

Primary Care Commissioning Committee Part 1

Wed 14 May 2025, 13:30 - 16:30

Agenda

13:30 - 13:30 **Agenda**

0 min

Hein van den Wildenberg

 2025 05 14 Item 00 ICB Primary Care Committee Agenda Pt 1.pdf (2 pages)

13:30 - 13:30 **1. Chair's Introduction**

0 min

Information

Hein van den Wildenberg

13:30 - 13:30 **2. Apologies for Absence**

0 min

Information

Hein van den Wildenberg

13:30 - 13:30 **3. Declarations of Interest**

0 min

Information

Hein van den Wildenberg

 2025 05 14 Item 03 Declarations of Interest.pdf (5 pages)

13:30 - 13:30 **4. Review of Minutes and Action Log from the March 2025 meeting**

0 min

Decision

Hein van den Wildenberg

 2025 03 11 Item 04 NWICB PCCC Minutes Part One.pdf (12 pages)

 2025 05 14 Item 04 PCCC Action Log Part One.pdf (1 pages)

13:30 - 13:30 **5. Forward Planner**

0 min

Information

Sadie Parker

 2024 05 14 Item 05 NWICB PCCC Forward Planner 2025 2026 Part One.pdf (1 pages)

13:30 - 13:30 **6. Risk Register**


0 min

Decision

Sadie Parker

 2025 05 14 Item 06 Risk Summary Report.pdf (5 pages)

 2025 05 14 Item 06 Risk Register.pdf (18 pages)

 2025 05 14 Item 06 Inphase Download.pdf (3 pages)

13:30 - 13:30 **Service Development**

0 min

Webb, Sarah
13/05/2025 08:43:19

13:30 - 13:30 7. Primary Care Access Improvement Plan

0 min

Information *Amanda Sear*

- 📄 2025 05 14 Item 07 Primary Care Access Improvement Plan PCCC Paper.pdf (3 pages)
- 📄 2025 05 14 Item 07 Primary Care Access Improvement Plan Board Paper.pdf (15 pages)

13:30 - 13:30 8. Long Term Plan - dentistry

0 min

Decision *Fiona Theadom*

- 📄 2025 05 14 Item 08 Long Term Plan - Dentistry.pdf (17 pages)

13:30 - 13:30 9. Integrated Performance Report

0 min

Decision *Diane Smith / Jane Hackett*

- 📄 2025 05 14 Item 09 Integrated Performance Report.pdf (3 pages)
- 📄 2025 05 14 Item 09 PCCC Proposals tier 1-3 KPI.pdf (3 pages)

13:30 - 13:30 10. Strategic Estates Report

0 min

Information *Paul Higham*

- 📄 2025 05 14 Item 10 Strategic Estates Update.pdf (11 pages)

13:30 - 13:30 11. Strategic Prescribing Report

0 min

Information *Michael Dennis*

- 📄 2025 05 14 Item 11 Strategic Prescribing Report.pdf (9 pages)

13:30 - 13:30 Finance & Governance

0 min

13:30 - 13:30 12. Delivery Group Reports • General Practice & Community Pharmacy • Dental Services Report

0 min

Information *Shepherd Ncube / Fiona Theadom*

- 📄 2025 05 14 Item 12 Delivery Group Report - Dental.pdf (4 pages)
- 📄 2025 05 14 Item 12 Delivery Group Report - GPCP.pdf (5 pages)

13:30 - 13:30 13. Strategic Finance Report M12

0 min

Information *James Grainger*

- 📄 2025 05 14 Item 13 Strategic Finance Report M12.pdf (8 pages)

13:30 - 13:30 14. Pharmaceutical Services Regulations Committee • Reports from the Pharmaceutical Services Regulations Committee • General Ophthalmic Services Quarter End Update report

0 min

Information *Gregg Syder*

Webb Smith
13/05/2025 08:49:19

- 📄 2025 05 14 Item 14 PSCR Quarterly Report Front Sheet.pdf (2 pages)
- 📄 2025 05 14 Item 14 PSCR Quarterly Report.pdf (4 pages)
- 📄 2025 05 14 Item 14 General Ophthalmic Services Update.pdf (3 pages)

13:30 - 13:30 15. National Contracts for 2025/26 • General Practice • Pharmacy

0 min

Information *Shepherd Ncube /Sharon Gardner*

- 📄 2025 05 14 Item 15 Contracts - General Practice.pdf (29 pages)
- 📄 2025 05 14 Item 15 Contracts Pharmacy.pdf (8 pages)

13:30 - 13:30 16. E-Declaration Report for General Practice

0 min

Decision *Shepherd Ncube*

- 📄 2024 05 14 Item 16 E-declaration report for General Practice.pdf (6 pages)

13:30 - 13:30 17. Local Dispute Resolution for Primary Care Contracts

0 min

Decision *Fiona Theadom*

- 📄 2025 05 14 Item 17 Local Dispute Resolution for Primary Care Contracts.pdf (15 pages)

13:30 - 13:30 Any Other Business

0 min

13:30 - 13:30 18. Any Other Business • Questions from the public

0 min

Information *Hein van den Wildenberg*

Meeting of the Norfolk and Waveney ICB Primary Care Commissioning Committee
Wednesday 14 May 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. <i>For Noting</i>	Chair
4.		Review of Minutes and Action Log from the March 2025 meeting <i>For Approval</i>	Chair
5.		Forward Planner <i>For Noting</i>	SP
6.	13:40	Risk Register <i>For Approval</i>	SP
Service Development			
7.	13:50	Primary Care Access Improvement Plan <i>For Noting</i>	AS
8.	14:00	Long Term Plan – Dentistry <i>For Approval</i>	FT
9.	14:10	Integrated Performance Report <i>For Approval</i>	Diane Smith/ Jane Hackett
10.	14:20	Strategic Estates Report <i>For Noting</i>	PH
11.	14:30	Strategic Prescribing Report <i>For Noting</i>	MD
Finance & Governance			
12.	14:40	Delivery Group Reports <ul style="list-style-type: none"> General Practice & Community Pharmacy Dental Services Report <i>For Noting</i>	SN/FT
13.	14:50	Strategic Finance Report M12 <i>For Noting</i>	JG
14.	15:00	Pharmaceutical Services Regulations Committee <ul style="list-style-type: none"> Reports from the Pharmaceutical Services Regulations Committee General Ophthalmic Services Quarter End Update report <i>For Noting</i>	GS
15.	15:10	National Contracts for 2025/26 <ul style="list-style-type: none"> General Practice Pharmacy <i>For Noting</i>	SN/SWh/SG
16.	15:20	E-Declaration Report for General Practice <i>For Approval</i>	SN
17.	15:30	Local Dispute Resolution for Primary Care Contracts <i>For Approval</i>	FT
Any Other Business			
18.	15:40	Any Other Business <ul style="list-style-type: none"> Questions from the public 	Chair
Date, time and venue of next meeting Tuesday 8 July 2025 13:30 – 16:30 – ICB PCCC To be held via videoconference and You Tube			

Item	Time	Agenda Item	Lead
		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 .	

Webb, Sarah
13/05/2025 08:58:19

**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	#####	Present	
Debbie Bartlett	Local Authority Partner Member on ICB	Norfolk County Council		X		Direct	Interim Executive Director Adult Social Services, Norfolk County Council	Jun-23	01/04/2025 Retired October 2024	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		Diss Parish Fields			X	Direct	Patient at a Norfolk and Waveney GP Practice	Jun-23	01/04/2025 Retired October 2024	Withdrawal from any discussions and decision making in which the Practice might have an interest
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

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		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 Stephengate Practice			X		GP partner of St Stephengate 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

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		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)										

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Bill Borrett	Member of the Integrated Care Board	Norfolk County Council		X		Direct	Elected Member of Norfolk County Council	2009		
		Breckland District Council		X		Direct	Elected Member of Breckland District Council	*2007		
		the Local Government Association Safer Communities Board		X		Direct	Member of the Local Government Association Safer Communities Board	*2021		
		Property Owner	X			Direct	Property Owner in Norfolk	*2003		
		North Elmham			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
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

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		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 Col and withdraw from meeting if discussions take place that might benefit Harleston practice

Webb Sarah
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Norfolk and Waveney Primary Care Commissioning Committee
Part One

Minutes of the Meeting held on
Tuesday 11 March 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 March 2025
Patricia D’Orsi	PDO	Executive Director of Nursing, Norfolk and Waveney ICB (joined 14:10)
Steven Course	SC	Executive Director of Finance, Norfolk and Waveney ICB
Karen Watts	KW	Director of Nursing and Quality, Norfolk and Waveney ICB (deputising for Tricia D’Orsi) (joined 14:00 left 14:10)

In attendance

Name	Initials	Position and Organisation
Lisa Drewry	LD	Executive Officer, Norfolk and Waveney Local Medical Committee
Gemma Claridge	GC	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
Andrew Hayward	AH	Trustee of Healthwatch Norfolk
Anne Heath	AHe	Associate Director, Digital, Norfolk & Waveney ICB
Kirsty Hockley	KH	Commissioning Support Officer, Pharmacy and Optometry, Norfolk and Waveney ICB (observing)
Shepherd Ncube	SN	Associate Director of Delegated Commissioning, Norfolk and Waveney ICB
Sadie Parker	SP	Director of Primary Care, Norfolk and Waveney ICB
Jayde Robinson	JRo	Jayde Robinson Head of Primary Care Workforce, 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
Jason Stokes	JS	Secretary, Norfolk Local Dental Committee (LDC)
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	Commissioning Support Officer – Dental, Norfolk and Waveney ICB – minute taker
Ian Wilson	IW	Executive Officer, Norfolk and Waveney Local Medical Committee

Apologies received

Name	Initials	Position and Organisation
Sarah Buchan	SB	Practice Manager Specialty Advisor

Mark Burgis	MB	Executive Director of Patients and Communities, Norfolk and Waveney ICB
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

No	Item	Action owner
1.	Chair's introduction The Chair welcomed attendees to the March 2025 Committee meeting.	Chair
	Matters Arising There were no matters arising.	
2.	Apologies for absence	Chair
	Apologies noted above. The Chair noted insufficient voting members were present at the start of the meeting for the meeting to be quorate. Quoracy obtained at 14:00.	
3.	Declarations of Interest <i>For Noting</i>	Chair
	None declared	
4.	Review of Minutes and Action Log from the January 2025 Committee <i>For Approval</i>	Chair
	The minutes were agreed to be an accurate record of the January 2025 Committee meeting and minutes would be sent to the Chair for signing. ACTION: SW to send Chair signed minutes for safekeeping. – Action completed and closed. Action Log The Chair noted all actions were marked as complete.	SW
5.	Forward Planner <i>For Noting</i>	SP
	SP highlighted the items in red on the forward planner and would not be presented today due to the number of items due and prioritising the agenda for this meeting. Work was underway on the forward plan for 2025/2026 and this would be presented at May 2025 Committee and shared offline in advance for comments. The forward plan was duly noted.	
6.	Risk Register <i>For Approval</i>	SP
	SP introduced a different format to the report. The new system for risk reporting, Inphase, the ICB adopted had reported some technical issues with the download. SP provided a summary report of all of the risks and there was a proposed new dental risk contained within the agenda pack. The current score placed it on the Operational Risk Register which would then be monitored through the Dental Services Delivery Group. SP proposed the medicines risk move to the Medicines Optimisation Programme Board which reported into the Commissioning and Performance	

<p>Webb, Sarah 13/05/2025 09:16</p>	<p>Committee. This followed a request from Michael Dennis as the risk was monitored there following the restructure of the organisation.</p> <p>IW had a question on BORR11 – the Resilience of General Practice. The impact of both the National Insurance (NI) uplift and the National Living Wage (NLW) increase do not seem to be reflected in the scores under that measure. IW asked for an explanation given the ongoing pressures on general practice from April 2025 onwards.</p> <p>SP invited JG to respond to this. A letter had been received before Christmas from the Secretary of State advising of an uplift but it was unclear how it translated into the budget.</p> <p>JG confirmed there was some disparity in our understanding of the published allocation uplift received from NHS. The current information from national colleagues was that negotiations were underway and there was potential for additional allocations to come. The ICB were unaware of when or to what value. JG was aware this did not provide a satisfactory answer but did provide some hope that the Secretary of State letter had a value against it which had not been reflected in the current allocation uplift.</p> <p>HW requested the team take an action to review the risk in light of the latest update and provide an update at the next meeting mid-May 2025 at which point there would hopefully be more clarity and the Committee could take a view. HW did not propose to change the risk yet and the totality of those further insights could help inform whether 16 was the right rating.</p> <p>SN added that he had discussions with a number of practices to understand their risks and the impact of the position was not yet clear. SN hoped that once further conversations had been held there would be a better understanding of this and would report back at the next Committee.</p> <p>ACTION - SN to review risk BORR11 Resilience of General Practice to ensure scoring is correct in view of NI and National Living Wage uplift</p> <p>LD reported on feedback reported into the LMC. Patient demand outstripped capacity and had impacted staff health and wellbeing and this increased week on week. LD asked if that could be considered when the risk was addressed as it was of concern.</p> <p>HW thanked LD and indicated in Part 2 there would be an opportunity to hold a deeper dive into resilience.</p> <p>HW confirmed he approved ORR16 move to another Committee.</p> <p>HW had a question on BORR27 The Resilience of Community Pharmacy as the Committee had not considered it in the round and it had a similar risk rating to the general practice risk. HW invited SG to explain the detail behind the risk and the key actions to help reduce the risk.</p> <p>SG thanked HW. It was important to recognise the risk for Community Pharmacy formally within the ICB and that Community Pharmacies were funded significantly differently from other providers with no support for estates, IT or training. Some of the generic financial issues raised remained the same as for the rest of primary care but pharmacy had its own challenges in adapting to change for the future. There was no confirmation of the new contract for</p>	<p>SN</p>
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pharmacy which remained in negotiation. This hampered the ability for the ICB and providers to strategically plan for the future due to the flat funding pharmacies received over the last 5 years. Financial viability remained one of the main drivers for the risk. There was the potential for more pharmacy closures which would in turn impact the ability of the remaining pharmacies to provide enhanced services such as Pharmacy First due to excessive demand to dispense.

SG referred to a poll in November 2024 of the National Pharmaceutical Association members in respect of collective action. There was overwhelming support for this course of action. No action had been decided upon and the outcome of contractual negotiations was awaited. If collective action was supported there was the potential for a reduction in opening hours and service provision.

The ICB had been able to mitigate some of the risk against the reduction in opening hours however the ICB would not be able to mitigate the service risk as it was an unknown entity.

Community pharmacy workforce remained unstable with high vacancy rates for both pharmacist and technicians and low whole time equivalent comparison to other areas in England. Community pharmacy had been tasked with the provision of more clinical services which required workforce transformation. There was a lack of funding support from NHS England into the training hub, plus no protected learning time for professionals in Norfolk and Waveney. Potentially the model was not sustainable for the future.

The ICB continued to work on long term development of the strategy and to support contractors to be fit for the future. The ICB was reviewing opportunities to support providers with some finances to ensure their businesses were fit to provide additional clinical services, (increasing consultation room space) and to invest in technology to support dispensing automation. Section 105 funding was currently the option being explored with the estates team. The ICB continued to work closely with contractors and the LPC to mitigate the risk.

HW referred to the last point around the special care dental services risk to be included. There was a proposed reduction in the mitigated score. HW asked FT to explain what drove the reduction in the mitigated score.

FT confirmed it was a new risk presented to delivery group earlier in the year hence the two actions highlighted.

The Special Care Dental Services more commonly known as Community Dental Services formed a critical part of the primary and community care dental pathway for which the ICB were responsible alongside secondary care.

It was important to recognise the risks around special care dental services, particularly as these services see, treat and care for our most vulnerable children and adults.

When the risk was first rated, it was rated high. A number of actions had since been taken to mitigate this. The proposal was to lower the risk to 12. Workforce across the whole of primary care dental services was a key risk and if the actions were not taken, then that risk may escalate.

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	<p>HW confirmed his agreement to accept the risk as proposed and if the risk dropped below 12 it would enter the Operational Risk Register.</p> <p>Risk register updates, including the transfer of the medicines risk, were approved.</p>	
7.	Strategic Digital Report	AH
	<p><i>For Noting</i></p> <p>AH presented the Strategic Digital Report to Committee for noting.</p> <p>Key Highlights:</p> <ul style="list-style-type: none"> • The infrastructure upgrade programme was coming to a close and all the practices would have WIFI installed, which was the last component of the programme that would go live in all GP practice sites by the end of March 2025. This would improve speed and ease working between sites as laptops and mobile devices connected seamlessly. The use of mobile devices was more reliable. • Closure of the Cloud Telephony Project at the end of March 2025, as planned. • AI and how this could be used to improve productivity was of great interest in primary care. Several projects would be started and a Governance Committee would be set up to consider all the issues related to the use of AI in the clinical environment. <p>HW had an interest in the NHS App as the Government had been vocal around its increased functionality both in secondary care but also in primary care. HW asked if AH could share any information on this.</p> <p>AH confirmed that 58% of residents were now registered on the NHS App and there was a desire to encourage the other 42% to use the NHS App. Healthwatch had done a fantastic job in engaging with different populations such as younger people that may not necessarily use GP practices as much.</p> <p>The focus was on integrating secondary care functions onto the App, the patient engagement portals for example, and the ability to book follow up appointments in secondary care. AH reported the functionality in primary care was good.</p> <p>Another development was the digital barcode for prescriptions that people would be able to take into a pharmacy, scanned in order to have a prescription issued.</p> <p>HW had a question around notes digitisation and asked if this was a pilot project with NHS England</p> <p>AH confirmed there was a new facility with NHS England, and a new way of digitising notes, known as the National Document Repository (NDR). As patients moved practice or babies were born, their record would be digital right from the start and paper records would not be moved to the new practice, they would be digitised instead.</p>	

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	<p>At the new GP practice, details would be logged in to the NDR and they would access the patient's record from there, download it and attach it to their GP clinical system to prevent paper-based records being moved around.</p> <p>Norfolk & Waveney was chosen as a pilot for this work as the ICB had various types of notes digitisation. Work had been done to digitise notes in the traditional way and attach to the patient record in the clinical system. Digitised notes were stored on the secure SharePoint site and on a hosted site. The NHS England project looked at various ways to get all of those notes onto the NDR and make them available. AH hoped to use some end of year funds to help digitise a few more practices as so much space was taken up with paper notes.</p> <p>HW thanked AH for her work and the update.</p> <p>The report was duly noted.</p>	
<p>8.</p>	<p>Primary Care Workforce Recruitment and Retention Programme - Strategic Report <i>For Noting</i></p>	<p>JRo</p>
	<p>JRo presented the Primary Care Workforce Recruitment and Retention Programme - Strategic Report for noting.</p> <ul style="list-style-type: none"> • The report provided a strategic overview of the last 12 months and the operational delivery that the primary care workforce team delivered in line with strategic ambitions. • Clear focus for a system wide approach for workforce planning process. • Real emphasis on the business intelligence modelling. • Expanded learning organisations across the system and educators. • Utilised AI software in terms of vacancy levels across the system within primary care. • Supported the roll out and expansion of our coastal rule programmes. • Delivered general practice and primary care network workforce programmes for a number of years. A focus this year with optometry workforce and dental workforce programmes. <p>HW thanked JRo for the update and opened for questions and comments.</p> <p>LD had concerns there were vacancies but practices were not able to recruit due to financial restrictions. LD was not aware this data was captured and thought this was a gap. LD acknowledged the work done to improve health and well-being however, the LMC were receiving reports staff were going off long term with stress and burnout due to resilience issues within general practice at the present time.</p> <p>JRo agreed AI mapping would only pick up vacancies being advertised as that was the data extracted. Vacancies not advertised through recruitment companies or externally were unable to be quantified. JRo highlighted practices were encouraged to utilise support and offers as outlined in the report but not every practice was taking up all workforce programmes offered which included health and well-being programmes. Only 79% of practices within general practice were actually utilising the support offered. JRo would continue to review what was on offer based on feedback from local intelligence that would help to inform the planning cycle for 25/26.</p>	

	<p>HW asked for the detail behind the workforce planning tool, asking if JRo could provide further information and what the functionality was.</p> <p>JRo confirmed this had been co-designed directly with general practices initially. The tool was flexible and could be applied to any primary care setting. This would look at their current workforce profile and future profile, for example staff retirement and vacancy levels and to look at the 5-year picture. In terms of recruitment and planning cycles it was a tool each practice could use for workforce requirements business modelling.</p> <p>HW asked for an estimate on how many practices were using this.</p> <p>JRo responded around 40% and Primary Care Networks were encouraged to use it. This was a fairly new tool and it was expected the utilisation of the tool would be enhanced. It had been showcased at the East of England and Regional Level so that others could adopt the model approach, as part of sharing best practice.</p> <p>NS asked if the workforce team had looked at the prospective dental school in Norwich as it might have a primary care workforce modelling in regard to supervisory and clinician time and the limit to the number of appointments being delivered. NS referred to the appendix which appeared to show the aim to recruit additional foundation training practices had not been the greatest success and asked if it would be a struggle to find sufficient practices that could help with education going forward.</p> <p>JRo thanked NS and agreed that the team had not been able to deliver what was intended due to the cycle of the approval process for training practices. JRo confirmed that her team were working with a number of practices now to increase placement capacity, and this would remain a key priority for 2025/26.</p> <p>HW thanked JRo for a good discussion.</p> <p>The report was duly noted.</p>	
<p>9.</p>	<p>NHSE 2025/26 priorities and operational planning guidance <i>For Noting</i></p>	<p>AS</p>
<p>Webb, Sarah 13/05/2025 08:19:19</p>	<p>AS presented the NHSE 2025/26 priorities and operational planning guidance for noting.</p> <p>AS highlighted the following:</p> <ul style="list-style-type: none"> • The annual operational planning exercise was being undertaken collaboratively across the ICS and all the Trust partnerships. • There was a focus on access and experience for our population. • Primary care formed a relatively small part of the whole exercise. • The aim was the expectation of the documentation remaining live across the ICS and with national and regional NSHE colleagues • To monitor interdependencies and a shared understanding of these, where risks are identified and how these would be monitored and mitigated throughout the year. • To tie the reporting with other items such as PCARP (primary care access recovery plan). <p>No questions received.</p>	

	HW thanked AS for the update.	
10.	Henoch-Schonlein Purpura Locally Enhanced Service <i>For Approval</i>	GC
	<p>GC presented the Henoch-Schonlein Purpura (HSP) Locally Enhanced Service paper for approval to commission a new locally enhanced service to cover HSP monitoring within primary care.</p> <p>GC provided a brief background and summary.</p> <ul style="list-style-type: none"> • HSP is an uncommon form of vasculitis which largely affects children – around 20 in 100,000. • Children are diagnosed in secondary care and when diagnosed required clinical monitoring for 6 months which involved up to 4 follow up appointments. • The current arrangement was that in some cases families were given a letter to take to the GP with instructions about monitoring the child. • There had been no agreed pathway or funding to support this within primary care. • Each hospital had a different pathway with different expectations from their local GPs. • Work had been undertaken by the ICB with the 3 acute trusts to unify a pathway. All 3 agreed to use the Nottingham Children’s Hospital guidance and the ICB had used this to base the specification on. • Currently practices may not have the expertise or the equipment (paediatric BP cuffs) required to do this work within their core service provision. • HSP monitoring has been identified as a clinical priority area by the System Interface Group. • The proposal had been taken through prioritisation, the Quality impact assessment and the Equality and Health Inequality impact assessment and through the triple lock for finances which had all been approved to support this service. The team was currently working through the provider selection regime process and the specification was now finalised. • Approval was sought from PCCC to allow providers to opt in to deliver the service if they wish from 1 April 2025. <p>IW thanked the ICB for the specification and the LMC were supportive of the specification and the paper.</p> <p>PD’O agreed that it was important to have this pathway which led her to consider there were other pathways to bring together and there was a need to have a rolling programme to review these.</p> <p>HW confirmed GC had the approval from Committee.</p> <p>Committee approved the request.</p>	
11.	Delivery Group Reports <ul style="list-style-type: none"> • General Practice & Community Pharmacy • Dental Services Report – focus on long term dental plan • Dental Development Group Report <i>For Noting</i>	SN/FT
	General Practice & Community Pharmacy	

SN confirmed the General Practice & Community Pharmacy Delivery Group report was for noting and was to keep members informed of discussions held on 14 January 2025 and 11 February 2025. Both meetings were well attended and declared quorate.

SN highlighted the approvals made:

- Received approval for the boundary changes for Park Surgery and Fleggburgh surgery in Great Yarmouth and Waveney.
- Approval for recommissioning of LES (local enhanced services) due to expire at the end of the year. LES would be commissioned in future rather than LCS (locally commissioned services).

Dental Development Group

FT provided a brief highlight on the Dental Development Group which was an informal forum where ideas were shared around dental commissioning plans and proposals. This report summarised the last meeting. FT commented how grateful the ICB were to all the local providers and stakeholders who participated in the Group to inform development of plans and the Group would continue into next year.

Dental Services Report – focus on long term dental plans

FT confirmed the report summarised the most recent two meetings of Dental Services Delivery Group from January and February 2025. Both meetings were fully quorate. FT drew attention to the decision made around the referral management system noting that the contract would be extended for the electronic system for oral surgery referrals going into Level 2 or Level 3 services.

The report also provided an update on progress on the long-term dental plan as an Appendix to the main report. Some of the plans laid out last May had taken time to progress and that was partly to ensure new pathways introduced worked successfully and were supported by clinical engagement and key stakeholders. FT confirmed the Child Focused Dental Practice pathway would be launched this month and the Shared Care Pathway in the early part of next financial year. FT drew attention to the unscheduled care/ urgent care treatment appointments and increased numbers provided. This service would continue into next year and planning guidance from the national team had been received as to what expectations were for the ICB for the next year.

FT compared the number of new patients seen in April 2023/24 to 2024/25: more than 4000 more new patients had been seen in 2024/25 than in the previous year. Plans for 2025/2026 and proposed outcome measures would be brought to the Committee in May 2025.

HW thanked FT for her update.

NS confirmed the government had decided not to proceed with the new patient premium which was introduced last year to encourage new patients where dentists were paid an additional fee. He believed the mobile dental van project was also unlikely to progress given the costs associated with this.

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	<p>PD'O was pleased to see the entry around Child Focused Dental Practices as paediatric data showed issues around extractions and PD'O hoped the increase in capacity should see better outcomes for children. PD'O asked FT when there would be enough coverage given the small number of 6 practices starting and what good coverage would look like.</p> <p>FT confirmed the ICB wanted to start small and undertake a collaborative working partnership within Community Dental Services. There was a need to ensure the pathway worked well and successfully before we sought to expand it. Work was being done with the Community Dental Service to understand the data and how much demand there was. FT pointed out that as access generally improved, the number of children who may need to go through this pathway may increase and therefore there may not be an initial reduction in children needing general anaesthetics in secondary care however, that was the long-term aim. The team was being supported by the ICB's Research and Evaluation team with the monitoring and evaluation of the programme, which would include both provider and patient key stakeholder feedback over the next 18 months.</p> <p>NS thanked FT and her team for the work done on the shared care pathway. NS informed Committee the shared care pathway was designed to help patients who struggled to find a dentist who had been advised by a consultant they must have their teeth and oral health assessed before they undertook any course of treatment and in many cases, this would be cancer treatment. This would be an extremely stressful time for cancer patients and NS welcomed this initiative.</p> <p>HW thanked NS for the recognition of this and thanked FT for the update.</p> <p>The reports were duly noted.</p>	
<p>12.</p>	<p>Strategic Finance Report <i>For Noting</i></p>	<p>JG</p>
	<p>JG presented the Strategic Finance Report to Committee for noting.</p> <p>JG highlighted some of the pertinent points and concentrated on the Executive Summary.</p> <ul style="list-style-type: none"> • At Month 10 the budget was forecast to be overspent by £8.9m. • This was split into £3.4m for GP prescribing and £5.5m for primary care. • For the GP prescribing overspend of £3m, the variance was predominantly down to the slippage in the original efficiency target. Slippage on these efficiencies had decreased in recent months mainly from direct prices the ICB had benefitted from. • There had been some benefit from back dated VAT claims for oxygen due to a change in the VAT treatment of oxygen costs and the ICB benefitted from zero rating of those oxygen invoices. • Primary care variance £5.5m. Locally commissioned services (LCS) had contributed £1.5m to that overspend due to the additional activity within the complex dressing scheme and a change in the payment mechanism for that LCS. • ARRS and Estates additional spend. The value of £3.5m ARRS expenditure had been paid to the ICB within Month 11 and that reduced the overall variance. • A further £0.5m of direct patient care increases mainly within estates related expenditure. 	

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	<ul style="list-style-type: none"> • Smaller variances with GP IT, optometry, dental and unidentified efficiencies within the Primary Care Directorate. • Efficiencies – Month 10 the efficiency delivery was up to 90% of the original target of £14.9m. Schemes overachieving were the price benefits from Rivoraxaban, Apixiban and oxygen costs. • 2025/26 planning - the recent allocation uplift guidance gave a figure of 2.57% recurrent which equated to £5.8m for primary medical care which was less than the headline number given by the Secretary of State letter where cash growth and 4.8% growth figure were quoted. This had been queried at a national primary care finance call where NHS England had said this was unusual for the figure to be quoted before negotiations were concluded and there was a possibility of further allocation revision going forward. <p>HW thanked JG for answering questions offline and had a question on the LCS Activity Tracker. He drew attention to lower expenditure on care homes and an increased expenditure on PSA. HW asked if there was anyone close the LCS activity.</p> <p>SN confirmed that a process was underway to review activities and would confirm back at a later date.</p> <p>ACTION: SN to report on LCS activity at a future Committee</p> <p>PD'O had attended a Norfolk & Waveney Primary Care Advanced Practice Learning and Networking Event and this was the first meeting. One of the areas spoken about was PSA and the variability and this was an opportunity to think about standardisation. PD'O would welcome a conversation with SP or one of her team on this work going forward to apply the right framework for screening in our areas as screening and immunisations would be handed to the ICB next year.</p> <p>ACTION: PD'O/SP/team to discuss a framework for screening and immunisations</p> <p>The Strategic Finance Report was noted.</p>	<p>SN</p> <p>PD'O SP</p>
<p>13.</p>	<p>Pharmaceutical Services Regulations Committee Reports from the Pharmaceutical Services Regulations Committee <i>For noting</i></p>	<p>GS</p>
	<p>GS presented the Reports from the Pharmaceutical Services Regulations Committee for noting.</p> <p>GS provided some background for context:</p> <ul style="list-style-type: none"> • The paper was prepared by Herts & West Essex Pharmacy and Optometry Team. • Pharmaceutical Services Regulations Committee (PSRC) was hosted and chaired by Herts & West Essex Integrated Care Board who worked on behalf of all 6 ICBs to makes decisions as part of the PSRC under the Pharmacy Regulation Act. <p>GS drew attention to various sections on the report which included:</p> <ul style="list-style-type: none"> • Market entry and market entry applications. • Market entry applications under appeal. 	

	<ul style="list-style-type: none"> • Fitness decisions and fitness decisions under appeal. • Regulatory timescales. <p>The paper highlighted the decisions made for the Committee.</p> <p>HW thanked GS for the update.</p>	
14.	Terms of Reference For Approval	FT
	<p>FT presented the Terms of Reference to Committee for approval.</p> <p>FT asked the Committee to approve the changes set out in the paper and recommend approval to the ICB Board.</p> <p>The changes were minor and included flexibility in local authority representation in order they could nominate an appropriate individual to attend and a minor change highlighted the oversight assurance role of the Committee and to make specific reference to Pharmacy First.</p> <p>HW confirmed that the Committee approved these amendments and they would be presented to ICB Board for final approval.</p>	
15.	Any Other Business	Chair
	There was no other business.	
	Questions from the Public	Chair
	There were no further questions and the meeting closed at 14:35 hours.	

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

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

Norfolk & Waveney IBC Primary Care Commissioning Committee - Part One Action Log
 14 May 2025

No	Meeting date added	Agenda Item	Owner	Action Required	Action Undertaken / Progress	Due date	Status	Date Closed
0197	11-Mar-25	6	SN	Risk Register Item - Review risk BORR11 Resilience of General Practice to ensure scoring is correct in view of NI and National Living Wage uplift	The 2025/26 GP Contract has been agreed, confirming an 8% uplift to the global sum. NHS England has stated that this uplift includes provision for the 1.2% National Insurance-related cost pressures. This represents a positive step towards strengthening resilience in general practice. It is recommended that the current risk score remains unchanged until ICB budgets are fully implemented in Q1. Propose to close	14-May-25	open	
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.	14-May-25	open	
0199	11-Mar-25	12	PDO / 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.	14-May-25	open	

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NWICB Primary Care Commissioning Committee Part One 2025-2026

Item	14-mai-25	08-jul-25	01-okt-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	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)
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-annually
Pharmaceutical Needs Assessment							SG	Released in October 2025
Long Term Plans 2025-2026	Y						FT/SN/SG	Dental May 2025, others TBC
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
Delivery Report		Y	Y	Y	Y	Y	AS/SP	Incorporate Operational Planning and Complaints (and possibly Director of Primary Care Overview).
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	Y	SG	Noting/assurance.
Optometry Services – contractual changes and other matters				Y		Y	SG	Noting/assurance
Freedom to Speak Up							DT	HW FTSU ICB sponsor - TBC
TIAA Audit Report		Y					LB	
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								

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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:	14 May 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.

Background and context to service risks

The primary care team leads undertook a deep dive meeting into the dental risks, facilitated by the corporate affairs team. This was valuable and enabled colleagues to review the way they were recording and updating risks in InPhase accordingly. Further deep dives meetings will be held in due course.

Use of the InPhase system itself remains challenging.

Community Pharmacy

The new Pharmacy contract was released end March 2025 alongside an economic analysis of the pharmacy sector which still confirms a £2bn funding deficit against what is provided versus what is needed to provide pharmaceutical services so although the new contract is positive it may not fully mitigate the risk. Remuneration of advanced services is changing with bundling of services being required to receive payments so this may result in some contractors to be at a disadvantage which may increase the risk of closure due to financial viability concerns which in turn would impact the ability of the remaining pharmacies to provide advanced services such as Pharmacy First due to excessive demand to dispense. Until the data is available to advise the ICB of the impact, a score reduction is not appropriate.

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Dentistry

The challenges around dental workforce recruitment and retention and contract reform remain in place and will take time to resolve. Whilst the ICB is able to mitigate some of the challenges however some of them remain outside ICB control. Until action is taken to resolve some of them, the stability of NHS dental services in Norfolk and Waveney remains fragile and there is an ongoing risk of practice switching to private practice. Improving access is directly linked to being able to recruit and retain a multi-skilled dental workforce across all dental services (primary, community and secondary care) and therefore the risk score remains the same in all of the risks.

General Practice

The primary risk facing general practice is around resilience, the main drivers are: workforce pressures, financial constraints, increased demand for services from the local population, and the need for greater efficiency savings.

To help address these challenges, the 2025/26 GP contract has been agreed, with a significant uplift in both core General Practice and Network Contract DES funding-amounting to a 7.2% increase. This represents the largest investment in general practice in over a decade. Additional funding is also anticipated following the 2025/26 DDRB pay review outcome. We note the LMC continues to be concerned about the impact of the NI employers contributions changes on practices and this will be monitored going forwards. At this stage the scoring of the risk has not been changed.

To manage demand and capacity, key actions include the rollout of GP improvement programmes, support for practices to adopt the Modern General Practice model, and the development of a neighbourhood approach aimed at tackling health inequalities through early intervention.

Recommendation to Committee:

To approve risk changes.

Governance

Committee Approval

Primary Care Commissioning Committee May 2025

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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											

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											
	25	BORR09 Resilience of NHS General Dental Services in Norfolk and Waveney	12	20											
	71	BORR Special Care Dental Services	12	16											
	23	BORR11 The resilience of general practice	12	16											
	56	BORR27 The resilience of Community Pharmacy	12	16											
ORR	53	ORR17 General Practice – Allied Health Professionals Workforce including PCN Additional Roles	8	12											
	54	ORR18 General Practice – Workforce (GPs and Nurses)	8	12											
	55	ORR19 Severe Mental Illness (SMI) Annual Physical Health Checks	8	12											
	56	PC06 Learning Disability Annual Physical Health Checks	9	9											

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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
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

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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)

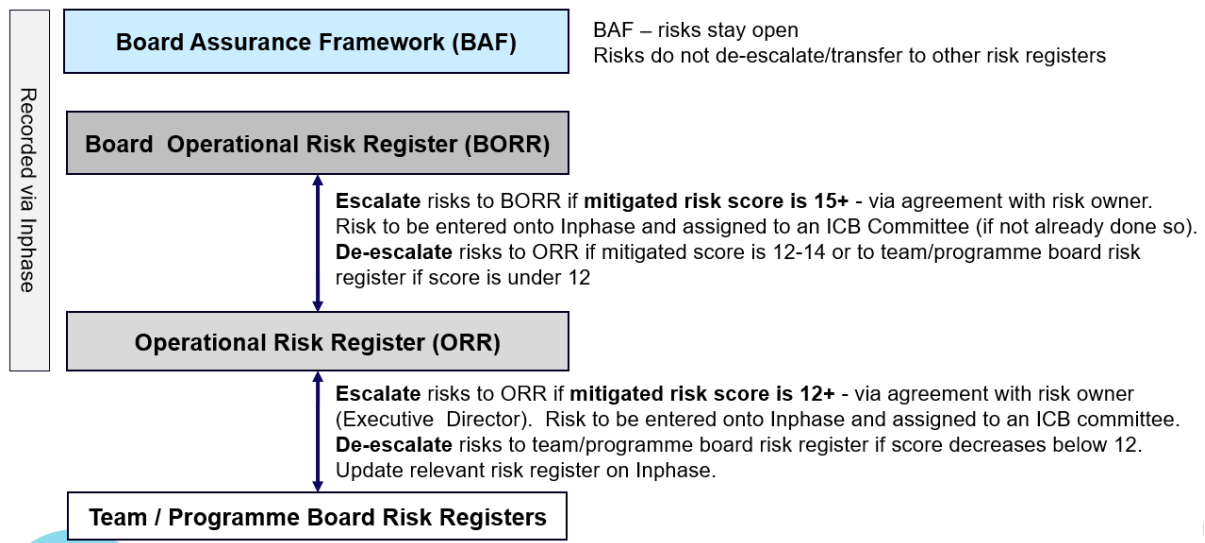
- Committee risks with a mitigated risk score of 12+
- Reported to EMT & reviewed by committees

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.



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Risk Id	Risk Title	Description	Risk Owner	Risk Committee	Operational Lead	Date Risk Identified	Target Delivery Date	Unmitigated Score	Mitigated Score	Target Score
23	The resilience of general practice	<ul style="list-style-type: none"> • 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	20	16	12

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Control Description	Action Description	Action Owner	Action Start Date	Action Due Date
Commencement of LMC General Practice Alert System sitreps	Delays to standard contract gap analysis by providers following prioritisation of national self-assessment tool. Work programme in development for system interface group to ensure this is built in for 2025.			
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.	<p>Work is underway to establish new local interface groups to support the interface work programme underway. A work programme for 2024/25 is in development.</p> <p>31.03.2025 update: Engagement with the three place leads East, West and Central (North, South and Norwich) has been established, to identify their lead in the Local Interface. All three place leads work slightly differently; East have an agreed operational meeting in place with primary and secondary care representation on a monthly basis, which the Interface Manager will attend to support. Central is currently transitioning, but have also engaged with Interface Manager to create space for conversations regarding interface with Practice Managers and along with West, raise issues direct. The Interface Manager also meets regularly with Trust Interface Leads, the LMC and other system leads to ensure continuity.</p> <p>Work programme for 2025 is in development and awaiting approval.</p>	Sadie Parker	01/01/2025	18/04/2025
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.	Roll out of pathology requesting progressing slowly, as per interface work. ICB Board has requested a plan and trajectory for this, which has been requested from JPUH and NNUH, QEH is already in place.	Amanda Sear	01/12/2024	18/04/2025
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.				
System interface group with representation from primary, community and secondary care system partners established. Local interface groups around the three acutes expected to be established by April 2025.				

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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
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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	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 commissioning plans, including the Long Term Dental Plan.	02/20/2025 Discussions underway to agree Year 2 mobilisation of Long Term Dental Plan commissioning for 2025/2026, subject to ICB governance approvals. This will include developing plans for long term sustainability of orthodontic services, commissioning of Level 2 services and oral health prevention for children and young people and older people. 20/03/2025 Plans to be submitted to OMB on 7 April and to Primary Care Commissioning Committee in May 2025 for approval 16/4/2025: Plans supported by OMB, individual project PMO and Triple Lock governance to follow. Implementation plans with timelines & roles being finalised by Dental Team.	Sadie Parker	02/01/2025	14/05/2025
Dental Services Delivery Group established reporting to PCCC	To mobilise the Shared Care Pathway with local providers and to agree referral pathway from secondary care to primary care	Fiona Theadom	20/02/2025	30/04/2025
Active engagement is taking place with dental contractors, LDC and Local Professional Network (and Managed Clinical Networks); A regular dental newsletter is in place	To commission additional 21,520 appointments to meet national target for ICB by end March 2026. Calculations to estimate impact for ICB finalised by 20/3/2025 for submission to NHS England by 27 March. To obtain approval from ICB OMB in April for investment To engage with local providers, agree plans for approval by Primary Care Commissioning Committee in May 2025 16/4/2025 - OMB agreed investment required. Discussions with local providers underway.	Fiona Theadom	20/02/2025	14/05/2025
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.				

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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
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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	Fiona Theadom	01/04/2025	not set
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	Sadie Parker	01/05/2024	31/05/2025
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	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	Fiona Theadom	20/02/2025	30/04/2025
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 ERIA completion. Date for completion revised to end May 2025	Sadie Parker	01/05/2024	31/05/2025

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32	Primary Care Resilience and Transformation	<p>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.</p> <p>Our high-level outputs include:</p> <ul style="list-style-type: none"> • 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 <p>Primary Care Services are the responsibility of the Integrated Care Board, including the recruitment and retention of healthcare professionals.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>	Mark Burgess	Primary Care Commissioning Committee	Sadie Parker	29-Aug-24	31-Mar-27	20	20	12
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<p>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.</p>	<p>•Oct Materials being developed to support general practice in referring to Pharmacy First. Relaunch of Pharmacy First coming on line in early November. NWCB performance on Pharmacy First is strong when compared to regional colleagues however there is more opportunity to increase referrals •Nov/Dec Pharmacy First activity continues to grow, however there remains much potential and referrals from general practice and NHS111 are relatively low. The likelihood of collection action by community pharmacy is increasing, following support to a national ballot by The National Pharmacy Association. Potential impact being modelled. •Jan Community Pharmacy Contract negotiations due to commence January 2025, likelihood of collective action is heavily dependent on the result of these negotiations. Norfolk and Waveney General Practice Referral Toolkit launched to support Pharmacy First which still shows steady growth. Workforce Rsk incorporated into overall Community Rsk PC20.</p>	<p>Sadie Parker</p>	<p>28/10/2024</p>	<p>28/02/2025</p>
<p>Clinical expertise provided by Clinical and Care Professional and Clinical Fellow roles across primary care.</p>	<p>Now/Dec Continuing to work on priority areas set out in Long Term Plan with a focus on health inequalities. Significant ongoing political interest, which impacts on capacity of the team. Clinical advisor has commenced in role and is already making an impact in the work we do and the support to the team. Jan The national DCRB 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 2025 16/4/2025 - OMB Approval received to enable individual project governance</p>	<p>Sadie Parker</p>	<p>28/10/2024</p>	<p>28/02/2025</p>
<p>Local LMC General Practice Alert System established which informs improvement and support work monitored through the PCCC.</p>	<p>Now/Dec Ongoing close monitoring of GP collective action. Referring by letter rather than form is increasing across practices, as reported by providers. Lack of winter resilience funding for general practice is causing concern with practices already reporting increased activity. At the same time, EDs are reporting a significant increase in minors activity. Vision and principles document has been approved, and a PCAPP report has been noted by the ICB Board at its me Jan Ongoing ICB monitoring of GP collection action with regional oversight. Increases being seen in primary care activity across emergency departments and general practice. 7.2% cash growth to GMS has been announced, equivalent to 4.8% real growth. National contract negotiations are ongoing.</p>	<p>Sadie Parker</p>	<p>28/10/2024</p>	<p>28/02/2025</p>
<p>Long term dental plan has been published, with delivery monitored through PCCC.</p>	<p>The focus for the remainder of the current financial year will be on developing a strategic framework for primary care. This will be set against the backdrop of uncertainty and unrest for many primary care providers in terms of national contracts and funding and at a time when national policy drivers are expected to come into play which support and accelerate opportunities for transformation. The document will seek to underpin long-term plans for each pillar and accommodate the forthcoming 10-year plan and operational guidance. The framework will seek to provide contractors and system partners with clarity on local priorities for primary care commissioning and support available for them to be confident and effective system partners. The framework will also reflect the opportunities associated with the significant levels of capital investment planned in N&W together with the collective focus across the ICS on addressing health inequalities.</p>	<p>Sadie Parker</p>	<p>28/10/2024</p>	<p>31/03/2025</p>

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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
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Advanced Practice Forum established.	<p>Latest NHSE workforce data illustrates the following:</p> <ul style="list-style-type: none"> •2.9% growth in Direct Patient Care workforce roles across N&W during the period of February 2024 vs February 2025 (651 WTE). •1.9% growth in non-clinical roles (1776 WTE) 	Jayde Robinson	22/04/2025	31/03/2026
AI software mapping and reports provided for vacancy levels for primary care.	<p>As of 22nd April 2025, the following positions currently advertised for recruitment within general practice, linked to this risk are:</p> <ul style="list-style-type: none"> •10 x Direct Patient Care Roles (Practice employed) •10 x non-clinical roles (Practice employed) 	Jayde Robinson	22/04/2025	31/03/2026
<p>Coastal and Rural project to support geographical areas facing greater challenges in recruitment, e.g. West and East</p> <p>Communication Engagement strategies updated to reflect PCN development updates and post pandemic environment.</p> <p>Workforce data to measure trajectory levels against actual recruitment.</p> <p>Workforce team recruited in ICB structure.</p> <p>Wide range of initiatives in place to support GP retention.</p> <p>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).</p> <p>PCN AFRS Workforce - online portal for 2024/25 for PCNs to update and draw national funding down to NHSE to inform Training Hub spending.</p> <p>Primary Care Networks (PCNs) supported to develop and implement workforce trajectories in support of the Additional Roles Recruitment Scheme (ARRS).</p> <p>Primary Care Equality, Diversity and Inclusion Fellow recruited.</p> <p>Primary Care Health & Wellbeing Fellow recruited.</p> <p>Primary Care Workforce Transformation Team supported by Clinical Fellowships and Secondments</p> <p>Primary Care Workforce Strategy 2024-2027</p> <p>Succession planning led recruitment to support practice and PCN with demand vs capacity requirements.</p> <p>Training Needs Analysis completed for 24/25.</p>				

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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
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<p>Advanced Practice Forum established.</p>	<p>Latest NHSE workforce data illustrates the following: •0% increase in Nursing workforce roles across N&W during the period of February 24 vs February 25. 444 WTE are in place across the system. •2.7% growth in GP workforce roles (excluding training GPs) during the same period. 536 WTE are in place across the system. •8.4% growth in GP Trainees across N&W during the same period. 155 FTE are in place across the system.</p>	<p>Jayde Robinson</p>	<p>22/04/2025</p>	<p>31/03/2026</p>
<p>AI software mapping and reports provided for vacancy levels for primary care.</p>	<p>As of 22nd April 2025, the following positions currently advertised for recruitment within general practice, linked to this risk are: •4 x Practice Nurse •3 x Advance Nurse Practitioner •12 x Salaried GPs</p>	<p>Jayde Robinson</p>	<p>22/04/2025</p>	<p>31/03/2026</p>
<p>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 AFRS 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.</p>				

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55	Severe Mental Illness (SMI) Annual Physical Health Checks	<p>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.</p> <p>2. There is a risk that the ICB may not meet the committed national target of 75% annual health checks delivered.</p> <p>3. There is a level of risk to practice resilience if the minimum threshold, and therefore payment, is not reached.</p>	Mark Burgis	Primary Care Commissioning Committee	Sadie Parker	27-Dec-24	31-Mar-26	16	9	4
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A 2-year improvement trajectory has been agreed with NHS England taking into account the revised national target	Complete routine SMI data update report for next GPCPDG meeting	Charles Morrow	27/03/2025	01/05/2025
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.	Conduct quarterly SMI working group with appropriate stakeholders.	Charles Morrow	27/03/2025	08/05/2025
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).				

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56	The resilience of Community Pharmacy	<p>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</p> <p>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.</p> <p>The rurality of Norfolk and Waveney does mean that this risk is significantly projected due to geographical distance between existing providers.</p>	Mark Burgis	Primary Care Commissioning Committee	Sharon Gardner	27-Dec-24	01-Sep-27	20	16	12
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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	Gregg Syder	10/04/2025	31/05/2025
Establishment of Head of Pharmacy Workforce role within the ICB reporting into the Chief Pharmacist	NPA ballot confirmation- no further details available with potential date for action to be set in the new year. Risk remains the same as above we no ability to plan for any reduction in service provision because of the collective action. Main services that could be impacted are delivery services, provision of Dossett boxes and public health service such as the provision of emergency contraception GS- 10/4/25 - New pharmacy contract announced 31/3/25 - NPA reviewing outcome and consulting with members regarding any future collective action.	Gregg Syder	21/02/2025	31/05/2025
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				

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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
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Active engagement with dental contractors, LDC and Local Professional Network (and Managed Clinical Networks), regular dental newsletter in place	To review GFFT 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 GFFT report outcomes indicators for reporting on a bi-monthly basis.	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 GFFT report for reporting alongside waiting list information. Bi-monthly meetings to review outcomes to be set up from May 2025.	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	Fiona Theadom	03/01/2025	30/04/2025
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				

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Risk ID	Risk Title	Description	Risk Owner	Risk Committee	Operational Lead	Date Risk Identified	Target Delivery Date	Unmitigated Score	Mitigated Score	Target Score	Control Description	Action Description	Action Owner	Action Start Date	Action Due Date
23	The resilience of general practice	<ul style="list-style-type: none"> 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 write 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 Burgess	Primary Care Commissioning Committee	Sadie Parker	01-Sep-20	31-Mar-26	20	16	12	Commencement of LMC General Practice Alert System steps	Delays to standard contract gap analysis by providers following prioritisation of national self-assessment tool. Work programme in development for system interface group to ensure this is built in for 2025.			
											PCN/NHS (additional rates reimbursement scheme) funding has provided additional capacity but has not grown in this contract year. CPs have been added to the scheme.	Work is underway to establish new local interface groups to support the interface work programme underway. A work programme for 2024/25 is in development.	Sadie Parker	01/01/2025	16/04/2025
											Local safety 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.	Roll out of a pathway reviewing provider (own) as per interface work. ICB Board has requested a plan and trajectory for this, which has been requested from PHM and NPHM. CPs in groups in place.	Wendie Bell	01/12/2024	28/04/2025
											Standard contract requirements in relation to gap analysis and action plans, including reviewing being reviewed by contract teams. New national requirement for providers to self-assess using national tool by 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 contracts.			
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 Burgess	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	Fiona Theobald	17/04/2025	31/07/2025
											Local dental contract under development.	18/4/2025 tender published for new contract in Hutt and Wals	Fiona Theobald	20/02/2025	31/07/2025
											Dental Development Group established to engage with key stakeholders to commissioning plans, including the Long Term Dental Plan.	02/02/2025 Discussions underway to agree Year 2 mobilisation of Long Term Dental Plan commissioning for 2025/2026, subject to ICB governance approval. This will include developing plans for safe term sustainability of orthodontic services, commissioning of Level 2 services and oral health prevention for children and young people and older people.	Sadie Parker	02/01/2025	14/05/2025
											Dental Services Delivery Group established reporting to PCCC	To finalise the Shared Care Pathway with local providers and to agree referral pathway from secondary care to primary care	Fiona Theobald	20/02/2025	30/04/2025
											Active engagement in taking place with dental contractors, LDC and Local Professional Network (and Managed Clinical Networks). A regular dental newsletter is in place	To commission additional 21,500 appointments to meet national target for ICB by end of March 2025. Calculators to estimate impact for ICB finalized by 20/02/2025 for submission to NHS England by 27 March.	Fiona Theobald	20/02/2025	14/05/2025
											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 to manage primary care dental services.	To obtain approval from ICB OMB in April for investment			
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 Burgess	Primary Care Commissioning Committee	Sadie Parker	01-Feb-24	31-Mar-26	20	18	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 ICs in region to monitor and agree outcome from April 2026	Fiona Theobald	01/04/2025	not set
											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.	NHS in quality team			
											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	Shared Care pathway under development by ICB. 02/02/2025 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 provide 20/03/2025 Options for referral pathway discussed with Right team	Sadie Parker	01/05/2024	31/05/2025
											Dental Services Delivery Group established reporting to PCCC	Suffolk and North East Essex (SNEE) lead for East of England (EoE) ICs in relation to secondary care matters that rely on collaboration and wider impact across EoE and for escalation. - MCN agreed by Primary Care Directors.	Sadie Parker	01/03/2024	30/09/2024
											NHS England Long Term Workforce plan published June 2024	02/02/2025 MCN work programme and resource need under review for 2025/2026. ICB requesting baseline data from N&W across by end March to inform next steps and support. SNEE project team reviewing oral surgery data L2 and L3) with MCN Chair chair support			
											NHS England Local Term Workforce plan published June 2023	20/03/2025 SNEE programme team have requested oral surgery data from Referral Management system providers. ICB receiving request with 10 team. SNEE programme to continue into 2025/2026, no additional resource required - completion date extended to 30/09/2025			
											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 secondary care contracts.	16/4/2025 Academic Programme report progress to date submitted to ICs, to present to Dental Services Delivery Group in June 2025 for review and to Dental Development Group for discussion			
											Local dental contract under development	Referral rates requested from 3 secondary care providers, required from MUM 04/03/2025	Fiona Theobald	20/02/2025	30/04/2025
											Standard contract requirements in relation to gap analysis and action plans, including reviewing being reviewed by contract teams. New national requirement for providers to self-assess using national tool by 6 monthly.	To share up an Equality Impact Assessment and Clinical Quality Risk Assessment with support from Quality team	Sadie Parker	01/01/2024	31/05/2025
											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 contracts.	20/03/2025 Evidence date has been requested from secondary care providers to inform EIM completion. Date for completion revised to end May 2025			
											NHS England Local Term Workforce plan published June 2023				
											NHS 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 secondary care contracts.				
Local dental contract under development															
Suffolk and North East Essex ICB (SNEE) lead in region for secondary care work programme.															
Clinical Advisor for Diversity recruited to ICB from October 2024															
Monthly Ombudsman in place at ICs in relation															

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55	Severe Mental Illness (SMI) Annual Physical Health Checks	<p>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.</p> <p>2.There is a risk that the ICB may not meet the committed national target of 75% annual health checks delivered.</p> <p>3. There is a level of risk to practice resilience if the minimum threshold, and therefore payment, is not reached.</p>	Mark Burgess	Primary Care Commissioning Committee	Sadie Parker	27-Dec-24	31-Mar-26	16	9	4	<p>A 2-year improvement trajectory has been agreed with NHS England taking into account the revised national target</p> <p>Increase SMI update and engagement via established communication channels, including but not limited to the GP Bulletin, Place colleagues, Intranet and Together for Mental Wellbeing campaigns</p> <p>Conduct quarterly SMI working group with appropriate stakeholders</p> <p>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</p> <p>Regular assurance reports to NHSE/IA/PCCC</p> <p>Practice sign-up to the SMI IES. This provides payment for enhanced checks (An additional payment for 3 extra checks)</p>	<p>Complete routine SMI data update report for next DPCPOG meeting</p> <p>Charles Morrow</p> <p>27/03/2025</p> <p>01/05/2025</p>	<p>Charles Morrow</p> <p>27/03/2025</p> <p>08/05/2025</p>
56	The resilience of Community Pharmacy	<p>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.</p> <p>The rurality of Norfolk and Waveney does mean that this risk is significantly projected due to geographical distance between existing providers.</p>	Mark Burgess	Primary Care Commissioning Committee	Sharon Gardner	27-Dec-24	01-Sep-27	20	16	12	<p>Engagement with all stakeholders to support update in Pharmacy services including locality teams, CPMS and the LNC</p> <p>Establishment of Head of Pharmacy Workforce role within the ICB reporting into the Chief Pharmacist</p> <p>Procurement of provider to manage a project focusing on the integration of community pharmacy with other healthcare providers, show case good practice, identify areas of improvement and further better working relationships</p> <p>Set in place with NHSE 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 opportunities</p> <p>Integration local risks to continue in line with the integration project to support local PCN support between community pharmacy and general practice to ensure accessibility available to pharmacies within rural areas additional functions overviewed</p> <p>Quality assurance collaboration with QA/ICB team in developing and maintaining the community Pharmacy risk register which outputs the pharmacy visit plan</p> <p>Strong engagement with CPMS provides a foundation of support for contractors in maximising opportunities available both nationally and those provided locally</p> <p>Inclusion of Community Pharmacy in the operational delivery group and also regular consulted around Pharmacy matters to PCCC</p>	<p>Detail Analysis of New Pharmacy Contract & Economic Report</p> <p>NPA final confirmation - no further details available with potential date for action to be set in the new year. Risk remains the same as above no ability to plan for any reduction in service provision because of the collective action. Main services that could be impacted are delivery services, provision of Diabetes and public health service such as the provision of emergency contraception</p> <p>05 - 10/04/25 - New pharmacy contract announced 31/03/25 - NPA reviewing outcome and consulting with members regarding any future collective action</p>	<p>Greg Syder</p> <p>10/04/2025</p> <p>31/05/2025</p> <p>Greg Syder</p> <p>21/02/2025</p> <p>31/05/2025</p>
71	Special Care Dental Services	Lack of resilience and stability for Special Care Dental Services (known as Community Dental Services)	Mark Burgess	Primary Care Commissioning Committee	Fiona Theadom	20-Feb-25	31-Mar-26	16	12	9	<p>Active engagement with dental contractors, LDC and Local Professional Network (and Managed Clinical Networks), regular dental newsletter in place</p> <p>Clinical expertise provided by NHSE through the LPLN, MCN and Senior Clinical Fellow roles during 2024/2025 for strategic development, transformation and commissioning purposes</p> <p>Dental Data Review being updated to inform commissioning plans</p> <p>Dental Development Group established to engage with key stakeholders to agree short term plan by Sept 2023</p> <p>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 collaborations</p> <p>Dental Services Delivery Group established reporting to PCCC</p> <p>ICB primary care team recruited and in place including Strategic Quality Dental Nurse in Quality team, ICB Clinical Adviser - Dentistry and Finance colleagues, and Commissioning Team for secondary care dental services</p> <p>NHS England Long Term Workforce plan published June 2023</p> <p>NHS Business Services Authority performance/quality management reporting and quality framework in place with regular meetings established with the ICB. Access to</p> <p>John Dental data management reports and dashboard for ICB staff</p> <p>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</p> <p>Quarterly contract review meetings in place with community dental services provider</p> <p>New focused dental budget for investment</p>	<p>To review GRRF report for Community dental services with provider, assess impact and next steps</p> <p>20/02/2025 meeting arranged with community dental services 2/4/2025 to discuss report and impact</p> <p>30/4/25 update. Agree to use GRRF report outcomes and data for reporting on a bi-monthly basis</p> <p>To review service provision and waiting lists with provider at quarterly meetings to inform future commissioning need</p> <p>20/02/2025 meeting arranged 2/4/2025 to review with provider</p> <p>30/4/2025 update. Agree to use outcome indicators in GRRF report for reporting alongside waiting list information. Bi-monthly meetings to review outcomes to be set up from May 2025.</p> <p>To consider opportunities for upskilling workforce through Level 2 accreditation to support recruitment and retention. Development work supported by MCN Chairs</p> <p>Discussions taking place with ICB Primary Care workforce team, local provider and MCN Chairs to agree support from ICB schemes for recruitment</p>	<p>Fiona Theadom</p> <p>01/02/2025</p> <p>30/06/2025</p> <p>Fiona Theadom</p> <p>20/02/2025</p> <p>31/10/2025</p> <p>Fiona Theadom</p> <p>20/02/2025</p> <p>30/06/2025</p> <p>Fiona Theadom</p> <p>03/01/2025</p> <p>30/04/2025</p>

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Subject:	ICB Report on primary care access recovery plan and improving the issues across the primary-secondary care interface
Presented by:	Amanda Sear, Head of Primary Care Strategic Planning
Prepared by:	Primary Care, Commissioning and Digital ICB Teams
Submitted to:	Primary Care Commissioning Committee
Date:	14 May 2025

Purpose of paper:

Following the report on progress against the national requirements set out by NHS England (NHSE) in the Plan for Recovering Access to Primary Care (PCARP taken to General Practice and Community Pharmacy Delivery Group on 8 April 2025), an updated version for presentation to the ICB Board meeting scheduled for 21 May 2025 in public is attached for noting.

Executive Summary:

The report has been revised to reflect feedback from the Delivery Group and the latest information available at the time of writing.

Recommendation:

The Committee are asked to note the Board report.

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Key Risks	
Clinical and Quality:	Quality and capacity in primary care can be impacted due to inefficient working arrangements across the primary- secondary care interface, causing resilience and workforce issues
Finance and Performance:	<p>Care capacity can be negatively impacted due to inefficient working arrangements across the primary-secondary care interface</p> <p>Failure to progress across all the interface requirements of the plan may affect the ICB's and ICS assurance process</p> <p>The ICB and system partners may have to consider developing alternative pathways to meet identified gaps in service provision</p>
Impact Assessment (environmental and equalities):	Reduced capacity could constrain the ability to address health inequalities.
Reputation:	<p>Non-delivery of the ambitions outlined within the plan poses a significant system reputational risk due to the high profile of the plan nationally</p> <p>Lack of perceived progress against primary secondary interface poses a reputational risk with primary care providers</p>
Legal:	None identified
Information Governance:	System IG Peer Group in place working across ICS.
Resource Required:	Primary Care Workforce Transformation, Primary Care Delegated Commissioning, Community Pharmacy, Medical, Digital and Commissioning teams all support contractors with delivery
Reference document(s):	<p>Delivery plan for recovering access to primary care (england.nhs.uk)</p> <p>Delivery Plan for Recovering Access – Update published 9 May 23 updated 3 September 2024 https://www.england.nhs.uk/long-read/delivery-plan-for-recovering-access-to-primary-care-2/</p> <p>Delivery Plan for Recovering Access – Update and Actions published April 2024</p>

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	<p>NHS England » Delivery plan for recovering access to primary care: update and actions for 2024/25</p> <p>Cloud Based Telephony https://www.england.nhs.uk/long-read/funding-for-practices-moving-to-digital-telephony/</p> <p>DPN Data Provision notice https://digital.nhs.uk/binaries/content/assets/website-assets/corporate-information/directions-and-data-provision-notices/data-provision-notices/cloud-based-telephony/20240816-cloudbasedtelephonydataprovisionnoticev1.0.pdf</p> <p>https://www.england.nhs.uk/gp/national-general-practice-improvement-programme/modern-general-practice-model/.</p>
NHS Constitution:	<p>NHS Standard Contract https://www.england.nhs.uk/publication/primary-medical-care-policy-and-guidance-manual-pgm/</p>
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	Paper taken to General Practice and Community Pharmacy Delivery Group on 8 April 2025 for assurance discussions; updated version taken to Primary Care Commissioning Committee on 14 May for noting
Process/Committee approval with date(s) (as appropriate)	Risk to resilience of primary care and transformation, on BAF and monitored through Primary Care Commissioning Committee, current score of 20

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Subject:	Report on primary care access recovery plan and improving the issues across the primary-secondary care interface
Presented by:	Mark Burgis, Executive Director of Patients and Communities
Prepared by:	Primary Care, Commissioning and Digital ICB Teams
Submitted to:	ICB Board
Date:	21 May 2025

Purpose of paper:

This paper is an opportunity for the Board to review progress at year end on [the Delivery Plan for Recovering Access to Primary Care](#); and, as part of this, the on-going work to support improvements across the primary-secondary interface. It will also provide an overview of Community Pharmacy.

The paper is for noting.

Executive Summary:

This paper sets out progress made against national requirements set out by NHS England (NHSE) in the Plan for Recovering Access to Primary Care (PCARP)

PCARP includes a range of actions across different areas, including the provision of digital infrastructure; the expansion of clinical services available at community pharmacies; incentives for groups of GP surgeries to work at scale; and workforce recruitment and retention schemes. What binds these actions together is the ways for ICBs to support primary care providers to work more closely together to better understand and respond to the needs of their population, with a focus on addressing health inequalities. This supports a move towards prevention while ensuring appropriate workload for general practice.

These initiatives are also sometimes referred to as “*modern general practice*” (see graphic for this model in body of paper) and are central to the 2022 publication: *Next steps for integrating primary care: Fuller Stocktake Report* [Fuller Stocktake](#).

Overarching aims for PCARP include:

- Improving patient experience of access and allocation
- Improving staff working environments
- Better aligning capacity with need

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Plan for Recovering Access to Primary Care (PCARP)

Key outcomes expected for the second half of 2024/25 included:

- Progress against our interface programme of work and delivery across four key areas
- Increased sign up to and usage of the NHS App together with ongoing support for educational events
- Completion of cloud-based telephony system upgrade programme for GP surgeries
- Support programme for GP surgeries (*General Practice Improvement Programme – GPIP*) to manage workload and better respond to patient needs through the adoption of *Modern General Practice* principles
- Promote a culture of quality improvement across primary care, harnessing the power of technology where appropriate to support this

1. Background

Norfolk & Waveney Integrated Care System's Vision for Primary Care is for primary care providers to work collaboratively, embedded in their communities, in a way which brings joy and meaning to the workforce and improves outcomes for all our residents.

The **Norfolk & Waveney Integrated Care System 5 Year Joint Forward Plan** includes an aim to bring primary care providers together with their communities and local partners to understand, and respond using their collective assets, to the needs of those they serve with a focus on targeting resource on the highest need - see **Ambition 2 Primary Care Resilience and Transformation** for more detail. [Primary Care, Joint Forward Plan](#)

This paper is presented in the spirit of our commitment to listen to those who receive, deliver or plan primary care.

2. Delivery Plan for Recovering Access to Primary Care - Key Metrics

Increase the use of NHS App and other digital channels to enable more patients access to their prospective medical records and manage repeat prescriptions.

- 559,008 Norfolk and Waveney (N&W) patients have registered for the NHS App (58% of GP patients 13 years +), seeing us broadly in line with national benchmarking, which shows 60% of GP patients aged over 13 have registered for the NHS App.
- N&W saw a significant increase in appointments being booked via the app in January 2025 (see Image 1 below), though there is variation across Primary Care Networks (PCNs). The range in appointments being booked via the app by GP surgery is extensive, with 3 surgeries showing 0 appointments to a surgery that has seen 37,605 appointments booked since the NHS App functionality was implemented. It should be noted that some surgeries use other online solutions to enable appointment booking.

Monthly Appointments Managed

Cancelled Booked

5,465

▲ 0.0%

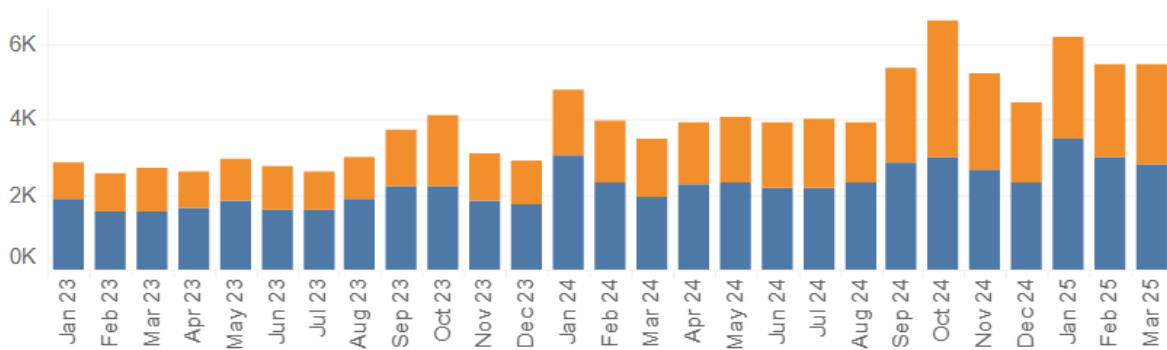


Image 1: Appointments Managed by N&W Registered Patients via the NHS App (Jan 2023 – March 2025)

- N&W ICB have the highest number of NHS App logins per 1000 GP registered population in the East of England (EoE) region (see Image 2 below). Other than October 2024 (which saw the highest total logins for N&W), March 2025 saw an increase in activity with 1,009,983 logins across N&W.

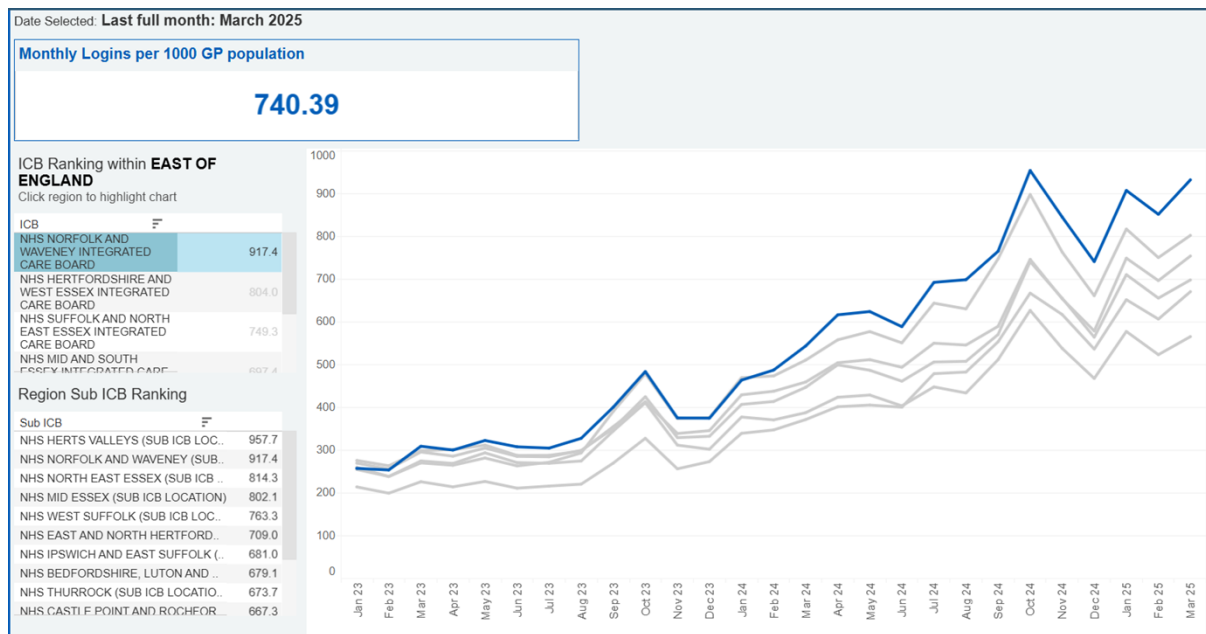


Image 2: Monthly NHS App Logins per 1000 GP registered population by EoE ICB (Jan 2023 – March 2025)

- N&W saw the highest number of repeat prescriptions being ordered via the NHS App in January 2025, with March 2025 showing similar activity (see Image 3 below).

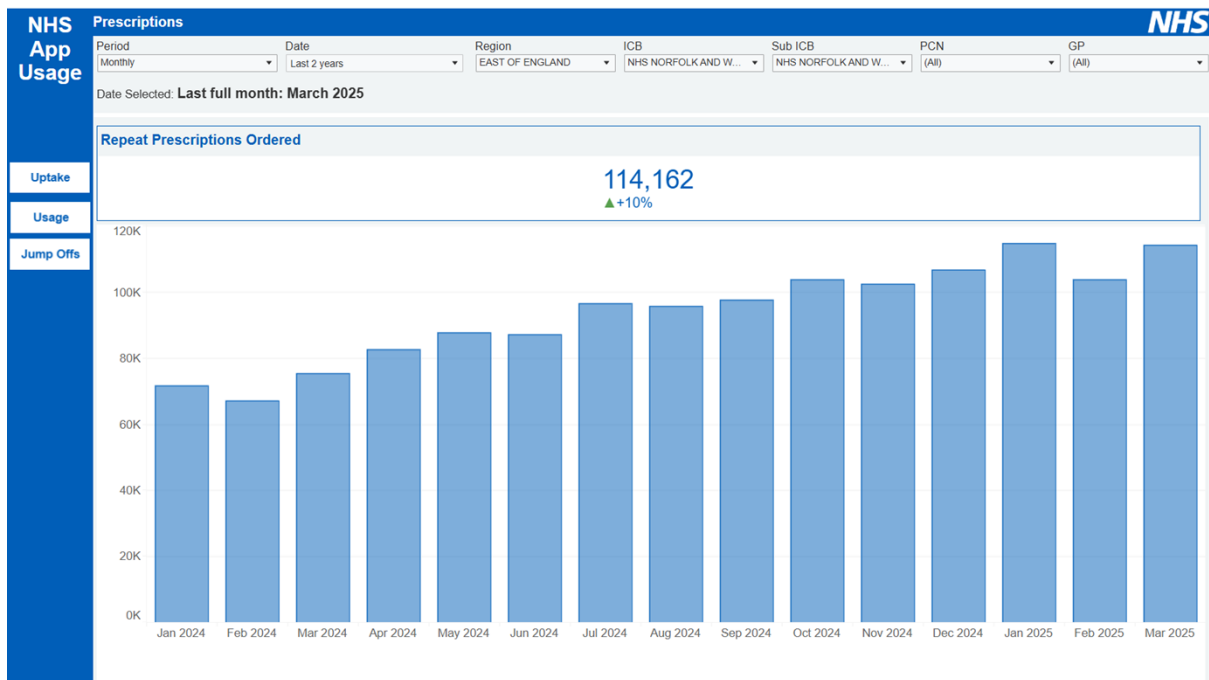


Image 3: Monthly NHS App Repeat Prescriptions Ordered (Jan 2023 – March 2025)

Next steps:

The GP Contract 2025/26 includes the aim that patients have an equitable experience across all access modes (phone, online, walking in). From 1 October 2025, practices will be required to keep their online consultation tool open for the duration of core hours (8.00am - 6.30pm) for non-urgent appointment requests, medication queries and admin requests. As of 31 March 2025, 19 of 20 PCNs in N&W have claimed for Domain 2 of the PCN Capacity & Access Improvement Plans (CAIP) for 2024/25, declaring their online consultation forms are available for patients to make administrative and clinical requests at least for the duration of core hours. Primary Care Commissioning and Digital teams will be supporting practices to either implement this contractual requirement by October or to manage demand if already being provided.

Another key digital requirement of the new GP Contract for 2025/26 is that by no later than 1 October 2025 practices will also be required to ensure the functionality of GP Connect is enabled which:

- Allows read only access to patient care records (GP Connect Access Record HTML and Structured) by (i) other NHS commissioned providers for the purposes of direct patient care and (ii) providers of private healthcare (only in cases where the private provider obtains explicit permission from the patient to access their NHS GP care record and they are providing direct patient care).
- Allows Community Pharmacy registered professionals to send consultation summaries into the GP practice workflow (GP Connect Update Record), which will reduce the admin burden for general practice teams.

The Primary Care Commissioning and Digital Teams will work together to identify gaps in delivery and support practices to deliver these new contractual requirements.

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Make on-line registration available in all practices by October 2024

All surgeries in N&W are using the national online registration system developed by NHS England. 2 N&W surgeries are taking part in an [automation pilot for the online registration](#) system and are due to go live with the pilot on 7 April 2025. This pilot will test direct integration between the *register with a GP surgery* service and GP IT systems, allowing data from patients who meet the pilot criteria to be automatically transferred into GP systems. The feedback from this pilot will guide a possible roll-out of the service.

Continue to expand self-referrals to appropriate services

As part of the 2023/24 operational planning guidance, with a refresh of expectations in 2024/25, ICBs were asked to implement self-referral pathways in 7 named pathways. 5 of these (MSK, Audiology (Elderly hearing) Podiatry, Weight Management and Wheelchair) are measured by the Community Services Data Set (CSDS), the remaining 2 are Community Equipment Services and Falls Service.

The community equipment provider Medequip and British Red Cross have patient-initiated provision in place. This supports hospital discharge, admission avoidance and elements are also incorporated into pathways for patients who have an 'open referral' into them. Factors must be considered regarding clinical and environmental assessment and risk to ensure appropriate equipment issue and use, as well as operational and cost pressures, when considering any self-referral option. Increasing access through self-referral will continue to be considered where appropriate and possible.

Self-referral data for services measured through the CSDS is shared with us by NSHE. The latest data available (for December 2024) shows that N&W continues to perform well when compared to other areas in the East of England Region.

ICB	ICB Rate* per 100,000	Lower 95% CI	Upper 95% CI	Nat rate* per 100,000	Difference to National
EAST OF ENGLAND					
NHS BEDFORDSHIRE, LUTON AND MILTON KEYNES INTEGRATED CARE BOARD	305.7	293.4	318.5	381.6	-75.9
NHS CAMBRIDGESHIRE AND PETERBOROUGH INTEGRATED CARE BOARD	288.1	276.6	300.0	381.6	-93.5
NHS HERTFORDSHIRE AND WEST ESSEX INTEGRATED CARE BOARD	117.3	111.8	123.0	381.6	-264.3
NHS MID AND SOUTH ESSEX INTEGRATED CARE BOARD	457.6	445.6	469.9	381.6	76.0
NHS NORFOLK AND WAVENEY INTEGRATED CARE BOARD	650.0	635.6	664.7	381.6	268.4
NHS SUFFOLK AND NORTH EAST ESSEX INTEGRATED CARE BOARD	481.3	468.2	494.7	381.6	99.7

NHSE colleagues are exploring, at a national level, how self-referral can be supported digitally on existing platforms, including the NHS App.

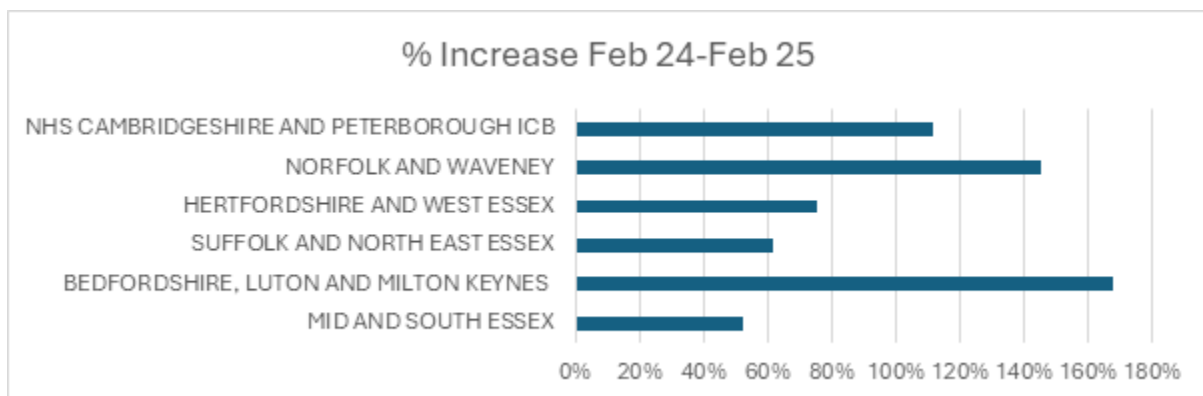
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3. Community Pharmacy Update

The initial target for Pharmacy First clinical pathway appointments was set at 5,240 consultations per month by end March 2025, this was based on a prediction that all contractors would achieve 30 clinical pathways per month by the end of the first year. This target was relevant at the time as minimum threshold targets for an additional payment were initially set at 30 from October 2024.

However, at this time indicative data was not available and therefore adjustments have been made throughout the initial 12 months of performance.

Since the start of the service in February 2024, Norfolk and Waveney ICB have seen a positive 145% increase in the use of the service, which is significant when compared to other ICBs in the region.



The total number of pharmacy contractors in Norfolk and Waveney is 170 and we have 167 community pharmacies signed up. Of those who are not signed up to deliver Pharmacy First:

- 1 is a DAC (Dispensing Appliance Contractor) and has not been signed up from the start.
- 1 is a DSP (Distance Selling Pharmacy)
- 1 has never been registered due to not having a consultation room

The target for Pharmacy First appointments for March 2026 has been provisionally set at 5660. This represents a 33% increase over the year in activity, using February 2025 data as a benchmark. This also takes into consideration the minimum threshold payments due to start in June 2024 following the release of the new Community Pharmacy Contractual Framework (CPCF) on the 31 March 2025. This will see pharmacies achieving 30 clinical consultations in a month receiving the maximum threshold payment of £1000 and those achieving 20-29 receiving a 50% reduced payment of £500.

Data shows 31% of Community Pharmacy contractors met the gateway of 30 in March 2024 with 13% achieving between 20 and 29 clinical consultations, giving an indication that as from June 2024, when the new thresholds come into effect, over 44% of contractors should be receiving some form of additional payment for Pharmacy First activity. The overall impact of the other contractors not meeting the threshold is not known.

Looking forward, and with the investment of a further £215 million nationally in Pharmacy First services, activity will be critical for pharmacies' financial viability going forward.

Other potential barriers that could restrict the ability to absorb the additional increase in activity are:

- Consultation room standards and or the ability to invest in a second consultation space to enable the service to work alongside others, for example during the flu vaccination season
- Clinical skill mix within the pharmacy e.g. lack of pharmacy technicians or accuracy checking technicians (ACT) which prevent the pharmacist having the capacity to leave the core contractual requirements of dispensing and checking to enable clinical services such as Pharmacy First

As an ICB we continue to work with our estates team to explore opportunities for acquiring funds that may enable pharmacies to be 'fit for the future' by having the ability to invest in the development of their pharmacy premises. Our ICB Pharmacy workforce team also continue to work with training providers and contractors to ensure all opportunities for additional training to enable Pharmacy technician qualifications are utilized.

Advancements in Pharmacy dispensing technology, which removes the needs for a final physical check by the pharmacist, are already available and are being used to great effect by some pharmacies to help support the resilience needed to enable the pharmacist to complete all services. This in turn makes them more service focused which will support activity increases and financial viability of the pharmacy.

The target for oral contraception (continuation and initiation) consultations presenting to community pharmacy directly by March 2025 was set at 250 per month. Data for March 2025 recorded 558 consultations resulting in a 100% increase in activity over a 6-month period. To date only 90% of contractors are registered to provide the service but with anticipated bundling of services to receive additional Pharmacy First payments, we expect this to increase to over 98% in line with the Pharmacy First and hypertension services, by the end of March 2026.

The target for Community Pharmacy Blood Pressure check appointments by March 2025 was set at 3,500 per month. Data for March 2025 recorded 3945 clinic checks and 276 ABPM checks (7% conversion) compared to the February 2024 data of 1,718 clinic checks and 77 ABPM checks (4% conversion).

Ambulatory blood pressure monitoring (ABPM) is a method of measuring blood pressure over a 24-hour period, typically while the patient goes about their normal activities ABPM checks.

With a shift of focus within the new contract to ABPM monitoring we do expect there to be an increase in the conversion rate with a national target of 10-12% but there is a risk that this could impact total activity with a drop-in clinic check activity.

Following a review of the 2024/25 data, new targets have been established for the oral contraception service and hypertension case finding service.

The target for oral contraception service consultations by March 2026 is set at 1,000 per month. The target for the hypertension service is set at 3,000 per month, the target reflects the hypertension service is limited by factors, including the availability of ABPM (ambulatory blood pressure monitoring) monitors and the capacity of follow-up treatment and interventions, including primary medical and wellbeing services. Amendments to the hypertension case finding service in the new Community Pharmacy Contractual Framework, has also indicated a change in the service to allow referrals from other healthcare providers such as dentists and optometrists could increase the outreach of the service and hence activity.

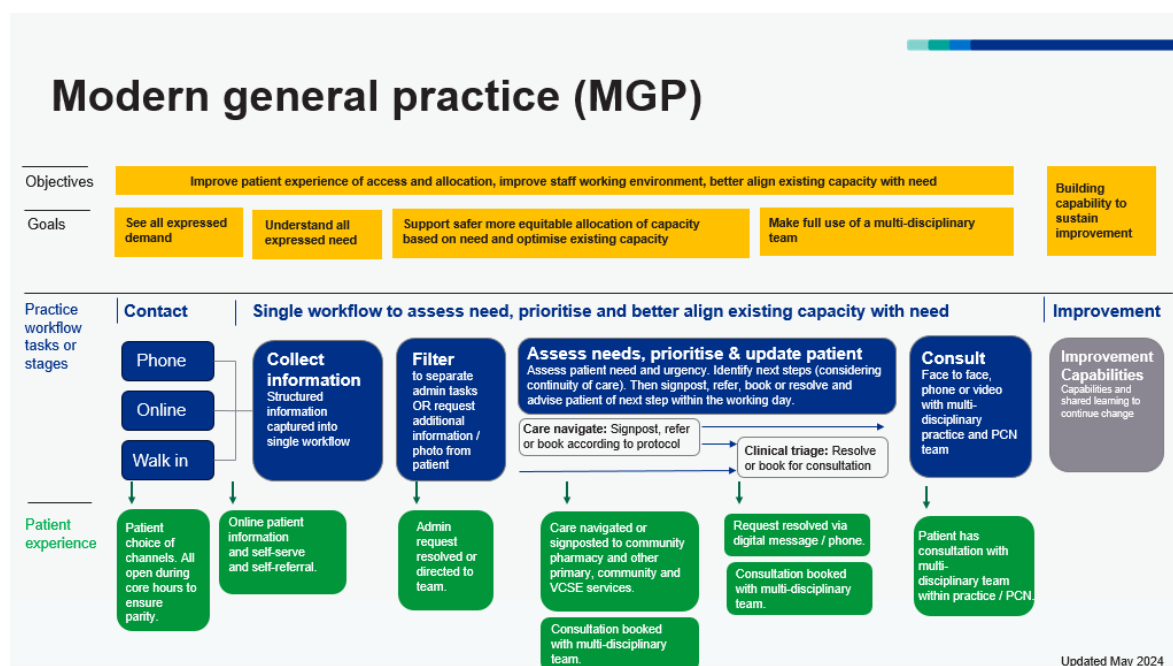
To support the continued development of the Pharmacy First service the ICB have provided the following resources to all contractors and stakeholders within Norfolk and Waveney ICB, including locum pharmacists who may travel to work within our ICB footprint

- Face-to-face contraception training workshop to support increase in registrations and increase activity by enhancing skills
- Pharmacy Integration Project – procurement of a provider to support integration of pharmacy services in Norfolk and Waveney
- Pharmacy First Toolkit to support General Practice colleagues in their knowledge of the service and to maximise the opportunity Pharmacy First provides in supporting capacity concerns.
- Pharmacy First poster designed for distribution across schools, colleges and universities

Utilisation of the Minor Illness Referral pathway has remained consistent with the previous CPCS (NHS Community Pharmacist Consultation Service) within Norfolk and Waveney averaging 626 per month, peaking at 743 referrals in March 2024.

The Urgent Medicine Supply service has seen a 25% increase year-on-year with over 12,500 supplies made over 12 months.

4. Adopting Principles from the ‘Modern General Practice’ Model



The cloud telephony program saw record investment in installing or upgrading digital phone lines and telephone systems designed to make booking GP appointments easier, including:

- 30 GP surgeries moving from sub-optimal phone systems to cloud based telephony, GP Voice platform to meet the latest NHS England requirements
- 20 GP surgeries receiving feature upgrades to their digital or cloud-based telephony systems to comply with the latest requirements
- 36 GP surgeries migrated to the GP Voice platform, from the original platform they were on as part of an earlier NHS England pilot scheme

All 3 phases listed above were completed on time and meet, or exceed, NHS England’s updated requirements for Cloud Telephony, supporting the Modern General Practice model under the National Framework for CBT suppliers.

All Norfolk and Waveney practices have CBT, but do not necessarily meet all the requirements (e.g. call back). Reasons for practices remaining with existing suppliers include recently agreed contracts which were not practical to change; existing suppliers not being on the national framework; and contracts which can facilitate callback but at an additional charge.

5. General Practice Improvement Programme (GPIP)

To date, a total of 31 practices have actively participated in the GPIP initiative, showcasing the commitment and engagement of practices toward enhancing patient care and operational efficiency. Looking ahead to 2025/26, a cohort of 6 practices has been confirmed for a locally commissioned scheme delivered in partnership with the RCGP (Royal College of General Practitioners), with potential for additional practices to join, contingent on securing funding.

Our operational plan includes a target of 50% participation across N&W surgeries by the end of 2025/26, subject to funding, with a focus on embedding the principles of Modern General Practice.

6. Capacity & Access Improvement funding 2024/25

All 20 PCNs submitted CAIP domain claims before the deadline of the 31st March 2025. Of those 20 PCNs, 19 of them have claimed for all three domains, with only one PCN (SNhIP) claiming for domain 1 & 3 only. This means practices will receive their Capacity and Access Improvement Funding payment to PCNs for 2024/25 shortly, which should account for 30% of the Capacity and Access Payment (CAP). The remaining 70% of the Capacity and Access Improvement funding was paid without any conditions via the Capacity and Access Support Payments made monthly over the year.

The three domains which PCN Clinical Directors were asked to declare achievement against each component for all the practices in their PCN were:

MGPA priority domain	All PCN practices to have following components in place and these continue to remain in place
1) Better digital telephony	<p>Digital telephony solution implemented, including call back functionality; and each practice has agreed to comply with the Data Provision Notice so that data can be provided by the supplier to NHS England.</p> <p>Digital telephony data is routinely used to support capacity/demand service planning and quality improvement discussions.</p>

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MGPA priority domain	All PCN practices to have following components in place and these continue to remain in place
2) Simpler online requests	<p>Online consultation (OC) is available for patients to make administrative and clinical requests at least for the duration of core hours.</p> <p>Practices have agreed to the relevant data provision notice (DPN) so that data can be provided by the supplier to NHS England as part of the 'submissions via online consultation systems in general practice' publication.</p>
3) Faster care navigation, assessment, and response	<p>Consistent approach to care navigation and triage so there is parity between online, face to face and telephone access, including collection of structured information for walk-in and telephone requests.</p> <p>Approach includes asking patients their preference to wait for a preferred clinician if appropriate, for continuity.</p>

7. Complete implementation of highly usable and accessible online journeys for patients

There will continue to be an emphasis on online access for patients in 2025/26 as directed by the new GP Contract. Work was undertaken in 2024/25 to lay the foundations for increasing online access, including what has been noted earlier in the report regarding CBT, NHS App usage for appointments, and moving to increased use of online forms, as well as the following:

- Prospective Records Access ([Prospective Records Access](#)) as of early March 2025, all N&W surgeries had enabled their organisational settings to allow prospective access to their patients (Step 1). There are four steps to prospective records access, with a focus on Step 1 and Step 3 (Step 3 - reviewing and enhancing patient access). There are currently 2 surgeries in N&W who have not enabled Step 3 and work is ongoing with the GP surgery teams to address the concerns raised around data protection
- All N&W GPs have opted into the Cloud-based Telephone Data Provision Notice (DPN) and the Online Consultation DPN

8. Build capacity

The Primary Care Workforce Strategy and Operational Delivery Plan was approved by the Primary Care Commissioning Committee on 10 September 2024 supporting the themes of "Train, Retain and Reform". The plan included 47 programmes, designed for delivery during 2024/25, all with key performance indicators (KPIs) to reflect both national and local targets

- Our Newly Qualified GP Incentive scheme received national recognition, and was awarded Highly Commended “Workforce Initiative of the Year”. Within 24/25 we supported 38 newly qualified ST3 (Speciality Training Year 3) GP Trainees have received substantive primary care employment offers through the 2024/25 scheme, 12 Newly Qualified General Practice Nurses/Nursing Associates
- ‘Golden Hello’ national and local incentive for dental professionals are in place, 46 dental professionals are being supported to secure substantive roles within primary care settings to date
- 93% of practices are now training practices, which has increased medical placements by 25%
- 95% of practices have been supported with continuous professional education programmes supporting our local population needs with long term conditions and health inequalities
- 79% of practices have taken up workforce retention support offers to retain and attract new talent within primary care
- The 2024 NHS General Practice Staff Survey indicates that our system has improved in most of the NHS People Promise elements compared to the 2023 results, with the exception of “Staff Engagement,” which showed no change from the previous year’s position

9. Cutting bureaucracy – background

The N&W System Interface Group, chaired by the ICB Executive Medical Director has continued to meet monthly, bringing together primary, secondary, community and mental health system partners; building on the consensus that when the interface between providers works well the patient experience is more positive. From April 2025 these meetings will move to quarterly and run alongside three local monthly meetings to encourage interface to become part of day-to-day conversations between providers.

A dedicated Interface Manager post has been in place for 8 months, leading on the coordination of engagement across system providers. A system-led workplan incorporating metrics will be developed for 2025/26 to incorporate the Government’s [Red Tape Challenge](#), demonstrate identified improvements, and to ensure that these are measured in a consistent way.

Ongoing reviews will support processes to remain ‘fit for purpose’ and provide assurance that providers have a defined Single Point of Contact for interface, which is universally recognised and understood.

Progress update against the four main National Primary Care Secondary Interface recommendations:

- **Onward referrals**
 - All providers acknowledged the importance of the communication and clarity of the consultant-to-consultant policy within their self-assessment gap analysis

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- A review of data collected through the Interface Reporting system supported an audit and review (ongoing) of compliance with the Consultant-to-Consultant referral policy
- **Complete care (fit notes and discharge letters)**
 - A Task & Finish group has been established to develop Referrals and Discharge Guidance for all providers and support in the development of the Electronic Patient Record project and remains work in progress
 - Fit note guidance and NHSE recommendations have been shared to all provider teams
- **Call and recall**
 - Trusts confirmed there are clear procedures for call and recall, with one Trust noting ongoing work is required to support compliance around communication with General Practice
 - All providers acknowledged communication regarding the policy for managing DNAs (did not attend) and re-referrals and continue to work to embed the recommendations
- **Single point of contact for clinicians**
 - All providers now have a generic contact email to support non-urgent queries, not all providers have departmental contacts emails in place

Cutting bureaucracy sits under our wider Interface workstream, key areas of focus during the second six months of March 2025 include:

- Ensuring non-medical health professionals can appropriately request laboratory tests via the WebICE system (for example for wound swabs, urine cultures, nutrition monitoring bloods) and similarly to receive their own results directly, to reduce clinical risk and prevent duplication of work
 - *This work is an integral piece to the development of radiology access and the Musculoskeletal Assessment and Treatment Service*
 - *The working group for the Norfolk & Norwich and James Paget Hospitals has been paused due to resource challenges. Implementation has been completed by the Queen Elizabeth Hospital*
- Ensuring allied health professionals working in the community, can appropriately request imaging via the WebICE system after completing training in line with Ionising Radiation (Medical Exposure) Regulations (for example first contact physiotherapists being able to request plain X-rays) and similarly to receive their own results directly
 - *A Task & Finish Group agreed the scope of practice for GP Practices, for approval by NNUH and JPUH, but the group has subsequently been paused due to resource challenges. Implementation has been completed by the Queen Elizabeth Hospital*

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- *Progress by community providers (NCHC and ECCH) has also been paused*
- Trusts issuing fit notes for the full duration of absence as opposed to passing these requests back to GPs
 - *A reduction in reporting on this issue was seen during October 2024 – March 2025. Trust are looking to enable electronic fit notes and are currently working through technical issues to support this.*
- Improving communication, such as timely discharge letters which appropriately and clearly signal any actions or important information for general practice
 - *Communication remains one of the highest issues reported in the interface reporting process, along with onward referrals. We continue to receive submissions that reflect concerns regarding communication delays, inadequate information or inappropriate transfer of workload through the interface process. A task & finish group was set up to address improvements in common language, response times and template discharge letters to support effective and consistent communication and this guidance was finalised in February 2025 with a collaborative input from all system leads.*
- Supporting local interface conversations to inform, collaborate and enable solution-based working
 - *Arrangements are in place to promote local discussions to improve interface and support the System Interface Group work programme. By building a foundation of strong relationships we aim to increase opportunities for peers to come together to be transparent about issues they face, which impact patient care, and co-design and agree solutions.*
- Implementing a single point of contact for all stakeholders to raise queries
 - *Ongoing work to ensure there is an effective point of contact for all providers has included a one stop process for practices to follow up with issues via the Interface NoW reporting process. Further work involved in ensuring departmental emails are noted on letters is being implemented with the introduction of Electronic Patient Record at the acutes.*

Recommendation:

Board members are asked to review the report and share feedback on progress reported against the ambitions of the *Delivery Plan for Recovering Access to Primary Care and General Practice and Secondary Care: Working Better Together*.

The Primary Care Commissioning Committee agenda for 14 May 2025 included this Board report for noting, it having been updated to reflect assurance discussions on delivery of PCARP at the General Practice and Community Pharmacy Delivery Group on 8 April 2025.

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Key Risks	
Clinical and Quality:	Quality and capacity in primary care can be impacted due to inefficient working arrangements across the primary- secondary care interface, causing resilience and workforce issues
Finance and Performance:	<p>Care capacity can be negatively impacted due to inefficient working arrangements across the primary-secondary care interface</p> <p>Failure to progress across all the interface requirements of the plan may affect the ICB's and ICS assurance process</p> <p>The ICB may have to consider developing alternative pathways to meet identified gaps in service provision</p>
Impact Assessment (environmental and equalities):	Reduced capacity could constrain the ability to address health inequalities.
Reputation:	<p>Non-delivery of the ambitions outlined within the plan poses a significant system reputational risk due to the high profile of the plan nationally</p> <p>Lack of perceived progress against primary secondary interface poses a reputational risk with primary care providers</p>
Legal:	None identified
Information Governance:	System IG Peer Group in place working across ICS.
Resource Required:	Primary Care Workforce Transformation, Primary Care Delegated Commissioning, Community Pharmacy, Medical, Digital and Commissioning teams all support contractors with delivery
Reference document(s):	<p>Delivery plan for recovering access to primary care (england.nhs.uk)</p> <p>Delivery Plan for Recovering Access – Update published 9 May 23 updated 3 September 2024 https://www.england.nhs.uk/long-read/delivery-plan-for-recovering-access-to-primary-care-2/</p> <p>Delivery Plan for Recovering Access – Update and Actions published April 2024</p>

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	<p>NHS England » Delivery plan for recovering access to primary care: update and actions for 2024/25</p> <p>Cloud Based Telephony https://www.england.nhs.uk/long-read/funding-for-practices-moving-to-digital-telephony/</p> <p>DPN Data Provision notice https://digital.nhs.uk/binaries/content/assets/website-assets/corporate-information/directions-and-data-provision-notices/data-provision-notices/cloud-based-telephony/20240816-cloudbasedtelephonydataprovisionnoticev1.0.pdf</p> <p>https://www.england.nhs.uk/gp/national-general-practice-improvement-programme/modern-general-practice-model/.</p>
NHS Constitution:	<p>NHS Standard Contract https://www.england.nhs.uk/publication/primary-medical-care-policy-and-guidance-manual-pgm/</p>
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	Paper taken to General Practice and Community Pharmacy Delivery Group on 8 April 2025 for assurance discussions; updated version taken to Primary Care Commissioning Committee on 14 May for noting
Process/Committee approval with date(s) (as appropriate)	Risk to resilience of primary care and transformation, on BAF and monitored through Primary Care Commissioning Committee, current score of 20

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Agenda item: 11

Subject:	Long Term Dental Plan – Project plan for 2025/2026
Presented by:	Fiona Theadom, Head of Primary Care Commissioning (Dental and GP)
Prepared by:	Fiona Theadom, Head of Primary Care Commissioning (Dental and GP)
Submitted to:	Primary Care Commissioning Committee
Date:	14 May 2025

Purpose of paper:

This paper sets out the objectives and commissioning intentions for Phase 2 of the Long-Term Dental Plan (approved May 2024) and requests approval from the Primary Care Commissioning Committee for the following:

- ICB’s proposed ambition for dental investment and commissioning plans during 2025/2026.
- The ICB’s plans to meet share of 700,000 additional appointments (21,520 additional urgent care appointments)
- The proposed measurable outcomes for the Long-Term Dental Plan, and
- To note the ICB’s intention to refresh the priorities for the next two years from April 2026.

This programme also aligns with the ICB’s Joint Forward Plan objectives and Operational Plans for 2025/2026.

The proposals are supported by the ICB’s Operational Management Board and a request through Triple Lock for the overall investment is in progress.

Executive Summary:

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Ambition 2 of the Joint Forward Plan (JFP) sets out the ICB's aim to support primary care resilience and transformation. Within this, there is an ambition to stabilise dental services through increasing dental capacity short-term and setting out a strategic direction for the next five years. To help meet this objective, the ICB developed its Long-Term Dental Plan (LTDP) which was approved in May 2024 and sets out how to build more sustainable primary care, community care and secondary care dental services in line with our responsibilities under the Delegation Agreement with NHSE.

Year One of the LTDP led to the following new care pathways being developed and implemented by end March 2025 with an investment (full year effect) of £7.35m:

- Urgent treatment service (contract to end March 2025)
- Shared Care Pathway (contract to end March 2027)
- Child Focused Dental Practices (contract to end March 2027)
- Access Improvement for new patients (recurrent investment)
- Workforce recruitment and retention plan (2024/2025)

The ICB also continued to work collaboratively with ICBs in the East of England around secondary care dental services recommendations and plans (led by SNEE ICB), other pathways including trauma and implementation of the East of England Paediatric Vision and Secondary Care Programme.

The ICB is now planning the development and implementation of Year Two plans and this paper sets out the aims, benefits and risks and funding proposals for approval. A workforce plan for 2025/2026 will again sit alongside commissioning plans as a fundamental element of building resilience and stability of NHS dental services in Norfolk and Waveney.

NHS England has placed a target on ICBs to increase the number of unscheduled care appointments offered to the population for 2025/26, the target for Norfolk and Waveney is 21,520 which will be monitored monthly against ICB plans.

Development of individual projects and new pathways will be managed in line with the agreed budget and ICB internal project governance processes and will include Equality Health Impact Assessments.

Two priorities, focusing on children and young people and reducing health inequalities, were agreed for two years until April 2026 and therefore the ICB will need to review and refresh the plan and priorities during this year.

Report

The ICB's JFP ambition for primary sets out our plans for developing our vision for accessible enhanced primary care, improving patient outcomes and experience. Our

plans for primary care reflect the transformation required to support the government's priorities of:

- Hospital to community
- Analogue to digital.
- Sickness to prevention.

Our approach will continue to be to work closely with our contractors and wherever possible create conditions which build trust and support collaborative working across the profession as well as with system partners and our communities.

We will continue to look for opportunities to attract, develop and retain our professional dental colleagues, building on the success of our work programmes in 2024/25. Active promotion of the key role oral health plays in addressing health inequalities as well as the general health and wellbeing of our population, from our children and young people through to those living in care homes will remain a central theme to our work programmes.

Linked to this, the ICB's Long Term Dental plan sets out the ICB's vision for what it wants to achieve over the next five years for dentistry; this is to:

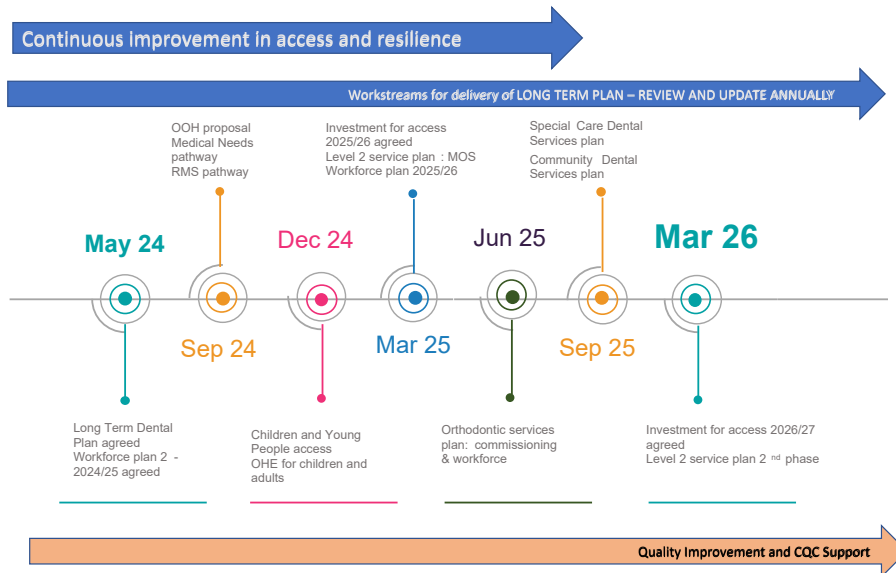
- To build stability and resilience across our NHS dental services
- To improve access to oral health care for Norfolk and Waveney's population
- To reduce health inequalities

A patient and public engagement survey in February 2024 identified the key priorities for the first two years of the LTDP to reduce health inequalities and to focus on improving children and young people's oral health. These priorities were overwhelmingly supported by feedback from the engagement exercise and the ICB is committed to undertaking a further engagement exercise in February/March 2026.

The ICB achieved the majority of its objectives for Year 1 and is now developing its plans for Year 2 as described in the LTDP.

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Timeline in summary



The significant challenges for improving the sustainability of local NHS dental services remain unchanged and directly impact on the ICB's ability to improve access to oral healthcare for its population and to reduce health inequalities.

Achievements in 2024/2025

- Access Improvement for new patients not seen in 24 months (recurrent funding), more than 98,000 new patients seen in 2024/2025.
- Unscheduled care (urgent treatment) pathway for individuals in dental pain delivering more than 2500 appointments per month. In 12 months to end March 2025, more than 25,000 appointments provided by local dental providers.
- Shared Care Pathway for individuals with medical needs mobilising May 2025
- Child Focused Dental Practices mobilised March 2025 with 6 practices
- Workforce – strategically recruited and retained 46 dental professionals within primary care settings
- Out of Hours – new service commissioned increasing number of sessions available at weekends from 2 to 3 sessions.
- Active engagement with local dental providers, Local Dental Committee and Regional Chief Dental Officers and Managed Clinical Network chairs continues alongside keeping local stakeholders informed

Funding for the above new pathways continues into 2025/2026 and beyond.

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Proposed commissioning intentions for 2025/2026

Plans for 2025/2026 as laid out in the Long-Term Dental Plan are summarised below, details are provided in appendix A alongside the estimated spend.

- **Special Care Dental Services** – planning and review in light of Getting It Right First Time report ([GIRFT-Community-Dental-Services-supplementary-report-FINAL-January-2025.pdf](#)) and East of England Paediatric vision, to support and improve service sustainability in the long term
- **Orthodontic Services** – long term sustainability of orthodontic services in Norfolk and Waveney
- **Oral health prevention**
 - Children and young people (linked to the government’s commitment to introduce a national supervised toothbrushing scheme, targeted at 3, 4 and 5 year olds most in need) working with local authority public health.
 - Older adults
- **Level 2 services** – commissioning services and supporting workforce recruitment and retention plans through upskilling, training and professional development. Support the national aim to shift care into the community
- **Access improvement**
 - Access to unscheduled care (national directive)
 - Targeted programmes including areas of deprivation and Armed Forces families, areas of geographical need
 - Pilots for targeting health inequalities in Norwich and West Norfolk working with Place teams
- **Targeted UDA uplift** in rural and coastal areas, and in areas of high deprivation
- **Workforce** recruitment and retention plans
- Looking at **digital technology and estates** to support and improve services for patients
- Commitment to carry out a second patient and public engagement in February/March 2026

NHS England Operational Planning Guidance 2025/2026

The Operational Planning Guidance requires the ICB to “*commission additional urgent dental appointments to deliver their share of the government’s manifesto commitment on delivery of an additional 700k urgent dental appointments.*” The ICB’s target is 21,520 additional appointments by end March 2026 funded through existing allocations using a baseline of 12 months urgent care activity to end June 2024.

The Finance and Contracting Guidance linked to this Guidance states the following:

Dental ringfence

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142. The utilisation of Pharmacy, Optometry and Dental ([POD allocation](#)) is subject to the rules set out in the [ICB and system finance business rules](#) – namely the duty to break even within the resource use limit. It is also subject to the additional rule that dental budgets are ringfenced and NHS England reserves the right to direct that any unused resources are used to improve dental access. Exceptionally, the unspent allocation may be returned to NHS England. A separate schedule will be issued setting out the ringfenced dental budget included in 2025/26 POD allocations.

143. For 2025/26 NHS England may agree to relax the dental ringfence (so that any underspends are retained locally) for ICBs which (i) deliver additional urgent care in line with the manifesto commitment, and (ii) improve dental access more broadly. Additional guidance will be issued on the opportunity to have the ringfence relaxed in 2025/26.

The ICB is also asked to report on unique patient activity on a 24 rolling month basis, split between adults and children. Growth targets set for 2025/2026 have been set to increase adults by 3.5% and children seen by 5%.

The ICB's plan for increasing UDA activity year on year has been set at 76% by end March 2026 compared to 65% in 2023/2024 and 73% forecast achievement at end March 2025.

There is a risk that with a focus on unscheduled care appointments this may divert the local clinical workforce away from stabilisation and routine dentistry, therefore reducing the ICB's ability to improve access to NHS dental services year on year and improve the population's oral health in the longer term.

Proposal for Unscheduled Care

The ICB first established a local scheme for urgent treatment appointments in October 2023 and the number of appointments now being provided by 26 providers across Norfolk and Waveney is approximately 2200 - 2500 per month.

The national target for the ICB is to provide an additional 21,520 appointments this year over and above the baseline figure of 48,898 (for period 12 months to June 2024). A new service specification has been developed by NHS England describing the service to be commissioned as unscheduled care (rather than urgent treatment) and linking to updated clinical standard for unscheduled care for ICBs to use when commissioning additional activity. The ICB has commissioned activity using two delivery models, one as an Enhanced UDA rate and the other is on a sessional basis (6 - 7 patients per session). Individuals will, as now, be signposted to a local provider via NHS 111.

The ICB has agreed provision through local providers.

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Funding

We recognise the need to balance investment and ICB cost constraints for 2025/2026. As access improves, patient charge revenue increases balancing the ICB's dental budget, however focusing on health inequalities and children and young people may not grow patient charge revenue received as quickly as desired.

The 2025/26 ringfenced dental budget has recently been confirmed as totalling £69.385m, which includes 3.29% growth. This covers Primary, Community and Secondary Dental. The ICB's ambition is to invest an additional £8m in 2025/2026, which includes additional investment of £1.7m (over and above the current investment of £1.6m) to increase the number of unscheduled care appointments for individuals in dental pain. There are risks to achieving this ambition which are described further below.

Recurrent investment to improve access for new patients and to fund a UDA uplift will be released from targeting individual underperforming contracts and renegotiating activity to a more achievable level of contracted activity. The table below details forecasted UDA/UOA delivery for 2024/25 and the ICB plans to renegotiate individual contracts that have underperformed year on year. It should be highlighted that underperformance is already forecast to drop and activity delivery improve from 65% to 73% for 2024/2025.

Forecast 2024/2025 UDA/UOA Delivery - No of Practices				
	No of Contracts	2024/25 Contract - UDA and UOA	2024/25 Forecast Outturn - UDA and UOA	%
No NHS activity delivered	5	82,454	25	0%
Less than 10%	2	30,937	450	1%
Between 10% and 30%	3	59,545	12,552	21%
Between 31% and 50%	9	117,330	46,920	40%
Between 51% and 75%	16	306,804	204,403	67%
Between 76% and 100%	46	539,761	480,006	89%
Between 101% and 110%	19	178,502	189,275	106%
Greater 110%	15	150,611	186,320	124%
Total	115	1,465,944	1,119,951	76%

For 2025/26 work will commence much earlier in the year to identify any underspends to support service investment.

The Operational Planning Guidance above indicates that NHS England will claw back any unspent monies at the end of the financial year unless the ICB can demonstrate it is investing to improve access for the ICB population. The proposed plan for 2025/2026

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aims to invest all funding available, however this is subject to being able to successfully deliver the plans.

Measurable Outcomes/Indicators

We recognise investment must be aligned to measurable outcomes and the Primary Care team is proposing the range of measures set out below be used to determine the success or otherwise of the Long-Term Dental Plan and if there is a positive impact on local providers and the local population.

The proposed outcome measures, also aligned to regional and national outcomes, are set out below:

- Growth in new patients: adults by 3.5% and children 5% from January 2025 baseline. To monitor uptake in IMD decile/ Core20 areas to monitor impact on health inequalities (refer heat maps in Appendix B). The ICB aims to build on this simple measure and correlate intelligence from a variety of sources over this year to assess the impact of the actions in the Long-Term Dental Plan on areas of deprivation and children and young people.
- Increase UDA activity achievement year on year: 2023/2024 = 65%, 2024/2025 = 73% and aim for 2025/2026 is 76%. It should be noted the ICB is moving towards establishing new pathways and services under flexible commissioning and sessional payment arrangements rather than always commissioning additional UDA activity. Currently, the ICB is allowing contractors to claim both a sessional payment and UDA activity to improve stability of services however this may not continue in the future with new pathways and contractors will only receive a sessional payment or contract under the standard contract terms.
- Reduction in treatment under General Anaesthetics (GA) in children and young people (Core20plus5 priority). This outcome has been identified as a regional Chief Dental Office indicator of success and is linked to the success of the CFDP pathway as it is anticipated that fewer children will require treatment under GA in the longer term with access to dental teams with enhanced training in general dental practice. Improving access to NHS dental services will generally enable shared care pathways with community dental services.
- Deliver 21,520 additional unscheduled care appointments in 2025/2026. Overall ambition is to reduce unscheduled care need by securing adequate access for new patients. The plan is to use existing process via NHS 111 to signpost patients to a provider closest to where an individual lives.
- Reduction in Urgent and Emergency Care activity in acute trusts and GP Front Door access by 1% in 2025/2026. Current activity is shown below for the period April 2024 – end Jan 2025.

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April 2024 – Jan 2025	% of overall activity	JPUH	NNUH	QEH
% of patients in ED for dental	5.3%	6.9%	4.6%	4.5%
GP Front Door	5.4%			
NHS 111	7.9%			
Out of Hours	0.7%			

The overall long term ICB ambition to provide NHS dental services for all who wish to access an NHS dentist would require significant investment if the local population is to be seen and treated in line with NICE recall intervals, personal to the individual clinical need. Some individuals can be seen once a year or less and others need to be seen more frequently to stabilise their oral health. Not all individuals wish to see an NHS dentist for a variety of reasons, including those who wish to access urgent care only when needed, those unable to afford NHS dental services and those who choose to access private services. This ambition is likely therefore to take a long time to achieve with the current challenges and is the reason the ICB has chosen to focus initially on children and young people and reducing health inequalities.

All new pathways and services are subject to monthly monitoring and individual evaluation plans, working with the ICB’s Research and Evaluation team. An oversight Task and Finish Group is being established to oversee this work.

By triangulating a number of data sources, soft intelligence and public feedback, the ICB aims to have a better understanding about where the biggest improvements in access are being seen and where the gaps still exist.

Benefits and Risks of Investment

The Year 2 plans represent a significant ambition by the ICB to invest the dental ring-fenced budget across a wide range of projects with the aim of reducing health inequalities and improving access to NHS dental services for the local population. Investment in primary care and community dental services reduces the impact on secondary care and urgent and emergency care services, and importantly supports the shift towards prevention, improving clinical quality outcomes for individuals.

A failure to invest reduces the ICB’s ability to meet national targets and to improve access for the local population, and in the longer term, reducing health inequalities, particularly for Core20 groups. It also risks NHSE clawing back dental monies that could be invested.

The highest risk to improving access to NHS dental services relates to the sustainability and resilience of local NHS dental practices, workforce recruitment and retention linked in part to the continuing challenge of the current dental contract. A lack of investment to

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support them through flexible commissioning and with workforce recruitment and retention to build sustainable and stable NHS dental services risks more NHS practices switching to private practice increasing the impact on most vulnerable children and adults, particularly those least likely to access healthcare services.

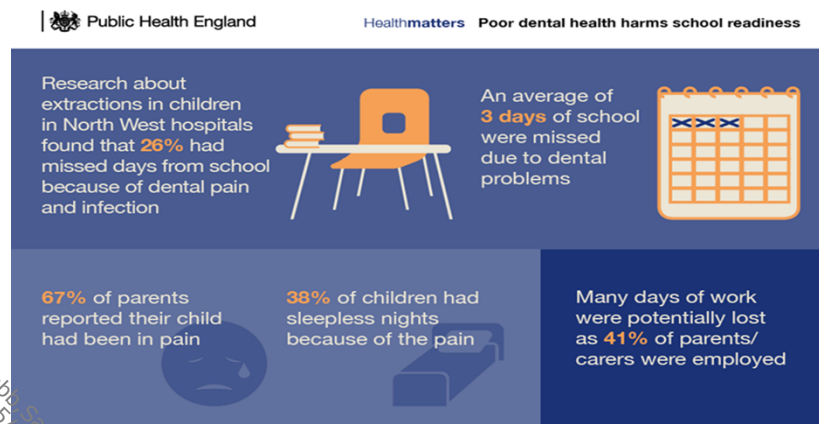
Without access to NHS dental services, there will be increased pressure on Emergency Departments, NHS 111 and wider Urgent and Emergency Care services which will be unable to cope with demand. It is also likely to lead to an increase in more complex cases requiring intervention in secondary care and potentially an increase in oral cancer and other poor health outcomes. Dental abscess is one of the top 10 conditions reported by the walk in centre in Norwich. In February 2025 alone, approximately 1200 NHS 111 calls related to dentistry matters.

Poor oral health can have a negative impact throughout life and can cause pain and infection, leading to difficulties with eating, sleeping, socialising and well-being^[1]. There are also significant costs on society associated with oral diseases^[2]. It can lead to days lost from work and school, and adversely affects people's quality of life^[3]

Dental decay and gum disease are the most common oral conditions and are largely preventable^[4]. Dental practice team members play an important role in identifying modifiable risks and helping individuals to recognise and minimise these risks and enhance protective factors³.

In a national oral health survey of adults attending general dental practices in 2018^[5] it was reported that generally, people who had last attended a dentist more than 2 years ago were more likely to have a treatment need and to report experiencing oral health impacts. They were also more likely to report a limitation in accessing a dental practice than participants who had last attended a dentist less than 2 years ago⁵.

For children, the impact may be greater and the infographic from Public Health England below highlights this.



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Delivering Year 2 of the Long-Term Dental Plan will actively support delivery of the ICS Health Inequalities Framework for Action, the ICB's Joint Forward Plan and Operational Plan to improve the resilience and transformation of primary care services and access for the local population.

Lack of ICB staff capacity and resources may impact the ICB's ability to deliver plans for 2025/2026. Across the ICB, resources to support dentistry commissioning are limited and the impact of national and local ICB restructuring this year is unknown.

The key risk relating to the dental workforce recruitment and retention within Norfolk and Waveney remains high and also likely to impact the ICB's ability to achieve its aims in the short and long term. Clinical resources may need to be diverted to deliver the ICB's target to increase the number of unscheduled care appointments instead of prioritising stabilisation and ongoing maintenance which improves oral health in the long term.

The Primary Care team is working closely with the ICB's Commissioning team around secondary care services building a baseline picture of secondary care to inform future plans however development of integrated commissioning and workforce plans across all dental services is critical to their success.

A joint working approach with local authorities to delivering public health services, oral health education and prevention, is also in place which will include collaboration to help deliver the local authority led target to provide toothbrushing for all 3, 4 and 5 year olds mandated by government ([Supervised toothbrushing for children to prevent tooth decay - GOV.UK](#)).

Recommendation to Primary Care Commissioning Committee:

The Committee are asked to approve:

- the commissioning and investment plans set out in this paper for 2025/2026.
- ICB plans to meet its share of 700,000 additional appointments (21,520 additional urgent care appointments).
- proposed measurable outcomes for the Long-Term Dental Plan

and to note the ICB's intention to review and refresh the Plan and priorities during this financial year.

If the Year 2 plans are approved, progress will be monitored quarterly by Dental Services Delivery Group with an update reported to PCCC in March 2026.

Key Risks	
Clinical and Quality:	Failure to continue to invest to improve services and access for local population will lead to poorer health outcomes and quality of care, particularly for those

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	individuals in Core20 vulnerable groups and those living in areas of deprivation. Upskilling the local workforce leads to improved retention and recruitment and better quality of care in the right place.
Finance and Performance:	The proposed plans represent a forecast investment for 2025/2026 in line with ring-fenced dental allocation
Impact Assessment (environmental and equalities):	Failure to invest will lead to poorer health and mental health outcomes, lost days at work and school and individuals travelling longer distances to access dental services (or not accessing them)
Reputation:	Failure to continue to invest to improve access for the ICB population will impact on the ICB's reputation and damage relationships with local providers and other key stakeholders. Pressures on other services in the system will continue, e.g. NHS 111, Emergency Departments, UEC, general practice, and secondary care. Failure to invest damages the ICB's reputation to deliver care for its local population
Legal:	N/A
Information Governance:	N/A
Resource Required:	Lack of capacity within ICB team to deliver plans – Primary Care team, Finance, Quality & clinical support
Reference document(s):	ICB Long Term Dental Plan, Primary Care Vision and Principles for Commissioning, Health Inequalities Framework for Action, NHSE Flexible Commissioning Guidelines 2023, NHS Operational Planning Guidance 2025/2026
NHS Constitution:	Patient Choice
Conflicts of Interest:	None identified
Reference to relevant risk on the Board Assurance Framework	BAF02 BORR08 / BORR09

Governance

Process/Committee approval with date(s) (as appropriate)	Audit Committee for information.
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References

- [1] PHE 2012, Inequalities in oral health in England available at: <https://www.gov.uk/government/publications/inequalities-in-oral-health-in-england>
- [2] OHID 2023, National Dental Epidemiology Programme (NDEP) for England: oral health survey of 5 year old children 2022 available at: <https://www.gov.uk/government/statistics/oral-health-survey-of-5-year-old-children-2022>
- [3] OHID 2021, Delivering better oral health: an evidence-based toolkit for prevention available at: <https://www.gov.uk/government/publications/delivering-better-oral-health-an-evidence-based-toolkit-for-prevention>
- [4] OHID 2022, Adult oral health: applying All Our Health available at: <https://www.gov.uk/government/publications/adult-oral-health-applying-all-our-health>
- [5] PHE 2019, Oral health survey of adults attending dental practices 2018 available at: <https://www.gov.uk/government/publications/oral-health-survey-of-adults-attending-dental-practices-2018>

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Long Term Dental Plan Objectives – Year 2, 2025/2026

Financial Year 2025/2026	Forecast spend 2025/26 '000s	Core20 / Health Inequalities	Reduces secondary care / UEC activity	Joint Forward Plan	National target	
Proposed new commitments/projects 2025/2026 (forecast investment)						
Community Dental Services review	N/A					To consider impact of GIRFT published Jan 2025, development of new Paediatric Service Specification in region and develop a set of outcome measures and updated indicators. To agree longer term sustainability of service provision.
Orthodontic Services review	£20					To develop options appraisal for long term plan from April 2027 to stabilise service provision
Oral Health prevention and education						
Children and Young People	See note					NHSE toothbrushing target for 3, 4 & 5 years mandated nationally, led by local authorities who will receive additional funding
Older People	£600					In collaboration with local authorities, to improve access to domiciliary services in Care homes and individual homes
Access Improvement (2nd phase)	£2,700					To improve access to NHS dental services through local community pilots, new contracts and expansion of existing provision to reduce health inequalities: <ul style="list-style-type: none"> • pilot in Norwich • pilot in West Norfolk • new services in South Norfolk • expansion of existing services across Norfolk & Waveney Relies on contract renegotiations and rebasing underperforming contracts to release funding.
Unscheduled Care services	£1,700					N&W target of 21,520. Proposal for dental nurse clinical triage within NHS 111 being considered.
Special Educational Needs Screening programme	tbc					To commission a screening service for dentistry and eye health in special educational school settings in line with national guidance

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Workforce recruitment and retention	£1500					
Level 2 services						
Minor Oral Surgery	£150					To secure a clinical triage system. Support Level 2 accreditation to upskill workforce supported by capacity to meet population need – led by region. Increased capacity to reduce secondary care service demand & wait lists
Endodontics & periodontics	£50					To commission ad hoc treatment based on historical pilot referral criteria and to scope long term option. Level 2 accreditation plans with region
Paediatrics Special Care Dental	To be confirmed					Level 2 accreditation to upskill workforce supported by commissioning plan to support access for most vulnerable patients (Core20).
Targeted UDA uplift (payment that NHS dentists receive)	£1500					Targeted UDA uplift in areas of high deprivation, rural and coastal to enable workforce recruitment and retention
Digital technology for dental practices	Flexi commissioning					Look at flexible commissioning options (cf other ICBs) to support shift to digital. Not funded by NHS.
Investment in estates/equipment	Flexi commissioning					Look at flexible commissioning options (cf other ICBs) to support investment in equipment and relocations. No capital funding for dentistry available
PROPOSED INVESTMENT (2025/26)	£8,250					

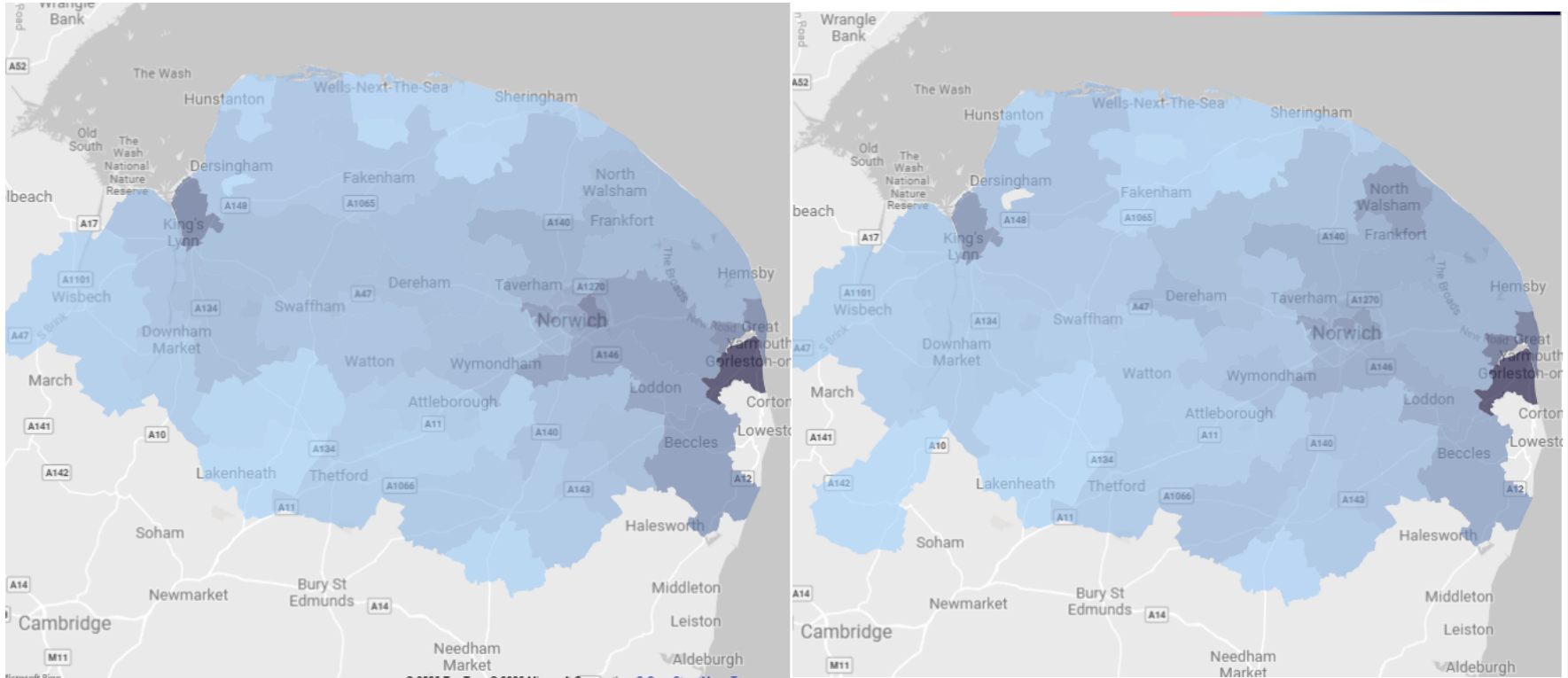
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Heat maps showing New Patients (in previous 24 months) for Previous 2 years

All IMD Deciles

2023/2024

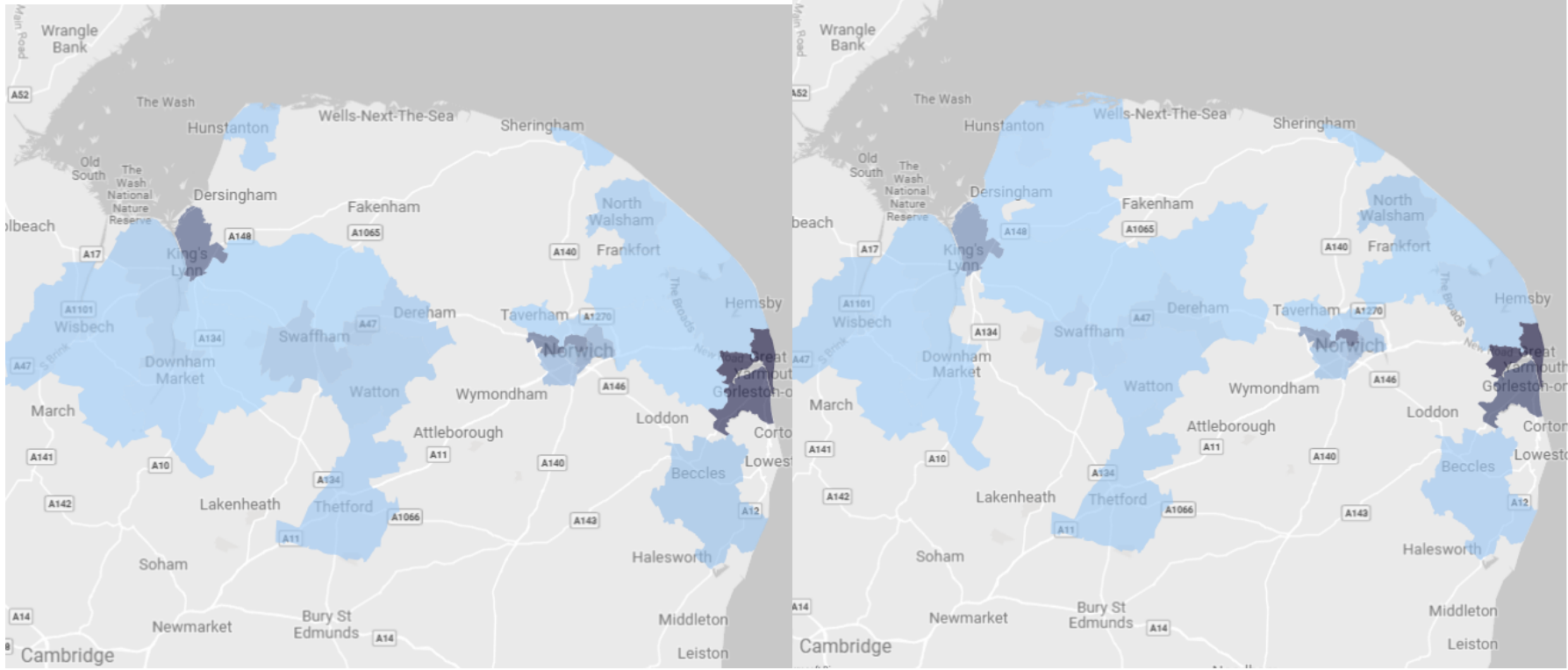
2024/25



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2023/2024 - IMD Deciles 1 and 2

2024/2025 - IMD Deciles 1 and 2



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Agenda item: 09

Subject:	Integrated Performance Report
Presented by:	Diane Smith, Head of Collaborative Commissioning & Performance, Norfolk and Waveney ICB
Prepared by:	Jane Hackett, Senior Commissioning Manager, Norfolk and Waveney ICB
Submitted to:	Primary Care Commissioning Committee
Date:	14 May 2025

Purpose of paper:

To approve the content of the Integrated Performance Report within the Primary Care Commissioning Committee governance structure.

Executive Summary:

The Business Intelligence Team and the Commissioning and Performance Team are working to refocus the Integrated Performance Report (IPR). There are currently around 500 metrics reported via the IPR. Insight tells us that most of these metrics are not used. The aim of refocusing is to simplify navigation of the IPR and ensure clarity on data sources and data quality.

It is important to make clear where the ICB receives assurance on system metrics, with designated Committees and, or Programme Boards identified as providing scrutiny, oversight and assurance.

The refocused IPR will enable appropriate narrative alongside the data, especially where metrics are 'off track', helping to identify root causes and corrective actions. It will allow planning guidance and constitutional metrics to be highlighted and linked to quality and risk management.

Critically, all groups will be limited to a maximum of 15 metrics on their regular IPR and a small sub-set will be represented at higher tiers of reporting.

This refocusing work will implement the processes and objectives set out in the Performance Management Framework and responds to recommendations in the audits from TIAA.

The slide enclosed with the agenda pack sets out the IPR metrics identified for:

- Dental Services Delivery Group

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- Community Pharmacy and General Practice Delivery Group
- Primary Care Commissioning Committee
- Governing Body

BI and Commissioning have worked closely with colleagues from within the Primary Care Delegated Commissioning Team (representing dental, pharmacy and general practice) to agree metrics which will best reflect system performance and to include planning and constitutional metrics. Not all metrics yet have a finalised data source and are still in development.

Recommendation to the Board:

Approve the content of the Integrated Performance Reports within the Primary Care Commissioning Committee governance structure.

Key Risks	
Clinical and Quality:	helping to identify root causes and corrective actions; allowing metrics to be linked to quality and risk management.
Finance and Performance:	Requirement of ICB Performance Management Framework and TIAA audit
Impact Assessment (environmental and equalities):	Performance metrics and related supplementary data can help identify and tackle health inequalities
Reputation:	Public assurance on planning guidance and constitutional metrics
Legal:	Public assurance on planning guidance and constitutional metrics
Information Governance:	N/A
Resource Required:	Narrators for the metrics have been identified within the Primary Care Delegated Commissioning Team
Reference document(s):	N/A
NHS Constitution:	Public assurance on planning guidance and constitutional metrics
Conflicts of Interest:	None identified
Reference to relevant risk on the Board Assurance Framework	N/A

Governance

Process/Committee approval with date(s) (as appropriate)	Audit Committee for information.
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Improving lives **together**

Norfolk and Waveney Integrated Care System

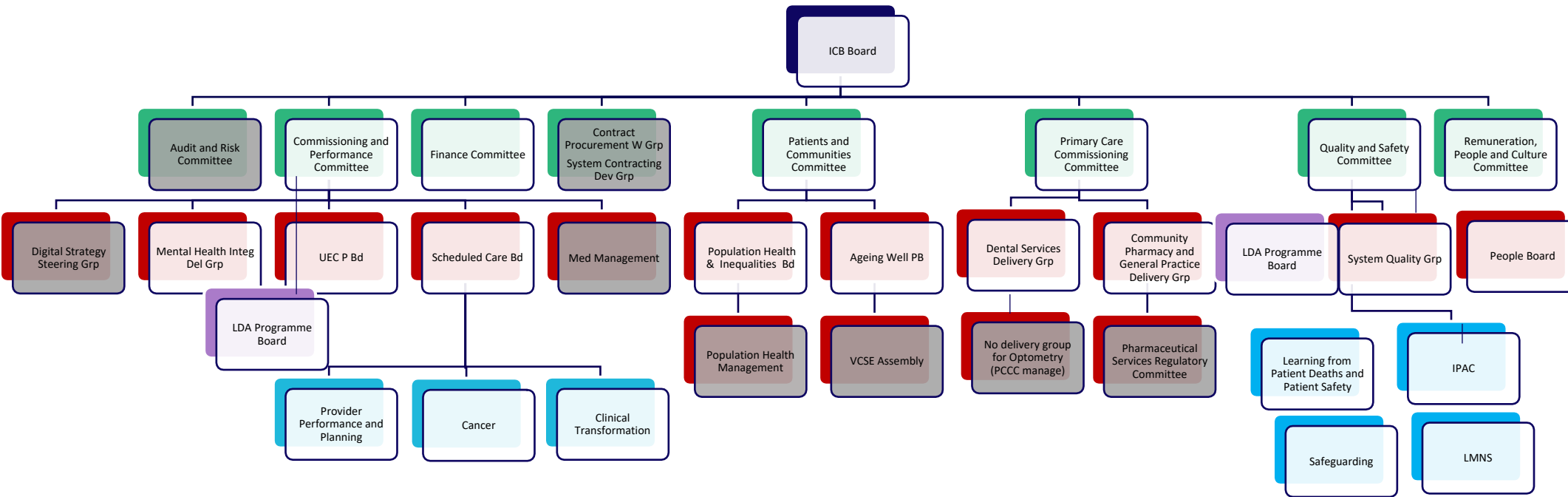
IPRv.2

Proposed KPI's

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Groups with Performance Oversight

Greyed groups do not monitor performance metrics



- Tier 1 is the Board of the ICB- Information on what decisions are reserved to the Board can be found in the Governance Handbook. This is in dark blue.
- Tier 2 are Committees- Information on what decisions are reserved to Committees can be found in the Governance Handbook. Committees also have an assurance function. These are in green.
- Tier 3 are programme Boards. They operate via the delegation to the relevant Director who sits on the Board. Their delegations can also be found in the Governance Handbook and within our detailed delegated financial limits document. These are in red.
- CYP is represented at the following Tier 3 Groups: MHIDG, HIB, SCB, DSDG, SQG
- Tier 4 are working groups- they do not make decisions but complete actions and are centred around task and finish. These are in blue.

Primary Care Commissioning Committee

To note:
 Planning Guidance 2025/26

Board

Dental

UDAs delivered as % of contracted (data being developed)
 UOA delivered as % contracted (data being developed)

Community Pharmacy & General Practice
 GP appointments; total

PCCC
 Committee

Dental

1. UDA delivered as % of contracted (data being developed)
2. UOA delivered as % contracted (data being developed)

CP and GP

3. GP appointments; total
4. GP booking to appointment within 2 weeks
5. SMI Health Checks
6. LD Health Checks
7. Pharmacy First – Hypertension
8. Pharmacy First – Contraception
9. Pharmacy First - Clinical pathways (combined) (*sore throat, earache, impetigo, sinusitis, uncomplicated UTIs, shingles, infected insect bites*)

10. NHS App use – downloads
11. NHS App use - accessing records basic and detailed
12. NHS App use - booking appointments
13. NHS App use - Repeats Prescriptions
14. Cloud Based Telephony - volume of calls (data being developed; may have to use GP survey data)
15. Cloud Based Telephony - calls dropped (data being developed; may have to use GP survey data)

Prog Board

Dental Services ODG

1. UDA delivered as % of contracted (data being developed)
2. UOA delivered as % contracted (data being developed)
3. Number of unique adults seen by a dentist v population / yr
4. Number of unique children seen by a dentist v population / yr
5. Increase the number of unscheduled dental appointments by 21,520 by March 26

Community Pharmacy and General Practice

1. GP appointments; total
2. GP booking to appointment within 2 weeks
3. SMI Health Checks
4. LD Health Checks
5. Pharmacy first; hypertension
6. Pharmacy first; contraception
7. Pharmacy First; 7 clinical pathways (combined)
8. NHS App use – downloads
9. NHS App use - accessing records basic and detailed
10. NHS App use - booking appointments
11. NHS App use - Repeats Prescriptions
12. Cloud Based Telephony - volume of calls
13. Cloud Based Telephony - calls dropped
14. Improve patient experience of access to general practice as measured by the ONS Health Insights Survey (data being developed; may use GP survey data for overall experience)

Agenda item: 10

Subject:	Estates – quarterly update
Prepared by:	Estates Team
Submitted to:	Primary Care Commissioning Committee
Date:	14 May 2025

Purpose of paper:

Update on Primary Care and other Estates issues, for information.

Contents

Premises Costs Directions 2024	1
Primary Care Utilisation and Modernisation Fund	1
Wave 4b Primary Care Hubs.....	2
PCN Estate Strategies and General Practice Estate Strategy	2
Norfolk and Waveney General Practice Estate: funding and projects.....	2
Scheme Spotlight: Drayton Medical Practice Extension	4
Demand & Capacity and Housing Developments	4
Rent reimbursement and rent reviews	5

Update:

The NHS (General Medical Services – Premises Costs) Directions 2024

Since the publication of the new Directions in May 2024, the Estates Team have been working to implement the necessary changes to process where required and to update existing local guidance and advice notes. This includes the need for the ICB to ensure evidence of negotiations between landlord and tenant, in respect of general practice lease rent reviews.

Primary Care Utilisation and Modernisation Fund

This Fund was announced by the Government in the October 2024 Spending Review. This is capital funding to support the better utilisation of the existing general practice estate, linked to creating capacity for the GP workforce. At the time of writing, the ICB was waiting for NHS England feedback on its expressions of interest for potential schemes, which totalled £1.3m. NHS England guidance was that any funding awarded must be spent by the end of December 2025. In addition, NHS England indicated they would require grant agreements to be put in place, which require legal input. The ICB has expressed concerns regarding the grant agreement process and highlighted the need for the process to be expedited in order to ensure this fund can fully benefit the system.

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Wave 4b Primary Care Hubs

Following agreement with the Department of Health and Social Care (DHSC), the programme end date was extended to 2025. A Gateway review will take place with DHSC in 2025, after the Department indicated to the ICB that they were content with progress reported on the programme as of the Spring of 2024. The Wave 4b Programme Board continues to track progress against plan and is supported by Steering Groups for the individual schemes.

Thetford (£2.8m) – Complete

The scheme for the refurbishment of Thetford Healthy Living Centre was completed in 2024. The scheme converted existing void admin space into 14 new consultation rooms alongside other improvements which have eliminated most of the void space from the premises. The majority of the new consultation rooms are for bookable use, but longer term (within the next 10 years) will be needed by primary care providers and transferred over to GMS space. Breckland PCN will be promoting the new space to maximise bookable usage, until the space is fully needed for primary care. The ICB have expressed interest to utilise the NHS Property Services “Open Space” booking system in the building. The benefit of this would be improved ease of booking and greater financial control on bookings.

Sprowston (£0.2m plus £1.0m landlord contribution) – Complete

The scheme for the refurbishment of Sprowston Primary Care Centre was completed early in 2025. This scheme makes better use of existing vacated space for provision of primary care, rather than the originally proposed extension. The ICB Estates and Infection Prevention and Control teams visited the site during the latter part of 2024.

King’s Lynn (£11.5m) – Complete and Rackheath (£10.6m) – due to complete Summer 2025

NHS Property Services have appointed Darwin Construction to oversee the design and build of the two new build schemes at Rackheath and King’s Lynn. The new builds will contain a mixture of tenants with approx. 35% of the space allocated for primary care and 65% for NHS trusts.

The King’s Lynn scheme completed late 2024 and became operational spring 2025 with the Primary Care Network (PCN) taking occupancy in March 2025. It is expected that other healthcare trust tenants will take occupancy during 2025.

The Rackheath scheme saw construction commence in August 2024 and is making good progress against programme. Pending utility connections, the scheme is expected to complete Summer 2025. A “first look” visit to the site for stakeholders took place early 2025. The build has been right sized for future population growth, which means the premises will include initial vacant space. Elements of this space will be made bookable via the NHS Property Services “Open Space” booking system and, depending on success, will expand to further space until needed by the general practice tenant.

PCN Estate Strategies and General Practice Estate Strategy

The Estates Team have produced an Interim General Practice Estates Strategy which will support the updated Primary Care Commissioning Strategy, along with the wider ICS Estates Infrastructure Strategy.

Norfolk and Waveney General Practice Estate: funding and projects

The majority of general practices have indicated the need for at least one estates scheme via the PCN Estate Strategies. These schemes range from new builds through to internal improvements or compliance work to existing buildings.

The allocation of “business as usual” capital funding from NHS England for primary care premises remains relatively low – £2.1m per annum for both premises and GPIT schemes.

The schemes/proposals being supported by NHS business as usual capital and/or revenue funding to support increased rent reimbursement are:

Practice	Scheme	Capital	Fees	Revenue	Total	NHS Capital 2024/25
Drayton Medical Practice (see separate paragraph)	Extension (due to complete June 2025)	Third party funding	✓	✓	£2.9m with £0.1m from NHS capital	£114k
Orchard Surgery	Reconfiguration			✓	Revenue only	£0
Magdalen Medical Practice <i>(Proposed – pending approval)</i>	Reconfiguration	✓	✓	✓	£0.3m 100% NHS capital	£318k
Brundall Medical Practice <i>Pending Grant Agreement</i>	Reconfiguration	✓	✓	✓	£67k £56k NHS capital	£76k* forecast allows for cost increase and GPIT tweaks.
East Norfolk Medical Practice - Lighthouse <i>Pending Grant Agreement</i>	Improvements	✓	✓	✓	£63k 100% NHS capital	£63k
Reepham & Aylsham Medical Practice <i>Pending Grant Agreement</i>	Improvements	✓	✓	✓	£45k £29k NHS capital	£60k* forecast allows for cost increase and GPIT tweaks.
Feasibility Studies (Mattishall, Watlington, North Walsham)	TBC		✓		£195k	£195k
Grand Total						£826k

The following projects completed in 2024/25:

Practice	Scheme
Blofield Surgery	312m ² extension to existing premises
Long Stratton Medical Partnership	153m ² extension to existing premises.

Seven new build schemes and one extension scheme received ICB Executive Management Team support for estimated revenue costs within the ICB medium term financial plan, which means they can progress with the business case process. In the scenario of scheme slippage un-utilised funds will be transferred to a reserve scheme. All of the below schemes will utilise non-NHS capital funding.

Scheme	Scheme
Attleborough	New build facility
Bridge Road Surgery	New build facility
Bungay Medical Centre	Extension (CIL funding awarded by East Suffolk Council)

Diss	New build facility
Humbleyard Practice	New build facility
North Walsham	New build facility
Shrublands	New build facility
Taverham	New build facility

Scheme Spotlight: Drayton Medical Practice Extension

A new extension (560m²) for the practice is currently nearing project end, with practical completion planned for the 21st June. After this date some time will be needed for mobilisation, to make the space ready to deliver services. The business case for the extension was approved by the ICB's Primary Care Commissioning Committee in July 2023. The new extension replaces a smaller extension and will provide increased clinical and admin space. Before and after floorplans can be found in Appendix 1 to this update report. Delivery of the project has taken longer than expected, due to a number of logistic issues outside of the landlord or contractor control.

The practice building is owned by Medical Centre Developments (MCD) who lease the building to Drayton Medical Practice to deliver their contractual services. MCD are funding the majority of £3.5m capital cost of the scheme in return for an increased rental value over a new 25-year lease for the premises. The construction element of the scheme has been undertaken by RG Carter, a local construction firm. The scheme has also benefited from a Section 106 arrangement which has enabled the land area the practice is located in to increase. Appendix 2 shows the wider site plan including the additional Section 106 area. This increase has meant that additional car parking can be fitted to site, enabled a new pedestrian access to the site from the rear, and allows the extension to fit more comfortably within the site boundary.

The ICB were invited to site earlier this month to review progress. Photos from the visit can be found in Appendix 3.

Demand & Capacity and Housing Developments

Amendments to the National Planning and Policy Framework (NPPF)

The Ministry for Housing, Communities and Local Government (MHCLG) published its revised NPPF on December 12th 2024. As part of the work, the Standard Method for Calculating Housing Need was updated, resulting in revised/increased housing targets across Norfolk and Waveney.

There is an interactive map created by Pegasus Group that breaks down the housing need figures by individual local authority. You can explore this map to see how housing targets have changed, here: [The New Standard Method - What Does it Mean for Local Housing Need? - Pegasus Group](#)

The Estates Team will work Local Planning Authority colleagues to ensure we proactively manage and incorporate these housing target increases into our strategies, demand and capacity modelling and relevant projects/work areas.

King's Lynn and West Norfolk (KL&WN) Local Plan Review

The King's Lynn & West Norfolk Local Plan has now been through examination and adopted as of 27th March 2025. The King's Lynn and West Norfolk Local Plan will guide development in the Borough until 2040, fully replacing the previous Local Plans: Core Strategy 2011 and the Site Allocations and Development Management Policies Plan 2016.

The Estates Team have an upcoming meeting with KL&WN colleagues to discuss Community Infrastructure Levy (CIL) and the capability of the ICB submitting applications for

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the use of CIL towards health infrastructure projects. This is an area that is currently restricted and efforts to unblock are ongoing.

Place Plans

The Estates Team are currently working on the development of 'Place Estate Infrastructure Plans'. These plans will support the wider System Estates Infrastructure Strategy by focussing on localised insights and development plans, providing a more comprehensive plan that addresses the specific needs and priorities of local healthcare services.

An initial draft has been developed for West Norfolk Place and shared with the ICB place team for comment and feedback. Other drafts are in development and will be circulated throughout May.

POD (Pharmacy, Optometry and Dentistry) Estate

Discussions have taken place with ICB colleagues regarding the inclusion of Pharmacy, Optometry and Dentistry in planning consultation responses. Moving forwards, requests for developer contributions through Section 106 will include any requirements for these services as and when needed, although securing contributions is not guaranteed.

To support this work and other areas of strategy, and development plans, the Estates Team are undertaking an exercise to gather more data on our POD estate; as well organisation names and locations, this work will assist with understanding building sizes, ownership models and lease details, utilisation and capacity information and cost information.

Holt Medical Practice Section 106 Works

Section 106 funding that was recently released from the local planning authority has been used to progress a programme of work which will deliver several small schemes aimed at improving patient access and service capacity at the Holt and Melton Constable sites and also in Blakeney, following the agreement to close the Blakeney branch surgery.

Updated Planning Contributions Dashboard

Capital funding sought through CIL and S106 developer contributions:

Date of latest update		25/04/2025				
	Sum of contributions sought	Sum of amount secured (£)	Sum of total available for draw down	Sum of total received by ICB	Sum of total invested by ICB	
Breckland (s106)	£5,936,222.00	£3,353,451.80	£670,509.28	£371,793.19	£0.00	
North Norfolk (s106)	£7,477,188.00	£802,011.54	£253,930.53	£242,914.24	£121,046.29	
Great Yarmouth (s106)	£3,049,217.00	£1,616,980.00	£0.00	£0.00	£0.00	
Greater Norwich (CIL) - (cover Norwich, South Norfolk & Broadland)	£245,827.00	£245,827.00	£0.00	£0.00	£0.00	
West Norfolk (CIL)	£0.00	£0.00	£0.00	£0.00	£0.00	
East Suffolk (CIL)	£2,060,903.00	£2,060,903.00	£2,060,903.00	£0.00	£0.00	
	£18,769,357.00	£8,079,173.34	£2,985,342.81	£614,707.43	£121,046.29	

Note: Restrictions are still impacting the ICB's ability to secure CIL across Norwich, South Norfolk, Broadland, and West Norfolk. Discussions to unblock these are ongoing.

Rent reimbursement and rent reviews

Since the publication of the 2024 Premises Costs Directions, the Estates Team has reviewed its template letters relating to rent reimbursement and rent reviews and made adjustments where appropriate. This was also an opportunity to do some general housekeeping of the templates the ICB inherited from NHS England. Regular reviews of our standard templates are ongoing.

As noted above, the revised Premises Costs Directions set out a new process which applies to leasehold rent reviews. This places a duty on GP practices to negotiate and agree a proposed revised market rent directly with their landlords. Practices must provide the ICB with evidence of that negotiation before the ICB is able to instruct the District Valuer. The Estates Team has produced an online template to aid practices with providing the relevant documentation. This is in its infancy and the team has just started to roll it out with a couple

Webb Jarvis
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of practices. The Estates Team will be able to report back at a later date with how well the process has performed.

During a given financial year, there are several moving factors with rent reimbursements. Actual amounts will alter after back dated arrears on upcoming uplifts/adjustments have been paid and accounted for. Therefore, the figures below are approximate.

For the period 2024/25 total expenditure for rent reimbursement was £15,836,181.

2024/25 Reviews

Month	No. of rent review approvals	Rent increases
April	1	£ 1,350.00
May	9	£ 43,250.00
June	2	£ 26,881.73
July	2	£ 6,650.00
August	5	£ 21,460.00
September	5	£ 16,250.00
October	2	£ 8,100.00
November	5	£ 19,000.00
December	1	£ 72,500.00 <i>(post completion of extension at Blofield Surgery)</i>
January	4	£ 8,350.00
February	1	£ 8,000.00
March	1	£ 1,100.00
TOTAL:		£232,891.73

2024/25 Appeals

Month	No. of appeals	Additional increase in rent post appeal <i>(not already included in table above)</i>
April	2	£6,800
May	0	-
June	1	£2,400
July	5	£17,390
August	1	£1,600
September	0	-
October	0	-
November	1	£ 9,641.00
December	1	£ 1,800.00
January	1	£ 3,200.00
February	1	£ 1,100.00
March	1	£ 8,000.00
TOTAL:		£51,931.00

2025/26 Reviews (to date)

Month	No. of rent review approvals	Rent increases
April	1	£2,500.00

2025/26 Appeals (to date)

Webb Sarah
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Month	No. of appeals	Additional increase in rent post appeal <i>(not already included in table above)</i>
April	0	-

Please note that the number of appeals each month does not directly correspond with the number of rent review approvals in the same month. The ICB may approve a rent review increase in one month, however, a notification of appeal of the rent determination may not be received until the following month or beyond. Direction 43 (3) of the new 2024 Premises Costs Directions requires practices to accept or not accept the determination of current market rental (CMR) value of its premises within the period of 12 weeks from the date the ICB gives notice to the practice. However, the Estates Team has updated its rent review template letters asking for practices to confirm acceptance as soon as possible, and to counter sign the letter and return to the team to confirm acceptance. This should remove any doubt as to whether a practice has or has not accepted the determination of CMR. To avoid a drawn-out process, and to try to eliminate a lengthy period of back-dated rent, the team regularly sends reminders to practices.

The Estates Team has implemented a further step in the review process, by way of updating the Valuation Office Agency (District Valuer) once a month of all acceptances of rent determinations. This will also enable the District Valuer to close his case files.

District Valuer Service Expenditure

2024/25	£55,013.45	Average instruction = £1,037.99
2025/26 (To Date)	£19,919.11	Average instruction = £1,327.94

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Appendix 3: Drayton Site Photos



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Agenda item: 11

Subject:	Medicines Optimisation team report
Presented by:	Michael Dennis, Associate Director of Pharmacy and Medicines Optimisation
Prepared by:	Michael Dennis, Associate Director of Pharmacy and Medicines Optimisation
Submitted to:	Primary Care Commissioning Committee
Date:	14 May 2025

Purpose of paper:

For information and discussion of strategic approach to medicines optimisation and to highlight some successes and challenges of implementing activity across a system

Executive Summary:

Our strategic priorities are highlighted and discussion on implementation is welcomed. This time I will focus on implementation of the green agenda with respect to medicines and the important work to reduce the risks associated with valproate prescribing

1. Focus area – implementation of Tirzepatide for obesity

- 1.1 NICE approved this drug in December 2024 and NHSE applied for delayed implementation timetable because of very significant affordability issues. NICE don't look at affordability the question they answer is if we have the money is it worth investing in and also only look at published (and potentially sponsored) trials rather than real world data.
- 1.2 given the impact on NHS resources, eligibility will need to be phased in across the entire eligible patient population. This means that a protocol for prioritising who gets initial access to treatment is needed

2. Prescribing team focus areas

2.1 The prescribing team is focused on supporting the prescribing quality scheme and an additional switch scheme which is in the final stages of development.

2.2 The prescribing quality scheme has facilitated some improvement in indicators (see below). The team continue to meet practices to facilitate implementation.

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- 2.3 We have now formed our medicines optimisation pillars and will be developing our pillar focus and strategy. Key work from our pillars is highlighted below.
- 2.4 We have a number of strategic priorities within the medicines workstream. Some of these are mandated by NHS England who have asked the ICB to pick 5 from a national list of medicines optimisation opportunities [here](#).
- 2.5 Our five are.

- Addressing problematic polypharmacy
- Addressing low priority prescribing
- Best value biologics in line with NHSE commissioning recommendations
- Improving valproate safety – see below
- Switching IV antibiotics to oral (hospital in-patients)

In addition to the above we also have an ICS zero carbon delivery group and we, the medicines team, work with partners to monitor the carbon footprint of key medicines and have helped develop long term plans to reduce this. The [NHS long term plan](#) (page 120) sets out the milestones for improvement.

We aim to encourage carbon footprint alternatives where clinically appropriate and reducing inhaler waste and recycling schemes where they exist.

3 MO Pillar highlight report – Quality and Safety

3.1 Teratogenic medicines

Valproate – referrals to secondary care for those female patients of childbearing age requiring review are being made – deadline given for all referrals to be completed by 18th April. Currently over 150 patients referred into secondary care who were previously not known to them (discharged) or not included in Pregnancy Prevention Programme. MHRA have confirmed there are no further changes to males prescribed valproate as previous anticipated – newly initiated patients must have a RAF form completed but existing patients will not require this

Topiramate - Majority of outstanding audits have been submitted by practices – team have contacted practices directly as now a priority. Prescribing guidance document in the process of being updated. Still awaiting further national guidance on prescribing off-label as no national direction on how these patients should be managed (essential tremor and idiopathic intracranial hypertension where treatment options would be limited). Once data has been finalised, we will work with secondary care to start referral process for female patients with epilepsy.

3.2 Dietetics

The team continue to provide support to primary care and the ICS via the dietetic queries mailbox.

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Education sessions are ongoing with care homes and domiciliary care on nutrition support, supporting food first initiatives to reduce inappropriate requests to primary care for ONS use, end-of-life care and dementia.

Paediatric oral nutritional supplements (ONS) guidelines due for publication at the end of April

3.3 Antimicrobial Stewardship (AMS)

NHS System Oversight Framework (SOF) Antimicrobial Prescribing Metrics for 2024-25 remained the same as 2023-24. The antibiotic volumes target is 0.871 or less antibacterial items per STAR-PU. The national target for percentage of broad-spectrum antibiotic prescriptions as a total of overall antimicrobial prescriptions is at or below 10%.

The ICB is continuing in a downward trend for both metrics

13 PCNs have improved their total antimicrobial prescribing figure in the 3-month period to end of Jan 2025

11 PCNs have improved their percentage of broad-spectrum items in the 3-month period to end of Jan 2025

PCN	Total antimicrobial prescribing /STARPU		Percentage of Broad-Spectrum prescription	
	Nov-24	Jan-25	Nov-24	Jan-25
West Norfolk Coastal	1.171	1.164	10.56%	10.39%
Fens and Brecks	1.136	1.128	9%	8.77%
North Norfolk 2	1.044	1.034	11.15%	11.12%
NHS Norfolk and Waveney	1.033	1.027	9.80%	9.77%
Mid Norfolk	1.027	1.013	8.72%	8.79%
South Waveney	1.025	1.016	9.90%	9.87%
Norwich	1.002	0.992	8.99%	9%
South Norfolk HIP	0.978	0.974	9.48%	9.36%
North Norfolk 4	0.976	0.966	10.56%	10.45%
Kings Lynn	0.972	0.994	10.33%	9.89%
North Norfolk 3	0.954	0.943	9.70%	9.60%
Swaffham and Downham Market	0.952	0.97	11.44%	11.89%
Lowestoft	0.95	0.948	9.44%	9.38%
England	0.948	0.937	7.61%	7.63%
Gt Yarmouth and Northern villages	0.934	0.925	7.40%	7.57%
Gorleston	0.905	0.907	10.62%	10.78%
Breckland Surgeries	0.904	0.904	8.98%	9.08%
North Norfolk 1	0.871	0.859	11.58%	11.52%
Ketts Oak	0.831	0.819	10.40%	10.13%

3.4 AMS supporting practices

AMS projects focused on as deep dives into outlier practices, using data including ePACT2 with a view to working directly with practices on specific area(s).

Projects include, Broad spectrum prescribing, paediatric prescribing (including overuse of liquids), UTI's and overall antibiotic prescribing.

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AMS discussions with Litcham, Bridge Street and Heacham practices – feedback & recommendations given and follow up in 3 months.

Three more practices identified who will be contacted next for initial discussions- practices are also welcome to contact us for support/ recommendations.

Producing educational content for practices on project areas and adding in specific bespoke content for practices as necessary.

3.5 Controlled Drugs

The team are contacting practices who have patients receiving prescriptions for the highest quantities of daily morphine equivalent, to obtain assurance about their management. A support pack is under development for practices to provide resources and advice when prescribing and reviewing controlled drugs.

3.6 Structured Medication Review (SMR) and Deprescribing

The team are reviewing resources and educational opportunities for clinical pharmacists to support SMR delivery and deprescribing. These will be located on Knowledge Now.

4 MO Pillar highlight report – Clinical Experience and Delivery

4.1 Delivering prescribing efficiencies:

The pillar is focussed on its commitment to supporting value-based prescribing initiatives, including QIPP projects and other strategic deliverables aimed at promoting appropriate prescribing, reducing waste and improving formulary compliance. Collaboration with system partners continues to be pivotal to achieving the pillar's key objectives.

The team actively engages with GP practices and PCNs through regular targeted practice prescribing reviews, conducted both in-person or virtually. These sessions are designed to address unwarranted variations in prescribing and agree actionable, value-based plans. Significant financial savings have been achieved through the facilitation of evidence-based prescribing. Notably, the use of Co-ordinate Rx has demonstrated an estimated overall in year savings of £295k.

The spend per ASTRO-PU (weighted units of prescribing) for some outlier GP practices has decreased over the year although a few of these practices still pose a challenge. The pillar will focus on ensuring GP practice nurses, particularly those involved in diabetes and respiratory prescribing, are fully integrated into Medicines Optimisation (MO) strategies. This will be achieved through extensive collaboration with the Integrated Care Board (ICB) educational groups and primary care teams.

Over the past year, the prescribing of unlicensed medicines in primary care has decreased significantly. By encouraging the use of licensed alternatives, the team has successfully improved outcomes and delivered better value for money. Norfolk and Waveney are now more favourably positioned when benchmarked regionally within the East of England.

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4.2 Collaboration with the ICB contracts & procurement team

In collaboration with the contracts and procurement team, the pillar continues to provide dedicated support to the Norfolk Hospice (Tapping House), ensuring that agreed medicines optimisation Key Performance Indicators are met. This partnership has contributed to a significant decrease in incurred spend as evidenced by invoices for medicines ordered by the hospice.

The pillar continues to engage with the three acute trusts to support efforts in reducing the stoma spend in primary care. The key focus remains on embedding medicines optimisation Key Performance Indicators (KPIs) into new company sponsored contracts as they come up for renewal.

A six-month evaluation of the on-going APMS (Appliance Prescription Management Service) pilot showed a 1% reduction in costs associated with growth, when benchmarked against GP Practices not aligned to the service and the national average. The results from this pilot have shown glimpses of savings albeit not consistently. The service is currently implementing agreed QIPP initiatives alongside trialling value for money stoma bags for suitable consenting patients and GP Practices. It is anticipated that an annual saving of £519 per patient can be achieved if the implementation is successful.

Furthermore, the providers Bullens, are willing to waive all costs associated with the delivery of the service. Effectively providing a zero-cost service funded only by nationally agreed Appliance Use Reviews.

4.3 Home Oxygen Service

Approximately 2,400 patients rely on home oxygen to manage severe respiratory and other health conditions, enhancing their overall health outcomes. These patients were successfully transitioned to the new provider, Baywater Healthcare on 1st February 2025 from BOC Ltd

The team continues to make efficiencies by monitoring agreed KPIs within the new contract and encouraging best practice within the system. Alongside making progress towards the Eight Key Performance Indicators (KPIs) set by NHS East of England. Norfolk & Waveney is favourably benchmarked against some of these KPIs but there is scope for further improvement.

5 MO Pillar highlight report – Interface and Formulary

The pillar work continues to work collaboratively with ICB colleagues and N&W system partners. Interface & Formulary Pillar continually review and update the Norfolk and Waveney netFormulary platform, ensuring evidence based best value medicines are highlighted for our local prescribers. The team continue to develop High Cost Drugs guidance and pathways in collaboration with the Acute Trusts, aiming for a “do it once approach” across the system. There is a focus on achieving best value from the use of medicines, including excluded from tariff High-Cost Drugs.

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This “do it once” approach has recently extended to the formation of the East of England Medicines Do it Once group (EofE MeDIG) – a collaborative approach by Area Prescribing Leads to avoid duplication and promote best value and reduced variation through sharing of best practice.

5.1 Best Value High Cost Drugs (HCD)

NHS England - National medicines optimisation opportunities 2025/26, opportunity 6, Using best value biologic medicines continues to be a priority. N&W use of ranibizumab biosimilar remains above the England average. This financial year will see the introduction of an additional best value option to treat medical retinal conditions – Aflibercept 2mg. A review of the [NHSE Commissioning Recommendations](#) for medical retinal vascular medicines is underway to outline the best values treatment choices. There is a significant opportunity to generate financial savings in N&W circa £2m.

Ustekinumab biosimilar initiations, and active switching is underway for all licensed indications for clinically appropriate patients. N&W is showing consistent savings month on month. March 2025 spend is less than half the average spend in the three months June-August 2024.

Future opportunities for ICB commissioned HCDs include Omalizumab and Vedolizumab.

5.2 NetFormulary and Knowledge NoW

Netformulary is built and managed in collaboration with our system partners. I&F team continues to work with NSFT colleagues to populate Mental Health Chapter 4; ensuring all previously agreed TAG decisions are clearly documented. Net formulary and KNoW continue to be a valuable resource to Health Care professionals. An e-mail banner and poster pop up on Teams is being used to remind system colleagues about these valuable resources.

5.3 System One Formulary

After a successful pilot, the localised System One formulary is being rolled out to GP practices. Our local platform has contributed to £153k efficiency savings to date for 2024/25. Currently 16 practices are using this formulary.

5.4 Therapeutics Advisory Group (TAG)

The role of the Therapeutics Advisory Group (TAG) is as an area prescribing committee, to provide informed, professional advice and recommendations for Norfolk and Waveney on the clinical use of medicines, dressings and other prescribable items that are commissioned by the ICB. TAG meetings have been well attended across the membership; April 2024 to March 2025 there were 8 meetings.

The meetings of the TAG continue to provide an important local forum for interactions that help to facilitate and maintain good working relations across several healthcare sectors.

2024-25 – 374 recommendations ratified by the Medicines Optimisation Programme Board

Webb, Sarah 13/05/2025 08:58:19	Formulary applications, pathways, commissioning reviews and prescribing guidance	NICE Guidance and Technology Appraisals	Interface issues, Shared Care Agreements, Prescribing Formulary Group updates, local PGDs, community trusts	Local and national guidance reviews – PAC, SPS, MHRA, NHSE etc.
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Total	115	118	86	55
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6 MO Pillar highlight report – Population Health and Data

6.1 Data provision

The team continues with the creation of datasets/analysis for wider MO team adoption/use (e.g., identifying practice outliers from BNF Chapters). Acute datasets are also provided on request.

6.2 Supporting BI

In collaboration with the data engineering team, a standardized medicines dataset is now accessible to Business Intelligence (BI) use. The data table provides more precise cost predictions which enables more accurate forecasting of prescribing costs from GP system data. This should support facilitation of medicines in future BI work.

6.3 Automated efficiency dashboard

The BI team has started to support our working on the development of an automated medicines efficiency dashboard, which aims to not only compare identical products for cost savings, but to also compare similar therapeutic products for potential opportunities.

6.4 Tirzepatide

With NHS England providing interim commissioning guidance for Tirzepatide's TA for obesity, we have provided detailed cohort information to the clinical transformation team to support their work.

6.5 Cost efficiency planning

The team have worked to identify and set targets for the 24/25 budgets, identifying ~£14m of cost cutting measures to introduce. Working with the Q&S team, we have finalised the measures to incentivise at a practical level and are currently creating the searches which will be used to track GP data centrally.

6.6 Invoice Management:

Significant progress made in reducing historic invoice backlog from over 500 invoices dating from 2019 to less than 10 historic invoices awaiting supplier credit confirmation. All invoices pending/awaiting payment are recent & awaiting information from suppliers.

Future work includes exploring more targeted interventions with Core20PLUS5, developing patient adherence indicators and clinical pathway indicators, and implementing additional data-driven initiatives to improve health outcomes.

7 MO Pillar highlight report – Workforce and Projects

7.1 Workforce

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Community Pharmacy Workforce Data - Key findings include growth in pharmacist headcount since 2021 but a reduction in FTE. There has also been an 11% decrease in pharmacy technicians, alongside changing of employment status from permanent to locum pharmacists. Legislative changes are supporting role expansion for pharmacy technicians, who can now perform more clinical services, such as vaccinations and certain health checks, potentially enhancing career attractiveness. Workforce challenges continue to impact on pharmacy workforce wellbeing, and access for patients to services due to temporary closures.

Foundation Trainee Placements 25/26 – changes to the training requirements for this year include the need for Trainee Pharmacists to complete prescribing competencies. Work is continuing with partnerships to implement quality training placements for students.

Foundation Trainee Placements 26/27 – the national Oriel employer upload window has recently closed, with an initial 38 placements shown across Norfolk and Waveney. Data cleansing is now in process to confirm the final number (up from 19 in previous year). It is anticipated that more community cross-sector placements will be available for selection this year.

Pre-registration Pharmacy Technicians – 9 out of 15 available commissioned places have been allocated funding for salary support to train a student. The nine students are either in Year 1 or Year 2 of their course. A national scheme has recently run for community pharmacy to train pharmacy technicians, but the final number of confirmed places are unknown within Norfolk and Waveney.

Pharmacy Careers – several events have been attended by the team to highlight available careers options in Pharmacy and continue to work with System Education Leads and the Careers Faculty.

7.2 Projects

Repeat Prescribing and Support – the RPS / RCGP Repeat Prescribing Toolkit has now been launched. The team are working to amend the audit which is intended to be completed as a multi-disciplinary audit to identify issues and improvement actions in repeat prescribing systems.

The team are also working in practices to identify interventions to improve repeat medication safety and costs. Several practices have expressed interest in the use of electronic Repeat Dispensing and plans are in place to support this work in the new year.

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Recommendation to Committee:

The committee is asked to note this report.

Key Risks	
Clinical and Quality:	Some key quality areas need focus and outlier performance needs addressing. Mitigated through the prescribing quality scheme
Finance and Performance:	Risks highlighted in report
Impact Assessment (environmental and equalities):	Not applicable
Reputation:	ICB practices remain outliers for some quality indicators and selective medication reviews may help address these
Legal:	Not applicable
Information Governance:	Not applicable
Resource Required:	Medicines optimisation team support to practices
Reference document(s):	Not applicable
NHS Constitution:	N/A
Conflicts of Interest:	GP dispensing practices may be conflicted with competing financial interests associated with dispensing costs
Reference to relevant risk on the Governing Body Assurance Framework	Prescribing cost risk noted on register

GOVERNANCE

Process/Committee approval with date(s) (as appropriate)	Monthly report to PCCC
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Agenda item: 12

Subject:	Dental Services Delivery Group Update
Presented by:	Sarah Johnson
Prepared by:	Sarah Johnson
Submitted to:	Primary Care Commissioning Committee
Date:	14 May 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
Meetings since the previous update to PCCC on 11th March 2025	8 th April 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 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	BAF02 – Primary Care Resilience and Transformation

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<p>relevant / aligned to this Committee.</p> <p><i>To note Operational Risk discussions</i></p> <p><i>To note details of key risks identified during items discussed</i></p>	<p>An update on the Risk Register was provided highlighting the new risk relating to Special Care and the resilience of primary care services. The Group approved the risk register mitigations.</p> <p>Risk ref 00000029 Secondary Care Dental Services (Oral Surgery and Maxillo Facial Services, Orthodontic Services) FT noted no significant changes in secondary care risk. Baseline information from the N&N was received, but data from JPUH and QEH is still pending. This information will help in forming a more detailed risk assessment.</p> <p>Risk ref 00000071 Special Care Dental Services The Special Care risk was assigned a RAG rating of 12 at Primary Care Commissioning Committee and will be monitored closely at DSDG, especially concerning workforce and mitigating actions. If there is a shift in these factors, the risk level may increase.</p> <p>Risk ref 00000025 Resilience of NHS General Dental Services in Norfolk and Waveney FT highlighted the resilience of primary care services, particularly general dental services. The phase two long-term dental plans were agreed upon internally and will go to the Primary Care Commissioning Committee for final commissioning approval in May, allowing for further investment in workforce.</p> <p>Outcome: Risk Register Report Approved.</p>
<p>Key items for Committee to take note of</p> <p><i>To highlight if any items include:</i></p> <ul style="list-style-type: none"> • <i>Changes to national policy/strategy</i> • <i>Quality & safety matters</i> 	<p>Dental Finance Report: The Dental Finance Report was presented which provided an overview of the dental finance report, highlighting the year-end numbers and the need to review contracts with no UDA delivery. The dental finance report was approved by the group.</p> <p>Quality Report: The Quality Report was presented which provided an overview of the Quality Report and emphasized the importance of the initiatives in supporting dental practices and improving patient care. The quality report was approved by the group.</p>
<p>Items receiving formal approval from the Delivery Group</p> <p><i>To include any financial risks</i></p>	<p>8th April 2025:</p> <ul style="list-style-type: none"> • PDS Plus contract extension – Approval for a 6-month extension to allow for further negotiations to convert existing PDS Plus contract to a GDS contract. Financial implication is likely to be reduced once contract converted to GDS.

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	<ul style="list-style-type: none"> • Service provision – Approval for an increase to UDA rate and a flexible commissioning approach following an existing dental provider business being sold in an area of high need. Plan to include expansion of services and inclusion of Unscheduled Care Service. • Practice sustainability – Approval to increase UDA rate, include Child Focused Dental Practices service within the current contract value, with a corresponding reduction in UDA activity and offer extended repayment scheme to a provider in an area of high deprivation. Cost pressure to ICB of UDA rate increase is c. £35k, this has now been included within the Dental budget for 2025/2026.
Items for escalation to PCCC	Practice Sustainability – Concerns around individual contract resilience were highlighted which will continue to be monitored by the Dental Commissioning Team.
Confirmation that the meeting was quorate and all Voting Members (or nominated deputies or making decisions on behalf of Voting Member) present	This meeting was quorate, Voting Members in attendance were: Mark Burgis Sadie Parker Fiona Theadom Marie McDermott Sarah Elliott

Recommendation to the Committee:

The Committee are asked to note the content of this report and the concern raised in relation to practice resilience.

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.

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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:	Conflict of Interest highlighted in relation to the Practice Sustainability item, the member of the group with the potential conflict of interest left the meeting for this item and was not party to the decision.
Reference to relevant risk on the Board Assurance Framework	

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Agenda item:

Subject:	General Practice & Community Pharmacy Delivery Group Report
Presented by:	Shepherd Ncube, Associate Director of Primary Care Commissioning
Prepared by:	Sharon Gardner, Head of Primary Care Commissioning Pharmacy and Optometry Sarah Webb – Primary Care Administrator
Submitted to:	Primary Care Commissioning Committee
Date:	14 May 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	8 April 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. <i>To note Operational Risk discussions</i>	BAF02 – Primary Care Resilience and Transformation Medicines management risk: 0000052 the transfer of this risk to the Medicines Optimisation Programme Board which reports into the Commissioning and Performance Committee was approved.

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<p><i>To note details of key risks identified during items discussed</i></p>	<p>General Practice Resilience: 0000023 The group discussed and noted the risks to general practice resilience. LMC raised concerns around continued reports of stress pressure and burnout with unfunded National insurance contributions adding further pressure. It was noted by SP that this financial pressure not only impacts general practice, it will also impact all primary care contractors</p> <p>Community Pharmacy Resilience: 0000056 The group discussed and noted the continued risk with financial viability of pharmacies, SG highlighted the new pharmacy contract which had been released 31st March 2025 which, although was a positive investment, had to be understood in context with the economic analysis report which highlighted a £2bn deficit in the funding needed to provide pharmaceutical services.</p>
<p>Key items for Committee to take note of</p> <p><i>To highlight if any items include:</i></p> <ul style="list-style-type: none"> • <i>Changes to national policy/strategy</i> • <i>Quality & safety matters</i> 	<p>8 April 2025</p> <p>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.</p> <p>Pharmacy First Update</p> <p>The group considered an update on the previous year's progress with Pharmacy First activity. Barriers and opportunities were discussed and resources shared that have been produced to support implementation and further progress</p> <p>Primary Care access Recovery Plan Update</p> <p>An update was received noting progress in various areas such as digital infrastructure, pharmacy first and workforce input. There was a discussion on the need to encourage more practices to participate in the general practice improvement programme.</p> <p>Contract monitoring report (E-Dec)</p> <p>An update on E-dec compliance was provided, noting an increase in high-priority flag questions marked as non-compliant and efforts to engage with non-compliant practices to improve their performance.</p>

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	<p>Prescribing Report</p> <p>The group noted a prescribing report, highlighting improvements in antimicrobial stewardship and efforts to address patient queries around ADHD medication.</p> <p>CQC inspection Humbleyard Practice</p> <p>The group received an update report on the recent CQC inspection for Humbleyard, noting the practices progress and ongoing support from the ICB to address the remaining issues.</p> <p>Finance Report:</p> <p>The group noted the forecast overspend had decreased to £6.2m. Key financial pressures included efficiency savings, prescribing costs, and locally commissioned services. Complex Dressing commissioning challenges and financial risks were briefly highlighted for members' attention.</p>
<p>Items receiving formal approval from the Delivery Group</p> <p><i>To include any financial risks</i></p>	<p>Chairs Action - Pharmacy Bank Holiday Commissioning Easter and May 2025</p> <p>Approval was completed offline prior to the meeting due to alignment of governance meetings supporting pharmacy commissioning on these dates.</p>
<p>Items for escalation to PCCC</p>	<p>There was one requiring escalation at the meeting.</p> <p>Community Pharmacy Contractual Framework (CPCF) Update</p> <p>During the Community Pharmacy risk discussion, SG confirmed the new Pharmacy contract had been announced on 31 March 2025. HW recommended that an overview of the new contract from a strategic level be bought at the next Committee meeting in May 2025 in order to provide context of this in relation to any mitigation of the Community Pharmacy Risk</p>
<p>Confirmation that the meeting was quorate and all Voting Members (or nominated deputies or making decisions on behalf of Voting Member) present</p>	<p>The meeting was confirmed quorate.</p> <p>Attendance at the meeting is set out below:</p> <p><u>8 April 2025</u></p> <p>Voting members Mark Burgis, Executive Director of Patients and Communities, NWICB - Chair Sadie Parker, Director of Primary Care, NWICB Sharon Gardner, Head of Primary Care Commissioning Pharmacy and Optometry, NWICB (deputising for Shepherd Ncube, Associate Director, Primary Care Commissioning, NWICB)</p>

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	<p>Rashmi Balakrishnan, Primary Care Finance Manager, NWICB (deputising for James Grainger, Head of Finance – Primary Care & Corporate/Reporting)</p> <p>Marie McDermott Senior Lead Quality Nurse, NWICB (deputising for Karen Watts, Director of Nursing and Quality)</p>
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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 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):	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.

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	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

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Improving lives **together**

Norfolk and Waveney Integrated Care System

2024/25 Primary Care Commissioning Committee Finance Report Norfolk & Waveney ICB

M12 2025

Primary Care Commissioning Committee 14th May 2025

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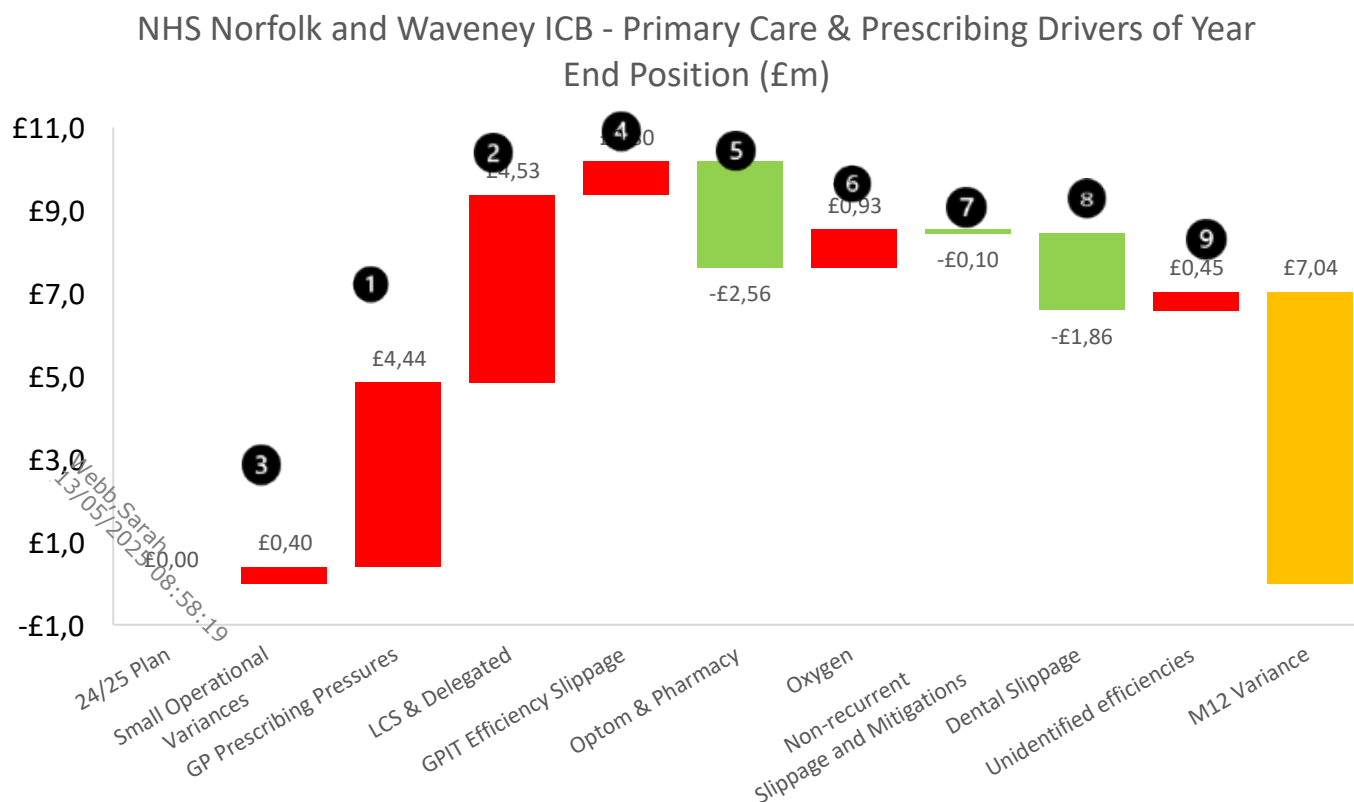
1.0 Executive summary – Reporting

Reported Financial Position: As of March 2025 (M12), the Primary Care & Prescribing reported position is £7m overspent.

	Annual Budget	Budget	Actual	Variance	Forecast	FOT Variance
	£m	£m	£m	£m	£m	£m
Reported	588.2	588.2	595.2	7.0	595.2	7.0

Variations:

The key operational variances are shown below:



The GP & Prescribing position is a £7m overspend noting the following variances.

- Unidentified Efficiencies in GP Prescribing is the reason for the overspend. The original stretch target was circa £4m which has been reducing due to DOAC switch benefits. 1
- LCS and Delegated budgets overspent because of prior year LCS cost pressures £3.64m for treatment rooms (complex dressings), phlebotomy and rent reviews in Delegated. In addition, there was some ARRS expenditure more than national funding. 2
- Small operational variance in other primary care e.g. MLL Data line increased costs, and delay in efficiencies in GPIT contract moving to new provider. 3
- Slippage in GPIT efficiency. 4
- Reduction is based primarily on the Community Pharmacy Contract Framework uplift. 5
- Backdated Home Oxygen VAT reclaim (4 years due to change in VAT rules) resulting in net Oxygen costs not yet received. 6
- Non recurrent Prior Year mitigations and slippage. 7
- Dental contract hand back and activity change. 8
- Unidentified Efficiencies in Primary Care has led to overspend. 9

Managing In-Year Risks:

• **Efficiencies**

The 24/25 plan required an ambitious efficiency target in order to balance the financial position at both ICB and ICS level which led to an Efficiency target of 6.25%. Whilst many schemes are still being worked, this gap is shown in ICB finance and also declared in the Financial Risk register.

2. Primary Care and Prescribing reporting M12

Sub-Directorate (£m)	Full Year Variance (underspend) / overspend	Variance – significant items
GP Prescribing Budget £205	£4.31 2.1%	The adverse variance is due to Unidentified Efficiencies £4.2m
Other Prescribing costs Budget £18	£1.47 8.0%	Mental Health drugs prescribing as a result of Right to Choose
Delegated Primary Care Budget £237	£0.89 0.4%	Rent Reviews
Local Enhanced Services(LES) Budget £12	£3.64 29.3%	Prior Year actuals came in higher than estimate in Treatment Rooms (Complex Dressings) and Phlebotomy
Other Primary Care Budget £14	£0.70 4.9%	Cost Pressures due to termination of MLL contract and deferral of GPIT contract efficiency beyond 24/25 mitigated by Prior Year benefits and Non recurrent income
Dental Budget £63	£(1.86) -2.9%	Slight underspend
Optom Budget £11	£(0.09) -0.8%	There have been increased home visits , NHS funded sight test and NHS funded glasses which is driving the adverse variance in this area.
Pharmacy Budget £27	£(2.48) -9.1%	Reduction is based primarily on the Community Pharmacy Contract Framework uplift.
Unidentified efficiencies Budget £0	£0.45 -100.0%	Efficiencies still being worked on
Total	£588 £7.04	

3. ICB Financial Position M12

Directorate Full Year Budget (£m)		M12 Full year Variance (underspend) / overspend	Variance – significant items
Acute		£11.91	Increase in activity in Independent sector providers (some offset in 'other' for additional ERF & SCC staff costs).
Budget	£1,366	0.9%	
Spec Comm		£(2.73)	Underspend on GPFP10s and other reserve balances
Budget	£206	-1.3%	
Community and Better Care Fund (BCF)		£5.28	Unidentified Stretch target and BCF Efficiency not delivered
Budget	£263	2.0%	
Continuing Healthcare		£7.33	Continued demand in Fast track, Adult LD and 5 new children's packages
Budget	£164	4.5%	
Mental Health MHIS		£(0.78)	Underspend due IPP LDA & CYP packages less activity pressures in patient choice.
Budget	£200	-0.4%	
Mental Health Non MHIS		£4.97	Increase in activity in Packages Of Care
Budget	£81	6.2%	
Prescribing		£5.78	NCSO overspend and weight management drugs, stretch efficiency target
Budget	£223	2.6%	
Primary Care		£1.26	Unidentified Efficiencies, LCS increase in complex dressings & Rent in Delegated Primary Care
Budget	£365	0.3%	
Other - Combined areas		£(0.30)	Dilapidations and other minor variances.
Budget	£25	-1.2%	
Planning		£(32.02)	Extra ERF for ISP and funding for SCC , Wave 4b reduction and RF profile and PY
Budget	-£9	343.2%	
Running Costs		£(0.91)	provision release for reorganisation costs and over achievement of vacancy factor
Budget	£21	-4.4%	
Total	£2,902	£(0.21)	

4.0 Prescribing Efficiencies M12

Prescribing Efficiencies Top Performing by value Budget (£000's)		Actual (£000's)	Var (£000's) Fav (Adv)	Variance – significant items
OptimiseRx			£142	
Budget	£2,400	£2,542	5.9%	Increased savings than plan as more surgeries use Optimise Rx
DT Windfall(Apixaban savings)			£(123)	
Budget	£2,310	£2,187	-5.3%	Decreased savings than plan as generic Apixaban was in short supply
Low Risk, cost effective switching programme			£284	
Budget	£600	£884	47.3%	Increased Savings than plan
New Rebate opportunities			£(400)	
Budget	£600	£200	-66.7%	Savings lower than expected
Rivaroxaban windfall			£1,672	
Budget	£600	£2,272	278.7%	Increased savings than plan as more patients patients prescribed Rivoraxaban
Low Priority Prescribing			£719	
Budget	£500	£1,219	143.8%	Increased savings than plan
Fostair Rebates			£195	
Budget	£475	£670	41.1%	Increased savings than plan
Greener/lower cost inhalers (supported by PQS/rebates) - 5%			£1	
Budget	£394	£395	0.3%	On Plan
Opioid costs (supported by PQS/rebates) - 10%			£(101)	
Budget	£360	£259	-28.1%	Under plan mainly due to elective surgery waiting times
Other Efficiencies			£267	
Budget	£2,497	£2,764	10.7%	Slightly delivering over plan
Sub-Total	10736	13392	£2,389	
Unidentified Savings			£(4,223.00)	
Budget	£4,223	£0	-100.0%	Stretch Target
Grand Total	£14,959	£13,392	£(1,567)	Net under delivery against plan

5.0 LCS Activity Tracker

Norfolk and Waveney ICB Locally Commissioned Services Activity Tracker

Locally Commissioned Service	Full Year Budget (£)	Full Year Actual (£)	Utilisation %	Comment
Care Homes	348,457	320,112	92%	Claims Due
Diabetes	459,260	616,993	134%	Claims Due
Eating Disorders	258,154	171,445	66%	Claims Due
Inclusion Health	462,613	357,542	77%	Claims Due
Mental Health SMI Health Checks	282,575	268,196	95%	Claims Due
Phlebotomy	5,161,091	5,935,503	115%	Claims Due
Proactive Healthcare	4,180,233	4,166,234	100%	Claims Due
PSA	308,211	437,015	142%	Claims Due
Shared Care	1,384,525	1,414,329	102%	Claims Due
Spirometry	393,486	386,792	98%	Claims Due
Treatment Room	2,184,696	3,942,884	180%	Claims Due
Warfarin	714,278	566,650	79%	Claims Due
MGUS	-	63,230	100%	Claims Due
Total	16,137,579	18,646,927	116%	

- Quarter 1 window closed on the 31st July (14th Aug for some schemes as problems with Ardens searches). Claims all processed for payment in August for all schemes.
- Quarter 2 window closed on the 31st October.
- Quarter 3 window closed on 31st Jan and Finance Team assessing underclaims.

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Appendix A – Detailed Financial Position

Norfolk and Waveney ICB		N&W ICB	N&W ICB Position at Month 12 £000s			N&W ICB Forecast £000s	
Service Line	Description	Annual Budget	Budget	Actual	Variance	Forecast	FOT Variance
Prescribing	Central Drugs	5,690,725	5,690,725	5,846,575	155,850	5,846,575	155,850
	GP Prescribing	204,832,123	204,832,123	209,138,865	4,306,742	209,138,865	4,306,742
	Medicines Management - Clinical	3,528,552	3,528,552	3,509,605	(18,947)	3,509,605	(18,947)
	Other Prescribing	5,979,898	5,979,898	6,503,151	523,253	6,503,151	523,253
	Oxygen	1,810,788	1,810,788	2,741,813	931,025	2,741,813	931,025
	Prescribing Incentives	1,291,118	1,291,118	1,170,001	(121,117)	1,170,001	(121,117)
Prescribing Total		223,133,204	223,133,204	228,910,010	5,776,806	228,910,010	5,776,806
Primary Care	Community Dental	3,470,928	3,470,928	3,327,985	(142,943)	3,327,985	(142,943)
	DOP Delegated pay	552,313	552,313	239,949	(312,364)	239,949	(312,364)
	GP Forward View	1,843,650	1,843,650	1,395,551	(448,099)	1,395,551	(448,099)
	Local Enhanced Services	12,399,953	12,399,953	16,038,365	3,638,412	16,038,365	3,638,412
	Optom	11,192,189	11,192,189	11,106,150	(86,039)	11,106,150	(86,039)
	Other Primary Care	3,688,265	3,688,265	4,036,053	347,788	4,036,053	347,788
	Pharmacy	27,168,198	27,168,198	24,691,186	(2,477,012)	24,691,186	(2,477,012)
	PMS to GMS Transition	0	0	0	0	0	0
	Primary Care Delegated Co-Commissioning	236,941,891	236,941,891	237,833,978	892,087	237,833,978	892,087
	Primary Care IT	8,825,609	8,825,609	9,623,430	797,821	9,623,430	797,821
	Primary Dental	44,557,007	44,557,007	42,999,307	(1,557,700)	42,999,307	(1,557,700)
	Secondary Dental	14,845,014	14,845,014	15,002,813	157,799	15,002,813	157,799
Unidentified efficiencies	(449,712)	(449,712)	0	449,712	0	449,712	
Primary Care Total		365,035,305	365,035,305	366,294,767	1,259,462	366,294,767	1,259,462
Prescribing & Primary Care Total		588,168,509	588,168,509	595,204,777	7,036,268	595,204,777	7,036,268

Webb Sarah
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Agenda item: 14

Subject:	Pharmaceutical Services Regulation Committee (PSRC) – Decisions Made (January 2025 to March 2025)
Presented by:	Gregg Syder – Commissioning Manager – Pharmacy and Optometry
Prepared by:	Gregg Syder – Commissioning Manager – Pharmacy and Optometry in conjunction with ICB contracting team hosted by Herts and West Essex ICB
Submitted to:	Primary Care Commissioning Committee Part 1
Date:	14 May 2025

Summary of Paper

The attached paper contains the fourth quarter (Q4) report from the Pharmaceutical Services Regulation Committee (PSRC) relating to the market entry and fitness decisions made at the monthly PSRC meetings 1st January 2025 to 31st March 2025 in relation to Norfolk and Waveney matters.

PSRC is hosted and chaired by NHS Hertfordshire and West Essex Integrated Care Board (HWE ICB) working on behalf of the 6 ICBs in the East of England.

Recommendation

Note the decisions made at the PSRC meetings between 1st January 2025 to 31st March 2025.

Key Risks	
Clinical and Quality:	The ICB is responsible for ensuring quality and performance in relation to the provision of community pharmacy services in Norfolk and Waveney and to escalate concerns, where appropriate, to PSRC for consideration.
Finance and Performance:	National funding formula for community pharmacy provision
Impact Assessment (environmental and equalities):	The Pharmaceutical Needs Assessment (PNA) is agreed by Health and Wellbeing Boards on a five year cycle. Significant changes in provision in the interim may need to be reviewed and changes to the PNA considered.

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Reputation:	Failure to adhere to the regulations can have reputational issues for the ICBs.
Legal:	Pharmaceutical Services Regulations
Information Governance:	N/A
Resource Required:	Primary Care and Quality teams
Reference document(s):	Pharmacy Manual, Pharmaceutical Services Regulations
NHS Constitution:	N/A
Conflicts of Interest:	None identified
Reference to relevant risk on the Board Assurance Framework	The resilience of primary care

Governance

Process/Committee approval with date(s) (as appropriate)	N/A
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To be completed by Meeting Secretary

Agenda item: 14

Paper No:



Meeting/Committee:	Primary Care Commissioning Committee
Venue:	Teams Meeting
Date:	14 May 2025

Title of Report	Pharmaceutical Services Regulation Committee (PSRC) – Decisions Made (January 2025 to March 2025)	
Presented by	Gregg Syder – Commissioning Manager – Pharmacy and Optometry	
Author	Katie Donohue, Commissioning Support Officer Reviewed/Updated by: Jackie Bidgood, Senior Contract Manager, Pharmacy and Optometry	
Commercially Sensitive	No	
Status	For:	Information
Finance Lead sign off (if required)	Name: NA	Date: NA
Conflict of Interest	None known.	
Governance and reporting – at which other meeting has this paper already been discussed (or not applicable)	This paper has not been discussed at other meetings however all decisions reported in this paper were made at the PSRC meetings held between 01st January to 31st March 2025.	Outcome of Discussion: All decisions made at the PSRC meetings are made in line with the Pharmaceutical Services Regulations 2013 (as amended)
ICS Engagement (Describe engagement and co-creation with ICS colleagues)	PSRC is hosted and chaired by NHS Hertfordshire and West Essex Integrated Care Board (HWE ICB) working on behalf of the 6 ICBs in the East of England. All ICBs are invited to attend. The meetings are governed by Terms of Reference (TOR) as set out in the Pharmacy Manual and have been ratified by PSRC.	

Executive Summary:

Following the delegation of pharmaceutical services by NHS England to Integrated Care Boards (ICBs) with effect from 1 April 2023, the six ICBs in the East of England have formed a Pharmaceutical Services Regulations Committee (PSRC) under section 65Z5 of the National Health Service Act 2006 (hereafter referred to as the 2006 Act).

By virtue of NHS England's Pharmacy Manual this Committee is responsible for making decisions required by the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013, as amended (hereafter referred to as the 2013 regulations). For the avoidance of doubt, this includes use of the fitness powers set out in the 2006 Act and the 2013 regulations. The PSRC is hosted by Hertfordshire and West Essex (HWE) ICB on behalf of the six ICBs.

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The PSRC is required to apply the regulatory tests as set out in the 2013 regulations to grant or refuse market entry applications and make decisions on fitness matters. PSRC meetings are held in two parts, the first to consider market entry applications and the second to consider and review fitness and matters of concern. ICBs are invited to Part 2 where there is an issue / concern that is relevant to their ICB, noting the sensitivities and confidential aspects of some discussions.

The Committee is required for certain applications to consider the information published in the Health and Wellbeing Boards (HWB) Pharmaceutical Needs assessment (PNA). Each Health and Wellbeing Board is required to publish a PNA every three years.

The following are the market entry and fitness decisions made at the monthly PSRC meetings between January 2025 to March 2025:

Market Entry - Decisions made (within scheduled PSRC meetings):

Application	Health and Wellbeing Board	Decision
Application in respect of distance selling premises: Charmer Consultants Ltd, Unit 2A, Forge Business Centre, Palgrave, Norfolk, IP22 1AP	Norfolk	Granted
Combined COO & NSCR: Application for inclusion in a pharmaceutical list: combined change of ownership and no significant change relocation application within Norfolk HWB's area: Medsio Ltd	Norfolk	Granted
Magdalen Medical Supplies Ltd - Change of Ownership (COO): Representations on Reg 26(1)	Norfolk	The Committee agreed the representations on Reg 26(1)

Market Entry - Decisions made (outside scheduled PSRC meetings – via e-mail):

Application	Health and Wellbeing Board	Decision
None		

Breach/Remedial Notices Issued – None

Market Entry Applications under Appeal

The following applications were sent to NHS Resolution, appealing the decisions made by PSRC:

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Application	HWB Area	Commissioner Decision	NHS Resolution Decision	Appeal Ref.
Magdalen Medical Supplies Ltd	Norfolk	PSRC Refused Application	Granted	SHA/26408
Foschell Ltd	Norfolk	PSRC Refused Application	TBC	SHA/26415
Hurn Chemist Ltd	Norfolk	PSRC Refused Application	TBC	SHA/26412
Sarracare Ltd	Norfolk	PSRC Refused Application	Refused	SHA/26438

Fitness Decisions (within scheduled PSRC meetings):

Fitness Notifications / Concerns	Health and Wellbeing Board	Decision
Fitness Review T & C Hunt (Pharmacy) Ltd – COSI	Norfolk	The Committee agreed that T & C Hunt (Pharmacy) Ltd remains a fit and proper person to be included on the Norfolk HWB pharmaceutical list.

Fitness Decisions (via Delegated Decision Making):

Fitness Notifications / Concerns	Health and Wellbeing Board	Decision
Theatre Street Medical Supplies Ltd – COSICOD	Norfolk	Fit and Proper
Care & Cure Partnership Limited – COSI	Norfolk	Fit and Proper
Laffak Ltd - COD	Norfolk	Fit and Proper

Fitness Decisions (outside scheduled PSRC meetings – via e-mail):

Fitness Notifications / Concerns	Health and Wellbeing Board	Decision
None		

Fitness Decisions under Appeal:

It is to be noted that fitness appeals do not go to NHS Resolution, instead they are heard by the First Tier Tribunal.

Application	HWB Area	Commissioner Decision	First Tier Tribunal Decision	Appeal Ref.
None				

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Regulatory Timescales:

The regulations set out timescales by which the ICB should process and determine applications. The P&O team constantly strive to meet timescales however there are occasions when timescales are exceeded. The timescales vary depending on the type of application, for example, a change of ownership application should be determined within 30 days, an unforeseen benefits application should be determined within 4 months. Consideration is therefore required as to how this can accurately be reflected in a quarterly report.

For this report and future reporting, the ICB will be informed of the number of applications completed within the relevant quarter that have exceeded the timescales. Where timescales have not been met, a brief reason and mitigations will be provided.

For Q4, all completed applications were determined within the regulatory timescales.

Recommendation(s):

Note the decisions made at the PSRC meetings between January 2025 to March 2025.

Next Steps:

- Reporting will occur on a quarterly basis.
- Members and colleagues in ICBs are welcome to attend any future PSRC meetings should they wish to learn more about the regulatory processes that are followed.

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To be completed by Meeting Secretary

Agenda item: 14

Paper No:



Meeting/Committee:	Primary Care Commissioning Committee
Venue:	Teams Meeting
Date:	14 May 2025

Title of Report	General Ophthalmic Services (GOS) Contracting – Quarter End Update Report (Q4 2024/25)	
Presented by	Gregg Syder – Commissioning Manager – Pharmacy and Optometry	
Author	Jackie Bidgood, Senior Contract Manager, Pharmacy and Optometry	
Commercially Sensitive	No	
Status	For:	Information
Finance Lead sign off (if required)	Name: NA	Date: NA
Conflict of Interest	None known.	
Governance and reporting – at which other meeting has this paper already been discussed (or not applicable)	This paper has not been discussed at other meetings however an update report on GOS contracting was requested by ICBs following delegation on 1 April 2023.	Outcome of Discussion: NA
ICS Engagement (Describe engagement and co-creation with ICS colleagues)	The Pharmacy and Optometry Team is employed and hosted by NHS Hertfordshire and West Essex Integrated Care Board (HWE ICB) but works on behalf of the 6 ICBs in the East of England. This is a standard report requested by ICBs following delegation.	

Executive Summary:

Following the delegation of General Ophthalmic Services (GOS) by NHS England to Integrated Care Boards (ICBs) on 1 April 2023, the Pharmacy and Optometry Contracting Team (P&O Team), manage the GOS contracting function on behalf of the six ICBs in the East of England.

GOS contracting is in summary, the provision of NHS sight tests to eligible patients either from a fixed premises (mandatory services contract) or from a patient's usual place of residence or at a Day Centre (additional services contract). The contracting aspect of NHS sight tests is the only element managed by the contracting team.

All other eye health services are commissioned by individual ICBs (excluding specialised services) or retained by NHS England at this stage (this may be subject to change). This includes:

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- Regional Eye Health Network Board (nb. ICBs are members of this Board) and the leadership for regional transformation programmes from this Board.
- Diabetic Eye Screening.

The purpose of this report is to provide an update on GOS contracting arrangements and set out the current GOS contracting position for the ICB.

This report produced for ICBs is reflective of Quarter 4 (Q4) position.

GOS Contracting Overview

An overview of the number of contractors for mandatory and additional services are set out below. ICBs should note that the numbers detailed in this paper will be subject to change as new applications are made and contracts are terminated by contractors. ICBs should therefore expect to see different numbers throughout the year.

Table 1

Mandatory	Additional
86	9

Change in Process

A recent process change initiated by NHS England (national team) addresses the handling of contracts and financial responsibilities when services are performed across different ICB areas.

Historically, where GOS contracts were held by a different ICB but services performed within your ICB area, the contractor is still included on the P&O Team database. The financial responsibility for these services is deducted from the ICB holding the contract.

For new applications, the process has been updated. If the main contract is held by another ICB but services are also performed within your ICB area, a contract will be issued for your ICB area. The financial responsibility will continue to be deducted from the ICB holding the main contract.

The P&O Team have a process in place, to validate those contractors who fall into this category prior to issuing a contract.

Claims Held Process

In January 2023, NHS England introduced a change to the minimum interval check process. Previously the check was limited to the contractor's own patient records however this has now been extended across England. Unfortunately, the systems at Primary Care Support England (PCSE) cannot identify a sight test outside of usual parameters until the point the sight test has been completed. As a result, there is a "backlog" of claims at PCSE. NHS England's policy position is to pay for all "claims held" that are a direct result of an early sight test however claims need to be verified by contractors and the ICB.

NHS England are working with PCSE to move the notification to an earlier stage in the PCSE Online claim sequence, however it is anticipated that this will not be completed until summer 2025. Until a system fix is mobilised a process for clearing the backlog of claims held has been implemented by the P&O Team.

The first wave of PCSE contractor data was received in the latter part of November 2024 with deadline of completion of Mid-February 2025. NHS England advised that the second wave of data would be issued in December 2024 however this has not yet happened. The P&O team await the information from NHS England.

Recommendation(s) and Next Steps:

The Committee are to:

- Note the content of this report.
- Note that any contractual issues requiring escalation (outside the remit of GOS contracting), will be sent to the relevant ICB Committee for decision as appropriate.
- Note that reporting will occur on a quarterly basis.

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GP CONTRACT CHANGES 25/26

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Context to the Contract Changes and Agreement

Government viewpoint:

There can be no funding without reform – the financial uplift is to drive forward initiatives to benefit both general practice and patients:

- Reduce bureaucracy by: cutting targets, increasing flexibilities in ARRS recruitment, taking forward measures identified by the Red Tape Challenge
- Push harder on preventing the biggest killers
- Incentivise improvements in continuity of care (in particular for those with long term conditions)
- Support the rest of the system to cut waiting lists and achieve the government's plan to meet the NHS standard of 92% of patients waiting no longer than 18 weeks for elective treatment

GPC England has now fully agreed changes to the 25/26 contract. We have received the Government's commitment in writing "to working with GPC England to secure a new substantive GP contract within this Parliament, without preconditions, based on collaborative work, and in the spirit of mutual trust and good faith...with General Practice at the heart of a neighbourhood health service."

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Overall Financials

- 1 year contract agreement
- Overall increase in investment of £889m across the core practice contract and the Network Contract DES
- This provides 7.2% cash growth on the contract funding envelope (estimated 4.8% real growth) – and includes:
 - Funding an assumed increase in salaries of 2.8% in 25/26
 - Continuation of GPs in the Additional Roles Reimbursement Scheme (ARRS)
 - Funding to cover the costs (i) of other cost growth pressures (including from premises and list growth) and (ii) to reflect the increased level and complexity of activity
- Most significant investment in over a decade with general practice contract funding growing at a faster rate than NHS funding as a whole
- In addition to the £889m increase in investment, practices can participate in a new enhanced service for advice and guidance (worth up to £80m)
- A further uplift may be made following the government's response to the Doctors' and Dentists' Pay Review Body (DDRB) outcomes for 25/26

Core Practice Contract

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Core GP Contract – Financials

- Global Sum payment per weighted patient has been uplifted by 8.26%, from £112.50 to £121.79
- GMS Out of Hours deduction remains at 4.75%, equating to £5.78
- The value of a Quality & Outcomes Framework (QOF) point has increased from £220.62 to £225.49
- Locum reimbursement rates have been uplifted in line with 25/26 real-terms values (compared to 18/19) – for parental leave, sick leave, prolonged study leave and suspension
- Item of Service (IoS) fee for routine childhood immunisations which are part of essential services has increased from £10.06 to £12.06 (the IoS fee for other vaccinations remains unchanged)

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Quality & Outcomes Framework

- Purpose: To improve the quality of care provided by general practices by rewarding them for achieving certain clinical outcomes and providing good quality care
- Comprises a wide range of indicators – with funding achieved conditional on performance
- Has been further streamlined in 25/26 with retirement of the 32 indicators which were income protected in 24/25
- Funding linked to the retired indicators has been invested into:
 - Other areas of the core GP contract: (i) Global Sum, (ii) increase in the IoS fee for routine childhood vaccinations, (iii) increase in locum reimbursement rates
 - The 9 cardiovascular disease (CVD) prevention indicators in QOF (as this is a national priority) – these indicators now comprise 222 points:
 - Lower thresholds – have been maintained at 24/25 levels
 - Upper achievement levels – have been raised as the indicators have increased significantly in value for 25/26
- A small number of technical changes have been made to bring indicators into alignment with updated NICE guidelines

Implications:

- Practices will see their QOF income fall in 25/26 as overall funding available under QOF has reduced
- Practices will need to work harder to achieve the new upper thresholds for the CVD indicators

QOF 25/26 – Indicators x 44

Clinical Indicators x 35 437 points			Public Health Indicators x 9 127 points
Atrial Fibrillation x 2 (AF006 & AF008) 24 points	Hypertension x 2 (HYP008 & HYP009) 52 points	Chronic Obstructive Pulmonary Disease x 1 (COPD010) 9 points	Blood Pressure x 1 (BP002) 15 points
Coronary Heart Disease x 3 (CHD005, CHD015 & CHD016) 54 points	Stroke & Transient Ischaemic Attack x 3 (STIA007, STIA014 & STIA015) 18 points	Dementia x 1 (DEM004) 14 points	Smoking x 2 (SMOK002 & SMOK004) 37 points
Cholesterol Control & Lipid Management x 2 (CHOL003 & CHOL004) 82 points	Diabetes Mellitus x 8 (DM006, DM012, DM014, DM036, DM020, DM021, DM034 & DM035) 78 points	Mental Health x 6 (MH002, MH003, MH006, MH007, MH011 & MH012) 28 points	Vaccination & Immunisations x 4 (VI001 to VI004) 64 points
Heart Failure x 4 (HF008, HF003, HF006 & HF007) 25 points	Asthma x 2 (AST012, AST007) 35 points	Non Diabetic Hyperglycaemia x 1 (NDH002) 18 points	Cervical Screening x 2 (CS005 & CS006) 11 points

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Other Changes to the Contract

NHSE have outlined a number of changes to the GP contract in 25/26 which have either been included in the updated Statement of Financial Entitlement or are pending amendment of the GP Contract Regulations (expected shortly) – including:

- Vaccinations & Immunisations: Significant changes are being made to the routine childhood and adult schedules
 - UKHSA published a [letter](#) on 30th April detailing changes to the childhood vaccination schedule from 1st July 2025 and 1st January 2026
- Digital: Aim is for patients to have an equitable experience across all access modes (phone, online, walking in):
 - From 1st October 2025: Practices will be required to keep their online consultation tool open for the duration of core hours (8.00am-6.30pm) for non-urgent appointment requests, medication queries and admin requests
 - By no later than 1st October 2025: Practices will be required to ensure functionality is enabled which allows (i) read only access to patient care records by other NHS commissioned providers and providers of private healthcare for the purposes of direct patient care and (ii) community pharmacists to send consultation summaries into the GP practice workflow
- Primary Care Patient Safety Strategy: Practices will be required to (i) have regard to the Patient Safety Strategy and (ii) register for an administrator account (unless their local risk management system is already connected) with the Learn From Patient Safety Events service

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Other Changes to the Contract

- Patient Charter: NHSE to publish a patient charter which will set out the standards a patient can expect from their practice
- Dissolution of Partnerships: The GP Contract regulations will be amended to make clear that GMS contracts can be terminated in the situation where there is no clear successor when a partnership dissolves
- Patients Registered OOA: There will be a contractual requirement for GP practices to work collaboratively with the ICB to implement out of area registration – to provide safeguards when practice lists are expanding rapidly with the registration of out of area patients
- Violent Patients: The process for patient removal will be made clearer in the GP Contract regulations, in a way that protects the right of practices to immediately remove violent patients whilst ensuring patient choice is retained when patients have not been immediately removed from their previous practice

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Network Contract Directed Enhanced Service

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Network Contract DES – Summary

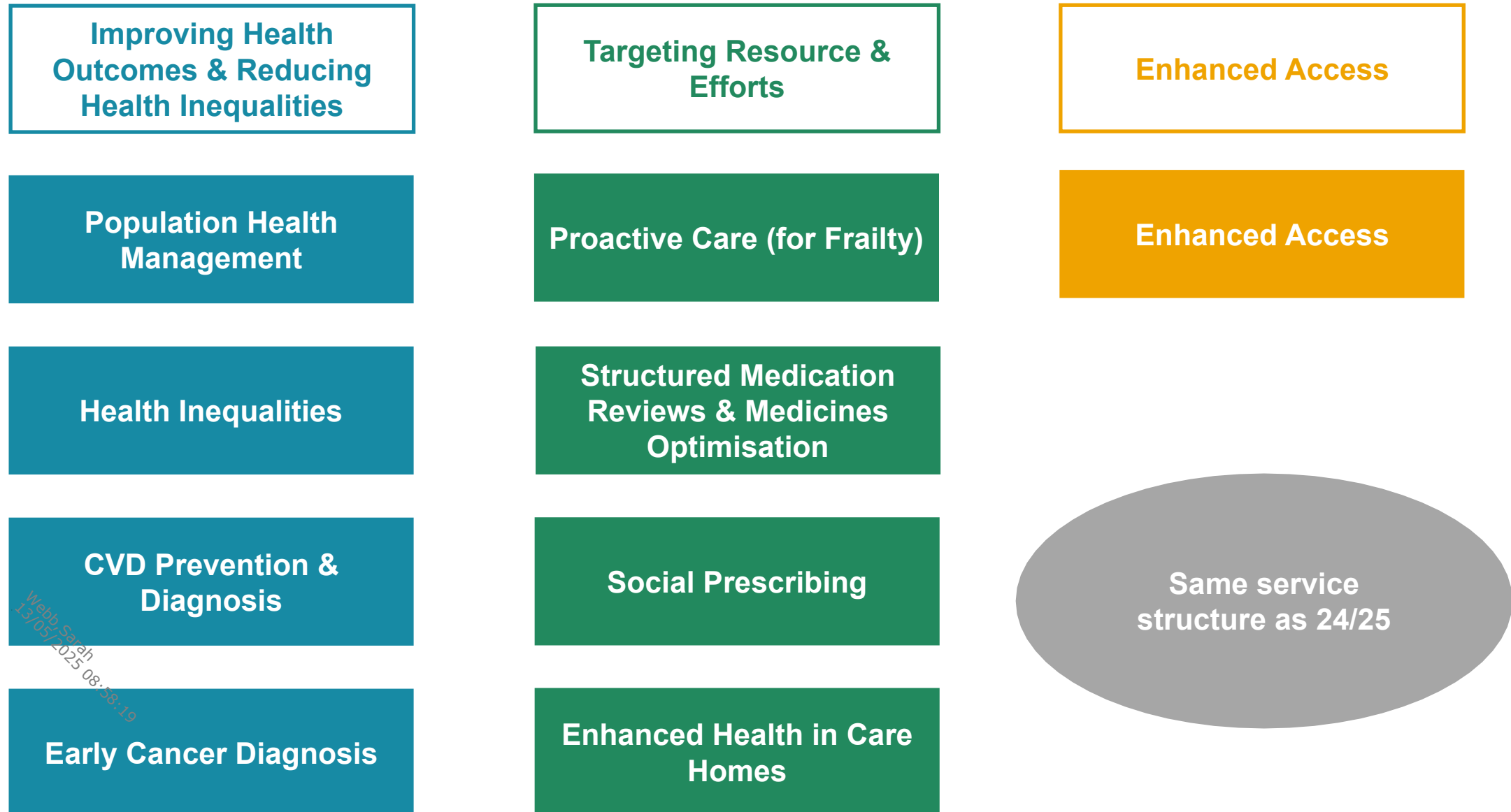
- Minor changes only to:
 - Financials
 - Service Requirements
 - Investment & Impact Fund
- More significant changes made to:
 - Additional Roles Reimbursement Scheme
 - Capacity & Access

4 key functions of a PCN:

- 1) Co-ordinate, organise and deploy shared resources to support and improve resilience and care delivery at both PCN and practice level
- 2) Improve health outcomes for its patients through effective population health management and reducing health inequalities
- 3) Target resource and efforts in the most effective way to meet patient need, which includes delivering proactive care
- 4) Collaborate with non-GP providers to provide better care, as part of an integrated neighbourhood team

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Network Contract DES: Clinical and Support Service Requirements 25/26



Network Contract DES: Additional Roles Reimbursement Scheme

- ARRS has further increased in flexibility to support PCNs to respond to their local workforce requirements
- Baseline increase in ARRS funding of circa 4.4% for 25/26 (once GP ARRS is annualised)
- Continuation of funding for GP posts – eligibility criteria remains those individuals who have obtained the CCT within the last two years (at the point of recruitment) and who have not been previously substantively employed as a GP in general practice
- Addition of 4 new nursing roles – Healthcare Support Worker, New to General Practice Nurse, Experienced General Practice Nurse and Consultant Nurse Primary Care
- Remaining caps on some posts have been removed

Implications:

- Most PCNs have fully or almost fully committed their ARRS allocation, so there is limited opportunity to recruit to the newly qualified GP and new nursing roles
- The uplift in funding may not fully cover the increase in employers' National Insurance contributions wef April 2025 and the 25/26 pay award

Network Contract DES: ARRS 25/26 – Clinical Roles

General Medical Practitioner	Clinical Pharmacist [Band 7/8a]	Consultant Nurse Primary Care [Band 8c] <i>New</i>	Nursing Associate [Band 4]	First Contact Physio [Band 7/8a]	Adult MH Practitioner [Band 4 to 8a]
Advanced Practitioner* [Band 8a]	Pharmacy Technician [Band 5]	Enhanced Practice Nurse [Band 7]	Student Nursing Associate [Band 3]	Occupational Therapist [Band 7]	CYP MH Practitioner [Band 4 to 8a]
Physician Associate [Band 7]	Community Paramedic [Band 7]	Experienced General Practice Nurse [Band 6] <i>New</i>	Healthcare Support Worker [Band 3] <i>New</i>	Dietician [Band 7]	Other direct patient care roles (with ICB agreement)
Apprentice Physician Associate [Band 5]		New to General Practice Nurse [Band 5] <i>New</i>		Podiatrist [Band 7]	

*Advanced Practitioner Roles: Clinical Pharmacist, First Contact Physiotherapist, Dietitian, Podiatrist, Occupational Therapist, Paramedic and Advanced Clinical Practitioner Nurse

Network Contract DES: ARRS 25/26 – Non Clinical Roles

**Social Prescribing
Link Worker
[Up to Band 5]**

**Care
Co-ordinator
[Band 4]**

**Digital &
Transformation
Lead
[Band 8a]**

**Health &
Wellbeing Coach
[Up to Band 5]**

**General Practice
Assistant
[Band 4]**

**Small increase only in
ARRS allocations for
25/26**

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Network Contract DES: Capacity & Access

Capacity and Access Support Payment:

- Remains unconditional for PCNs (no reporting requirements)
- Paid in 12 equal monthly instalments

Capacity and Access Improvement Payment: Has reduced from three to two domains:

- Domain 1: Incentivises PCNs to use the intelligence provided by digital risk stratification tools to risk stratify their patients in accordance with need, including to identify those that would benefit most from continuity of care (with a named GP, where appropriate)
- Domain 2: Continues to focus on supporting modern general practice access – including:
 - a) Routine use of digital telephony data to support capacity/demand service planning and quality improvement discussions
 - b) Consistent approach to care navigation and triage so there is parity between online, face to face and telephone access, including collection of structured information for walk-in and telephone requests
 - c) Asking patients their preference to wait for a preferred clinician if appropriate, for continuity
 - d) Ensuring online consultation is available for patients to make administrative and clinical requests at least during core hours
- 100% of funding can only be received if achievement is demonstrated across both domains and by all practices within a PCN

(National) Enhanced Services

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General Practice Requests for Advice & Guidance Enhanced Service – Summary

- New ES introduced for 25/26 which supports GPs in managing non-urgent (elective) patients that they may be considering referring to secondary care
- Aims: To improve patient care, reduce unnecessary referrals to hospitals, shift some care to the community and help ensure patients receive the most appropriate care in the right setting
- Relates to pre-referral advice and guidance (A&G) – specialist advice which supports a clinical dialogue, enabling a referring clinician to seek advice from a consultant led specialist service about a named patient prior to, or instead of, referral
- Requests are not limited to specific specialities or clinical conditions
- There is not a requirement that pre-referral A&G is sought prior to referrals being made
- £80m national funding envelope for 25/26 (NWICB allocation = £1.554m) with practices able to claim a £20 IoS fee per GP led request for pre-referral A&G
- ICBs may introduce a mechanism to cap the number of (monthly, quarterly or annual) A&G requests which can be claimed per practice
- The service specification sets out eligibility criteria, including the identification of appropriate cases

General Practice Requests for Advice & Guidance Enhanced Service – Oversight & Governance

- NHSE has published an A&G operational delivery framework for 25/26 – as a tool to support ICBs to ensure A&G is implemented effectively
- From April 2025, ICBs are required to use the framework to understand their progress on the uptake and quality of A&G
- The framework sets out a range of indicators and associated minimum standards which ICBs are required to self-assess against
- ICBs must (i) submit their baseline and quarterly self-assessment results to NHSE and (ii) produce and implement a delivery plan
- There needs to be material progression over each quarter to demonstrate maturity by Q4 25/26
- Primary and secondary care interface groups should use the action plan to consider areas of strong practice, areas in need of improvement, areas where consistency can be improved, and actions needed to implement the minimum standards and accelerate maturity
- In March 2026, ICBs to complete an evaluation of 25/26 and use this to develop a plan for delivering high quality A&G in 26/27

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Other Enhanced Services

Weight Management ES

- Will continue into 25/26, retaining the £11.50 referral payment
- As with previous years, each participating practice will be given a “Referral Allocation” which is the capped number of referrals to Weight Management services that the GP practice can make which attract a payment under the ES

Learning Disability Health Check ES

- 3 year contract covering the period 25/26 to 27/28
- Updated service specification awaited

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Recent NHSE Guidance & Policies

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Recent NHSE Guidance and Policies

Road to Recovery: The Government's 2025 Mandate to NHS England

New Operating Model

Revenue Finance & Contracting Guidance for 25/26

Priorities and Operational Planning Guidance 25/26

Capital Guidance for 25/26

Neighbourhood Health Guidelines 25/26

Standardising Community Health Services: Phase 1

Reforming Elective Care for Patients Plan

Guidance on Neighbourhood MDTs for C&YP

Better Care Fund Planning Requirements 25/26

Informed by Fuller 'Stocktake', Hewitt Review and Lord Darzi's Investigation of the NHS in England

NHS 10 Year Health Plan (to be published shortly)

Neighbourhood Health Guidelines 25/26

- Context:
 - More people are living with multiple and more complex problems and the absolute and relative proportion of our lives spent in ill-health has increased
 - Need to move to a neighbourhood health service that will deliver more care at home or closer to home, improve people's access, experience and outcomes, and ensure the sustainability of health and social care delivery
- Neighbourhood health aims to create healthier communities, helping people of all ages live healthy, active and independent lives for as long as possible – while improving their experience of health and social care and increasing their agency in managing their own care
- This will be achieved by better connecting and optimising health and care resource through 3 key shifts:
 - **From hospital to community** – providing better care close to or in people's own homes, helping them to maintain their independence for as long as possible, only using hospitals when it is clinically necessary for their care
 - **From treatment to prevention** – promoting health literacy, supporting early intervention and reducing health deterioration or avoidable exacerbations of ill health
 - **From analogue to digital** – greater use of digital infrastructure and solutions to improve care
- All parts of the health and care system (primary care, social care, community health, mental health, acute, and wider system partners) will need to work closely together to support people's needs more systematically, building on existing cross-team working (such as primary care networks, provider collaboratives) and collaboration with the voluntary, community, faith and social enterprise sector
- The guidelines outline the priority areas and objectives for moving towards a neighbourhood health service

Neighbourhood Health Guidelines 25/26

Initial Core Components

Population Health Management

Modern General Practice

Standardising Community Health Services

Neighbourhood Multi-Disciplinary Teams

Integrated Intermediate Care with a 'Home First' Approach

Urgent Neighbourhood Services

Aims (5 to 10 Years)

NHS and social care working together to prevent people spending unnecessary time in hospital or care homes

Strengthening primary and community based care to enable more people to be supported closer to home or work

Connecting people accessing health and care to wider public services and third sector support, including social care, public health and other local government services

Activity

2025/26 Focus

Cohort: Adults, children and young people with complex health and care needs who require support from multiple services and organisations

Neighbourhood Health and PCNs

- The Network Contract DES advises that PCNs form an important part of wider Integrated Neighbourhood Teams (INTs)
- One of the 4 core key functions of a PCN is to collaborate with non-GP providers to provide better care, as part of an INT
- A PCN must contribute to the delivery of multi-disciplinary proactive care for complex patients at greatest risk of deterioration and hospital admission, by risk stratifying patients and offering care in accordance with DES guidance
 - This must be done as part of INTs, with the aim of reducing avoidable exacerbations of ill health, improving quality of care and patient experience, and reducing unnecessary hospital admission
- Role of PCN Clinical Director includes working with local partners to support establishment of INTs and ensure PCN participation within its INT
- Role of PCN Digital & Transformation Lead includes supporting the effective adoption of national and local initiatives, including integrated working at neighbourhood and place level to improve access to services for patients

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Summary and Areas of Focus for the ICB

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Summary

- 1 year contract agreement, essentially a rollover with only minimal changes
- Additional investment has gone into:
 - The core GP contract
 - The new General Practice Requests for Advice & Guidance Enhanced Service
 - Continuation of newly qualified GPs in the Additional Roles Reimbursement Scheme with funding at full year effect (with ARRS funding and ARRS GP funding now combined into a single pot)
- There are, however, implications around QOF income and ARRS allocations which the ICB needs to be cognisant of in terms of individual practices and PCNs
- There is significant uncertainty about contracts and funding beyond the end of this financial year
- Neighbourhood health is a 'golden thread' throughout recent NHSE guidance/policies but is not yet fully reflected in GP and main provider contracts
- The 10 Year Health Plan will be key in determining the direction of travel in transforming the model of care and will set out the full vision for neighbourhood health

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Areas of Focus for the ICB

NHSE's 2025/26 Priorities and Operational Planning Guidance sets out the national priorities for ICBs – at high level these include working together with providers to:

- Reduce demand through developing Neighbourhood Health Service models with an immediate focus on preventing long and costly admissions to hospital and improving timely access to urgent and emergency care
- Make full use of digital tools to drive the shift from analogue to digital
- Address inequalities and shift towards secondary prevention

In terms of specific national priorities:

National Priority	ICBs should:
Improve patients' access to general practice	<ul style="list-style-type: none">• Continue to support general practice to enable patients to access appointments in a more timely way and improve patient experience – including ensuring that all GP practices inform patients, on the day they first make contact, how their request will be handled• Put in place action plans by June 2025 to improve contract oversight, commissioning and transformation for general practice, and tackle unwarranted variation• Continue to support the delivery of modern general practice and target support to practices based on their ability to provide access and a good overall experience for patients

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Areas of Focus for the ICB (continued)

National Priority	ICBs should:
Reduce the time people wait for elective care	<ul style="list-style-type: none"> Optimise referral management including through use of high quality specialist advice and guidance
Improve A&E waiting times and ambulance response times	<ul style="list-style-type: none"> Set the foundations of the neighbourhood health model by continuing to embed, standardise and scale core components of existing practice – including taking a consistent, system-wide population health management approach to patient segmentation and risk stratification
Address inequalities and shift towards prevention	<ul style="list-style-type: none"> Agree local ambitions and delivery plans for vaccination and screening services and services aimed at addressing the leading causes of morbidity and mortality such as cardiovascular disease and diabetes
Make the shift from analogue to digital	<ul style="list-style-type: none"> Ensure that all providers proactively offer NHS App-first communications to patients (with due regard to digital inclusion), by default through the NHS Notify service Ensure that all GP practices have enabled all core NHS App capabilities – including health record access, online consultations, appointment management, prescriptions management, online registration, and patient messaging
Live within the budget allocated, reduce waste and improve productivity	<ul style="list-style-type: none"> Reduce unwarranted variation in prescribing, implement the guidance on ‘Low value prescribing’ and ensure that patients are prescribed the best value biological medicine where a biosimilar medicine is available

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Agenda item: 15

Subject:	Community Pharmacy Contractual Framework: Implications and Opportunities
Presented by:	Sharon Gardner- Head of Primary Care Commissioning Pharmacy and Optometry
Prepared by:	Sharon Gardner- Head of Primary Care Commissioning Pharmacy and Optometry
Submitted to:	Primary Care Commissioning Committee
Date:	14 May 2025

Purpose of paper:

The purpose of this paper is for noting.

This paper provides context on the recent conclusion of the Community Pharmacy Contractual Framework (CPCF) negotiations. It outlines the contract's key objectives, funding arrangements, and its expected impact on community pharmacies and wider healthcare system. The paper also examines how the CPCF supports the ambitions of the NHS Long Term Plan, particularly in addressing challenges related to medicine supply, enhancing clinical services, promoting public health

Executive Summary:

The new Community Pharmacy Contractual Framework (CPCF), formally communicated on 31st March 2025, represents a significant step forward in integrating community pharmacies into the broader healthcare system.

Key highlights of the framework include:

- **Increased Funding:** A 19.7% rise in funding to £3.073 billion, alongside the decision not to recover £193 million of historic overpaid funding.
- **Expanded Services:** Introduction of new services such as a national emergency contraception service and the inclusion of medicines for depression in the New Medicine Service.
- **Pharmacy First Initiative:** Continued funding to grow this service, enhancing access to primary care.

The contractual framework aims to stabilise medicine supply, improve public health outcomes, and relieve pressure on urgent and primary medical services. By fostering collaboration with local primary care networks and prioritising quality and safety, the framework positions community pharmacies as integral partners in delivering healthcare.

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However, although this is seen as a positive step forward in pharmacy funding it is important to view this in context and should be read alongside the [Economic Analysis of NHS Pharmaceutical Services in England](#). The economic analysis highlights that delivering community pharmacy services at the current funding levels is not economically sustainable for almost all community pharmacies. This means the current ICB risk 'The resilience of Community Pharmacy' mitigated score remains unchanged at 16 due to lack of data in relation to the impact of the new funding agreement on the sustainability of pharmacies.

Report

Background

The 2019-2024 Community Pharmacy Contractual Framework was a five-year agreement designed to integrate community pharmacies more closely with NHS services and support the delivery of the NHS Long Term Plan.

Key Features of the plan were:

- **Funding Stability:** The contract provided £2.592 billion annually, ensuring financial predictability for pharmacies.
- **Service Expansion:** It introduced the NHS Community Pharmacist Consultation Service (CPCS), allowing pharmacies to handle referrals from NHS 111 and other healthcare providers.
- **Quality Focus:** The Pharmacy Quality Scheme (PQS) encouraged pharmacies to meet specific clinical and safety standards.
- **Public Health Role:** Pharmacies were positioned as key players in preventative healthcare, supporting key fields such as smoking cessation and vaccinations.
- **Digital Advancements:** Investments in electronic prescriptions and data-sharing improved efficiency and patient care.

The framework aimed to enhance pharmacy clinical roles, but its key aim was to ensure long-term sustainability which ultimately led to a 5-year deal. However, whilst nominal funding levels have remained relatively stable, real-term cuts have occurred due to inflation, rising operational costs, and adjustments in reimbursement mechanisms equating to approx. £790 million.

Between 2019 and 2024, England saw a net loss of over 1,200 community pharmacies. Whilst data is not available for the exact term of 2019 to 2024 for Norfolk and Waveney, we are aware that in September 2017 there were 164 Community Pharmacies in Norfolk, by March 2022 this had reduced to 157, and the latest figure from January 2025 shows a further decline to 144 contractors. Suffolk, which contains contractors for Waveney, has also seen a similar decline from 145 in 2018 to 127 in 2025.

Historically, community pharmacies have played a crucial role in dispensing medications, offering health advice, and supporting public health initiatives. In 2019 NHS England (NHSE) set out how they would work to embed and integrate community pharmacy into the NHS, delivering more clinical services and making them the first port of call for many minor illnesses. In 2023 this was recognised with an additional investment of £645 million over two years, expanding community pharmacy clinical service and making better use of the clinical skills of both pharmacists and pharmacy technicians.

Although funding constraints and policy shifts have necessitated a revised framework to ensure sustainability and efficiency, there is a key shift in the utilisation of the clinical potential of the pharmacy workforce.

Economic Analysis of NHS Pharmaceutical Services in England

In 2022, as part of the final negotiated Community Pharmacy Contractual Framework (year 4 and 5 deal) NHS England committed to 'commission an economic analysis of NHS pharmaceutical services through an independent review using data provided by contractors and to work with the Pharmaceutical Services Negotiation Committee (now known as Community Pharmacy England CPE) on the review'

The study aimed at addressing three research questions and was conducted between April 2024 and January 2025

- 1) What is the full economic cost of delivering NHS pharmaceutical services
- 2) Are NHS community pharmacy businesses sustainable under the current funding model, including the current trajectory (of costs and activity) of the sector?
- 3) Which clinical services can be most efficiently delivered from community pharmacy as compared with general practice or the wider NHS?

The data sample covered over 10% of all pharmacies nationally which was believed to provide a robust basis on which to undertake the analysis described in the report by Frontier Economics. Data was not available for individual ICBs or geographic participants.

The analysis highlighted several key findings, particularly regarding financial sustainability and operational challenges:

- Community pharmacies in England faced a substantial shortfall in funding. The projected gap is estimated to be £2.308 billion, reflecting the increasing costs of service delivery compared to available funding.
- By 2029/30, the full economic cost of NHS pharmaceutical services could reach £8.106 billion, driven by inflation, wage increases, and expanded service offerings.
- Around 47% of pharmacies were not profitable in their last accounting year
- Between January 2021 and November 2024 there was a net reduction in the number of pharmacies in England of 7%.
In the last year this reduction was concentrated in the large pharmacy chains. The number of pharmacies in other archetypes (e.g. independent pharmacies and smaller chains) has risen over the last year, as smaller companies bought some of the pharmacies being closed by the larger chains.
- 37% of pharmacies would be deterred from closing because of the costs incurred in doing so (e.g. redundancy costs, lease commitments, loss of assets intended to support pension).
- An increasing number of pharmacies are defaulting on Direct Debit payments for stock.
- 99.9% of pharmacies reported that financial pressures in the last 3 years had led to significant changes in the management of staff, 99.9% reported changes in operations, 74.7% reported significant changes in financing their business, and 81.0% reported significant changes in property management due to financial pressures

NHS England's findings confirmed the financial challenges facing pharmacy contractors and the need for revised funding models to ensure long-term sustainability and prevent disruptions in pharmaceutical services.

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Community Pharmacy Contractual Framework (2024-2025 and 2025-2026)

At the end of March 2025, funding and other arrangements for community pharmacies for both 2024/25 and 2025/26 were finalised. Overall, the new framework builds on the foundation of the 2019–2024 framework but introduces more robust funding, expanded services, and a stronger emphasis on clinical integration. It aims to position community pharmacies as essential partners in the healthcare system.

Overview of 2024/2025 Contract

- Funding guaranteed to the sector through CPCF rose to £2,698m (4.1% increase)
- All forecast activity for the year was fully funded
- Medicines margin increased to £850m

Overview of the 2025/2026 Contract

- Funding rose to £3.076 billion which represents a 19.7 % increase on the 2023-2024 funding levels on a like for like basis and 15% on 2024-2025
- Funding for Pharmacy First and other Primary Care Access Recovery Plan services is confirmed at £215 million and can be earned in addition to the CPCF funding
- Agreement to write off £193 million of historic medicine margin over delivery. Had this not been written off this would have been recouped from the pharmacies directly and not via the ICB.
- The prioritisation of funding for community pharmacy in 2025/2026 follows the publication of the economic analysis and recognises the financial pressure the sector is facing is significant
- Fee change, alongside an increase to medicines margin, will deliver the additional funding to the sector. The most significant changes are shown below and reflect the shared priority to help stabilise the core service of dispensing given financial the challenges community pharmacies continue to face.

Fee	Previous fee	New fee
Single Activity Fee	£1.27	£1.46
Pharmacy Contraception Service (initiation and ongoing supply)	£18	£25
Pharmacy First <ul style="list-style-type: none">• Minor Illness• Clinical Pathways	£15	£17
New Medicine Service	Up to £28	£14 for intervention £14 for follow up
Hypertension Case Finding Service <ul style="list-style-type: none">• Clinic Check• ABPM	£15 £45	£10 £50.85

***ABPM- Ambulatory Blood Pressure Monitoring**

Pharmacy First

There has been an additional national £215 million investment to enable the service to continue to grow. However, additional payments will become part of a 'bundled service' offer which will mean initially contractors will have to be registered to provide all 3 services (Pharmacy First, Hypertension Case Finding and Contraception) eventually moving to a requirement to show delivery for any additional payments. A stepped approach will allow

contractors to prepare with additional requirements being added in October 2025 and March 2026

From June 2025, the current threshold payment of £1000 for 30 clinical pathway consultations will have a lower tier introduced which will see contractors completing between 20-29 consultations receiving a threshold payment of £500.

Service Expansions and Changes

- **Hypertension Case Finding service-** Fees restructured to better support service aim of identifying cases of high blood pressure on the over 40s (move to focus on Ambulatory Blood Pressure Monitoring)
- **New Medicine Service-** introduction of a new therapeutic area of depression
- **Inclusion of Emergency Contraception** provision within the existing contraception service – although local public health commissioned services exist in most ICB areas the introduction of a national scheme will provide equitable access to oral emergency contraception. Although the local Norfolk and Waveney service will cease, using a phased approach, it is still unclear how the previous funding will be reinvested. We will continue to work with our local public health team to ensure that should the funding remain available that we consider other community pharmacy services that could be introduced to support population health outcomes.
- **Smoking Cessation Services-** introduction of additional Patient Group Directions (PGDs) and expansion of skill mix to enable delivery of PGDs by pharmacy technicians
- **Pharmacy Contraception Service-** introduction of a new PGD and expansion of skill mix to enable delivery of PGDs by pharmacy technicians

Pharmacy Quality Scheme (PQS)

Although the success of the PQS across the last CPCF 5-year deal is recognised, the uplifting of fees to start to stabilise services had to take priority. A targeted PQS was reinstated from 1st April 2025 with a lower value than previous years' value of £30 million nationally. The criteria focus on key priority areas building on the previous success of the scheme and will include 3 domains

- 1) **Gateway** – Registered to provide Pharmacy First and Pharmacy Contraception Service
- 2) **Medicines Optimisation-** Requirements around Palliative and End of Life Care (PEoLC), Respiratory and clinical service training
- 3) **Patient Safety-** focus on Sepsis training and safeguarding

Regulatory

- No clinical audits in 2025/2026
 - Maximum of 4 health campaigns – 2 will be nationally set and 2 will be determined by the ICB, although details of the process for this have not yet been confirmed
 - More scope to amend core opening hours to be introduced – this may support contractors to amend opening hours to ensure they remain financially viable but could pose a risk to accessibility to pharmaceutical services during late nights and weekends.
- Need for patients who pay NHS charge to sign prescriptions to be removed

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- Distance Selling Pharmacies will no longer be able to provide Advanced and Enhanced services to patients on the pharmacy premises- this could pose a risk to our flu vaccination and covid programmes and reduce the number of providers available to provide the service
- New Medicine Service subcontracting to be stopped

Digital Developments

Up to £8 million of funding nationally secured for community pharmacy will be used to support digital developments in 2025 to 2026. This will enable work to continue to deliver developments for the pharmacy sector in 2025 to 2026 to better support delivery of clinical services, including the introduction of emergency contraception as part of the contraception service, and patient group direction supplies as part of the smoking cessation service. It currently unclear whether any investment will be made available on a local level.

Summary

Community pharmacy has a key role in supporting patients in the communities they serve, and this is essential in delivering the government’s ambition to rebuild the NHS and make it fit for the future. The new pharmacy contract is a step change for the sector, recognises the scale of the national funding gap and is a first step towards sustainability for the sector.

The government is committed to working with the sector over the coming years to:

- stabilise community pharmacy
- build on what we have achieved to date
- lay the foundations for an independent prescribing service to harness its full potential in the future

Norfolk and Waveney ICB also recognises the potential of Community Pharmacy within the wider integrated care system and continues to work with partners to ensure the potential of pharmacy clinical services, such as Pharmacy First, are harnessed and utilised by all, not only to support patient access, but also to support the financial viability of our pharmacy contractors and improve primary care resilience more widely.

Recommendation to the Board:

- Note the finalised 2025-2026 Community Pharmacy Contractual Framework and the opportunities it presents, not only for the sector but the wider Integrated Care System
- Note the focus of the new contract on clinical pharmacy services, building on what has been achieved to date
- Acknowledge that, although the new contract is a positive step change, a national funding gap is likely to remain. This therefore doesn’t change our current assessment of the risk to the resilience of community pharmacy in Norfolk and Waveney.

Key Risks

Clinical and Quality:

Pharmacy is not regulated by the CQC therefore the role of the senior quality pharmacist within the ICB remains critical to ensure clinical assurances are provided due to the uplift of clinical services from pharmacies

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Finance and Performance:	Pharmacy First Services are a key focus within the ICB operational planning document to ensure focus remains on performance against expectations
Impact Assessment (environmental and equalities):	Financial stability of the Community Pharmacy sector will provide continuity of care in the community and will ensure that accessibility to pharmaceutical services remains high, ensuring consistent access to healthcare services for all. Evidence shows that 41% of the permanent closures took place in the 20% most deprived parts of England. Norfolk and Waveney ICB do not currently hold data to understand if the local landscape mirrors that of national picture and work will be conducted to understand this through the review of the new contract and economic analysis' findings.
Reputation:	Continued engagement and good local relationship with Community Pharmacy Norfolk/Suffolk (LPC) on national/local priorities to continue to ensure NWICB is working in line with future pharmacy aspirations and opportunities
Legal:	Community Pharmacy Contractual Framework (CPCF) 2025/2026
Information Governance:	Information Governance matters will be highlighted as and when appropriate. None are applicable on this paper
Resource Required:	N&W Pharmacy and Optometry Primary Care Commissioning team N&W ICB finance Pharmacy Lead N&W ICB BI team Pharmacy Contracting team (hosted by Herts and West Essex on behalf of the East of England)
Reference document(s):	Community Pharmacy Contractual Framework: 2024 to 2025 and 2025 to 2026 - GOV.UK https://www.gov.uk/government/publications/community-pharmacy-contractual-framework-2024-to-2025-and-2025-to-2026 CPCF settlement: 2024/25 and 2025/26 - Community Pharmacy England https://cpe.org.uk/our-work/negotiations/cpcf-settlement-2024-25-and-2025-26/
NHS Constitution:	NHSE/ICB Delegation Agreement
Conflicts of Interest:	ICB master register checked and no conflict apparent
Reference to relevant risk on the Board Assurance Framework	BAF02 Primary Care Resilience and Transformation. BORR 27 The Resilience of Community Pharmacy

Governance

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Process/Committee approval with date(s) (as appropriate)	
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Agenda item: XX

Subject:	2024/25 Annual GP Practice Self-Declaration Summary Report
Presented by:	Shepherd Ncube - Associate Director of Primary Care Commissioning
Prepared by:	Jordan Bingley - Primary Commissioning Manager
Submitted to:	Primary Care Commissioning Committee
Date:	14 May 2025

Purpose of paper:

This report presents an overview of submissions within Norfolk and Waveney, highlights areas of strength and risk, and outlines a proposed action plan to support practices in meeting their contractual responsibilities.

Executive Summary:

- A total of 105 GP practices operates within Norfolk and Waveney.
- 99 practices (94%) successfully completed the eDEC submission.
- 6 practices did not submit data due to challenges such as system access and staffing constraints. These are being followed up by the commissioning

Report

Assurance Highlights from 2024/25 eDEC Submission

- **Overall Contractual Compliance**

The majority of practices reported **full compliance** with their contractual obligations, an encouraging position for the system overall.

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Regulatory and Professional Registration

100% of practices confirmed compliance with:

- CQC registration for clinical services
- Professional registration for all clinical staff

Premises and Suitability

- All practices reported that their premises are fit for purpose and suitable to meet the needs of their local populations.

Infection Prevention and Control (IPC)

Full compliance across all practices on:

- Infection control procedures
- Decontamination protocols
- Ongoing IPC governance

Workforce Standards

Practices are meeting expectations in:

- Recruitment and induction
- Training, supervision, and professional development
- Valid DBS checks and employment contracts

Vaccination Compliance

- Near 100% compliance across all indicators, a clear strength across the system.

Learning Disability and DNACPR Protocols

- All practices have procedures in place to ensure that DNACPR decisions for patients with a learning disability follow best practice, with regular reviews in place.

Staffing Needs Assessment

- The vast majority of practices have completed workforce risk assessments to determine appropriate staffing levels.

Safeguarding Policies

- 100% compliance with safeguarding policies for both children and adults-a critical area of assurance.

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- **Language and Interpretation Support**
 - All practices have access to **interpreting services** for non-English-speaking patients, helping reduce inequalities in access and care.
- **Access to Consultations**
 - Practices are offering care to all patients via **both virtual and face-to-face consultations**, supporting accessible and flexible service delivery.

5. Key Areas for Improvement

Practice closures during core hours

Nationally, around 15% of GP practices in England report some form of closure during core hours (8:00 am – 6:30 pm, Monday to Friday). This reflects a wider systemic issue that warrants further exploration. Within our system, this trend is consistent and will require closer scrutiny from commissioners to ensure patient access is not compromised. In particular, further work is needed to:

- Clarify and strengthen local processes for approving NHS 111 emergency diversion arrangements, which should only be used on an exceptional basis.
- Ensure all practices can demonstrate arrangements for patients to access essential services when practices are closed during core hours. A small proportion have not confirmed these safeguards.

Additionally, a notable number of practices across Norfolk and Waveney do not accept registrations from patients residing outside their usual catchment area. While this is in line with national trends and optional under current guidance, commissioners will continue to monitor its impact on access.

Patient and Public Engagement

While most practices report compliance with the requirement to engage with their local populations, there remains a significant shortfall in evidence of consistent engagement with Patient Participation Groups (PPGs) throughout the year. This presents a clear opportunity for improvement in demonstrating patient voice and co-production in service development.

Whistleblowing and Staff Safeguarding

A small number of practices have not identified an external contact point (e.g., Freedom to Speak Up Guardian or local whistleblowing lead) for staff to raise concerns in confidence. This is an important aspect of a safe and transparent working culture and will be addressed through targeted support.

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Continuity of Care

The data indicates that further support is needed to embed the routine identification of patients who would benefit from continuity of care with their named GP and support team. While performance is in line with national averages, this remains a key priority under the GP contract to support proactive care.

Dispensing Practice Compliance

- In relation to dispensing practices, the majority in Norfolk and Waveney are currently non-compliant with requirements relating to the handling of controlled drugs. Specifically, many practices are unable to evidence that:
 - Clear procedures are in place,
 - These are consistently followed in practice,
 - And that monitoring and regular review processes are established.

This will be a priority area for further discussion with the ICB's Medicines Management Team, with the aim of providing practical guidance and supporting compliance.

Proposed Improvement Plan

1. Identification of Non-Compliant Practices

- Review the E-Dec report to pinpoint practices flagged as non-compliant.
- Categorise non-compliance issues by priority (e.g., High, Medium, Low) and areas of concern (e.g., governance, services, IT systems).

2. Initiate Engagement

- Contact identified practices to schedule discussions with relevant N&W Commissioning manager.
- Communicate the purpose of these engagements, emphasizing collaboration and support.

3. Conduct Tailored Discussions

Hold individual consultations with each practice to:

- Understand their unique challenges and reasons for non-compliance.
- Provide clear explanations of compliance requirements.
- Offer practical recommendations and solutions.

4. Develop Support Resources

- Create tailored guidance materials addressing common compliance challenges.
- Provide ongoing access to expert advice, training, and tools.

5. Implement Progress Tracking

Set measurable goals and deadlines for practices to address each non-compliance issue.

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- Establish a follow-up schedule to monitor progress, offering additional guidance if necessary.

6. Report and Review Outcomes

- At the end of Q1, evaluate the compliance status of all engaged practices.

Conclusion and recommendation to the Board:

This report provides assurance that the majority of practices in Norfolk and Waveney are meeting their contractual eDEC obligations. Where gaps have been identified, proactive steps are underway to address them.

Approval is sought to implement the above proposed action plan and continue close monitoring and engagement to support all practices towards full compliance.

Key Risks	
Clinical and Quality:	Failure to comply with service quality elements could amount to a breach of contract by practices, this could mean that practices do not meet clinical services registration and professional registration requirements. Increased serious incidents if structures are not in place
Finance and Performance:	N/A
Impact Assessment (environmental and equalities):	Gaps in services are likely to perpetuate inequalities
Reputation:	Serious incidents are likely to attract media interest. Commissioner is at risk of meeting its commitment to meeting the needs of the local population.
Legal:	Practices at risk of not complying with legal requirements if not complaint with clinical services and professional registration, compliance with medicines management and premises requirements.
Information Governance:	N/A
Resource Required:	Commissioning managers, PLACE Colleagues and Practice staff and PCN input
Reference document(s):	N/A
NHS Constitution:	Commitment to Quality of Care, working together for Patients, Everyone Counts.
Conflicts of Interest:	None identified

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Reference to relevant risk on the Board Assurance Framework	Resilience risk in General Practice and Primary Care
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Governance

Process/Committee approval with date(s) (as appropriate)	Audit Committee for information.
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Agenda item: 17

Subject:	Local Dispute Resolution Policy for Primary Care Contracts
Presented by:	Fiona Theadom, Head of Primary Care Commissioning (Dental and GP)
Prepared by:	Fiona Theadom, Head of Primary Care Commissioning (Dental and GP)
Submitted to:	Primary Care Commissioning Committee
Date:	14 May 2025

Purpose of paper:

To seek approval for the new Local Dispute Resolution Policy for Primary Care Contracts.

Executive Summary:

Norfolk and Waveney ICB (ICB) is required to put arrangements in place to resolve disputes and appeals relating to Primary Care Contracts (GMS, PMS, APMS, GDS, PDS, GOS) locally in the first instance, before referral, if necessary, to NHS Resolution ([Primary Care Appeals - NHS Resolution](#)). This document describes the local process and how it links to formal NHS mechanisms.

The Primary Care contract clauses are generic in their description of Dispute Resolution and the first clause states:

“In the case of any dispute arising out of or in connection with the Contract, the Contractor and the Commissioner must make every reasonable effort to communicate and co-operate with each other with a view to resolving the dispute, before referring the dispute for determination in accordance with the *NHS dispute resolution procedure* (or, where applicable, before commencing court proceedings).....”.

The contract clauses relating to Dispute Resolution survive the expiry or termination of the Contract.

Appendix A to this paper sets out proposals for a Local Dispute Resolution Policy for primary care contracts.

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It should be noted that Community Pharmacy Contractual matters are managed by the Pharmacy and Optometry Team hosted by Hertfordshire and West Essex ICB via a local Memorandum of Understanding with all 6 ICBs in the region. Pharmaceutical contracts are regulated and monitored through the Pharmacy Services Regulatory Committee. As such, local dispute resolution is enacted in accordance with the Pharmacy Regulations and Pharmacy Manual by the Pharmacy and Optometry team and as such do not fall under the direct accountability of Norfolk and Waveney ICB. Decisions will be reported to the Primary Care Commissioning Committee.

Report

Norfolk and Waveney ICB (ICB) is required to put arrangements in place to resolve disputes and appeals relating to Primary Care Contracts (GMS, PMS, APMS, GDS, PDS, GOS) locally in the first instance, before referral, if necessary, to NHS Resolution ([Primary Care Appeals - NHS Resolution](#)). The proposed Policy will apply therefore to primary care medical, dental and optometry contracts and services.

Commissioners are required to manage disputes at local level before either party can escalate to NHS Resolution Primary Care Appeals for resolution. It is important that Commissioners and primary care providers take every opportunity to discuss and negotiate, where possible, to try and resolve any contractual dispute arising from the primary care contract. It is only when all avenues are exhausted should a dispute be raised with the ICB's Local Dispute Resolution Panel. Mediation should also be considered as an option although both parties need to agree to participate.

Disputes can arise from any aspect of the primary care contract, including a failure to agree contract variations, where termination is recommended or disagreement about contract payment terms. Both parties may find it helpful to refer to dispute outcomes published by NHS Resolution to see if any may be applicable to their case before considering whether to raise a dispute.

The proposed Policy sets out the process for managing disputes at local level if parties are unable to reach a solution. It is important that both parties have a clear understanding of what the dispute is about and their preferred individual solution prior to presenting evidence to the local dispute panel.

Proposed membership of the Panel is to ensure that disputes are managed independently of the Primary Care discussions that have taken place. Either party may invite a representative of the Local Representative Committee to attend.

If a local dispute policy is not in place, disputes cannot be escalated to NHS Resolution Primary Care Appeals.

It is proposed that the Policy and the process is reviewed after each dispute panel to ensure learning outcomes are recorded and shared with all parties involved and with local primary care providers and Local Representative Committees on an anonymised basis if deemed appropriate. If it is necessary to update the Policy

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before the review date of 12 months, any proposed changes will be presented to Committee for approval.

Recommendation to the Committee:

Members of the Committee are asked to approve the proposed Local Dispute Resolution Policy.

Key Risks	
Clinical and Quality:	Contractual disputes may impact clinical care and quality of services provided, rapid resolution, through a formal process if necessary, is therefore key to maintaining standards and quality of care
Finance and Performance:	Disputes relating to contractual issues may impact performance and potentially finance if about payments. The ability for rapid resolution through a formal process if necessary is therefore important.
Impact Assessment (environmental and equalities):	N/A
Reputation:	Failure to resolve disputes will impact the ICB's reputation and that of local primary care providers and potentially other key stakeholders including the local population
Legal:	Not applicable
Information Governance:	All information governance guidance will be followed for individual panels as required
Resource Required:	Primary Care Commissioning, panel members
Reference document(s):	Primary Care Contract Regulations and Primary Care Handbooks/Guidance Manuals
NHS Constitution:	N/A
Conflicts of Interest:	None identified. Conflicts of Interest will be managed in line with ICB guidelines and policy for individual panels.
Reference to relevant risk on the Board Assurance Framework	BAF02 Sustainability and Transformation of Primary Care Services

Governance

Process/Committee approval with date(s) (as appropriate)	Audit Committee for information.
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Norfolk and Waveney ICB

Local Dispute Resolution for Primary Care

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Document Control Sheet

This document can only be considered valid when viewed via the ICB's intranet. If this document is printed into hard copy or saved to another location, you must check that the version number on your copy matches that of the one online.

Approved documents are valid for use after their approval date and remain in force beyond any expiry of their review date until a new version is available.

Name of document	Local Dispute Resolution for Primary Care
Version	V1.0
Date of this version	29 April 2025
Produced by	Fiona Theadom, Head of Primary Care Commissioning (Dental and GP)
What is it for?	Policy outlines the local dispute resolution process for primary care contracts prior to escalation to NHS Resolution
Evidence base	Primary Care regulations (GMS, PMS, APMS, GDS, PDS and GOS) require commissioners to have a local dispute policy in place to manage contract disputes under the Regulations and reduce the need to escalate to NHS Resolution
Who is it aimed at and which settings?	Primary Care Providers – medical, dental and optometry services Pharmaceutical Services are managed via a separate process
Consultation	Not applicable
Impact Assessment:	
Other relevant approved documents	
References:	Primary Care Regulations (GMS, PMS, APMS, GDS, PDS and GOS)
Monitoring and Evaluation	
Training and competences	
Reviewed by:	Primary Care Commissioning Committee
Approved by:	
Date approved:	
Signed:	
Dissemination:	[to be completed by Corporate Governance]
Date disseminated:	[to be completed by Corporate Governance]
Review Date:	May 2026 or before if statutory change is required.
Contact for Review:	Primary Care Commissioning team

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Version Control

Revision History	Summary of changes	Author(s)	Version Number

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1 INTRODUCTION

Norfolk and Waveney ICB (ICB) is required to put arrangements in place to resolve disputes and appeals relating to Primary Care Contracts (GMS, PMS, APMS, GDS, PDS, GOS) locally in the first instance, before referral, if necessary, to NHS Resolution ([Primary Care Appeals - NHS Resolution](#)). This document describes the local process and how it links to formal NHS mechanisms.

The Primary Care contract clauses are generic in their description of Dispute Resolution and the first clause states:

“In the case of any dispute arising out of or in connection with the Contract, the Contractor and the Commissioner must make every reasonable effort to communicate and co-operate with each other with a view to resolving the dispute, before referring the dispute for determination in accordance with the *NHS dispute resolution procedure* (or, where applicable, before commencing court proceedings).....”.

The contract clauses relating to Dispute Resolution survive the expiry or termination of the Contract.

2 PURPOSE

This document sets out the formal process for resolving contractual disagreements between primary care contractors and the ICB (as Commissioner) relating to primary medical, dental, ophthalmic or pharmaceutical services. It describes the arrangements for dealing with disputes relating to contractual terms within a primary care contract. It covers:

- The local resolution process;
- Formal NHS disputes and appeals procedures;
- Non-NHS contracts;

The process may be initiated by either party to the contract and are likely to fall under four main headings: Payments; Contract Variations; Compliance with contractual terms; Contract terminations.

3 SCOPE

Primary Care Services – medical, dental (primary and community care) and optometry services.

Out of Scope

Pharmaceutical Services are managed by Hertfordshire and West Essex ICB under a Memorandum of Understanding with all six ICBs in the region. To avoid duplication and to ensure a consistent approach is taken, Pharmaceutical Services disputes will continue to be managed by Hertfordshire and West Essex ICB as set out in the NHS England Pharmacy Manual. Decisions are taken by Pharmaceutical Services Regulations Committee and can be escalated to NHS Resolution or through Fitness to Practice. They will be reported to the ICB’s Primary Care Commissioning Committee.

4 DEFINITIONS

APMS Alternative Primary Medical Services as described in the Regulations

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GDS	General Dental Services as described in the Regulations
GMS	General Medical Services as described in the Regulations
GOS	General Optical Services as described in the Regulations
LDC	Local Dental Committee
LMC	Local Medical Committee
LOC	Local Optical Committee
LPC	Local Pharmaceutical Committee
PDS	Personal Dental Services as described in the Regulations
PMS	Personal Medical Services as described in the Regulations

Refer also to the links to the relevant Primary Care Contract Regulations are listed in Section 11 of this Policy for full definition description.

5 ROLES AND RESPONSIBILITIES

All disputes for primary care will be handled by the Associate Director of Primary Care or Head of Primary Care Commissioning. Panel membership will comprise:

- Director or Executive Director
- 1 Clinical member (to be nominated by Chair of Primary Care Commissioning Committee)
- 1 Non-Executive Board Member

Panel members must not have been involved in the matter under dispute.

The panel will nominate one of its members to be Chair, and this individual will have the casting vote.

6 LOCAL DISPUTE RESOLUTION PROCESS

It is anticipated that most disagreements can be resolved through communication and co-operation, as part of normal contractual relationships. The ICB and contractors will make every reasonable effort to try and resolve issues locally through discussion and negotiation before considering referral to NHS Resolution (or, where appropriate, through the courts).

A two stage local resolution process will apply both to disputes and appeals:

Stage 1

The Associate Director of Primary Care Commissioning or Head of Primary Care Commissioning and other relevant ICB staff (depending on the nature of the dispute/appeal), will meet the contractor (normally virtually) to explore and, if possible, resolve the matter. The ICB will make a written record of the meeting, which will be signed by both parties and shared with participants.

At this stage, mediation may be offered to both parties to try and resolve the dispute. Mediation may only progress with agreement of both parties.

If no solution is agreed, the contractor should write to the ICB's Associate Director of Primary Care Commissioning or Head of Primary Care Commissioning within 14 days stating its intention to continue the dispute and requesting a Local Resolution Panel. If the ICB initiated the dispute, it will inform the contractor within 14 days that it proposes to convene a Local Resolution Panel.

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Stage 2

For disputes/appeals not resolved at Stage 1, the ICB will convene a Local Resolution Panel to meet as soon as practicable, giving reasonable notice to all parties. Both parties must have a clear understanding of the dispute and what it is about and why a panel needs to be convened.

The panel will be convened with membership drawn from the ICB's Primary Care Commissioning Committee Voting Members and either an Executive Director or a Director. All arrangements for convening and supporting local resolution panels will be coordinated by the Primary Care Commissioning team.

Either party may invite the relevant professional representative committee (LMC, LOC, LDC, LPC) to act as advisor to the panel if they feel this would be helpful and appropriate. Professional advisors (e.g. solicitors and accountants) will not normally attend as representatives unless specially requested. If a solicitor does accompany the contractor, the Chair will make it clear that the panel is not a statutory tribunal. The contractor should notify the Chair of the name of anyone who will be accompanying them at least 7 days before the hearing. Virtual hearings may be held.

The panel may choose to co-opt a maximum of 2 individuals with relevant specialist expertise or knowledge. These individuals may have the status either of advisors to the panel or of full decision making members. The decision to involve these individuals, and their status, will be made by the panel Chair prior to the meeting, and will be recorded and communicated to the contractor.

The contractor and the ICB will be asked to present their cases to the panel and may call witnesses. Panel members will be given the opportunity to ask questions. After presenting their cases the contractor and ICB will withdraw, and the panel will deliberate and reach a decision. The panel's discussions will remain confidential.

The panel representative will notify the contractor and Corporate Affairs team of its decision, including any recommendations, in writing within 7 days of the hearing.

A summary report of any Local Resolution Panels held will be taken to the Primary Care Commissioning Committee. Where appropriate, decisions will be reported to a full meeting of the ICB Board for information. Depending on the nature of the case involved, the report may be made either to a public or private session of the board meeting.

If no solution can be agreed locally, either party to the dispute may refer the matter on to NHS Resolution. On request, the ICB will advise the contractor on the appropriate steps for taking forward the dispute/appeal.

Disputes relating to decisions pre-delegation to ICBs

Under the Delegation Agreement with NHS England for primary care services, ICBs may be asked to support or manage disputes arising from the period pre-delegation in addition to those that arise post-delegation. Where the outcome of a dispute relates to a decision made by NHS England prior to delegation of primary care services to ICBs, the ICB must liaise with NHS England regional team to agree the proposed way forward prior to informing the contractor how the dispute will be managed.

NHS Disputes Resolution & Appeals Procedures

Disputes relating to NHS contracts can be taken through to NHS Resolution. Appeals against other non-contractual ICB decisions can also be dealt with through formal NHS

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procedures. The mechanism for referring disputes/appeals and the process for determining them, are set out in detail in the relevant primary care legislation. The ICB can advise contractors on the appropriate steps for taking forward a specific dispute/dispute/appeal, as and when the need arises.

Non-NHS Contracts

Where the contract is a legal rather than an NHS contract (e.g. because the contractor does not have NHS Body status within their contract) there is the option of referring a dispute either through NHS procedures or via the courts. In either case, the local resolution process described above will be used first.

Contractors who do not have NHS Body status can opt to use NHS Resolution Procedure with or without the agreement of the ICB. Where the ICB has initiated the dispute, it can refer it on through the NHS procedure only if the contractor has agreed to this in writing.

If a dispute is referred for NHS consideration the resulting determination will be binding on both parties and cannot then be referred on to a court.

The following factors should be taken into account in deciding whether to pursue a dispute through the NHS or legal process:

- how long each process is likely to take;
- costs can be awarded against the unsuccessful party in court proceedings, but not in the NHS dispute resolution procedure;
- the NHS procedure is private, whereas court proceedings (or at least the outcome) are generally public.

7 EQUALITY

In applying this policy, the ICB will have due regard for the need to eliminate unlawful discrimination, promote equality of opportunity, and provide for good relations between people of diverse groups, in particular on the grounds of the following characteristics protected by the [Equality Act \(2010\)](#); age, disability, sex, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, and sexual orientation, in addition to offending background, trade union membership, or any other personal characteristic.

An Equality Impact Assessment is included in Appendix A

8 MONITORING AND REVIEW

This policy will be reviewed annually by the Primary Care Commissioning Committee, or sooner if necessary due to guidance/legislative change(s).

9 DATA PROTECTION

In applying this policy, the ICB will have due regard for the [Data Protection Act 2018](#) and the requirement to process personal data fairly and lawfully and in accordance with the data protection principles. Data Subject Rights and freedoms will be respected, and measures will be in place to enable employees to exercise those rights. Appropriate technical and organisational measures will be designed and implemented to ensure an appropriate level of security is applied to the processing of personal information.

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Employees will have access to a Data Protection Officer for advice in relation to the processing of their personal information and data protection issues.

10 ASSOCIATED DOCUMENTATION

Medical Services Advice Note 3 – Branch Surgery Closures (May 2024)
Medical Services Advice Note 4 - Branch Surgery service provision (August 2024)

Dental Services Primary Dental Contract Clawback Policy (January 2024)

11 REFERENCES

Links to external reference documents:

NHS England Policy Handbooks for Primary Care

[NHS England » Policy book for primary dental services](#)

[NHS England » Primary medical services policy and guidance manual \(PGM\)](#)

[NHS England » Policy Book for Eye Health](#)

Primary Care Regulations

[The National Health Service \(General Dental Services Contracts\) Regulations 2005](#)

[The National Health Service \(General Medical Services Contracts\) Regulations 2015](#)

[The General Ophthalmic Services Contracts Regulations 2008](#)

[The National Health Service \(Personal Medical Services Agreements\) Regulations 2015](#)

[The National Health Service \(Personal Dental Services Agreements\) Regulations 2005](#)

[The Alternative Provider Medical Services Directions 2019](#)

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APPENDIX A: EQUALITY IMPACT ASSESSMENT

Step 1: Aims and purpose of the proposal / policy being assessed

(This should reflect what the policy is intending to achieve and how it seeks to achieve, it is this intention that the assessment seeks to measure, consider who benefits and how and who doesn't and why, also consider the impact of associated aims).

The Policy is designed to set out a local process for resolving primary care contractual disputes, initially through negotiation and discussion and this is unsuccessful, to put in place a formal local dispute resolution panel to consider the evidence of both parties. This process is required to be completed before either party can ask NHS Resolution to consider a contractual dispute.

Step 2: Screening process for relevance to equality & diversity issues

Does this proposal / policy have any equality & diversity relevance in the following areas?

(This should be considered in relation to the formulation and application of the policy. As far as possible engagement with the relevant staff network groups should take place to identify any potential areas of relevance).

A Age	The policy is inclusive for all
B Disability	Panel may need to make reasonable adjustments to consider evidence as required
C Gender reassignment	The policy is inclusive for all
D Marriage and Civil Partnership	The policy is inclusive for all
E Pregnancy and maternity	The policy is inclusive for all
F Race	The policy is inclusive for all
G Religion or belief	The policy is inclusive for all
H Sex	The policy is inclusive for all
I Sexual orientation	The policy is inclusive for all
J Other issues	Panel may need to make reasonable adjustments to consider evidence as required

Step 3: If you have answered, "Yes", to any of the protected characteristic boxes in Step 2, a full impact assessment is required

Are any of the protected characteristic boxes in Step 2 marked "Yes"?

Not applicable

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Step 4: Examination of available information (sources can include but are not restricted to – ESR data; MI relating to Recruitment /Employee Relations/Attrition; Industry best practice; legal overview; research articles; matters arising from judgements tested during consultation; consider four-fifths rule to assess difference).

Not applicable

Step 5: Full Impact Assessment Process

Step 5a: Consultation Log

Where are the consultation records stored?

Step 5a: Consultation Log	Step 5a: Consultation Log	Step 5a: Consultation Log	Step 5a: Consultation Log

Step 5b: EIA Action Plan: Workforce Impacts (internal)

Potential issues or impacts
(positive and negative)

Step 5c: EIA Action Plan: Service Delivery Impacts (external)

Potential issues or impacts
(positive and negative)

Step 6: Monitoring and review arrangements

How will the implementation of the proposal / policy be monitored, and by whom?

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Following each event, the Primary Care team will consider any learning and feedback from all parties involved in the process to determine if changes to the process and Policy need to be made.

What is the timetable for monitoring, with dates?

Formal review will take place annually. Monitoring will occur as and when a dispute is raised.

Step 7: Public availability of reports / result

Disputes may be published in Primary Care Commissioning Committee where in the public interest.

NHS Resolution report outcomes for primary care appeals are available publicly on their website at [Home - NHS Resolution](#)

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