. GP referral - Use the dataset to target support (if funded) by the coaches/community pharmacy PCN leads and other relevant networks. Collaborate with GP contract team and neighbourhood teams to make Pharmacy first referral numbers a key metric in quality & variance and access reviews. Utilise the information contained within the Pharmacy Dashboard to identify non/low referring practices. Significant changes in referral numbers - GP management team to be accountable for improving pharmacy first referrals from GP practices. Review of eDEC submission working with practices to identify barriers Use the Pharmacy Dashboard to review Pharmacy sign up to and uptake of services, and ensure key areas have good coverage based on population need eg. hypertension in high cardiovascular disease areas. Ensure the Pharmacy Dashboard content is reviewed regularly to ensure new services are being monitored. Revew data sharing options back with providers eg. urgent medicines use with practices, to drive improvement. NENC ICB communications team are developing a series of webinars between Pharmacy and General Practice, the first webinar held on 6th May "Available without prescription - Over the counter medication (OTC) stakeholder webinar, next planned webinar "Prescribing and Deprescribing Antidepressants" and impact of these will be reviewed, pending future opportunities.	Every GP practice in NENC is using GP connect with access record enabled. Work towards GP practices increasing their pharmacy first referral activity. Data driven intervention that includes the GP contracting team/neighbourhood team working towards addressing unwarranted variation and understand the reasons for any variation - To link with the quality and variation process and timescales once reviewed and new process established. All GP triage tools will point results to an electronic pharmacy first referral to pharmacy using the BARS system or EMIS local service button and not simple patient signposting.	To work with national team towards: 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	**Low**	A paper exercise rather than a digital confirmation that the service is live (i.e. self declared). Pharmacy first referrals is too far down the ICB/GP/Neighbourhood priority list - needs to be consistently championed across the health system by all system leaders to change system and patient beliefs and behaviours. Pending NHS England providing datasets. Potential financial pressures and rationalisation of priorities and must do, may stall/delay some areas of work as full detail of costs materilise.	Digital confirmation that systems are live in each GP practice. System leadership to champion pharmacy first and the benefits it brings. ICB insights team need to review data and work with national colleagues to ensure appropriate reporting can be produced (is aligned to measurements). Continue with LPC support and engagement. NHS England support at national and regional level, specifically in relation to data and guidance. Reliance on published activation data - noting that TPP update record data is not yet available but is to be delivered soon.
The ICB has continued to commission for the next 6months the Covid Medicines Delivery Unit (CMDU) and the Extended Minor ailment sites through ICB funding. The original 10 Independent pathfinder sites now have an option to take the national £500 which has been offered. The ICB MO team to further develop prescribing monitoring using EPACT data so that pharmacy independent prescribing is monitored in similar ways to all other prescribing. Monitor supplies delivered, identifying inappropriate supplies, along with relevant governance intervention. Signposting to further governance implementing national guidance eg. formulary and prescribing guidelines. A community pharmacy clinical services strategy will be delivered by end Q2 2026-27 to understand current provision and future options to meet population need. Recommendations from this will be implemented from Q3 onwards, pending national discussions on the future of independent prescribing services. Neighbourhood commissioning team in partnership with MO to develop service specification, based on outcomes from the strategy. Explore the findings from the NHSE Independent Prescibing Pilot and applicability to NENC population and pharmacies. NENC pharmacies involved in the pilot using ePACT2 data when available Explore opportunities to build relationships between pharmacy and GP practices in order to target services appropriately, train workforce and maximise referrals - eg Primary care collaborative, PCNs, GP support with DPP provision. Explore the possibility to incorporate ePACT2 trend data into the NENC pharmacy dashboard Understand the current geographic provision, and opportunities, gaps and barriers to future spread of independent prescribing services eg. workforce. Review potential mitigations eg. GP support with DPP provision.	CMDU continues to deliver to patients. Up to 10 IP sites generating EPS prescriptions. National governance guidelines implemented and monitoring of CP Ips is part of the BAU meds optimisation team activity.	to work with national team towards: Reported as a % of IP's registered to deliver NHSE community pharmacy services KPI >90%. Consultation numbers as a % of total site level PF consultations. Generation of IP prescribing report	**Medium**	Funding for IP/CMDU is until 31 September - what happens 1 October and beyond. Pending NHS England providing datasets. Potential financial pressures and rationalisation of priorities and must do, may stall/delay some areas of work as full detail of costs materilise.	ICB insights team need to review data and work with national colleagues to ensure appropriate reporting can be produced (is aligned to measurements). Continue with LPC support and engagement. NHS England support at national and regional level, specifically in relation to data and guidance.
Explore the possibility to incorporate uptake/ePACT2 data into the NENC pharmacy dashboard Monitoring the data on period of treatment such that the average is above 6months allowing for 3months initiation and longer ongoing supplies. Set up a communication method for community pharmacies to be able to share ongoing service updates eg. GP Teamnet. Targeted interventions for outliers to ensure operating within guidelines. Explore approaches to monitoring patient level outcomes.	Prescribing by GPs should fall. NENC to be ranked in the top 25% of ICBs. 3 months period of supply only used for initiation, after that the period of supply should be at least 6months.	Report that describes the number of ongoing supplies made for a period of 9-12 months as a percentage of all ongoing supplies made	**Medium**	GP Practices may not encourage patients to seek supply via Pharmacy. Local coaches would be able to support with this should funding be agreed. Pharmacies may offer too short a supply, monitoring and intervention will be in place to mitigate the risk of patients receiving a poor service with multiple appointments. Pending NHS England providing datasets. Potential financial pressures and rationalisation of priorities and must do, may stall/delay some areas of work as full detail of costs materilise.	ICB insights team need to review data and work with national colleagues to ensure appropriate reporting can be produced (is aligned to measurements). Funding for PCN/Coaches is under consideration. Continue with LPC support and engagement. NHS England support at national and regional level, specifically in relation to data and guidance.
DMS has been included in the Trust service development and improvement plan for all NENC Trusts from 2026-27. Action planning is in place for Trusts in this transition year. To explore best practice across NENC and England to further develop this work. Monitor rates of usage for NENC Trusts. Explore the opportunities to work with Primary Care Secondary Care Interface teams as to which action plans contain information on work being undertaken. Review the learning from the Pilot (from winter planning work) undertaken in Newcastle, consider learning for wider implementation. Use learning to clearly articulate the individual and system safety and financial benefits from increased use of DMS. Use this messaging to embed use of DMS in all relevant discharge pathway conversations across NENC.	DMS is embedded as a BAU activity in all trusts discharge processes. Each trust actively making DMS referrals Each trust promoting DMS with patients so patients know what to expect from the service on leaving hospital. NENC CPs DMS income is above national average per 1000 discharges	Trust DMS referral numbers per 1000 discharges. Trust to monitor readmissions following recent discharge and if the discharge has had a DMS or not. NENCs trust DMS rate will rank in top 25% Nationally.	**Medium**	Potential lack of integration/investment into IT solutions. There are NHS Mail based solutions available which can be mobilised by trusts in the short term to prove benefit and help build a trust business case for IT investment in an integrated solution. Potential lack of hospital incentive/commitment. Use any contractual levers, VSM Comms to be shared with hospitals and identify a DMS champion in the hospital, Should it be the bed manager? Pending NHS England providing datasets. Potential financial pressures and rationalisation of priorities and must do, may stall/delay some areas of work as full detail of costs materilise.	ICB insights team need to review data and work with national colleagues to ensure appropriate reporting can be produced (is aligned to measurements). Collaborative work with meds op team and untilisation of lead pharmacists in neighbourhoods. Support from secondary care provider collaborative. Continue with LPC support and engagement. NHS England support at national and regional level, specifically in relation to data and guidance - trust level reporting matched to pharmacy completion required subject to national reporting being made available.

Ensure there is a community pharmacy voice at every vaccination public health committee/board. To establish baseline population need data to enable targeted interventions in improving access. Providers will be commissioned via an EOI across NENC, site selection will engage neighbourhoods+. Utilise 'here to help' communications routes for HPV vaccination, targeting population cohorts with support from GPs. Ensure sites are accessible to book. Linking to contraception services making every contact count. Ensure wider healthcare teams are aware of how to use NHS Service Finder to signpost people to local services.	Increasing the availability of HPV across the community. HPV vaccination rates in these cohorts will be in top 25% Nationally. HPV vaccination by community pharmacy will be ranked in the top 25% activity.	Monitoring and identifying target cohort and reporting against vaccination numbers delivered by community pharmacy	**Medium**	Risk - we do not know whether locally or nationally commissioned. Need to seek clarity from the national team/NHSEngland. The service is not funded sufficiently to encourage CPs to sign up. To seek feedback from LPCs and to work with LPCs/CPE. Risk is that there wont be a national booking system/IT recording systems available and therefore patients wont be able to see where this is available. Ahead of any national programme NENC could commissioned by wise immunise for a local booking system, and create a local PharmOutcomes template to record activity, possibly via PSNE Ltd. Pending NHS England providing datasets. Potential financial pressures and rationalisation of priorities and must do, may stall/delay some areas of work as full detail of costs materilise.	ICB insights team need to review data and work with national colleagues to ensure appropriate reporting can be produced (is aligned to measurements). Support from the NEY/ICB imms team to champion community pharmacy as a vaccination provider with great access for patients. Continue with LPC support and engagement. NHS England support at national and regional level, specifically in relation to data and guidance.
Ensure all community pharmacies have fully enabled the capability for patients to track their prescription status using the NHS App. Monitor uptake and review outliers, including via relevant governance routes. Set clear expectations to pharmacies as to what additional communication tools look like and how they will be provided. Inform CP network of the ICBs ambition around this. Identify exceptional performers for buddy support and providing learning. Utilise 'here to help' communications routes to inform the public of expectations and promote uptake. Provide local resources to pharmacies to promote on-site. Engage the NENC ICB CCIO digital team to inform the programme and learn from general practice experience.	NENC to be the first ICB to achieve this.	Reported as number of community pharmacy sites (and percentage of total estate) with prescription tracking functionality enabled. 50% of community pharmacies have tracking enabled by March 2026	**Medium**	IT systems not ready. Significant community pharmacy costs - purchase and operational costs. Risk data is not available to see who has switched this on. Pending NHS England providing datasets. Potential financial pressures and rationalisation of priorities and must do, may stall/delay some areas of work as full detail of costs materilise.	ICB insights team need to review data and work with national colleagues to ensure appropriate reporting can be produced (is aligned to measurements). Continue with LPC support and engagement. NHS England support at national and regional level, specifically in relation to data and guidance.

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	ICB	NHS NORTH EAST AND NORTH CUMBRIA INTEGRATED CARE BOARD						
PCT Feedback	**Theme**	**Prompts**	**Practical Actions (Scope, Scale, Schedule)**	**Expected outcomes (Dates, Milestones)**	**Measurement (national, local indicators)**	**Delivery confidence *(High, Medium or Low)***	**Key risks and mitigation**	**Support requirements**
	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.	Provider selection strategy to have ICB governance sign off. Implementation of provider selection strategy; Procurement of service Assessment of bids Communication of outcomes Contract Issue and mobilisation for successful bids.	Project timeline delivered, procurement of service June/October 26, Assessment of bids Autumn. Contract award and mobilisation Jan/Mar 27.	Continuous monitoring of project deliverables and timelines.	Medium	Timeline slips through regular project team monitoring will be robust.	Support from finance and procurement ICB teams and LOCs.