Appendix B: Lancashire and South Cumbria ICB, Draft 2026/27 Primary Care Action Plan

Primary Care Action Plan Template for the Medium Term Planning Framework

ICB	NHS LANCASHIRE AND SOUTH 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 Primary Care Contracts Sub-Committee on a quarterly basis, with each of the ICB's four contractor groups taking responsibilty for their sections of the Plan.

Name of the ICB SRO for the plan: Peter Tinson

Name of Head of Primary Care: Peter Tinson

Lead for GP Dashboard: Donna Roberts / Sarah Squires

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:

Lancashire and South Cumbria ICB Primary Care Action Plan governance / sign-off:

12.05.26 Executive Committee (draft)	17.06.26 Commissioning Committee (final)
20.05.26 Commissioning Committee (draft)	23.06.26 Executive Committee (final)
	16.07.26 Primary Care Contracts Sub-Committee (final)

General Practice

ICB	NHS LANCASHIRE AND SOUTH CUMBRIA INTEGRATED CARE BOARD						
Theme	**Prompts**	**Practical Actions (Scope, Scale, Schedule)**	**Expected outcomes (Dates, Milestones)**	**Measurement (national, local indicators, as applicable)**	**Delivery confidence *(High, Medium or Low)***	**Key risks and mitigation**	**Support requirements**
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.	A three phased plan to be actioned during the year: **Phase 1.** Data Quality Improvement - M1-4 . Focus on improving practice coding and data quality (DQ) through; - development of local support guides, webinars and training sessions. - targeted practice 1 :1 support from the DQ Team, prioritised by those practices with the highest rates of inconsistent mapping in GPAD data. **Phase 2.** Understand baseline. M5. Re-visit and review ICB data and plan, once data quality improved and a better understanding of the metric's baseline is possible **Phase 3** Practice data interpretation and delivery support - M6 onwards. Place and practice level data review and interpretation to identify the most effective support. • Continued targeted DQ support (where needed) • Prioritised practice support from Clinical Lead, Commissioners, liaise with practices to understand drivers and refine support accordingly. • Urgent same-day appointment data in ICB proactive visit packs	90% of clinically urgent appointments seen on the same day (GPAD) by March 2027. Reduction in inconsistent mapping of GPAD evident in M5 data. Currently at 10.8%, aim to reduce by 50% to <5.2% by M5. Reduction in unmapped appointments GPAD evident in M5 data. Currently at 0.017%, aim to reduce by 50% to <0.085% by M5. Improved recording of 'non-clinically urgent' appointments which took place within 1 and 2 weeks, from M3 onwards.	% of clinically urgent appointments seen on the same day (GPAD) Inconsistent mapping (GPAD) Unmapped appointments (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 Data to understand operational capacity pressures in general practice fed into system-wide oversight arrangements. L&SC LTC LES data - no. holistic assessments, social prescribing referrals, Non-elective admissions data SHREWD	**Medium**	- Analysis of current data shows significant DQ issues and therefore the ICB and practices' baselines are unclear. Mitigation - Phase 1 actions outlined and subsequent reassessment of data once DQ improved. - Staff capacity to deliver. - In-year implementation of the ICB's new operating model and further staff reductions Mitigation: Re-visit GP Action Plan post implementation of operating model and revise as required - Impact of BMA collective action, Mitigation:: monitor activity and stand-up EPRR if and when required. Maintain LMC communications. Intelligence gathering processes estblished.	Awaiting details of a national central support hub to understand how the ICBs support to offer to practices can further compliment. ICB Access to General Practice Dashboard only contains data up to January 2026. Reinstatement of national Peer Ambassador funding. Understand that NHSE will seek to collab with the ICB on those most challenged providers when they are identified during M1-4.
	- Supporting practices' understanding of demand/capacity optimisation. This should include further embedding of modern general practice and population health management/risk stratification.	Targeted practice support as needed following proactive or reactive visits, identification of outliers, or on request by practice. Proactive and Reactive GP Support Framework FINAL.pdf Planned programme of webinars (Big Conversations) with a focus on demand and capacity management, implementation of modern general practice and population health management throughout the year. Which will include the lessons learned and experiences of those practices who participated in the 2025/26 GPIP. PCBC_programme_2026.pdf ides and information repositories, including local case studies on the Access section of the ICB's GP Intranet site. This will build upon the guides previously developed during 2025/26, which will also be reviewed and amended to include feedback as lessons learned from the previous years.. The above will be informed by the continual monitoring of ICB and practice performance of access metrics, and also link to the contract compliance as per rows 11-15.	Increase in ICB's Online Consultation Rates/1,000 pop, volumes and hour of day, throughout the year. 80% reduction in the number of practices identified as having negative variation (OC rate <5) by March 2027. Currently L&SC has 23 practices identified *(this includes practices where OC provider data not is not captured).* Achieve ICB GPAD plan for 2026/27		**Medium**	- Staff capacity and the ICB's new operating model. Mitigation: Re-visit GP Action Plan post implementation of operating model and revise as required . - Changes to CAIP reduced ICB visibility to understand practices transition to MGP Mitigation: utilise data availble and soft intelligence gained through PM meetings, practice visits and feedback. - Impact of BMA collective action, including the initial action regarding DSAs. Mitigation: monitor activity and stand-up EPRR if and when required. Maintain LMC communications. Intelligence gathering processes estblished. ICB utilising NHSE response letter to DSA actions.	Awaiting final reports from 2025/26 practice GPIP programme Reinstatement of national Peer Ambassador funding.
	- 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.	GP out of hours arrangements will remain in place in all areas outside of GP core hours. IUC providers operate CAS 24/7 in their respective areas. Their take includes patients who have been transferred by NHS 111 (telephony and online), NWAS lower acuity ambulance patients and HCP support. They have a variety of community, primary care and secondary care services available that they can divert and direct patients to other than E.Ds. Call before convey services are in place, acute visiting services and GP out of hours services will operate when core Primary Care is closed ensuring there is 24/7/365 Primary Care cover across LSC. The ICB continues to invest in a LTC enhanced service which has demonstrably supported a reduction in non-elective admissions and increased social prescribing referrals. This was included in the ICB's 2025/26 plan with the 2026/27 LTC element building on the success and lessons learned from the previous year. LTC LES 26-27 FINAL.pdf assurance checks undertaken in advance of each bank holiday for each pillar of primary care, and circulated internally for System-wide updates. Refer to embedded example from 25 May 2026. 25 May 2026 bank holiday assurance summary final.pdf	*Delivery of 80k holistic health care assessments through the LTC LES by March 2027;* *10% reduction in non-elective admissions for targeted cohorts* *5% of holistic health assessments undertaken during 2026/27 resulting in a referral to social prescribing.* *Assessment of PC bank holiday provison undertaken before each bank holiday.*		**Medium**	- Staff capacity and the ICB's new operating model. Mitigation: Re-visit GP Action Plan post implementation of operating model and revise as required .	

	- Monitoring, reporting and response of system pressures for general practice. This could include use of tools such as Operational Pressures Escalation Levels (OPEL) framework	All practices are able to report and escalate their pressure levels via the ICB's SHREWD VitalHub system, with Primary Care Commissioner attendance and updates provided to the SCC a minimum of once per week. National surveillance data and local soft intelligence (i.e. feedback from practice manager meeting and other practice interactions) is also used to understand local pressures. Uptake of the new system has been low in practices as, due to funding restrictions, there is no incentivisation available. Plans to increase submissions include improved reporting to practices, further developing the Primary Care reports available, and continued encouragement of practice sign-up, and further GP training sessions provided in advance of winter. The ICB also plans to explore the potential to establish sentinel practice reporting in year, however this is pending resources.	Update of GP sections on SHREWD platform by July 2026, to show greater granularity at place level, submission trend charts and collated narratives. Bespoke GP training session to be provided by SHREWD on the new GP sections and how to access and undrstand wider system and provider statuses - by August 2026. Increase in the number of practices frequently submitting pressure SitRep statuses via SHREWD. Aiming for 50% increase in the number of practices reporting by September 2026.		**Low**	Staff capacity and the ICB's new operating model. Mitigation: Re-visit GP Action Plan post implementation of operating model and revise as required - GP Practice engagement Mitigation: continued use of soft intelligence and engagement through LMC. - Impact of BMA collective action, Mitigation:: monitor activity and stand-up EPRR if and when required. Maintain LMC communications. Intelligence gathering processes estblished.	
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**	Discussions are taking place with practice managers to promote scheme and to start to develop plans to fully utilise funding. Following publication of the guidance by NHSE the ICB will work with practices to implement the reimbursement scheme. The ICB ensures practices are kept up to date with any relevant guidance.	PCNs optimise usage of CAP funding. PCNs optimise usage of Additional Roles Reimbursement Scheme (ARRS) roles. Maintain and build on ARRS GP headcount for 2025/26 (114 GPs).	Fully qualified GPs (FTE) GPs recruited through ARRS ARRS roles % utilisation of ARRS funding	**High**		Awaiting publication of the guidance by NHSE
	-Promote recruitment of GPs and other roles through additional roles reimbursement scheme.	There are Workforce Development managers (WDM) within the training Hub who's roles are to support PCN's to fully utilise their ARRS budget.	Maintain and build on other ARRS roles recruited during 2025/26. Maintain/improve L&SC's utilisation of ARRS funding in from 2025/26 level.		**High**	- WDMs in place for part of the year. Mitigation: transitions to business as usual.	
Unwarranted variation in access in different parts of the country	Plans should set out the practical steps the ICB will take to: -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.	The ICB's Proactive and Reactive GP Support Framework (embedded in cell C5) considers a range of data to inform which practices are offered a proactive visit in-year. Support is offered at these visits and there is an overarching support repository, which is also included in the Proactive and Reactive GP Support Framework. ICB continues to commission an LTC LES (embedded in cell C6) which delivers in excess of 80k holistic health care assessments to targeted populations as informed by risk stratification. ICB has established a system-wide referral and outpatient optimisation group whose work plan includes clinical policies, tier 2 services, advice and guidance, and addressing variation in planned care referrals, pathology and diagnostic requests. TOR RODM Draft May 26 V0.4_.pdf Targeted Demand Management (TDM) which re effective treatment to target through outreach in disadvantaged communities across LSC. Targeting delivery through use of practice lists and local knowledge (PHM). ICB is developing a combined support package for general practice to support increasing the number of people with diagnosed CVD to be treated to target. Support package will brings together business intelligence, data quality and pharmacist expertise and, using local dashboard, be targeted to where greatest variation in the system is observed (i.e. practice furthest from targets).	Continuation of practice improvement visits and cascading of good practice, with a target of 66 proactive visits to take place by March 2027. Delivery of 80k holistic health care assessments through the LTC LES by March 2027; 10% reduction in non-elective admissions for targeted cohorts 5% of holistic health assessments undertaken during 2026/27 resulting in a referral to social prescribing. Demand management commissioning intentions agreed with providers. Increased identification of people with CVD in disadvantaged communities (Core20) - where recorded prevalence is currently low. Increased treatment to target for CVD management. Reduce inequalities in emergency admissions for myocardial infarction and stroke Reduce inequalities in percentage of patients who are managed to target for hypertension, atrial fibrillation and cholesterol	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 eDEC L&SC LTC LES data - no. holistic assessments, social prescribing referrals, Non-elective admissions data L&SC Proactive visit data CVDPrevent and locally developed dashboards (based on EMIS coded data) for hypertension and lipids management, available at ICB, PCN, and general practice level – these capture identification and treatment/management measures. Aligned to national ambitions: •80% people with diagnosed hypertension treated to target •65% people 25-84 years with 20% or higher CVD risk score on lipid lowering therapies •95% with recorded CVD treated with lipid lowering therapy •95% people 18 years+ with recorded atrial fibrillation and CHA2DS2-VASc score of 2 or more, who are currently treated with anticoagulation drug therapy	**Medium**	Staff capacity and the ICB's new operating model. Mitigation: Re-visit GP Action Plan post implementation of operating model and revise as required - Number of visits will be dependant upon capacity.	
	-Support, monitor and ensure compliance with the GP contract. This should include the GP contract changes introduced in October 2025 as well as the new 2026/27 GP contract requirements. Plans would benefit from specific reference to the governance mechanisms that will be used to monitor compliance.	ICB has an operational access group in place to ensure oversight in relation to the access GP contract changes. This work will be considered as BAU. All contractual non-compliance is be reviewed through monthly Primary Medical Services Group meetings.and contractual notices issued if required (this includes NWRS submission requirements). This is assessed through the annual eDEC submissions process, scheduled and adhoc compliance checks; following validation/confirmation of non-compliance. Primary Medical Group Terms of Reference.pdf For the 2025/26 eDEC cycle, 144 practices submitted declarations stating non-compliance to one or more questions, which breaks down to: 125 practices declared non compliance to high priority questions, 55 to medium priority questions and 24 to low priority questions. The ICB Place Teams are currently undertaking a verification process with practices to establish true non-compliance vs answer errors, this includes any non-compliance regarding opening hours. The outcome of the eDEC verification process will be considered by PMSG in August alongside the issuing of breach notices and the suggested process from NHSE for opening hours non-compliance.	The ICB will review Access Contractual compliance through the operational access group . Any contractors who are outliers will be prioritised and escalated to PSMG. Consideration of any identified non-compliance by PMSG and the issuing of contractual notices as required throughout the year. 2025/26 eDEC verification process completed by July 2026 and reported to PMSG in August 2026. Issuing of 2025/26 eDEC related breach notices from August 2026 onwards, following consideration by PMSG.		**High**	- Unable to monitor all practice's Online Consultation (OC) data as currently not all OC systems data is able to be reported by national data collections. Mitigation: raised with NSHE as requires a national solution. - OC system capping, the ICB only has access to one OC System's data to monitor this (ACCURX). - Staff capacity and the ICB's new operating model as described in cell G4. - NHSE support.	Enable all OC systems to be included in national data collections, and inclusion of whether practices have applied caps.

	-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.	The ICB's Proactive and Reactive GP Support Framework (embedded in cell C5) considers a range of data to inform which practices are offered a proactive visit in-year. Support is offered at these visits and there is an overarching support repository. The ICB's GP Access Operational Group's work plan focuses on monitoring and facilitating the ICB's, PCN's and Practices implementation of modern general practice and the associated requirements. The planned work is outlined in row 5, as it is viewed to be synonymous with demand and capacity. In addition, website checks of all GP Practices to support and ensure continued compliance i.e. YYGP, online registrations, OC switched on etc, will take place in quarter 1, with further follow-up checks undertaken on 10% of practices per quarter. Each of the below interventions will be used appropriately after consideration of evidence - both variation and local intelligence to use judgement and expertise to identify what will be best for the practice, individual patients and the local population: - Contractual levers - Reactive pathway - visit and support / intervention - Proactive support visits (and ability to move up priority of visit) - Peer support - Topic specific support, i.e.: - Digital support i.e. NHS App Ambassadors - Shared learning i.e. Primary Care Big Conversation webinars, Digital Town Hall meetings.	Continuation of practice improvement visits and cascading of good practice, with a target of 66 proactive visits to take place by March 2027. In year improvements in ICB performance Reduction in number of practices identified as having negative variation for Access on GP Dashboard, from 24		**Medium**	- Unable to monitor all practice's OC data as described in cell G11. - National issues with EMIS (Optum) to alter their NHS App settings for Prospective Records is hampering at least 11 practices in L&SC. Staff capacity and the ICB's new operating model. Mitigation: Re-visit GP Action Plan post implementation of operating model and revise as required .	Enable all OC systems to be included in national data collections. NHSE to resolve the issue with EMIS (Optum) to allow GP practices identified as not having updated their NHS APP to alter their settings. This affects 11 LSC practices, and resolution of this issue would further enable these practices to also achieve 'step 4'.
	-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.	The ICB will continue to use its own locally developed Proactive and Reactive GP Visit Framework to identify practices that require support and determine their support needs. This framework has been developed following the first year of implementation in 2025/26. Numerous lessons learned events have taken place following visits to ensure that processes have been refined. In addition, new practices can be put forward for consideration of a visit in year should new concerns be raised regarding their performance. In 2025/26, the ICB completed eight reactive practice visits and has identified a further four for 2026/27 (to date). In 2025/26, the ICB completed 18 of 33 planned proactive visits; three of these escalated to reactive visits, in addition a further five of those planned are scheduled for the first two months of 2026/27. The remaining 10 did not take place due to capacity (7) or lack of practice engagement (3). For the 2026/27 year the ICB has developed a list of circa 66 practices intended for a proactive visit, which were identified as described in row 15 (delivery dependent on capacity). Of the 33 L&SC practices identified by NHSE (>3,500 pts/GP), four are national GP dashboard negative outliers for Access and Patient Experience (scores have been locally adjusted for the NHS111 metric and local OC provider knowledge). A further three have a negative outlier score of 3. The ICB is aware of all seven through variation and proactive visit processes and is either already supporting them or completing due diligence to inform proactive visits in the 2026/27 programme. The remaining 26 practices will continue to be monitored in line with ICB processes.	Continuation of practice improvement visits and cascading of good practice, with a target of 66 proactive visits to take place by March 2027. Ongoing -General practice improvement		**Medium**	- Unable to monitor all practice's OC data as described in G11. Staff capacity and the ICB's new operating model. Mitigation: Re-visit GP Action Plan post implementation of operating model and revise as required . - Number of visits will be dependant upon capacity.	Enable all OC systems to be included in national data collections. Reinstatement of national Peer Ambassador funding.
	-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.	Practices who appear to be an outlier in respect of access are offered support and input into the proactive visit, i.e. this could be fom the Data Quality Team, Training Academy, clinical lead, access lead. Practices may be offered peer support from other practices demonstrating best practice. If a practice triggers the reactive pathway a comprehensive improvement plan is developed through identification of KLOEs. ICB has no funding available to commission PLS, which has previously been funded nationally.	Increase in uptake of support offers (due to national requirement for practices to engage with support from their integrated care board).		**High**	Staff capacity and the ICB's new operating model as described in cell G4.	National PLS funding as provided in previous years. Reinstatement of national Peer Ambassador funding.
	-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.	Data triangulation underpins the proactive visit framework. This includes the national GP Dashboard, local GP Dashboard, quality indicators locally, meds opt locally, complaints data, soft intelligence etc. Where negative variation is highlighted these practices are offered a proactive visit. There are plans to introduce a variation group to actively monitor trends. Future medium to long term intention for improvement support to be provided by the Con-federation, which is being developed. Currently 24 LSC practices are identified on the GP Dashboard as having negative variation, of those 6 received support visits during 2025/26 and 11 have been identified for visits this year. The remaining 7 practices will continue to be monitored and reviewed for requiring additional support. LSC had 33 practices identified as having pt/GP ratios of >3.5k. Having reviewed the practice's data the ICB believes there is no proven single 'cause and affect' conclusions which can be made. From our list of 33 practices, between performance and populations per GP, for example - after adjustment of practices scores for OC systems and NHS111 metrics, the ICB has just 4 of the 33 practices who are a negative outlier for Access and Pt Experience. The ICB will work with the 33 practices to verify any data quality issues (14/33 practices have not updated their NWRS data in the last 12 months), and potential access and outcome issues will be picked up through existing variation processes. The ICB will also ensure that the patient ratio data is considered in furture practice prioirtisation and visits processes.	Ongoing -General practice improvement Reduction in number of Access negative variation practices by 20% by August 2027. Con-federation - ongoing phased development. Inclusion of Pt/GP ratios included in data triangulation and proactive visits framework during 2026/27.		**Medium**	- Unable to monitor all practice's OC data as as described in cell G11. Staff capacity and the ICB's new operating model as described in cell G4	Enable all OC systems to be included in national data collections.

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.	Maintain a standardised GPIT core offer across all practices, including online consultation, messaging, online booking and cloud-based telephony. Provide targeted support to practices identified as outliers using national and local access, demand and utilisation datasets. Embed optimisation of digital tools within Access Operational Group activity - utilise Frontline Productivity support functions when these become funded and available. Support practices to use population health management, demand and capacity planning tools to inform access and workforce decisions. Support system-wide guidance and peer support to promote consistent and effective use of GPIT in line with the Modern General Practice model and GP contract requirements.	Business as usual monitoring via PCN Digital Transformation and GP Practice digital leads.	• GP Dashboard – Access metrics (appointments by route) • GPAD – appointment volumes and categories • Cloud-based telephony dataset (calls answered, abandoned, call-backs per 1,000 pop) • Reduction in variation across access indicators (GP Dashboard) • % practices meeting digital access contractual requirements • Reduction in complaints related to access/navigation • % of practices utilising AVT • Qualitative productivity benefits (time released for care) • Staff feedback (local evaluation) • Completion of IG, DPIA and clinical safety assurance • No reported patient safety incidents attributable to AVT • System learning shared via digital/access forums • % Monitor national NHS App dashboards • NHS App log-ins and feature usage • App appointment booking activity • % providers onboarded to NHS Notify	**Medium**	Staff capacity and the ICB's new operating model. Mitigation: Re-visit GP Action Plan post implementation of operating model and revise as required	Frontline Productivity (FP) funding for Digital Pathways Optimisation Team and GPIT Optimisation Support released in a timely manner so resources are available. Procurement and contracting support available to manage tendering of resources funded by FP
	- Support implementation of new technologies, including ambient voice technology (AVT)	Identify and support early adopter practices that are using/self-piloting Ambient Voice Technology (AVT). Advise practices on appropriate digital, information governance and clinical safety assurance and their responsibilities as data controllers to ensure this is in place prior to implementation in line with national guidance. Monitor adoption, usage and emerging benefits to inform future roll-out decisions. Share learning, best practice and evaluation outputs through established system forums to support informed adoption across general practice.	Local data collection via practice self-declaration and existing access groups.		**Medium**	Staff capacity and the ICB's new operating model. Mitigation: Re-visit GP Action Plan post implementation of operating model and revise as required	Frontline Productivity (FP) funding for AVT solutions released in a timely manner so resources are available. Procurement and contracting support available to manage tendering of resources funded by FP
	- 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.	Continue to signpost all available support material to Monitor NHS App usage and appointment publishing through national reporting mechanisms then work with outliers via existing engagement routes sharing best practice across all PCNs and practices for local implementation.	% App usage based on national dashboards against target 95% (post triage)		**Medium**	Staff capacity and the ICB's new operating model as described in cell G4. - Potential impact of BMA collective action as described in cell G4.	Frontline Productivity (FP) funding for Digital Pathways Optimisation Team and GPIT Optimisation Support released in a timely manner so resources are available. Procurement and contracting support available to manage tendering of resources funded by FP
	- Transition all direct-to-patient communications to NHS Notify, retiring local communication systems, and use NHS App 'push' notifications as the primary method of contacting patients. Transitions should begin in 2026/27, with all providers completing migration by the end of 2028/29.	Produce a cost and benefits analysis of NHS Notify V local systems in use and work with national and local IT providers to ensure the best value for money and inclusive patient engagement options are considered and adopted.	Reduction in local SMS/letter systems		**Medium**	Staff capacity and the ICB's new operating model as described in cell G4. - Potential impact of BMA collective action as described in cell G4.	Technical changes to support, delivery and patient facing systems to be built into the "Transform" phases of GPIT "transfer" following the announcement of CSU closures and requirement to shift operational GPIT support elsewhere.
System and broader transformation	Plan should set out strategic approach for: **- Engagement of people and communities** to understand needs and co-design services	Strategic engagement around general practice isn't generally carried out by ICB, however engagement is always a key component of any practice changes (i.e. contractual changes, list dispersals, mergers, etc). ICB has a robust engagement infrastructure. Public engagement and involvement are essential components of all decision-making. The ICB hears views from members of the public from a range of different sources including proactive engagement and outreach, general enquiries, complaints, subject access requests and population health approaches to community mobilisation with communities and partners.			**High**		
	- Utilisation and planning of estates to support alignment and integration supported across PCNs, neighbourhoods and Primary/Secondary/Community Care.	The ICB Infrastructure strategy, alongside the primary care capital investment plans include extensive plans regarding the strategic intension of the ICB to develop infrastructure to support PCN's, Neighbourhoods, primary, community and out of hospital secondary care.	Business as usual monitoring of capital investments is ongoing, the monitoring of estate utilisation within individual sites to develop and reconfigure services and determine investments is also ongoing.		**Medium**	- Revenue mitigation: on a case by case basis different models will be utilised to minimise revenue implications. Staff capacity and the ICB's new operating model. Mitigation: Re-visit GP Action Plan post implementation of operating model and revise as required	NHS Property Services supporting the ICB Estates team to improve occupancy and utilisation
	- Staffing and alignment to neighbourhood development.	The ICB is progressing planning to support more integrated working to align with neighbourhood development. This includes proposals for a new interim neighbourhood development board as a partnership forum for system development and the launch of our new operating model which will clarify further commissioning footprints and neighbourhood development emphasis.			**High**		
	- Investment and resourcing, specifically how this compares to previous years.	The ICB has significantly invested in LES 2025/26 which has continued into 2026/27 with some requirements changed.			**High**	- Continuing to prove value for money.	

Pharmacy

ICB	NHS LANCASHIRE AND SOUTH CUMBRIA INTEGRATED CARE BOARD

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
Embedding pharmacy clinical services, ensuring that local commissioning discussions utilise Pharmacy First and other pharmacy clinical services to support local system, primary care/ urgent demand pressures	Plans should set out the practical steps the ICB will take to: -Address **unwarranted variation** in delivery of community pharmacy advanced services and improve system confidence, e.g. identify pharmacies where service demand is above capacity and create a plan to help decompress or support to improve access and reduce unwarranted variation	Embedded Pharmacy Access Programme that offers support to both Pharmacies and GP practices in terms of referrals into pharmacy advanced services. This work is now BAU for the ICB which includes continuing the routine communication of the community pharmacy offer using established channels such as GP webinars, intranet, protected learning time and similar which take place on weekly/monthly cycles. Delivery is monitored monthly via the Primary Care Contracts Sub-committee who receive an integrated performance report which includes key delivery metrics Unwarranted variation will be picked up in the implementation section of the access programme. The Local Pharmaceutical Committee continue to support variation and GP referrals are discussed as part of the GP pro-active visits. Pharmacy%20Access%20Programme%20-	BAU - the ICB will continue to monitor on routine basis however there is no data to support which limits delivery. Outliers will be prioritised.	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	**High**	Risks: Data Flow ICB Restructure Capacity NHSE Support We are unable to mitigate any of these risks.	
	-Support community pharmacies to improve the quality of data shared and captured through the pharmacy clinical services	Embedded Pharmacy Access Programme that offers support to both Pharmacies and GP practices in terms of referrals into pharmacy advanced services. This work is now BAU for the ICB which includes continuing the routine communication of the community pharmacy offer using established channels such as GP webinars, intranet, protected learning time and similar which take place on weekly/monthly cycles. Delivery is monitored monthly via the Primary Care Contracts Sub-committee who receive an integrated performance report which includes key delivery metrics Unwarranted variation will be picked up in the implementation section of the access programme. The Local Pharmaceutical Committee continue to support variation and GP referrals are discussed as part of the GP pro-active visits.	BAU - the ICB will continue to monitor on routine basis however there is no data to support which limits delivery. Outliers will be prioritised.		**High**	Risks: Data Flow ICB Restructure Capacity NHSE Support We are unable to mitigate any of these risks.	
	-Improve Pharmacy First utilisation rates. Including through Integrated Urgent Care providers (NHS111 telephony).	Embedded Pharmacy Access Programme that offers support to both Pharmacies and GP practices in terms of referrals into pharmacy advanced services. This work is now BAU for the ICB which includes continuing the routine communication of the community pharmacy offer using established channels such as GP webinars, intranet, protected learning time and similar which take place on weekly/monthly cycles. Delivery is monitored monthly via the Primary Care Contracts Sub-committee who receive an integrated performance report which includes key delivery metrics Unwarranted variation will be picked up in the implementation section of the access programme. The Local Pharmaceutical Committee continue to support variation and GP referrals are discussed as part of the GP pro-active visits.	BAU - the ICB will continue to monitor on routine basis however there is no data to support which limits delivery. Outliers will be prioritised.		**High**	Risks: Data Flow ICB Restructure Capacity NHSE Support We are unable to mitigate any of these risks. - Potential impact of BMA collective action as described in cell GP tab, cell G4.	
	-Reduce utilisation of the urgent repeat medicines pathway e.g. monitoring activity, identifying patterns, addressing issues and promoting good prescription re-ordering practice	Embedded Pharmacy Access Programme that offers support to both Pharmacies and GP practices in terms of referrals into pharmacy advanced services. This work is now BAU for the ICB which includes continuing the routine communication of the community pharmacy offer using established channels such as GP webinars, intranet, protected learning time and similar which take place on weekly/monthly cycles. Delivery is monitored monthly via the Primary Care Contracts Sub-committee who receive an integrated performance report which includes key delivery metrics Unwarranted variation will be picked up in the implementation section of the access programme. The Local Pharmaceutical Committee continue to support variation and GP referrals are discussed as part of the GP pro-active visits.	BAU - the ICB will continue to monitor on routine basis however there is no data to support which limits delivery. Outliers will be prioritised.		**High**	Risks: Data Flow ICB Restructure Capacity NHSE Support We are unable to mitigate any of these risks.	
	-Monitor antimicrobial supplies made under the Pharmacy First service and address outliers	Monitored by NHSE	Monitored by NHSE		**Monitored by NHSE**	Monitored by NHSE	
	-Improve the quality of the Hypertension Case Finding Service, e.g. monitor ABPM conversion rates, identify and address outliers	Embedded Pharmacy Access Programme that offers support to both Pharmacies and GP practices in terms of referrals into pharmacy advanced services. This work is now BAU for the ICB which includes continuing the routine communication of the community pharmacy offer using established channels such as GP webinars, intranet, protected learning time and similar which take place on weekly/monthly cycles. Delivery is monitored monthly via the Primary Care Contracts Sub-committee who receive an integrated performance report which includes key delivery metrics Unwarranted variation will be picked up in the implementation section of the access programme. The Local Pharmaceutical Committee continue to support variation and GP referrals are discussed as part of the GP pro-active visits.	BAU - the ICB will continue to monitor on routine basis however there is no data to support which limits delivery. Outliers will be prioritised.		**High**	Risks: Data Flow ICB Restructure Capacity NHSE Support We are unable to mitigate any of these risks.	

Continue developing the relationships between general practice and community pharmacy to support access to pharmacy services	Plans should set out the practical steps the ICB will take to: - Ensure GP Connect Update and Access Record are enabled and being utilised.	Continue to signpost all available support material to Monitor NHS App usage and appointment publishing through national reporting mechanisms then work with outliers via existing engagement routes sharing best practice across all PCNs and practices for local implementation.	% App usage based on national dashboards against target 95% (post triage)	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	**Medium**	Staff capacity in the ICB new structure and operating model Mitigation: Review post structure implementation - Potential impact of BMA collective action as described in cell GP tab, cell G4.	
	- Improve GP referral numbers in Pharmacy First service.	Embedded Pharmacy Access Programme that offers support to both Pharmacies and GP practices in terms of referrals into pharmacy advanced services. This work is now BAU for the ICB which includes continuing the routine communication of the community pharmacy offer using established channels such as GP webinars, intranet, protected learning time and similar which take place on weekly/monthly cycles. Delivery is monitored monthly via the Primary Care Contracts Sub-committee who receive an integrated performance report which includes key delivery metrics Unwarranted variation will be picked up in the implementation section of the access programme. The Local Pharmaceutical Committee continue to support variation and GP referrals are discussed as part of the GP pro-active visits.	BAU - the ICB will continue to monitor on routine basis however there is no data to support which limits delivery. Outliers will be prioritised.		**High**	Risks: Data Flow ICB Restructure Capacity NHSE Support We are unable to mitigate any of these risks. - Potential impact of BMA collective action as described in cell GP tab, cell G4.	
	- Identify and investigate significant changes in referral numbers. This could included auditing variation linked to use of GP online consultation tools.	Embedded Pharmacy Access Programme that offers support to both Pharmacies and GP practices in terms of referrals into pharmacy advanced services. This work is now BAU for the ICB which includes continuing the routine communication of the community pharmacy offer using established channels such as GP webinars, intranet, protected learning time and similar which take place on weekly/monthly cycles. Delivery is monitored monthly via the Primary Care Contracts Sub-committee who receive an integrated performance report which includes key delivery metrics Unwarranted variation will be picked up in the implementation section of the access programme. The Local Pharmaceutical Committee continue to support variation and GP referrals are discussed as part of the GP pro-active visits.	BAU - the ICB will continue to monitor on routine basis however there is no data to support which limits delivery. Outliers will be prioritised.		**High**	Risks: Data Flow ICB Restructure Capacity NHSE Support We are unable to mitigate any of these risks.	
Introduce prescribing-based services into community pharmacies during 2026/27	Plans should set out the practical steps the ICB will take to: - Incorporate **Independent Prescribing** into existing medicine optimisation **governance processes and audit of provider reports** / audits of activity outside the scope of the service specification or defined clinical competence and action plan to address any identified issues.	The ICB participated in the IP pathfinder programme for community pharmacy, which ended in December 2025. We extended the service to March 2026 for all sites and are in the process of extending 3 sites to October 2026 with the national funding. The service is embedded into governance processes which includes alignment with existing NMP policy and assurance of competences. The service specification outlines the provider responsibilities for auditing prescribing and ensuring IP competencies. We await the potential national service later in the year following contract negotiation talks.		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. There is no NHSE service currently and hence PF does not yet have prescribing. We measured compliance with the pilot and will be running ePACT prescribing report as we continue with the pathfinder service.	**Medium**	We do not have a local commissioned service so we await a national roll out. Although we have the capacity to audit in the IP pathfinder programme, this will not be sustainable when all community pharmacies go live, therefore audits and competence will need to be in the service specifications. There will be a national performers list.	
	- Identify and review independent prescriber prescribing that includes local formulary adherence, antimicrobials and opioids. This will be possible through analysis of ePACT2 data.	This will be the responsibility of the providers as outlined in any service specifications. We will include community pharmacy in ePACT data reports			**Low**	The current medicines structure does not include pharmacy and therefore does not have the capacity to analyse data and work with community pharmacy We are unable to mitigate against this risk.	
Monitor community pharmacy contraception service, focussing on ongoing supply length and emergency contraception	Plans should set out the practical steps the ICB will take to: -**Audit ongoing contraception supplies** and produce an action plan for increasing the length of ongoing supplies made under the service.	Embedded Pharmacy Access Programme that offers support to both Pharmacies and GP practices in terms of referrals into pharmacy advanced services. This work is now BAU for the ICB which includes continuing the routine communication of the community pharmacy offer using established channels such as GP webinars, intranet, protected learning time and similar which take place on weekly/monthly cycles. Delivery is monitored monthly via the Primary Care Contracts Sub-committee who receive an integrated performance report which includes key delivery metrics Unwarranted variation will be picked up in the implementation section of the access programme. The Local Pharmaceutical Committee continue to support variation and GP referrals are discussed as part of the GP pro-active visits.	BAU - the ICB will continue to monitor on routine basis however there is no data to support which limits delivery. Outliers will be prioritised.	Report that describes the number of ongoing supplies made for a period of 9-12 months as a percentage of all ongoing supplies made	**High**	Risks: Data Flow ICB Restructure Capacity NHSE Support We are unable to mitigate any of these risks.	
	- Monitor patient level outcomes to identify patients who through the Emergency Contraception service then go on to be initiated on longer term contraception.	Embedded Pharmacy Access Programme that offers support to both Pharmacies and GP practices in terms of referrals into pharmacy advanced services. This work is now BAU for the ICB which includes continuing the routine communication of the community pharmacy offer using established channels such as GP webinars, intranet, protected learning time and similar which take place on weekly/monthly cycles. Delivery is monitored monthly via the Primary Care Contracts Sub-committee who receive an integrated performance report which includes key delivery metrics Unwarranted variation will be picked up in the implementation section of the access programme. The Local Pharmaceutical Committee continue to support variation and GP referrals are discussed as part of the GP pro-active visits. No data sets currently to support this work.	BAU - the ICB will continue to monitor on routine basis however there is no data to support which limits delivery. Outliers will be prioritised.		**High**	Risks: Data Flow ICB Restructure Capacity NHSE Support We are unable to mitigate any of these risks.	

Maximise use of the Discharge Medicines Service to reduce medicines harm and reduce readmissions	Plans should set out the practical steps the ICB will take to monitor and increase NHS trust referrals into the Discharge Medicines Service.	DMS is currently fully supported by East Lancashire Hospitals Trust (ELHT) and University Hospitals of Morecambe Bay Trust(UHMB) with close collaboration from Community Pharmacy Lancashire and South Cumbria. A commitment has just been reached with the ICS Directors of Finance to support future funding of a platform for delivering DMS across the whole ICS as a result of presenting data collated from the Trusts currently undertaking DMS during the pilot project over the past 3 years . An options appraisal to decide the best route to enable Lancashire Teaching Hospitals Trust, Blackpool Teaching Hospitals Trust and Lancashire and South Cumbria Foundation Trust is currently being put together to present to Chief Pharmacists along with evidence from the pilot with the aim to set the remaining Trusts up during FY26/27. A monthly stakeholder meeting is currently in place to minitor and support DMS all Trusts are invited to send representations to this and it is hoped the non-partcipating trsust will join once the confirmation of the funding is agreed at the nexr meeting with DoF's	By end of FY26/27 to have all Lancashire and South Cumbria ICS Trusts delivering DMS. Currently ELHT and UHMB deliver around 1300 referrals a month it would be hoped by FY27/26 this could be in the order of 3000+ referrals per month once the additional Trusts are fully up and running	Trust DMS referral numbers per 1000 discharges	**High**	- Persuading Chief Pharmacists from the two non-participating Acute Trusts to engage with DMS, Mitigation: the Mental Health trust have already indicated a willingness to participate if funding has been confirmed, - this will hopefully be mitigated now that agreement from DoF's has been reached to support funding of the platform to deliver referrals, along with evidence from the pilot that there is little, to no impact, on the Trust Pharmacy team in making referrals. - Technical issues met when implementing an integrated solution to deliver DMS - Mitigation - the Refer-To-Pharamcy platform has been integrated in two tof the 5 Trusts in the ICS and dicussions already held have confimed tha the necessary messaging to integrate others trusts is already utilised therefore this should be feasible with minimal.	Follow up from DoF's on commitment for funding of the DMS delivery platform Support from ICS Pharmacy team to encourage non-participating trusts to engage with the project to implement DMS in their trusts
Make HPV vaccination available at pharmacies for women and young people who missed out on vaccination at school	Plans should set out the practical steps the ICB will take to allocate support and resource to optimise uptake of the HPV vaccine by utilising access benefits of community pharmacy.	Vaccinations sit with NHSE not ICB	Vaccinations sit with NHSE not ICB	Monitoring and identifying target cohort and reporting against vaccination numbers delivered by community pharmacy	**Vaccinations sit with NHSE not ICB**		
Ensure all community pharmacies have fully enabled the capability for patients to track their prescription status using the NHS App	Plans should set out the practical steps the ICB will take to support full adoption and integration of the NHS App into community pharmacies to support operations and patient communication. This could include support for more local engagement with pharmacy sites and support for funding or implementation of technologies such as scan-to-shelf.			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	**low**	A lack of resource and funding for ICB level engagement and implementation support. We are unable to mitigate against this risk.	Funding to support the implementation of new technologies in Community Pharmacy

Dental

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Urgent and unscheduled care	Plans should set out the practical steps the ICB will take to: - Better match capacity to demand and reduce **unutilised appointments**	The Dental Commissioning plan has been embedded in to the return to highlight the full plan being implemented by the ICB for Dental Services. This plan is in addition to the implementation of the contractual reforms. Item 6_Dental Investment 2026_27 Refresh FINAL.pdf	Business as Usual - the ICB will continue to monitor on activities on a routine basis however there are concerns over the availability of activity reports regarding the reform impacts. Outliers will be prioritised.	The ICB has a plan for identifying the urgent dental demand and capacity, with national reforms and local pathways to manage patient demand. Direct demand managed via the L&SC ICB Call handling Service, incorporating NHS 111 referral via a soft transfer. Allocation of resources to monitor activity and management performance identified within the risk section	**High**	Risks: Data Flows and provision of information. The ICB Restructure, and the direct impact on staffing capacity and corporate / historic knowledge Operational Capacity NHSE Support We are unable to mitigate any of these risks.	
	- Optimise 111/unscheduled care pathways to support access to urgent and unscheduled care	The ICB communication team will continue to promote the NHS111 and local call handling service to patients within the ICB.	Refer to cell D4		**High**	Refer to cell G4	
	- Utilise comms to improve patient awareness of and access to urgent and unscheduled dental care appointments	Reference the Dental Commissioning plan	Refer to cell D4		**High**	Refer to cell G4	
	- Provide comprehensive out of hours urgent and unscheduled dental care provision	Reference the Dental Commissioning plan	Refer to cell D4		**High**	Refer to cell G4	
	- 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	Reference the Dental Commissioning plan	Refer to cell D4		**High / Medium**	Refer to cell G4	
	- Ensure processes in place for the review and implementation of flexibility of the mandated proportion of 10:10	Reference the Dental Commissioning plan	Refer to cell D4		**High / Medium**	Refer to cell G4	
Maximising and optimising the spend of the dental ring-fence	Plans should set out the practical steps the ICB will take to: - Ensure collaborative working to improve efficient and reduce duplication across their commissioning teams	Reference the Dental Commissioning plan	Refer to cell D4	Monthly Golden Hello reporting	**High / Medium**	Refer to cell G4	
	- Ensure continued focus on developing the dental workforce with plans to include consideration of dental recruitment incentives	Reference the Dental Commissioning plan	The DRIS programme has ended with effect from 31/03/26. The reporting of workforce remains a contractual requirement. There is no local incentive scheme within the commissioning plan		**Medium**	Refer to cell G4	
Implementing the 2026 dental payment and quality contract reforms	Plans should set out the practical steps the ICB will take to: - Ensure contract variations for the 2026 reform package are issued and signed by providers ahead of April 2026	The ICB has progressed and issued all the contractual variations, letter and guidance required as part of the Contract Reforms.	Refer to cell D4	Additional reporting by NHSE Central required to support the monitoring of the dental reforms	**High / Medium**	Refer to cell G4	
	- Support dental providers with implementation of the new changes	The ICB engages on a regular basis with the profession - directly with providers and indirectly via the Local Dental Committee and Local Dental Networks	Refer to cell D4		**High / Medium**	Refer to cell G4	
	- Encourage the uptake of funded annual appraisal and participation in the dental QI programme	Ref D12 & D13	Refer to cell D4		**High / Medium**	Refer to cell G4	
	- Establish peer groups for dental providers participating in QI and align these to local clinical leadership	Ref D12 & D13	Refer to cell D4		**High / Medium**	Refer to cell G4	

Improving access to NHS dental services	Plans should set out the practical steps the ICB will take to: -Identify unwarranted variation identified using national datasets and local intelligence efit from referencing specific interventions.	Reference the Dental Commissioning plan	Refer to cell D4	Nationally provided QI datapacks will provide insights on variation in NICE recall	**High / Medium**	Refer to cell G4	
	- Identify and implement intervention to address unwarranted variation and reduce health inequalities. Plans will ben	Reference the Dental Commissioning plan	Refer to cell D4		**High / Medium**	Refer to cell G4	
Procurement of dental checks for CYP SEND pupils	Plan should provide strategy for the procurement of dental checks for CYP SEND pupils within residential and day special educational settings.	The process to develop and procure the dental services within Special Educational Schools is ongoing	Assessment of the demand from the SES providers is ongoing, once capacity requirements are known the next steps will be assessed	ICB returns via regions on progress to date	**High / Medium**	Refer to cell G4	Procurement support has been arranged from NECS / CSU

Optom

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Procurement of sight tests for CYP SEND pupils	Plan should provide strategy for the procurement of sight tests for CYP SEND pupils within residential and day special educational settings.	ICB executive agreement for the procurement confirmed 11.02.26 The procurement has been included on the regional procurement schedule and is in collaboration with Greater Manchester and Cheshire and Merseyside ICBs The procurement support is being provided by NECS Weekly procurement meetings are in place which are facilitated by NECS	27.03.26- advert published 30.04.26- Provider response submission 01.05.26-29.05.26 - Evaluation of provider response submissions 01.06.26 - 01.09.26- 3 month termination notice for existing proof of concept agreements 25.06.26-approval of recommended bidder 09.07.26 - issue contract award 10.07.26 to 24 .07.26- contract signing with providers 10.07.26 -31.08.26- mobilisation of service 01.09.26 - service commencement 31.09.29 - end of 3 year contract term	The service will be delivered in line with the national specification issued by NHS England Number of special educational settings participating in the service Number of pupils receiving eyesight tests via the service Establishment of improved working relationships with special educational settings and development of a wider understanding of visual challenges for children in a SES	**Medium**	No providers submitting responses for the contract opportunity Mitigation: review options for the provision of the service Awareness and uptake with families or schools not fully informed of the service - joint communication strategy to raise awareness among schools parents and carers Provision of cost effective service within current financial envelope Mitigation: A review of the financial envelope, level of eyesight test fee and associated activity levels to be undertaken if no providers identified	Procurement support as identified via the regional procurement schedule ICB contracting support in relation to provider contract documentation Ongoing contract monitoring of provider contracts over the 3 year contract term