NHS
Lancashire and South Cumbria
Integrated Care Board

Approved by email

Minutes of the Primary Care Commissioning Committee Held in Public on 13 February 2025 at 10.00am via MS Teams

Name	Job Title	Organisation
Members		
Debbie Corcoran	Chair/Non-Executive Member	L&SC ICB
Dr David Levy	Medical Director	L&SC ICB
Peter Tinson	Director of Primary & Community Commissioning	L&SC ICB
John Gaskins	Associate Director of Finance	L&SC ICB
Prof Craig Harris	Chief Operating Officer & Chief Commissioner	L&SC ICB
Dr Julie Colclough	Partner Member for Primary Medical Service	L&SC ICB
Paul Juson	Head of Assurance Delivery Primary Care	L&SC ICB
Andrew White	Chief Pharmacist	L&SC ICB
Participants		
Donna Roberts	Associate Director Primary Care, Lancashire (Central)	L&SC ICB
Amy Lepiorz	Associate Director Primary Care, South Cumbria and Lancashire (North)	L&SC ICB
David Bradley	Clinical advisor for Dental Services	L&SC ICB
In Attendance		
Claire Lewis (deputising for Kathryn Lord)	Associate Director – Quality Assurance	L&SC ICB
Sarah Mattocks (deputising for Debra Atkinson)	Head of Governance	L&SC ICB
Amanda Bate (deputising for Neil Greaves)	Head of Communications and Engagement (Transformation)	L&SC ICB
Claire Moore	Head of Risk, Assurance and Delivery	L&SC ICB
Jo Leeming	Committee and Governance Officer	L&SC ICB

No	Item	Action
Standing Items		
PCCC/ 17/25	**Welcome, Introductions and Chair's Remarks** The Chair welcomed the committee and members of the public who had joined today. Members of the public were asked to mute themselves and turn their cameras off, and that the chat function not be used. Four questions had been submitted which were pertinent to the committee since it last met. These questions were related to access to dental services, veteran friendly accreditation of GP practices, a complaint regarding a medical practice, and a question regarding the	

No	Item	Action
	dental contract. The question regarding dental services and the complaint would be responded to by the patient experience team. The ICB veteran lead had provided a response regarding the accreditation question, and this had been sent to the individual. The question regarding the dental contract had been shared with primary care for a response to be provided to the individual. Given that item 7 of today's meeting was dental commissioning, the dental concern and contract question had been shared with the presenter for consideration when this item was presented. The committee had received accounts from the public prior to this meeting and previous meetings with concerns regarding accessing dental services.	
PCCC/ 18/25	**Apologies for Absence / Quoracy of Meeting** Apologies for absence had been received from Neil Greaves (Amanda Bate deputising), Kathryn Lord (Claire Lewis deputising), Debra Atkinson (Sarah Mattocks deputising), Corrie Llewellyn, David Blacklock, Lindsey Dickinson and Umesh Patel. The meeting was declared quorate.	
PCCC/ 19/25	**Declarations of Interest** **(a) Primary Care Commissioning Committee Register of Interests** Noted. The Chair stated that D Bradley would be contributing factual comments only in relation to item 7 due to his role as Clinical advisor for Dental Services. **RESOLVED: The declaration relating to items on the agenda were noted. The Chair asked that she be made aware of any declarations that may arise during the meeting.**	
PCCC/ 20/25	**(a) Minutes of the meeting held on 16 January 2025 and Matters Arising:** **RESOLVED: The committee approved the minutes of the meeting held on 16 January 2025.** **(b) Action Log** The log was updated accordingly.	
Governance and Operating Framework		
PCCC/ 21/25	**Risk Management Report** The report presented an update on the risk management activity undertaken for those risks related to the business of the Primary Care Commissioning Committee (PCCC) since the last report presented in October 2024. C Moore presented the report and advised there were 3 risks held on the Operational Risk Register (ORR) with Corporate Oversight (CO) through the Executive Management Team (EMT). Section 3 provided a table with a summary of updates made to the risks since the report was last presented in October 2024. It was queried whether the score for Risk ID ICB 013, which was jointly held with Quality Committee, could be reduced. It was advised the risk score was being held cautiously until the proactive GP quality support visits had been rolled out fully and the pathway had been tested completely. However, it was felt once this was in place the risk score could be reduced. It was noted that Risk ID ICB 007 had a closure date of March 2026 and a target score of 8, and it was questioned if this was achievable. It was advised that the original date had been set in line with recovery from Covid, but it would be good for it to be reviewed in line with the Dental Commissioning Plan. As this query had an inextricable link to item 7, it was	

No	Item	Action
	agreed this would be reviewed once this item had been discussed. The committee confirmed it had been assured of the plans in place to mitigate the risks. **RESOLVED: the committee:** • **noted the contents of the report.** • **noted the risk management activity undertaken during the reporting period.** • **reviewed the risks relating to the business of the PCCC (Appendix 1).** • **noted for information all risks held on the ORR (Appendix 2).**	
PCCC/ 22/25	**PC Integrated Performance Report January 2025** The report provided a Summary and Benchmarking table on page 3, that gave a 'snap-shot' overview of the ICBs current performance for the metrics, followed by a more detailed overview of each metric displayed on separate pages (page 4 onwards). January 2025 report, points of note: • The number of general practice appointments delivered in a month exceeded 1 million for the first time ever. 1,099,329 appointments were delivered in October 2024 which was 31% higher than in September. This is predominantly due to the influenza vaccination programme which commenced on 1 October and has also affected the performance of metrics 2 and 3. • A further practice had reduced their prescribing of broad-spectrum antibiotics to below 10%, bringing the total to 177/197 practices having achieved the threshold. • LSC continued to see a reduction in the prescribing of high dose opioids, with reductions having been seen in all sub-ICB areas since 2019. Although the ICB's prescribing remained above National levels, the gap was closing as the reduction in LSC was at a faster rate. • LSC achieved the Quarter 3 milestone of 60% of children seeing an NHS dentist in the past 12 months (61.8%) To support the ongoing development of this report a workshop session would be taking place with the metric Senior Responsible Officers (SROs) to ensure the quality and consistency of the narratives provided; especially regarding details of actions and intended impacts. P Tinson introduced the report and advised that further work was required to reflect the triple A style reporting. The summary and benchmarking sheet referenced what was being done regarding variation in delivery in terms of location and providers. This was being picked up as part of the practice visits. Some of the positive metric scores were referenced and acknowledged. However, it was noted that on page 31 the RAG rating colours for opioids appeared to be incorrect as this was a good news story overall. The increased level of detail and assurance was recognised, and it was felt that to have the data at a point in time with more insight added into the narrative was very useful. In terms of GP FTE clinical staff group per 10,000 weighted patients, it was noted that Blackburn with Darwen was rated red but there was some variation within that locality. It was questioned if this is being picked up by the GP practice visits and it was advised that discussions and detailed analysis had been undertaken in this area around GP staffing. There had been a change to the skill mix, which differed across practices with comparatively fewer GPs but more other clinical staff in Blackburn with Darwen. However, it was for each practice to determine the balance of staffing as there was no single model of how a practice should be	

No	Item	Action
	staffed and each practice would approach this individually. It was agreed that good practice needed to be identified and then this could be shared with others. There had been a significant growth of other clinical staffing roles but that did not mask that the number of GPs remained lower in some areas of the region. It was recognised that continued investment was required in the primary care training hub and recruitment, and the Visa sponsorship scheme. Practice size had a big impact in terms of what some staffing models looked like and smaller practices with fewer patients and staff could explore with neighbouring practices approaches to resilience. The low number of referrals for the Acute Respiratory Infection (ARI) Hub in Fleetwood was noted and it was questioned how support was provided and options considered to ensure people in those areas had access to those services. It was advised that delivery of the ARI hubs had been reviewed in terms of lessons learnt and how the offer was communicated and presented. The primary care team was confident that the commissioned activity would be delivered by the end of this financial year. This was linked to item 10 on the agenda, the Planning and Policy Update: NHSE Operational Planning Guidance 2025/26 as one of national priorities from NHSE was the continued roll out of the modern general practice programme. This would include workload management, triage, signposting, and so on, and there was more that could be done around this, but it was dependent on investment and support for practices. It was requested that the oversight by committees/groups was reviewed as it remained inaccurate, and People Committee for example needed to be added due to its responsibility for workforce planning. The report should also be presented at future People Committee meetings. The committee recognised continued work to address unwarranted variations being addressed, and where appropriate mechanisms were in place. Assurance had been given around the KPIs and areas rated as red, and the further development and planned workshop was noted. It was also noted there would be an updated report presented at the next meeting of the Finance and Performance Committee for information only. **RESOLVED: the committee received the Primary Care performance report and:** • **noted achievement against the key performance indicators for Lancashire and South Cumbria.** • **supported the actions being undertaken to improve performance against metrics in this report.**	**PT / SM**
Commissioning Decisions		
PCCC/ 23/25	**Dental Commissioning Plan** The paper presented the Dental Commissioning Plan for the next five years. This plan built on the Dental Access and Oral Health Improvement Plan presented to the committee in November 2023. P Tinson noted thanks to the team for the work undertaken on the plan and advised that dental funding was one of a small number of strictly ringfenced budgets for the ICB. The paper had been brought in the context of the wider organisational planning process, and any discussion today would be subject to the outcome of discussions at the March Board meeting on the financial plan and commissioning intentions.	

No	Item	Action
	A Lepiorz presented the paper and highlighted some key points. The ICB had been working with stakeholders to address issues in access to NHS dental services. Improvements had been made since the delegation of dental services however, services remained a challenge nationally and locally across all sectors, with pressures in primary care services being well publicised. The current dental budget remained ring fenced, and while the budget was fully allocated, there were non-recurrent and recurrent resources that would become available due to the nature of how the NHS commissioned and contracted with providers. Nationally, central government was requesting that ICBs improved access to urgent care services. Both the urgent care investment and the integrated access pathway would contribute to the additional 700,000 appointments that the government was requesting the NHS deliver. The proposed plan had been clinically led with input from several stakeholders and was a fully funded and affordable investment proposal. Due to the ICB now being in formal intervention, the Chair requested a governance perspective around the commissioning intentions as the committee was being asked to review and approve the plan. C Harris noted the need for the plan and the current limitations in commissioning of dental services. However, the ICB was now under scrutiny and in NHS Oversight Framework 4 (NOF4) since the last plan was developed and all plans were now subject to an approval process at Board. Therefore, this would be considered as part of the commissioning intentions, strategy and planning, and financial planning and budget envelope. This would culminate in a decision at Board in March. This process would need to be followed and the decision making aligned with the legal requirements in relation to the ICB's turnaround status.. It was noted that any feedback from the paper from the committee would be fed back to Board, which would inform any decision made. It was questioned when any outcomes would be seen from the focused piece of work required to understand what intervention was needed to address that restoration of access on the Fylde Coast and Blackpool is slower than in the rest of Lancashire and South Cumbria, noting there had been a disproportionately higher number of contract hand backs in this local area. It was advised this work had not yet commenced but one of the first tasks would be mobilisation of a task and finish group. An understanding of why access rates had not improved was needed then solutions would be formed. It was expected it would be around 12 months before any impact would be seen. Reference was made to Appendix 1 – original programme outcomes, and it was questioned if any impact had been seen. It was advised more work was needed but there had been more expressions of interest from providers than required, which was positive. The team had also been working closely with the Local Dental Committee (LDC) to ensure the plan was attractive to the market but also value for money for the NHS. With regards to Appendix 4 – details of the schemes, and particularly the children's access and oral health improvement pathway, it was queried when data would be available to demonstrate the impact. It was advised this had started in September, but the numbers had been slow in coming through. It had been planned to be evaluated after 12-18 months to determine if this should be rolled out fully, but it would now more likely be 18 – 24 months for this to be piloted with a review to determine if it should be commissioned. The focus on the aging population was acknowledged, which was a shift from previous plans. The inclusion of the development of a provider collaborative as part of the Quality Improvement Scheme was noted and it was questioned what would be expected to be different with this compared to delivery by clinical	

No	Item	Action
	networks. It was advised there had previously been short-term quality initiatives at the end of the financial year, but this would involve work with dental commissioners to build on learning. Provider collaboratives had been developed in Pharmacy and Optometry; therefore, this would fit in strategically and aligned with ICB commissioning. It was questioned how the underspend was considered and if there was any learning where there had been under-delivery. It was explained that much had been modelled on what would be spent from day 1 with the intention of being ambitious but realistic as to when services could mobilise. The funding must be spent in 2 years' time, but consideration was being given as to how this could be spent. Historically, the dental contract would only deliver 90% and there would be a need to look at where the remainder should be committed to. It was agreed it was a fine balance and acknowledged that the access pathway would allow flex up and down. A query was raised regarding the availability and consistency of the dental workforce, and it was advised that the team had been working closely with the dental profession as workforce would be a key enabler of the plan. Some changes had also been made to contracts for increased flexibility to attract people into dental roles. Work was also being undertaken around how some services could be delivered by dental staff rather than dentists. The biggest challenge was that private dentistry was more attractive than NHS dentistry, but the schemes aimed to attract and retain more dentists. It was advised there had not yet been a national contract review update, but this would be part of any discussions regarding the plan. The committee thanked the team for all for the work undertaken on the plan. Assurance of the testing and robustness of the plan was noted and the committee supported that the plan be incorporated into the commissioning intentions and financial plans to be considered by the Board. It was discussed and agreed that the Dental Group would have oversight of operational matters. Reflecting on Risk ID ICB 007, it was agreed the risk score was correct, but the date expected to close this felt ambitious. It was noted it would be subject to in year monitoring. It was difficult to predict when it could be closed but was likely it would need another 2 years to allow the programme to be fully embedded. Further assurance was requested that the ambition and pace was there whilst being realistic about the overall timescale. **RESOLVED: the committee agreed:** • **to the 5-year Dental Commissioning Plan being incorporated into the Commissioning Intentions and the associated forward financial plans to be considered by the ICB Board, and through any necessary processes resulting from the ICB entering segment 4 of the NHS oversight framework.** • **to receive 6 monthly updates of progress.**	
Group Reporting		
PCCC/ 24/25	**Group Escalation & Assurance Report** The report highlighted key matters, issues, and risks discussed at the below group meetings since the last report to the Committee on 16 January 2025 to advise, assure and alert the Primary Care Commissioning Committee. • Primary Medical Services Group: Peter Tinson (Director of Primary and Community Care)	

No	Item	Action
	• Primary Dental Services Group: Amy Lepiorz (Associate Director Primary Care) • Pharmaceutical Services Group: Amy Lepiorz (Associate Director Primary Care) • Primary Optometric Services Group: Dawn Haworth (Head of Delivery) • Primary Care Capital Group: Paul Juson (Head of Delivery Assurance) Each summary report also highlighted any issues or items referred or escalated to other committees or the Board. Appended to the report were the risks currently being managed by the respective groups. **RESOLVED: The committee received and noted the Alert, Assure, Advise (AAA) reports from the five delegated primary care groups and risk registers from each group.**	
Other Items for Approval		
PCCC/ 25/25	**Primary Care Commissioning Committee Groups Decision Making Matrix - Review** The ICB holds over 1,000 core primary care contracts, resulting in the need to make a significant number of contractual decisions. The contractual requirements for all four primary care contractor groups are underpinned by national legislation and contractual frameworks. In addition, NHS England publishes policy books to support commissioners in the interpretation of the legislation and to ensure consistency in approach to contractual and commissioning decisions. In accordance with the legislation, national contract models and policy books, the types of decisions that need to be made can be roughly split into three types - those where the commissioner has no discretion if due process has been followed; those where the commissioner has a degree of discretion but there is a clear policy to be followed (local or national); those where the commissioner has more flexibility in its decision making. A decision-making matrix was in place between the main Committee and 5 supporting groups, and had been developed based on these principles to support the committee to safely and effectively discharge its duties. The decision-making matrix was approved by the Primary Care Commissioning Committee (PCCC) in May 2024. The decision-making matrix had been reviewed by a working group to ensure it enabled the PCCC to focus on its strategic assurance responsibilities and its supporting groups to make operational decisions. It was noted that the paper was thorough and acknowledged that this now needed to be reframed due to the governance review being reported through to the Board in March. Therefore, rather than the committee agreeing any additional delegations to the subgroups, the arrangements would remain as before until decisions had been made at Board. However, any views or feedback from members of the committee would inform the proposal to Board in March. It was agreed that it was a good robust piece of work with reasonable and sound suggestions for changes to delegations. **RESOLVED: The committee endorsed the approach but subject to governance review presented to Board in March and would be enacted subject to this.**	
Items to Receive and Note		
PCCC/ 26/25	**Planning and Policy Update: NHSE Operational Planning Guidance 2025/26** NHSE Operational Planning Guidance was published on 30 January 2025	

No	Item	Action
	alongside Neighbourhood Guidelines which aim to help integrated care boards (ICBs), local authorities and health and care providers continue to progress neighbourhood health in 2025/26 in advance of the publication of the 10 Year Health Plan. The paper provided a summary of the key expectations for primary care with two key commissioning priorities: • General practice access • Urgent dental care In addition, all parts of the health and care system are tasked with working closely to progress neighbourhood health, standardising the following six core components: • Population health management • Modern general practice • Standardised community services • Neighbourhood multi-disciplinary teams • Integrated intermediate care with a 'Home First' approach • Urgent neighbourhood services P Tinson noted this paper had been referenced at earlier points in the meeting, which indicated much of the work was already being undertaken. Primary care was a focus for planning but there was not much change in terms of the operational asks. It was noted that some of the access related metrics in the performance report were not contractual requirements. It was advised that improvement visits should continue with practices and then any variations discussed and explored. This would then determine any support required. There would be continued implementation of the national model for modern general practice and one of the intentions from the Primary Care provider collaborative was that colleagues who had implemented this in their practices would provide guidance and support to other practices. Work was being undertaken around the NHS app capabilities as one of the transformation priorities was around digital. There were ongoing discussions with NHSE around reasonable urgent NHS dental services and if this should be a target area. It was noted this was a great piece of work that would make a real difference to primary care and the required system working across partners as this was all intertwined with social care. However, interlinking had been providing lots of challenges at grassroots level. It was questioned how the Board would be sighted on this moving forwards. It was advised that the commissioning intentions would be aligned to this, and the roadmap being worked on with partners across the ICB. Also, the existing reformed integrated neighbourhood team group being led by Place clinical and care professional leads would enact it. It was noted the plan did not seem too different from the current priorities, but that it would be useful to understand the status of current delivery and what needed to be done for next year. More support would be required for practices to roll out modern general practice. By securing time and support from those practices who had already implemented this would be the best way to progress this although it was recognised this would require some financial investment. PA Consulting had been working with the team on an improved roadmap for delivery. One of the difficulties was around pressure on staff as there was a need to ensure how transformational activity could be supported and that clinicians were given the headroom for this to be undertaken. It was queried how satisfaction would be measured, and it was noted the most accurate view would be obtained from the patient survey. Complaints would also be a good barometer for any barriers or issues to be identified from particular	

No	Item	Action
	practices. **RESOLVED: The committee received and noted the guidance. Assurance around recovery mechanisms both individually and as ICB.**	
Standing Items		
PCCC/ 27/25	**Committee Escalation and Assurance Report to the Board** The Chair confirmed that this would be produced and submitted to Board.	
PCCC/ 28/25	**Items Referred to Other Committees** No direct referrals but the points related to the Integrated Performance Report and inclusion of People Committee to support connectivity.	
PCCC/ 29/25	**Any Other Business** None.	
PCCC / 30/25	**Items for the Risk Register** None.	
PCCC / 31/25	**Reflections from the Meeting** Good discussions, particularly regarding the dashboard and needs to go back up to the Board.	
PCCC / 31/25	**Date, Time and Venue of Next Meeting: TBC**	