Healthier Together
Improving health and care in Bristol, North Somerset and South Gloucestershire

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Primary Care Highlight Report

November 2025

Primary Care Access 2025/26

Operational Planning

- The NHSE operational plan for 2025/26 sets out expected improvements for Primary Care. These are around the continuation of delivery of the modern general practice access, with a focus on improving patient access and experience, delivering additional urgent dental appointments and delivering Pharmacy First consultations.

- Targets are set in response to the operational plan and these are:

  - Appointments in General Practice
  - % of general practice appointments within 2 weeks of booking
  - Units of dental activity delivered
  - Number of Pharmacy First consultations (oral contraception, Blood Pressure, clinical pathways)

- This report shows delivery highlights for each of the 4 areas of Primary Care with core and system measures that are produced in a report by our BI team.

General Practice

Deliverable
Deliver the Access Improvement Delivery Plan

2. Assure. What has been delivered? What are the key upcoming deliverables?

Delivery

- Overall number of GP appointments in 25/26 as of September 25 is 3.44% higher than the previous year and above operational plan target
- Percentage of GP appointments seen within 2 weeks remains around 80%, higher than the SW average of 77% but slightly below the national average of 81%
- Percentage of appointments delivered face to face remains consistently around 62% and telephone appointments remains just under 30%
- NHS app sign up has increased to 68% of the population with a large increase to 41% having notifications on. 24% of messages now being sent through the NHS app. Estimated monthly savings are over £10,000 per month.
- NHS App sessions continue to be held by practices and community groups to support digital inclusion
- Capacity and Access Improvement (CAIP) plans received from all PCNs
- Significant ongoing work to review and update Local Enhanced Services to support GP Collective Action
- Practices supported with GP contract changes for 25/26:
    - You and Your General Practice must be on practice websites
    - GP Connect Access Record (HTML and Structured) and Update Record must be enabled within GP Practice clinical systems.
    - Online consultation tools must be switched on for the duration of core hours as with phone and walk-in access.

Upcoming Deliverables

- PCN CAIP declaration forms to be sent out and payments to be made on receipt
- Monitor data and continue to support practices with contractual requirements
- Finalise methodology for advice and guidance enhanced service.
- Delivery of SDF projects
- Establish data feed from GP OPEL dashboards to ICB Care Traffic Control

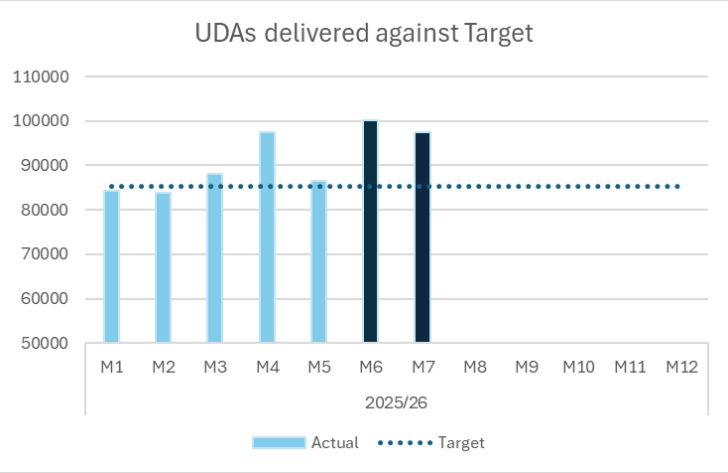
Dental

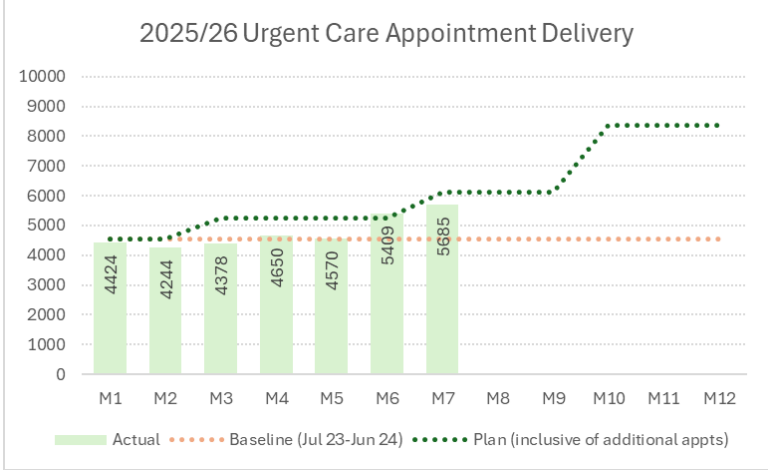
Deliverable

Deliver the BNSSG Dental Strategy

2. Assure. What has been delivered? What are the key upcoming deliverables?

Delivery





2025/26 - UDAs delivered at Month 7				2025/26
YTD Plan	YTD Actual	Difference (No)	Achievement (%)	Total Target
597,111	637,651	40541	106.79%	1,023,618

Comparing 2024/25 performace with 2025/26		
YTD in 2024/25	YTD IN 2025/26	Difference
571,655	637,651	65,996

2025/26 - Urgent Care Appointments delivered at Month 6				2025/26	2025/26
YTD Plan	YTD Actual	YTD Achievement(No)	YTD Achievement (%)	Plan	Target (%)
36,199	33,360	-2839	-7.8%	73,501	100%

**data is based on FP17 submissions; practices have two months to submit their returns.*
Data shown is the most recent received. Therefore the last two months data is subject to change

*BSA open data source & eDEN Analytics

Workstream Updates

Urgent Care

As part of phase 1, the 19,076 additional urgent care appointments have been commissioned. Practices were selected based on an open expression of interest criteria, geography and using Indices of Deprivation (IMD). UC activity is increasing and above baseline, however it remains below target.
Phase 2 is focusing on delivery by working closely with comms colleagues and increasing public awareness of the additional capacity as well as working closely with our Dental Helpline provider to ensure all appointments are utilised. We are exploring direct booking options/online platforms. In addition, a national incentive was launched in to encourage all practices to deliver urgent care.

UDA delivery

There has been steady improvement of UDA delivery. A £32 uplift to minimum UDA value has been applied.
As part of supporting access for vulnerable groups, the Children in Care service has been extended by 6 month. A model for Child Friendly Dental Practice is being developed by the Managed Clinical Network. A Cancer Action Support Service (CASP) for patients with head and neck cancer is due to be launched.
Supervised toothbrushing (STB) continues to be delivered in schools based in IMD 1-6 and additional settings have been targeted in collaboration with the Local Authority; the contract with the provider has been extended to Feb 2027.
Dental Electronic Referrals (DERs) procurement is now complete and a provider has been selected. This aims to strengthen pathways into secondary care. The system is due to go live in Feb 2026..

Upcoming Deliverables

Review of underperforming contracts to allow rebasing in 2026/27; this will inform procurement of dental activity in areas of highest need

Eye Care

Deliverable
Re-establish the Eye Care Delivery Board and develop delivery plan

2. Assure. What has been delivered? What are the key upcoming deliverables?

Delivery

- Eye Care Delivery Board meeting in November
- Macular Pilot evaluation received. Task and finish group to be established to confirm ongoing commissioning arrangements.
- SW working group for Sensory checks in Special Educational Settings established
- Prior Information Notice (PIN) prepared for community optometry locally enhanced services delivery across the ICB
- Input into System Planning with eyecare priorities

Upcoming Deliverables

- Task and finish group to be set up for macular pilot - assessing data and establishing funding arrangements following pilot completion
- Procurement for eye checks in Special Educational Settings to be agreed
- Work with procurement team to procure community optometry locally enhanced services for glaucoma referral refinement, cataract pre-operative assessment and post-operative follow-up
- Explore direct referral pathways from community optometrists to ophthalmology services for all eye conditions

Community Pharmacy Deep Dive

Purpose	To support GP Practices nationally - Community Pharmacy(CP) has the potential to move > 30million appointments from GPs every year through the Pharmacy First service. In addition, further appointments can be made available by providing oral contraception and undertaking BP checks within Community Pharmacy.
High level timescales 2025/26	**Pharmacy First Service:** Minor ailments and clinical pathways with 23 national PGDs and 3 local PGDs for 7 conditions ongoing. Pharmacy Contraception Service & Hypertension Case Finding - increase referrals **Community Pharmacist Independent Prescribing Pathfinder pilot.**

Community Pharmacy

Progress Q2(July 25 – September 25)
Minor ailments and Clinical Pathways • BNSSG - Highest performing ICB in the Country/100,000 patients. • In Sept 91% surgeries referred > 20 patients/month, 83% surgeries referred > 40 pt/month. • 41% surgeries referred > 125 patients/month. • Average of 11,239/month referrals made to community pharmacy (CP) in Q2, • >1900 appointments have been referred from UEC to CP via Pharmacy First (PF) • NHSE are now funding EMIS local services which is integrated into EMIS and enables referrals to be made in an efficient way which helps support making formal referrals to CP easier.

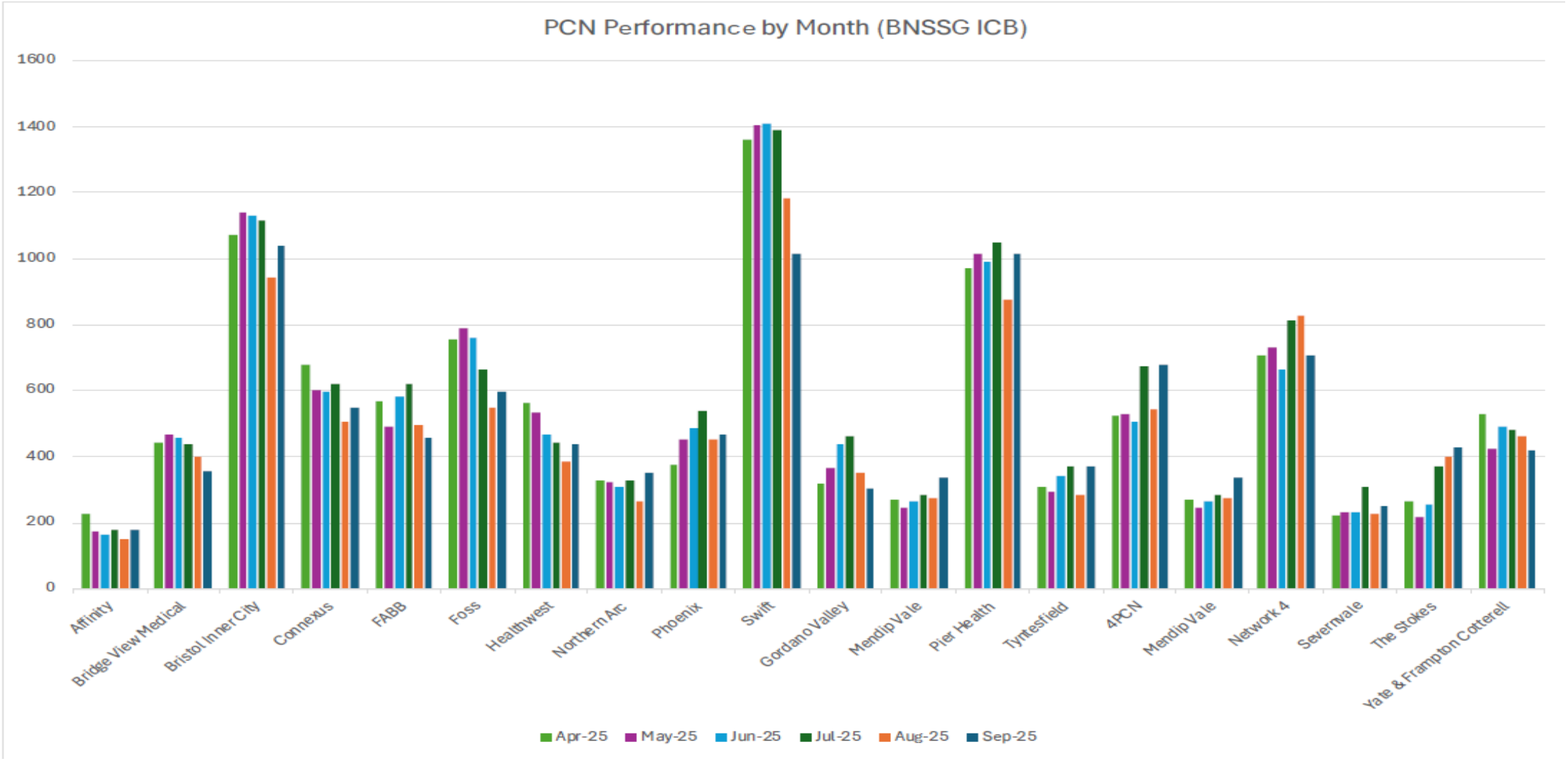
Pharmacy First (PF)

Progress Q2(July 25 – September 25)

Minor ailments and Clinical Pathways:

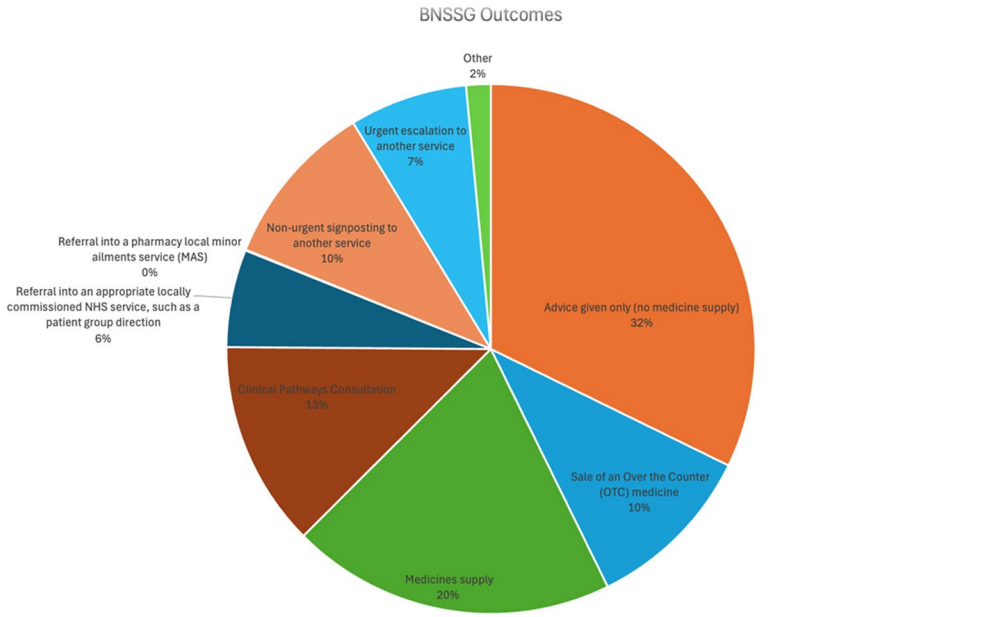
- ICB continues to work with CP/ PCN leads and LPC to embed PF referrals, set up regular face to face meetings to share learning.
- CP PCN leads are leading CP/GP PCN meetings 3 /year and face to face meetings with CP and GP practices
- Continue working with UECs, Acute Trusts and BrisDoc to undertake formal electronic referrals to CP
- Agreement for Local Enhanced Services (LES) PGDs for Hydrocortisone, Chloramphenicol and Otitis Externa and to expand further

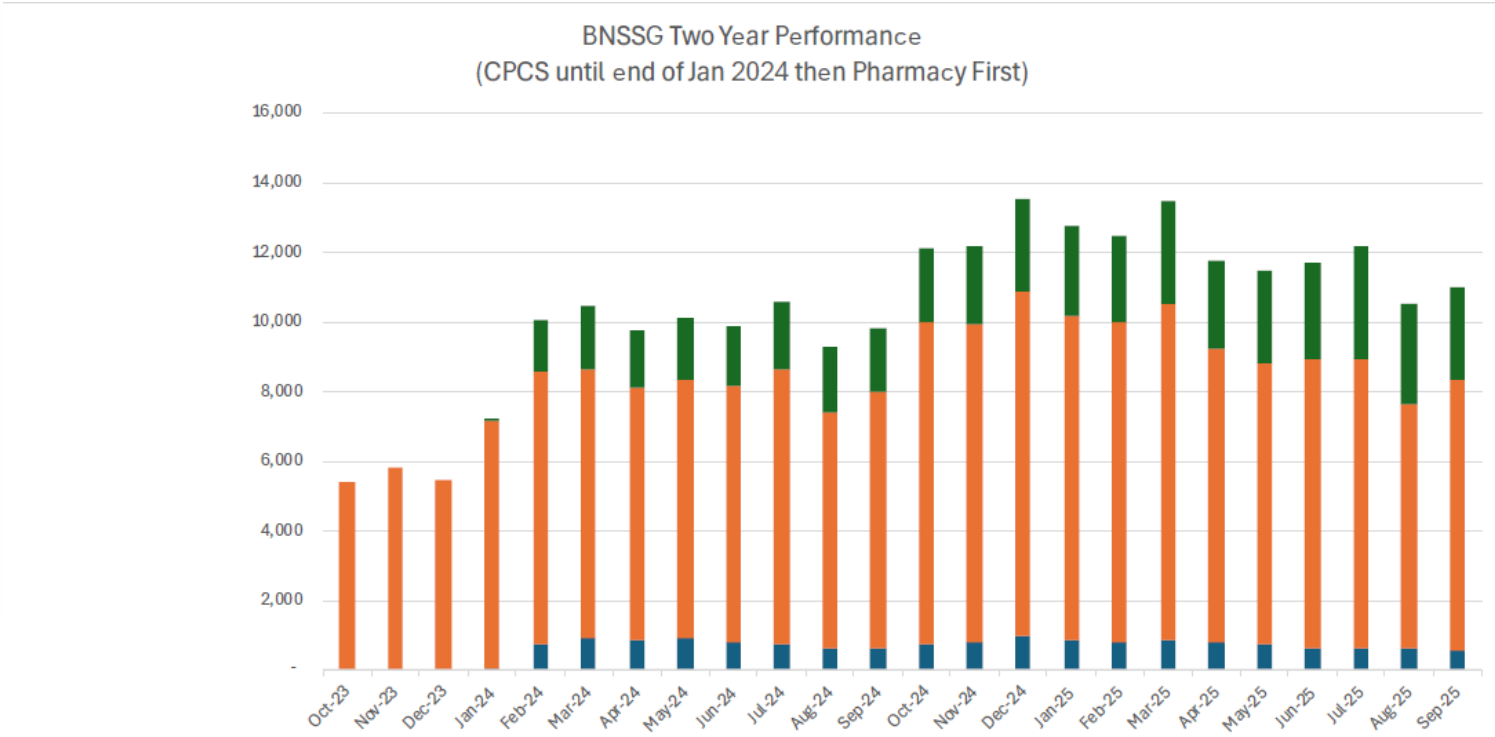
Pharmacy First (PF)



Pharmacy First

- 69% referrals to CP are from GPs, 26% self-referral and 5% from 111
- Over the last 12 months >100,000 referrals made to CP from GP practices
- 80% of referrals are completed by CP





	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Onward referral from another pharmacy	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Self Referral	-	-	-	30	1,477	1,876	1,658	1,758	1,701	1,922	1,894	1,840	2,139	2,251	2,683	2,582	2,481	2,933	2,521	2,631	2,768	3,288	2,842	2,666
GP Referral	5,425	5,801	5,444	7,163	7,823	7,707	7,274	7,416	7,368	7,902	6,762	7,326	9,237	9,176	9,860	9,283	9,236	9,713	8,445	8,067	8,285	8,311	7,013	7,752
NHS111	-	-	-	24	769	909	844	926	792	744	633	647	736	781	994	888	776	842	784	752	639	603	654	589

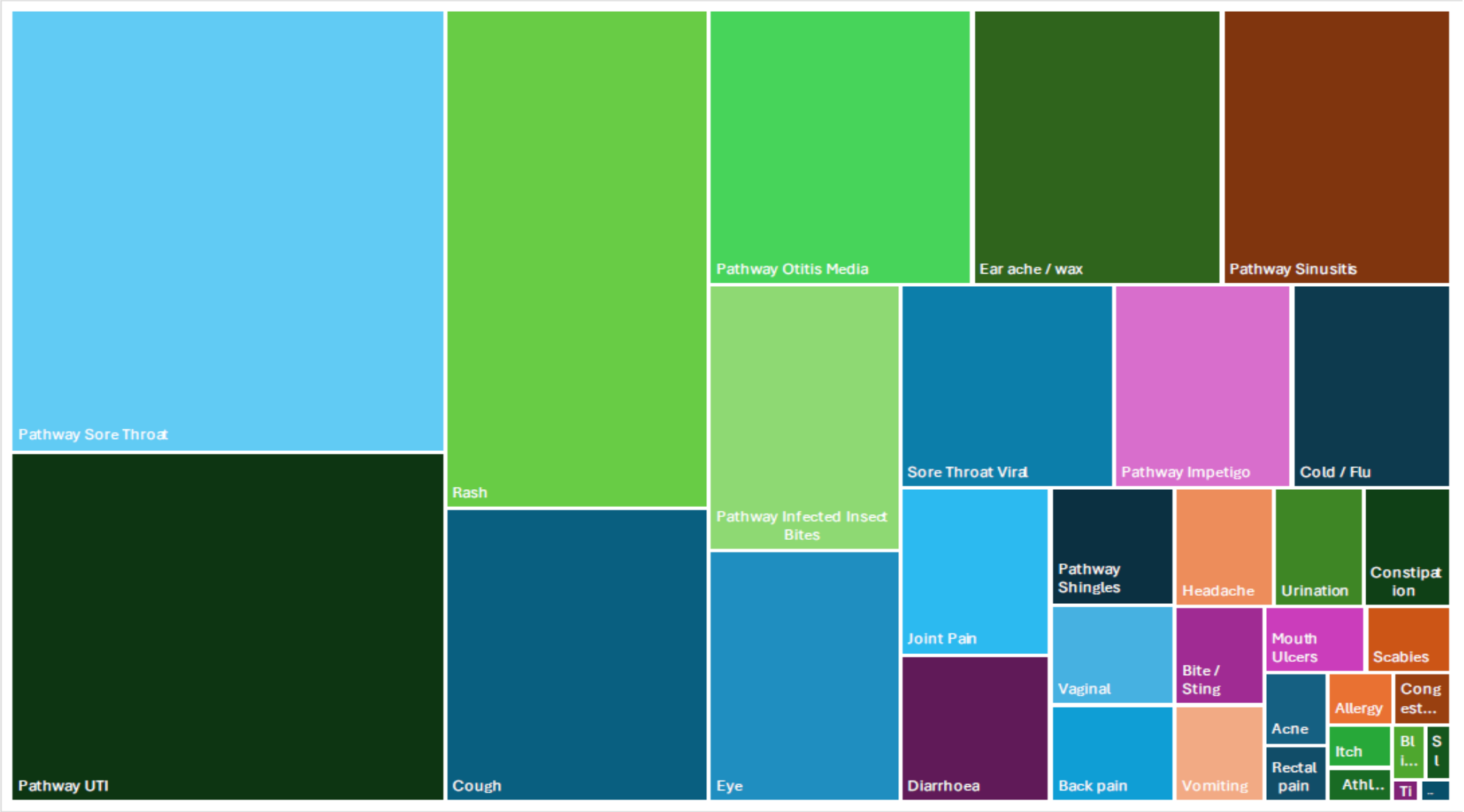
Next Steps:

- Expand LES PGDs for minor ailments eg Nystatin
- Work with those practices not referring to CP and CP not undertaking PF

Minor Conditions treated for PF

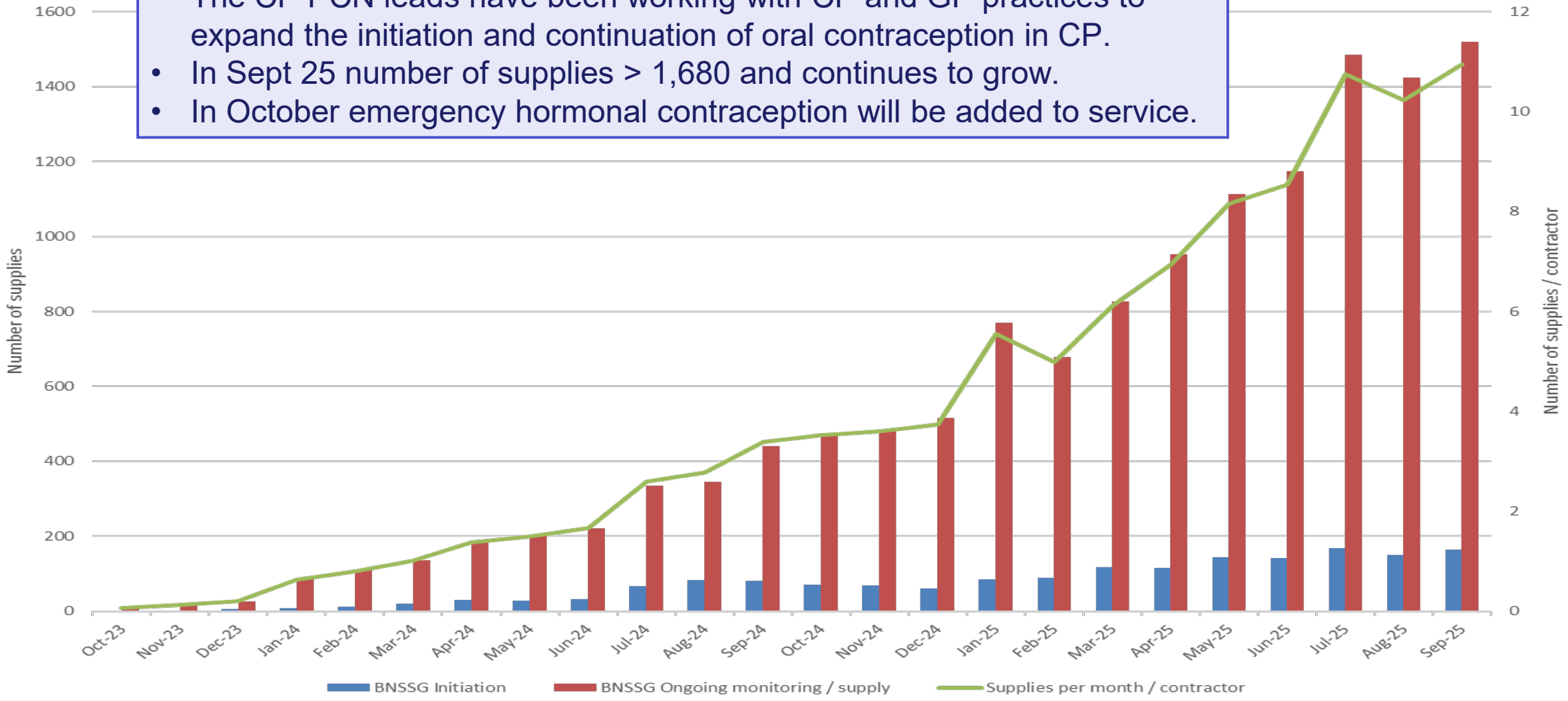
Main conditions treated

- Sore Throat
- UTI
- Skin Rash
- Cough
- Otitis Media
- Infected Insect Bites
- Eye



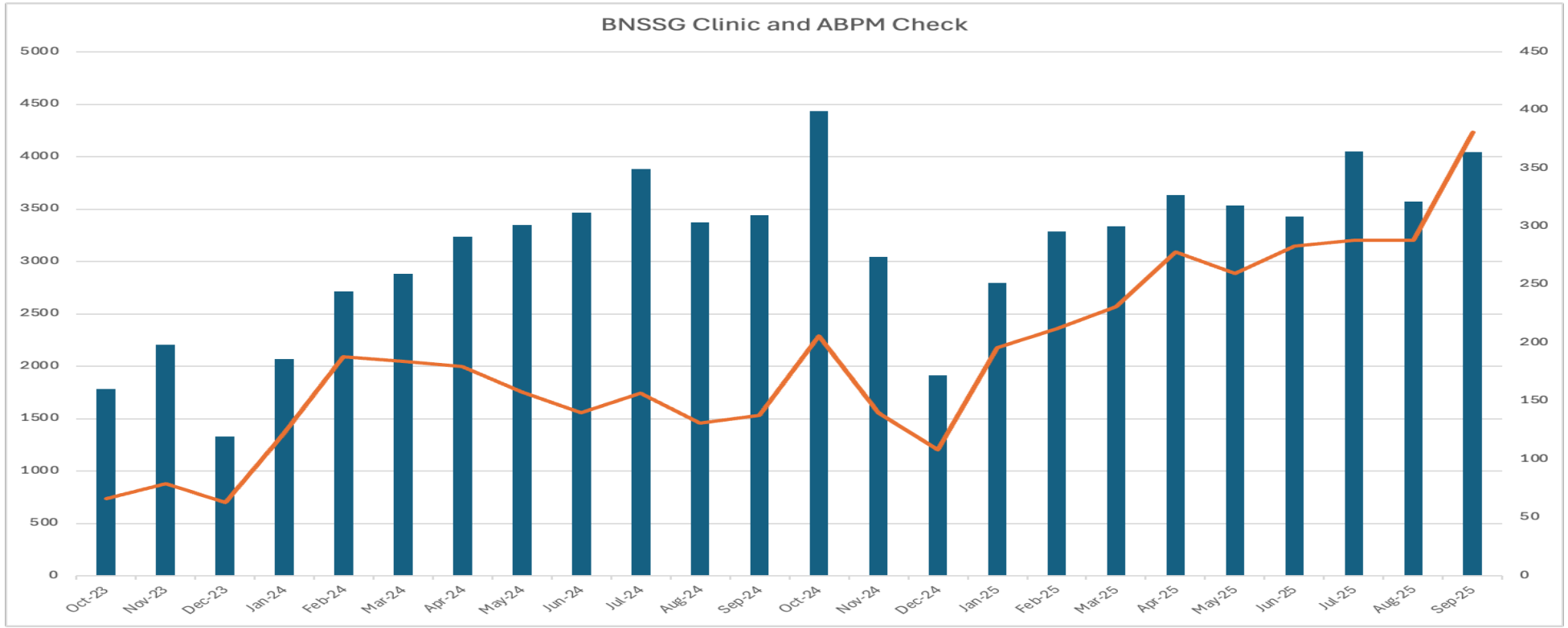
Pharmacy First - Contraception

- The CP PCN leads have been working with CP and GP practices to expand the initiation and continuation of oral contraception in CP.
- In Sept 25 number of supplies > 1,680 and continues to grow.
- In October emergency hormonal contraception will be added to service.



Pharmacy First - Hypertension

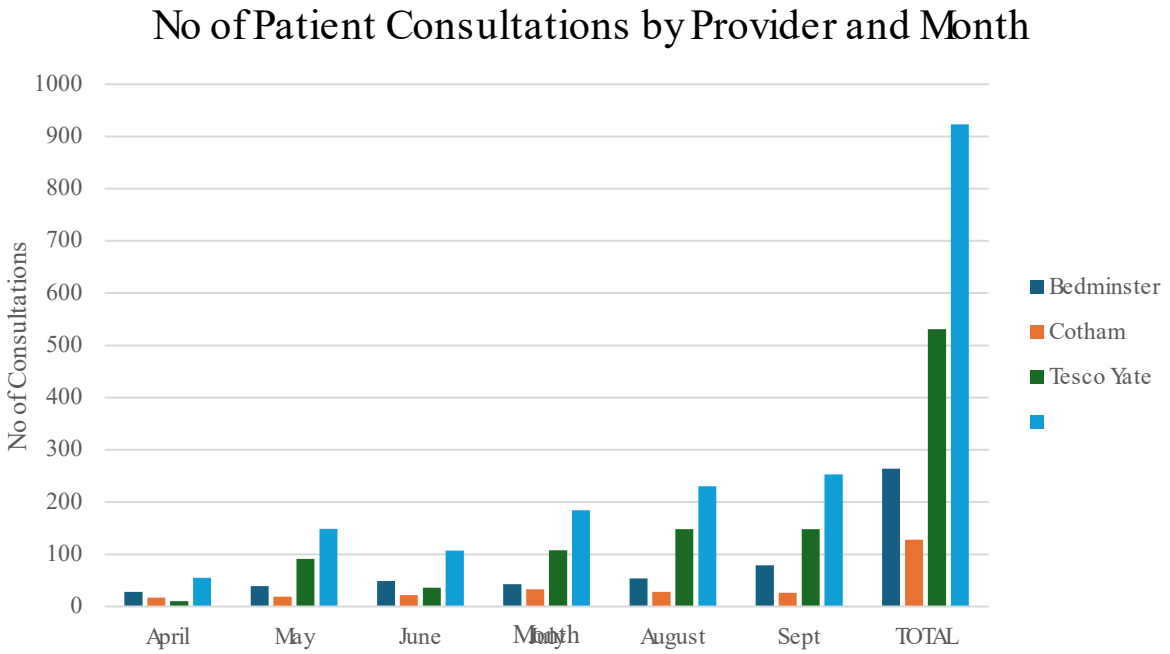
- Work is ongoing with CP PCN leads to increase hypertension case finding & Ambulatory BP monitoring checks (ABPM) (which involves wearing a device to record BP over a 16-hour period which is more accurate than one off readings)
- Further plans with Comms team to attend outreach events
- Engaging practices with increasing referrals from practices to Community Pharmacy for BP checks
- New Medicines Supply Service plus for hypertension pilot to increase medicines adherence in areas where patients are not reaching BP targets



Key:
Blue- BP Clinic Check (Numbers on LHS)
Orange –ABPM (Numbers on RHS)

Community Pharmacy Independent prescribing (IP) Pathfinder

- Live in April 2025 -3 Sites Yate, Cotham, Bedminster
- Pilot to test use of an IP within CP & reduce GP referrals, Extension of PF Minor illness
- Most common conditions: Sore Throat, Ear, Skin, UTI
- 972 consultations (April-Sept) – 961 face to face
- 117 patients feedback, 99% very likely to use service again.
- 31% outside GP hours (weekends or >6pm)
- 50 GP practices across BNSSG
- 65% of patients have been walk-ins/self-referrals
- 24 % of patients have come via GP referral
- 7.5% were referred from UTC/minor injuries, NHS 111 or out of hours GP



Consultation outcome headlines:

- 32.1% of consultations resulted in advice only
- 12.3% resulted in advice and the supply of an OTC
- 52.1% resulted in advice and the prescription of a medicine
- 79% of patients seen would have made a GP appointment, 5 % would have attended A&E
- 3.1% patients were signposted; 3.3% patients were referred on to another HCP.
- Just 12 patients were referred back for a routine GP appointment (**1.23% of total patients**)
- Additional 16 patients (**1.65% of total patients**) were referred for an urgent GP appointment, 2 patients being referred directly to A&E.
- ePACT prescribing data from April to July -cost of prescription medicines supplied via the IPPP £1,147.84.

Next Steps

- NHSE pilot -only funded until Dec 25
- ICB extending pilot to March 26
- Lipid point of care pilot in 2 sites
- Continue to increase number of CP undertaking IP course by funding Designated prescribing practitioners (DPPs)

Primary - Core Measures

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GP Appointments - ICB

444,670

by Month

% of GP appointments seen within tw…

80 %

by Month

% Units of dental activity delivered - I…

119 %

Achieving Operational Plan of 68 %

by Month

Pharmacy First consultations (oral co…

10,542

Achieving Operational Plan of 8,000

by Month

Focus Measures

		Latest Period	Unit	Target	Month Value (RAG vs Target)	Vs Nat Avg	Month Value Change	Month % Change	Distance From Target	Value YTD	YTD vs Plan
% of GP appointments seen within two weeks	ICB	Aug 25	%		79.91	Worse	0	-0.51	NA	80	-
% of resident population seen by an NHS dentist – adults	ICB	Jul 25	%	34.28	✗ 25.93	Worse	0	0.58	91,566	26	-8
% of resident population seen by an NHS dentist – children	ICB	Jul 25	%	52.61	✓ 55.86	Better	0	0.41	-	55	2
% Units of dental activity delivered	ICB	Jul 25	%	68	✓ 119.23		15	14.67	-	105	37
GP Appointments	ICB	Aug 25	Count	446,957	✗ 444,670		-88689	-16.63	NA	2435297	51,919
Number of completed Refs to Pharmacy First from 111	ICB	Aug 25	Count		654		51	8.46	NA	3489	-
Number of completed Refs to Pharmacy First from GP	ICB	Aug 25	Count		7,013		-1298	-15.62	NA	40528	-
Number of self referrals to Pharmacy First	ICB	Aug 25	Count		2,842		-446	-13.56	NA	14181	-
Pharmacy First consultations (oral contraception, BP, clinical pathways)	ICB	Jun 25	Count	8,000	✓ 10,542		241	2.34	NA	31307	7,307
Total referrals to Pharmacy First (GP, 111, Self)	ICB	Aug 25	Count		10,509		-1693	-13.87	NA	58198	-
Units of Dental Activity	ICB	Jul 25	Count	81,682	✓ 97,393		9375	10.65	NA	353588	17,953
Urgent dental appointments	ICB	Aug 25	Count	5,251	✗ 4,508		-142	-3.05	NA	22204	-2,617

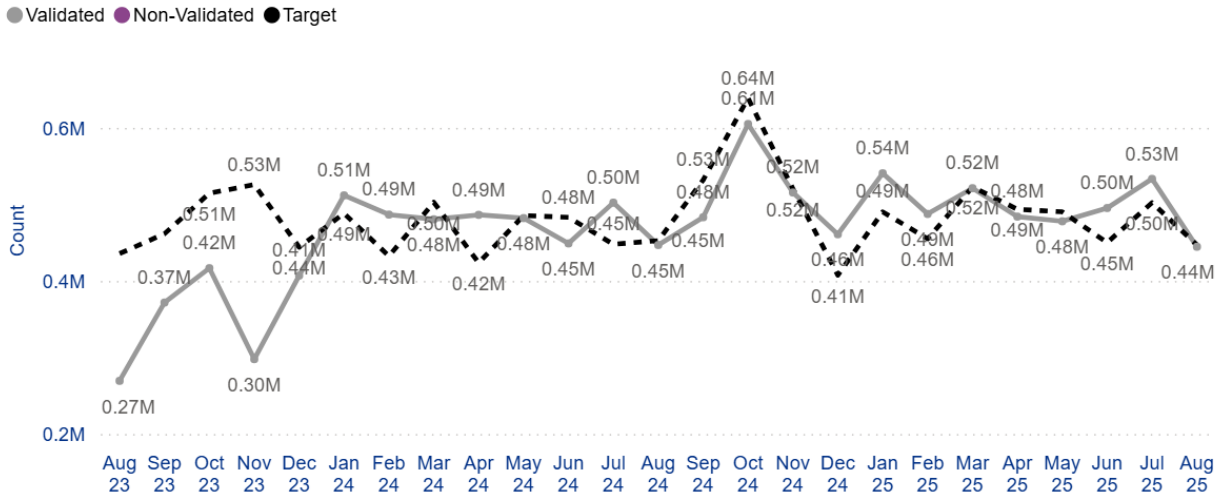
Note: Delay to Dental data, only July data available currently. Delay to Pharmacy First consultations (oral contraception, BP, clinical pathways), only June data available

Focus Summary

Measure	Narrative
% of GP appointments seen within two weeks	% of GP appointments seen within two weeks remains stable at around 80%
% Units of dental activity delivered	UDA delivery is on target. The ICB continue to hold regular contract meetings with providers with an aim to improve performance.
GP Appointments	Overall number of GP appointments as of Aug 25 is 2.9% higher than the previous year
Number of completed Refs to Pharmacy First from 111	Number of completed Refs to Pharmacy First from 111 increased slightly in August
Number of completed Refs to Pharmacy First from GP	Number of completed Refs to Pharmacy First from GP reduced in August as expected over the summer
Number of self referrals to Pharmacy First	Number of self referrals to Pharmacy First reduced in August as expected over the summer
Pharmacy First consultations (oral contraception, BP, clinical pathways)	New operational metric of community pharmacy consultations (clinical pathways, oral contraception consultations and blood pressure checks), delivering over plan.
Total referrals to Pharmacy First (GP, 111, Self)	Overall reduction in referrals to Pharmacy First in August as expected over the summer
Units of Dental Activity	UDA delivery is on target. The ICB continue to hold regular contract meetings with providers with an aim to improve performance.
Urgent dental appointments	Urgent Care Activity is below plan. The ICB continue to work with providers to streamline processes to access urgent dental care appointments including deepdive into 111 access. The ICB have further commissioned more providers to deliver urgent care as per a new national scheme to incentivise providers. The ICB have launched a public awareness campaign about the additional activity commissioned.

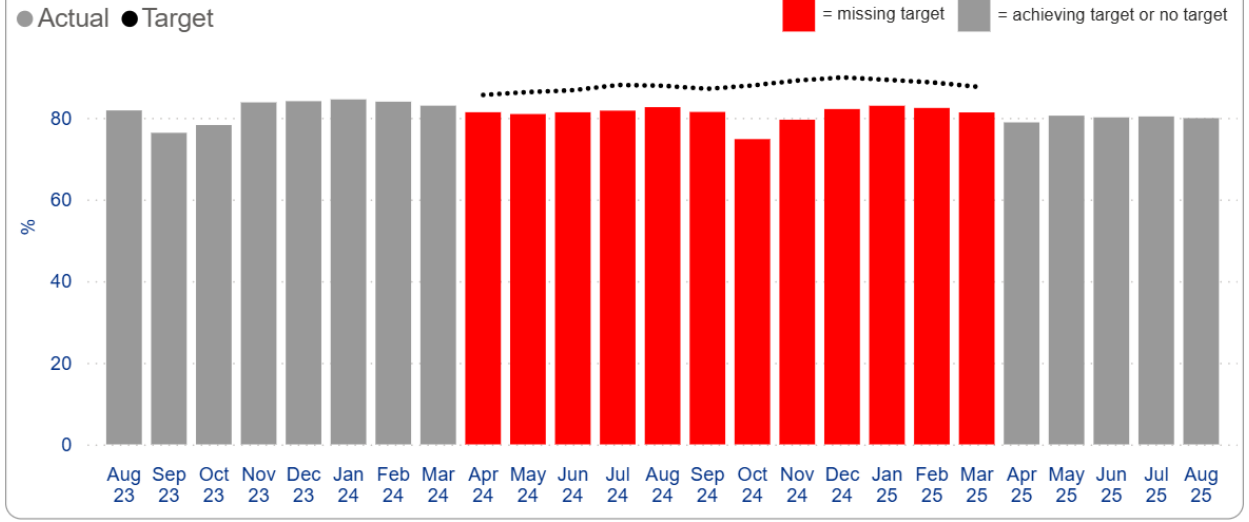
GP Appointments

Visualisation



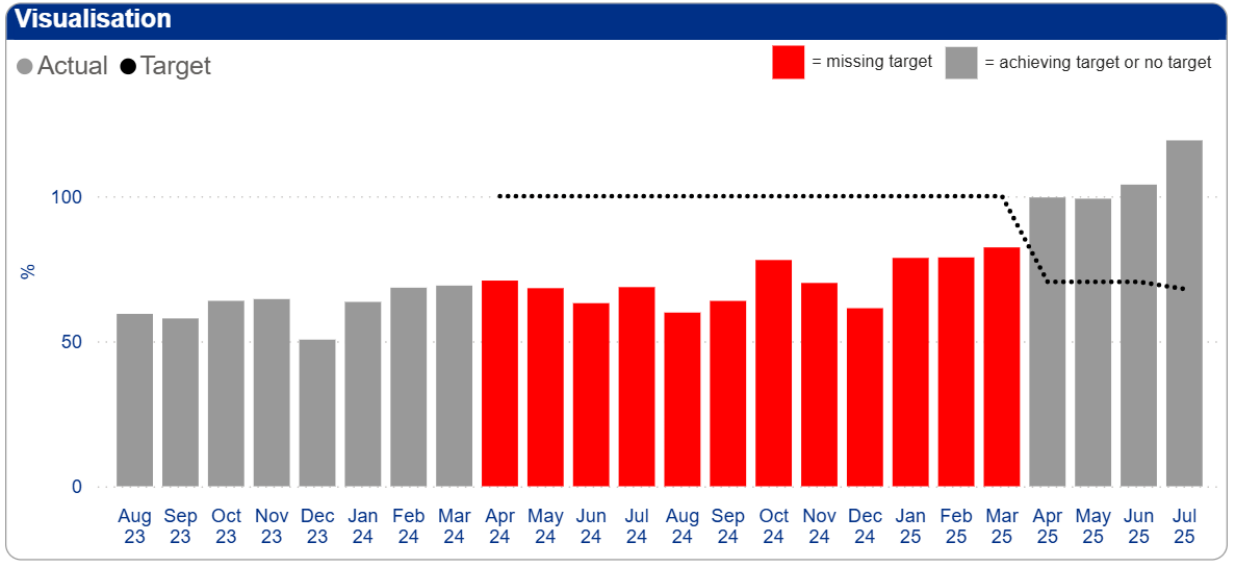
% of GP appointments seen within two weeks

Visualisation



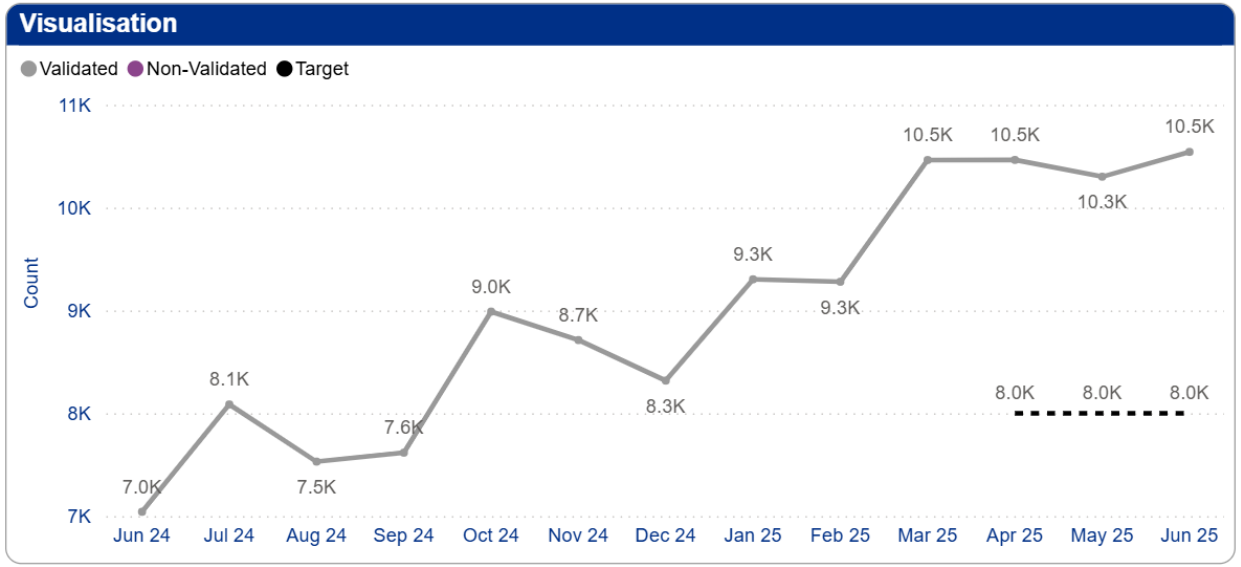
% Units of dental activity delivered

Visualisation



Pharmacy First consultations (oral contraception, BP, clinical path…

Visualisation



Summary

Primary

	Unit	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr …	May 25	Jun 25	Jul 25	Aug 25
% of GP appointments seen within two weeks	%	74.77	79.52	82.13	82.94	82.40	81.31	78.86	80.51	80.09	80.32	79.91
% of resident population seen by an NHS dentist – adults	%	25.47	25.41	25.39	25.49	25.52	25.61	25.88	25.71	25.78	25.93	
% of resident population seen by an NHS dentist – children	%	51.81	52.30	52.57	52.95	53.29	54.38	54.82	55.14	55.63	55.86	
% Units of dental activity delivered	%	77.98	70.08	61.37	78.71	78.87	82.34	99.55	99.13	103.98	119.23	
GP Appointments	Count	605,…	515,…	460,…	540,…	487,…	521,…	484…	477,…	495,280	533,359	444,670
Number of completed Refs to Pharmacy First from 111	Count	736	781	994	888	776	856	812	769	651	603	654
Number of completed Refs to Pharmacy First from GP	Count	9,237	9,176	9,860	9,283	9,236	9,912	8,556	8,205	8,443	8,311	7,013
Number of self referrals to Pharmacy First	Count	2,139	2,251	2,683	2,582	2,481	2,971	2,556	2,683	2,812	3,288	2,842
Pharmacy First consultations (oral contraception, BP, clinical pathways)	Count	8,989	8,712	8,318	9,303	9,279	10,463	10,…	10,301	10,542		
Total referrals to Pharmacy First (GP, 111, Self)	Count	12,112	12,208	13,537	12,753	12,493	13,739	11,9…	11,657	11,906	12,202	10,509
Units of Dental Activity	Count	93,1…	83,678	73,274	92,491	92,671	96,751	84,…	83,911	88,018	97,393	
Urgent dental appointments	Count							4,424	4,244	4,378	4,650	4,508

Appendix (South West)

Reporting Month

Aug 25

NHS
Bristol, North Somerset and South Gloucestershire
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Primary

	Unit	Latest Period	BNSSG	BSW	Cornwall	Devon	Dorset	Glos	Somerset	BNSSG SW Rank	National Avg	Prev Mth	% Change
% of GP appointments seen within two weeks	%	Aug 25	79.91	75.68	78.95	80.44	73.52	72.92	76.50	2 / 7	81.44	80.32	-0.51
% of resident population seen by an NHS dentist – adults	%	Jul 25	25.93	22.91	21.43	19.52	24.81	21.15	17.39	1 / 7	27.37	25.78	0.58
% of resident population seen by an NHS dentist – children	%	Jul 25	55.86	53.45	55.73	42.40	51.73	51.00	38.82	1 / 7	54.19	55.63	0.41

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BNSSG ICB Primary Care Committee Meeting

Minutes of the Meeting Held on Tuesday 23rd September 2025 9:00 – 11:00

DRAFT Minutes

Present		
Alison Moon (*Chair*)	Chair of Committee, Non-Executive Member – Primary Care	AM
Jenny Bowker	Deputy Director of Performance Delivery, Primary Care & Children's Services, BNSSG ICB	JB
Richard Brown	Chief Officer, Avon Local Pharmaceutical Committee	RB
Debbie Campbell	Chief Pharmacist and Director of Medicines Optimisation, BNSSG ICB	DC
Jamie Denton	Head of Finance, Primary, Community & Non-Acute Services, BNSSG ICB	JD
Ellen Donovan	Independent Non-Executive Member, BNSSG ICB	ED
Katie Handford	Models of Care Manager, BNSSG ICB	KH
Bev Haworth	Head of Primary Care, BNSSG ICB	BH
John Hopcroft	Avon Local Optical Committee	JH
David Jarrett	Chief Delivery Officer, BNSSG ICB	DJ
Matt Lenny	Director of Public Health, North Somerset Council	ML
Susie McMullen	Head of Contracts: Children's, Community and Primary Care, BNSSG ICB	SMc
Dr Joanne Medhurst	Chief Medical Officer, BNSSG ICB	JM
Dr Shaba Nabi	Chair, Avon Local Medical Committee	SN
Prof Sarah Purdy	Partner Non-Executive Member, North Bristol NHS Trust	SP
Michael Richardson	Director of Nursing and Deputy CNO, BNSSG ICB	MR
Rosi Shepherd	Chief Nursing Officer, BNSSG ICB	RS
Jacci Yull	Patient & Safety Quality Lead, BNSSG ICB	JY
Apologies		
Dr Katrina Boutin	GP & GP Collaborative Board Medical Director	KB
Jeff Farrar	Chair of the BNSSG ICB	JF
Nikki Holmes	Head of Primary Care, Southwest, NHS England, and Improvement	NH
Matthew Jerreat	Clinical Chair of the Southwest Local Dental Network	MJ
Hayley Richards	Non-Executive Director, Sirona	HR
George Schofield	Avon Local Dental Committee Secretary	GS
In Attendance		
Vicki Court	Patient Safety Specialist, BNSSG ICB	VC
Sandie Cross (*minutes*)	EA to Dave Jarrett, BNSSG ICB	SLC

	Item	Action
1	**Welcome and Apologies** Alison Moon (AM) welcomed everyone to the Primary Care Committee (PCC). Apologies are noted as above.	
2	**Declarations of Interest** AM asked for any declarations of interest to be made. Vicki Court (VC) is attending the PCC to present the Patient Safety Quality Report. VC had no interests to declare. Richard Brown (RB) noted his role representing JHoots Pharmacy and pharmacies across BNSSG, as part of the Local Pharmacy Committee (LPC) but confirmed this was the reason for his attendance, to represent pharmacies. No other declarations to note, and no existing declarations of interest relating to agenda items at the PCC meeting today.	
3	**Minutes of the Previous Meeting held on 24th June 2025** The minutes from the PCC meeting on 24th June 2025 were reviewed. The minutes were agreed to be an accurate record of the meeting. These minutes have been approved and will be forwarded to the ICB Board for information.	
4	**Review of Action Log** The action log was reviewed: (*Please refer to the action log for full details*) To note, all outstanding actions have been closed.	
5	**Update on JHoots Pharmacy** Dave Jarrett (DJ) provided a brief introduction, highlighting the escalation of risks related to JHoots Pharmacy Group over the summer, and the need for the Committee to be assured of actions being taken. He emphasised the rapidly evolving situation and the potential significant impact on the wider health and care system. Jenny Bowker (JB) was invited to present the briefing. JB provided a comprehensive update on the operational and financial difficulties facing the JHoots Pharmacy Group across the Southwest and outlined the context and escalation of concerns regarding JHoots' resilience. On 22nd August 2025, Waitrose Portishead evicted JHoots with immediate effect, leading to contingency plans redirecting patients to the Victoria Square branch. Portishead Medical Centre has since given JHoots notice to vacate by end of September 2025, leaving only West Hill Pharmacy. JHoots has indicated intent to submit relocation applications, but none received yet; a tight deadline has been set. JB advised that the Southwest Commissioning Hub has issued breach notices, financial withholdings for suspensions, and requested improvement plans from JHoots, with limited response. Coordination with other regions and national colleagues is ongoing, and learning is being shared to inform future regulatory changes. Legal advice is being sought regarding contracts with no premises. It is reported that other sites (Westbury, Fishponds & Beechwood) have also experienced suspensions and may serve notice on tenancy agreements. JB advised that Local Authority partners are engaged regarding Pharmaceutical Needs	

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	Assessment (PNA) and potential supplementary statements if formal closures and market exits occur. JB reported that JHoots operates 52 pharmacies in the Southwest, with 12 in BNSSG, including recent acquisitions from Lloyds and Boots. Five sites under separate management remain stable; concerns focus on newly acquired sites. Issues include sustained service suspensions (notably in two Weston sites since June), lease instability, staff not being paid (impacting retention), stock shortages, and effects on vulnerable groups (e.g., methadone users). JB explained that neighbouring pharmacies are under pressure, focusing on dispensing rather than enhanced services, which is impacting their income and resilience. It is recognised that practices face increased workload due to changing nominations and patient complaints. To note, the risk register rating was increased to 20 due to these factors and will be updated to reflect the increased risk rating and ongoing actions. <u>Questions/Reflections Raised.</u> ➢ Matt Lenny (ML) discussed the need for clear, consistent messaging to the public, local MPs and councillors to maintain confidence during the transition. JB advised the team is coordinating with communications teams and local authority partners to ensure stakeholders are informed about mitigations and contingency arrangements. ➢ Rosi Shepherd (RS) highlighted risks to vulnerable populations, access to medication, and the strain on remaining pharmacies, and emphasised the need for both local and broader mitigation strategies, including regional and national escalation. ➢ RS described ongoing regional meetings to share learning and coordinate responses, as well as escalations to national bodies for additional support. The issue is not isolated to BNSSG but is seen across the southwest and nationally. ➢ Sarah Purdy (SP) discussed the possibility of innovative approaches to pharmacy provision, such as redeploying NHS-employed pharmacists, but emphasised that supporting the existing network is likely more effective than creating new models in the current financial climate. JB noted ongoing market interest and applications for Portishead but cautioned against overgeneralising the JHoots situation. RB emphasised the need to support the existing network rather than destabilise it with new models. ➢ Shaba Nabi (SN) asked about JHoots' delivery of Pharmacy First services and whether their inability to fulfil contracts should affect enhanced services? JB deferred to RB, who confirmed JHoots is not providing additional services beyond dispensing. ➢ SN urged sensitivity in language when discussing community pharmacies as private businesses, noting their status as independent contractors to the NHS. ➢ Ellen Donovan (ED) sought assurance on contract management skills and operational resources to support patients. Suggested a future lessons-learned review on contract award processes. JB confirmed there is close work with the commissioning hub, reprioritisation of ICB resources, and the team are seeking independent legal advice. ➢ Debbie Campbell (DC) noted the operational impact on neighbouring pharmacies and GP practices, including increased workload and the need for immediate support. Highlighted the importance of patient messaging and kindness to staff.	

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	➢ Michael Richardson (MR) asked about the impact of distance selling pharmacies (DSPs) on high street pharmacies. Richard Brown responded that DSPs are a small part of the ecosystem and not a major destabilising factor. Richard Brown (RB) discussed the broader context of pharmacy sector instability, highlighting national funding shortfalls, regulatory constraints, and the risk of wider market failure, while emphasising the need for national support, regulatory review, and collaborative regional action. RB explained that current pharmacy regulations are designed to protect the network but are not equipped to handle large-scale failures like those seen with JHoots. The rules around market entry and exit are tightly controlled, and the situation is unprecedented, prompting calls for regulatory review. RB highlighted that the national contract underfunds the safe operation of the pharmacy network by approximately £2 billion, leading to financial instability across the sector. Many pharmacies are struggling to remain open, with owners making personal financial sacrifices. The Committee agreed on the need for clear, coordinated communications, ongoing legal and contractual actions, and operational support for affected pharmacies and practices. There was consensus on escalating the issue regionally and nationally, and on the importance of supporting the resilience of the remaining pharmacy network. The Committee acknowledged the need for a future lessons-learned review and for ongoing monitoring of market applications and regulatory developments. The committee noted the need to manage the narrative between the PNA and the current situation, and to keep communications open with all stakeholders. AM summarised the discussion, emphasising the complexity and multi-level nature of the issue, the need for assurance on short-term remedies, and the importance of supporting local leadership and capacity. JB confirmed she had what she needed from the committee for next steps. **Actions and Next Steps Noted**: 1. Communications: Agreed to refresh and coordinate messaging for the public, stakeholders, MPs, and councillors, especially regarding Portishead. 2. Capacity Risks: JB to clarify what work will not be possible due to reprioritisation and seek ICB support for capacity issues. 3. Short/Medium/Long-Term Planning: Develop a clear action plan with timelines for immediate, medium, and long-term actions, including direct support for practitioners. 4. JB to provide update on progress at next PCC. AM concluded on behalf of the Committee and agreed the need to update the risk register to reflect current risks and actions. Consensus was reached on the need for ongoing regional/national escalation, operational support and open communication. The Committee agreed to escalate key risks to the board, and to plan for a future lessons-learned review. The importance of supporting staff and maintaining system resilience was emphasised. **PC Corporate Risk Register & Emerging Risks** Due to time restraints at the meeting today, agreed to take the risk register as read, and items have already been discussed, namely JHoots.	**JB** **JB** **JB** **JB**

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	DJ noted the ongoing risk on the register regarding GP collective action and mitigation efforts. Highlighted a new position from the GPC to go back into dispute with the government over contractual changes, particularly online consultations. Stated that further implications for the system are possible, and asked SN for additional insight. SN explained the process and implications of the trade dispute, emphasizing that the immediate risk is the October 1st contractual changes, not the dispute itself. Shared survey results indicating only 47% of practices are currently compliant with the new requirements, highlighting significant system risk and potential impact on urgent care. Bev Haworth (BH) provided assurance that the ICB has been supporting practices with transformation and access and is monitoring compliance. Noted ongoing work with practices and NHS England to provide support and guidance. Susanna McMullen (SMc) confirmed the ICB's supportive approach to contract compliance, emphasizing collaboration and reasonable timescales for practices to adapt, but noted that persistent non-compliance would lead to formal notices. SN requested a measured approach to enforcement, allowing practices time for quality improvement and transformation rather than quick fixes that could harm the system. AM stressed the importance of open communication between LMC, ICB, and stakeholders, and noted the risk should be escalated to the ICB Board. **9:40 – Ellen Donovan left the PCC meeting.** **9:50 – Jenny Bowker left the PCC meeting.** **9:50 – Richard Brown left the PCC meeting.** **9:50 – Rosi Shepherd left the PCC meeting.** **The Primary Care Committee received and noted the PC Corporate Risk Register and Emerging Risks. The Primary Care Committee noted the update on JHoots Pharmacy.**	
6	**PCOG Report** AM introduced the PCOG report agenda item, noting that the Committee typically reviews this report thoroughly at each meeting, and understands its rhythm and the types of decisions made by PCOG. She invited DJ to present. DJ stated he would take the PCOG report as read, focusing on key areas due to time constraints and the importance of other agenda items. DJ highlighted that the main strategic issues discussed at PCOG in July and September 2025, were the JHoots Pharmacy situation and the GP collective action (GPCA), both of which had already been covered in detail earlier in the PCC meeting. DJ noted the continued learning and development in dental contracts, specifically the review and support for two new dental facilities, including the use of Equality Impact Assessment (EIA), and Quality Impact Assessment (QIA) processes. This was described as a positive, but not as strategically significant as the pharmacy and GP issues. No questions were raised. **The Primary Care Committee formally received and noted the PCOG Report, and AM acknowledged the work of PCOG on behalf of the ICB.**	

	Item	Action
7	**Operational Plan & Joint Forward Plan** BH provided an update on the requirements for the 2025/26 operational planning round: BH explained the Committee received two documents: - 1. The General Practice Commissioning and Transformation (CATS) tool. 2. The June report (action plan). The CATS tool was used to assess the baseline and inform the action plan, covering strategic approach, governance, enabling functions, data use, learning, and stakeholder engagement. BH reported that the self-assessment rated the ICB at Level 3 (wanting to achieve Level 4), with no concerns about achieving this. Two areas require further work: peer ambassadors/leadership (in progress) and ongoing workforce development. The June report details current status and plans to reach Level 4. Medium confidence was expressed in delivery due to resource uncertainty. NHSE provided positive feedback, especially on proactive and targeted support for practices and workforce planning. It is noted the ICB will continue quarterly reporting against the plan to NHSE. BH reported the planning cycle for 2026/27 has started, with the ICB aiming to be proactive and not wait for late national guidance. ➢ The planning framework aligns with the 10-year plan and system priorities. ➢ Planning principles are being developed in alignment with Gloucestershire, but separate plans will be maintained. ➢ A cross-check has been completed against the joint forward plan and the 10-year plan. ➢ A launch event was held to kick off the process. <u>Next steps include:</u> 1. Scheduling relevant meetings, developing the plan for all of primary care, and following established governance routes (SDU, PCOG, Health Care Improvement Group (HCIG), PCC). 2. National guidance and templates are expected in November, with a draft submission due in December and final submission by March. <u>Questions/Reflections Raised</u>: ➢ AM asked about checks and balances for the self-assessment scoring, questioning how the committee can be assured of the accuracy of the Level 3 rating. BH explained the governance process: documents are reviewed by the Primary Care Committee (PCC), Primary Care Operational Group (PCOG), and the Quality and Resilience Group, which includes broad representation. ➢ AM asked if quarterly reporting would be a significant workload. BH confirmed it would require considerable time and resource, aligning with earlier discussions about capacity concerns. ➢ AM raised the issue of dental underperformance, noting a repeat of last year's underspend and asking about mitigations and assurance for the committee. BH offered to bring a more detailed report to the next committee meeting, including data on initiatives and their impact. She noted that the UDA (Units of	

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	Dental Activity) trajectory was on track, but urgent dental care and expressions of interest were still being monitored. AM thanked BH for the report, asking if anything further was required from the Committee? BH requested the Committee's continued assurance and support at the appropriate points in the timetable. **10:00 – John Hopcroft left the PCC meeting.** **10:05 – Sarah Purdy left the PCC meeting.** **The Primary Care Committee noted and accepted the Operational Plan and Joint Forward Plan.**	
8	**Primary Care Finance Report** Jamie Denton (JD) presented the key points from the general medical and POD primary care financial reports, highlighting the financial position for month 4 and the overall system financial position. JD reported the system financial position at month four showed a £1.3 million overspend, with a forecast to achieve break-even by year-end. For general practice, there was a £1 million underspend year-to-date, with a similar underspend forecast for the year. The Doctors and Dentists Remuneration Board (DDRB) allocation provided an additional £2 million for general practice to fund a 4% pay increase. The POD financial position showed a £300,000 underspend year-to-date, with a forecast of just under £1 million underspend by year-end. JD flagged an emerging risk in the acute financial position, particularly due to increased demand for direct access diagnostics and pathology, which could impact the overall system position. Questions Raised: ➢ DC asked if the pharmacy underspend could be used to support pharmacy resilience, given the earlier discussion on pharmacy risks. ➢ JD explained that the position was not fully calculated yet, but the scale of the acute risk was significant. He stated that while the underspend might not be directly used, the priority should be continuity of service, especially for pharmacy. ➢ SMc added that the legal advice and procurement legislation were being explored to determine if the underspend could be used for pharmacy support. JD confirmed an increase in dental activity and no current underspend but highlighted the risk of a back-ended cost surge in urgent care. He noted the establishment of a programme board to develop and implement new initiatives quickly if needed. **The Primary Care Committee noted recommendations in the report and accepted the summary financial plan, the key risks and noting the position.**	

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9	**General Practice, Performance, Contracts & Quality Updates** **Patient Safety Quality Report** MR introduced Vicki Court (VC), the new patient safety specialist, and explained that the paper was a "take stock" review of patient safety in general practice. He emphasised the importance of understanding current risks and the need to link this work to the transition programme. MR advised the team will be undertaking the same process again for Pharmacy, Optometry and Dental (POD) services, with a further report being available at the next PCC reflecting on this. VC summarised the key points, noting: ➢ General practice in BNSSG is generally safe, but visibility of patient safety risks could be improved. ➢ National and local reporting systems (including dashboards) are limited in capturing patient safety metrics for general practice. ➢ The 2019 NHS Patient Safety Strategy is not easy transferable to general practice; a primary care-specific patient safety strategy was published last year. ➢ Learning from Patient Safety Events (LFPSE) is a national system to report patient safety events and is a contractual requirement for General Practice to sign up to. Currently there are significant limitations to using LFPSE: time-consuming to upload patient safety events, information is not validated, and because of this, reliability of system information is poor. ➢ Key elements of the strategy include safety culture, safety systems (e-learning), insight (incident management and LFPSE), involvement (patient participation), and quality improvement. ➢ The ICB recommends signing up to LFPSE but continuing to use local processes for now. ➢ The top three national incident themes for general practice are misdiagnosis, medication-related incidents, and delayed referral. The strategy recommends focusing on these as a proportionate response. ➢ There is a gap in triangulating local clinical risks with national and local patient safety metrics, and general practice lacks the infrastructure to implement all elements of the strategy. ➢ The ICB plans to co-produce mitigating actions to support implementation of the primary care patient safety strategy with general practice and is meeting with the GPCB chair to discuss practical support. <u>Questions/Reflections Raised included</u>: ➢ AM asked for clarification on focusing on the top three incident themes and whether practices are still expected to reflect on all events. VC confirmed that practices should reflect on all events, but the ICB will focus on the main themes for system-wide improvement. ➢ AM asked about the spread of quality improvement initiatives and how learning is shared across practices. VC acknowledged this as a gap and said the ICB supports shared learning at a micro level but there is an opportunity to share learning across all General Practice in BNSSG. ➢ AM asked how the patient safety strategy links to the broader risk-based approach discussed throughout the meeting. VC emphasised the need to articulate risks, understand dynamic risk assessment, and involve service users in identifying what matters most.	

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	➢ MR noted that the LFPSE platform's limitations are a national issue and have been escalated regionally and nationally. NHSE has promised updates in the new year. ➢ JM asked for clarification on how the ICB can identify local themes given the variation in incident reporting systems and the limitations of LFPSE. VC explained that the ICB needs to understand the current "mixed economy" of reporting, work with GPCB to gather information, and focus on ensuring all practices have some incident management system. She acknowledged the need for a short, medium, and long-term plan. AM summarised the discussion, noting the importance of moving from a position statement to a clear action plan with priorities and timelines for the next meeting. She emphasised the need to link the work to what will make the most impact for the population and to clarify roles and responsibilities. **Actions and Next Steps Noted:** 1. GPCB Engagement: VC to meet with the GPCB chair to discuss how to gather local patient safety data and co-produce practical support actions. 2. Short/Medium/Long-Term Plan: VC to develop a clear plan outlining immediate, medium, and long-term priorities for patient safety in primary care, to be presented at the next meeting. 3. Governance Improvement: VC to work on increasing general practice involvement in patient safety governance and improving the spread of quality improvement initiatives. 4. National Escalation: MR to continue escalating LFPSE platform issues regionally and nationally and monitor for promised updates. 5. Collaboration: VC to consult with JM and others, to ensure the plan is action-oriented and addresses variation in reporting **10:35 Jenny Bowker rejoined the PCC meeting.** **The Primary Care Committee:** **1. Noted the current position and limitations of the patient safety reporting system.** **2. Agreed to focus on the top three national incident themes while working to improve local data collection and sharing.** **3. Requested a clear, actionable plan for patient safety in primary care for the next meeting.** **4. Supported ongoing engagement with GPCB and escalation of national system issues.** **Medicines Optimisation Report** AM introduced the Medicines Optimisation Report agenda item and asked DC if the report could be taken as read or if there were key points to highlight. DC confirmed the report could be taken as read but reflected on the earlier patient safety discussion, noting that medicines optimisation is a key theme in patient safety. DC stated that the report provides assurance that the team is on top of most known themes but acknowledged the ongoing challenge of underreporting in primary care, including both general practice and pharmacy, optometry, and dentistry (POD) services. DC highlighted that recurring events, particularly around insulin, continue to be a focus, with ongoing work to address root causes. She mentioned a significant piece	

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	of work underway regarding the use of Patient Safety Data Systems (PSDS) and improving reporting across interfaces, including digital solutions to support information exchange. DC proposed to follow up with VC, JM and MR outside the PCC meeting, to explore how to further support medicines optimisation and align with other emerging patient safety themes. AM supported the idea of cross-system learning, especially in the context of the upcoming transition with Gloucestershire and suggested sharing best practices between systems. She noted this could be discussed further at a later date. AM asked if there were any questions or comments for DC on the report, noting its clarity and the significant work involved. No further questions or comments were raised by the committee. **Actions and Next Steps Noted:** 1. Collaboration: DC to follow up with VC, JM and MR, to explore further support for medicines optimisation and integration with patient safety work. 2. Cross-System Learning: DC and team to consider opportunities for sharing best practices and learning with Gloucestershire as part of the transition process. **The Primary Care Committee** **1. Noted the Medicines Optimisation Report and the assurance provided regarding current themes and ongoing work.** **2. Supported continued collaboration and integration with patient safety initiatives.** **3. Agreed to consider further cross-system learning opportunities with Gloucestershire.** **Primary Care Services Highlight Report** AM introduced the Primary Care Highlight Report and invited Katie Handford (KH) and BH to present. KH provided context for the reports, noting: ➢ The Primary Care Highlight Report gives a high-level overview of the four primary care areas and tracks metrics aligned to the operational plan. ➢ The report format includes a summary slide with 12-month rolling activity and Southwest averages. ➢ The General Practice Highlight Report was developed in response to the Access Recovery Plan and includes high-level metrics at BNSSG level, reviewed at practice level to identify and support practices needing help. ➢ Support is offered by the One Care General Practice Support Team or NHS England Practice Level Support Team. ➢ The next steps in the report were written before the contract dispute announcement; capacity and access improvement plans are due from practices by the end of the month and will be reviewed. ➢ The report also references the Urgent Care Network's work on the winter action plan and O cards, linking to previous discussions on system resilience. AM praised the format and noted the progress shown in the report, especially the delivery against Units of Dental Activity (UDAs).	

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	AM asked about the Eye Care Board: specifically, whether it has set objectives and if the activities listed are derived from those objectives or if more exist? KH explained that the Eye Care Board is still establishing itself, with some staff changes causing delays, but expects more progress as the team stabilises. BH added that the current focus is on four key lines from the operational plan and JFP, with the ambition to develop a wider delivery plan as resources allow. She committed to making these priorities clearer in future reports. AM supported prioritising a few high-impact optometry objectives rather than trying to do everything, referencing the difference in approach compared to the dental strategy. AM asked about the General Practice Access Recovery Highlight Report, specifically regarding the primary-secondary care interface group. She requested more clarity on expected outputs and outcomes, noting that much of the current description is about process rather than results. BH acknowledged the request and said recent submissions to NHSE from all providers (including Sirona Community Services and AWP Mental Health Trust) have helped focus on outputs. She committed to including this in the next report. AM noted that the reports are clear and well-structured, and acknowledged the significant work involved. She emphasized the importance of focusing on outcomes and next steps. JB expressed appreciation for the development of the reports, and thanked BH, KH and Urvi Makwana for their work. **Actions and Next Steps Noted**: 1. Eye Care Board Objectives: KH and BH to clarify and communicate the Eye Care Board's objectives and priorities in future reports. 2. Primary-Secondary Care Interface Outputs: BH to ensure future reports include clear outputs and outcomes for the primary-secondary care interface group, reflecting recent provider submissions. 3. Capacity and Access Improvement Plans: Team to review practice submissions by the end of the month and incorporate findings into future reporting. **The Primary Care Committee:** **1. Noted the Primary Care Highlight Report and General Practice Access Recovery Highlight Report.** **2. Supported the current focus on key priorities and the commitment to clarify objectives and outcomes in future reports.** **3. Agreed to continue reviewing and refining the reporting format and content to ensure clarity and focus on impact.**	
10	**Key Messages for the ICB Board** AM indicated there were a few key messages from the PCC meeting today, to be reported back to the ICB Board, and noted that there were items to escalate. She stated she would take some time to consider these messages and report them to the ICB Board.	
11	**Primary Care Operational Group (PCOG) Minutes 8th July & 9th September 2025** **The Primary Care Committee received the PCOG minutes for information.**	

	Item	Action
12	**Any Other Business** AM provided an update on the transition process, noting the lack of a formal announcement for the ICB Chief Executive and the resulting limitations on progress. She mentioned the first Transition Committee meeting had taken place, and there were early signs of committee alignment, particularly for non-executive and executive leadership. She explained that the governance structure for future meetings (joint or in common) was not yet determined, and that Gloucestershire's committee structure would need to be considered. The PCC noted the need to review the forward planner at the next meeting. No further AOB to note.	
	Date of Next Meeting Tuesday 25th November 2025 9:00–11:00am, held via MS Teams	