Primary Care Commissioning Committee Part 1

Tue 08 July 2025, 13:30 - 16:00

Agenda

13:30 - 13:30 0 min

Agenda

Hein van den Wildenberg

2025 07 08 Item 00 ICB Primary Care Committee Agenda Pt 1.pdf (1 pages)

13:30 - 13:30 0 min

1. Chair's Introduction

Discussion *Hein van den Wildenberg*

13:30 - 13:30 0 min

2. Apologies for Absence

Information *Hein van den Wildenberg*

13:30 - 13:30 0 min

3. Declarations of Interest

Information *Hein van den Wildenberg*

2025 06 18 Item 03 ICB Master Register.pdf (4 pages)

13:30 - 13:30 0 min

4. Review of Minutes and Action Log from the May 2025 meeting

Decision *Hein van den Wildenberg*

2025 05 14 Item 04 NWICB PCCC Minutes Part One.pdf (11 pages)
2025 07 08 Item 04 PCCC Action Log Part One.pdf (1 pages)

13:30 - 13:30 0 min

5. Forward Planner

Information *Sadie Parker*

2024 07 08 Item 05 NWICB PCCC Forward Planner 2025 2026 Part One.pdf (1 pages)

13:30 - 13:30 0 min

6. Risk Register

Decision *Sadie Parker*

2025 07 08 Item 06 Risk Summary Report.pdf (4 pages)
2025 07 08 Item 06 Risk Register.pdf (10 pages)

13:30 - 13:30 0 min

Service Development

13:30 - 13:30 0 min

7. Strategic Primary Care Workforce Recruitment and Retention Programme Report

Decision *Ben Chandler*

2025 07 08 Item 07 Strategic Primary Care Workforce Recruitment and Retention Programme Report.pdf (6 pages)
2025 07 08 Item 07 Appendix A - Operational Delivery Plan 25_26.pdf (3 pages)

13:30 - 13:30
0 min

8. Strategic Framework for Primary Care

Decision *Amanda Sear*

- 2025 07 08 Item 08 Strategic Framework for Primary Care Front Sheet.pdf (3 pages)
- 2025 07 08 Item 08 Strategic Framework for Primary Care.pdf (14 pages)

13:30 - 13:30
0 min

9. Update on Operational Planning ~ GP Action Plan

Decision *Amanda Sear*

- 2025 07 08 Item 09 Update on Operational Planning.pdf (5 pages)

13:30 - 13:30
0 min

Finance & Governance

13:30 - 13:30
0 min

10. Delivery Group Reports• General Practice & Community Pharmacy• Dental Services Report• Dental Development Group

Information *Sharon Gardner / Sarah Johnson*

- 2025 07 08 Item 10 GPCP Delivery Group Report.pdf (6 pages)
- 2025 07 08 Item 10 Dental Services Report.pdf (4 pages)
- 2025 07 08 Item 10 Dental Development Group Report.pdf (4 pages)

13:30 - 13:30
0 min

11. Strategic Finance Report M02

Information *James Grainger*

Supplementary report to follow

- 2025 07 08 Item 11 Strategic Finance Report M02.pdf (8 pages)

13:30 - 13:30
0 min

12. TIAA Report

Information *Sharon Gardner*

- 2025 07 08 Item 12 TIAA Report - front sheet.pdf (4 pages)
- 2025 07 08 Item 12 TIAA Report.pdf (13 pages)

13:30 - 13:30
0 min

13. Any Other Business • Questions from the public

Discussion *Hein van den Wildenberg*

NHS
Norfolk and Waveney
Integrated Care Board

Meeting of the Norfolk and Waveney ICB Primary Care Commissioning Committee
Tuesday 8 July 2025, 13:30 Part 1
Meeting to be held via video conferencing and You Tube

Item	Time	Agenda Item	Lead
1.	13:30	**Chair's Introduction**	Chair
2.		**Apologies for Absence**	Chair
3.		**Declarations of Interest** To declare any interests specific to agenda items. Declarations made by members of the Primary Care Committee are listed in the ICB's Register of Interests. *For Noting*	Chair
4.		**Review of Minutes and Action Log from the May 2025 meeting** *For Approval*	Chair
5.		**Forward Planner** *For Noting*	SP
6.	13:40	**Risk Register** *For Approval*	SP
		Service Development	
7.	13:50	**Strategic Primary Care Workforce Recruitment and Retention Programme Report** *For Approval*	Ben Chandler
8.	14:00	**Strategic Framework for Primary Care** *For Approval*	AS
9.	14:10	**Update on Operational Planning ~ GP action plan** *For Approval*	AS/SP
		Finance & Governance	
10.	14:30	**Delivery Group Reports** • **General Practice & Community Pharmacy** • **Dental Services Report** • **Dental Development Group** *For Noting*	SG/SJ
11.	14:40	**Strategic Finance Report M02** *For Noting*	JG
12.	14:50	**TIAA Report** *For Approval*	SG
		Any Other Business	
13.	15:00	**Any Other Business** • **Questions from the public**	Chair
Date, time and venue of next meeting **Wednesday 1 October 2025 13:30 – 16:30 – ICB PCCC** **To be held by videoconference and You Tube**			
Any queries or items for the next agenda please contact: **nwicb.primarycarecommissioningcommittee@nhs.net**			
Questions are welcomed from members of the public. **Please send by email: nwicb.contactus@nhs.net** **For a link to the meeting in real-time, please click here**			

NHS Norfolk and Waveney Integrated Care Board (ICB)
Register of Interests

Declared interests of the Primary Care Commissioning Committee

Name	Role	Declared Interest- (Name of the organisation and nature of business)	Type of Interest			Is the interest direct or indirect?	Nature of Interest	Date of Interest		Action taken to mitigate risk
			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests			From	To	
Ian Wake	Executive Director of Adult Social Services	Norfolk County Council		X		Direct	Executive Director of Adult Social Services, Norfolk County Council	14/10/2025	Present	
Dr Hilary Byrne	Partner Member - Primary Medical Services	Attleborough Surgeries	X				GP and partner Attleborough Surgeries	2001	Present	
		MPT Healthcare	X				Director MPT Healthcare	2020	Present	
		SNHIP PCN					Clinical Director SNHIP PCN	2023	Present	
		Norfolk Community Health Care					Husband is an employee of NCHC	2021	Present	
Steven Course	Executive Director of Finance, Norfolk and Waveney ICB	March Physiotherapy Clinic Limited	N/A			Indirect	Wife is a Physiotherapist for March Physiotherapy Clinic Limited	2015	Present	Will not have an active role in any decision or discussion relating to activity, delivery of services or future provision of services in regards March Physiotherapy Clinic Limited
Patricia D'Orsi	Executive Director of Nursing, Norfolk and Waveney ICB	Royal College of Nursing		X		Direct	Professional Body - RCN Union	Ongoing		Inform Chair and will not take part in any discussions or decisions relating to RCN
Karen Watts	Director of Nursing and Quality, Norfolk and Waveney ICB	Coltishall surgery			**X**		Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
		Norfolk and Norwich University Hospital			**X**	**Indirect**	Son-in-law is a Cardiology Consultant at the NNUH with sessions at JPUH	Jun-23	Present	I inform the chair and will not take part in any discussion or decision that may benefit cardiology at the NNUH and JPUH
		Royal College of Nursing			**X**	**Direct**	Member of the Royal College of Nursing Union	1980	Present	Inform the chair and will not take part in any discussions or decisions relating to the RCN
Hein van den Wildenberg	Non-Executive Member, Norfolk and Waveney ICB	Lakenham Surgery			X		Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
		College of West Anglia			X	Direct	Governor at College of West Anglia (Note: the College hosts the School of Nursing, in partnership with QEHKL and borough council)	2021	Present	Low risk. In the unlikely event that a risk arises I will discuss and agree any appropriate steps which need to be taken with the ICB Chair
		Broadland Housing Association	X			Direct	Non-Executive Director and Board member for Broadland Housing Association	2024	Present	Will excuse myself from any decisions relating to Broadland Housing Association
Norfolk and Waveney ICB Attendees										

Mark Burgis	Executive Director of Patients and Communities, Norfolk and Waveney ICB	Lakenham Practice	**X**			**Indirect**	Wife is Nurse Prescriber who is currently undertaking occasional locum work at Lakenham Practice in Norwich. Wife receives an income from the practice when undertaking locum shifts at the practice	Aug-21	Present	Declare at any relevant meetings and remove myself from any significant discussions or decisions relating to the practice
		Drayton Medical Practice			**X**		Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
Shepherd Ncube	Associate Director of Primary Care Commissioning	Nothing to Declare	N/A			N/A	N/A	N/A		N/A
Sadie Parker	Director of Primary Care, Norfolk and Waveney ICB	Active Norfolk			**X**		Board member for Active Norfolk	2019	Present	Declare interest in meetings where relevant, agree any resulting action with the chair. Seek advice in advance where possible. COI training undertaken
		St Stephensgate Practice			**X**		GP partner of St Stephensgate Practice, Director of N2S	2023	Present	Declare interest in any meetings where relevant, ensure any potential for conflict is overseen by line manager to ensure robust decision-making. Agree any action with the chair of the meeting. Seek advice when unsure. Recuse myself from any situations likely to place myself or my friend in a compromised position. COI training undertaken.
Oliver Loveless	Head of Primary Care Strategic Planning (on secondment until end of March 2024)	Cromer Group Practice			X	Indirect	Partner works for the ICB	Oct-22	**31-Mar-25**	Withdrawal from any discussions and decision making in which the Practice might have an interest
Amanda Sear	Head of Primary Care Strategic Planning	ICB			X	indirect	Partner is an ICB Clinical Advisor and local GP	2025	present	COI training undertaken. Advice to be sought in the event that a piece of work overlaps where a decision is made that relates to partner interest Discussion with the chair ahead of relevant meeting where a potential COI
		Chet Valley Medical Practice			X	direct	Patient at a Norfolk and Waveney GP Practice	2025	present	
Sharon Gardner	ICS Community Pharmacy Clinical Lead	Humbleyard Medical Practice			**X**		Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
		Locum Work	**X**				Self-employed Locum Pharmacist in addition to my role in the ICB. Complete self-employed Locum Work as a pharmacist for various pharmacy contractors for whom we are responsible for commissioning since April 2023	Apr-23	Present	No information sharing of non-public workstreams during locum work and conflict to be raised at all relevant meetings where discussions/decision relate to the conflict declared. Also remove myself from any decision making around any locally commissioned services as and where relevant
		Royal Pharmaceutical Society Great Britain		**X**			Royal Pharmaceutical Society Great Britain. Member of the RPSGB which is over and above that of my professional membership of the GPHC	*01/07/2000	Present	Low/negatable risk. If there is an issue it will be raised at the time

Sarah Johnson	Senior Primary Care Commissioning Manager - Dental	Sheringham Medical Practice			X		Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
Fiona Theadom	Head of Primary Care Commissioning, Norfolk & Waveney ICB	Nothing to Declare				N/A	N/A			N/A
Local Medical Committee Attendees										
Lisa Drewry	Executive Officer, Norfolk & Waveney LMC	Burnham Market			X	Direct	Registered patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
Ian Wilson	Executive Officer with Norfolk & Waveney Local Medical Committee	Drayton Medical Practice			X	Direct	Registered patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
Joni Graham	Executive Officer Norfolk & Waveney Local Medical Council	Orchard Surgery			X	Direct	Registered patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
Naomi Woodhouse	Norfolk & Waveney Local Medical Committee Chief Executive Officer	Long Stratton Medical Practice			X	Direct	Registered patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
Practice Managers drawn from General Practice Attendees										
Sarah Buchan	PCCC Practice Manager Specialty Advisor	Fakenham Medical Practice			X		CEO at Fakenham Medical Practice. Employed by practice	Feb-18	Present	Withdrawal from any discussions and decision making in which the Practice might have an interest.
		NN1 Ltd			X		Member of NN1 Ltd. Employed by practice member of NN1 Ltd	Apr-23	Feb-25	Withdrawal from any discussions and decision making in which the PCN might have an interest.
		NN PM group			X		Chair of NN PM group. Employed by member practice	Mar-20	Feb-25	To not relay any information discussed about these practices at the PCCC.
		Norfolk Community Health and Care NHS Trust and Cambridge Community Services	X				Chief Information Officer, NCHC and Cambridge Community Services. Employed by NCHC	Feb-25	Present	Withdrawal from any discussions and decision making in which NCHC might have an interest. To not relay any information discussed about NCHC at the PCCC.
		Humbleyard Medical Practice			X		Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
Health and Wellbeing Board Attendees (Norfolk and Suffolk)										
Healthwatch Attendees (Norfolk and Suffolk)										
Andrew Hayward	HealthWatch Norfolk Trustee	East Harling & Kenninghall GP Practice			X	Direct	Registered patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
		HealthWatch Norfolk			X	Direct	Trustee and board member HeathWatch Norfolk	2020	Present	To be raised at all meetings where discussions or decisions relate to the conflict declared.
		East Harling Parish Council			X	Direct	Member, East Harling Parish Council	2020	Present	
		NHS England		X		Direct	GP appraiser. Paid on a self-employed basis by NHSE.	2015	Present	
Sally Watson	Healthwatch Suffolk Engagement and Community Manager	Nothing to Declare	N/A				N/A	N/A		N/A
Other Primary Care Members										

Andrew Bell	Vice-Chairman Norfolk Local Dental Committee General Dental Practitioner in Norfolk and Waveney	Norfolk and Waveney		X		Direct	General Dental Practitioner and Partner in a group of practices in Norfolk and Waveney. GDP and Partner for John G Plummer and Associates	2014	Present	I would exclude myself from any discussions particular to our GDS and specialist contracts or remove myself as per the wishes of the committee
		Norfolk Local Dental Committee			X	Direct	Norfolk Local Dental Committee. I am the Vice-Chairman	2016	Present	This is unlikely to impact on working with the ICB. I would exclude myself from any section of a meeting that ICB members felt appropriate.
		British Dental Association			X	Direct	I am a member of the General Dental Practice Committee (GDPC)	2022	Present	This is unlikely to impact on working with the ICB. I would exclude myself from any section of a meeting that ICB members felt appropriate.
		Bridge Road GP Surgery, Oulton Broad			X	Direct	Registered patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
Deborah Daplyn	Co-Chair. Norfolk & Waveney Local Optical Committee	Norfolk and Waveney	X			Direct	Employed optometrist working in N&W. Directly provide commissioned services on the frontline	May-23	Present	Decision taken to be a Provider of commissioned services is not taken by me but at a head office level. I receive no extra remuneration
		Sheringham Medical Practice			X	Direct	Registered patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
Tony Dean	Joint Chief Officer, Community Pharmacy Norfolk & Suffolk	Docking & Great Massingham Surgeries			X	Direct	Registered patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
Lauren Seamons	Joint Chief Officer, Community Pharmacy Norfolk & Suffolk	The Hollies , Downham Market			X	Direct	Registered patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
Jason Stokes	Secretary Norfolk Local Dental Committee (LDC)	NHS GDS Provider	X			Direct	NHS GDS Provider. I am paid by the NHS to deliver NHS primary care dental services	2007	Present	I will absent my self from decisions that could impact the nature of my contract and/or remuneration
		British Dental Association			X	Direct	BDA PEC Member (NED) I am a Non-Executive Director of the dental trade union (British Dental Association)	2012	Present	I will declare this interest and respond to any concerns about the need to mitigate this risk
Nick Stolls	Dental Advisor to PCCC	Harleston Dental Practice	X			Indirect	Landlord of Harleston Dental Practice	2001	2024	Declare CoI and withdraw from meeting if discussions take place that might benefit Harleston practice

NHS
Norfolk and Waveney
Integrated Care Board

Norfolk and Waveney Primary Care Commissioning Committee
Part One

Minutes of the Meeting held on
Wednesday 14 May 2025 at 13:30
via video conferencing and YouTube

Voting Members – Attendees

Name	Initials	Position and Organisation
Hein Van Den Wildenberg	HW	Non-Executive Member, Norfolk and Waveney ICB (deputy Chair) – Chair for May 2025
Sarah Elliott	SE	Finance Manager – Delegated Primary Care, Norfolk and Waveney ICB (deputising for the Executive Director of Finance, Steven Course)
Karen Watts	KW	Director of Nursing and Quality, Norfolk and Waveney ICB (deputising for the Executive Director of Nursing, Tricia D'Orsi)

In attendance

Name	Initials	Position and Organisation
Jordan Bingley	JB	Primary Care Commissioning Manager, Norfolk and Waveney ICB
Craig Boyles	CB	ICS Estates Programme Manager, Norfolk and Waveney ICB
Sarah Buchan	SB	Practice Manager Specialty Advisor
Mary Cummins	MC	Primary Care Commissioning Support Officer, Norfolk and Waveney ICB
Michael Dennis	MD	Head of Medicines Optimisation, Norfolk and Waveney ICB
Lisa Drewry	LD	Executive Officer, Norfolk and Waveney Local Medical Committee
Debbie Ebenezer	DE	Senior Primary Care Commissioning Manager (Medical) Norfolk and Waveney ICB
Carl Gosling	CG	Senior Delegated Commissioning Manager Primary Care, Norfolk and Waveney ICB
Sharon Gardner	SG	Head of Primary Care Commissioning Community Pharmacy and Optometry, Norfolk and Waveney ICB
Joni Graham	JGr	Executive Officer (Estates, Digital, Pharmacy & Prescribing) Norfolk & Waveney Local Medical Committee
Paul Higham	PH	Associate Director Estates, Norfolk and Waveney ICB
Kirsty Hockley	KH	Commissioning Support Officer, Pharmacy and Optometry, Norfolk and Waveney ICB minute taker
Sarah Johnson	SJ	Senior Primary Care Commissioning Manager (dental)
Cath McWalter	CMcW	Senior Lead Primary Care Estates Manager, Norfolk and Waveney ICB
Shepherd Ncube	SN	Associate Director of Delegated Commissioning, Norfolk and Waveney ICB
Sadie Parker	SP	Director of Primary Care, Norfolk and Waveney ICB
Lauren Seamons	LS	Joint Chief Officer, Community Pharmacy Norfolk

Amanda Sear	AS	Senior Primary Care Strategic Planning Manager, Norfolk & Waveney ICB
Diane Smith	DS	Head of Collaborative Commissioning and Performance, Norfolk and Waveney ICB
Nick Stolls	NS	Specialty Dental Advisor
Gregg Syder	GS	Commissioning Manager – Pharmacy and Optometry, Norfolk and Waveney ICB
Fiona Theadom	FT	Head of Primary Care Commissioning, Norfolk and Waveney ICB
Sarah Webb	SW	Primary Care Administrator, Norfolk and Waveney ICB
Stuart White	SWh	Senior Commissioning Manager, Delegated Primary Care Medical (GP), Norfolk and Waveney ICB
Ian Wilson	IW	Executive Officer, Norfolk and Waveney Local Medical Committee

Shadowing

Name	Initials	Position and Organisation
Lynda Stockwell	LS	Head of Place Quality (Central), Norfolk and Waveney ICB

Apologies received

Name	Initials	Position and Organisation
Steven Course	SC	Executive Director of Finance, Norfolk and Waveney ICB
Patricia D'Orsi	PDO	Executive Director of Nursing, Norfolk and Waveney ICB
Mark Burgis	MB	Executive Director of Patients and Communities, Norfolk and Waveney ICB
Deborah Daplyn	DD	Chair, Norfolk and Waveney Local Optical Committee Optical Contractor working within ICB boundaries
James Grainger	JG	Head of Finance Primary Care and Corporate, Norfolk and Waveney ICB
Jason Stokes	JS	Secretary, Norfolk Local Dental Committee (LDC)
Peter Taylor	PT	Assistant Director, Public Health Commissioning Norfolk County Council, Public Health
Ian Wake	IWa	Chair, Partner Member – Local Authority (Norfolk) Norfolk and Waveney ICB
Sally Watson	SWa	Healthwatch Suffolk – Community & Engagement Manager

No	Item	Action owner
1.	**Chair's introduction** The Chair welcomed attendees to the May 2025 Committee meeting.	**Chair**
	Matters Arising There were no matters arising.	
2.	**Apologies for absence**	**Chair**
	Apologies noted above.	
3.	**Declarations of Interest** *For Noting*	**Chair**
	None declared	
4.	**Review of Minutes and Action Log from the March 2025 Committee** *For Approval*	**Chair**

	The minutes were agreed to be an accurate record of the March 2025 Committee meeting and minutes would be sent to the Chair for signing. **<u>Action Log</u>** There were three items on the action log. **Item 197**: Proposed to be closed, with a suggestion to discuss it during the risk register agenda item. **Item 198**: Report on LCS activities. The proposal was to change the due date to July. There was also a question from a member of the public about the LCS activity tracker, which might provide inspiration for this point. **Item 199**: The proposal was to change the due date to July. HW asked if there were any other comments on the action log. No additional comments were made.	**SW**
5.	**Forward Planner** *For Noting*	**SP**
	SP introduced the new forward planner, noting that it was likely to be adapted throughout the year The planner was now structured in terms of how the agenda was organised, which would make it clearer to see what was proposed to be heard and when. Meetings would be held every other month following agreed changes at the last Committee meeting. The forward planner was duly noted.	
6.	**Risk Register** *For Approval*	**SP**
	SP apologised for the print set up of the new system, which was still making it challenging to view the full risks. No new risks were highlighted, no changes in scoring, and no risks de-escalated this month. SP mentioned a helpful deep dive meeting with corporate affairs colleagues focused on dental risks however this was applicable to other risks also. Future meetings had been arranged to address other risks. SP highlighted that the National Insurance issue affected all primary care contractors, not just general practice. Feedback received indicated that this risk may be more significant for practices with higher numbers of salaried doctors compared to those with higher numbers of partners. The impact of this issue was being monitored, and no changes in risk scores had been made. LD commented that pressures and resilience in general practice had not improved, with practices still under continued stress. Practices in rural areas struggled to recruit experienced GPs due to insufficient funding. Additionally, vacancy rates were not accurately reported because many practices had not advertised due to lack of funds. LD expressed concern about the resilience of general practice and the health and wellbeing of staff, noted that patient demand exceeded capacity and there had been no visible decrease in these pressures. A wellbeing meeting had been instigated to support this. FT highlighted no colleagues from the LDC were present in the meeting and that the risk of National Insurance issue was significant for NHS dental services, with no additional monies for dentistry. The risk remained high around their stability and results.	

	HW suggested keeping a watching brief on the National Insurance risk and mentioned it affected all primary care providers. HW would raise the National Insurance issue to the Board next week. The voting members approved the risk report.	
7.	**Primary Care Access Improvement Plan** *For Noting*	**AS**
	AS introduced the Primary Care Access Improvement Plan for noting. This item had previously been discussed by the delivery group in April. Feedback from the delivery group included a short paragraph which explained the different topics. The Primary Care Recovery and Access Plan (PCARP) was a national plan introduced in 2023 and had now come to an end. This was the final report that would need to go to the public Board. AS mentioned, at the national level, there was a draft plan which would build on the PCARP plan, but this would take a while before it was available. HW inquired who would present this at the ICB Board, and AS confirmed MB was the Executive lead, with SP available if needed. HW opened for comments and questions, noting many on the call had been part of the delivery group discussion. HW observed that the plan was light on dentistry, which AS confirmed was by design, as PCARP mainly focused on implementing the modern general practice model and pharmacy first. The report was noted.	
8.	**Long Term Plan – Dentistry** *For Approval*	**FT**
	FT introduced the Long-Term Plan for Dentistry for approval, and highlighted points on the report of year one's progress and the ambition for year two projects. The primary aims were to support local provider resilience, improve patient access, and reduce health inequalities. An additional national target was to contribute to 700,000 additional unscheduled care appointments, which FT felt confident could be addressed. The investment came from the dental ring-fenced budget, with recurrent investment which needed to be freed up through targeted rebasing or renegotiating under-delivering contracts. The plan included measurable outcomes, with a focus on monitoring contracts and delivering pathways and new services to ensure benefits and value for money. FT emphasised the need to measure patient experience and monitor areas of deprivation using heat maps and a deeper dive on specific areas of deprivation. Risks related to delivering the plan were highlighted in the paper. KW expressed interest on the focus of patient experience and evaluation of support plans, enquired about feedback from dentists. FT mentioned positive feedback from providers and the Local Dental Committee (LDC) about proactive engagement and support. NS added that Norfolk and Waveney ICB was seen as a beacon of good practice in working with dental providers. NS highlighted challenges in commissioning primary care dentistry and the	

	impact of diverting funds to urgent care, enquiring about the relaxation of ring-fencing for 2025–26 and expected delivery of UDAs. FT confirmed the budget was ring-fenced for that year and explained the approach to rebasing underperforming contracts. Funding was awaiting approval. HW suggested bringing a status update to the Committee halfway through the year for October–December and confirmed the Committee's support for the recommendations outlined in the paper.	
9.	**Integrated Performance Report** *For Approval*	**DS**
	DS introduced the Integrated Performance Report (IPR) for approval, emphasised the ICB's duty to ensure value for money, quality of care, and achievement of outcomes for the population. The IPR had been redeveloped over six months, driven by a TIAA audit and recommendations from 2024. The report aimed to refine and reduce the number of key performance indicators (KPIs), remove duplication, and introduce statistical process control (SPC) charts. The IPR included assurance narratives which explained performance positions, actions, owners, and timelines. The reporting layers followed the scheme of delegation, covering the ICB Board, Committees, and programme boards. The final slide outlined the KPIs, aligning with national planning guidance, PCARP, and involved work with subject matter experts in dental, pharmacy, general practice, and business intelligence. SP highlighted the importance of the performance report and the need for a narrative report around primary care. SP suggested updating the Board on Pharmacy First uptake and considered whether to continue monitoring GP appointment bookings within two weeks, as this had dropped. NS suggested clarifying the definition of unique patients, children, and adults from the dental perspective. LS praised the report and recommended including metrics for Pharmacy First minor ailments referrals from NHS 111, urgent medicine supplies, and the number of prescriptions dispensed. SG provided context on NHS England's focus on clinical conditions for Pharmacy First and agreed on the importance of referrals from NHS 111. SB supported dropping the two-week GP appointment metric, noted it could skew results. HW suggested consideration of additional Board-level metrics and emphasised the need for a dynamic approach to the IPR. SN suggested aligning the decision to drop the two-week metric with regional practices. DS acknowledged the feedback and emphasised the flexibility of the IPR to adapt to future changes, such as the 10-year plan. DS confirmed the inclusion of definitions for unique patients and the importance of aligning with NHS England's focus on clinical conditions for Pharmacy First. The Committee approved the content of the IPR, and SN was tasked with clarifying the alignment of dropping the two-week GP appointment metric with regional practices. **Action:** SN to clarify the alignment of dropping the two-week GP appointment metric with regional colleagues and ensure it does not conflict with broader NHS guidelines.	**SN**
10.	**Strategic Estates Report** *For Noting*	**PH**

	PH provided an update on the Strategic Estates Report for noting PH highlighted the nearing completion of the Wave 4B programme, which began in 2019. The King's Lynn Health Hub had opened and was delivering clinical services, with positive feedback from primary care tenants. The Magna Medical Centre was due to completed this summer, with the earliest opening in September 2025. The building will initially have vacant space, with some areas bookable via NHS Property Services from January 2026 the following year. With regard to the Primary Care Utilisation and Modernisation Fund, Norfolk and Waveney were allocated £1.9 million. Initially, six schemes were listed up to £1.3 million, but seven schemes were now included, which brought the total to £1.7 million, leaving £0.2 million as contingency. There was an opportunity to swap and change schemes throughout the year, pending guidance from NHS England. PH issued a public apology to the six practices named by the DH, as they had only expressed an interest and there was no commitment at this stage. The main risk remained the legal side of the process, with ongoing issues between NHS England solicitors and practice solicitors. The funding award was required to be spent by December 2025, with schemes to be delivered by March 2026. The Drayton scheme was due for completion the following month, with practical completion and handover to the practice on June 21, 2025. The scheme involved the demolition of a previous extension and its replacement with a larger extension, including six consultation rooms, digital rooms, a physiotherapy room, two new treatment rooms, and additional admin space. The scheme benefited from a Section 106 arrangement, with a small parcel of land next to the existing practice enabling the car park extension. The landlord had made a significant capital investment, and the ICB had contributed to increased revenue costs. SP highlighted PH and the team for their support and progress in moving through schemes. SP appreciated the spotlight section in the paper and suggested including discussions on missed schemes in future papers. SP also noted the importance of seeing the cost pressures related to rent reviews and the strain on budgets due to building costs and new builds. SP acknowledged innovative ways of attracting funding for other primary care contractor groups. LS expressed pleasure in seeing the inclusion of pharmacy alongside optometry and dentistry in considerations, particularly around Section 106 funding. LS emphasised the importance of addressing consultation room capacity in pharmacies. PH provided a comprehensive update on the Strategic Estates Report, highlighted the progress and challenges in various schemes. The Committee appreciated the detailed report and the efforts to improve the primary care estate.	
11.	**Strategic Prescribing Report** *For Noting*	**MD**

	MD provided an update on the Strategic Prescribing Report for noting and emphasised that prescribing medicine was the most common intervention in the NHS and the second biggest cost next to staff. The team was involved in various work streams, with a significant focus on cost efficiencies, had identified £14 million in cost efficiencies and working on implementation plans. The antimicrobial stewardship efforts had shown positive results, with a downward trend in antibiotic prescribing, particularly through targeted work with PCNs and practices. MD highlighted the implementation of obesity drugs, specifically Tirzepatide (Mounjaro), which was phased in with a narrow cohort initially, starting in Tier 3 services from April 2025 and expected in primary care from July 2025. The phased approach was due to the high cost and limited capacity, with ongoing discussions about other potential cost-effective obesity drugs. SG enquired about the inclusion of Pharmacy First transactions in the antimicrobial stewardship data, and MD agreed to clarify this when he had further information. KW and SP congratulated the team on their work in antimicrobial prescribing, noted its impact on reducing Clostridium difficile cases. SP also mentioned the practice visit programme. SP invited MD and the team to join and discuss relevant medicines-related topics. MD confirmed the importance of adhering to NHS England's phased approach for obesity drugs, with JG adding that managing the phasing would be challenging due to limited capacity and resources. The Committee noted the detailed report and the efforts to improve prescribing practices.	
12.	**Delivery Group Reports** • **General Practice & Community Pharmacy** • **Dental Services Report** *For Noting*	**SN/FT**
	SN provided updates on the Delivery Group Report for General Practice and Community Pharmacy. The report was noted, with no matters for escalation. Several items discussed were aligned with the agenda, which included resilience and risk in general practice and community pharmacy. SN highlighted the ongoing challenges and the importance of addressing resilience in general practice, while SG emphasised there was a need for continued support for community pharmacies. FT presented the Dental Services Report, noting that the meeting was quorate and decisions reflected concerns around the resilience and stability of NHS dental services. The Committee discussed the importance of monitoring these risks and supporting local providers to ensure stability and access to dental care. The reports provided valuable insights into the current state of primary care services and highlighted areas for continued focus and improvement. Both reports were noted.	
13.	**Strategic Finance Report M12** *For Noting*	**SE**

	SE introduced the Strategic Finance Report for M12 for noting and highlighted the final report for the 2024-2025 financial year. The report showed primary care was £7 million overspent against a budget of £588 million, with total spending at £592 million. The adverse variances included £4.4 million in prescribing costs and £4.5 million in primary care, largely due to Local Commissioned Services (LCS) and complex dressings, additional rent reimbursements, and increased costs. Favourable variances included a £2.5 million underspend in the pharmacy budget, attributed to an uplift for the Community Pharmacy Contractual Framework (CPCF) contract that was allocated based on a fair share basis but required less spending than anticipated. Other variances were noted in oxygen, GPIT, and dental services. SE also mentioned the significant efficiency savings achieved in prescribing; several schemes delivered over £2 million in efficiencies each.HV asked for more details on the £2.5 million underspend in the pharmacy budget. SE explained that it related to an award for the uplift to the 2024-2025 contract received in February 2025 for the CPCF (Community Pharmacy Contractual Framework), allocated based on a fair share basis but with a lower requirement for actual spending. . NS raised a question about the dental budget, noted an in-year underspend of £1.86 million and asked why it was not fully spent given the challenges in dentistry. SE explained the underspend included provisions for UDA (Units of Dental Activity) delivered in April and May 2025 and mentioned that NHS England had clawed back funding at the end of the financial year. HW suggested taking this as an action point to provide a well-rounded explanation at the next meeting. **Action:** SE to provide a clear explanation of the dental budget underspend, covering the £1.86m in-year underspend, April–May 2025 UDA provisions, and the ~£5m NHS England clawback. LS enquired if the pharmacy budget was ring-fenced and if the late payment would be carried forward. SE was unsure and agreed to clarify this. **Action:** SE to clarify whether the pharmacy budget is ring-fenced and if the late payment received at the end of the year will be carried forward The Committee acknowledged the report, and the efforts made to achieve efficiency savings.	**SE** **SE**
14.	**Pharmaceutical Services Regulations Committee** • **Reports from the Pharmaceutical Services Regulations Committee** • **General Ophthalmic Services Quarter End Update report** *For Noting*	**GS**
	GS introduced the Pharmaceutical Services Regulations Committee (PSRC) report and the General Ophthalmic Services (GOS) Quarter End Updated reports for noting; both were for information purposes only.	

	The PSRC report provided an overview of market entry decisions, market entry applications, fitness decisions, and regulatory time scales within the committee. The GOS report detailed contractual changes and updates in optometry services over the last quarter. GS emphasises that the Pharmacy and Optometry team, hosted at Herts and West Essex, operated on behalf of all six ICBs following the delegation of GOS services and pharmaceutical contracting from April 1, 2023. SG confirmed that there were no specific issues to note from the reports.	
15.	**National Contracts for 2025/26** • **General Practice** • **Pharmacy** *For Noting*	**SN/SWh/SG**
	SN and SG provided detailed overviews of the national contracts for 2025/26 for General Practice and Pharmacy for noting. SN highlighted the Government's commitment to reducing bureaucracy, increasing flexibility around the Additional Roles Reimbursement Scheme (ARRS), and focussed on prevention for major health issues. The one-year contract agreement included a 7.2% cash growth, with an estimated 4.8% real growth. Key improvements included an increase in the global sum payment per weighted patient and an uplift in the Quality and Outcomes Framework (QOF) points. The contract also emphasised the importance of continuity of care and the use of population health management to address health inequalities. SN noted the sign-up process for practices had begun, with a focus on improving access, reducing elective treatment wait times, and addressing health inequalities. SG discussed the Community Pharmacy Contractual Framework (CPCF) for 2025/26, which included a 19.7% increase in funding. SG emphasised that while this was a significant uplift, it was aimed to address the flat funding of the past five years. The contract included increases in service remuneration and continued funding for Pharmacy First, with plans to expand services such as the new contraception service. SG highlighted the importance of supporting the increase in activity for these services and noted the economic analysis commissioned by NHS England, which revealed a significant funding shortfall for pharmacies. Despite the positive step of the new contract, SG acknowledged financial viability concerns remained for many pharmacies. SG emphasised the need for a revised funding model to ensure long-term sustainability and mentioned the ICB's plans to develop a long-term pharmacy strategy. Both items were noted.	
16.	**E-Declaration Report for General Practice** *For Approval*	**SN**
	SN introduced the E-Declaration Report for General Practice for approval. SN emphasised its importance as a key contractual requirement. Out of 105 practices, 99 completed the annual requirement, with six practices having faced challenges such as system access issues and staffing problems.	

	SN highlighted 100% of practices confirmed compliance with regulatory and professional registration requirements, and all reported their premises were fit for purpose. The report also showed strong compliance in areas such as infection prevention control and the use of language and interpretation services. However, there were areas which needed improvement, including practice closures during core hours, strengthening local processes for NHS 111 emergency arrangements, and enhancing patient participation groups (PPGs). SN proposed an action plan to address these areas and support practices in achieving full compliance. JB confirmed the practices which had not met the requirements this year were not the same as those from previous years, indicating no recurring issues with specific practices. The report and recommendations were approved.	
17.	**Local Dispute Resolution for Primary Care Contracts** *For Approval*	**FT**
	FT introduced the paper for approval, the Local Dispute Resolution policy for Primary Care Contracts FT highlighted the need to update the outdated policy. The new policy was designed to cover primary medical, dental, and optometry services, explicitly excluding pharmacy disputes, which were managed by the Pharmaceutical Services Regulatory Committee under the pharmacy regulations and Policy manual. The policy aimed to resolve contractual disputes through a structured approach involving initial engagement with the contractor, discussion, negotiation, and, where appropriate, mediation. FT emphasised the goal was to resolve disputes amicably and only escalate to a dispute panel if necessary. The dispute panel would be convened as a last resort, and its decision could be further escalated to NHS Resolution by either party if they were not satisfied with the outcome. FT noted the policy's approach was to ensure fair and transparent handling of disputes, aiming to maintain good relationships between the ICB and contractors. The Committee approved the proposed policy, which recognised its importance in effectively managing contractual disputes and ensuring compliance with regulatory requirements. FT also mentioned the exact makeup of the dispute panel would be confirmed offline, ensuring the panel composition was appropriate for handling the disputes. The policy was approved.	
18.	**Any Other Business**	**Chair**
	There was no other business.	
	Questions from the Public One question was received on local enhanced services. The question and answer would be responded to and posted on the public facing internet.	**Chair**
	There were no further questions, and the meeting closed at 15:17 hours.	

Name:	Signature: [obj]	Date:
Signed on behalf of NHS Norfolk and Waveney Integrated Care System		

Webb Sarah
02/07/2025 11:09:26

Code
RED Overdue
AMBER Update due for next Committee GREEN Update given
BLUE Action Closed

NHS
Norfolk and Waveney
Integrated Care Board

Norfolk & Waveney IBC Primary Care Commissioning Committee - Part One Action Log
8 July 2025

No	Meeting date added	Agenda Item	Owner	Action Required	Action Undertaken / Progress	Due date	Status	Date Closed
0198	11-Mar-25	12	SN	Strategic Finance Report - Report on LCS activity, in view of lower expenditure in care homes and increased expenditure on PSA at a future Committee.	A dashboard is in process of being developed and the should be available for use to commissioners by end of Q1. The proposed plan is to produce a quarterly activity monitoring report for LCS. Suggest changing due date to July. Good progress has been made, the dashboard was successful launched on 01/07/2026 and practices have started utilising it reporting. An initial review report using the LCS dashboard will be made available to PCCC. This action is being recomended for closure and for the initial review report to be heard in October.	01-Oct-25	open	
0199	11-Mar-25	12	PD'O / SP	Strategic Finance Report - Discuss a framework for screening and immunisations	ICB have not yet been notified regarding change of delegation following the recent announcement with regard to running costs. Hold action until ICB have clarity of future delegation and responsibilities. Suggest changing due date to July. Update: Region has verbally confirmed delegation will likely still take place from April 2026 as planned and is intending to resurrect regional meetings with systems. It's likely a different approach to delegation will be required now that ICB clusters are confirmed. Suggest to close and manage through the regional working group.	08-Jul-25	open	
0200	14-May-25	4	SW	Send signed minutes to Chair	SW sent signed minutes to Chair	08-Jul-25	Closed	14-May-25
0201	14-May-25	9	SN	Integrated Performance Report - SN to clarify the alignment of dropping the two-week GP appointment metric with regional practices and ensure it does not conflict with broader NHS guidelines.	A meeting with NHSE regional colleagues was held on 1 July 2025. While no definitive answer was provided, it was acknowledged that the measure is helpful for understanding access to non-urgent GP appointments. It was agreed that further discussion should take place at the upcoming weekly regional primary care meetings with other ICBs in the region. This action can now be closed and monitored as part of the GP Access Action Plan for 2025/26.	08-Jul-25	open	
0202	14-May-25	13	SE	Strategic Finance Report M12 SE to provide a clear explanation of the dental budget underspend, covering the £1.86m in-year underspend, April–May 2025 UDA provisions, and the ~£5m NHS England clawback.	The final position for 2024/25 Dental was breakeven, which included an NHS England clawback of £5.84m. Had this not been clawed back the Dental budget would have been £5.84m underspent. The UDA provision for April to May 2025 has not been calculated, this will be picked up after Quarter 1. The UDA delivery calculation for 2024/25 is being concluded with year end clawbacks currently being finalised. Propose to close.	08-Jul-25	open	
0203	14-May-25	13	SE	Strategic Finance Report M12 SE to clarify whether the pharmacy budget is ring-fenced and if the late payment received at the end of the year will be carried forward	The Pharmacy budget is not ring fenced therefore the 2024/25 underspend wasn't carried forward. Propose to close.	08-Jul-25	open	

NWICB Primary Care Commissioning Committee Part One 2025-2026

Item	14-May-25	08-Jul-25	01-Oct-25	12-Nov-25	14-Jan-26	11-Mar-26	Lead officer	Notes
Standing Items								
Risk Register	Y	Y	Y	Y	Y	Y	SP/FT/AS	All risks to be considered following ICB Governance Audit recommendations - link in with InPhase updates for OMB. (InPhase to be updated monthly and summary to be presented at delivery groups) AS to write the report for risks.
Service Development								
Strategic Estates Report	Y			Y			PH	Noting/assurance - bi-annual report
Strategic Digital Report			Y			Y	AH	Noting/assurance - bi-annual report
Strategic Primary Care & Workforce Recruitment and Retention Programme Report		Y			Y		JRo	bi-annual report
Pharmaceutical Needs Assessment				Y			SG	Released in October 2025
Locally Commissioned Services			Y			Y	GC/SN	bi-annual report
GP Action Plan		Y				Y	SN	
Practice Visit Programme			Y			Y	SN	For Noting
Delivery Report		Y	Y	Y	Y	Y	AS/SP	Incorporate Operational Planning and Complaints For July, Update on Operational Planning which includes the GP Action Plan
Long Term Plans 2025-2026	Y			Y			FT/SN/SG	May 2025 Dental Q1 May 2025 November 2025 medical LTP
Finance and Governance								
Strategic Finance Report	Y	Y	Y	Y	Y	Y	JG	Noting/assurance
Strategic Prescribing Report	Y		Y		Y		MD	Noting/assurance quarterly
General Practice & Community Pharmacy Delivery Group Report	Y	Y	Y	Y	Y	Y	SN/SG	Noting/assurance
Dental Services Delivery Group Report	Y	Y	Y	Y	Y	Y	FT	
Dental Development Group Report		Y	Y	Y	Y	Y	FT	Noting/assurance
Terms of Reference Review						Y	FT	Approved at March ICB Board
Reports from the Pharmaceutical Services Regulations Committee	Y		Y	Y	Y	Y	SG	Noting/assurance. (1/4ly reporting)
Optometry Services – contractual changes and other matters				Y		Y	SG	Noting/assurance
Freedom to Speak Up							DT	HW FTSU ICB sponsor - TBC
TIAA Report		Y					SG	
Delivery Plan for Recovering Access to Primary Care	Y						LB	GPCPDG in April, PCCC in May, Public Board May (bi-annually). (Audit process flagged to PCCC first then Board)
Strategic Framework for Primary Care		Y					AS	
Any Other business								
Policies for review								Committee are responsible for the oversight of these
Other								
Director of Primary Care Report			Y				AS	

Agenda Item 06

Norfolk and Waveney
Integrated Care Board

Subject:	Risk Summary Report
Presented by:	Sadie Parker, Director of Primary Care, NHS Norfolk & Waveney ICB
Prepared by:	Sadie Parker, Director of Primary Care, NHS Norfolk & Waveney ICB, Sarah Webb, Primary Care Administrator, NHS Norfolk & Waveney ICB
Submitted to:	Primary Care Commissioning Committee
Date:	8 July 2025

Purpose of Paper:

To provide an overview of risks held at Committee and changes in risks/risk status.

Executive Summary:

New risks escalated: No new risks

Changes to held risks: No changes to held risks.

Risks de-escalated: No risks de-escalated.

The team continues to monitor the impact of these identified risks on each primary care contractor group. The ICB's financial position and the need to identify recurrent and non-recurrent savings, could mean difficult funding decisions needing to be made which impact primary care and potentially further exacerbate these risks. The team is currently working on options for identifying potential commissioning changes as part of financial recovery, which will be discussed in detail with contractor groups/ their representatives in due course.

Recommendation to Committee:

To approve risk report.

Governance

Committee Approval	Primary Care Commissioning Committee July 2025

1. Board Assurance Framework (BAF) risks			2025-26 Monthly Risk Rating (April-March)											
Ref.	Risk Title	Tolerated	1	2	3	4	5	6	7	8	9	10	11	12
32	BAF02 - **Primary Care Resilience and Transformation**	12	20	20	20									

2. Board Operational Risk Register (BORR) and Operational Risk Register BORR/ORR risks				2025-26 Monthly Risk Rating (April-March)											
	InPhase Ref.	Risk Title	Tolerated	1	2	3	4	5	6	7	8	9	10	11	12
BORR	29	**BORR08 - Secondary care dental services (Oral Surgery and Maxillo Facial Services, Orthodontic Services)**	12	20	20	20									
	25	**BORR09 Resilience of NHS General Dental Services in Norfolk and Waveney**	12	20	20	20									
	71	**BORR Special Care Dental Services**	12	16	16	16									
	23	**BORR11 The resilience of general practice**	12	16	16	16									
	56	**BORR27 The resilience of Community Pharmacy**	12	16	16	16									
ORR	53	**ORR17 General Practice – Allied Health Professionals Workforce including PCN Additional Roles**	8	12	12	12									
	54	**ORR18 General Practice – Workforce (GPs and Nurses)**	8	12	12	12									
	55	**ORR19 Severe Mental Illness (SMI) Annual Physical Health Checks**	8	12	12	12									
	tbc	**PC06 Learning Disability Annual Physical Health Checks**	9	9	9	9									

1. Board Assurance Framework (BAF) risks			2024-25 Monthly Risk Rating (April-March)											
Ref.	Risk Title	Tolerated	1	2	3	4	5	6	7	8	9	10	11	12
	BAF02 - **Primary Care Resilience and Transformation**	12					20	20	20	20	20	20	20	20

2. Board Operational Risk Register (BORR) and Operational Risk Register BORR/ORR risks				2024-25 Monthly Risk Rating (April-March)											
	Ref.	Risk Title	Tolerated	1	2	3	4	5	6	7	8	9	10	11	12
BORR		**BORR08 - Secondary care dental services (Oral Surgery and Maxillo Facial Services, Orthodontic Services)**	12			16	16	16	16	16	16	16	16	16	16
		BORR09 Resilience of NHS General Dental Services in Norfolk and Waveney	12	20	20	20	20	20	20	20	20	20	20	20	20
		BORR11 The resilience of general practice	12	16	16	16	16	16	16	16	16	16	16	16	16
		BORR27 The resilience of Community Pharmacy	12							16	16	16	16	16	16
ORR		**ORR17 General Practice – Allied Health Professionals Workforce including PCN Additional Roles**	8	12	12	12	12	12	12	12	12	12	12	12	12
		ORR18 General Practice – Workforce (GPs and Nurses)	8	12	12	12	12	12	12	12	12	12	12	12	12
		ORR19 Severe Mental Illness (SMI) Annual Physical Health Checks	8	12	12	12	12	12	12	12	12	12	12	12	12
		ORR16 Hypnotics and anxiolytics prescribing – propose to move to Medicines Optimisation Programme Board	9	12	12	12	12	12	12	12	12	12	12	12	12

Appendix 1 – Risk management structures

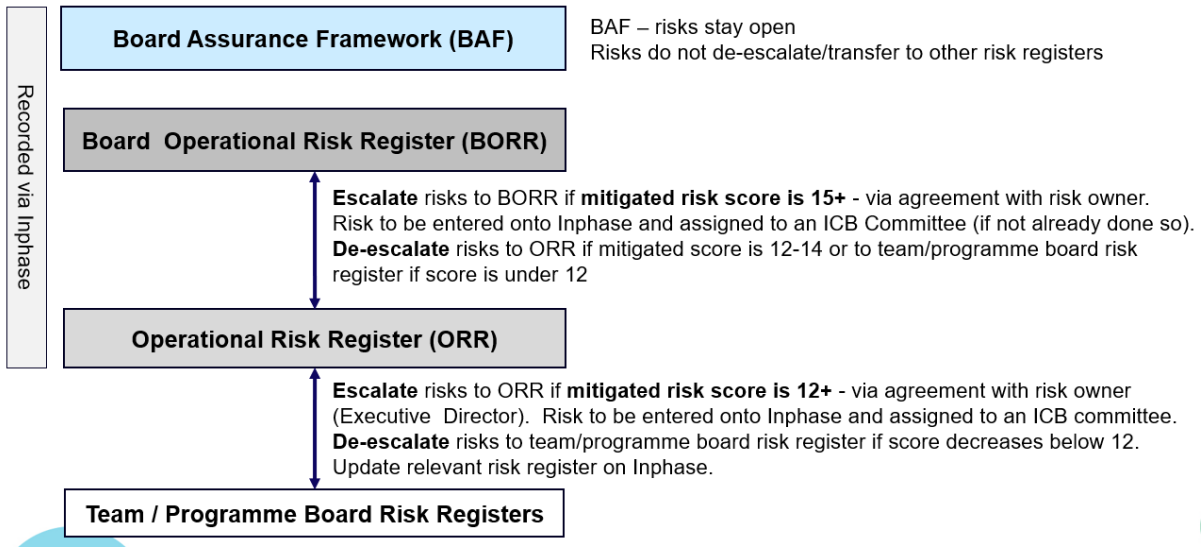
Board Assurance Framework (BAF)
- Strategic risks aligned to the eight ambitions within the Joint Forward Plan
- Risks stay open
- BAF is reported to the Board in public

Board Operational Risk Register (BORR)
- Committee risks with a mitigated risk score of 15+
- Risks reviewed and challenged by the Executive Management Team
- BORR is reported to the Board in public

Operational Risk Register (ORR)
- Committee risks with a mitigated risk score of 12+
- Reported to EMT & reviewed by committees

BAF, BORR and ORR Risks are:
- **Recorded and reported on via inphase**
- **Owned by an Executive Director**
- **Aligned to an ICB Committee**

Team / Programme Board risk registers
- Mitigated risk score under 12
- Risk registers should be reviewed at least monthly.
- Managed within each team.



Risk Id	Risk Title	Description	Risk Owner	Risk Committee	Operational Lead	Date Risk Identified	Target Delivery Date
23	The resilience of general practice	• There is a risk to the resilience of general practice due to several factors including workforce pressures and increasing workload (including workload associated with secondary care interface issues). • There is also evidence of increasing poor behaviour from patients towards practice staff, leading to retention and recruitment issues. • Following the GP contract agreement, the BMA campaign has been paused at a national level, however, the actions may continue at a local level. The participation of individual practices is a choice for them. • The initial national GP contract price uplift does not cover the required increase in meeting the minimum wage, however global sum has since been further uplifted. • The LMC wrote to practices to cease uncommissioned work. Further communications are likely. • Individual practices could see their ability to deliver care to patients impacted through lack of capacity and the infrastructure to provide safe and responsive services will be compromised. • This will have a wider impact as neighbouring practices and other health service partners take on additional workload which in turn affects their resilience. • This may lead to delays in accessing care, increased clinical harm because of delays in accessing services, failure to deliver the recovery of services adversely affected, and poor outcomes for patients due to pressured general practice services.	Mark Burgis	Primary Care Commissioning Committee	Sadie Parker	01-Sep-20	31-Mar-26

Unmitigated Score	Mitigated Score	Target Score	Control Description
20	16	12	Commencement of LMC General Practice Alert System sitreps
			PCN ARRS (additional roles reimbursement scheme) funding has provided additional capacity but has not grown in this contract year. GPs have been added to the scheme.
			Locality teams and strategic primary care teams structured around supporting the resilience of general practice. All practices have previously been supported to review business continuity plans.
			Standard contract requirements on interface - gap analysis and action plans, including monitoring being reviewed by contracts team. New national requirement for providers to self-assess using national toolkit 6-monthly.
			Primary care workforce and training team working closely with locality teams to ensure training available to support practices and PCNs in setting up and maintaining services
			Contractual requirement for commissioners to have a 3 year rolling programme to review service quality and contractual compliance for the agreed medical services contracts.
			Local interface groups have been established and commenced in an informal capacity from May 25. The system leads continue to meet quarterly. This aims to support the resilience of practice by establishing firm engagement with all provider leads.

25	Resilience of NHS General Dental Services in Norfolk and Waveney	Primary Care Services became the responsibility of the Integrated Care Board from 1st April 2023, the risk is the unknown resilience, stability and quality of dental services, and critical challenges relating to the recruitment and retention of dentists and dental care professionals and the limitations of the national dental contract. This could lead to a poor patient experience for our local population with a lack of access to NHS general dental services and Level 2 dental services and increased demand on secondary care services, including emergency departments.	Mark Burgis	Primary Care Commissioning Committee	Sadie Parker	01-Apr-23	31-Mar-26

20	20	12	Clinical expertise provided by NHSE through the Regional Chief Dental Officers, MCN supported by ICB Senior Clinical Fellow roles during 2024/2025 for strategic development, transformation and commissioning purposes.	To tender for Out of Hours service in King's Lynn 12/6/2025 - interim solution being explored to start Sept 2025	Fiona Theadom	17/04/2025	31/07/2025
			Ring fenced dental budget for investment	16/4/2025: tender published for new contract in Holt and Wells	Fiona Theadom	20/02/2025	31/07/2025
			Dental Development Group established to engage with key stakeholders to to commissioning plans, including the Long Term Dental Plan.	To mobilise the Shared Care Pathway with local providers and to agree referral pathway from secondary care to primary care 30/5/2025: discussions to agree referral pathway from secondary to primary care taken place and Dental Development Group views sought. Long term solution being assessed, options for an interim solution being explored. Providers selected. Training plans being developed. Delay due to challenge finding referral pathway solution.	Fiona Theadom	20/02/2025	31/07/2025
			Dental Services Delivery Group established reporting to PCCC				
			Active engagement is taking place with dental contractors, LDC and Local Professional Network (and Managed Clinical Networks); A regular dental newsletter is in place				
			ICB primary care team recruited and in place working alongside newly recruited Quality Dental Nurse in Quality team and Finance colleagues, and Planned Care Team (for secondary care dental services)				
			NHS Business Services Authority performance/quality management reporting and quality framework in place with regular meetings established with the ICB. Access to eDen dental data management reports and dashboard for ICB staff.				
			NHS England Long Term Workforce plan published June 2023				
			Clinical Dental Advisor role recruited for ICB in 2024 to replace NHS England roles				
			Dental Data Review being updated to inform commissioning plans.				
			Dental Long Term Plan and local Primary Care Workforce Plan agreed 7 May 2024 sets out ambitions for primary care, Level 2 and secondary care service collaboration				
			Primary care workforce and training team working closely with primary care commissioning team to ensure workforce retention programmes and training support is linked to the Dental Delivery Plans.				

29	Secondary care dental services (Oral Surgery and Maxillo Facial Services, Orthodontic Services)	Primary Care Services, and secondary care dental services, became the responsibility of the Integrated Care Board from 1st April 2023, the risk is the unknown resilience, stability and quality of secondary care dental services, and critical challenges relating to the recruitment and retention of professionals and waiting lists, and resources within the ICB Primary care team to implement the recommendations from the East of England NHSE report lack of resources to monitor and manage 3 secondary care contracts.	Mark Burgis	Primary Care Commissioning Committee	Sadie Parker	01-Feb-24	31-Mar-26

20	16	12	Active engagement with dental contractors, secondary care, LDC and Local Professional Network (and Managed Clinical Networks), regular dental newsletter in place	16/4/2025: Trauma service extended into 2025/2026. Task and Finish Group established with all ICBs in region to monitor and agree outcome from April 2026 MOU in draft form 12/6/2025: new reporting form in use by providers, claims validated by MCN Chairs prior to payment authorisation by ICB. T&F Group meets weekly to review data, discuss concerns and agree remedial action plan.	Fiona Theadom	01/04/2025	31/03/2026
			Clinical expertise provided by NHSE through the Regional Chief Dental Officers and Managed Clinical Networks extended for 2024/2025 for strategic development, transformation and commissioning purposes.	Shared Cared pathway under development by ICB. 02/20/2025 service specification finalised. Small number of providers (3 - 4) selected to participate. Working with NHSE WTE to agree training for provider dental teams. Considering options for referral pathway from secondary care to provider. 20/03/2025 Options for referral pathway discussed with Digital team 12/6/2025: delay in finding solution to referral pathway, approval for interim solution being sought. Training for providers being planned.	Sadie Parker	01/05/2024	31/07/2025
			Dental Long Term Plan and local primary care Workforce Plan agreed 7 May 2024 sets out ambitions for primary care, Level 2 and secondary care service collaboration	Suffolk and North East Essex ICB (SNEE) lead for East of England (EoE) ICBs in relation to secondary care matters that rely on collaboration and wider impact across EoE and for escalation., MOU agreed by Primary Care Directors. 02/20/2025 MOU work programme and resource need under review for 2025/2026. ICB requesting baseline data from N&W acutes by end March to inform next steps and support. SNEE project team reviewing oral surgery data (L2 and L3) with MCN Chair support 20/03/2025 SNEE programme team have requested oral surgery data from Referral Management system provider. ICB reviewing request with IG team. SNEE programme to continue into 2025/2026, no additional resource required - completion date extended to 30/9/2025 16/4/2025 update: Programme report progress to date published to ICBs, to present to Dental Services Delivery Group in June 2025(for noting) and to Dental Development Group for discussion 30/5/2025 - report to DSDG in June	Sadie Parker	01/05/2024	30/09/2025
			Dental Development Group established to engage with key stakeholders to input to commissioning plans	Baseline data requested from 3 secondary care providers, received from NNUH 04/03/2025 and JPUH 12/6/25. QEH data response chased. Unable to review data until all three reports received.	Fiona Theadom	20/02/2025	31/07/2025
			Dental Services Delivery Group established reporting to PCCC	To draw up an Equality Impact Assessment and Clinical Quality Risk Assessment with support from Quality team 20/03/2025 Baseline data has been requested from secondary care providers to inform EHIA completion. Date for completion revised to end May 2025 12/6/2025 Baseline data for 1 acute pending receipt. Limited resources within the dental team to complete EHIA may delay completion further.	Sadie Parker	01/05/2024	31/08/2025
			NHS England Long Term Workforce plan published June 2023				
			NHSE Recommendations for secondary care services in East of England 2024 published.				
			ICB primary care team recruited and in place working alongside newly recruited Quality Dental Nurse in Quality team and Finance colleagues to manage primary and community care contracts.				
			Ring fenced dental budget for investment				
			Suffolk and North East Essex ICB (SNEE) lead in region for secondary care work programme.				
			Clinical Advisor for Dentistry recruited to ICB from October 2024				
			Monthly OMFS meetings in place all ICBs in region				

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32	Primary Care Resilience and Transformation	Under the Joint Forward Plan we have committed to integrating primary care services to deliver improved access (including digital tools and remote monitoring offers, etc.) to a wider range of services from multi-professional teams, focused on preventing illness and improving outcomes for our population within their communities. Our high-level outputs include: • Developing a vision for providing accessible enhanced primary care services • Improving patient outcomes and experience • Stabilise dental services and setting a strategic direction for the next five years Primary Care Services are the responsibility of the Integrated Care Board, including the recruitment and retention of healthcare professionals. There are particular risks to the resilience of general practice, access to NHS dentistry treatment and Level 2 dental services which are reflected in the risk scores. The community pharmacy and optometry landscape is less defined at the time of writing, but workforce and funding challenges are evident across community pharmacy which represent a risk, but could potentially be supported through greater integration and collaborative working with other primary care providers. Limitations of national contracts, collective action by General Practice, independent contractors 'handing back' NHS contracts, workload pressures, recruitment and retention and interface challenges are, together, impacting on access to high quality, sustainable primary medical, community pharmacy and dentistry services together with Level 2 dental services for our population. This may lead to delays in accessing care, unavailability of care (particularly dentistry), increased clinical harm because of delays in accessing services, failure to deliver the recovery of services adversely affected, and poor outcomes for patients due to pressured, and fragile services. As the cornerstone of healthcare, primary care resilience risks system ability to deliver against key workstreams, including the overall aim of moving towards a more population-based proactive community model of care which addresses prevention, health inequalities and improves outcomes. Reduced access in primary care may also impact on the resilience of other system providers.	Mark Burgis	Primary Care Commissioning Committee	Sadie Parker	29-Aug-24	31-Mar-27

20	20	12	Operational readiness work is seeking to align the Primary Care Team with colleagues from Workforce, Estates, Digital, Place, Quality, Planned Care and Finance, etc. to support joined up primary care; including access to sustainable dentistry and general practice services.	10 June - all previous actions completed, risk to be reviewed and updated by end of August	Sadie Parker	28/10/2024	31/08/2025
			Clinical expertise provided by Clinical and Care Professional and Clinical Fellow roles across primary care.	The national DDRB uplift for dental contractors has yet to be confirmed and applied adding to the concerns about the impact on practice incomes in April 2025. There may be an increased risk of contract terminations. Long Term Plan 24/25 individual pathways will be fully mobilised by end March 2025. Planning for implementing 2025/26 plans has commenced to agree project plans, resources and financial impact (where relevant) for approval. 20/03/2025 To obtain approval for Phase 2 Long Term Dental Plans 2025/2026 from Operational Management Board in April and Primary Care Commissioning Committee in May 30/05/2025 Dental investment and Year 2 commissioning plans approved by Primary Care Commissioning Committee and through Triple Lock in May 2025 10 June - all actions complete, update will be given and risk reviewed by end of August	Sadie Parker	28/10/2024	31/08/2025
			Local LMC General Practice Alert System established which informs improvement and support work monitored through the PCCC.	The framework has been refreshed to reflect the changes to ICBs and the recently published ICB Blueprint. The updated document will be discussed and approval sought at July PCCC	Sadie Parker	29/05/2025	31/07/2025
			A long-term dental plan has been published, with delivery monitored through PCCC.				
			ICB organisational change programme has seen a reduction in vacancies within the Primary Care Commissioning and Strategic teams.				
			Performance/quality management and reporting in place.				
			Primary Care Access Recovery Plan delivery reported regularly to ICB Board and NHS assurance meetings.				
			Ring-fenced budgets and commissioning targeted to simultaneously support population need and resilience.				
			An overarching strategic vision and principles for primary care are being finalised to support the development long-term plans for general practice and community pharmacy during 2024/25, followed by optometry.				
			System Interface Group and matrix working in place to support national requirements for self-assessment.				
			Strong relationships in place with local representative committees across all primary care services				

53	General Practice - Allied Health Professionals Workforce including PCN Additional Roles	Lack of general practice (GP) Additional Roles (ARRS) and Direct Patient Care roles in the workforce due to vacancies and recruitment and retention challenges. The impact on the service delivery to patients.	Mark Burgis	Primary Care Commissioning Committee	Jayde Robinson	27-Dec-24	31-Mar-26

16	12	8	Advanced Practice Forum established.	Latest NHSE workforce data illustrates the following: • 2.0% decline in Direct Patient Care workforce roles across N&W during the period of April 2024 vs April 2025 (640 WTE). • 1.1% growth in non-clinical roles (1778 WTE)	Jayde Robinson	06/06/2025	31/03/2026
			AI software mapping and reports provided for vacancy levels for primary care.	As of 6th June 2025, the following positions currently advertised for recruitment within general practice, linked to this risk are: • 4 x Direct Patient Care Roles (Practice employed) • 7 x non-clinical roles (Practice employed)	Jayde Robinson	06/06/2025	31/03/2026
			Coastal and Rural project to support geographical areas facing greater challenges in recruitment, e.g. West and East				
			Communication Engagement strategies updated to reflect PCN development updates and post pandemic environment.				
			Workforce data to measure trajectory levels against actual recruitment.				
			Workforce team recruited in ICB structure.				
			Wide range of initiatives in place to support GP retention.				
			National workforce reporting service - Practices report monthly, PCNs report quarterly, contractual requirement as part of General Medical Services (GMS) and PCN Directed Enhanced Services (DES).				
			PCN ARRS Workforce - online portal for 2024/25 for PCNs to update and draw national funding down to NHSE to inform Training Hub spending.				
			Primary Care Networks (PCNs) supported to develop and implement workforce trajectories in support of the Additional Roles Recruitment Scheme (ARRS).				
			Primary Care Equality, Diversity and Inclusion Fellow recruited.				
			Primary Care Health & Wellbeing Fellow recruited.				
			Primary Care Workforce Transformation Team supported by Clinical Fellowships and Secondments				
			Primary Care Workforce Strategy 2024-2027				
			Succession planning led recruitment to support practice and PCN with demand vs capacity requirements.				
			Training Needs Analysis completed for 24/25.				

54	General Practice - Workforce (GPs and Nurses)	Lack of general practice GPs and Nurse workforce due to vacancies and impending staff retirements. The impact on the service delivery to patients.	Mark Burgis	Primary Care Commissioning Committee	Jayde Robinson	27-Dec-24	31-Mar-26

16	12	8	Advanced Practice Forum established.	Latest NHSE workforce data illustrates the following: • 0.6% decrease in Nursing workforce roles across N&W during the period of April 24 vs April 25. 436 WTE are in place across the system. • 1.7% growth in GP workforce roles (excluding training GPs) during the same period. 530 WTE are in place across the system. • 7.5% growth in GP Trainees across N&W during the same period. 148 FTE are in place across the system.	Jayde Robinson	06/06/2025	31/03/2026
			AI software mapping and reports provided for vacancy levels for primary care.	As of 6th June 2025, the following positions currently advertised for recruitment within general practice, linked to this risk are: • 2 x Practice Nurse • 2 x Advance Nurse Practitioner • 5 x Salaried GPs	Jayde Robinson	06/06/2025	31/03/2026
			Coastal and Rural project to support geographical areas facing greater challenges in recruitment, e.g. West and East				
			Communication Engagement strategies updated to reflect PCN development updates and post pandemic environment.				
			Workforce data to measure trajectory levels against actual recruitment.				
			Wide range of initiatives in place to support GP retention.				
			National workforce reporting service - Practices report monthly, PCNs report quarterly, contractual requirement as part of General Medical Services (GMS) and PCN Directed Enhanced Services (DES).				
			PCN ARRS Workforce - online portal for 2024/25 for PCNs to update and draw national funding down to NHSE to inform Training Hub spending.				
			Primary Care Equality, Diversity and Inclusion Fellow recruited.				
			Primary Care Health & Wellbeing Fellow recruited.				
			Primary Care Networks (PCNs) supported to develop and implement workforce trajectories in support of the Additional Roles Recruitment Scheme (ARRS).				
			Primary Care Workforce Transformation Team supported by Clinical Fellowships and Secondments				
			Primary Care Workforce Strategy 2024-2027				
			Succession planning led recruitment to support practice and PCN with demand vs capacity requirements.				
			Training Needs Analysis completed for 24/25.				
			Workforce team recruited in ICB structure.				

55	Severe Mental Illness (SMI) Annual Physical Health Checks	1.The ICB is at risk of failing to meet its commissioning commitment to meet the needs of its SMI population which leads to a clinical risk that patients with SMI will experience significant health inequalities and a 15-20% higher mortality when compared to their peers. 2.There is a risk that the ICB may not meet the committed national target of 75% annual health checks delivered. 3. There is a level of risk to practice resilience if the minimum threshold, and therefore payment, is not reached.	Mark Burgis	Primary Care Commissioning Committee	Sadie Parker	27-Dec-24	31-Mar-26

16	9	4	A 2-year improvement trajectory has been agreed with NHS England taking into account the revised national target	Conduct quarterly SMI working group with appropriate stakeholders.	Charles Morrow	27/03/2025	31/03/2026
			Increase SMI uptake and engagement via established communication channels, including but not limited to the GP Bulletin, Place colleagues, Intranet and Together for Mental Wellbeing channels.				
			Plan in place to increase uptake of SMI checks across N&W and regularly reviewed by PCCC and MH boards.				
			Quarterly steering group has been established with input from Mental Health and Locality colleagues to review performance, risk and to discuss any challenges or service improvements.				
			Regular assurance reports to NHSE/I & PCCC.				
			Practice sign up to the SMI LES. This provides payment for enhanced checks (An additional payment for 3 extra checks).				

56	The resilience of Community Pharmacy	The resilience of Community pharmacy is at risk due to several factors contained within this report, including workforce pressures which although workforce is led through a different directorate is incorporated within this risk due to its relevance The risk could ultimately lead to an increase in the number of permanent closures of pharmacies within our ICB which would reduce the accessibility of pharmacy services to our population. It could also lead to reduction to service provision including both core and advanced. The rurality of Norfolk and Waveney does mean that this risk is significantly projected due to geographical distance between existing providers.	Mark Burgis	Primary Care Commissioning Committee	Sharon Gardner	27-Dec-24	01-Sep-27

20	16	12	Engagement with all stakeholders to support uptake in Pharmacy services including locality teams, CPNS and the LMC	Detail Analysis of New Pharmacy Contract & Economic Report 22/05/2025 - Work in line with development of long term plan.	Gregg Syder	10/04/2025	31/07/2025
			Establishment of Head of Pharmacy Workforce role within the ICB reporting into the Chief Pharmacist				
			Procurement of provider to manage a project focussing on the integration of community pharmacy with other healthcare providers, show case good practice, identify areas of improvement and facilitate better working relationships				
			MoU in place with HWE ICB for the delivery of contractual services on the behalf of the East of England. Ability through this team to monitor contractual activity including closures but also market entry applications.				
			Integration Lead Role to continue in line with the Integration project to support local PCN support between community pharmacy and general practice to ensure opportunities available to pharmacies within clinical service additional funding is maximised				
			Quality assurance collaboration with QA ICB team in developing and maintaining the community Pharmacy risk register which outputs the pharmacy visit plan				
			Strong engagement with CPNS provides a foundation of support for contractors in maximising opportunities available both nationally and those provided locally				
			Inclusion of Community Pharmacy in the operational delivery group and also regular reporting around Pharmacy matters to PCCC				

71	Special Care Dental Services	Lack of resilience and stability for Special Care Dental Services (known as Community Dental Services)	Mark Burgis	Primary Care Commissioning Committee	Fiona Theadom	20-Feb-25	31-Mar-26	
16	12	9	Active engagement with dental contractors, LDC and Local Professional Network (and Managed Clinical Networks), regular dental newsletter in place	To review GIRFT report for community dental services with provider, assess impact and next steps 20/3/2025 meeting arranged with community dental services 2/4/2025 to discuss report and impact 16/4/25 update: Agreed to use GIRFT report outcomes indicators for reporting on a bi-monthly basis. 12/6/25: provider undertaking gap analysis of service provision and GIRFT recommendations to review with ICB and agree action plan. Bi-monthly meetings established with ICB and provider to review data collection, KPIs and gap analysis	Fiona Theadom	01/02/2025	30/06/2025	
			Clinical expertise provided by NHSE through the LPN, MCN and Senior Clinical Fellow roles during 2024/2025 for strategic development, transformation and commissioning purposes	To review service provision and waiting lists with provider at quarterly meetings to inform future commissioning need 20/3/2025 meeting arranged 2/4/2025 to review with provider 16/4/2025 update: Agreed to use outcome indicators in GIRFT report for reporting alongside waiting list information. Bi-monthly meetings to review outcomes to be set up from May 2025. 30/5/2025: meeting with CDS to agree updates to KPIs including those aligned to CFDP pathway. Key areas identified to focus on in next six months: Gap analysis against GIRFT recommendations and to identify possible areas of improvement for discussion with ICB underway. Concerns about the high number of recalls needs further understanding of reasons. Standardising pre-op assessments across all 3 acute sites to improve efficiency, availability of paediatric anaesthetists a risk. Also discussed domiciliary provision and need to liaise with other providers to minimise duplication and improve access.	Fiona Theadom	20/02/2025	31/10/2025	
			Dental Data Review being updated to inform commissioning plans	To consider opportunities for upskilling workforce through Level 2 accreditation to support recruitment and retention. Development work supported by MCN Chairs	Fiona Theadom	20/02/2025	30/06/2025	
			Dental Development Group established to engage with key stakeholders to agree short term plan by Sept 2023	Discussions taking place with ICB Primary Care workforce team, local provider and MCN Chairs to agree support from ICB schemes for recruitment 30/05/2025: CDS updated ICB at meeting on 28/5/2025 on successful appointment and advertisements for a number of clinical roles. Appointment to training posts have been paused.	Fiona Theadom	03/01/2025	30/09/2025	
			Dental Long-Term Plan and local primary care Workforce Plan agreed 7 May 2024 sets out ambitions for primary care, community dental services, Level 2 and secondary care service collaboration					
			Dental Services Delivery Group established reporting to PCCC					
			ICB primary care team recruited and in place working alongside Quality Dental Nurse in Quality team, ICB Clinical Advisor - Dentistry and Finance colleagues, and Commissioning Team (for secondary care dental services)					
			NHS England Long Term Workforce plan published June 2023					
			NHS Business Services Authority performance/quality management reporting and quality framework in place with regular meetings established with the ICB. Access to eDen dental data management reports and dashboard for ICB staff.					
			Primary care workforce and training team working closely with primary care commissioning team to ensure workforce retention programmes and training support is linked to the Dental Delivery Plans					
			Quarterly contract review meetings in place with community dental services provider					
			Ring fenced dental budget for investment					

Norfolk and Waveney
Integrated Care Board

Agenda item: 07

Subject:	**Strategic Primary Care Workforce Recruitment and Retention Programme Report 2025/26**
Presented by:	**Ben Chandler, Senior Workforce Special Projects Manager**
Prepared by:	**Jayde Robinson, Head of Primary Care Workforce Transformation** **Keri Robinson, Senior Workforce Special Projects Manager**
Submitted to:	**Primary Care Commissioning Committee**
Date:	**8 July 2025**

Purpose of paper:

To note the Programme and Financial information linked within the report.

To approve funding to the value of £2.8m to deliver the GP, Dental and Optometry Retention Programmes with the aim of increasing and stabilising Primary Care workforce across Norfolk and Waveney, supporting patient access to primary care services.

To note the operational delivery plan **(Appendix A)** which is to support sustainability resilience of the Primary Care workforce.

The total funding allocation of £2.8m has been approved through the Triple Lock process and aligns with the strategic objectives of the Primary Care Workforce Strategy, ICS Training Hub (TH) contract, and the NHS Long Term Workforce Plan.

Executive Summary:

Primary care is the foundation of health systems, providing accessible, continuous, and comprehensive care for communities. As challenges such as an increasingly complex workload, rising public expectations, workforce shortages, and an aging demographic continue to strain resources, strategic investments and planning have become essential.

To address these issues, the 2025/26 Primary Care Workforce Delivery Plan focus on the continuation and expansion of the GP, Dental, and Optometry Primary Care Programmes. Funding of £2.8 million will be allocated within 2025/26 financial year as follows: £1,500,000 for the Dental Workforce, £1,287,500 for the General

Practice Workforce, and £50,587 for the Optometry Workforce. Note the Community Workforce programme is led through the Medical Directorate.

The primary care workforce strategy aims to enhance workforce resilience, improve access to services, and address inequalities. The delivery plan aligns with the NHS Long Term Workforce Plan, Primary Care Workforce Strategy, ICS TH Contract, and Five-Year Joint Forward Plan. The programmes focus on training, retaining, and reforming workforce practices to ensure sustainability and resilience in primary care settings.

The proposed programmes are essential to meet the requirements of the ICS TH Contract and to secure workforce stability and service delivery across primary care sectors. For General Practice, the allocation reflects a 12% reduction from the 2024/25 model, due to the reduction in national funding. For Dental services, there has been an 8% increase in workforce system financial support available to ensure the adequate supply of workforce necessary to sustain primary care dentistry. There is no separate funding allocation for dental workforce initiatives and therefore this forms part of the overall dental allocation. There is no recurrent funding streams made available for optometry workforce development, which relies on successful funding bid applications to the national team.

The report identifies several risks that the proposal aims to mitigate, including limited access to NHS general medical and dental services for vulnerable patient groups, increased impact on Emergency Departments and NHS 111, and the unstable supply of workforce within general medical and dental professions.

The Paper requests approval for the allocation of 2025/26 funding as proposed, noting the support received within the operational delivery plan **(Appendix A)** to support sustainability of the Primary Care workforce. The approved funding will enable the implementation of key initiatives to train, retain, and reform the primary care workforce in Norfolk and Waveney.

Introduction

The executive summary highlights the challenges faced by the primary care workforce. Additionally, Norfolk and Waveney are experiencing significant difficulties within clinical professional groups due to various factors, owing to:

- Aging demographic of our local workforce
- Declining GP Partnerships
- Reduction in numbers of learners applying for courses and universities
- Access of dental services provision through a sustainable workforce supply
- No dental school within the eastern region, limiting recruitment opportunities
- Flexible way of working through locums and part-time sessions.

The Primary Care Workforce Strategy sets out the aspirations for the workforce going forward to enable individuals to develop and progress in roles, with a clear focus on Train, Retain and Reform.

Nationally mandated targets, list below, have been strategically aligned to the key domain areas, which include:

Train

- Increase the number of medical and dental placements within primary care settings by 50% by 2032 including enhancing training opportunities for the existing workforce to improve skills and competencies.

Retain

- Reduce workforce leaver rates by 15% within primary care by 2038, which we will Implement strategies to retain the current workforce, including career development and support initiatives.

Reform

- Grow the number & proportion of NHS staff working in primary to enable more preventative & proactive care by 73% by '2037, which includes innovation and reform workforce practices to ensure sustainability and resilience.

Building on the success from 2024/25

1. There has been a 91% uptake of all workforce programmes offered within general practice showing a 3% increase from the previous year. This has resulted in:
    a. 2% increase of GP FTE numbers since 2019 whilst the headcount has increased by 7% indicating flexible working models are in place across the system.
    b. The number of GPs in training grade has increased by 42% since 2019 which is now placing 148 GP trainers into our system.
    c. 93% of GP practices are now an approved learning organisation, increasing medical placements by 25% during 2024/25.
    d. Direct Patient Care roles since 2019 have increased by 27% within General Practice and a further 90% within Primary Care Networks, illustrating a multi-disciplinary team workforce approach being adopted within primary care settings.

2. There has been a 40% uptake of all workforce programmes offered within dentistry showing a 19% increase from the previous year. This has resulted in:
    a. Locally commissioned services being clinically supported through Dental Fellowships particularly around Child Friendly Dental Practices and Units of Dental Activity supporting dental access to our population
    b. 40% increase of approved dental training practice across the system during 2024/25 supporting Foundational Dental placements within primary care
    c. 57% increase in recruitment and retention of dental professionals during 2024/25.

Funding
The funding amount of £2.8 million has been approved through the Triple Lock process for the 2025/26 financial year, comprising:

Recurrent
- £1,500,000 for Dental Workforce, identified within the "dental ring-fenced budget"
- £1,287,500 for General Practice Workforce, utilising System Development Funding (SDF)*

Non-recurrent
- £50,587 for Optometry Workforce, awarded to N&W through an external funding bid at the end of Q4.

*Funding is provided to ICBs via Primary Care System Development Funds to support the development and running costs of a General Practice Retention programme within primary care settings. The ICB is contractually required to have this programme in place under the ICS Training Hub.

Please note: the General Practice funding amount (£1,287,500) does not include Continuous Professional Development (CPD) funding, this will be allocated as non-recurrent funding to the value of £210,677.64, which is awaiting Triple Lock approval.

Operational Delivery
The Norfolk and Waveney operational delivery plan **(Appendix A)** outlines the workforce programmes for each primary care sector on an annual basis. This dynamic plan adapts to the evolving workforce profile of primary care teams, emphasising the importance of nurturing local talent, attracting skilled individuals, and retaining staff across the system. Key stakeholders have been involved throughout the development of these programmes, which aim to enhance workforce resilience, improve patient access particularly for deprived communities, promote equality across rural, coastal, and inclusion health groups and foster innovation in care delivery. The appendix also details specific targets and KPIs aligned with the TH contract, NHS Long Term Workforce Plan, and other key frameworks, providing a roadmap for sustainable and effective workforce development for the 2025/26 financial year.

Risks
This paper identifies the following potential risks the proposal aims to mitigate.
- Limited access to NHS general medical and dental services for vulnerable patient groups and in areas of deprivation.
- Increased impact on Emergency Departments, NHS 111, and other system partners due to lack of access to NHS general medical and dental services.
- Negative impact on the overall health and wellbeing of the local population.
- Lack of patient access to NHS general medical and dental activity appointments within Norfolk and Waveney.
- Lack of health and wellbeing support offers provided to our primary care workforce teams, resulting in higher leaver rates.

- Unstable supply of workforce within general medical and dental professions across Norfolk and Waveney.
- Inability to support practice resilience, business continuity management, and service delivery, including reduced activity performance in primary care services.
- Lack of medical and dental placements across the system reducing the opportunity for a growth in workforce recruitment across the system.

It is important to note that the delivery of the operational delivery plan (**Appendix A**) relies heavily on the Primary Care Workforce Team infrastructure. However, the ongoing ICB organisation restructuring process could significantly impact this delivery, which remains unmitigated.

Conclusion

The 2025/26 funding request aims to build on the successes of the previous year and ensure the continued development and sustainability of the Primary Care workforce. The approved funding will enable the implementation of key initiatives to train, retain, and reform the primary care workforce in Norfolk and Waveney.

Recommendation to Committee:

To note the Programme and Financial information linked within the report. To approve funding to the value of £2.8m to deliver the GP, Dental and Optometry Retention Programmes with the aim of increasing and stabilising Primary Care workforce across Norfolk and Waveney, supporting patient access to primary care services. To note the operational delivery plan **(Appendix A)** which is to support sustainability resilience of the Primary Care workforce.

Key Risks	
Clinical and Quality:	Failure to invest in NHS primary care workforce will lead to reduced access and long-term health problems for our local population and a reduction in the quality of dental services
Finance and Performance:	Failure to invest in NHS primary care workforce is likely to lead to higher costs in secondary care and a reduction in patient charge revenue which may result in a cost pressure for the ICB in the future
Impact Assessment (environmental and equalities):	Implementation of the proposed short-term plan will help to reduce some health inequalities in improving access to some services.
Reputation:	The ICB's reputation will be negatively impacted if it is unable to deliver its commitment to implementing a short-term plan to stabilise NHS dental service workforce. This programme seeks to build on our HSJ award nomination success.

Legal:	N/A
Information Governance:	N/A
Resource Required:	Primary Care, Quality, Finance, Workforce, Local Professional Network and Managed Clinical Networks
Reference document(s):	Dental contract regulations, NHS England Dental Policy Handbook, Oral Health Needs Assessment 2023, TH contract
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	25 - Resilience of NHS General Dental Services in Norfolk and Waveney 32 - Primary Care Resilience and Transformation 53 - General Practice: Allied Health Professionals Workforce including PCN Additional Roles 54 - General Practice: Workforce (GPs and Nurses)

Governance

Process/Committee approval with date(s) (as appropriate)	

KPI	KPI Description	Clarification	Baseline Guidance	Our Baseline
1	% of PCNs offered support on workforce planning, advice, and identification of needs for patients and populations.	Training Hubs are expected to offer support on workforce planning for the benefit of patients and population. Training Hubs will need to share examples they have used across the regions. This may include dedicated workshops or the use of workforce planning tools. Many KPIs are dependent on system requirements around workforce planning and the Training Hub offer. It is important to note that Training Hubs will need to demonstrate what support they offer, although not all PCNs will take it up.	Regions to establish a baseline date with an ambition to meet 100% coverage by year 3.	100%
2	% of nurses and allied health professions (AHP) staff offered continuing professional development (CPD) funding.	Training Hubs are required to demonstrate how they will support the workforce to access CPD although not all will take it up. This may be through investing, planning (understanding the needs of the workforce) and promoting relevant CPD events across a system. Other examples could include sending emails outlining any opportunities available or providing relevant webinars.	Regionally determined.	100%
3	% increase of nurses and AHP staff take-up of CPD funding.	Looking at data extracted from the baseline date to see if there is a decrease in the number of workforce accessing CPD. A summary of the reasons why, could be inserted in the comments section of the survey. Please note that this funding is agreed annually and stated in the national specification.	To be regionally determined based on previous year's figures.	10%
4	% of primary care workforce offered training provided by the ICS Training Hub.	Number of ICS agreed workstreams promoted and delivered or commissioned through Training Hubs. There will not be a requirement to deliver training to all the workforce as there will be many interdependencies, such as type of training, sources of funding, etc.	Total number of workforce in post using National Workforce Reporting Service (NWRS) data from the baseline date.	75%
5	Breakdown of professions undertaking training	Includes those on the additional roles reimbursement scheme (ARRS) clinical and allied health profession (AHP) roles listed on the Heath and Care Professions Council (HCPC) website.https://www.hcpc-uk.org/about-us/who-we-regulate/the-professions/	List of all professions in primary care as of the baseline date, to be regionally determined.	No set baseline. Free text only
6	Number of non-clinical apprenticeships supported across primary care	There are many interdependencies within this KPI including apprentice employer responsibilities. Understanding needed around how Training Hubs support the take-up of non-clinical apprenticeships across primary care. This could include transferring levy or signposting to places such as the Health Apprenticeship Standards Online (HASO) website or accessing further support from HEE Apprenticeship Relationship Managers. https://haso.skillsforhealth.org.uk/	Year 1, % to be determined by regions, based on current baseline figures and growth projections across an ICS footprint for primary care, year 2 and year 3, to be determined.	No set baseline. Numberical answer.
7	Number of clinical apprenticeships supported across primary care.	There are many interdependencies within this KPI including apprenticeship employer responsibilities and an understanding around how Training Hubs can support the take-up of clinical apprenticeships across primary care. This could include transferring levy or signposting to places such as the HASO website or accessing further support from HEE Apprenticeship Relationship Managers. https://haso.skillsforhealth.org.uk/	Target to be determined by regions, based on current baseline figures and growth projections across an ICS footprint for primary care.	No set baseline. Numberical answer.

8	% of PCNs utilising Knowledge and Library Services (KLS)	The NHS Knowledge and Library Hub connects healthcare staff and trainees to a significant range of high-quality knowledge and evidence resources, services, tools, and databases. Accessed using NHS OpenAthens (either sign in or register) or through your local NHS Health library. Some Training Hubs have access to dedicated primary care KLS specialists. The ambition is for all Training Hubs to promote utilisation of the Knowledge and Library Services.	Target to be determined by regions based on access to Knowledge and Library Services	10%
9	Training Hubs have an equality, diversity, and inclusion (EDI) strategy with an operational plan to support the ICS EDI strategy.	Training Hubs can only influence the education and training section of an ICS strategy. The response for this question will be a narrative.	ICS plans – regions to provide local context.	Yes, with narrative to provide detail.
10	Training Hubs to deliver education and training activity based on ICS plans to reduce health inequalities	The response for this question will be a narrative. Training Hubs are requested to scope and implement requirements based on ICSs working closely with relevant organisations.	ICS strategy on reducing health inequalities.	Yes, with narrative to provide detail.
11	Number of EDI events to support the ICS EDI strategy.	The number of EDI events held per region. The purpose and aims of any events will require system engagement and an understanding of the key educational priorities to be addressed. Some of these events could be raising awareness or formulating the ICS EDI strategy from a primary care perspective.	To be determined by the regions.	1, with narrative to provide detail.
12	Engage with HEEs Differential Attainment (DA) Leads to access the support toolkit and guidance on reducing differential attainment.	Training Hubs are requested to work with HEE regional staff to access support and guidance from DA leads including the DA toolkit (https://learninghub.nhs.uk/). This KPI will drive better understanding around how Training Hubs can support the reduction of differential attainment.	Regionally dependant.	Yes
13	Training Hubs are expected to demonstrate their process for dealing with complaints and quality concerns to include a) Number of quality concerns raised. b) Number of complaints received.	Quality data is available through the National Education and Training Survey (NETS). In addition, Training Hubs are required to provide information about how they collect, report and deal with any concerns, complaints, or issues.	To be determined by Training Hubs.	No set baseline.
14	% of placements increase.	Training Hubs are working with HEE local offices to increase placement capacity at scale, through the recognition of learning environments, some at PCN level for the multi professional workforce. This KPI focuses on the number of new training programme or university course placements required. These will only be placements facilitated by the Training Hub and may not include groups such as GP trainees where Training Hub involvement is limited.	10% +, to be determined by regions based on current placement approval, data, and growth projections across an ICS footprint for primary care.	10%
15	All professions to be offered practice placements.	This KPI focuses on the range of professions that Training Hubs work with. Support for practices taking on learners from a variety of programmes through practice placements. These include all ARRS roles (where educational placement is required), AHP learners and GP places (where appropriate). The HEE quality management process to increase learning environments and educators supports this KPI to approve multi professional learners at scale.	Region to determine.	Not set baseline. Tick box for professions and free text for others.
16	Compliance with regulatory standards and HEE Quality Framework.	Assurance that the HEE process for recognition of learning environments and educators has been followed. All placements should comply with professional regulatory standards and the HEE Quality Framework.	Percentage of placements facilitated by the Training Hub meeting standards within the HEE Quality Framework.	100%
17	% increase in the number of approved educators and supervisors.	Aligned to the HEE quality management process for primary care. This will also include recognition of roadmap verification supervisors for the first contact practitioners (FCP) programme.	To be determined by regions based on the number of trained and approved supervisors. Total number of educators in post from the baseline date.	10%

18	Number of educators and supervisors who have attended educational update training provided by Training Hubs	t will be important to consider what update training can be provided for educators and supervisors. Training Hubs are encouraged to signpost or deliver relevant training where appropriate. This KPI will identify what training the Training Hubs are involved in (scoping, delivering, or signposting.)	To be determined by Training Hubs and regions.	High variance across 6 systems. To be determined once all plans have been submitted.
19	% of PCNs who are actively engaged in promoting new roles and how new ways of working in primary care can support population health needs.	Requires both narrative as well as numeric data. The intention is to monitor active engagement with PCNs around the understanding of new roles and how they can support new ways of working in primary care around population health needs. Examples could include providing delivery of fellowship programmes, supporting transition into primary care, or helping the rollout of the FCP career roadmaps.	Target to be determined by regions	40%
20	Number of newly qualified health professionals who are supported to take up a primary care role.	This KPI has many interdependencies, but this is specific where Training Hubs have worked to support learners and trainees who have then been employed - post qualification into primary care. It is expected that some of this information is kept by the Training Hub, with further opportunity to work with employers to understand how they have supported the transition into primary care. This will usually apply to GPs, nurses, and physician associates (PAs).	To be determined by regions.	20

Norfolk and Waveney
Integrated Care Board

Subject:	**Primary Care Strategic Framework and Workstreams**
Presented by:	**Amanda Sear, Head of Primary Care Strategic Planning**
Prepared by:	**Amanda Sear, Head of Primary Care Strategic Planning**
Submitted to:	**Primary Care Commissioning Committee Part One**
Date:	**8 July 2025**

Executive Summary

The framework has been developed following feedback from PCCC in March and incorporates conversations with stakeholders as requested by Committee Members.

The adoption of the framework and workstreams will see a focus across four key areas for the remainder of the 2025/26 financial year

- Primary Care Input into System Planning and Decision Making
- Understand resource, demand and capacity
- Role of Primary Care in Tackling Health Inequalities
- Future Models of Primary Care

Background:

The Primary Care Strategic Framework is intended for a wide audience, including those receiving, delivering, planning and working in partnership with primary care. It is presented at a time of great change for all parts of our Integrated Care System, with four workstreams proposed for 2025/26. The workstreams are designed to support the development of sustainable primary care provision and enhanced services delivered in the community, required for the transition to neighbourhood health care models.

The framework was revised to incorporate feedback following the PCCC discussion in March. It was revisited in the light of the announcement made by the Secretary of State for Health and Social Care on 1 April on ICB running costs and the subsequent publication of the ICB Blueprint V1 and cluster working arrangements with Suffolk and North East Essex ICB.

It sets out an approach for system partners to work together with us to enable primary care contractors to be well-equipped to understand the needs of their population, ensure access to high-quality services and prioritise resource and work collaboratively in a way which improves population health outcomes.

The framework builds on the vision and principles for primary care agreed during 2024 and should support the delivery/development of long-term plans for dentistry, community pharmacy, general practice and optometry.

It proposes four areas of focus for the remainder of the 2025/26 year, thought to be critical in supporting primary care to be a credible and confident system partner, with contractors working together to understand and respond to the needs of their population, aligned with the national direction of travel.

The approach set out in the framework reflects the need to strengthen primary care as part of the development of neighbourhood health care models.

The adoption of the framework and workstreams form part of our GP Action Plan, required as part of our NHSE 2025/26 Priorities and Operational Planning Guidance submission.

Workstreams under the Primary Care Strategic Framework will form part of our GP Action Plan, as part of wider ICS operational delivery plans for 2025/26. They will be delivered in a way to reflect Joint Forward Plan Ambitions for 2024/25 – 2028/9 Primary Care Resilience and Transformation and will take learning from the SNEE Future Shift, seeking to embrace the principle of collective accountability across all partners within the ICS to make enhanced care available in primary care settings which responds to the needs of our population at a neighbourhood level.

Recommendation:

The Committee is asked to approve the Primary Care Strategic Framework and four workstreams for the remainder of the 2025/26 financial year:

- Primary Care Input into System Planning and Decision Making
- Understand resource, demand and capacity
- Role of Primary Care in Tackling Health Inequalities
- Future Models of Primary Care

and agree to review progress and provide assurance against delivery on a quarterly basis through the Committee or Operational Delivery Groups

Key Risks	
Clinical and Quality:	Population health outcomes and capacity in primary care could be improved through wider engagement with tools and support programmes available
Finance and Performance:	Care capacity can be negatively impacted due to inefficient working arrangements across the primary care
Impact Assessment (environmental and equalities):	Increased capacity and capability could increase the ability to address health inequalities.
Reputation:	Integrated Care Boards (ICBs) hold delegated responsibility from NHS England for commissioning and overseeing primary care, which includes ensuring its long-term viability. Neighbourhood health guidance emphasises the importance of strengthening primary and community-based care to enable more people to be supported closer to home or work as central to delivery the aims for all neighbourhoods over the next 5-10 years.
Legal:	None identified
Information Governance:	None identified
Resource Required:	ICS partners will need to work together, to support the development of primary care to be credible and confident system partner, with contractors enabled to offer service which are fit for the future
Reference document(s):	NSHE Priorities and Planning Guidance 2025/26 https://www.england.nhs.uk/long-read/2025-26-priorities-and-operational-planning-guidance/ NSHE Neighbourhood Health Guidelines 2025-26 https://www.england.nhs.uk/long-read/neighbourhood-health-guidelines-2025-26/
NHS Constitution:	https://www.england.nhs.uk/publication/primary-medical-care-policy-and-guidance-manual-pgm/ Delegation Agreement
Conflicts of Interest:	Declarations of interest are held on record, there were no direct conflicts of interest noted for this report
Reference to relevant risk on the Board Assurance Framework	Risk to resilience of primary care and transformation, on BAF and monitored through Primary Care Commissioning Committee, current score of 20
Governance	Previous discussion at PCCC on 11 March 2025 – feedback incorporated into Framework presented to July PCCC
Process/Committee approval with date(s) (as appropriate)	N/A

Norfolk and Waveney
Integrated Care Board

Primary Care Strategic Framework

June 2025

Introduction

Primary care is key to the health and wellbeing of everyone living-in, working, or visiting Norfolk and Waveney. Most NHS contacts take place within a primary care setting.

As we await the publication of the NHSE 10-Year Health Plan in the summer of 2025, we know it will be based on '***three big shifts'*** to a ***neighbourhood care model***.

National 'three big shifts'

Hospital to community
moving care from hospitals to communities

Analogue to digital
making better use of technology in health and care

Sickness to prevention
spotting illnesses earlier and tackling the causes of ill health

Primary care is fundamental to achieving these aims, but primary care providers cannot do this alone. They will need to work with each other, their local communities and as part of the health and care system across Norfolk and Waveney to create the conditions for a neighbourhood primary care model which is fit for the future.

What is primary care

Primary care services are the day-to-day healthcare available where people live or work and usually the first-place people go when they need health advice or treatment. Primary care is made up of four 'pillars': ***community pharmacy, dentistry, general practice, and optometry***.

Who delivers primary care services

In Norfolk and Waveney, primary care services are delivered by around 450 independent contractors, many of whom are also small business owners.

Primary care contractors have seen both demand and complexity of healthcare need increase in the populations they serve. Together with recruitment and retention challenges across the clinical workforce; reductions in funding and the impact of the Covid-19 pandemic, these factors have driven changes in the way primary care services are delivered. It is, however, noted that primary care needs radical reform to reflect the integrated care systems they are part of with a focus on pro-active, patient-centred, and technologically enhanced care, to improve health outcomes and address health inequalities

Integrated Care Boards (ICBs) have been tasked with key requirements for neighbourhood health services during 2025/26, focused on population health management, modern general practice, and integrated care. The requirements aim to improve population health outcomes through collective understanding of local needs, designing targeted interventions, and ensuring efficient resource allocation. As we lean into neighbourhood care and place-based partnership working, it is worth noting that where it works well, it is often built around trusted bodies, and familiar expertise rooted in communities (e.g. community pharmacies and GP surgeries)

Primary care resilience and transformation

Our population has told us what matters to them, with primary care ***resilience and transformation*** identified as one of our eight ambitions covered by the Integrated Care System Joint Forward Plan JFP 8 Ambitions

As noted in other strategies, the word 'system' has different meaning for different people. In this case, it means organisations coming together to tackle a common goal, considering the desired outcome rather than individual or organisational interests.

The Model Integrated Care Board Blueprint sets out refreshed roles of ICBs and providers, including assumptions around the transition of some functions and activities, including delivery at scale (e.g. primary care operations and transformation) and the growth of others (e.g. shifting focus from institutions to population outcomes) Blueprint .

A managed transition of primary care **transformation and operational** functions will require a shared understanding by system partners of how we will need to work together to adapt capability and build capacity to support this. As we move towards this evolving landscape, we will be adopting new commissioning models, aligned to long-term goals and exploring sustainable, fairer funding and payment mechanisms that better support transformation

Credible primary care input into **ICB core functions** will be needed to successfully develop and deliver these. Areas such as assessing population needs; long-term development of pathways; setting strategic priorities and evaluating impact, including unwarranted care variations will all benefit from the local experience and expertise sitting within primary care.

Building the capability and capacity for primary care to become a credible, at-scale, system partner is suggested as a key building block/workstream for quarters 3/4 of 2025/26.

Background

The framework builds on the development of the primary care vision and principles agreed during 2024 and will support long-term plans for each pillar.

N&W ICS Primary Care Vision

Primary care providers working collaboratively, embedded in their communities, in a way which brings joy and meaning to the workforce and improves outcomes for the residents of Norfolk and Waveney

Community Pharmacy

Consistent offer available for advice, clinical services, and medicines 'on the high street' and online

Dentistry

Access to NHS dentistry for those who need it; prevention and urgent care; universal oral health promotion

General Practice

Access to holistic medical care from 'cradle to grave' for registered patient lists

Optometry

First point of call 'on the high street' for eye related screening, advice, and treatment

The framework aligns with to deliver key national and local frameworks to support an at-scale strategic commissioning approach to coordinated, and equitable primary care access and outcomes, including:

Norfolk and Waveney Integrated Care Strategy and Norfolk Joint Health and Wellbeing Strategy sets out the need to integrate primary care with broader health and social care services to deliver population-based care, focusing on prevention, early intervention, and holistic care. ICP Strategy

N&W Joint Forward Plan Ambition 2 – Primary Care Resilience and Transformation, aims to integrate primary care services to deliver improved access to a wider range of services from a multi-disciplinary team. JFP Ambition 2

N&W Health Inequalities Framework for Action highlights the shared accountability for all ICS partners in addressing health disparities by targeting resources and interventions where they are most needed, especially in underserved communities. Primary care is central to identifying and addressing the social determinants of health, improving access to care, and ensuring services are tailored to the needs of diverse communities. Health Inequalities

N&W Population Health Management Strategy focuses on the role of data to shape proactive care models. By identifying at-risk populations early and addressing health inequalities through targeted interventions, the strategy aims to reduce preventable disease and hospitalization. Primary care plays a pivotal role in implementing this strategy through consistent coding, early identification, risk stratification, and the management of long-term conditions. Population Health

N&W Clinical Strategy focuses on integrating NHS services. It includes the development of new care models, reducing variation, and ensuring services are evidence-based and equitable, particularly for the most vulnerable groups. Clinical Strategy

N&W People Plan and Primary Care Workforce Plans both set out our approach to recruitment and retention to develop a sustainable and diverse primary care workforce, enabling professionals to deliver high-quality care to all patients. People Plan

N&W Digital Roadmap outlines how digital tools can enhance the delivery of care in primary care settings, enable better data sharing, digital consultations, and remote monitoring, especially for those with complex and long-term health conditions. Digital

Fuller Stocktake recognises that primary care remains the cornerstone of health and care systems. Developing integrated, accessible, and proactive care on a neighbourhood footprint to communities, with special attention to people with complex needs and health inequalities are key themes. Fuller Stocktake

Darzi Report stresses the importance of delivering services closer to home through integrated primary and community care, enhancing patient outcomes through seamless service delivery and reducing reliance on acute services. Darzi Report

NHSE 2025/26 Priorities and Operational Planning Guidance includes reference the central role of primary care in delivering accessible, proactive, and integrated healthcare at a neighbourhood level. It includes a requirement to increase the number of urgent dental appointments and improve access to general practice during 2025/26. 25/26 Guidance

Recognising that we are working in an evolving landscape, the work programmes to support the adoption of this framework will be continually reviewed to align national and local developments.

What are we trying to achieve

The framework takes a broad view of primary care, aligned to our ICS Primary Care Vision & Principles agreed last year. It will underpin long-term plans for each of the four pillars. Together these plans will be designed to enable a unified approach by primary care contractors in shaping neighbourhood care models for our population.

The framework and priority areas for quarters 3 & 4 2025/26 will need to link with ***primary care resilience and transformation***, as set out in the ICS Joint Forward Plan JFP Primary Care Ambition .

Resilience and Transformation

For the purposes of this framework, resilience and transformation for primary care is viewed through the following lens:

Resilience - a whole system approach to creating conditions for primary care contractors to anticipate, plan and adapt to change, opportunity and challenge, rather than react or resist – ensuring our population have access to enhanced primary care services which are fit for the future

Transformation - primary care-led, system-enabled, progressive journey to build strong foundations by '*doing things smarter'*, progressing to '*doing smarter things*' and ultimately *re-shaping primary care* as part of a neighbourhood care model

Access, Demand and Capacity

The largest volume of NHS patient contacts take place in primary care.

Everyone's experience of accessing care for themselves, or someone they care for, is an individual one, influenced by many things.

Experience for both those receiving and giving care can be negatively impacted when there is a mismatch between expectations and what is offered; or when there is a mismatch between demand and capacity.

To develop a system approach to improving access to primary care services, a deeper, and shared, understanding of ***demand and capacity*** across primary care is necessary. Developing a collective understanding of demand and capacity is key and suggested as a priority area for quarters 3 & 4 2025/26.

Demand is all the requests and work associated with those who come into primary care. It can be related to patient appointments, referrals, investigations, reviews, or follow up. It can come in from many sources, such as digital, telephone, walk in, automated and can be both on an ad-hoc (e.g. same day care needs) and anticipated (long-term condition reviews, repeat medication) basis.

The full range of routine primary care services are not available 24/7, so demand can build up in terms of requests for help, referrals, investigations which can lead to backlogs when these demands cannot be met at the time they are generated.

Part of understanding demand is capturing unmet demand and appreciating the impact of this on patient experience, outcomes and when/how demand can transfer to different parts of our system.

Understanding demand is key to informing allocation and prioritisation of resources to agree outcomes.

Capacity is the resources available to respond to demand.

In primary care settings this usually depends on multi-disciplinary teams being available, room availability, clinical supervision, etc. Particularly challenging is ensuring capacity across over 400+ independent contractors, is focused in the right way.

When patient demand exceeds the capacity provided then it is possible a backlog can grow despite having unused clinic slots (e.g. at particular times of the day or 'do not attend').

Balancing ‘same day’ demand with ongoing or proactive treatment and continuity of care is a particular challenge with considerations including staff annual leave, mandatory and additional study leave, sickness, time out for urgent meetings, supervision, management tasks, etc.

Understanding demand, capacity and need

Developing a collective understanding of demand, capacity and need is a key building block to reimagining what a neighbourhood response should look like, and it is suggested as a priority for quarters 3 & 4 2025/26.

Areas which could benefit from a system-wide, at scale approach include:

- Embracing the ‘digital front door’ offer; exploring greater collaboration and use of technology for ‘back office’ functions to manage demand, including ‘seasonal peaks’ in activity, staff sickness, etc.

- At scale collaboration between contractors to clinically triage and treat patients to understand and meet same day clinical need in primary care settings; avoiding staff burnout and enabling change required to design and implement neighbourhood healthcare fit for the future.

  Clinical triage, part of the national Modern General Practice model, is used to prioritise care in other settings such as A&E. It can be helpful to understand the difference between demand and need to determine where both can be best met to improve health and wellbeing outcomes.

- Strategic commissioning will need to focus on improving population health outcomes, and access to high-quality services through the best use of resource both now and in the future. Developing a structured process to understand demand, capacity and need, across primary care will support the use of existing resource and inform local commissioning going forward.

Creating the conditions

The introduction of Primary Care Networks in 2019 and the creation of the N&W Integrated Care Partnership, in 2022 provide much of the architecture required to support primary care providers to work together and move to integrated neighbourhood care.

The relational and holistic approach, seen throughout primary care, naturally lends itself to proactive care wrapped around communities and their needs. The ongoing interest from Government and NHS England signalled in the Fuller Review (2022) was reiterated in the Darzi report (2024) and is key to the 2025/26 Priorities and Operational Planning Guidance, which demonstrates the need for at-scale change has been well understood nationally for some time.

Changes to both primary care and system behaviours and mindsets are required to shift from a supply-led appointment system which consumes workforce, resources and attention, to one that puts primary care and the natural communities they serve - an estate, ward or village – at the centre of planning and investment within the system.

Our system has much to offer in terms of innovation capability, financial risk management to drive neighbourhood care. Acknowledging primary care contractors work at very different scales and with very different traditions, an at-scale system approach should support ICS organisations to come together at Place to succeed in partnership with the communities they serve.

Leaning into primary care and neighbourhood working offers opportunities to improve experience and outcomes for patients, reduce overall demand on statutory services, develop community resilience, and enable workforce retention. Our system, including primary care contractors, cannot afford not to embrace these opportunities.

Working with our population and contractors, to reimagine what primary care *'fit for the future'* will look like is a priority for everyone.

Health Inequalities

Transforming Primary Care to Tackle Inequalities

Primary care contractors are pivotal to the delivery of key aspects on our inequality and prevention commitments.

Primary care's significant, but underdeveloped, role in this area can be at risk when seen as "something extra" and funded or commissioned separately. A system approach to education and training on the social determinants of health; better sharing and integrating data information systems; maintaining effective partnerships and multi-disciplinary teams across primary care, particularly for those in leadership roles, is a priority area for transformation and resilience.

The comprehensive and inclusive approach outlined in our **Health Inequalities Framework for Action** and the **Population Health Management Strategy** must also be embraced across primary care. As part of a whole-system approach primary care contractors may need support, through data, intelligence, and fairer funding models to deliver measurable reductions in variation in outcomes and inequalities.

The role of primary care in tackling health inequalities is suggested as a priority area for Q3 & 4 2025/26.

Organising Principles

One way of delivering primary care services will not suit all providers or residents. There can be no 'one size fits all' and any future model of primary care will need to accommodate diverse ways of working, differing infrastructures and build the capacity and capability required to meet population health needs.

To be successful, transformation must be owned and led by primary care, and the adoption of the framework will be key to developing a truly whole-system approach required to enable primary care to become a confident and credible system partner.

The adoption of the framework and commitment to priority workstreams should be seen as the start of a journey: confirming commitment to an evolving system approach for moving forward. It will also support the development of long-term delivery plans for each of the four pillars over time.

Primary care contractors, able to work together at system, place, and neighbourhood level are essential for moving towards person-centred neighbourhood care models. As effective ICS partners at system, place and neighbourhood level they will need to come together with their communities to combine resource and empower their workforce without the need to change current mandates of individuals or organisations.

We are suggesting all parts of our system adopt the guiding principles below

- **Primary Care supported to work together as a credible and confident ICS Partner**
- **Primary care resilience and workforce wellbeing is everybody's business**
- **Primary care input in all stages of ICS planning and decision making**
- **Integrated teams where beneficial, hospital only when necessary**
- **Prevention, self-care, communities, and primary care first**
- **Sustainable, joined up, at-scale strategic commissioning for enhanced primary care**
- **Funding and resource to reflect population need with targeted outcomes**
- **Sharing of information to understand resource and outcomes**
- **Adoption of national and ICS strategies, working for communities not organisations**

System Priority Areas

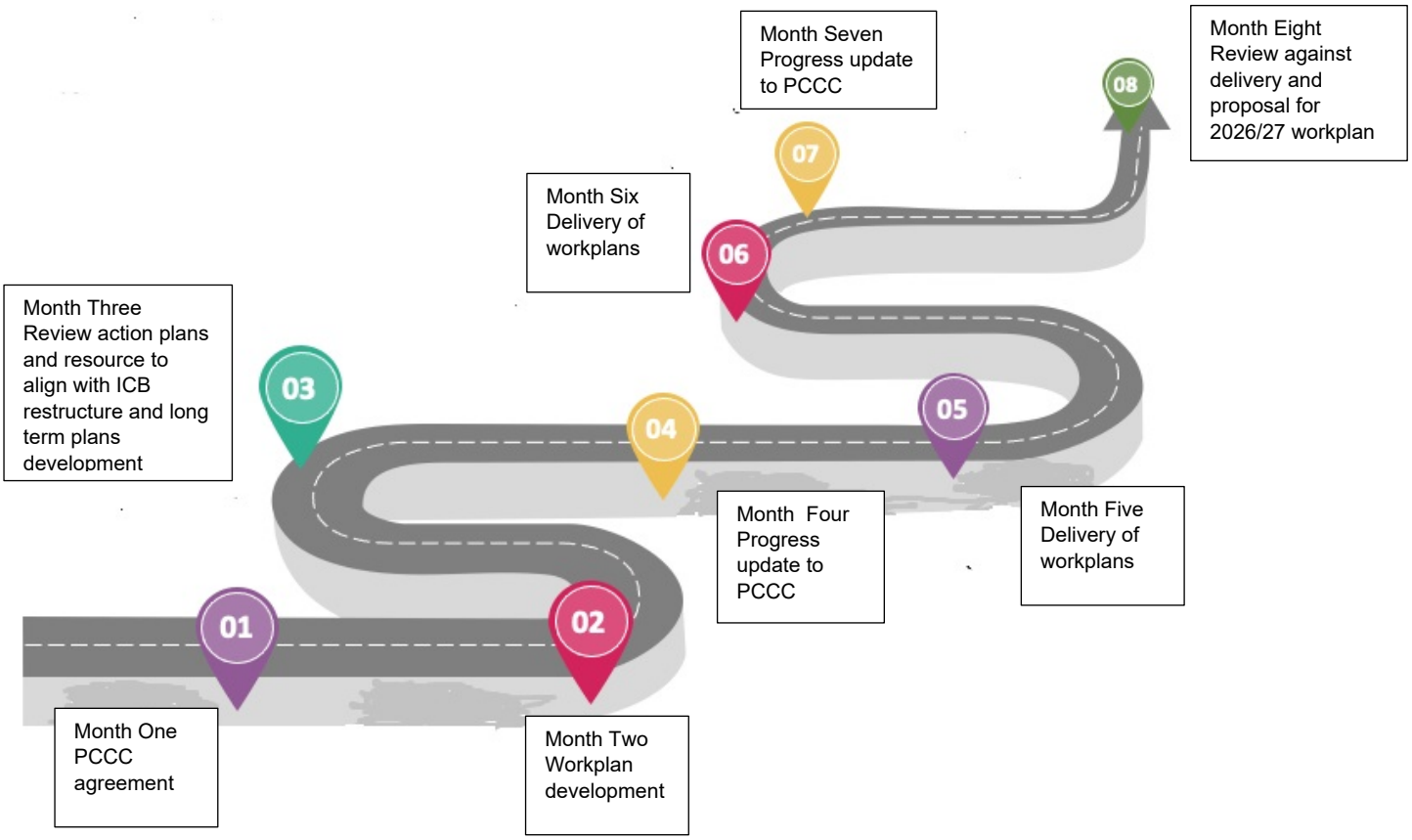
We have set out here what areas we believe should be prioritised initially so we can be confident a primary care-led, whole-system approach can be developed which is fit for the future within the evolving ICS landscape and supports the shifts towards ICB led strategic commissioning and provider-led operational and transformational leadership.

- Primary Care Input into System Planning and Decision Making
- Understand resource, demand and capacity
- Role of Primary Care in Tackling Health Inequalities
- Future Models of Primary Care

How are we going to do it?

Suggested next steps and timelines:

- If approved, we will begin an engagement exercise to socialise the framework with key stakeholders and primary care contractors.
- Workplans will be developed for each workstream agreed, and key points from action plans and the framework will be fed into long-term planning for each of the four pillars of primary care
- Work with primary care contractors to use their collective energy and resource to ensure they are credible and confident system partners focused on providing accessible services designed to meet the needs of their communities



We will continue to share, listen and incorporate feedback from stakeholders and review in line with national and local priorities and provide updates to PCCC at the end of quarters 2, 3 & 4

Norfolk and Waveney
Integrated Care Board

Subject:	**Operational Planning 2025/26 Update – GP Action Plan**
Presented by:	**Amanda Sear, Head of Primary Care Strategic Planning**
Prepared by:	**Amanda Sear, Head of Primary Care Strategic Planning**
Submitted to:	**Primary Care Commissioning Committee Part One**
Date:	**8 July 2025**

Background

The paper provides an update on our primary care operational planning submission, building on the headline submission made in response to the NHSE 2025/26 Priorities and Operational Planning Guidance which came to the Primary Care Commissioning Committee on 11 March 2025, submitted on 27 March 2025.

The Committee is asked to note the update and consider and approve a proposal to provide regular updates being added to the forward planner for scrutiny against performance to provide assurance against delivery.

The overall aim of the primary care headline submission was to improve access, efficiency, and integration within the broader healthcare system, by:

Enhancing Access to General Practice

- Improving patient experience and ease of access to GP services
- Ongoing expansion of **digital tools** to streamline appointment booking, including better use of the **NHS App** and online consultation platforms
- Supporting the implementation of **Modern General Practice** to manage patient demand effectively and optimisation of **Pharmacy First**
- Encouraging **Neighbourhood Health Service models** to provide **integrated, proactive, and personalised care**
- Improving contract oversight, commissioning and transformation and tackling unwarranted variation

Expanding Urgent and Preventive Dental Care

- Increasing the availability of **urgent dental care** with an additional **700,000 unscheduled care appointments** to address access issues.
- Supporting **dental workforce expansion** and contract reforms to improve care delivery

The requirements for more detailed plans, building on the headline submission were communicated during May, namely a **GP Action Plan**, using an NHSE template to be submitted by 30 June 2025, which was completed.

The GP Action Plan is an internal document written for NHSE and will inform the team's 2025/26 workplan. The plan has been shared with voting members and local dentistry, medical and pharmacy committees.

Feedback from NHSE national team is expected and will be shared as part of future updates.

Executive Summary

Key metrics across community pharmacy, dentistry and general practice were agreed with NHSE during May, following the headline submission discussed at PCCC in March 2025. We have committed to work with our contractors to offer our population access to almost 100k Pharmacy First, hypertension and contraception contacts; 30k unscheduled dental appointments and over 7.5m appointments across GP Practices and Primary Care Networks during 2025/26.

The GP Action Plan was developed by colleagues across primary care teams with support and guidance from NHSE Primary Care Regional colleagues and incorporates all the actions from the original primary care headline submission made during March 2025.

The **GP Action Plan** brings together our approach and actions to meet the requirements set out in the Planning Guidance including ***improving patients' access to general practice, improving patient experience, and improving access to urgent dental care,*** *providing our share of the national 700,000 additional urgent dental appointments.*

The GP Action plan covers three areas:

- improving contract oversight
- addressing unwarranted variation
- commissioning and transformation

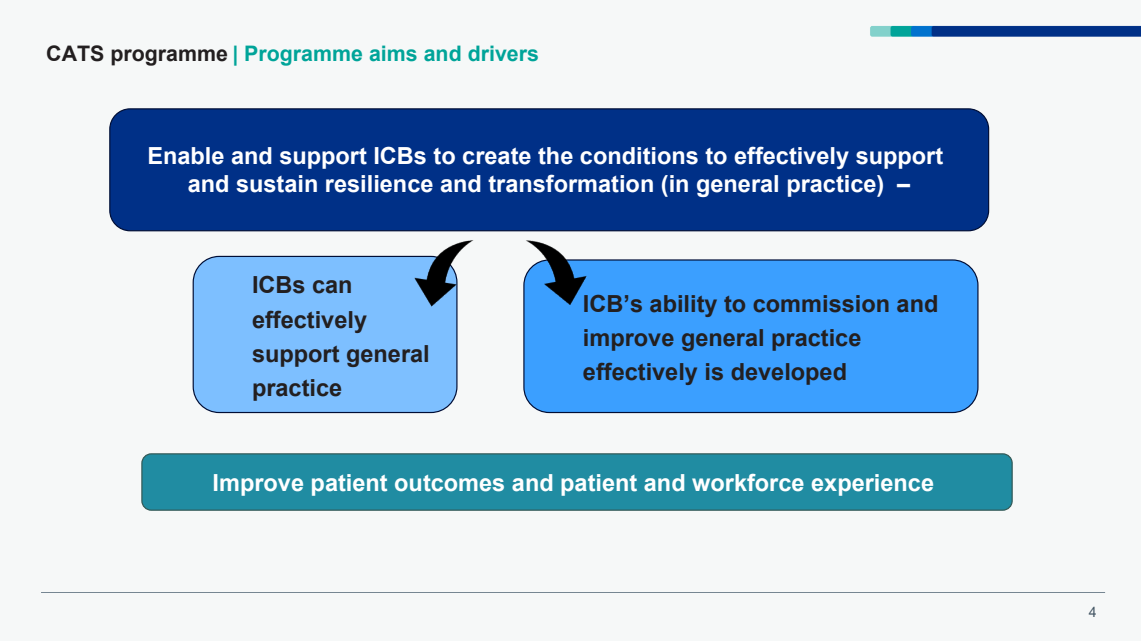
It includes an overview of our approach to each area together with actions from work programmes, with which the Committee will be familiar, including Pharmacy First, General Practice Improvement Programme, Modern General Practice.

The primary care team will engage with the commissioning and transformation support (CATS) programme over the Summer, and make use of national resources to develop capabilities with the team across the three areas of focus in the GP Action Plan to:

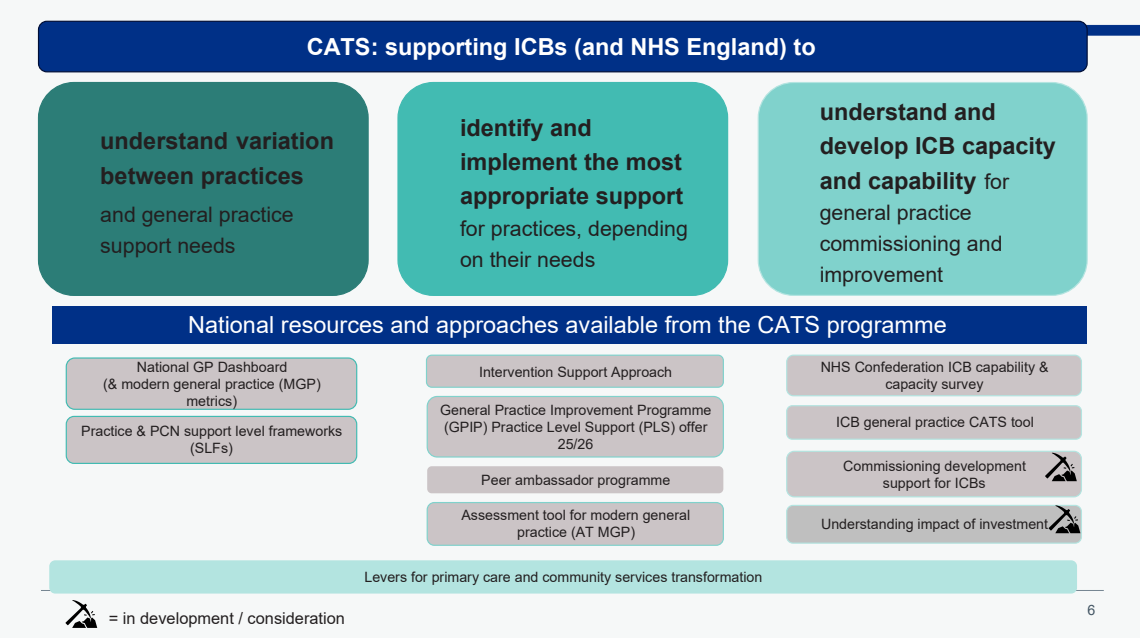
- understand variation and support needs in general practice;
- identify and implement appropriate support; and
- develop their own (ICB) capacity and capability to commission for improvement

Arrangements for a facilitated group discussion, led by NHSE colleagues, are being finalised to bring ICB colleagues together to undertake a self-reflection exercise. The outputs will inform any development and/or support needs across the team to address any areas identified needing improvement. ICB cluster arrangements will provide opportunities for sharing learning and good practice as part of this exercise.

A visual of the NHSE ICB CATS Programme aims and drivers can be seen below



The visual below shows how the CATS programme links with some of the workstreams within the GP Action Plan (e.g. GPIP – general practice improvement programme, SLFs – support level framework.) Many of these workstreams will be familiar to the Committee with papers having been presented for discussion and agreement over recent months.



A new NHSE GP Dashboard for commissioners has recently been launched, which provides insights into general practice activity, including:

- GP Access and Experience
- GP Workforce
- Clinical Outcomes and Quality
- GP Vaccinations and Screening

The dashboard uses interactive charts and graphs to present the data, highlighting variations in delivery and outcomes. It has been designed to support the identification of best practice as well as areas where further exploration to develop a shared understanding of population need and how it can best be addressed within existing resources and improved in future commissioning models may be beneficial. Over time the dashboard is expected to become a key tool to support delivery of the GP Action Plan, as future releases progress.

All workstreams under the GP Action Plan will be delivered in a way to reflect Joint Forward Plan Ambitions for 2024/25 – 2028/9 Primary Care Resilience and Transformation

Recommendation:

The Committee is asked to note the update on the GP Action Plan and approve the proposal to regularly review progress and provide assurance against delivery of our primary care operational planning guidance requirements on a regular basis through the Committee or Operational Delivery Groups.

Key Risks	
Clinical and Quality:	Population health outcomes and capacity in primary care could be improved through wider engagement with tools and support programmes available
Finance and Performance:	Care capacity can be negatively impacted due to inefficient working arrangements across the primary care
Impact Assessment (environmental and equalities):	Increased capacity and capability could increase the ability to address health inequalities.
Reputation:	Integrated care boards (ICBs) lead the process of planning and arranging services to deliver the expectations set out in Operational Planning Guidance, including ensuring the reforms are put in place to secure a sustainable health system in the future and a drive more integrated care through the development of neighbourhood health services
Legal:	None identified
Information Governance:	None identified
Resource Required:	Primary Care Workforce Transformation, Primary Care Delegated Commissioning, Community Pharmacy, Medical, Locality, Digital and Commissioning teams work together, and with contractors, to improve access and experience to primary care services for our population
Reference document(s):	NHSE Priorities and Planning Guidance 2025/26 https://www.england.nhs.uk/long-read/2025-26-priorities-and-operational-planning-guidance/ NHSE Neighbourhood Health Guidelines 2025-26 https://www.england.nhs.uk/long-read/neighbourhood-health-guidelines-2025-26/
NHS Constitution:	https://www.england.nhs.uk/publication/primary-medical-care-policy-and-guidance-manual-pgm/
Conflicts of Interest:	Declarations of interest are held on record, there were no direct conflicts of interest noted for this report
Reference to relevant risk on the Board Assurance Framework	Risk to resilience of primary care and transformation, on BAF and monitored through Primary Care Commissioning Committee, current score of 20
Governance	Previous update taken to Parts 1 and 2 Primary Care Commissioning Committee on 11 March 2025
Process/Committee approval with date(s) (as appropriate)	N/A

Norfolk and Waveney
Integrated Care Board

Agenda item: 10

Subject:	**General Practice & Community Pharmacy Delivery Group Report**
Presented by:	**Sharon Gardner, Head of Primary Care Commissioning Pharmacy and Optometry**
Prepared by:	**Shepherd Ncube, Associate Director of Primary Care Commissioning** **Sharon Gardner, Head of Primary Care Commissioning Pharmacy and Optometry**
Submitted to:	**Primary Care Commissioning Committee**
Date:	**8 July 2025**

Purpose of paper:

To provide the Committee with an update on the work of the General Practice and Community Pharmacy Delivery Group since the previous Primary Care Commissioning Committee.

This paper is for noting.

Delivery Group:	General Practice & Community Pharmacy Delivery Group
Delivery Group Chair	Mark Burgis, Executive Director of Patients and Communities
Meetings since the previous update to PCCC on	10 June 2025
Overall objectives of the Delivery Group:	The purpose of the meeting is to provide a framework for effective decision making in relation to certain contractual matters for dental services / medical services / community pharmacy under delegated authority from the ICB's Primary Care Commissioning Committee ("PCCC").
Main purpose of meeting:	To contribute to the overall delivery of the ICB's objectives to create opportunities for the benefit of local residents, to support Health and Wellbeing, to improve access and transform services by providing oversight and assurance to PCCC on the exercise of the ICB's delegated primary care commissioning functions and any resources available for investment in primary, community and secondary dental care.

BAF and any Committee risks relevant / aligned to this Committee. *To note Operational Risk discussions* *To note details of key risks identified during items discussed*	**General Practice Resilience: 00000023** **Community Pharmacy Resilience: 00000056** The group discussed and noted that the mains risks around resilience in general practice and community pharmacy remained with no changes to the operational risk register since the last meeting The group also acknowledged that the new Inphase risk reporting system was still being adapted into the meeting governance. This raised concerns around the reporting accuracy and an informal action was set to ensure that all risks were accurately captured in Inphase and were consistently reflected in meeting reports, with updates verified for completeness and accuracy
Key items for Committee to take note of *To highlight if any items include:* • *Changes to national policy/strategy* • *Quality & safety matters*	**Operational Risk Register** The Operational Risk Register was presented to the group for discussion and was approved by voting members. No significant changes in risk scores were reported since the last update. Resilience risks across all primary care services were highlighted and discussed, with a focus on potential challenges and mitigation strategies. **Learning Disability (LD) Health Checks- End of Year Report** The end-of-year report on Annual Health Checks was presented to the group. The ICB has exceeded the national minimum requirement of 75% (achieved 76.8%) for the number of eligible individuals receiving Annual Health Checks for the first time, despite an increase in register size. All five localities-West, Norwich, North, South, and Great Yarmouth & Waveney-performed strongly. We are pleased to report that all localities met or exceeded the national target, apart from West Norfolk, which narrowly missed the threshold. However, the group was assured that focused efforts are already underway in West Norfolk to strengthen delivery and support improvement in the next reporting year. Due to technical issues with NHS England's national system, not all completed checks were captured in the national dataset. This issue has been acknowledged by NHS England, which has agreed to allow manual data adjustments and enable payments to practices accordingly. The group recognised the importance of building on this success and agreed to continue efforts to sustain and improve performance in the year ahead. **Local Enhanced Services (LES) Update**

	An update on the LES was provided noting that the ICB commissioned fourteen services, eight of which had transitioned to local enhanced services. Some services that had expired at the end of March 2025 were recommissioned and planning for 2026-2027 year had already begun. The team has also begun discussions with Suffolk colleagues to compare LES provision. The hard work of the lead commissioner and the LMC was acknowledged.

Items receiving formal approval from the Delivery Group *To include any financial risks*	**Chairs Action- Practice Premises Business Case** One Chair's Action was taken in relation a practice premises business case, which was addressed outside of the meeting. Approval was sought by the ICB Estates team for a premises scheme involving extension, refurbishment, and improvement works. The scheme is fully funded through Community Infrastructure Levy (CIL) funding. Approval was sought to provide assurance to the key stakeholders and the ICB will additionally fund the associated GPIT costs. **Forward Planner 2025/26** A request to cancel the October 2025 delivery group meeting due to a clash with the Primary Care Commissioning committee (PCCC) was sought and approved. **National General Practice Improvement Programme (GPIP) Proposal** The National General Practice Improvement Programme (GPIP) was introduced to the group as a proposal for approval. Positive feedback from practices that had been on the previous cohort was shared noting significant time savings for clinicians and admin staff. The proposed use of the national funding allocation for 2025-2026 was outlined which included train-the-trainer sessions and refresher sessions for practices that have previously completed GPIP The Group reviewed and approved the proposed use of the non-recurrent NHS England PLS allocation for the GPIP programme. An action was taken away for the ICB and LMC to explore how GPIP can support practices, identified via GPAS as needing support by highlighting the benefits of the programme

	British Sign Language (BSL) Interpreting Contract This was presented to the group for approval asking for a six-month extension to the current contract arrangements to be applied. The report highlighted the recent publication of the NHS England patient safety and healthcare inequalities improvement framework which underscored the need for effective translation services. The request for a six-month extension to the current contract arrangements was approved by the group to allow the for the necessary engagement with service users and the primary care workforce ahead as part of the procurement process. **Pharmacy August Bank Holiday Commissioning** This was presented to the group seeking approval for the commissioning of 10 pharmacies to support the provision of pharmacy services over the August bank holiday. necessitating the singular request for funding. It highlighted the positive impact of the commissioned pharmacies, with over 2,000 patient contacts on Easter Monday alone, and an increase in Pharmacy First activity on bank holidays. The group approved the funding request and acknowledged the aspiration to continue to provide coverage on all bank holidays. **Alternative Provider Medical Services (APMS) Contract Review Group - Terms of Reference update** This was presented to the group for approval and sought approval for a change in the APMS group's terms of reference. This group had been overseeing the transition of the APMS contracts into long-term contracts. The addition requested for the Terms of Reference was an expansion of the group's scope to include the British sign language (BSL) contract and the special scheme for vulnerable people. The group approved the updated Terms of Reference.
Items for escalation to PCCC	There were no items requiring escalation to PCCC
Confirmation that the meeting was quorate and all Voting Members (or nominated deputies on making decisions on behalf of Voting Member) present	The meeting was confirmed quorate. Attendance at the meeting is listed below: 10 June 2025 **Voting members** Mark Burgis, Executive Director of Patients and Communities, NWICB - Chair

	Shepherd Ncube, Associate Director, Primary Care Commissioning, NWICB James Grainger, Head of Finance – Primary Care & Corporate/Reporting Karen Watts, Director of Nursing and Quality

Recommendation to the Committee:

The paper is for noting purposes.

Key Risks	
Clinical and Quality:	The Group will be monitoring quality improvement and development of a performance dashboard and overall assurance framework
Finance and Performance:	Finance is represented within the membership of the Delivery Group and a Voting Member. Performance and spend against the relevant budget is monitored in detail and reported to the Committee. Any potential financial risks are highlighted to the Committee in this report.
Impact Assessment (environmental and equalities):	Each proposal is accompanied by an Equalities Health Impact Assessment to inform the Group's decision making. Papers to DSDG/GPCPDG seek to identify potential impact on equalities and mitigating actions required. Action will be taken to draw up Equality Health Impact Assessments for all new projects, pathway or service developments and proposals.
Reputation:	Healthwatch Norfolk and Healthwatch Suffolk, Local Professional Network and the Local Representative Committee are all represented on the Group
Legal:	Terms of reference, General Practice Contracts, NHS (pharmaceutical and local pharmaceutical services) regulations 2013 (the 2013 regulations)
Information Governance:	Information Governance matters will be highlighted as and when appropriate
Resource Required:	Primary Care Commissioning Team
Reference document(s):	Primary medical services regulations, statement of financial entitlements, premises directions and policy guidance manual, delegation agreement with NHS England.
NHS Constitution:	N/A
Conflicts of Interest:	To note any specific Conflicts of Interests from Delivery Group meeting here and how managed are described above under each item, where appropriate. Arrangements are in place to manage conflicts of interest at each meeting and to accurately record and manage them.

Reference to relevant risk on the Board Assurance Framework	BAF02 – Primary Care Resilience and Transformation BORR11 – Resilience of General Practice BORR27 – Resilience of Community Pharmacy

Norfolk and Waveney
Integrated Care Board

Agenda item: 10

Subject:	**Dental Services Delivery Group report**
Presented by:	**Sarah Johnson, Senior Primary Care Commissioning Manager**
Prepared by:	**Fiona Theadom, Head of Primary Care Commissioning (Dental and GP** **Sarah Johnson, Senior Primary Care Commissioning Manager**
Submitted to:	**Primary Care Commissioning Committee**
Date:	**8 July 2025**

Purpose of paper:

To provide the Committee with an update on the work of the Dental Services Delivery Group since the previous Primary Care Commissioning Committee.

This paper is for noting.

Delivery Group:	Dental Services Delivery Group
Delivery Group Chair	Mark Burgis, Executive Director – Patients and Communities
Meetings since the previous update to PCCC on 14 May 2025	Tuesday 10 June 2025
Overall objectives of the Delivery Group:	The purpose of the meeting is to provide a framework for effective decision making in relation to certain contractual matters for primary care, community care and secondary care dental services under delegated authority from the ICB's Primary Care Commissioning Committee ("PCCC").
Main purpose of meeting:	To contribute to the overall delivery of the ICB's objectives to create opportunities for the benefit of local residents, to support Health and Wellbeing, to improve access and transform services by providing oversight and assurance to PCCC on the exercise of the ICB's delegated primary care commissioning functions and any resources available for investment in primary, community and secondary dental care.

BAF and any Committee risks relevant / aligned to this Committee. *To note Operational Risk discussions* *To note details of key risks identified during items discussed*	BAF02 – Primary Care Resilience and Transformation BORR08 – Secondary Care services BORR09 – Resilience and Stability of Primary Care Dental Services No key changes to any of the risks above reported to the Board or Primary Care Commissioning Committee ORR – Special Care Dental Services Positive updates in relation to recruitment, however stability and resilience concerns remain unchanged. No changes to RAG or risk level.
Key items for Committee to take note of *To highlight if any items include:* • *Changes to national policy/strategy* • *Quality & safety matters*	• The Group received an update on the regional Secondary Care Recovery Programme led by Suffolk and North East Essex ICB. Projects to date include a review of minor oral surgery referral data, sedation services, paediatric services and Temporomandibular joint disorders (TMJ) services. • The Group noted the positive report on significant work to stabilise a dental practice resulting in improved financial stability, successful recruitment and an improvement in performance • A report from the Primary Care Workforce team was received by the Group noting that funding has been approved through Triple Lock for the ICB plans for 2025/26
Items receiving formal approval from the Delivery Group *To include any financial risks*	• The Group approved the final version of the Dental Contract Assurance Framework • Approval to incorporate for a GDS contract was agreed, subject to confirmation of Care Quality Commission approval and inclusion of a change of control clause in the GDS contract on novation and PSR process completion. • The Group approved the governance arrangements enabling Norfolk County Council and the ICB to work collaboratively to commission the national Supervised Toothbrushing Scheme • Commissioning plans to increase unscheduled care capacity were approved • A proposal to implement contract amendments to stabilise a rural practice and improve resilience was approved • The Group approved a six-month extension of interpreting and translation services contracts for primary care to allow time for robust engagement with service users and workforce to be undertaken.

Items for escalation to PCCC	No items were identified for escalation to the Committee
Confirmation that the meeting was quorate and all Voting Members (or nominated deputies for making decisions on behalf of Voting Member) present	The meeting was quorate. Conflicts of Interest were noted for two items and the individual concerned asked to leave the meeting during the agenda item discussion. Voting Members present: Mark Burgis, Executive Director of Patients and Communities Karen Watts, Director of Nursing and Quality Shepherd Ncube, Associate Director of Primary Care Commissioning (attending for Sadie Parker, Director of Primary Care) Sarah Elliott, Finance Manager – Delegated Primary Care (attending for James Grainger, Head of Finance – Primary Care and Corporate)

Recommendation to the Committee:

To note the report, risk updates and decisions taken by the Dental Services Delivery Group on 10 June 2025

Key Risks	
Clinical and Quality:	The Group will be monitoring quality improvement and development of a performance dashboard and overall assurance framework
Finance and Performance:	Finance is represented within the membership of the Delivery Group and a Voting Member. Performance and spend against the relevant budget is monitored in detail and reported to the Committee. Any potential financial risks are highlighted to the Committee in this report.
Impact Assessment (environmental and equalities):	Each proposal is accompanied by an Equalities Health Impact Assessment to inform the Group's decision making. Papers to DSDG seek to identify potential impact on equalities and mitigating actions required. Action will be taken to draw up Equality Health Impact Assessments for all new projects, pathway or service developments and proposals.
Reputation:	Healthwatch Norfolk and Healthwatch Suffolk, Local Professional Network and the Local Representative Committee are all represented on the Group
Legal:	Terms of reference, general dental services contracts, regulations and Dental Policy Handbook
Information Governance:	Information Governance matters will be highlighted as and when appropriate
Resource Required:	Primary Care Commissioning Team
Reference document(s):	General dental services contracts, regulations and Dental Policy Handbook

NHS Constitution:	N/A
Conflicts of Interest:	To note any specific Conflicts of Interests from Delivery Group meeting and how managed are described above under each item, where appropriate. Arrangements are in place to manage conflicts of interest at each meeting and to accurately record and manage them.
Reference to relevant risk on the Board Assurance Framework	BAF02 Primary Care Resilience and Transformation

Norfolk and Waveney
Integrated Care Board

Agenda item: 10

Subject:	**Dental Development Group report**
Presented by:	**Sarah Johnson, Senior Primary Care Commissioning Manager – Dental**
Prepared by:	**Sarah Johnson, Senior Primary Care Commissioning Manager – Dental**
Submitted to:	**Primary Care Commissioning Committee**
Date:	**8 July 2025**

Purpose of paper:

To provide the Committee with an update on the work of the Dental Development Group since the previous Primary Care Commissioning Committee.

This paper is for noting.

Dental Development Group:	Dental Development Group
Group Chair	Sadie Parker, Director of Primary Care
Meetings since the previous update to PCCC on 14 May 2025	20 May 2025
Overall objectives of the Dental Development Group:	The Group enables the prioritisation of dental strategy work and workforce planning alongside identification and support for wider system projects which aim to improve dental access for children and adults, practice resilience and development of services.
Main purpose of meeting:	The purpose of the meeting is to provide a "safe space" for stakeholders to come together to discuss and drive delivery of Norfolk and Waveney dental ambitions. To share information, soft intelligence and to agree actions as to how best to work together and enable a joined up approach to solution finding under delegated authority from the ICB's Primary Care Commissioning Committee ("PCCC").
BAF and any Committee risks	The work of the Dental Development Group aims to find solutions to mitigate the risks for primary care,

relevant / aligned to this Committee.	community care and secondary care dental services however it is not the Group's role to monitor risks. BAF02 – Primary Care Resilience and Transformation BORR08 – Secondary Care Dental Services BORR09 – Resilience and Stability of Primary Care Dental Services ORR – Resilience and Stability of Special Care Dental Services
Key items for Committee to take note of *To highlight if any items include:* • *Changes to national policy/strategy* • *Quality & safety matters*	The Group received an update on the ICB's Year 2 – Long Term Dental Plan ambitions, including: • Resilience and stability • Workforce • Orthodontic commissioning • Special Care Dental Services • Access Improvement The Group suggested the ICB review the Mid and South Essex ICB Care Home model and assess its applicability for Norfolk and Waveney. To investigate the needs for individuals in supported living arrangements and consider integrating them into the access improvement scheme. Proposals for workforce recruitment and retention plans were presented to the Group including: • First Five programme • Student placements • Overseas recruitment • Health and Wellbeing The Group suggested sharing user friendly guidance about the Golden Hello scheme with potential candidates to ensure clarity and understanding. Shared Care Pathway - options for managing referrals from secondary care to primary care Shared Care practices were considered and recommendations made. The Group suggested considering the inclusion of inpatients and sedation services in the shared care pathway.
Items receiving formal approval from the Delivery Group *To include any financial risks*	The role of the Dental Development Group is to make recommendations to the Dental Services Delivery Group and Primary Care Commissioning Committee; it is not a decision making forum.
Items for escalation to PCCC	None identified

Confirmation that the meeting was quorate and all Voting Members (or nominated deputies for making decisions on behalf of Voting Member) present	The Terms of Reference do not require the meeting to be quorate.

Recommendation to the Committee:

To note the report and recommendations from Dental Development Group members

Key Risks	
Clinical and Quality:	The Group will be monitoring quality improvement and development of a performance dashboard and overall assurance framework
Finance and Performance:	Finance is represented within the membership of the Group. Performance and potential spend against the relevant budget is monitored in detail and reported to the Committee. Any potential financial risks are highlighted to the Committee in this report.
Impact Assessment (environmental and equalities):	Each proposal is accompanied by an Equalities Health Impact Assessment to inform the Group's decision making. Papers to Dental Development Group seek to identify potential impact on equalities and mitigating actions required. Action will be taken to draw up Equality Health Impact Assessments for all new projects, pathway or service developments and proposals.
Reputation:	Healthwatch Norfolk and Healthwatch Suffolk, Local Professional Network and the Local Representative Committee are all represented on the Group
Legal:	Terms of reference, general dental services contracts, regulations and Dental Policy Handbook
Information Governance:	Information Governance matters will be highlighted as and when appropriate
Resource Required:	Primary Care Commissioning Team
Reference document(s):	General dental services contracts, regulations and Dental Policy Handbook
NHS Constitution:	N/A
Conflicts of Interest:	To note any specific Conflicts of Interests from Delivery Group meeting here and how managed are described above under each item, where appropriate. Arrangements are in place to manage conflicts of interest at each meeting and to accurately record and manage them.

Reference to relevant risk on the Board Assurance Framework	BAF02 - Primary Care Resilience and Transformation

Improving lives **together**

Norfolk and Waveney Integrated Care System

2025/26 Primary Care Commissioning Committee

Finance Report Norfolk & Waveney ICB

M2 2025

Primary Care Commissioning Committee 8th July 2025

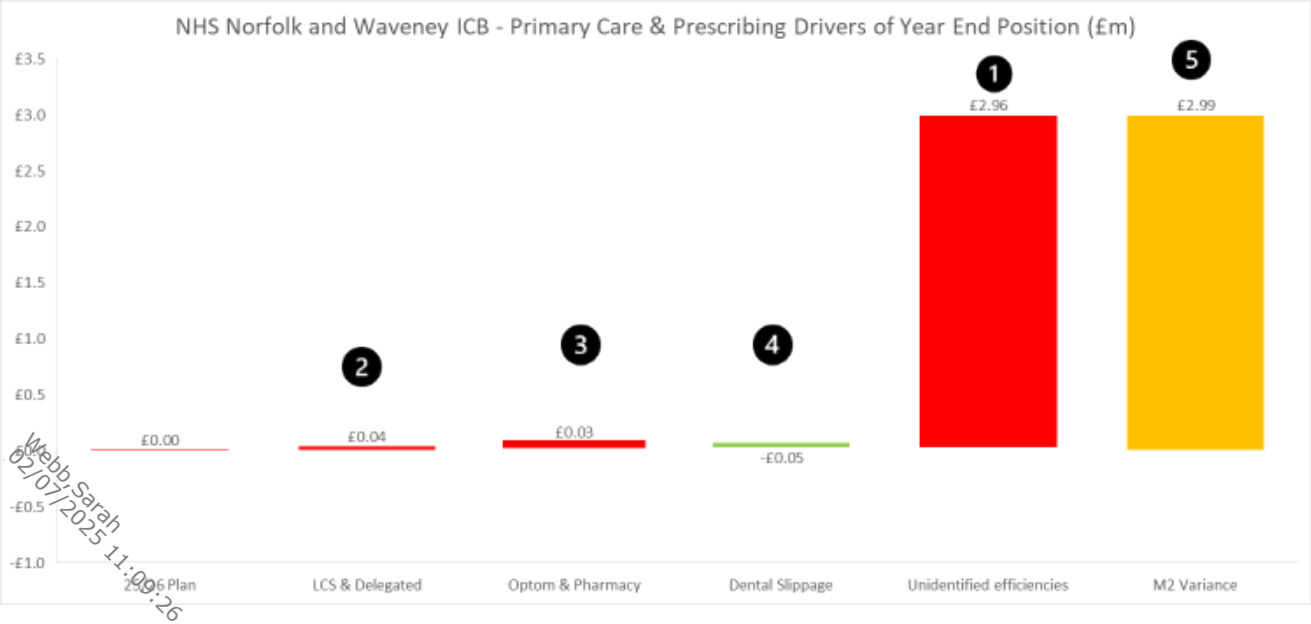
Contents

1.0 Executive summary – Reporting

Reported Financial Position: As of May 2025 (M2), the Primary Care & Prescribing reported position is £3m overspend due to Unidentified Efficiencies budget reduction.

	Annual Budget	Budget	Actual	Variance	Forecast	FOT Variance
	£m	£m	£m	£m	£m	£m
Reported	616.8	103.8	104.1	0.3	619.8	3.0

Variances:
The key operational variances are shown below:



The GP & Prescribing position is a £3m overspend noting the following variances.

- Unidentified Efficiencies in Primary Care approx. £3m and schemes are being identified and is the reason for the overspend. 1
- LCS and Delegated are broadly on plan 2
- Pharmacy is broadly on plan 3
- Dental broadly on plan 4
- Unidentified Efficiencies in Primary Care has led to overspend. 5

Managing In-Year Risks:

- **Efficiencies**

The unidentified efficiency requirement is currently being worked upon and there are some efficiencies that are being currently captured with regards to the conversion of APMS contracts to GMS and the reduction of some contracts by circa 6% on their expiry in lieu of their conversion to GMS. The potential saving in 25/26 is £0.5m and when fully validated will partly offset the £3m savings required.

Primary Care Commissioners and the finance team are working together on both recurrent and non-recurrent savings ideas to attempt to offset the remaining £2.5m. They will be brought to the Finance Recovery meetings ran in conjunction with PMO.

2. Primary Care and Prescribing reporting M2

Sub-Directorate (£m)		Full Year Variance (underspend) / overspend	Variance – significant items
GP Prescribing		£0.00	On Plan
Budget	£208	0.0%	
Other Prescribing costs		£0.00	On Plan
Budget	£21	0.0%	
Delegated Primary Care		£0.04	Broadly on plan
Budget	£255	0.0%	
Local Enhanced Services(LES)		£0.00	On Plan
Budget	£16	0.0%	
Other Primary Care		£(0.03)	Broadly on plan
Budget	£13	-0.2%	
Dental		£(0.05)	Broadly on plan
Budget	£72	-0.1%	
Optom		£0.00	On Plan
Budget	£12	0.0%	
Pharmacy		£0.0	Broadly on plan
Budget	£23	0.1%	
Unidentified efficiencies		£3.0	Efficiencies still being worked on
Budget	-£3	-100.0%	
Total	**£617**	**£3.0**	

3. ICB Financial Position M2

Directorate Full Year Budget (£m)	M2 Full year Variance (underspend) / overspend	Variance – significant items
Acute Budget £1,387	£9.41 0.7%	Sustainable commissioning QIPP
Spec Comm Budget £249	£0.00 0.0%	On Plan
Community and Better Care Fund (BCF) Budget £259	£8.80 3.4%	Sustainable commissioning QIPP
Continuing Healthcare Budget £168	£0.04 0.0%	Broadly on plan
Mental Health Budget £306	£2.97 1.0%	Sustainable commissioning QIPP
Prescribing Budget £229	£0.00 0.0%	On Plan
Primary Care Budget £388	£2.97 0.8%	Sustainable commissioning QIPP
Other - Combined areas Budget £23	£0.27 1.2%	VOID Property costs
Planning Budget -£34	£(24.46) 71.4%	Sustainable commissioning QIPP in above areas partially offset
Running Costs Budget £16	£0.00 0.0%	On Plan

4.0 Prescribing Efficiencies M2

Prescribing Efficiencies Top Performing by value Budget (£000's)		Actual (£000's)	Var (£000's) Fav (Adv)	Variance – significant items
OptimiseRx			£0	Increased savings than plan as more surgeries use Optimise Rx
Budget	£2,100	£2,100	0.0%	
Rivaroxaban savings			£0	Decreased savings than plan as generic Apixaban was in short supply
Budget	£1,650	£1,650	0.0%	
Low Risk, cost effective switching programme			£0	Increased Savings than plan
Budget	£1,500	£1,500	0.0%	
Other Switches			£0	Savings lower than expected
Budget	£1,250	£1,250	0.0%	
Oral Nutritional Supplements			£0	Increased savings than plan as more patients patients prescribed Rivoraxaban
Budget	£750	£750	0.0%	
Deprescribing SMRs			£0	Increased savings than plan
Budget	£750	£750	0.0%	
Patent expirations			£0	Increased savings than plan
Budget	£660	£660	0.0%	
Sitagliptin Switch			£0	On Plan
Budget	£600	£600	0.0%	
Dressings			£0	Under plan mainly due to elective surgery waiting times
Budget	£500	£500	0.0%	
Other Efficiencies			£0	Slightly delivering over plan
Budget	£2,655	£2,655	0.0%	
Sub-Total	12415	12415	£0	
Unidentified Savings			£0.00	Stretch Target
Budget	£1,585	£1,585	0.0%	
Grand Total	**£14,000**	**£14,000**	**£0**	Net under delivery against plan

5.0 LES Activity Tracker

Locally Commissioned Service	Full Year Budget (£)	Full Year Actual(£)	Utilisation %	Comment
Care Homes	367,966		0%	Claims Due
Diabetes	639,413		0%	Claims Due
Eating Disorders	177,237		0%	Claims Due
Inclusion Health	362,275		0%	Claims Due
Mental Health SMI Health Checks	302,617		0%	Claims Due
Phlebotomy	6,364,963		0%	Claims Due
Proactive Healthcare	4,180,233		0%	Claims Due
PSA	449,250		0%	Claims Due
Shared Care	1,446,144		0%	Claims Due
Spirometry	428,851		0%	Claims Due
Treatment Room	3,945,713		0%	Claims Due
Warfarin	568,691		0%	Claims Due
MGUS	180,000		0%	
Henoch-Schönlein purpura (HSP)	20,000		0%	Claims Due
				Claims Due
Total	**19,433,353**	-	0%	

- The above budgets are subject to approval, Q1 claims are not due till July end .

Appendix A – Detailed Financial Position

Norfolk and Waveney ICB		N&W ICB	N&W ICB Position at Month 2 £000s			N&W ICB Forecast £000s	
Service Line	Description	Annual Budget	Budget	Actual	Variance	Forecast	FOT Variance
Prescribing	Central Drugs	6,171,637	978,489	978,489	0	6,171,637	0
	GP Prescribing	208,224,822	35,575,707	35,575,714	7	208,224,823	1
	Medicines Management - Clinical	3,148,581	488,412	488,412	0	3,148,582	1
	Other Prescribing	7,170,253	937,528	937,528	0	7,172,138	1,885
	Oxygen	2,788,684	400,000	400,000	0	2,788,684	0
	Prescribing Incentives	1,318,877	0	0	0	1,318,877	0
Prescribing Total		**228,822,854**	**38,380,136**	**38,380,143**	**7**	**228,824,741**	**1,887**
Primary Care	Community Dental	3,607,334	601,222	558,548	(42,674)	3,564,661	(42,673)
	DOP Delegated pay	384,233	53,714	45,839	(7,876)	384,233	(0)
	GP Forward View	752,092	134,402	134,403	1	752,092	0
	Local Enhanced Services	15,933,643	3,062,531	3,062,531	0	15,933,643	(0)
	Optom	11,903,391	1,990,645	1,993,986	3,341	11,906,732	3,341
	Other Primary Care	4,843,618	678,561	669,038	(9,524)	4,839,032	(4,586)
	Pharmacy	23,434,252	4,119,503	4,089,586	(29,917)	23,464,703	30,451
	PMS to GMS Transition	0	0	0	0	0	0
	Primary Care Delegated Co-Commissioning	254,603,463	42,433,017	42,433,017	0	254,642,808	39,345
	Primary Care IT	7,486,512	1,411,746	1,411,546	(201)	7,464,851	(21,661)
	Primary Dental	52,736,570	8,788,616	8,785,573	(3,043)	52,733,661	(2,909)
	Secondary Dental	15,261,641	2,543,607	2,543,607	(0)	15,261,641	(0)
	Unidentified efficiencies	(2,964,849)	(428,124)	0	428,124	0	2,964,849
Primary Care Total		**387,981,900**	**65,389,442**	**65,727,673**	**338,232**	**390,948,056**	**2,966,157**
Prescribing & Primary Care Total		**616,804,754**	**103,769,578**	**104,107,816**	**338,239**	**619,772,797**	**2,968,044**

Norfolk and Waveney
Integrated Care Board

Agenda item: 12

Subject:	**TIAA audit for Primary Care Services (Pharmacy, Optometry, Dental and Medical)**
Presented by:	**Sharon Gardner, Head of Primary Care Commissioning Pharmacy and Optometry**
Prepared by:	**Sharon Gardner, Head of Primary Care Commissioning (Pharmacy and Optometry)** **Fiona Theadom, Head of Primary Care Commissioning (Dental and Medical)** **Shepherd Ncube, Associate Director of Primary Care**
Submitted to:	**Primary Care Commissioning Committee (PCCC)**
Date:	**8 July 2025**

Purpose of paper:

For approval. This paper is to inform the PCCC about the TIAA audit outcomes and to seek agreement on the recommendations and actions being taken.

Executive Summary:

Responsibility for pharmaceutical, optometry and dental services transferred to the ICB on 1st April 2023 in addition to the prior delegation of medical services in 2017 to five individual Clinical Commissioning Groups (CCGs). The 2025 TIAA audit follows on from the previous audit of April 2024 which reviewed the implementation of transition plans for these services with a key focus on risks.

The most recent audit focused on implementation of the April 2024 recommendations, assurance against the Primary Care Self-Declaration for 2024/25 where ICBs are asked to complete a self-assessment template (NHS England » Primary care commissioning assurance framework) for NHS England (NHSE), RAG rating the ICB against several primary care commissioning elements
There was also a focus on internal governance processes to ensure we are meeting the ICB's responsibilities under the Delegation Agreement with NHS England (NHSE).

The TIAA audit outcome shows there is "Reasonable Assurance" on how the risks are being managed with good practice identified with contractual assurance frameworks and the setting of key performance indicators for primary care services.

A copy of the report is attached as Appendix A for information. Committee members are asked to note the key findings and to agree with the management plans in place to address the recommendations.

Report

As part of the ICB's annual audit programme, an audit was undertaken of the delegated functions for pharmaceutical, optometry, dental and medical (General practice) services, against the Delegation Agreement and Assurance Framework (NHS England » Primary care commissioning assurance framework)

The audit was conducted in March and April 2025 through interviews with key ICB individuals involved in commissioning the four primary care services and quality improvement. Relevant documentation was shared with TIAA as evidence.

The report identifies three important risk areas, which are control issues where action should be taken at the earliest opportunity and three routine risk areas where action should be taken by the ICB. No urgent control issues were found, which would need immediate action.
The important risk area recommendations are:

- In relation to Pharmacy and Optometry the ICB should finalise, publish and monitor performance against the pharmacy strategy and should complete and formally approve short-term priorities for optometry services.
- The ICB should establish its goals for the Additional Roles Reimbursement Scheme and how value for money can be measured across the Primary Care Networks' use of these funds. A framework is to then be developed to guide and monitor progress in delivering the objectives.
- In relation to the Primary Care Network direct enhanced service (PCN DES), the ICB should work with the NHSE and PCNs to establish a longer-term solution for the lack of data quality in relation to enhanced hour bookings. In the meantime, should progress the short-term solution for self-assessment declaration and spot checks through the ICB's primary care visit programme.

The routine risk area recommendations are:

- In relation to the risk register entry, resilience of NHS General Dental Services the ICB must ensure that the control gap in relation to knowledge of dental contractors is clearly stated and addressed.
- In relation to the submitted self-declared document and the GP practice visit programme, the ICB is to review the assessment based on risks and actions set out within the operational plan submitted to NHSE.
- In relation to the delivery of Pharmacy First the ICB must ensure the development of a dashboard to enable monitoring of Pharmacy First performance, and monitoring to commence to ensure performance is in line.

The report highlights that arrangements are partially in place to address governance and compliance against the directed risk “Failure to properly direct the service to ensure compliance with the requirements of the organisation” but highlighted that risk mitigation is fully in place.

It also highlights that arrangements are partially in place to address performance management against the delivery risk “Failure to deliver the service in an effective manner which meets the requirements of the organisation”.

The findings acknowledge the sustained work that the primary care commissioning team continues to undertake to deliver assurance to NHSE under the Delegation Agreement and the embedding of primary care services into the ICB governance framework.

Recommendation to the Board:

To note the findings and approve the recommendations and management plans being taken to address the recommendations.

Key Risks	
Clinical and Quality:	Embedded processes and controls and understanding risks will improve management of delegated functions including responsibility for quality
Finance and Performance:	Management and controls in place in line with the assurance framework to support financial and performance management
Impact Assessment (environmental and equalities):	None identified
Reputation:	Good contract assurance and monitoring processes in place can preserve the reputation of the ICB as commissioner and also providers
Legal:	None identified
Information Governance:	None identified
Resource Required:	Primary Care Commissioning Teams ICB quality team ICB finance team ICB business intelligence teams
Reference document(s):	TIAA audit April 2024 NHS assurance framework for primary care NHS England » Primary care commissioning assurance framework) services and completed self-assessment form
NHS Constitution:	N/A
Conflicts of Interest:	None identified but arrangements are in place to manage conflicts of interest.

Reference to relevant risk on the Board Assurance Framework	BAF02 – Primary Care Resilience and Transformation BORR08 – Secondary Care Dental Services BORR09 – Resilience of General Dental Services BORR11 – Resilience of General Practice BORR27 – Resilience of Community Pharmacy

Governance

Process/Committee approval with date(s) (as appropriate)	

NHS Norfolk and Waveney ICB

Assurance Review of Primary Care Delegated Commissioning

May 2025

Final

Executive Summary

OVERALL ASSESSMENT

ASSURANCE OVER KEY STRATEGIC RISK / OBJECTIVE

BAF 02: Primary Care Resilience and Transformation.

KEY STRATEGIC FINDINGS

- **A Primary Care strategic framework and associated operational plans are in place to improve services in relation to delegated commission. However, these are not supported by Pharmacy or Opthalmic Strategies.**
- **Governance processes and scrutiny of Primary Care Delegated Commissioning continue to work well within the ICB through the Primary Care Commissioning Committee, supported by its operational groups.**
- **Collaborative work is in place for integration with other providers and Primary Care Networks, however more work is needed to establish how value for money is provided within the overall context of primary care.**
- **A review of evidence supporting the 23/24 Assurance Framework submission and developments during 2024/25 confirmed improvements have been made. Further improvements needed includes continued development of dashboards to support monitoring of contract delivery and the 2025/26 operational plans submitted to NHSE, the team are aware and are addressing.**

GOOD PRACTICE IDENTIFIED

- **Control Assurance frameworks are in place for primary medical and dental services. Key performance indicators have been set for primary care services for 2025/26.**

SCOPE

The NHS England Primary care commissioning assurance framework requires ICBs to complete the self-declaration retrospectively by the end of the financial year and returns should be reviewed through the ICB's internal audit process and ICBs will need to report to NHS England Regional teams if any audit recommendations are made and implemented.

ACTION POINTS

Urgent	Important	Routine	Operational
0	3	3	0

Assurance - Key Findings and Management Action Plan (MAP)

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
1	Directed	The previous audit recommended that pharmacy and optometry strategies be produced. Management's response was that the pharmacy strategy would be developed by the end of March 2025 and the optometry long term strategy to follow in 2025/26, with short term priorities completed in October 2024. The pharmacy strategy is currently in progress and optometry short term plans have been drafted. The latter includes longer term focus of prevention, inequalities, engagement and integration and resilience.	To finalise, publish and monitor performance against the pharmacy strategy and to complete and formally approve short-term priorities for optometry services.	2	*The recommendation has been accepted by the management team, and we can confirm that a pharmacy strategic plan is currently in development. While the draft is not yet in a format suitable for formal ICB governance approval, we are actively working to establish a clear strategic timeline in May. This timeline will support structured progress and completion across 2025/6. This should align with the forthcoming publication of the NHS long term plan anticipated in June 2025.* *Short term Optometry focus to be reviewed and formal plan to be documented and drafted for approval. Barrier to long term system wide planning is the lack of a team focused on the transformation of eye care pathways within the ICB who would focus on the enhanced service transformation within the community outside of the remit of the GOS contract.*	*31st March 2026 for both plans*	*Head of Primary Care Commissioning Pharmacy and Optometry*

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PRIORITY GRADINGS

1	URGENT	Fundamental control issue on which action should be taken immediately.
2	IMPORTANT	Control issue on which action should be taken at the earliest opportunity.
3	ROUTINE	Control issue on which action should be taken.

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
5	Delivery	From discussion with the Senior Commissioning Manager and the Lead Senior Primary Care Commissioning Manager – GP Medical funding for the Primary Care Network (PCN) Directed Enhanced Service (DES) contract is mostly made of Additional Roles Reimbursement Scheme (ARRS) which is c£29m. The number of Whole Term Equivalents (WTE) for each of the five PCNs shows considerable variations with the highest being 19.64 and the lowest being 9.04 and there is no stipulation on how the PCNs spend on this contract.	The ICB to establish its goals for the Additional Roles Reimbursement Scheme and how value for money can be measured across the PCNs use of these funds. A framework to then be developed to guide and monitor progress in delivering the objectives.	2	*While national guidance already exists for Primary Care Networks (PCNs) on the use of the ARRS scheme, outlining each role and its delivery requirements, developing a separate ICB framework would duplicate existing efforts.* *In addition, comparison of FTE would not be recommended as many roles have different funding bands which will impact the overall FTE figure. PCN's will have different WTE as there are variable allocations (i.e. some PCNs are larger than others) and they have determined different staffing skill mixes.* *The ICB's role is to monitor PCN ARRS based on the premise of the network contract DES, i.e. to address population health needs and health inequalities.* ***Implementation Objective:** Alternatively, the ICB should support the effective use of this national guidance by recommending that all patient-facing appointments are appropriately coded within clinical systems. This will enable PCNs to assess the impact of ARRS roles using both qualitative and quantitative metrics. To support this, the ICB should develop and implement a Business Intelligence (BI) dashboard that visualises key data such as appointment delivery, long-term condition (LTC) management, and other relevant outcomes. This tool will assist PCNs in workforce planning and ensure alignment with system-wide strategic objectives.*	*31st May 2026*	*Head of Primary Care Workforce*

PRIORITY GRADINGS

1	URGENT	Fundamental control issue on which action should be taken immediately.
2	IMPORTANT	Control issue on which action should be taken at the earliest opportunity.
3	ROUTINE	Control issue on which action should be taken.

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
6	Delivery	The DES PCN contract also includes a requirement for enhanced hours. Due to system limitations, it is not possible for the ICB to validate patients who have been offered appointments in enhanced hours; a work around has therefore been devised for a self-declaration every quarter, to be signed off by the PCNs.	The ICB to work with the NHSE and PCNs to establish a longer-term solution for the lack of data quality in relation to enhanced hour bookings. In the meantime, to progress the short-term solution for self-assessment declaration and spot checks through the ICB's primary care visit programme.	2	*Recommendation accepted. Review booked appointments on quarterly basis and provide a report to the ICB Delivery Group.* *Support PCNs to provide a monthly/quarterly return confirming the number of Enhanced Access Appointments offered and the number of appointments booked.* *ICB primary care Commissioning managers to review enhanced access data as part of the practice visit improvement programme.*	*30 March 2026*	*Associate Director of Primary Care Commissioning*

PRIORITY GRADINGS

1	URGENT	Fundamental control issue on which action should be taken immediately.
2	IMPORTANT	Control issue on which action should be taken at the earliest opportunity.
3	ROUTINE	Control issue on which action should be taken.

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
2	Directed	A check made against the risk register entry BORR09, Resilience of NHS General Dental Services and the draft Dental Service operational plan 2025/26 confirmed that control gaps included lack of in-depth knowledge about the resilience and stability of all dental services across Norfolk and Waveney: primary, community and secondary care services. It is not clear from the actions stated how this is to be resolved.	To ensure that the control gap in relation to knowledge of dental contractors is clearly stated and addressed.	3	*Recommendation accepted. Knowledge of ICB staff has developed significantly since April 2023 when the ICB took on responsibility as managing each contract event develops learning of individuals and the team, with reference to the NHSE Dental Policy Handbook, Regulations and using PCC for advice as required. Through proactive engagement with local providers, clinical colleagues and LDC, knowledge grows about individual providers and the challenges that impact on resilience and stability. As the ICB's understanding grows, it can (and is) put in a range of measures to build resilience and stability, e.g. use of flexible commissioning, rates of pay for dentists, workforce support, individual contract changes (subject to PSR). A BI Performance Dashboard is also being developed to monitor individual contracts. To note that some matters are outside the ICB's control, e.g. dental contract reform, investment in dentistry and long term workforce engagement with NHS services, ability to switch to private practice.* *The risk register updates will in future address the gaps in controls to provide assurance however it should be noted that InPhase only allows Controls and Actions to be input and updated.*	*Long term plan runs to 31/05/2029. Year 2 of the plan measures for 2025/2026 by 3/3/2026*	*Head of Primary Care Commissioning (Dental and GP)*

PRIORITY GRADINGS

1	URGENT	Fundamental control issue on which action should be taken immediately.
2	IMPORTANT	Control issue on which action should be taken at the earliest opportunity.
3	ROUTINE	Control issue on which action should be taken.

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
3	Directed	In terms of General Practice, the Assurance self-assessment return states that all areas are green. However, it is noted within the NHSE plan that a structured Practice Visit Programme (2025/2026) will be implemented to support quality improvement in general practice. This suggests that contract support was not fully embedded at the time of the 2023/24 return.	To review the assessment based on risks and actions set out within the operational plan submitted to NHSE.	3	*We accept the recommendation. The Practice Visit programme has commenced, with two practices visited to date- Magdalen and The Hollies. The plan for 2025/26 is to carryout 35 practice visits across the system per year.* *Review the Assurance self-assessment return submitted to NHS E to ensure actions set out in the Operational plan align in respect of the practice visit programme which was not fully embedded at the time of the 2023/24 return.* *To ensure quality and consistency, eDEC results will be incorporated into the practice visit discussions.* *A bi-annual progress report will be submitted to the respective governance structures to provide oversight, monitor implementation, and support continuous improvement.*	*31/03/2026*	*GP-Senior Commissioning Manager-*

PRIORITY GRADINGS

1	URGENT	Fundamental control issue on which action should be taken immediately.
2	IMPORTANT	Control issue on which action should be taken at the earliest opportunity.
3	ROUTINE	Control issue on which action should be taken.

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
4	Delivery	Pharmacy First includes - 1) 33% annual increase to all clinical pathway activity; 2) Hypertension: annual 12 month ICB average of 2750 hypertension appointments per month and increasing the number of pharmacies registered to provide the service from 93% to 98%; 3) Contraception: 12 month end target of 1000 contraception appointments with an uplift in pharmacy registered to provide the service from 85% to 98%. The Head of Primary Care Commissioning Community Pharmacy and Optometry stated that there is no dashboard in place currently but one has been requested.	The dashboard to enable monitoring of Pharmacy First performance to be put in place, and monitoring to commence to ensure performance is in line.	3	*The Pharmacy dashboard is in the process of being finalised with the BI team. The dashboard provides focus on the 3 main areas of focus within the operation planning tool of Pharmacy First clinical pathways, Hypertension case finding with a focus on APBM monitoring and the contraception service.* *The dashboard has currently gone for final review and sign off and the BI team have advised that is should be available for use from the end of May.*	*30/06/2025*	*Head of Primary Care Commissioning Pharmacy and Optometry*

PRIORITY GRADINGS

1	URGENT	Fundamental control issue on which action should be taken immediately.
2	IMPORTANT	Control issue on which action should be taken at the earliest opportunity.
3	ROUTINE	Control issue on which action should be taken.

Operational - Effectiveness Matter (OEM) Action Plan

Ref	Risk Area	Finding	Suggested Action	Management Comments
No OEMs arising.				

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ADVISORY NOTE

Operational Effectiveness Matters need to be considered as part of management review of procedures.

Findings

Directed Risk:

Failure to properly direct the service to ensure compliance with the requirements of the organisation.

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
GF	**Governance Framework**	There is a documented process instruction which accords with the relevant regulatory guidance, Financial Instructions and Scheme of Delegation.	Partially in place	1	-
RM	**Risk Mitigation**	The documented process aligns with the mitigating arrangements set out in the corporate risk register.	In Place	-	-
C	**Compliance**	Compliance with statutory, regulatory and policy requirements is demonstrated, with action taken in cases of identified non-compliance.	Partially In Place	2, & 3	-

Other Findings

In line with Ambition 2a within the 2024/25 Joint Forward Plan and following the ICB's consultation with Norfolk Healthwatch, leads from the acute sector and professional leads, and the Primary Care and Pharmacy and Dental Delivery Groups, a draft Strategic Framework: Primary Care Vision & Principles document has been produced. This was presented for discussion and approval at the Primary Care Commissioning Committee (PCCC) at its September meeting. The Committee members raised a series of challenges which was taken forward after proposals agreed. The updated Strategic Framework: Primary Care Vision & Principles was represented for information at the PCCC's December meeting. The 2025/26 JFP Ambition 2 has been updated by the Primary Care team and the full JFP was presented to the ICB in March 2025 for their approval.

Specific Key Performance Indicators (KPIs) for primary care covering all four services are included within the initial Operational Plan submitted to NHSE with a final submission due to NHSE by June 2025. Arrangements are in place to ensure that the submission is submitted on time.

The Terms of Reference for the PCCC and the Operational Delivery Groups sets out the different levels of decision making for these two bodies. A review of the Committee and Delivery Group Papers confirmed that the PCCC decisions were strategic in nature and included any escalated strategic issues from the delivery groups.

The ICB has one primary care strategic risk on its Board Assurance Framework (BAF): Primary Care Resilience and Transformation, and four risks on the Board Operational Risk Register (BORR). The latter risks provide more granularity in respect of the objectives in respect of the three services who have resilience issues; namely medical, pharmacy and dental services. A review of the last three Board and PCCC papers confirmed that these risks are presented at all meetings.

Other Findings

A review of updated documentary evidence relating to the 2024/2025 NHSE assurance submission confirmed some progress has been made in relation to each of the four services provided. The table below shows the number of green RAG rated assessments out of the total number criteria set for each element of each service. See Table 1 below.

Table 1 – Summary of Assurance Submission to NHSE 2023/24 and agreed estimated assessment for 2024/25

Service	Compliance Mandated	Service Planning/Provision	Contracting	Contractor Performance	Overall
Pharmaceutical	1/1 -----→----1/1	4/5----→---4/5	N/A	2/2---→---2/2	7/8-----→----7/8
Opthalmic	1/1------→----1/1	0/1----→---1/1	0/1---→----1/1	1/1---→---1/1	2/4-----→----4/4
Dental	1/1------→----1/1	1/1---→----1/1	0/2---→----2/2	0/1---→---0/1	2/5-----→----4/5
General Practice	1/1------→----1/1	1/1---→----1/1	2/2---→----2/2	1/1---→---1/1	5/5-----→----5/5
Overall	4/4-----→ ----4/4	6/8--→----7/8	2/5---→----5/5	4/5---→---4/5	16/22--→ 20/22

The table above shows that overall, the ICB RAG rated 16 out of the 22 compliance areas available as Green for the 2023/24 submission. The other six areas were RAG rated as Amber. Following review of the evidence provided there are four areas where improvements had been made. These were in the areas of service planning and contracting within Opthalmic and Dental services. A summary of each service in the order they are presented within the submission and examples of exceptions to the mandated requirements are explained below.

In terms of the Pharmaceutical Services seven out of eight areas were RAG rated green, with amber assessed within service planning and provision and contractor performance monitoring where developments for these are still required. A review of the risk BORR 27 the resilience of Community Pharmacy, confirmed that gaps in controls include lack of a performance dashboard and contract visit programme. Actions to address these within the risk register are stated as ongoing and rated as amber.

In terms of the Opthalmic Services, two out of the four criteria were RAG rated green and two were RAG rated amber. The two amber rating criteria were within service provision and planning and contracting. The issues were that there was a lack of monitoring of quality-of-service provision and that not all contracts had been signed. These have been addressed through recruitment to the team, embedded arrangements with the HWE ICB, and all contracts being reported as signed. This means all criteria are Green for this delegated service.

With regards to Dental Services three out of the six compliance criteria were rated as amber; these were two within contracting and one for contract monitoring and performance. From a review of updated evidence provided and implementation of the previous Internal Audit recommendations, it was agreed that the same assessment for this year would move the two contracting areas to Green. There is however more work to do in terms of monitoring the quality of service provided by contractors.

In terms of primary medical services, evidence was provided through all areas demonstrating continuation of longer standing delegated arrangements in place. The documentation included approval of Local Enhanced Services (LES), example of closure processes for a medical centre and procurement and monitoring of Alternative Provider Medical Services (APMS) including the Health Outreach APMS – Special Allocation Scheme. It also included how the ICB monitors practices and alerts the PCCC of those with a resilience risk.

A recommendation was made in the previous audit to schedule visits for all pharmacists RAG rated red, and these visits to be undertaken timely. A review of the latest pharmacy contract and quality risk register shows that there is still one pharmacy of the original four identified RAG rated red has not been visited, but this is due to a matter being dealt with by the NHSE Counter Fraud Team.

Delivery Risk:

Failure to deliver the service in an effective manner which meets the requirements of the organisation.

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
PM	Performance Monitoring	There are agreed KPIs for the process which align with the business plan requirements and are independently monitored, with corrective action taken in a timely manner.	Partially in place	4, 5, & 6	-
S	Sustainability	The impact on the organisation's sustainability agenda has been considered.	Out of Scope	-	-
R	Resilience	Good practice to respond to business interruption events and to enhance the economic, effective and efficient delivery is adopted.	Out of Scope	-	-

Other Findings

There are two national indicators that relate to Primary Care included in the ICB's Integrated Quality and Performance Report (IQPR) which is presented at Board meetings. These are: Continue to improve the experience of access to primary care, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are accessed the same or next day according to clinical need; and Increase dental activity by implementing the plan to recover; and reform NHS dentistry, improving units of dental activity (UDAs) towards pre-pandemic levels. Both of these, key performance indicators are reported as not meeting their current target and are unlikely to meet the target by the end of the financial year. Improvement plans are included for both of these within the 2025/26 Operational Plan submitted to NHSE.

In addition to the mandated NHSE key performance indicators the audit reviewed other examples of performance monitoring for the Primary Care Access Recovery Plan (PCARP) including Pharmacy First, and Primary Care Network Directed Enhanced Service (PCN DES).

In terms of PCARP, a ICB Board report presented at its meeting in November 2024 showed that it was updated on performance in relation to the action plan. The plan includes performance metrics in respect to the implementation and use of technology to enable access, self-referral pathways and community pharmacy initiatives (Pharmacy First) such as the provision of seven clinical pathways, hypertension and contraception. As agreed, the audit involved further review of Pharmacy to ascertain what is being monitored and how it fits in with the overall strategic aims for Primary Care. Pharmacy First is a national initiative and the ICB is required to provide a return on activity numbers for clinical pathways, blood pressure monitoring and oral contraception. This is information is fed back via a Pharmacy First Reporting Tool which shows how the ICB compares against an indicative contribution and with other ICBs nationally. The ICB is performing above the indicative contribution for Blood Pressure tests, but this is not the case for Clinical Pathways and Oral Contraception. Plans and key performance indicators are in place to improve the position for these services within the 2025/6 Operational Plan.

In terms of the PCN DES, an update was provided by the Senior Commissioning Manager, Delegated Primary Care – medical (GP) to the General Practice & Community Pharmacy Delivery Group to set out the proposed approach for monitoring and delivering the requirements of the PCN DES network contract and attempts to define each area of the PCN DES and suggests ways that they can be monitored and supported. Inherent weaknesses within monitoring processes were highlighted for the delivery group to agree the proposed approach for monitoring and reporting on the PCN DES.

EXPLANATORY INFORMATION

Appendix A

Scope and Limitations of the Review

1. The definition of the type of review, the limitations and the responsibilities of management in regard to this review are set out in the Annual Plan. As set out in the Audit Charter, substantive testing is only carried out where this has been agreed with management and unless explicitly shown in the scope no such work has been performed.

Disclaimer

2. The matters raised in this report are only those that came to the attention of the auditor during the course of the review, and are not necessarily a comprehensive statement of all the weaknesses that exist or all the improvements that might be made. This report has been prepared solely for management's use and must not be recited or referred to in whole or in part to third parties without our prior written consent. No responsibility to any third party is accepted as the report has not been prepared, and is not intended, for any other purpose. TIAA neither owes nor accepts any duty of care to any other party who may receive this report and specifically disclaims any liability for loss, damage or expense of whatsoever nature, which is caused by their reliance on our report.

Effectiveness of arrangements

3. The definitions of the effectiveness of arrangements are set out below. These are based solely upon the audit work performed, assume business as usual, and do not necessarily cover management override or exceptional circumstances.

In place	The control arrangements in place mitigate the risk from arising.
Partially in place	The control arrangements in place only partially mitigate the risk from arising.
Not in place	The control arrangements in place do not effectively mitigate the risk from arising.

Assurance Assessment

4. The definitions of the assurance assessments are:

Substantial Assurance	There is a robust system of internal controls operating effectively to ensure that risks are managed and process objectives achieved.
Reasonable Assurance	The system of internal controls is generally adequate and operating effectively but some improvements are required to ensure that risks are managed and process objectives achieved.
Limited Assurance	The system of internal controls is generally inadequate or not operating effectively and significant improvements are required to ensure that risks are managed and process objectives achieved.
No Assurance	There is a fundamental breakdown or absence of core internal controls requiring immediate action.

Acknowledgement

5. We would like to thank staff for their co-operation and assistance during the course of our work.

Release of Report

6. The table below sets out the history of this report.

Stage	Issued	Response Received
Audit Planning Memorandum:	17th December 2024	24th January 2025
Draft Report:	25th April 2025	6th May 2025
Final Report:	7th May 2025	