

# Primary Care Commissioning Committee Part 1

Wed 14 January 2026, 14:00 - 17:00

## Agenda

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**14:00 - 14:00** **Agenda**

0 min

*Hein van den Wildenberg*

 2026 01 14 Item 00 ICB Primary Care Committee Agenda Pt 1.pdf (2 pages)

**14:00 - 14:00** **1. Chair's Introduction**

0 min

*Information* *Hein van den Wildenberg*

**14:00 - 14:00** **2. Apologies for Absence**

0 min

*Information* *Hein van den Wildenberg*

**14:00 - 14:00** **3. Declarations of Interest**

0 min

*Information* *Hein van den Wildenberg*

 2026 01 14 Item 03 DOI register.pdf (4 pages)

**14:00 - 14:00** **4. Review of Minutes and Action Log from the November 2025 meeting**

0 min

*Decision* *Hein van den Wildenberg*

 2025 11 19 Item 04 NWICB PCCC Minutes Part One.pdf (7 pages)

 2026 01 14 Item 04 PCCC Action Log Part One.pdf (1 pages)

**14:00 - 14:00** **5. Forward Planner**

0 min

*Information* *Sadie Parker*

 2025 11 19 Item 05 NWICB PCCC Forward Planner 2025 2026 Part One.pdf (1 pages)

**14:00 - 14:00** **6. Risk Register, including Proposed New Dental Risk**

0 min

*Decision* *Sadie Parker / Fiona Theadom*

 2026 01 14 Item 06 Risk Register - front sheet.pdf (6 pages)

 2026 01 14 Item 06 - Proposed Revised Risk for Dentistry.pdf (7 pages)

 2026 01 14 Item 06 Risk Register Inphase Drawdown.pdf (12 pages)

**14:00 - 14:00** **Service Development**

0 min

**14:00 - 14:00** **7. Director of Primary Care Report**

0 min

*Information* *Sadie Parker*

 2026 01 14 Item 07 Director of Primary Care Report.pdf (5 pages)

Wendy Stah  
07/01/2026 14:06:21

## 14:00 - 14:00 8. Primary Care Operational Plan Update

0 min

Information *Amanda Sear*

📄 2026 01 14 Item 08 Operational Planning Update - January 2026.pdf (4 pages)

## 14:00 - 14:00 9. GP Action Plan Report

0 min

Decision *Shepherd Ncube*

📄 2025 01 14 Item 09 GP Action Plan.pdf (13 pages)

## 14:00 - 14:00 10. Workforce • Strategic Primary Care & Workforce Recruitment and Retention Programme Report • Strategic Pharmacy Workforce Report

0 min

*Jayde Robinson and Helen Palmer*

📄 2026 01 14 Item 10 Strategic Primary Care Workforce Recruitment and Retention Programme Update Report.pdf (12 pages)

📄 2026 01 14 Item 10 Appendix A - 25-26 Primary Care Workforce Operational Delivery Plan Status.pdf (3 pages)

📄 2026 01 14 Item 10 Appendix A - 25-26 Primary Care Workforce Operational Delivery Plan Status Page 2.pdf (3 pages)

## 14:00 - 14:00 Finance & Governance

0 min

## 14:00 - 14:00 11. Delivery Group Reports • General Practice & Community Pharmacy Delivery Group • Dental Services Delivery Group Report • Dental Development Group

0 min

Information *Shepherd Ncube / Fiona Theadom*

📄 2026 01 14 Item 11 GPCP Delivery Group Report.pdf (8 pages)

📄 2026 01 14 Item 11 Dental Services Delivery Group report.pdf (4 pages)

📄 2026 01 14 Item 11 Dental Development Group Report.pdf (3 pages)

## 14:00 - 14:00 12. Pharmacy Integration Project Final Outcome Report

0 min

Information *Sharon Gardner*

📄 2026 01 14 Item 12 Pharmacy Integration Project Final Outcome Report.pdf (6 pages)

📄 2026 01 14 Item 12 CPIP Final Report.pdf (27 pages)

## 14:00 - 14:00 13. Strategic Framework for Primary Care

0 min

Information *Amanda Sear*

📄 2026 01 14 Item 13 Primary Care Strategic Framework Update.pdf (7 pages)

## 14:00 - 14:00 14. Strategic Prescribing Report

0 min

Information *Michael Dennis*

📄 2026 01 14 Item 14 Prescribing Report.pdf (15 pages)

## 14:00 - 14:00 15. Strategic Finance Report

0 min

Information *James Grainger*

📄 2026 01 14 Item 15 25-26 M9 Primary Care Commissioning Committee Finance Report.pdf (8 pages)

## 14:00 - 14:00 Any Other Business

0 min

Web: Sarah  
07/01/2026 14:56:21

14:00 - 14:00 **16. Any Other Business**

0 min

*Information*

*Hein van den Wildenberg*

Webb, Sarah  
07/01/2026 14:56:21

Meeting of the Norfolk and Waveney ICB Primary Care Commissioning Committee  
Wednesday 14 January 2026, 14:00 Part 1  
Meeting to be held via video conferencing and You Tube

Item	Time	Agenda Item	Lead
1.	14:00	<b>Chair's Introduction</b>	Chair
2.		<b>Apologies for Absence</b>	Chair
3.		<b>Declarations of Interest</b> 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.		<b>Review of Minutes and Action Log from the November 2025 meeting</b> <i>For Approval</i>	Chair
5.		<b>Forward Planner</b> <i>For Noting</i>	SP
6.	14:10	<b>Risk Register, including Proposed New Dental Risk</b> <i>For Approval</i>	SP FT
<b>Service Development</b>			
7.	14:20	<b>Director of Primary Care Report</b> <i>For Noting</i>	SP
8.	14:25	<b>Primary Care Operational Plan Update</b> <i>For Noting</i>	AS
9.	14:30	<b>GP Action Plan Report</b> <i>For Approval</i>	SN
10.	14:40	<b>Workforce</b> <ul style="list-style-type: none"> <li>Strategic Primary Care &amp; Workforce Recruitment and Retention Programme Report</li> <li>Strategic Pharmacy Workforce Report</li> </ul> <i>For Approval/For Noting</i>	JRo/HP
<b>Finance &amp; Governance</b>			
11.	14:50	<b>Delivery Group Reports</b> <ul style="list-style-type: none"> <li>General Practice &amp; Community Pharmacy Delivery Group</li> <li>Dental Services Delivery Group Report</li> <li>Dental Development Group</li> </ul> <i>For Noting</i>	SN/FT
12.	14:50	<b>Pharmacy Integration Project Final Outcome Report</b> <i>For Noting</i>	SG
13.	14:55	<b>Strategic Framework for Primary Care</b> <i>For Noting</i>	AS
14.	15:00	<b>Strategic Prescribing Report</b> <i>For Noting</i>	MD
15.	15:05	<b>Strategic Finance Report</b> <i>For Noting</i>	JG
<b>Any Other Business</b>			
16.	15:15	<b>Any Other Business</b> <ul style="list-style-type: none"> <li>Questions from the public</li> </ul>	Chair
<p>Date, time and venue of next meeting Wednesday 11 March 2026 14:00 – 17:00 – ICB PCCC To be held by videoconference and You Tube</p> <p>Any queries or items for the next agenda please contact: <a href="mailto:sarah.webb7@nhs.net">sarah.webb7@nhs.net</a>; <a href="mailto:mary.cummins3@nhs.net">mary.cummins3@nhs.net</a></p> <p>Questions are welcomed from members of the public. Please send by email: <a href="mailto:nwicb.contactus@nhs.net">nwicb.contactus@nhs.net</a></p>			

Item	Time	Agenda Item	Lead
For a link to the meeting in real-time, please click <a href="#">here</a>			

Webb, Sarah  
07/01/2026 14:56:21

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

**Declared interests of the Primary Care Commissioning Committee**

Name	Role	Declared Interest- (Name of the organisation and nature of business)	Type of Interest			Is the interest direct or indirect?	Nature of Interest	Date of Interest		Action taken to mitigate risk
			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests			From	To	
Ian Wake	Executive Director of Adult Social Services	Norfolk County Council		X		Direct	Executive Director of Adult Social Services, Norfolk County Council	14/10/2025	Present	
Patricia D'Orsi	Executive Director of Nursing, Norfolk and Waveney ICB	Royal College of Nursing		X		Direct	Professional Body - RCN Union	01-Oct-25		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 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
		Norfolk and Norwich University Hospital			X		Son-in law is a cardiology consultant at the NUUH with sessions at JPUH	01/06/2023	Present	Declare at any relevant meetings and will not take part in any discussions or decisions relating to interest
		Royal College of Nursing Union				Indirect	Member of the Royal College of Nursing Union	30/07/1980	Present	Declare at any relevant meetings and will not take part in any discussions or decisions relating to interest
		Suffolk County Council			X		Daughter is an Occupational Therapist employed as a locum by Suffolk County Council	31/07/2025	Present	Declare at any relevant meetings and will not take part in any discussions or decisions relating to interest
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
<b>Norfolk and Waveney ICB Attendees</b>										
Mark Burgis	Executive Director of Patients and Communities, Norfolk and Waveney ICB	Lakenham Practice				Indirect	Wife is Nurse Prescriber who is currently undertaking locum work at Lakenham Practice in Norwich. Wife receives an income from the practice when undertaking shifts at the practice	02/08/2021	Present	Declare at any relevant meetings and will not take part in any discussions or decisions relating to interest
		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

Webb Sarah  
07/01/2025 14:56:21

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		Volunteer non-executive board director for Active Norfolk	10/06/2019	Present	Declare at any relevant meetings and will not take part in any discussions or decisions relating to interest
		St Stephensgate Medical Practice				Indirect	Personal friendship with GP partner	03/04/2023	Present	Declare at any relevant meetings and will not take part in any discussions or decisions relating to interest
Amanda Sear	Head of Primary Care Strategic Planning	Chet Valley			X	Direct	Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
		Norfolk and Waveney Integrated Care Board			X	Indirect	Partner is an ICB Clinical Advisor and local GP	Ongoing		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 appears and agreeing action, such as stepping out of the meeting  To be declared at any meetings where relevant.
Sharon Gardner	Head of Primary Care Commissioning - Pharmacy	Locum Pharmacist	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	01/04/2023	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
		Pharmaceutical Society of Great Britain		X			Member of the Royal Pharmaceutical Society of Great Britain	24/07/2000	Present	Declare at any relevant meetings and will not take part in any discussions or decisions relating to interest
		Humbleyard Practice (Mulbarton)			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
		PM healthcare	X				Mentorship contract with PM healthcare. Mentorship programme with the pharmaceutical company Chiesi managed through PM healthcare Contracted as self-employed locum pharmacist to provide one mentorship session (30mins) per quarter over a 12 month period to date (Oct 25)	01/01/2025	31/12/2025	Withdrawal from any decisions making or conversations that involve PM healthcare or Chiesi conflict to be raised at all relevant meetings where discussions/decision relate to the conflict declared.
Sarah Johnson	Senior Primary Care Commissioning Manager - Dental	Cromer Group 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

Sarah Johnson  
27/01/2025 14:56:21

		Treetops Dental Practice			X		Receiving treatment from Treetops Dental Practice	13/10/2025	Present	Declare at any relevant meetings and will not take part in any discussions or decisions relating to interest
Fiona Theadom	Head of Primary Care Commissioning, Norfolk & Waveney ICB	Nothing to Declare				N/A	N/A			N/A
<b>Local Medical Committee Attendees</b>										
Lisa Drewry	Executive Officer, Norfolk & Waveney LMC	Nothing to Declare				N/A	N/A			N/A
Ian Wilson	Executive Officer with Norfolk & Waveney Local Medical Committee	Nothing to Declare				N/A	N/A			N/A
Joni Graham	Executive Officer Norfolk & Waveney Local Medical Council	Nothing to Declare				N/A	N/A			N/A
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
		Norfolk and Norwich University Hospital				Indirect	Family Member works at the NNUH	01/01/2024	Present	Declare at any relevant meetings and will not take part in any discussions or decisions relating to interest
<b>Practice Managers drawn from General Practice Attendees</b>										
Sarah Buchan	PCCC Practice Manager Specialty Advisor	Fakenham Medical Practice			X		CEO at Fakenham Medical Practice. Employed by practice	Feb-18	31-Aug-25	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	31-Aug-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 prac	Mar-20	31-Aug-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	31-Aug-25	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	31-Aug-25		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
<b>Health and Wellbeing Board Attendees (Norfolk and Suffolk)</b>										
<b>Healthwatch Attendees (Norfolk and Suffolk)</b>										
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 for Healthwatch Norfolk which has ICB contracts.	2020	Present	Declare at any relevant meetings and will not take part in any discussions or decisions relating to interest
		NHS England		X		Direct	Providing GP appraisals on a self employed basis.	2015	Present	Declare at any relevant meetings and will not take part in any discussions or decisions relating to interest
Sally Watson	Healthwatch Suffolk Engagement and Community Manager	Nothing to Declare			N/A		N/A	N/A	N/A	

Webb Sarah  
07/01/2026 13:56:21

**Other Primary Care Members**

Andrew Bell	Vice-Chairman Norfolk Local Dental Committee General Dental Practitioner in Norfolk and Waveney	John G Plummer and Associates	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	01/09/2014	Present	Declare at any relevant meetings and will not take part in any discussions or decisions relating to interest
		Norfolk Local Dental Committee		X		Direct	Chairman Norfolk Local Dental Committee	17/03/2025	Present	Declare at any relevant meetings and will not take part in any discussions or decisions relating to interest
		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
		Primary Care Workforce Team		X			Fellow within Primary Care Workforce Team	01/08/2025	Present	Declare at any relevant meetings and will not take part in any discussions or decisions relating to interest
Deborah Daplyn	Co-Chair. Norfolk & Waveney Local Optical Committee	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	Norfolk Hospice				Indirect	Daughter a palliative care nurse for Norfolk Hospice, Hillington	07/07/2021	Present	Declare at any relevant meetings and will not take part in any discussions or decisions relating to interest
		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)	British Dental Association		X		Direct	I am a board member for the dental trade union	01/01/2025	Present	Declare at any relevant meetings and will not take part in any discussions or decisions relating to interest
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  
07/01/2026 14:56:21

**Norfolk and Waveney Primary Care Commissioning Committee**  
**Part One**

**Minutes of the Meeting held on**  
**Wednesday 11 November 2025 at 15:30**  
**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 –Chair for November 2025 meeting
James Grainger	JG	Head of Finance Primary Care and Corporate, Norfolk and Waveney ICB (Deputising for Howard Martin Executive Director of Finance Norfolk, Waveney, and Suffolk & North East Essex ICB)
Karen Watts	KW	Director of Nursing and Quality, Norfolk, and Waveney ICB (deputising for Lisa Nobes Executive Director of Nursing, Norfolk, Waveney, and Suffolk & North East Essex ICB)

**In attendance**

Name	Initials	Position and Organisation
Andrew Bell	AB	Vice Chairman Norfolk Local Dental Committee (LDC)
Craig Boyle	CB	ICS Estates Programme Manager, Norfolk, and Waveney ICB
Mark Burgis	MB	Executive Director of Patients & Communities, Norfolk and Waveney ICB
Tony Dean	TD	Joint Chief Officer at Community Pharmacy Norfolk & Suffolk
Sharon Gardner	SG	Head of Primary Care Commissioning Community Pharmacy and Optometry, Norfolk and Waveney ICB
Andrew Hayward	AHa	Trustee of Healthwatch Norfolk
Paul Higham	PH	Associate Director of Estates, Norfolk, and Waveney ICB
Kirsty Hockley	KH	Commissioning Support Officer, Pharmacy and Optometry, Norfolk and Waveney ICB minute taker
Catherine McWalter	CMcW	Senior Lead Primary Care Estates Manager, Norfolk, and Waveney ICB
Shepherd Ncube	SN	Associate Director, Primary Care Commissioning, Norfolk, and Waveney ICB
Sadie Parker	SP	Director of Primary Care, Norfolk and Waveney ICB
Amanda Sear	AS	Head of Primary Care Strategic Planning, Norfolk & Waveney ICB
Nick Stolls	NS	Specialty Dental Advisor, Norfolk & Waveney ICB
Gregg Syder	GS	Commissioning Manager – Pharmacy and Optometry, Norfolk & Waveney ICB
Fiona Theadom	FT	Head of Primary Care Commissioning (Dental and Medical), Norfolk, and Waveney ICB
Sarah Webb	SW	Primary Care Administrator Norfolk & Waveney ICB
Ian Wilson	IWi	Executive Officer, Norfolk and Waveney Local Medical Committee

Apologies received

Name	Initials	Position and Organisation
Deborah Daplyn	DD	Co-Chair Norfolk and Waveney Local Optical Committee (LOC)
Michael Dennis	MD	Head of Medicines Optimisation, Norfolk, and Waveney ICB
Howard Martin	HM	Executive Director of Finance for Norfolk and Waveney and Suffolk & North East Essex ICB
Lisa Nobes	LN	Director of Nursing at NHS Suffolk and North East Essex ICB
Lauren Seamons	LS	Joint Chief Officer at Community Pharmacy Norfolk & Suffolk
Jason Stokes	JS	Secretary, Norfolk Local Dental Committee (LDC)
Peter Taylor	PT	Assistant Director, Public Health Commissioning Norfolk County Council, Public Health
Ian Wake	IW	Chair, Partner Member – Local Authority (Norfolk) Norfolk and Waveney ICB

No	Item	Action owner
1.	<b>Chair's introduction</b> The Chair welcomed attendees to the November 2025 Committee meeting. Quoracy for the meeting was noted.	Chair
2.	<b>Apologies for absence</b> Apologies noted above.	Chair
3.	<b>Declarations of Interest</b> <i>For Noting</i> There were no declarations of interest declared.	Chair
4.	<b>Review of Minutes and Action Log from the October 2025 Committee</b> <i>For Approval</i> The minutes were agreed to be an accurate record of the October 2025 Committee meeting and minutes would be sent to the Chair for signing. <b>Action: SW to send signed minutes to the Chair for safekeeping.</b> <b>Action Log</b> HW noted that there were three actions shown as in progress with due dates in January 2026. SW provided an update on action 0209. JR confirmed the monthly Business Intelligence Report on ARRS appointed activity had been fully established and was issued at the end of each month to the ICB Finance team and Primary Care workforce team for monitoring. The report was broken down by appointed delivery methods, DNA links, practice, and PCNs. A new tab had been created on the old monthly financial allocations spend, which provided value for money metrics against all ARRS roles, calculated based on appointment delivery, DNA attendance, and PCN. This report was produced monthly by the ICB Finance team and issued internally for noting, and JR proposed that this action be closed. HW confirmed that item 211 was closed and, after an update on a query from the last meeting, item 212 was closed No further comments were raised, and the updates were noted.	SW

5.	<b>Forward Planner</b> <i>For Noting</i>	SP
	<p>SP presented the forward planner for noting and explained the items on the agenda were as expected for the month except for two items highlighted in red. SP clarified these exceptions were due to scheduling issues with delivery groups, as the relevant meetings had not taken place during the period.</p> <p>The report was duly noted.</p>	
6.	<b>Risk Register</b> <i>For Approval</i>	SP
	<p>SP presented the risk register for approval and reported no new risks had been escalated, no changes had been made to held risks, with no de-escalations at this stage.</p> <p>SP mentioned a recent deep dive into workforce risks and ongoing work on revisions, which had been delayed due to work pressures from procurements and contract requirements, the plan was to bring updates to the January Committee meeting.</p> <p>SP also noted that primary care risks would be discussed with the Board through the Board report, which would support their ongoing work.</p> <p>HW raised a query about the risk score for general dentistry resilience in Norfolk and Waveney, noted inconsistency between reports which showed scores of 16 and 20, and emphasised the importance of clarifying this before the next Board meeting.</p> <p>SP responded that the score had initially been rated high when delegated commissioning assumed responsibility, reflected contract challenges, but had been reduced following successful workforce schemes and flexible commissioning guidance. SP would investigate exactly when the change occurred and apologised for any inconsistency. HW suggested a follow-up discussion to clarify the matter.</p> <p>SN commented on the workforce deep dive, which highlighted a robust system initiative, maximised additional roles, improvements in access and patient experience, and noted that there were more job seekers than vacancies. SN also mentioned concerns raised about the quality of annual health checks for learning disabilities (PC 06) in a recent quality oversight meeting, stating that further details were being sought, but expressed confidence in the quality assurance workforce and the health improvement team's work with practices.</p> <p>HW concluded that the Committee approved the risk register.</p> <p><b>Action</b></p> <p><b>Clarify and Align Risk Score for General Dentistry (Norfolk and Waveney): SP to investigate and confirm the correct risk score for the resilience of general dentistry in Norfolk and Waveney, addressing inconsistencies between reports (score shown as 16 in the committee report, but previously reported as 20 to the board). SP and HW to discuss and ensure consistency in reporting before the next board meeting.</b></p>	SP

Webb, Sarah  
07/01/2026 14:48:21

7.	<p><b>Director of Primary Care Report, including a Primary Care Operational Plan Update</b> <i>For Noting</i></p>	
	<p>SP presented a comprehensive update which highlighted both current and future work of the Directorate. SP credited AS for drafting much of the report and noted the inclusion of an appendix which detailed the operational planning underway, particularly the commissioning intentions developed jointly with Suffolk colleagues as part of a joint strategy.</p> <p>SP emphasised the rapid pace required for this work, which was scheduled to be presented to the Board in due course. SP described collaborative efforts with Suffolk, participation in NHS England’s commissioning and transformation support programme, and the focus on future strategic commissioning roles, especially in primary care.</p> <p>The team actively managed risks, ongoing procurements, winter vaccination campaigns, and general winter readiness, as well as supporting practices in implementing new contractual requirements from October 2025.</p> <p>SP discussed plans to support general practice in adapting to neighbourhood changes, noting that neighbourhoods would encompass all primary care providers and stressed the importance of positioning commissioners and providers to meet local health needs.</p> <p>SP also mentioned the national review of the Carr-Hill formula for GP practice funding, which was outdated and not reflective of current communities, and stated the team was closely monitoring this development. SP invited Committee members to request more detailed updates on specific areas, and HW responded that more granularity around neighbourhood health would be valuable once further guidance and work were available.</p> <p>No further questions or comments were raised – the report was duly noted.</p>	
8.	<p><b>Strategic Estates Report</b> <i>For Noting</i></p>	PH
	<p>PH presented the Strategic Estates Report for noting. PH summarised the progress and successes noting four out of seven schemes were on track to be completed by end of March 2026, which exceeded initial expectations. PH explained the schemes had been RAG rated, with the two largest—Lawson Road and Magdalen Medical Practice remaining incomplete for various reasons.</p> <p>Magdalen Medical Practice had received full sign-off from the ICB and NHS England, but the grant agreement was still pending due to paperwork required from the practice, meaning completion within the financial year unlikely and necessitating a spread across two years.</p> <p>Lawson Road was rated red, as it had not yet been approved by the ICB due to value for money concerns and rental increases; PH and team planned to meet with the landlord to address these issues scheduled end of November 2025.</p> <p>Regarding Magna Medical Centre, PH reported that a practical completion inspection had occurred, but the building did not pass due to minor snags, with a re-inspection scheduled for Monday 24<sup>th</sup> November 2025. Norfolk</p>	

	<p>Community Health and Care planned to move in during early December 2025, while the practice would follow after Christmas or in February 2026, with bookable space available for NHS Trusts.</p> <p>PH also flagged ongoing challenges in accessing funding via the Greater Norwich local plan and a paper would be presented to the ICB Executive for a decision on this.</p> <p>PH spotlighted three community infrastructure funding schemes—Bungay Medical Practice, Beccles, and Cutlers Hill in Halesworth—totalling £6.5 million in capital investment, with work started at Bungay, Cutlers Hill expected to begin after tendering, and Beccles receiving a £4.2 million extension approved by Suffolk Council, pending NHS approvals and planning permission.</p> <p>PH noted that the Beccles award was among the largest in the country for Section 106 funding.</p> <p>Committee members, including SP and KW, expressed appreciation for the estates team’s work, highlighting the importance of new facilities for future primary care and recruitment.</p> <p>HW stated he would share these successes with the Board. The report was duly noted.</p>	
<p><b>9.</b></p>	<p><b>Delivery Group Reports</b></p> <ul style="list-style-type: none"> <li>• <b>Dental Services Report</b></li> </ul> <p><i>For Noting</i></p>	<p><b>FT</b></p>
	<p>FT presented the Delivery Group Report for Dental Services for noting. FT stated the October meeting was held correctly, with no declarations of interest identified for the session. The group reviewed several items for discussion, the focus on operational and strategic aspects of dental service delivery.</p> <p>Three specific items were formally approved by the delivery group, and the details of these approvals were documented in the report provided to the Committee. FT emphasised the report contained comprehensive information about the decisions and discussions held and made herself available to address any questions from Committee members.</p> <p>No questions were raised by Committee members, and the report was duly noted.</p>	
<p><b>10.</b></p>	<p><b>Reports from the Pharmaceutical Services Regulations Committee</b></p> <ul style="list-style-type: none"> <li>• <b>Reports from the Pharmaceutical Services Regulations Committee</b></li> <li>• <b>General Ophthalmic Services Quarter End Update report</b></li> </ul> <p><i>For Noting</i></p>	<p><b>SG</b></p>
	<p>GS presented the Reports from the Pharmaceutical Services Regulations Committee (PSRC). GS clarified the agenda included two separate reports for noting purposes only.</p> <p>The first report detailed the activities of the PSRC, hosted by the pharmacy and optometry contracting team at Hertfordshire and West Essex. The</p>	

Webb, Sarah  
07/01/2026 14:56:21

	<p>second report provided a quarter-end update on General Ophthalmic Services (GOS), also managed by the same team.</p> <p>The GOS report outlined any new contracts, contract amendments, and contractual actions taken under the GOS contract during the reporting period. GS emphasised that, although both reports were included together on the agenda, the GOS report was a separate entity from the PSRC report.</p> <p>GS offered to answer any questions but indicated that the reports were comprehensive and intended for information only.</p> <p>HW acknowledged the clarity of the reports, and no Committee members raised further questions. The reports were duly noted.</p>	
<b>11.</b>	<p><b>Strategic Finance Report</b> <i>For Noting</i></p>	<b>JG</b>
	<p>JG presented the Strategic Finance Report for Month 7 (M07) for noting. JG took the report as read and highlighted key financial outcomes for the Committee.</p> <p>JG reported the primary care prescribing directorate was forecast to underspend by £2m for the financial year, this figure comprised several material over- and underspends. Specifically, GP prescribing areas had underspent by £500k, attributed to planned efficiencies and additional benefits from CAT M and NCSO. Within the delegated and LCS cost centres, there was a £3m underspend due to procurement savings and in-year allocation benefits.</p> <p>The optometry and pharmacy area showed a £2.1m underspend, resulting from CPCF (community pharmacy contract framework) fair share allocation benefits. These underspends were offset by £3m of budgeted efficiencies now being achieved in the delegated primary care and pharmacy sub-directorates.</p> <p>JG also noted a new cost pressure of £1m related to GPIT stranded costs, accrued due to the upcoming end of the AGEM GPIT contract in February 2026. JG referenced the breakdown of prescribing efficiencies and the update on LCS claims included in the report.</p> <p>HW requested that a more qualitative and holistic update on the LCS activity tracker be brought to a future Committee, which included insights into what was working well and areas that needed attention and HW suggested collaboration with SP to determine timing.</p> <p>JG agreed to this request.</p> <p><b>Action</b> JG to provide a more qualitative and holistic update on the LCS activity tracker be brought to a future Committee</p> <p>The Committee found the report clear, and HW noted the positive underspend against budget, with no further questions raised the report was duly noted</p>	<b>JG</b>
<b>12.</b>	<p><b>Any Other Business</b></p>	<b>Chair</b>

	There was no other business.	
	<b>Questions from the Public</b>	<b>Chair</b>
	There were no questions from the public, and the meeting closed at 16:30 hours.	

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

Webb, Sarah  
07/01/2026 14:56:21

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 January 2026

No	Meeting date added	Agenda Item	Owner	Action Required	Action Undertaken / Progress	Due date	Status	Date Closed
0204	08 July 2025	7	JR	Strategic Primary Care Workforce Recruitment and Retention Programme Report A strategic workforce view on pharmacy would be brought to a future Primary Care Commissioning Committee meeting (PCCC).	This will be done as part of the next workforce update in January 2026. JR confirmed this is in January 2025 update. Action can be closed.	14-Jan-26	Closed	24-Dec-25
0206	08 July 2025	7	JR	Strategic Primary Care Workforce Recruitment and Retention Programme Report BC to provide a geographical update on workforce programme uptake at the next meeting.	This detail will be provided as part of the Strategic Primary Care & Workforce Recruitment and Retention Programme Report using geographical visualisation mapping tools. The next report will be featured on the 14th January 2026. JR confirmed this is in January 2025 update. Action can be closed.	14-Jan-26	Closed	24-Dec-25
0213	19 November 2025	4	SW	Minutes Send signed minutes to the Chair for safekeeping.	SW sent signed minutes to Chair.	19-Nov-25	Closed	08-Dec-25
0214	19 November 2025	6	SP	Risk Register Clarify and Align Risk Score for General Dentistry (Norfolk and Waveney): SP to investigate and confirm the correct risk score for the resilience of general dentistry in Norfolk and Waveney, addressing inconsistencies between reports (score shown as 16 in the committee report, but previously reported as 20 to the board). SP and HW to discuss and ensure consistency in reporting before the next board meeting.	The score has been confirmed as 16 (there was an error in the Board report which was highlighted to Board members at the meeting). The risk is being reviewed as per previous discussions and will be re-scored before being brought to PCCC for approval. Suggest to close this action.	19-Nov-25	In progress	
0215	19 November 2025	11	JG	Strategic Finance Update HW requested that a more qualitative and holistic update on the LCS activity tracker be brought to a future Committee, which included insights into what was working well and areas that needed attention and HW suggested collaboration with SP to determine timing.		11-Mar-26		

Webb Sarah  
07/01/2026 14:56:21

NWICB Primary Care Commissioning Committee Part One 2025-2026

Item	14-May-25	08-Jul-25	01-Oct-25	19-Nov-25	14-Jan-26	11-Mar-26	Lead officer	Notes
<b>Standing Items</b>								
Risk Register	Y	Y	Y	Y	Y	Y	SP/SN/AS	
<b>Service Development</b>								
Director of Primary Care Report			Y	Y	Y	Y	AS	Standing item
Primary care operational plan report			Y	Y	Y	Y	AS	Standing item update on Operational Plan
Strategic Estates Report	Y			Y			PH	Noting/assurance - bi-annual report
Strategic Digital Report			Y			Y	AH	Noting/assurance - bi-annual report
Strategic Primary Care & Workforce Recruitment and Retention Programme Report		Y			Y		JRo	Bi-annual report Pharmacy to be included - January 2026
Pharmaceutical Needs Assessment							SG	TBC once local authorities confirm timelines
Locally Enhanced Services			Y			Y	GC/SN	bi-annual report. No changes of significance to report in October - report to March 2026.
GP Action Plan				N	Y	Y	SN	Added onto forward plan
Complaints & Patient Experience								TBC
<b>Finance and Governance</b>								
Strategic Finance Report	Y	Y	Y	Y	Y	Y	JG	Noting/assurance
Strategic Prescribing Report	Y		Y		Y		MD	Noting/assurance quarterly
General Practice & Community Pharmacy Delivery Group Report	Y	Y	Y	Y	Y	Y	SN/SG	Noting/assurance
Dental Services Delivery Group Report	Y	Y	Y	Y	Y	Y	FT	
Dental Development Group Report		Y	Y	Y	Y	Y	FT	Noting/assurance
Terms of Reference Review						Y	FT	Annual review
Reports from the Pharmaceutical Services Regulations Committee	Y		Y	Y	N	Y	SG	Noting/assurance. (1/4ly reporting)
Optometry Services – contractual changes and other matters						Y	SG	Noting/assurance
Freedom to Speak Up							PS	TBC
TIAA Report		Y					SG	
Strategic Framework for Primary Care		Y			Y		AS	
<b>Any Other business</b>								
Policies for review								Committee are responsible for the oversight of these when relevant

Webb Sarah  
07/01/2026 14:56:21

**Item 06**

<b>Subject:</b>	Risk Summary Report
<b>Presented by:</b>	Sadie Parker, Director of Primary Care
<b>Prepared by:</b>	Amanda Sear, Head of Primary Care Strategic Planning and Shepherd Ncube, Associate Director of Primary Care Commissioning
<b>Submitted to:</b>	Primary Care Commissioning Committee
<b>Date:</b>	14 January 2026

**Purpose of Paper:**

The purpose of this paper is to provide the committee with an update on the current position on risk management in primary care, and to outline the progress made in reviewing current risk, and our approach to risk assessment and management since the last meeting in November 2025.

**Executive Summary:**

**New risks identified and escalated:** No new risks have been identified for escalation since the last meeting, however following review of risks through deep dive meetings, a combined and revised dental risk is presented for approval.

**Changes to held risks:**

Workforce Risk: risks 54 and 55 were reviewed as part of the team’s deep dive review. Significant progress had been made in improving the workforce risks and the review panel felt that the initial risk had significantly reduced for clinical roles and recommended a further review of the risks and reduction in risk scores for the workforce team. A further review was completed and recommendations to close these risks were made to the Delivery Group meeting in December 2025. This proposal was approved subject to ratification by PCCC in January 2026.

**Risks de-escalated:**

Workforce risks had been de-escalated via the Delivery Group meeting held in December 2025 subject to ratification by PCCC in January 2026.

**Key highlights since the last meeting:**

- **Workforce Risks:** A deep dive review of workforce risks was completed, and the risk level was approved by the Delivery Group, subject to final approval by PCCC in January 2026. Please see the separate workforce paper for the rationale and recommendations.
- **Dental Risk:** A draft proposal to reframe the dental risk was presented and supported by the Dental Delivery Group in December 2025. It was agreed that a paper seeking

Webb, Sarah  
 07/01/2026 14:56:21

approval will be presented to PCCC in January 2026, following a deep dive review and recommendation to focus on improving patient access, treatment, and experience.

- **SMI Risk:** The final deep dive review of the SMI risk is scheduled for 12 January 2026, and a verbal update will be provided at the Committee meeting.
- **Community Pharmacy Resilience (InPhase 56 / BORR27):** Further discussions have taken place within the commissioning team, and a deep dive review of the community pharmacy resilience risk is scheduled for 19 January 2026.

## Background and context to service risks

In Quarter 1, the Audit and Risk Committee (ARC) asked for greater assurance on how committees review and manage their risks. To support this, a timetable was agreed to carry out detailed reviews (“deep dives”) of all risks on the register. These reviews will test whether risks are scored appropriately, whether actions in place are sufficient, and whether any gaps in managing risks are being identified and addressed.

## Progress Made so far

Work continues to strengthen oversight of the risk register and ensuring that risks are actively discussed, regularly reviewed, and supported towards resolution and improvement continues.

### Workforce

- Recruitment success rate across general practice roles reached 97% (plan vs. trajectory).
- Reductions in medical locum and GP retainer vacancies, with an increasing number of medical staff seeking salaried positions, supporting system-wide workforce stability.
- National workforce data indicates positive trends, with the system ranked 3rd nationally and 1st across the East of England.
- The ICS Training Hub’s continuation until 31 March 2027 reinforces retention and operational support mechanisms.
- The Primary Care Workforce Team will continue monitoring workforce trajectories and planning cycles to maintain and strengthen workforce stability.

### Resilience in general Practice

Work to review and reframe the general practice resilience risk is ongoing and will be presented to the March Committee meeting for approval.

## Recommendation to Committee:

Committee members are invited to:

- Approve the risk register, including the proposed revised dental risk, and the closure of the workforce risks 54 and 55 at committee level and transfer to standard monitoring (please see the separate workforce paper later on the agenda).
- Note the ongoing work to improve and strengthen our approaches to risk management, including ensuring that risks are regularly reviewed, appropriately scored, and that mitigating actions are in place.

Webb Sarah  
07/01/2026 14:56:21

## Governance

Delivery Group Approval	
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Webb, Sarah  
07/01/2026 14:56:21

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

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

Webb Sarah  
07/01/2026 14:56:21

## 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

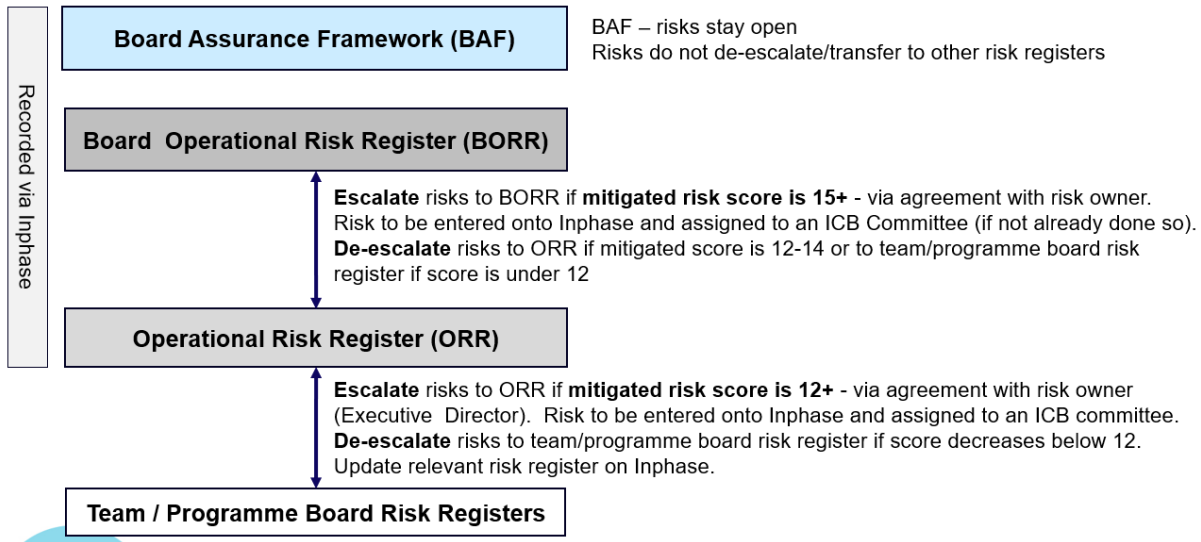
### BAF, BORR and ORR Risks are:

- 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.

Webb Sarah  
07/01/2026 14:56:21



Webb Sarah  
07/01/2026 14:56:21

Agenda item: 06

<b>Subject:</b>	<b>Risk Register – Dentistry</b>
<b>Presented by:</b>	<b>Fiona Theadom, Head of Primary Care Commissioning (Dental and GP)</b>
<b>Prepared by:</b>	<b>Fiona Theadom, Head of Primary Care Commissioning (Dental and GP)</b>
<b>Submitted to:</b>	<b>Primary Care Commissioning Committee</b>
<b>Date:</b>	<b>14 January 2026</b>

**Purpose of paper:**

To consider proposed changes to the risks for dental services consolidating three dental risks into one overall risk for dentistry.

**Executive Summary:**

The ICB currently has three dental risks, two fall under the responsibility of the Primary Care Commissioning Committee as the risk ratings are 16, and one is an operational risk managed at Dental Services Delivery Group meetings with a risk rating of 12. The three risks relate to general dental services, secondary care and community dental services respectively.

The team has recently undertaken a deep dive into the primary care risks and has concluded that they should be reframed to shift the focus from provider resilience to patient access, health inequalities and population health. This is in line with the proposed shift for all primary care risks and aligning with the 10 year Neighbourhood Health plan.

It was also agreed there should be a shift from detailed, tick-box action plans to more strategic, system-level actions in addressing major systemic issues like dental service provision.

This paper proposes a single new risk based on the proposed shift for approval by Committee. A draft consolidated risk for dentistry was shared with members of the Dental Services Delivery Group in December 2025 for feedback and it was recommended that success measures should be described although this does not currently fit with the Inphase reporting format.

Webb, S  
07/01/2026 14:56:21

## Report

Under the Delegation Agreement with NHS England, the ICB Primary Care team is responsible for commissioning primary care, community care and secondary care dental services, and whilst each of them has their individual challenges and risks, there are overarching risks that impact across all dental services.

The ICB currently has three dental risks, two of which fall under the responsibility of the Primary Care Commissioning Committee as the risk ratings are 16, and one is an operational risk managed at Dental Services Delivery Group meetings with a risk rating of 12. The three risks relate to general dental services, secondary care and community dental services.

The team has recently undertaken a deep dive into the dentistry risks and has concluded that they should be reframed to shift the focus from provider resilience to patient access, health inequalities and population health. This is in line with the proposed shift for other primary care risks and aligning with the NHS 10-year plan.

It was also agreed there should be a shift from detailed, tick-box action plans to more strategic, system-level actions in addressing major systemic issues like dental service provision. In considering why there is a risk for dental services within the ICB, it is helpful to reflect on the definition of oral health.

Oral health is defined as 'a standard of health of the oral and related tissues, which enables an individual to eat, speak and socialise without active disease or embarrassment and which contributes to general wellbeing'. Good mouth care is more than dental care or the absence of oral disease.

Evidence shows that hospitalisation is associated with deterioration in oral health. In turn this has been linked to: poor mouth care leading to limited eating and drinking, resulting in malnutrition and dehydration, affecting recovery and can delay discharge from hospital, increasing care costs.

## Proposed Changes

A proposed single new risk is attached as Appendix A.

It is proposed that risks should be considered in terms of patient and community impact, particularly regarding access and health inequalities. The key factors contributing to a lack of access in dental services include workforce recruitment and retention and concerns around the national contract with dental practices being able to opt to go private, impacting NHS provision and exacerbating inequalities.

It is important the risk assessment is supported by data and is evidence based, for example, annual epidemiology survey outcomes, complaints data, number of practices accepting new patients and utilisation of unscheduled care appointments as sources of intelligence.

Webb  
07/01/2025 14:56:21

It is hoped by consolidating multiple dental risks into a single, patient- and system-focused risk, this reduces the reporting burden and better reflects the interconnectedness of primary, secondary, and special care dental services.

Health inequalities should also be explicitly addressed in the risk descriptions so that neighbourhood level decision making can be influenced and enable providers to also understand their responsibilities for reducing health inequalities.

### **Risk Scoring and Mitigation Strategies**

The team re-examined the rationale behind current risk scores for dental services, discussing what would be required to reduce these scores, and considered the impact of workforce shortages, contract reform, and long-term planning. It is felt that the high score is still justified due to the significant impact of poor oral health on broader health outcomes and the current fragility of dental service provision.

The risk is also long term in nature and therefore it is suggested that target delivery is aligned with the end of the ICB's Long Term Dental Plan in March 2029 as significant improvements are unlikely to be achieved within one or two years.

It is likely that the criteria for reducing risk scores include a reduction in complaints, increased urgent treatment activity, successful commissioning and delivery of additional activity, and the reinvestment of underperformance funds would be necessary to justify lowering the risk score. These outcomes are aligned with delivering the ICB's Commissioning Intentions from April 2026 and the Medium Term Plans.

### **Measuring success**

The risk remains long term and therefore a reduction in risk score may not be achievable within the timeframe of the ICB's Long Term Dental Plan to 2029 however it is proposed that measuring success is aligned with the ICBs' Commissioning Intentions and Medium Term Plans for next three years:

- reduced underperformance levels (Operational Planning target 2026/27 – 2028/29)
- increased use of full dental budget
- reduction in number of dental practices terminating their NHS contracts each year
- increase in workforce numbers (achieved 2025/26) through successful recruitment and retention
- reduction in number of complaints and concerns relating to access to oral health care or urgent dental care
- increase in number of new patients being seen by NHS dental practices (Operational Planning target 2026/27 – 2028/29)

Webb, Sarah  
07/01/2026 14:56:21

- reduction in extractions under general anaesthetic for children (Core20plus5 ambition)
- reduced need for urgent dental care appointments (utilisation rates).

### Next steps

The format shown in Appendix A is aligned with the InPhase reporting format and ICB Risk Management Framework. If the proposed new risk is approved, InPhase will be updated to remove the current risks and replace with the new risk.

It is likely that during 2026/2027, a consolidated risk with Suffolk will be developed for approval under the governance arrangements from April 2026.

### Recommendation to the Committee:

To approve the new risk for NHS dental services.

Key Risks	
<b>Clinical and Quality:</b>	Managing risks effectively will help to drive up improvements in oral health and clinical quality.
<b>Finance and Performance:</b>	Not applicable
<b>Impact Assessment (environmental and equalities):</b>	Without a good understanding of the risks linked to a lack of oral health services, it is not possible for the ICB to address health inequalities and address unwarranted variation in access to services.
<b>Reputation:</b>	Managing risks effectively helps to ensure the ICB's reputation is not negatively impacted and issues can be escalated for early resolution, where possible
<b>Legal:</b>	Not applicable
<b>Information Governance:</b>	Not applicable
<b>Resource Required:</b>	Primary Care Commissioning
<b>Reference document(s):</b>	TIAA Audits for primary care services, ICB Risk Policy
<b>NHS Constitution:</b>	N/A
<b>Conflicts of Interest:</b>	None identified
<b>Reference to relevant risk on the Board Assurance Framework</b>	BAF02

Webb Sarah  
07/01/2026 14:56:21

## Resilience of NHS Dental Services in Norfolk and Waveney

<b>Unmitigated risk score</b>	<b>20</b>	Likelihood 5 Consequence 4
<b>Mitigated risk score</b>	<b>16</b>	Likelihood 4 Consequence 4
<b>Target risk score</b>	<b>12</b>	Likelihood 3 Consequence 4

### Description

There is a risk that provision of NHS oral health services will not meet population need due to the critical challenges relating to the recruitment and retention of clinical and non-clinical staff and the limitations of the national dental contract in attracting clinicians to work in the NHS and in Norfolk and Waveney. Poor oral health also leads to poor physical and mental health wellbeing. This risk is further heightened for Core20Plus groups in not being able to access oral health services.

Dental providers could cease to offer access to NHS oral health services leading to reduced access to NHS services for our local population and unwarranted variation in access to services. This will result in increased demand on secondary care services, including emergency departments, those waiting for complex medical treatment and waiting times for complex restorative dental treatment, and lead to poorer health outcomes for the local population and widening existing health inequalities.

### Risk scores

Scores have been derived with referencing the ICB's Risk Management Framework.

The likelihood of NHS dental services failing (or terminating contracts to switch to private provision) is high. Some of the factors influencing this remain outside of the ICB's control, e.g. contract reform, long term workforce planning at national level and increasing business costs. Some mitigation measures are happening, such as the contract reform changes being introduced from April 2026 although it is too early to determine whether these will have a positive or negative effect.

The mitigating actions which the ICB itself is able to put in place are directly linked to the continuation of the dental ring fenced budget (recently confirmed until April 2029) and having robust workforce plans that are fully integrated with and underpin the ICB's commissioning intentions. Robust contract management to ensure effective use of public monies and reinvestment where need is determined.

Taking account of the mitigating actions, the team have therefore assessed the likelihood as high and the consequences as high resulting in a current risk score of 16. Long term, it is realistic to expect some level of risk and therefore the target is set at 12.

## Controls

Ring fenced dental budget for the period April 2026 – March 2028

ICB Long Term Dental Plan 2024 – 2029 approved May 2024 (*Norfolk and Suffolk ICB to develop long term plan for merged ICB from April 2026*)

Primary Care Commissioning Committee and Dental Services Delivery Group assurance and oversight of commissioning decisions and contractual matters under the Delegation Agreement

Clinical expertise informing commissioning plans and pathway development

Evidence based, data driven commissioning supported by the Consultant in Dental Public Health

Active engagement with local clinicians, the Local Dental Committees, ICB Dental Development Group, Clinical Fellows, Regional Chief Dental Office and Managed Clinical Network Chairs to deliver a collaborative approach to commissioning. ICB Long Term Dental Plan 2024 – 2029 in conjunction with an annual integrated workforce recruitment and retention plan

Integrated partnership working between Primary Care Workforce and Primary Care Commissioning teams to ensure workforce schemes align with commissioning intentions to deliver a sustainable and effective workforce plan

Active engagement with key stakeholders through MP and local councillor briefings and HOSC to raise awareness of the challenges and risks in delivering ICB commissioning plans for oral health services.

Public and patient survey completed February 2024

## Mitigation actions

Using data and evidence based commissioning to direct services where they are most needed (“everyone needs something, some people need more”).

Embed a responsibility to reduce health inequalities when developing all commissioning plans, new services and pathways

Embed a shared responsibility into dental contracts to support commissioning aims to reduce health inequalities

Understanding population health data and oral health needs to inform commissioning intentions in line with the NHS Strategic Commissioning Framework and to support the shift to neighbourhood health

Development and implementation of a workforce recruitment and retention plan for both clinical and non-clinical roles that directly and indirectly integrates with commissioning plans to improve access to NHS dental services for N&W population

Webb, Sarah  
07/01/2025 11:58:21

Assessing the risk of providers with multiple contracts (> 70% of dental contracts held by providers with multiple contracts), establishing regular meetings with providers to mitigate risk of unplanned changes to service delivery

Developing contingency plans for planned and unplanned loss of NHS services  
Proactive monitoring of contracts and strengthening relationships between all local providers (primary, community and secondary care) to maintain service continuity

Development of an integrated approach to commissioning across all dental services and utilising flexible commissioning where appropriate

National contract reform from April 2026.

Webb, Sarah  
07/01/2026 14:56:21

Risk ID	Risk Title	Risk Description	Risk Owner	Risk Committee	Operational Lead	Risk Identified	Target Date	Unmitigated score	Mitigated Score	Target Score	Controls	Action	Action Owner	Start Date	Due Date
23	The resilience of general practice	<ul style="list-style-type: none"> <li>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).</li> <li>There is also evidence of increasing poor behaviour from patients towards practice staff, leading to retention and recruitment issues.</li> <li>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.</li> <li>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.</li> <li>The LMC wrote to practices to cease uncommissioned work. Further communications are likely.</li> <li>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.</li> <li>This will have a wider impact as neighbouring practices and other health service partners take on additional workload which in turn affects their resilience.</li> <li>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.</li> </ul>	Mark Burgis	Primary Care Commissioning Committee	Amanda Sear	01 Sep2020	31 Mar 2026	20	16	12	<ul style="list-style-type: none"> <li>Commencement of LMC General Practice Alert System sitreps</li> <li>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.</li> <li>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.</li> <li>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.</li> <li>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</li> <li>Contractual requirement for commissioners to have a 3 year rolling programme to review service quality and contractual compliance for the agreed medical services contracts.</li> <li>Local interface groups have been established and commenced in an informal capacity from May 25. The system leads continue to meet quarterly. This aims to support the resilience of practice by establishing firm engagement with all provider leads.</li> </ul>				

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07/01/2026 14:56:21

25	Resilience of NHS General Dental Services in Norfolk and Waveney	There is a risk that access to NHS dental services will not meet population need due to the critical challenges relating to the recruitment and retention of dentists and dental care professionals and the limitations of the national dental contract in attracting clinicians to work in the NHS and in Norfolk and Waveney. This could lead to dental providers ceasing to offer NHS general dental services and Level 2 services leading to reduced access to NHS services for our local population. This will result in increased demand on secondary care services, including emergency departments and waiting times for complex treatment and poorer poor oral health outcomes for the local population.	Mark Burgis	Primary Care Commissioning Committee	Sadie Parker	01 Apr 2023	28 Mar 2028	16	12	12	Clinical expertise provided by NHSE through the Regional Chief Dental Officers, MCN supported by ICB Senior Clinical Fellow roles during 2024/2025 for strategic development, transformation and commissioning purposes.	To tender for Out of Hours service in King's Lynn 12/6/2025 - interim solution being explored to start Sept 2025 31/7/2025: Tender published for new contract from December 2025. Interim solution being offered by CDS from Sept 2025 21/08/2025: no updates whilst tender live 14/10/2025: new provider successfully appointed. Mobilisation phase to start services Dec 2025 23/12/2025: contract award confirmed, start date to be agreed	Fiona Theadom	17 Apr 2025	31 Jan 2026
											Ring fenced dental budget for investment	16/4/2025: tender published for new contract in Holt and Wells 31/7/2025: tender stopped to undertake service review. To publish new tender in August 2025 21/08/2025: Invitation to Tender documents being finalised for publishing in Sept 2025 14/10/2025: Tender active 05/11/2025: Tender moderation underway 23/12/2025: contract award agreed, subject to standstill period from 19/12/2025	Fiona Theadom	20 Feb 2025	31 Mar 2026
											Dental Development Group established to engage with key stakeholders to to commissioning plans, including the Long Term Dental Plan.	31/7/2025: ICB developing criteria to apply framework to determine eligibility for a targeted UDA uplift to support workforce recruitment and retention. Supported by Consultant in Dental Public Health team. To present to Primary Care Committee in Oct 2025. 15/09/2025: Framework agreed, to apply by end Nov 2025 14/10/2025: panel being arranged to review framework and apply to contracts, subject to approval. 10/11/2025: panel meeting 7/11/2025, to present recommendations to Delivery Group in Dec 2025. 23/12/2025: assessment process reviewed and updated. To present recommendations to PCCC Jan 2026	Fiona Theadom	02 Jun 2025	31 Jan 2026
											Dental Services Delivery Group established reporting to PCCC	31/7/2025: To review national checklist and trajectory by end August 2025, agree action plan. 21/08/2025: Data from NHS 111, GP Front Door, OOH and ED with a dental disposition received to review. Monthly reporting template updated to request utilisation data from 1/9/25. Review target trajectory vs delivery monthly and report to NHSE 15/09/2025: monthly monitoring and scrutiny continues. Communications and Engagement plan agreed, to finalise timeline. To review NHS 111 pathway. 10/11/2025: new national scheme launched Oct 2025 - 28 N&W providers accepted offer to meet target by end Mar 2026 in addition to locally commissioned service. Communications plan active. 23/12/2025: contract reform from April 2026 to introduce mandatory urgent care slots	Fiona Theadom	21 Jul 2025	31 Mar 2026
											Active engagement is taking place with dental contractors, LDC and Local Professional Network (and Managed Clinical Networks); A regular dental newsletter is in place	ICB primary care team recruited and in place working alongside newly recruited Quality Dental Nurse in Quality team and Finance colleagues, and Planned Care Team (for secondary care dental services)			

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07/01/2026 14:56:21



29	Secondary care dental services (Oral Surgery and Maxillo Facial Services, Orthodontic Services)	The risk for secondary care dental services is the unknown resilience, stability and quality of secondary care dental services, with critical challenges relating to the recruitment and retention of professionals and waiting lists. There is a risk associated with a lack of resources within the ICB Primary care team to implement the recommendations from the East of England NHSE report and to regularly monitor and manage 3 secondary care contracts.	Mark Burgis	Primary Care Commissioning Committee	Sadie Parker	01 Feb 2024	31 Mar 2026	20	16	12	Active engagement with dental contractors, secondary care, LDC and Local Professional Network (and Managed Clinical Networks), regular dental newsletter in place	31/7/2025: ICBs have developed a Standard Operating Procedure for all trauma providers to comply with and contract variation to be signed. Plan for ICBs to go through governance processes Q3 2025/26 for service continuation decision from April 2026 21/08/2025: work underway to reaccredit existing performers and finalise SOP/Clinical guidance 15/09/2025: Clinical advisory group established reporting to the ICB Steering Group to complete clinical guidance and SOP and other related tasks by 15/10/25 to inform commissioning plans 14/10/2025: work continues to finalise clinical specification and SOP 23/12/2025: approval for service to continue for 6 months + 6 months from April 2026 aligned to SNEE and MSE ICB position to agree service improvements and long term future of service	Fiona Theadom	01 Apr 2025	31 Mar 2026
											Clinical expertise provided by NHSE through the Regional Chief Dental Officers and Managed Clinical Networks extended for 2024/2025 for strategic development, transformation and commissioning purposes.	Shared Cared pathway under development by ICB. 02/20/2025 service specification finalised. Small number of providers (3 - 4) selected to participate. Working with NHSE WTE to agree training for provider dental teams. Considering options for referral pathway from secondary care to provider. 20/03/2025 Options for referral pathway discussed with Digital team 12/6/2025: delay in finding solution to referral pathway, approval for interim solution being sought. Training for providers being planned. 31/7/2025: Interim solution for referrals from secondary care to primary care agreed with increase in sessions for clinical advisor to end Oct 2025. To mobilise service start in early August. 15/9/2025: service started Aug 2025 supported by clinical advisor. Interim solution in place to manage referrals	Sadie Parker	01 May 2024	31 Mar 2027
											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	31/7/2025: Solution for referrals from secondary care to primary care by end Oct 2025 continue to be explored. There is a risk no value for money solution found in time. Update 21/08/2025 - interim solution in place to end Oct. 15/09/2025: options being explored 14/10/2025: interim solution extended to end March 2026 23/12/2025: no permanent solution yet found	Fiona Theadom	01 Jul 2025	31 Mar 2026
											Dental Development Group established to engage with key stakeholders to input to commissioning plans	Baseline data requested from 3 secondary care providers, received from NNUH 04/03/2025 and JPUH 12/6/25. QEH data response chased. Unable to review data until all three reports received. Update 21/8/2025: situation updates received from all three providers for ICB to review 14/10/2025: data review delayed due to lack of capacity within the primary care dental team.	Fiona Theadom	20 Feb 2025	30 Nov 2025

Webb, Sarah  
07/01/2026 14:56:21



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. Our high-level outputs include:</p> <ul style="list-style-type: none"> <li>Developing a vision for providing accessible enhanced primary care services</li> <li>Improving patient outcomes and experience</li> <li>Stabilise dental services and setting a strategic direction for the next five years</li> </ul> <p>Primary Care Services are the responsibility of the Integrated Care Board, including the recruitment and retention of healthcare professionals. There are particular risks to the resilience of general practice, access to NHS dentistry treatment and Level 2 dental services which are reflected in the risk scores. The community pharmacy and optometry landscape is less defined at the time of writing, but workforce and funding challenges are evident across community pharmacy which represent a risk, but could potentially be supported through greater integration and collaborative working with other primary care providers. Limitations of national contracts, collective action by General Practice, independent contractors 'handing back' NHS contracts, workload pressures, recruitment and retention and interface challenges are, together, impacting on access to high quality, sustainable primary medical, community pharmacy and dentistry services together with Level 2 dental services for our population. This may lead to delays in accessing care, unavailability of care (particularly dentistry), increased clinical harm because of delays in accessing services, failure to deliver the recovery of services adversely affected, and poor outcomes for patients due to pressured, and fragile services. As the cornerstone of healthcare, primary care resilience risks system ability to deliver against key workstreams, including the overall aim of moving towards a more population-based proactive community model of care which addresses prevention, health inequalities and improves outcomes. Reduced access in primary care may also impact on the resilience of other system providers.</p>	Mark Burgis	Primary Care Commissioning Committee	Amanda Sear	29 Aug 2024	31 Mar 2027	20	20	12	Operational readiness work is seeking to align the Primary Care Team with colleagues from Workforce, Estates, Digital, Place, Quality, Planned Care and Finance, etc. to support joined up primary care; including access to sustainable dentistry and general practice services.	10 June - all previous actions completed, risk to be reviewed and updated by end of August	Sadie Parker	28 Oct 2024	31 Aug 2025
											Clinical expertise provided by Clinical and Care Professional and Clinical Fellow roles across primary care.	20/03/2025 To obtain approval for Phase 2 Long Term Dental Plans 2025/2026 from Operational Management Board in April and Primary Care Commissioning Committee in May 30/05/2025 Dental investment and Year 2 commissioning plans approved by Primary Care Commissioning Committee and through Triple Lock in May 2025 10 June - all actions complete, update will be given and risk reviewed by end of August 23/12/2025: Good progress achieving delivery of LTDP Year 2 plans including workforce programmes. Some delays to delivery of programmes due to lack of capacity. To review and agree a joint plan with Suffolk by end March 2026	Sadie Parker	28 Oct 2024	31 Mar 2026
											Local LMC General Practice Alert System established which informs improvement and support work monitored through the PCCC.				
											A long-term dental plan has been published, with delivery monitored through PCCC.				
											ICB organisational change programme has seen a reduction in vacancies within the Primary Care Commissioning and Strategic teams.				
											Performance/quality management and reporting in place.				
											Primary Care Access Recovery Plan delivery reported regularly to ICB Board and NHS assurance meetings. 2024/25 plan has now been completed, many objectives transferred to GP Action Plan and Operational Planning submission for primary care - delivery being monitored through PCCC.				
											Ring-fenced budgets and commissioning targeted to simultaneously support population need and resilience.				
											An overarching strategic vision and principles for primary care and a strategic framework for primary care have been agreed by PCCC and are posted on Connect NoW and are included in the relevant meeting packs/notes				
											System Interface Group and matrix working in place to support national requirements for self-assessment.				
Strong relationships in place with local representative committees across all primary care services															

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07/01/2026 14:56:21

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 2024	31 Mar 2026	16	8	8	Advanced Practice Forum established.	Latest NHSE workforce data illustrates the following: • 2.0% decline in Direct Patient Care workforce roles across N&W during the period of October 2024 vs October 2025 (640 WTE). • 2.6% decline in non-clinical roles (1740 WTE)	Jayde Robinson	23 Dec 2025	31 Mar 2026
											AI software mapping and reports provided for vacancy levels for primary care.	As of 1st December 2025, there were following positions currently advertised within general practice: • 1 x Non Clinical • 2 x Direct Patient Care (GPA, HCA)	Jayde Robinson	23 Dec 2025	31 Mar 2026
											Coastal and Rural project to support geographical areas facing greater challenges in recruitment, e.g. West and East				
											Communication Engagement strategies updated to reflect PCN development updates and post pandemic environment.				
											Workforce data to measure trajectory levels against actual recruitment.				
											Workforce team recruited in ICB structure.				
											Wide range of initiatives in place to support GP retention.				
											National workforce reporting service - Practices report monthly, PCNs report quarterly, contractual requirement as part of General Medical Services (GMS) and PCN Directed Enhanced Services (DES).				
											PCN ARRS Workforce - online portal for 2024/25 for PCNs to update and draw national funding down to NHSE to inform Training Hub spending.				
											Primary Care Networks (PCNs) supported to develop and implement workforce trajectories in support of the Additional Roles Recruitment Scheme (ARRS).				
											Primary Care Equality, Diversity and Inclusion Fellow recruited.				
											Primary Care Health & Wellbeing Fellow recruited.				
											Primary Care Workforce Transformation Team supported by Clinical Fellowships and Secondments				
											Primary Care Workforce Strategy 2024-2027				
											Succession planning led recruitment to support practice and PCN with demand vs capacity requirements.				
Training Needs Analysis completed for 24/25.															

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07/01/2026 14:56:21

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 2024	31 Mar 2026	16	8	8	Advanced Practice Forum established.	Latest NHSE workforce data illustrates the following: • 1.8% decline in Nursing workforce roles across N&W during the period of October 24 vs October 25. 432 WTE are in place across the system. • 0.8% decline in GP workforce roles (excluding training GPs) during the same period. 528 WTE are in place across the system. • 2.6% growth in GP Trainees across N&W during the same period. 159 FTE are in place across the system. Norfolk and Waveney now ranked 3rd in the country for positive workforce variance. We are reporting 97% against planned recruitment vs. actual across the system	Jayde Robinson	23 Dec 2025	31 Mar 2026
											Al software mapping and reports provided for vacancy levels for primary care.	As of 1st December 2025, the following positions currently advertised for recruitment within general practice, linked to this risk are: • 2 x GP partner • 7 x GP salaried • 1 x Practice Nurse	Jayde Robinson	23 Dec 2025	31 Mar 2026
											Coastal and Rural project to support geographical areas facing greater challenges in recruitment, e.g. West and East				
											Communication Engagement strategies updated to reflect PCN development updates and post pandemic environment.				
											Workforce data to measure trajectory levels against actual recruitment.				
											Wide range of initiatives in place to support GP retention.				
											National workforce reporting service - Practices report monthly, PCNs report quarterly, contractual requirement as part of General Medical Services (GMS) and PCN Directed Enhanced Services (DES).				
											PCN ARRS Workforce - online portal for 2024/25 for PCNs to update and draw national funding down to NHSE to inform Training Hub spending.				
											Primary Care Equality, Diversity and Inclusion Fellow recruited.				
											Primary Care Health & Wellbeing Fellow recruited.				
											Primary Care Networks (PCNs) supported to develop and implement workforce trajectories in support of the Additional Roles Recruitment Scheme (ARRS).				
											Primary Care Workforce Transformation Team supported by Clinical Fellowships and Secondments				
											Primary Care Workforce Strategy 2024-2027				
											Succession planning led recruitment to support practice and PCN with demand vs capacity requirements.				
Training Needs Analysis completed for 24/25.															
Workforce team recruited in ICB structure.															

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07/01/2026 14:55:21

55	Severe Mental Illness (SMI) Annual Physical Health Checks	1. The ICB is at risk of failing to meet its commissioning commitment to meet the needs of its SMI population which leads to a clinical risk that patients with SMI will experience significant health inequalities and a 15-20% higher mortality when compared to their peers. 2. There is a risk that the ICB may not meet the committed national target of 75% annual health checks delivered. 3. There is a level of risk to practice resilience if the minimum threshold, and therefore payment, is not reached.	Mark Burgis	Primary Care Commissioning Committee	Sadie Parker	27 Dec2024	31 Mar 2026	16	9	4	A 2-year improvement trajectory has been agreed with NHS England taking into account the revised national target	Investigate and identify the cause of difference within the National data, and the ICB data. As of 02/10/2025, a potential cause has been identified. It appears that while both the N&W ICB and NHSE systems utilise opt-out data, the N&W ICB uses practice-level data, whereas national reports use the National Data Opt-Out. Because the National Data Opt-Out is pseudonymised, it is not possible to produce a fully accurate solution. N&W ICB has an opt-out rate of 5.3% based on national data; however, even after applying this rate we find that local figures remain different to the nationally produced data. Due to current operational pressures across the ICB, data teams do not currently have the capacity to investigate this issue further. We await the next available national data. Previous position: Initial discoveries have been made. Contact between NHSE and ICB colleagues ongoing. Action has been taken to reduce the difference (a change to the included codes to ensure alignment)	Charles Morrow	13 Aug 2025	11 Dec 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	13 Aug 2025	11 Sep 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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07/01/2026 14:56:21

56	The resilience of Community Pharmacy	The resilience of Community pharmacy is at risk due to several factors contained within this report, including workforce pressures which although workforce is led through a different directorate is incorporated within this risk due to its relevance The risk could ultimately lead to an increase in the number of permanent closures of pharmacies within our ICB which would reduce the accessibility of pharmacy services to our population. It could also lead to reduction to service provision including both core and advanced. The rurality of Norfolk and Waveney does mean that this risk is significantly projected due to geographical distance between existing providers.	Mark Burgis	Primary Care Commissioning Committee	Sharon Gardner	27 Dec2024	01 Sep 2027	20	16	12	Engagement with all stakeholders to support uptake in Pharmacy services including locality teams, CPNS and the LMC	Deep dive of the current referral information for Pharmacy first clinical pathways from external stakeholders such as GPs and NHS 111 to enable us to track trends and improvement. Lack of digital integration does encourage verbal signposting rather than electronic referral so the data may not provide an accurate local picture will give us a current baseline and trend	Sharon Gardner	19 Aug 2025	20 Aug 2025
											Establishment of Head of Pharmacy Workforce role within the ICB reporting into the Chief Pharmacist				
											Procurement of provider to manage a project focussing on the integration of community pharmacy with other healthcare providers, show case good practice, identify areas of improvement and facilitate better working relationships				
											MoU in place with HWE ICB for the delivery of contractual services on the behalf of the East of England. Ability through this team to monitor contractual activity including closures but also market entry applications.				
											Integration Lead Role to continue in line with the Integration project to support local PCN support between community pharmacy and general practice to ensure opportunities available to pharmacies within clinical service additional funding is maximised				
											Quality assurance collaboration with QA ICB team in developing and maintaining the community Pharmacy risk register which outputs the pharmacy visit plan				
											Strong engagement with CPNS provides a foundation of support for contractors in maximising opportunities available both nationally and those provided locally				
											Inclusion of Community Pharmacy in the operational delivery group and also regular reporting around Pharmacy matters to PCCC				

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07/01/2026 14:56:21

71	Special Care Dental Services	There is a risk that Special Care Dental Services (known as Community Dental Services) may not be able to deliver care to vulnerable patient groups in a timely manner due to workforce vacancies. This could lead to increased waiting times for vulnerable children and adults receiving care.	Mark Burgis	y Care Commissioning Committee	Fiona Theadom	20 Feb 2025	31 Mar 2026	12	9	9	Active engagement with dental contractors, LDC and Local Professional Network (and Managed Clinical Networks), regular dental newsletter in place	To review GIRFT report for community dental services with provider, assess impact and next steps 20/3/2025 meeting arranged with community dental services 2/4/2025 to discuss report and impact 16/4/25 update: Agreed to use GIRFT report outcomes indicators for reporting on a bi-monthly basis. 12/6/25: provider undertaking gap analysis of service provision and GIRFT recommendations to review with ICB and agree action plan. Bi-monthly meetings established with ICB and provider to review data collection, KPIs and gap analysis 31/7/2025: GIRFT report key performance indicators in development, reviewed at bi-monthly on 30/7/2025	Fiona Theadom	01 Feb 2025	30 Sep 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	CDS to work collaboratively with CFDP practices to increase the number of referrals from CDS into CFDP practices. Activity monitored on a bi-monthly basis by ICB. 21/8/2025: pathway under monthly review with data collection in place, referrals lower than expected therefore discussions taking place with all parties about how to increase referral activity 15/09/2025: steps to agree increase in CFDP referrals discussed and agreed with SPCD/CDS 14/10/2025: work continues to increase referrals from CDS into CFDP to reduce waiting lists. Access to CFDP sedation pathway agreed with one provider to support CDS to reduce waiting lists for CFDP 05/11/2025: monthly review meeting 6/11/25 - in depth data review planned 26/11/2025 23/12/2025: data review 17/12/2025 complete. Block transfer cases from CDS to CFDP underway increasing CFDP activity	Fiona Theadom	01 Apr 2025	31 Mar 2026
											Dental Data Review being updated to inform commissioning plans	31/7/2025: Bi-monthly meetings in place to review data and key performance indicators. Meeting on 31/7/2025 highlighted workforce gaps in recruitment for 3 clinical posts and request for ICB support submitted to ICB Primary Care Workforce team. Foundation trainee post unfilled. 21/8/2025: New reporting format and data review with provider 30/7/2025. New national reporting requirements to commence Sept 2025. 14/10/2025: to review Q2 data at review meeting on 5/11/25 to assess performance and activity for six months 5/11/2025: quarterly review meeting held. In depth data review planned 26/11/2025. Positive update on workforce recruitment 23/12/2025: workforce vacancies remain a challenge, advertisements live for 4 vacancies.	Fiona Theadom	20 Feb 2025	30 Nov 2025
											Dental Development Group established to engage with key stakeholders to agree short term plan by Sept 2023	To consider opportunities for upskilling workforce through Level 2 accreditation to support recruitment and retention. Development work supported by MCN Chairs. 23/12/2025: programme yet to start	Fiona Theadom	20 Feb 2025	31 Mar 2026

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<b>Subject:</b>	<b>Director of Primary Care Report</b>
<b>Presented by:</b>	<b>Sadie Parker, Director of Primary Care</b>
<b>Prepared by:</b>	<b>Amanda Sear, Head of Primary Care Strategic Planning &amp; ICB Primary Care Team</b>
<b>Submitted to:</b>	<b>Primary Care Commissioning Committee</b>
<b>Date:</b>	<b>14 January 2026</b>

**Purpose of paper:**

To provide an updated overview of the work governed by the Primary Care Commissioning Committee, in line with the ICB's delegation agreement with [NHS England](#).

**Executive Summary:**

The report seeks to provide wider context for the updates and decisions coming to the Primary Care Commissioning Committee for consideration.

At the time of writing, the consultation period for the proposed Norfolk and Suffolk ICB structure remains live.

National guidance on the new contractual arrangements to underpin collaborative neighbourhood working has been delayed, while negotiations on national contracts for primary care providers are ongoing.

Medium-term planning submissions continue to evolve as work begins to understand investment across Norfolk and Suffolk into primary care, outside of national contracts. This is an incredibly complex area, with multiple interdependencies that are not always visible or fully understood. These connections span across commissioning, workforce, estates, and digital infrastructure, making it essential to approach this work with a system-wide perspective

Overall, whilst there remain many uncertainties around the detail, the direction of travel is becoming clearer in terms of the role of ICBs as strategic commissioners. Perhaps the most significant challenge is how we bring these elements together and ensure alignment with the work already underway within the team to support the transition and build a shared understanding of how our delegation from NHSE (through a formal delegation agreement) impacts this.

Against this backdrop, our aim is to stay flexible and pragmatic - sequencing decisions as guidance lands, maintaining clear read-across to neighbourhood priorities, and keeping stakeholders sighted on how the team's work will knit these strands into a coherent, implementable plan.

## **Current priorities and resource commitments**

The coming months mark the start of a critical phase for primary care development within the Norfolk and Waveney system. Our work will take place within a changing landscape of contractual arrangements and collaborative delivery models designed to strengthen care at neighbourhood level.

To support this, we have secured resource to hold a structured series of workshops to support Norfolk and Waveney ICS in developing a future model of neighbourhood care aligned with the NHS 10-Year Plan, including one focused on primary care. The proposal is still being finalised, but a workshop-based approach will aim to ensure broad engagement, transparency, and practical outputs that address the complexity and inter-dependencies inherent in transforming primary care.

An initial submission has been made in response to the Medium-Term Planning Framework for Norfolk and Suffolk. While many of the current primary care metrics remain broadly consistent with previous years - and some are still subject to national negotiation – the focus on activity and access alone does not reflect the scale of transformation ahead. These measures must now be considered alongside integrated contract management, a focus on improving outcomes, addressing health inequalities and the alignment of investment across organisations.

Procurement, an ongoing cycle, will continue to be guided by clear principles and priorities, including tackling health inequalities and improving outcomes, while evolving to reflect changes in the national landscape and the ICB's organisational development. The final quarter for 2025/26 will include concluding some current procurement exercises, mobilising recently awarded contracts, and preparing for future commissioning rounds, all underpinned by a commitment to transparency, collaboration, and delivering the best possible value for our populations.

At the same time, our primary care strategic framework will need to support new ways of working, ensuring risks and interdependencies are managed and governance arrangements are fit for purpose and support the Norfolk and Suffolk footprint from April 2026.

Organisational change, including the forthcoming voluntary redundancy programme, may present challenges such as the loss of organisational memory, capacity and potential distraction during implementation.

Primary care contractor development is a major priority, with work already underway and expert support secured to strengthen capability across the system.

Taken together, these developments signal the beginning of a significant transition toward a more integrated and collaborative model of care.

## **Looking ahead**

As we enter this next phase, our focus is not only on meeting immediate operational requirements but on laying the foundations for a resilient system that can deliver better outcomes for our communities. The changes ahead represent a substantial shift in how care is planned and delivered. While challenges such as organisational change and provider readiness will require careful navigation, they also present an opportunity to strengthen partnerships and build capacity for the future. Through shared commitment and clear

strategic direction, we can ensure that primary care continues to play a central role in improving health and wellbeing.

The next few months will test the resilience of primary care. Through proactive planning, collaborative working, and targeted support, Norfolk and Waveney ICB aims to maintain safe, high-quality care for our communities while progressing towards long-term transformation goals.

National primary care contracts and contract reform for GP practices, primary care networks, dentistry, and community pharmacy are currently under negotiation for introduction from April 2026. While we expect these agreements to focus on improving access, prevention, and integrated care, details are unlikely to be available for some time. We are committed to supporting future changes, working with local partners to ensure they are implemented in a way that delivers sustainable, high-quality care for our communities.

The national procurement of training hub contracts, suggested to cover the four pillars of primary care from April 2027, could present significant opportunities and challenges. Development of a workforce strategy across all primary care services will underpin the ICB's ability to successfully deliver transformation.

Expected areas of change include:

- Improved access standards for GP and dental services
- Greater focus on prevention, including oral health and long-term condition management
- Expansion of clinical roles across primary care
- Integration of services across neighbourhood teams for joined-up care
- Digital and data improvements to support patient experience and population health
- New funding and performance frameworks linked to outcomes and equity

Proactive engagement with primary care contractors to explore their thinking and understand progress toward forming local primary care collaboratives started during December 2025. It is hoped this dialogue will help shape a shared vision for neighbourhood care, grounded in partnership and aligned with the needs of our local populations.

Further details on single and multi-provider neighbourhood contractual arrangements, as outlined in the NHS 10-Year Health Plan, have been delayed.

The NHS Long Term Workforce plan is signalled to be out from Q2 2026/27.

**Recommendation:**

The Committee is asked to note the report and request further information on any areas not covered elsewhere in the agenda pack.

Key Risks	
<b>Clinical and Quality:</b>	Quality and capacity in primary care could be improved through wider engagement with tools and support programmes available
<b>Finance and Performance:</b>	Care capacity can be negatively impacted due to inefficient working arrangements across primary care

<b>Impact Assessment (environmental and equalities):</b>	Increased capacity and capability and integrated working across all primary care services could increase the ability to address health inequalities.
<b>Reputation:</b>	Integrated care boards (ICBs), through delegation for primary care, lead the process of planning and arranging services for contractors to deliver in ways which best meet population needs, address health inequalities. Primary care access will be key to the shift to <a href="#">neighbourhood health services</a> , which are in central to delivering locally on the ambitions in the 10-year health plan for integrated, sustainable health and care
<b>Legal:</b>	None identified
<b>Information Governance:</b>	None identified
<b>Resource Required:</b>	Primary Care Workforce Transformation and Primary Care Delegated Commissioning Teams alongside Medical, Locality, Digital , Health Inequalities, and Commissioning teams all support contractual delivery and transformation
<b>Reference document(s):</b>	<p>NHSE Priorities and Planning Guidance 2025/26  <a href="https://www.england.nhs.uk/long-read/2025-26-priorities-and-operational-planning-guidance/">https://www.england.nhs.uk/long-read/2025-26-priorities-and-operational-planning-guidance/</a></p> <p>NHSE Planning Framework – September 2025  <a href="#">NHS England » Planning framework for the NHS in England</a></p> <p>NHSE Neighbourhood Health Guidelines 2025-26  <a href="https://www.england.nhs.uk/long-read/neighbourhood-health-guidelines-2025-26/">https://www.england.nhs.uk/long-read/neighbourhood-health-guidelines-2025-26/</a></p> <p><a href="#">ICB Model Blueprint</a> - update published on 28 May 2025</p> <p><a href="#">Fit for the Future</a> - 10-Year Plan published on 3 July 2025</p> <p><a href="#">Model Region Blueprint</a> - article published 11 September 2025</p> <p><a href="#">Planning Framework</a> - published 24 October 2025</p> <p><a href="#">Strategic Commissioning Framework</a> - published 5 November 2025</p>
<b>NHS Constitution:</b>	The four pillars of primary care operate under distinct contractual frameworks and guidance: the Primary Care Policy and Guidance Manual (general practice), the Drug Tariff and Pharmaceutical Services Regulations (pharmacy), the Dental Policy Book and GDS/PDS Regulations (dentistry), and the Optical Policy Book and GOS Regulations (optometry). Collectively, these form the Primary Care Contractual Frameworks.

	<a href="https://www.england.nhs.uk/publication/primary-medical-care-policy-and-guidance-manual-pgm/">https://www.england.nhs.uk/publication/primary-medical-care-policy-and-guidance-manual-pgm/</a> <a href="#">NHS England » Policy book for primary dental services</a> <a href="#">NHS England » Pharmacy Manual</a> <a href="#">NHS England » Policy Book for Eye Health</a>
<b>Conflicts of Interest:</b>	Declarations of interest are held on record; there were no conflicts of interest noted for this report
<b>Reference to relevant risk on the Board Assurance Framework</b>	Risk to resilience of primary care and transformation, on BAF and monitored through Primary Care Commissioning Committee, current score of 20
<b>Governance</b>	Not applicable
<b>Process/Committee approval with date(s) (as appropriate)</b>	Not applicable

Webb, Sarah  
07/01/2026 14:56:21

**Item 08**

<b>Subject:</b>	<b>Primary Care Operational Planning</b>
<b>Presented by:</b>	<b>Amanda Sear, Head of Primary Care Strategic Planning</b>
<b>Prepared by:</b>	<b>Amanda Sear, Head of Primary Care Strategic Planning</b>
<b>Submitted to:</b>	<b>Primary Care Commissioning Committee</b>
<b>Date:</b>	<b>14 January 2026</b>

**Executive Summary**

The paper provides an update on progress against the process for primary care operational planning, as set out in the NHSE [Planning Framework](#) published in September 2025, to the development of plans for the five-year period to 2026/27 to 2030/31.

The Committee is asked to note the update and request any further information required to support the ongoing, evolving, planning process, as part of the wider changes to the NHSE landscape.

**Background and Next Steps**

The current operational planning round reflects a changing dynamic across the system, with many submissions now being led by providers rather than the Integrated Care Board (ICB). For primary care, however, the ICB continues to make submissions due to the complexity of national contractual frameworks and the need for system-level coordination.

The metrics for the current planning cycle remain broadly consistent with previous years, with a continued focus on appointment volumes, the expansion of Pharmacy First consultations, and ensuring timely access to clinically urgent care. These priorities will shape the primary care work programme across Norfolk and Suffolk, supporting resilience and equitable access. It is important to note that some elements will be influenced by national contract negotiations, which may introduce further adjustments as the planning process progresses.

A list of metrics from the planning submission template can be found in Appendix A.

Importantly, operational planning and delivery across primary care is not solely about meeting numerical targets. It is intrinsically linked to the ambitions set out in the NHS 10-Year Health Plan, particularly the development of neighbourhood models of care. This requires a shift from provider-level activity to population-level capacity planning, embedding collaboration across primary care, community services, and wider system partners. The goal is to align operational delivery with improving population health outcomes rather than focusing narrowly on organisational targets.

The introduction of the new Norfolk and Suffolk footprint brings additional considerations. While many metrics remain nationally defined, there are areas where we have some discretion in how capacity is used and priorities balanced across the combined geography. Achieving consensus on these elements will require constructive dialogue both internally and with NHS England colleagues. This planning round therefore represents an opportunity to harmonise approaches across Norfolk and Suffolk, ensuring consistency while making best use of local flexibility to reflect population needs.

The initial submission made in December was necessarily high level, and feedback is expected which will need to be incorporated into a full submission by mid-February. Until this feedback is received, the full scope of the ask will not be clear. This update should therefore be viewed as part of an ongoing process, requiring continued collaboration between commissioners, NHS England, and providers to refine and agree the final position.

In the meantime, the commissioning intentions provide useful context for the direction of travel and the ICB's priorities, discussions around which have already come to this committee and involved engagement with providers.

While some numbers are expected to be challenging and others will require technical discussions about capacity and utilisation, this planning round should be seen as a step toward system transformation.

By working collectively as a primary care community and aligning with neighbourhood ambitions, we have an opportunity to move toward a sustainable, integrated health system that delivers better outcomes for all.

**Recommendation:**

The Committee are asked to note the updates on operational planning and are invited to provide feedback on areas of particular interest or future updates they would like to see

As the local planning process becomes clearer, further updates will come to PCCC

Key Risks	
<b>Clinical and Quality:</b>	Population health outcomes and capacity in primary care could be improved through confident and credible primary care input into operational planning and delivery
<b>Finance and Performance:</b>	Care capacity can be negatively impacted due to lack of credible primary care input into operational planning and delivery
<b>Impact Assessment (environmental and equalities):</b>	Increasing capacity and capability could increase our collective ability to address health inequalities
<b>Reputation:</b>	Integrated care boards (ICBs) lead the process of planning and arranging services to deliver the expectations set out in Operational Planning Guidance, including ensuring the reforms are put in place to secure a sustainable health system in the future and a drive more integrated care through the development of <a href="#">neighbourhood health services</a>
<b>Legal:</b>	None identified
<b>Information Governance:</b>	None identified
<b>Resource Required:</b>	A wide range of ICB teams, including Primary Care Workforce Transformation, Primary Care Delegated Commissioning, Locality, Digital and Commissioning teams work together, and with contractors, to improve access and experience to primary care services for our population

Approved by Sarah 17/01/2026 14:56:21

	Primary care contractors working together to engage with planning delivery of the best outcomes for local populations and the most effective use of collective resources.
<b>Reference document(s):</b>	<p>NHSE Priorities and Planning Guidance 2025/26</p> <p><a href="https://www.england.nhs.uk/long-read/2025-26-priorities-and-operational-planning-guidance/">https://www.england.nhs.uk/long-read/2025-26-priorities-and-operational-planning-guidance/</a></p> <p>NHSE Planning Framework – September 2025</p> <p><a href="#">NHS England » Planning framework for the NHS in England</a></p> <p>NHSE Neighbourhood Health Guidelines 2025-26</p> <p><a href="https://www.england.nhs.uk/long-read/neighbourhood-health-guidelines-2025-26/">https://www.england.nhs.uk/long-read/neighbourhood-health-guidelines-2025-26/</a></p>
<b>NHS Constitution:</b>	<p>NHSE Primary Care Commissioning Framework</p> <p><a href="https://www.england.nhs.uk/publication/primary-care-commissioning-assurance-framework/">https://www.england.nhs.uk/publication/primary-care-commissioning-assurance-framework/</a></p> <p>NHSE Strategic Commissioning Framework</p> <p><a href="#">NHS England » Strategic commissioning framework</a></p>
<b>Conflicts of Interest:</b>	Declarations of interest are held on record, there were no conflicts of interest noted for this report
<b>Reference to relevant risk on the Board Assurance Framework</b>	Risk to resilience of primary care and transformation, on BAF and monitored through Primary Care Commissioning Committee, current score of 20 - currently under review
<b>Governance</b>	Previous updates have been taken to Primary Care Commissioning Committee during 2025 - the submission is signed off by the ICB Board
<b>Process/Committee approval with date(s) (as appropriate)</b>	N/A

Webb, Sarah  
07/01/2026 14:56:21

## Appendix A

The planning submission covers the following areas for primary care:

- Appointments in General Practice
- Count of Pharmacy First Consultations
- Number of clinically urgent appointments seen on the same day
- Number of clinically urgent appointments
- Percentage of clinically urgent appointments seen on the same day
- Urgent dental appointments
- The number of unique adults with a postcode within each ICB who have received a course of treatment at any NHS dental contract within the past 24 months
- The number of adults (18+) with a resident postcode within each ICB registered at any GP practice. Data as per 1st of each month.
- Percentage of resident population seen by an NHS dentist - adult
- The number of unique children with a postcode within each ICB who have received a course of treatment at any NHS dental contract within the past 12 months
- The number of children (under 18s) with a resident postcode within each ICB registered at any GP practice. Data as per 1st of each month
- Percentage of resident population seen by an NHS dentist - child
- UDAs delivered in the quarter for contracts where annual UDA target >100
- Expected UDA delivery standardised by working days where annual UDA target >100
- Units of dental activity delivered

Not all areas were required to be completed in the initial December submission and work will continue following feedback from NHSE.

The final submission for primary care will be shared with the Primary Care Commissioning Committee, together with feedback received.

Webb, Sarah  
07/01/2026 14:56:21

Agenda item: 09

<b>Subject:</b>	<b>GP Action Plan Delivery Report</b>
<b>Presented by:</b>	<b>Shepherd Ncube, Associate Director of Primary Care Commissioning</b>
<b>Prepared by:</b>	<b>Shepherd Ncube, Associate Director of Primary Care Commissioning Carl Gosling, Lead Senior Primary Care Commissioning Manager (Medical Services)</b>
<b>Submitted to:</b>	<b>Primary Care Commissioning Committee</b>
<b>Date:</b>	<b>14 January 2026</b>

**Purpose of paper:**

This paper aims to provide assurance to PCCC on progress against the GP Action Plan submitted to NHS England in June 2025 and seeks approval for the proposed recommendations. It summarises delivery across the agreed priority areas, highlights key achievements, and identifies emerging risks and challenges. The paper is intended to provide confidence that actions are being implemented as planned and that momentum is being maintained. Its primary focus is on the practice visit programme, the general practice improvement programme, Advice and Guidance, Commissioning and Transformation Support (CATS), tackling unwarranted variation, and the general practice contract review project.

**Executive Summary:**

The GP Action Plan was developed in line with national Operational Planning Guidance and agreed with NHS England in July 2025, comprising 15 priority areas to strengthen general practice delivery, sustainability, and patient outcomes across Norfolk and Waveney. This report provides assurance to the Primary Care Commissioning Committee (PCCC) on progress against the agreed actions and confirms that delivery remains on track across the majority of workstreams.

Overall progress has been strong, with clear evidence of improved contract oversight, effective commissioning and transformation activity, and growing system maturity in the use of data and digital tools. Key areas of delivery include the APMS contract review programme, Enhanced Access monitoring, Advice and Guidance implementation, Pharmacy First, the Commissioning and Transformation Support (CATS) programme, and the practice visit and unwarranted variation programme.

Notable achievements include the establishment of robust contractual monitoring arrangements for Enhanced Access, successful progress towards stabilising general medical services previously commissioned through APMS contracts, positive system engagement through the CATS self-assessment process, increasing uptake of the NHS App, and strong early performance and patient feedback from Pharmacy First. Work to strengthen leadership capability, peer support, and commissioning skills is well advanced and aligned with wider system transformation, including preparations for the creation of the planned new ICB.

Where variation or delivery challenges have been identified, these are being managed through established contract management, support, and governance arrangements. Clear plans are in place to maintain momentum, embed completed actions into routine business processes, and continue delivery beyond the formal scope of the GP Action Plan where appropriate.

## **Report:**

### **Background information**

Fifteen priority areas were agreed with NHS England as part of the ICB GP Action Plan in July 2025. Good progress has been made in areas including contract oversight and primary care digital delivery, with further work underway to strengthen transformational leadership.

This paper focuses on progress across the following areas: contract management, including the Alternative Provider Medical Services (APMS) contract review project; implementation of Advice and Guidance; clinical priorities for learning disabilities and serious mental illness; Pharmacy First; development of a strategic framework; locally enhanced services; tackling unwarranted variation; and the practice visit programme.

The GP Action Plan was presented to PCCC on 8<sup>th</sup> July 2025, where it was agreed to make the Action Plan a regular item on the PCCC agenda to monitor progress and ensure continuous improvement.

### **Improving contract oversight**

The Primary Care Access Recovery Plan (PCARP) was established to improve patient access to general practice by reducing unwarranted variation, increasing appointment availability, strengthening call handling and triage, and improving patient experience. It focused on supporting practices with high demand and embedding more consistent approaches to access and utilisation.

When the GP Action Plan was developed in July 2025, it was anticipated that NHS England would publish further national guidance to support ICB implementation of PCARP. We now understand that no additional guidance will be issued. As a result, the relevant PCARP actions have been completed and embedded within routine commissioning, contract management, and performance monitoring arrangements.

**Position going forward:**

It is recommended that the PCARP section of the GP Action Plan is formally closed. Ongoing assurance will be maintained through existing business-as-usual processes, including access dashboards, practice engagement, and the practice visit programme.

**Contract Management-Alternative Provider Medical Services (APMS Contract)**

As previously reported to PCCC in July 2025, the plan is to eliminate short-term contracts for the provision of primary medical services by March 2027, and good progress has been made towards this goal. This forms part of our long-term strategy to build sustainable resilience in general practice and deliver the ICB efficiency programme.

Norfolk and Waveney ICB had seven APMS contracts under review, each at different stages of procurement or transition to long-term arrangements. Five of these practices are on track to move to GMS contracts from April 2026. One practice has already successfully transitioned, one has closed with patients registered at one of two other local practices, while the remaining three are at the procurement award stage and preparing for mobilisation. The final two practices, located in Great Yarmouth and Waveney, are at the start of their procurement process, well ahead of schedule. New contracts for these are expected to commence in October 2026.

Progress and efficiency savings are being realised as planned and are monitored through quarterly financial reports and contract reviews. The bi-weekly internal ICB contract meetings have supported the APMS review programme effectively. Following a recent review of the terms of reference, the meeting frequency has been changed to monthly to allow more time for procurement work. All contract risks were assessed as low during procurement. The frequency will be reviewed again before mobilisation of the new contracts.

**Primary Care Network DES-Enhanced access**

As part of the GP Action Plan, a system has now been agreed to monitor delivery of the Primary Care Network (PCN) DES Enhanced Access (EA) requirement. The objectives were to understand local delivery models, support contractual compliance, assess utilisation rates, and inform future service development.

ICB commissioners agreed to introduce and implement a standard reporting template with PCNs and practices, and this action has been completed. In addition, completed Enhanced Access submissions were reviewed to identify any contractual gaps and to assess utilisation by the end of July, in line with the agreed actions.

All actions relating to this priority area have now been completed. This element of the GP Action Plan is therefore being reported for closure and will move into routine monitoring through established contractual compliance processes.

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07/01/2026 14:56:21

Through this review, one PCN was identified as experiencing challenges in meeting contractual requirements. Targeted support is being provided through standard contract management arrangements to support improvement and compliance.

Benchmarking with neighbouring ICBs identified that there is currently no consistent or formalised approach to monitoring Enhanced Access delivery. Our monitoring framework has been shared as part of system learning and best practice.

### **Advice and Guidance**

An Advice and Guidance (A&G) Interface Team for Norfolk and Waveney meets monthly, supported by primary care clinicians, to ensure that frontline experience continues to inform its ongoing development. The A&G programme forms a key component of the wider Elective Recovery (ER) Framework and directly contributes to several performance metrics within the GP Action Plan, including:

- Reducing unnecessary outpatient referrals through timely use of Advice and Guidance.
- Improving time-to-treatment for patients requiring elective care.
- Increasing the proportion of care appropriately managed within primary and community settings rather than secondary care.

Expected outcomes include strengthened system-wide elective recovery, improved patient access to timely and appropriate care, and measurable improvements across these key performance areas.

### **Improving Commissioning and Transformation**

#### **Commissioning and Transformation Support (CATS)**

As part of the GP Action Plan, the ICB commissioning team, supported by members of the wider multidisciplinary team, undertook a self-assessment of commissioning and transformation capability. This was facilitated by NHS England and delivered across two well-attended sessions, held on 1 September 2025 and 17 September 2025, with representation from a broad range of multidisciplinary colleagues.

The self-assessment exercise is being aligned to the milestones agreed within the GP Action Plan and is being tracked through a highlight report. The assessment identified the following priority development areas:

- Strategic leadership
- A shared understanding of the case for change across the team and system
- General practice contracting, commissioning and transformation delivery
- Engagement with practices and PCNs
- Patients, communities and peer leadership

In light of the significant organisational change currently underway within the ICB, including the planned merger with Suffolk in the next financial year, it was agreed to

focus on a smaller number of realistic and deliverable priorities that align with existing work programmes. These areas are:

- Considering how Protected Learning Time for practices might be accommodated within the new contractual requirements and developing robust processes accordingly.
- Transformational leadership, including peer ambassador roles
- Strengthening commissioning skills, knowledge and capability within the commissioning team

The key actions for this element of the GP Action Plan have been completed and the recommendation is that this action is closed from this action plan. Delivery of the agreed priority areas will continue outside the scope of the GP Action Plan and will be progressed in collaboration with Suffolk from April 2026.

## **Primary Care Digital Workstream**

### **NHS App**

The NHS App continues to make positive progress as part of Norfolk and Waveney's digital transformation and broader efforts to improve patient access. Uptake has increased steadily, with 61% of eligible patients (587,054 patients) now registered as of October 2025, moving the system toward the target of 60% by the end of August 2025. In August 2025 alone, 130,821 prescriptions were requested via the App. National NHS App dashboard data is used to track uptake, registrations, and active usage for services such as appointment booking, prescription orders, and access to health records, providing assurance that digital engagement is growing as expected. The GP action plan dashboard will also include this data and will be updated monthly.

### **What will be included in the GP Action Plan Dashboard:**

- Number of patients registered and actively using the NHS App
- Volume of appointments booked, prescriptions ordered, and records accessed through the app

These are the milestones that we have agreed on in the GP action Plan:

### **NHS App Ambassadors**

There are currently 10 ambassadors, with a target of 50 by March 2026. Ambassadors are provided with communication toolkits, case studies, and analytics support to help champion App adoption across their networks, while also embedding digital-first approaches throughout primary care. This will be tracked on proposed the GP Action Plan dashboard.

### **Online Consultations**

Practices are encouraged to make full use of their chosen Online Consultation and Video Consultation (OCVC) systems to enhance patient access, streamline workflows,

and improve efficiency. Work is ongoing to ensure that all in-built functionalities are fully utilised to support total triage approaches. The agreed milestone was that the training sessions will be recorded and uploaded on dedicated channels.

### **Pharmacy First**

Pharmacy First will be embedded within the GP Action Plan dashboard, with a dedicated data section powered by the ICB Data Hub. This enables tracking of delivery against key service targets and milestones, supporting early identification of emerging issues and provides direction for ICB support.

#### **Targets and milestones include:**

- Hypertension case-finding: Increase pharmacy registration from 90% to 95%
- Contraception provision: Increase registration from 47% to 75%
- Referral rates from general practice and NHS111: Increase from 15% to 20% by March 2026
- Contractor activity: Increase from 6,353 (baseline established December 2024) to 9,146 by March 2026

These have been agreed on the GP action plan.

The Pharmacy Integration Project runs until September 2026, after which:

- A baseline will be established using project findings
- A plan will be developed to address any issues identified
- Learning will be shared and successful interventions scaled up

The dashboard, developed by the ICB Data Hub, gets updated at the beginning of each month and provides updates and visual insights into:

- Activity trends across hypertension, contraception and 7 clinical conditions
- Top-performing pharmacies and site-level comparisons
- Activity by deprivation level and geographic distribution

### **Pharmacy First Friends and Family**

To date, 17 patient feedback responses have been received in relation to Pharmacy First, with all responses being 100% positive. Feedback is collated through Microsoft Forms, enabling the identification of emerging themes and trends over time. In recognition of this success, the ICB will be issuing letters and certificates of appreciation to participating pharmacies, acknowledging their valuable contribution to the ongoing effectiveness of the Pharmacy First initiative.

Webb, Sarah  
07/01/2026 14:56:21

## **Strategic Framework**

The Primary Care Strategic Framework establishes a clear roadmap for transformation, ensuring alignment with local healthcare priorities and national policy direction. Year one (2025–2026) will focus on foundational enablers including workforce development, digital integration, and service redesign, creating the infrastructure for sustainable, high-quality primary care. An annual delivery plan will be updated to reflect emerging needs and system pressures, ensuring ongoing improvement in service access, care quality, and health equity.

The framework and associated workstreams were formally adopted at the July PCCC. Each workstream supports delivery of ICB and NHS England strategic aims and will be underpinned by detailed implementation plans, metrics, and defined governance routes.

### **Workstreams:**

1. **Primary care input into system decision-making** – Strengthen representation in Integrated Care Board and Place governance forums; support leadership development for PCN Clinical Directors and Practice Managers; embed the primary care perspective in population health management and service transformation decisions.
2. **Understanding resources, demand, and capacity** – Develop a single, integrated dataset for primary care demand, workforce, and capacity; use this intelligence to inform commissioning intentions, estates planning, and targeted investment; support equitable resource distribution based on population need and deprivation indices.
3. **Future model of primary care** – Design and test sustainable models of multidisciplinary primary care at scale; embed digital tools, proactive care planning, and personalised care approaches; align future models with cluster-based working and ICB Blueprint priorities.
4. **Role of primary care in tackling health inequalities** – Deliver targeted interventions using Core20PLUS and local population health data; strengthen community partnerships and social prescribing; ensure equity of access and outcomes across diverse patient groups.

The framework aligns to the ICB Blueprint, NHS Long Term Plan, and NHS Oversight Framework (2025–2026) domains, including quality of care, access, and experience; preventing ill health and reducing inequalities; workforce sustainability and wellbeing; finance and productivity; and leadership and system integration.

Progress against the Primary Care Strategic Framework will be tracked and assured through monthly highlight report on workstream milestones, key performance indicators, risks, and mitigations. The framework has been developed and approved, and it is recommended that this element of the GP Action Plan is formally closed.

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07/01/2025 14:56:21

## **Locally Enhanced Services (LES)**

Locally commissioned primary care services represent an annual investment of approximately £15 million, supporting the ICB's ambition to deliver joined up and sustainable commissioning of enhanced services that meet the needs of local populations, strengthen practice resilience, and support workforce development.

Currently, services are commissioned and delivered at an individual practice level, with 13 live service lines. The Proactive Healthcare LES operates through a blend of place-based, PCN-level, and individual models, reflecting differing local delivery arrangements.

Of the existing services, six remain under LCS arrangements, while eight have been recommissioned as LES. Nine LCS and LES services are due to expire on 31 March 2027, while four LES and one LCS are scheduled to end on 31 March 2026, at which point recommissioning the one LCS as and Local Enhanced Primary Care Service is planned. Thirteen services are funded through the ICB Primary Care LCS/LES budget, with one LES continuing under historic arrangements of the reinvestment of PMS monies from NHS England.

Procurement and engagement plans are being developed for all service lines due to end in March 2026 with all Governance processes to be completed in time for service continuity from 1 April 2026. An internal review report and recommendations were approved by the Primary Care Commissioning Committee (PCCC) in July 2025 to recommission the service lines expiring on the 31<sup>st</sup> March 2026 subject to governance completion. A supporting project implementation plan, including detailed procurement and engagement timelines, is on track for completion by end October 2026.

All practices have been offered the opportunity to review their sign up to deliver 2025/26 LES services by 30 September 2025 following the release of the final financial tariffs, ensuring continuity and equitable access across Norfolk and Waveney. Uptake levels remain high, and ongoing engagement with practices will address any gaps in delivery.

Implementation of the Ardens LCS Essentials Dashboard continues to strengthen contract management and reporting capability. The majority of GP surgeries have now signed up to the dashboard, which enables consistent data capture at practice, PCN, and ICB level. Alternative reporting arrangements are in place for those unable to use the Ardens system, ensuring comprehensive oversight. The dashboard provides meaningful, standardised information to measure outcomes and support performance assurance.

Through this programme, Norfolk and Waveney are establishing a coherent commissioning framework for enhanced primary care services, providing greater alignment across practices and localities. The expected outcomes include:

- A clear, Primary Care Commissioning Committee approved approach for all local primary care services.
- Completion of procurement plans for 5 services expiring March 2026 and 9 services expiring March 2027.
- Full alignment of service delivery under ICB cluster arrangements.

Webb, Sarah  
07/01/2026 14:56:21

- Universal LES participation by practices across the system for 2025/26.
- Enhanced data quality and reporting consistency through Ardens dashboard implementation.

Progress is monitored through the PMO team, with monthly highlight reports submitted to committee for ongoing assurance.

### **Development of Peer Ambassador roles**

Two peer ambassadors have been confirmed to support the implementation of the GP Action Plan. Regular review meetings have been established to ensure regular engagement and oversight of progress against the agreed priority areas.

The focus of this work is on:

- Building on awareness and understanding of the Modern General Practice (MGP) agenda across participating practices
- Increase uptake and utilisation of practice-level support offers
- Enhance the delivery and effectiveness of locally commissioned services
- Improve compliance and consistency in the use of online consultation systems

Progress will be monitored and reported through a structured highlight report. This approach will enable the early identification of achievements, barriers, and emerging themes, providing qualitative evidence to inform future performance measures and data collection frameworks.

The next steps for commissioners and the identified peer ambassador is to firm up the areas of work to focus on and this will be agreed by end of January 2026.

### **Tackling Unwarranted Variation & The Practice Visit Programme**

As part of the GP Action Plan, eight practices were initially identified as showing negative variation in GP access and experience, 11 practices in clinical outcomes and care quality, and seven practices in vaccination uptake. The ICB has been working proactively to address these areas, and significant improvements have been made.

As at 7 January 2026, triangulated data shows continued improvement across all domains. Norfolk and Waveney now has:

- Four practices with overall negative variation in GP Access and Experience (reduced from eight)
- Three practices with overall negative variation in Workforce
- Four practices with overall negative variation in Clinical Outcomes and Care Quality (reduced from eleven)
- No practices with overall negative variation in Vaccinations and Screening
- No practices with overall negative variation in Medicines Management

Webb, Sarah  
07/01/2026 14:56:21

While performance data remains dynamic and may fluctuate month to month, these trends demonstrate clear and sustained improvement, with positive outcomes for both practices and patients. The ICB will continue to work closely with practices, including through the established practice visit programme, to maintain momentum and support further improvement across all domains.

The practices referenced in this update are not necessarily the same as those included in the original GP Action Plan, as the underlying data is refreshed on a monthly basis and practice-level positions may change over time. The ICB has reviewed all practices included in the original list and does not have significant concerns. In many cases, the identified variation relates to data inaccuracies, delays in national data updates, or unrefreshed datasets rather than underlying performance issues. Nonetheless, this process has been valuable in enabling closer review and constructive engagement with practices.

A new system has now been established to strengthen how variation is identified, discussed, and addressed. Following each update, the medical team will meet to review and discuss the practices who are in the negative variation. These discussions will include consideration of whether a practice visit has already taken place, is scheduled, or should be prioritised for early engagement.

### **Learning Disability (LD) and Serious Mental Illness (SMI) Health Checks**

The focus has been on practices that did not achieve the minimum 75% delivery rate in 2024/25. In the GP action plan we have set out to:

- GPs in N&W delivered 5,594 LD Health Checks in 2024/25. The target for 2025/26 is 5,952 Health Checks completed by year-end.
- Delivery of SMI Health Checks is currently at 68%, with a target for 75% of eligible patients to receive a Health Check by the end of Q4 2025/26.
- By the end of Q2 2025/26, the number of patients who have never received an LD Health Check should show a measurable decrease.
- By the end of Q4 2025/26, there will be improved uptake among LD patients aged 14–17 years and SMI patients aged 40–44 years.

National Indicators:

- Achieve a minimum of 75% delivery for LD & SMI Health Checks by Q4 2025/26 (NHS England data).
- Increase the proportion of PCNs meeting the higher threshold for IIF HI03 via CQRS Network Contract DES claims at year end.

Local Indicators:

- Deliver 5,952 LD Health Checks and 75% SMI Health Checks by Q4 2025/26 (as reported on the N&W ICB Primary Care BI Dashboard).

Webb, Sarah  
07/01/2026 14:56:21

LD and SMI Health Check data is sourced from the N&W ICB Data Hub through two main reports:

- *Learning Disability Health Checks CQRS* – national data, updated monthly.
- *Learning Disability Health Checks Local* – local data, refreshed weekly. SMI Health Check data is available on the *SMI Healthchecks* dashboard, refreshed weekly for practices with a Data Sharing Agreement.

Data is sourced from both national (CQRS) and local (weekly refreshed) dashboards.

### **General Practice Improvement Programme (GPIP)**

A total of 31 practices have participated in the GPIP and the plan is to increase the number of practices fully implementing or working towards modern general practice to 49 by end of Q4 2026. Good progress has been made with the GPIP Practice Level Support Package and this will be reported the GP action Plan dashboard. The Digital section will show how practices are increasing their use of the NHS App and Pharmacy First, giving us a clear view of how digital tools are being adopted to support access and manage demand.

The GP Action Plan dashboard will track changes to online consultation offers and triage processes, helping us understand how practices are improving the way patients are navigated to the right care.

Updates on Cloud based telephony (CBT) will be shared through highlight reporting or narrative updates where relevant.

This approach ensures the committee receives a balanced view of progress using data where it's available and meaningful, while also recognising where frontline insights are more appropriate.

### **Conclusion**

The GP Action Plan is being delivered as intended and is providing a strong framework for improving oversight, capability, and performance across primary care. The actions agreed with NHS England have either been completed or are progressing in line with milestones, with clear governance and assurance mechanisms in place.

The Committee can be assured that the ICB has a firm grip on delivery, supported by improved data intelligence, strengthened contract management, and constructive engagement with practices and PCNs. Completed elements of the Action Plan are now embedded within routine monitoring and operational processes, ensuring sustainability and ongoing assurance.

Remaining priorities are clearly defined and aligned with existing programmes of work, enabling continued progress during a period of organisational change and future system integration. Ongoing reporting through highlight reports and dashboards will provide continued transparency and assurance to PCCC as delivery continues.

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## Recommendation to the Board:

- Note and discuss the contents of the progress update report
- Review progress made to date
- Approve closure of the PCARP, CATS, Enhanced Access and Strategic Framework delivery actions
- Agree that remaining actions continue to be delivered and monitored through existing governance arrangements

The committee are invited to share any feedback on areas of particular interest or if there is anything else they would like to see.

Key Risks	
<b>Clinical and Quality:</b>	Ongoing variations in the GP Action Plan submissions may impact timely identification of quality and performance issues. Ongoing Data Hub insights will support early interventions.
<b>Finance and Performance:</b>	Delays or incomplete GP Action Plan submissions may limit the ICB's ability to track performance against national and local targets. This could impact assurance under the NHS Oversight Framework and delay allocation of resources or targeted support. Regular monitoring through the Data Hub and follow-up with practices will help reduce this risk.
<b>Impact Assessment (environmental and equalities):</b>	Increased capacity could increase the ability to address health inequalities
<b>Reputation:</b>	Risk that insufficient visibility of progress on GP Action Plans could affect confidence (NHSE, practices, and the public). Clear reporting to committee and communication of will help maintain confidence.
<b>Legal:</b>	N/A
<b>Information Governance:</b>	N/A
<b>Resource Required:</b>	GP Action Plan Submission Data Hub
<b>Reference document(s):</b>	Norfolk and Waveney ICB Strategic Framework – <i>Primary Care Strategic Framework v1.1</i> <a href="#">Primary-Care-Strategic-Framework-1-1.docx</a>

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07/01/2026 14:56:21

	NHS England <i>NHS Oversight Framework 2025/26</i> (updated 22 July 2025) <a href="#">NHS England » NHS Oversight Framework 2025/26</a>
<b>NHS Constitution:</b>	N/A
<b>Conflicts of Interest:</b>	Declaration of Interest are held on record, none to report.
<b>Reference to relevant risk on the Board Assurance Framework</b>	BAF02 – Primary Care Resilience and Transformation. This is monitored through the Primary Care Commissioning Committee. It's current score is 20 and is under review.
<b>Governance</b>	Previous papers taken to Primary Care Committee on September 2025

<b>Process/Committee approval with date(s) (as appropriate)</b>	Audit Committee for information.
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07/01/2026 14:56:21

Agenda item: 10

<b>Subject:</b>	<b>Strategic Primary Care &amp; Workforce Recruitment and Retention Programme Update Report</b>
<b>Presented by:</b>	<b>Jayde Robinson, Head of Primary Care Workforce Transformation</b>
<b>Prepared by:</b>	<b>Ben Chandler, Senior Workforce Special Projects Manager Keri Robinson, Senior Workforce Special Projects Manager Jayde Robinson, Head of Primary Care Workforce Transformation</b>
<b>Submitted to:</b>	<b>Primary Care Commissioning Committee</b>
<b>Date:</b>	<b>14 January 2026</b>

**Purpose of paper:**

1. To note the primary care strategic workforce recruitment and retention programme update and financial information linked within the report.
2. The committee is asked to approve the following in relation to primary care workforce risks (54 and 55):
  - Agree with the review team’s assessment that mitigation measures have successfully met the organisation’s risk appetite.
  - Approve closure of the risks, recognising that the target risk scores have been achieved.
  - Acknowledge that workforce schemes will continue to be monitored through standard oversight processes by the ICB Workforce Team.
  - Note that overall risk levels have reduced sufficiently to move from increased oversight to standard monitoring, with delivery options considered at an acceptable level of reward

**Executive Summary:**

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

To address these issues, the 2025/26 Primary Care Workforce Delivery Plan focuses on the continuation and expansion of the GP, Dental, and Optometry Primary Care Programmes. Funding of £3.3 million was allocated within 2025/26 financial year.

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

## **Introduction**

During the past year, the Primary Care Workforce team has diligently focused on enhancing and stabilising our primary care workforce, resulting in a notable positive change. These improvements are already contributing to the effective delivery of primary care services to our local community. Moreover, they reflect strong alignment with the strategic commissioning intentions for Norfolk and Suffolk, ensuring readiness to address future requirements and priorities.

This report provides an update on the progress and developments of primary care workforce programmes that were formally approved by the Primary Care Commissioning Committee (PCCC) in July 2026. These programmes, which have received strategic endorsement, are integral to supporting the delivery of primary care services within the region. The following sections outline key achievements of these initiatives.

## **Funding**

The funding amount of £3.3 million was approved by PCCC and Triple Lock for the 2025/26 financial year, comprising:

### Recurrent

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

### Non-recurrent

- £50,587 for Optometry Workforce, awarded to N&W through an external funding bid at the end of Q4.
- £210,677.64 Continuous Professional Development (CPD) funding for General Practice
- £198,900 Advance Practice funding for General Practice
- £103,610 Pre-Registration Trainee Pharmacy Technician
- £20,000 Community Prescribing .3

\*Funding is provided to ICBs via Primary Care System Development Funds to support the development and running costs of the N&W Primary Care Workforce Delivery Plan 25/26. The ICB is contractually required to have this programme in place under the ICS Training Hub.

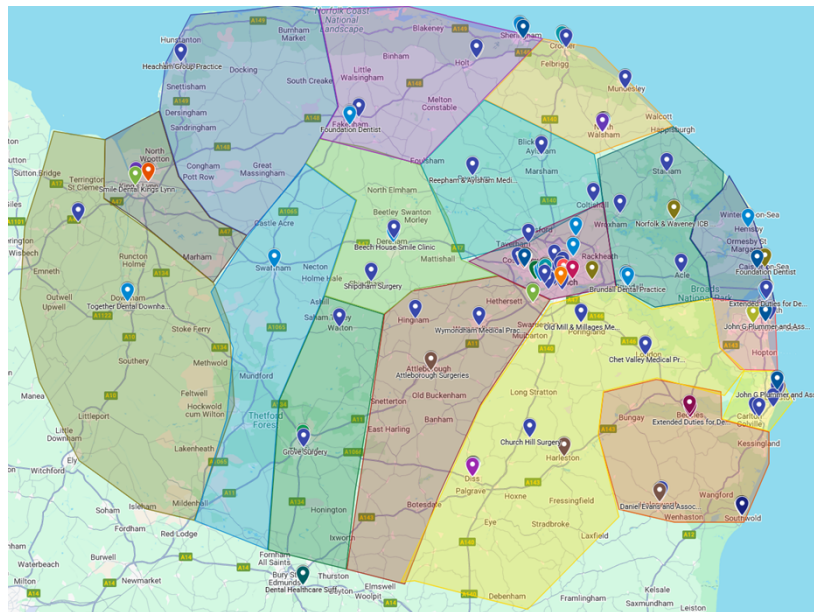
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07/01/2026 14:56:21

## Programme Update & Highlights

Of the 39 approved primary care workforce programmes, 41% have successfully met all key performance indicators, including 17% that have exceeded their agreed targets and delivered outcomes beyond original expectations. A further 41% programmes are currently in delivery and progressing in line with plan, with full completion anticipated. 1% of the programmes are not expected to be delivered. A detailed overview of all programmes and their status is provided in **Appendix A**.

## Dental Workforce

The image below illustrates the uptake of Dental Schemes across Norfolk and Waveney, highlighting an 14% increase in adoption compared with the 2024/25 programmes.



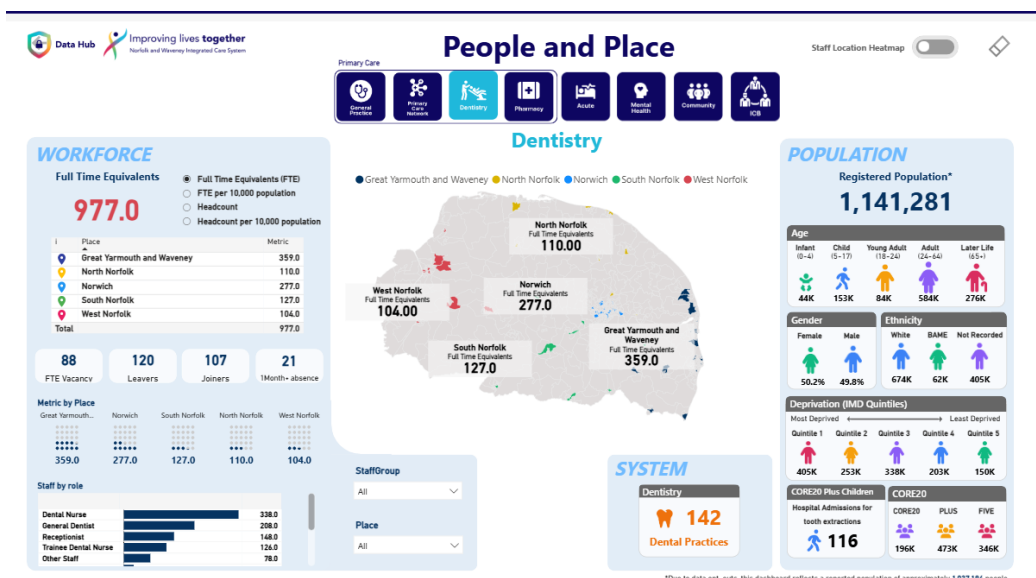
Highlights include:

- Deliver a Norfolk and Waveney specific Golden Hello incentive package to support the recruitment and retention of dental professionals across the system, strengthening frontline services. This initiative has driven a measurable increase in uptake by 48%, supporting the recruitment of 50 new dental professionals to the area to date.
- Supporting dental practices in becoming Learning Organisations, enabling them to host Dental Foundation Training (DFT) students and/or university-level placements. This programme has strengthened the baseline position, with one additional approved practice secured. A further 10 dental practices have expressed interest in becoming DFT practices, with applications currently being submitted for approval through the regional dental deanery.
- Significant progress was made in the latter part of the year to encourage practices to adopt the Greener Dentistry Toolkit and begin embedding sustainability actions within their green plans. Engagement has increased from a zero baseline in 2024/25 to 11 practices currently participating. There is clear potential to build on this momentum in 2026/27 by further supporting

Webb, Sarah  
07/01/2026 14:56:21

participating practices and encouraging wider uptake, including support to review and update sustainability plans across the system.

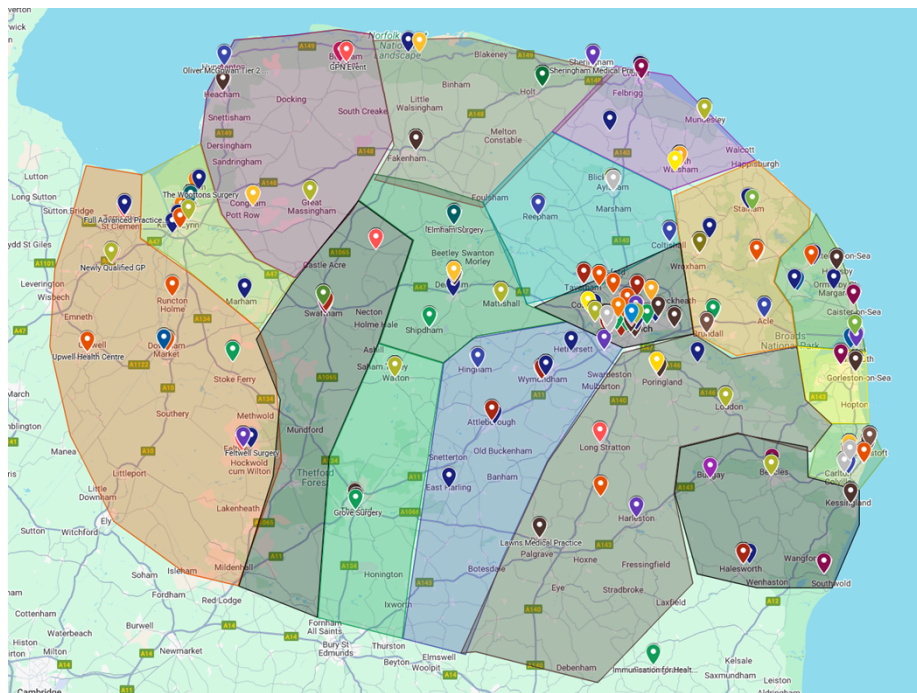
- Strong sector engagement has supported the recruitment of 12 new dental apprentices this year, representing a 41% increase compared with the previous year. With the national development of a Level 4 Oral Health Practitioner apprenticeship, there are expanded opportunities to strengthen this component of the Grow Your Own Workforce initiative.
- In collaboration with the national More and Different programme, current gaps and opportunities in both clinical and non-clinical career pathways within dentistry have been identified. Building on this work, a targeted initiative will be launched in Lowestoft as part of the Coastal Navigators Network. The programme will be led by the introduction of a Norfolk and Waveney Dental Nurse Fellowship from Q4.
- Norfolk and Waveney has taken a regional leadership role, alongside the East of England's national coordination, in redeveloping the Level 2 service specifications for Periodontics, Endodontics, and Paediatric specialities. Key achievements include supporting a regional accreditation panel, developing a triage pilot plan, and leading engagement with regional dentists to design an optimal service delivery pathway, with implementation planned for 2026/27. Workforce development has also been a priority, with clear progression routes to MSc-level training identified for 2026/27.
- The Dental Workforce Business Intelligence dashboard is now live, offering a robust platform to monitor workforce trends, identify emerging challenges, and evaluate programmes. By enabling data-driven decision-making and measuring programme impact, it supports strategic workforce planning and optimisation. Notably, the area has seen a 2% increase in dental professionals over the past six months, the first growth since 2019.



Webb, Sarah  
07/01/2026 14:56:21

## General Practice and Primary Care Network Workforce

The image below shows the current adoption of GP Schemes in Norfolk and Waveney, highlighting a 99% adoption rate across the system.

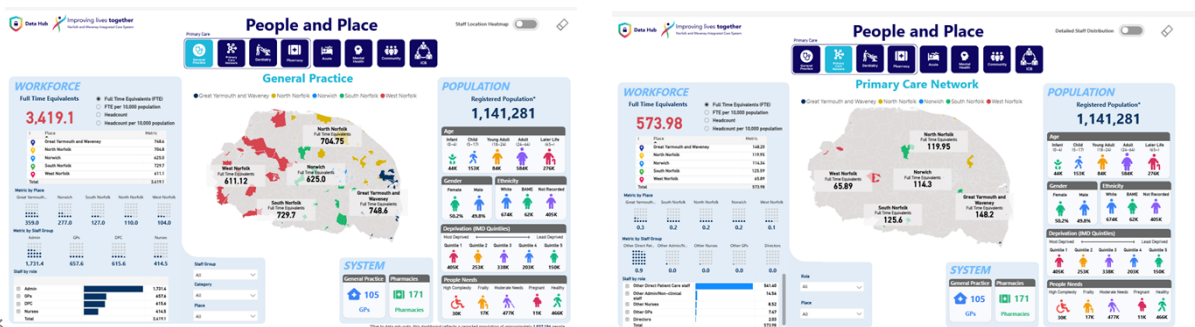


Highlights include:

- The latest data from the national GP Dashboard shows that Norfolk and Waveney has improved its national ranking from 13th to 3rd, demonstrating positive workforce growth. Additionally, it now holds the top position in the East of England, reflecting the dedication from the ICB and the strong support of our system partners.
- Norfolk and Waveney participated in the NHS General Practice Staff Survey for the third consecutive year, achieving a 73% increase in practice participation and receiving 529 responses. Survey results are expected by Spring 2026.
- The scope of Newly Qualified Incentives has been broadened to encompass post-registration GPs, Nurses, Paramedics, Pharmacists, Pharmacy Technicians, and GPs in ARRS roles. Expressions of interest are being accepted until mid-January, with 39 incentives approved to date. Notably, this represents a 22% reduction compared to previous years, highlighting the need to assess engagement and consider strategies to maintain uptake.
- To support delivery of Oliver McGowan mandatory training for General Practice, which focuses on learning disability and autism awareness, uptake across the system has reached 88.7%. This programme has been strategically expanded to all the four sectors of primary care, providing staff with Tier 1 and Tier 2 training and strengthening workforce capability, equity of care, and compliance with national standards across the system.

Webb, Sarah  
07/01/2026 14:56:21

- A range of development opportunities has been launched for non-clinical GP staff and has received positive feedback to date. This success is largely attributed to proactive engagement with system stakeholders, which has helped identify knowledge and skill gaps within the non-clinical workforce. This focus recognises that non-clinical staff represent 52% of the general practice workforce and manage the majority of patient access across multiple communication channels.
- 96% of general practices within our system are now NHSE-approved learning organisations, able to host medical placements, including 233 accredited primary care educators. This represents a 29% increase compared with the previous year, reflecting significant growth in our capacity to support medical education and workforce development.
- Partnered with GP practices across Norfolk and Waveney to drive the integration of volunteer support, enhancing staff efficiency and improving patient access and experience. Conducted on-site assessments and gathered stakeholder feedback, revealing strong interest in Digital Support Volunteers to facilitate the shift from analogue to digital systems and increase adoption of the NHS App
- Our information is now fully integrated into the Connect Now Digital Platform for primary care staff, enhancing digital engagement and enabling real-time monitoring of interactions with our resources. Weekly newsletter engagement consistently exceeds 200 views, while primary training pages receive an average of 287 views per month, demonstrating effective digital reach and adoption.
- The General Practice and Primary Care Network Workforce Business Intelligence dashboard is now live, offering a robust platform to monitor workforce trends, identify emerging challenges, and evaluate programmes. By enabling data-driven decision-making and measuring programme impact, it supports strategic workforce planning and optimisation. Notably, the area has seen a 15% increase in Primary Care Networks Additional Roles over the past 12 months.



From Q2 onwards, vacancy growth has moderated, with GP and non-clinical roles accounting for 66% of advertised positions across the system.

Webb Sarah  
07/01/2025 14:56:21

Count of Staff Group	Column Labels									
Row Labels	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Grand Total
<b>General Practice</b>	<b>38</b>	<b>40</b>	<b>33</b>	<b>25</b>	<b>8</b>	<b>10</b>	<b>16</b>	<b>9</b>	<b>13</b>	<b>192</b>
Admin	12	9	10	7		1	1	1	1	42
Direct Patient Care (DPC)	6	7	3	2		1	3		2	24
GPs	12	16	14	13	8	7	9	8	9	96
Nurses	7	8	6	3		1	3		1	29
Other (blank)	1									1
<b>General Practice- Pharmacy</b>	<b>3</b>	<b>4</b>	<b>2</b>	<b>3</b>			<b>1</b>		<b>3</b>	<b>16</b>
Direct Patient Care (DPC)	3	4	2	3			1		3	16
<b>Grand Total</b>	<b>41</b>	<b>44</b>	<b>35</b>	<b>28</b>	<b>8</b>	<b>10</b>	<b>17</b>	<b>9</b>	<b>16</b>	<b>208</b>

### Continuous Professional Development (CPD)

A new approach to CPD funding for General Practice Nursing, Midwifery, and AHP staff in 2025/26 has been approved by the Training Needs Analysis Steering Group and endorsed by the Primary Care Commissioning Committee (PCCC). Developed in response to stakeholder feedback, the pilot allocates CPD funding to PCNs on a weighted basis, reflecting workforce size and local priorities.

Each PCN has submitted an assurance plan aligned with local needs and objectives, which has been positively received by GP practices and the Local Medical Committee (LMC). The pilot will be monitored throughout 2025/26 to inform the design of future CPD funding models and support broader workforce development strategies. It is anticipated that 1,668 staff members will benefit from CPD investment representing a 10% increase on the previous year.

### Optometry Workforce

The image below shows the current adoption of Optometry workforce schemes in Norfolk and Waveney, highlighting a 50% increase in adoption compared with the 2024/25 programmes.



Webb, Sarah  
07/01/2026 14:56:21

Highlights include:

- We have established a robust and strategic partnership with the Local Optical Committee (LOC), founded on shared objectives and mutual respect. Through regular engagement, transparent decision-making, and sustained dialogue, we have ensured alignment on key priorities.
- This collaboration has delivered high-impact initiatives, including the Newly Registered Optometrist Incentive, launched in Q3, achieving a 50% increase compared with the previous year. This success reflects close joint working with the LOC and Optometry Commissioning colleagues and demonstrates the value of aligned strategic effort.
- Looking ahead, Continuous Professional Development (CPD) workstreams are scheduled for launch in Q4. These initiatives are designed to address the gaps identified in the Training Needs Analysis of the optometry workforce, strengthening skills, career development, and service quality across the sector.
- Complementing these initiatives, the introduction of a structured coaching and mentoring programme for optometry staff, also launching in Q4, will act as a strategic enabler of workforce transformation and service sustainability. By providing targeted professional support, the programme will enhance leadership capability, clinical confidence, and workforce adaptability, directly supporting system priorities for quality, productivity, and resilience.

### **Challenges of the Primary Care Workforce Delivery Plan 2025/26**

Despite the successful execution of the 2025/26 operational delivery plan, several challenges have been identified, these include:

- Implementing new workforce models and development pathways necessitates shifts in established behaviours and mindsets. Resistance to change remains a key barrier, particularly where traditional approaches are deeply embedded, with initiatives such as training opportunities, yet to achieve meaningful uptake.
- Challenges persist in engaging PCNs with Continuous Professional Development days, particularly in creating capacity within clinical workloads. Participation can be affected by seasonal pressures and ensuring that communications consistently reach the appropriate individuals remains an ongoing issue.
- The Physician Associate (PA) workforce is experiencing national and local pressures. The Leng Review has created uncertainty around PA scope, deployment, and integration, compounded by ongoing legal challenges and variations in national leadership. Indemnity under the CNSGP provides some reassurance, but ambiguity continues to affect retention and workforce stability. Recruitment is limited, with only two local vacancies advertised in the past year, and the closure of the UEA PA programme will reduce future student placements. Attrition to alternative careers is contributing to a

Webb, Sarah  
07/01/2026 14:56:24

reduction in available clinicians. Without national clarity and coordinated leadership, recruitment pipelines and workforce planning across primary and secondary care may be further affected.

- Training provider engagement (Dental & Optometry): Securing reputable training providers to deliver agreed offers has been challenging due to a historically fragmented local landscape, where individual practices have independently commissioned training. This has constrained system-level relationships with providers and limited access to suitable options without reliance on paid memberships or additional procurement routes.
- ICB organisational changes may have implications for the future capacity and sustainability of the Primary Care Workforce Team. Support for the primary care workforce is being positioned within the “Strategic Workforce” remit of the proposed staff consultation. Role and responsibility changes with potential impact on project continuity will require management. The procurement of the National Training Hub Contract from 1<sup>st</sup> April 2027, with a potentially expanded scope across the four primary care pillars, offers a means to strengthen workforce development and support delivery and is welcome.

## Primary Care Workforce Risks

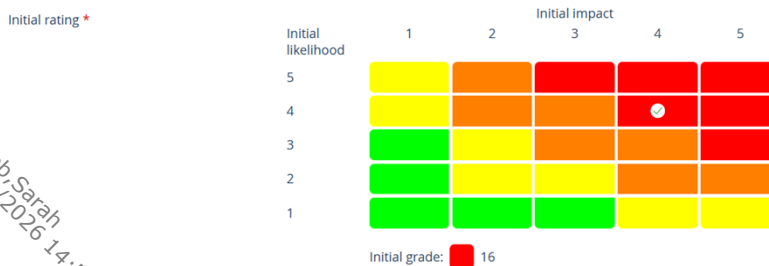
This paper summarises progress during 2025/26 on two key workforce risks and provides updates on their status. On 9 December 2025, the General Practice & Community Pharmacy Delivery Group reviewed a proposal to reduce both risk scores, following mitigation measures that have now brought them within the tolerated risk appetite level.

The workforce review focused on two primary care workforce risks:

1. **Risk 54:** Shortages in the general practice medical and nursing workforce, driven by vacancies and impending retirements, with consequential impact on patient access and service delivery.
2. **Risk 55:** Vacancies and retention challenges within Additional Roles Reimbursement Scheme (ARRS) and Direct Patient Care roles, also affecting service delivery capacity.

Both risks previously had unmitigated scores below the threshold:

### Unmitigated Risk Score



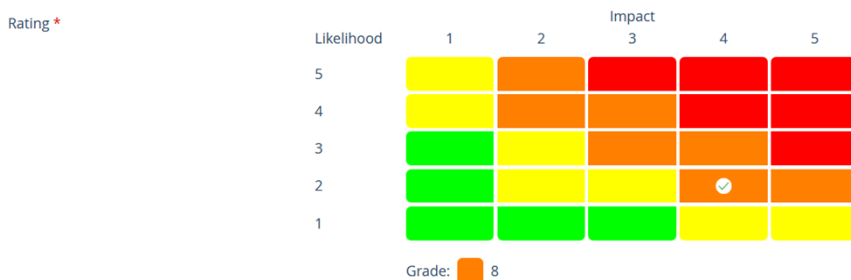
Webb, Sarah  
07/01/2026 14:56:21

Key progress highlights from actions implemented:

- Recruitment success rate across general practice roles reached 97% (plan vs. trajectory).
- Reduction in medical locum and GP retainer vacancies, with an increasing number of medical staff seeking salaried positions, supporting system-wide workforce stability.
- National workforce data indicates positive trends, with the system ranked 3rd nationally and 1st across the East of England.
- The ICS Training Hub’s continuation until 31 March 2027 reinforces retention and operational support mechanisms.
- The Primary Care Workforce Team will continue monitoring workforce trajectories and planning cycles to maintain and strengthen workforce stability.

The review team concluded that mitigation measures have successfully reduced both workforce risks to levels within the organisation’s risk appetite.

Mitigated Risk Score



They also confirmed that the target risk score has been achieved and formally request approval to close the risk, noting that ongoing monitoring of workforce schemes will continue through the standard oversight processes of the ICB Workforce Team.

Target Risk Score



The General Practice & Community Pharmacy Delivery Group approved the following recommendations on 9<sup>th</sup> December 2025, and the Primary Care Commissioning Committee is now being asked to ratify these decisions in relation to the primary care workforce risks (54 and 55):

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07/01/2026 14:56:21

- Agree with the review team’s assessment that mitigation measures have successfully reduced both workforce risks to within the organisation’s risk appetite.
- Approve closure of the risks, recognising the target risk scores have been achieved.
- Acknowledge that workforce schemes will continue to be monitored through standard oversight processes by the ICB Workforce Team.
- Note that overall risk levels have reduced sufficiently to move from increased oversight to standard monitoring, with delivery options considered at an acceptable level of reward.

**Recommendation to Committee:**

1. To note the primary care strategic workforce recruitment and retention programme update and financial information linked within the report.
2. The committee is asked to approve the following in relation to primary care workforce risks (54 and 55):
  - Agree with the review team’s assessment that mitigation measures have successfully met the organisation’s risk appetite.
  - Approve closure of the risks, recognising that the target risk scores have been achieved.
  - Acknowledge that workforce schemes will continue to be monitored through standard oversight processes by the ICB Workforce Team.
  - Note that overall risk levels have reduced sufficiently to move from increased oversight to standard monitoring, with delivery options considered at an acceptable level of reward

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

Webb Sarah  
07/01/2024 14:56:21

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

## Governance

<b>Process/Committee approval with date(s) (as appropriate)</b>	Audit Committee for information.
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Webb, Sarah  
07/01/2026 14:56:21

Key :  
 Delivered above target - Dark Green  
 Delivered on target - Light Green  
 On track to be delivered - amber  
 Not delivered/unable to be delivered - Red

PMO Pillar	PMO Programme	Sector	Contractual KPI's - NHSE (see KPI tab for detail)	Aims - What are the aims of your project, these can be specific or wider, you might have one overall aim and then individual aims for parts of the project	PCW Targets These are the locally set targets, they should SMART targets closely linked to the aims of the project.	Project Delivery Status December 25	Rationale for non delivery of target
Clinical Leadership Development	Practice Partnership Development Programme	GP	1, 19, 20	To support the recruitment of new or returning GP partners within Norfolk and Waveney by offering targeted incentives that encourage GPs to consider partnership roles in the region.	1. Support recruitment of 2 partners by 31/12/25.	1. Delivered above target	
Clinical Leadership Development	Bespoke Retention Packages	Dental	19, 20	To develop a bespoke support package for both clinical and non-clinical staff, specifically targeting practices with fewer than 20 employees located in high-deprivation areas, aligned with the Core20PLUS5 framework, to enhance workforce wellbeing and retention.	1. Design bespoke retention package for clinical and non-clinical staff in Norfolk and Waveney Dental Practices by 30/09/25.	1. Delivered on target	
Clinical Leadership Development	Coaching and Mentoring Support - Akeso	All	1, 19, 20	To enhance the retention of healthcare professionals in General Practice and Dental workforce by providing coaching that can help refine skills, foster leadership, and promote well-being.	1. Engage Pharmacy and Optometry stakeholders to assess interest in extending the coaching offer and record feedback by 31/12/2025. 2. Contact 100% of Dental & General Practices to promote the new coaching offer by 31/08/2025. 3. Ensure all 200 coaching sessions are utilised by 31/12/26.	1. Delivered on target 2. Delivered on target 3. On track to be delivered	
Clinical Leadership Development	Clinically Led Workforce Transformation Programme	GP	1, 19, 20	To deliver clinically led innovations and targeted interventions—driven by the Primary Care Workforce Transformation (PCWT) Fellows—that support specific clinical cohorts across primary care settings.	1. Target First Contact Practitioner Musculoskeletal specialists to enhance workforce progression into advanced practice by another 30% (6 PCN's) by 31/12/25 to support new ways of working and streamline the patient pathway. 2. Develop a preceptorship for paramedics/FCPs for first initial year for support & training - support the three new recruits immediately but future recruits by 31/12/2025 3. Deliver 3 targeted upskilling workshops or e-learning modules for the physician associate workforce by 01/03/26 with 80% of attendees reporting increased confidence or competence. 4. Support recruitment of 3 Registered Nurses and 10 Registered Nursing Associates into general practice settings, to address workforce shortages and improve patient care delivery by 31/03/26. 5. Support recruitment of 1 Professional Nurse Advocate within general practice to support nurse wellbeing, professional development, and restorative supervision across the workforce by 31/03/26. 6. Increase the number of Nursing Supervisors and Educators within the system by 15% compared to the March 2024 baseline, to strengthen clinical education capacity and supervision for student and newly qualified nurses by 31/03/26. 7. Support 20 general practices with General Practice Nurse (GPN) skill mix reviews and workforce planning interventions, to optimise service delivery and prepare for future workforce needs by 31/03/26.	1. Not delivered - 2. On track to be delivered 3. On track to be delivered. 4. On track to be delivered 5. On track to be delivered 6. Exceed target at 19% 7. Exceed target by 120% (44 visits)	1 Unable to be delivered due to complexities of those employed in ARRS roles through a third party employer & uncertain financial times for PCNs.
Communication	Primary Care Digital targeting recruitment	All	1, 19, 20	To pilot the use of digital targeting within a specific place and specific role to increase applications and recruitment.	1. Procure a new digital provider to deliver a recruitment campaign across 5 primary care practices by 31/09/25. 2. Pilot a digital marketing campaign covering 5 primary care roles within Norfolk & Waveney by 31/12/25. 3. Increase role-specific joining rates compared to the 2024 baseline by 31/03/26.	1. Delivered on target 2. On track to be delivered 3. On track to be delivered	
Development of Systems	Schwartz Rounds	All	1, 2, 3, 5, 9, 11	To offer a safe and confidential group reflective practice forum for staff, that will help to combat isolation across the ICS thus improving morale and increasing workforce retention.	1. Deliver 14 Schwartz Rounds by 31/03/26. 2. Achieve a 50% evaluation response rate from participants for each session.	1. On track to be delivered 2. Not on track to be delivered (currently 38.7%)	Unlikely the 50% evaluation response rate will be achieved, due to the number of Schwartz Rounds sessions to be delivered by March 2026.
Digital Innovation	ConnectNow Intranet	All	1, 4, 8, 10, 11, 19, 20	To develop and implement the new ConnectNow Intranet platform for use by primary care throughout the system	1. Launch an easily accessible and dedicated Primary Care Workforce resource section on Connect NoW by 31/07/25. 2. Increase the number of views to the PCWT General Practice Catalogue by 10% against the baseline of 250 (May 25 data) by 31/12/25.	1. Delivered 2. Delivered above target	
Education and Training	Mandatory Training Delivery	GP	2, 3, 4, 5, 10	To support delivery of nationally mandated training for General Practice (i.e. Oliver McGowan)	1. Ensure 80% uptake of available of Oliver McGowan (OM) training places by N&W Primary Care staff by 31/12/25 2. Ensure 30% of GP workforce trained in Tier 1 and Tier 2 by 31/12/25.	1. Above Target (88.7%) 2. Above target (November 2025) - currently at 30.12%	
Education and Training	Newly Qualified Clinical & Medical Programme	GP	1, 19, 20	To support newly qualified registered clinicians into roles in general practice, to assist workforce planning, recruitment and retention.	1. Deliver 30 incentives to newly qualified clinicians in Norfolk and Waveney by 31/12/2025.	1. Delivered 26.7% above target - 38 currently approved 10/12/25	
Education and Training	CPD Programme	GP	2, 3, 4, 5, 10	To ensure all Registered Nursing Associates, Registered Nurses, Registered Midwives and Registered Allied Health Professionals are offered and undertaking Quality Continuous Professional Development (CPD) opportunities, with a focus on reducing health inequalities.	1. Achieve a Training Needs Analysis response rate of 50% of GP practices by 01/04/25. 2. Increase the uptake of Continuing Professional Development by 10% (target to achieve this is 1668 staff undertaking CPD) by 31/03/26 3. Deliver one Health Inequalities training session for Primary Care by 31/03/26.	1. Delivered above target - 55% completion rate. 2. On track to be delivered (currently at 1563 staff trained 16/12/25) 3. On track to be delivered	
Education and Training	ENHANCE Generalist	All	4, 5, 10	To deliver the national ENHANCE programme through a series of training events aimed at introducing participants to the ENHANCE training and support their ongoing professional development.	1. Deliver training to 120 participants by 31/12/25. 2. Support delivery of 1 Quality Improvement project by 31/03/26.	1. Delivered above target 2. On track to be delivered	

Webb Sarah  
 07/01/2026 14:56:21

Education and Training	Bespoke Retention Packages	Dental	4, 5, 10	To ensure dental professionals are offered and undertaking Quality Continuous Professional Development (CPD) opportunities, with a focus on reducing health inequalities.	1. Achieve a Training Needs Analysis response rate of 30% of Dental practices by 16/06/25. 2. Provide a package of CPD training to 100% of dental staff by 31/12/25.	1. Delivered on target 2. Delivered on target	
Education and Training	FCP Supervisor Project	GP	2, 3, 4, 18	To support First Contact Practitioners (FCPs) On track to be delivering toward supervisor status by addressing the current shortage of accessible FCP supervisors across the locality.	1. Deliver 4 East of England First Contact Practitioner (FCP) Supervisor Courses by 31/03/26.	1. On track to be delivered	
Education and Training	Terms of Agreement Training	Dental	1, 14, 15, 20	To provide support to overseas dentists, helping them join the performers list.	1. Deliver 8 Terms of Agreement (TOA) training events by 31/12/25. 2. Create TOA Community with TOA dentists engaged by 31/12/25. 3. Develop Post-TOA support package by 31/12/25 for delivery 26/27	1. Complete 2. Complete 3. Complete	
Placements	GP Placement Capacity Increase	GP	14, 15	To support increased placement capacity throughout General Practice	1. Establish a baseline number of clinical and medical student placements by 30/09/25.	1. Behind target, however anticipated delivery by March 2026.	Delayed due to roll out of PATH system, which is waiting approval from Joint Controllers Group (DPO for Primary Care).
Placements	General Practice Apprenticeships	GP	6, 7	To promote and support the uptake of apprenticeships across primary care roles, strengthening workforce development and career progression pathways.	1. Support successful enrolment of 25 apprenticeships in N&W General Practices by 31/03/26.	1. Delivered above target	
Placements	NTP Fellowships & Supporting Mentors	GP	1, 4, 10, 19, 20	To support newly qualified GPs to transition into substantive careers within Norfolk and Waveney's Primary Care sector from structured education for the final year of the programme, including the provision of mentors.	1. Support 17 GP New to Practice Fellows for year two of their Fellowship programme by 30/09/25. 2. Provide 10 hours of mentorship via the Supporting Mentors programme to each New to Practice GP Fellow by 31/03/26.	1. Delivered on target 2. Delivered on target	
Placements	Dental Apprenticeships	Dental	6, 7	To recruit and upskill existing practice staff through the Dental apprenticeship programme, strengthening workforce capacity and supporting long-term career development in primary care dentistry.	1. Recruit 12 dental apprenticeships by 31/12/25.	1. On track to be delivered	
Support for New GP Educators	New GP Educator Programme	GP	18	To support newly qualified GP Educators following successful completion of the Aspiring Educator Programme.	1. Deliver 2 new educators forum sessions which incorporates patient quality themes by 31/03/26. 2. Deliver 1 workshop on Building and Maintaining Trusting Relationships focusing on patient quality by 31/03/26.	1. Delivered on target 2. On track to be delivered	
System Wide and Place Based Transformation	Dental Learning Organisation Expansion	Dental	14, 15, 17, 18	To support dental practices in becoming "Learning Organisations," this programme will enable hosting of Dental Foundation Training (DFT) students and/or university-level placements. It will include incentives for Dental Supervisors, dental equipment grants, and other measures to foster a strong learning environment. By implementing these elements, the programme aims to enhance training pathways and develop the dental workforce effectively.	1. Approval of one new Dental Training Practice in N&W by 30/06/25. 2. Support two applications for Dental Foundation Training Practice for NHS England (NHSE) Panel review by 31/03/26.	1. Complete 2. On track to be delivered	
System Wide and Place Based Transformation	Overseas Workforce Visa Support	Dental	1, 20	To provide practices with support to encourage overseas dental professional recruitment.	1. Provide visa support to 8 dental practices in Norfolk & Waveney by 31/12/25.	1. Delivered 12.5% above target - 9 currently approved 09/12/2025	
System Wide and Place Based Transformation	General Practice Learning Organisation & Aspiring Educators Programme	GP	12, 13, 14, 15, 16, 17, 18	To consolidate the Tier 3 and Learning Organisation (LO) Incentive Programme with the Aspiring Educators Programme into a single initiative that will support practices to develop their placement capacity, educator & supervisor numbers and support General Practice/PCNs to become learning organisations.	1. Increase the number of Learning Organisations (LOs) across Norfolk & Waveney by one by 31/03/26. 2. Support the approval of at least 30 new aspiring GP educators by 31/03/26. 3. Support the approval of 10 additional multiprofessional primary care educators and supervisors by 31/03/26.	1. Delivered above target 2. Delivered on target 3. On track to be delivered	
System Wide and Place Based Transformation	Underperforming Dental Practice Support	Dental	9, 10, 19	To deliver a support package for dental practices that are/at risk of under delivering their Unit of Dental Activity (UDA)s. Supporting development of all non-clinical roles within General Practice.	1. Offer a support package to 100% of practices identified as underperforming by 31/12/25. 1. Deliver a bespoke development programme for the non-clinical workforce in General Practice by 01/09/25.	1. Delivered on target 1. Delivered on target	
System Wide and Place Based Transformation	General Practice Workforce Transformation	GP	1, 19, 20				
System Wide and Place Based Transformation	General Practice Induction Programme	GP	1, 4, 5, 10, 19, 20	To provide training days to support new members of staff transition into roles in primary care.	1. Launch an induction programme specifically designed to support all GP staff in Norfolk and Waveney Primary Care by 30/06/25. 2. From July 2025, deliver bi-monthly induction sessions, ensuring participation from new staff across at least 5 different roles per session by 31/12/25.	1. Delivered 2. On track to be delivered	
System Wide and Place Based Transformation	Equality, Diversity and Inclusion (EDI) Programme	All	9, 11	To provide Equality, Diversity and Inclusion (EDI) training and events to enable Primary Care Providers to better address EDI challenges in their workforce and patient populations.	1. Deliver 3 training events by 01/02/26.	1. On track to be delivered	
System Wide and Place Based Transformation	Greener Dentistry	Dental	1, 19	To support practices to review and update their sustainability plans.	1. Increase the number of dental practices using the greener dentistry toolkit to 15 across N&W by 01/12/25.	1. On track to be delivered	
System Wide and Place Based Transformation	Health and Wellbeing Programme	All	1, 4, 5, 20	To deliver a health & wellbeing offer to primary care workforce, supporting staff resilience, retention, and overall wellbeing across Norfolk and Waveney.	1. Deliver Health & Wellbeing offer to 600 primary care staff by 31/03/26. 2. To recruit 10 Dental Health & Wellbeing Ambassadors and Champions by 31/12/25.	1. On track to be delivered 2. Delivered	
Workforce Planning	Late Stage Career Recruitment	Dental	1, 17, 18	To design and deliver a targeted recruitment campaign that attracts late-stage career dentists to Norfolk and Waveney, supporting workforce sustainability and service continuity.	1. Develop recruitment strategy by 01/09/25. 2. Support recruitment of 2 late-stage career dentists into N&W by 31/03/26.	1. Complete 2. On track to be delivered	
Workforce Planning	GP Visa Reimbursement	GP	1, 20	To support General Practices in the recruitment of international General Practitioners by providing funding and guidance for visa sponsorship.	1. Provide GP Visa reimbursement to 8 general practices in Norfolk & Waveney by 31/12/25.	1. Delivered 62.5% above target - 13 currently approved 15/12/25	

Workforce Planning	N&W Bespoke Golden Hellos	Dental	1, 19, 20	To deliver a N&W specific Golden Hello package to support recruitment and retention of dentists in N&W.	1. Deliver 16 Golden Hello Incentives to Dental Professionals in Norfolk and Waveney by 31/01/25.	1. Delivered above target	
Workforce Planning	Optometry	Optom	1, 4, 5, 10, 19, 20	To support newly qualified Optometry professionals in securing permanent roles within Norfolk and Waveney's primary care sector, while identifying and addressing training needs to deliver targeted development opportunities that enhance eye care services and reduce health inequalities.	1. Achieve a Training Needs Analysis response rate of 20% of Optometry practices by 30/09/25. 2. Offer five Newly Qualified Optometrist incentives to support healthcare professionals to take up a role in Primary Care by 31/12/25. 3. Deliver one Health Inequalities training session by 31/03/26.	1. Delivered above target - 27.91% completion rate. 2. Delivered above target - 8 approved 3. On track to be delivered	
Workforce Planning	Flexible Staff Pool (FSP)	GP	1.00	To support the mandated commitment to ensure there is a Digital Flexible Pool Provider in Place for Norfolk and Waveney	1. Procure a provider of the mandated Flexible Staff Pool (FSP) solution by 15/06/25.	1. Delivered on target	
Workforce Planning	Workforce & Succession planning support	Dental	1, 19, 20	To engage practices in order to understand a the Place level what workforce support is required.	Support practices that are identified as a high risk of partnership succession by 31/12/25.	1. Delivered on target	
Workforce Planning	Primary Care Young People Engagement	All	1, 6, 7, 19	To develop career pathways in general practice and dentistry that may include university-level education within Norfolk and Waveney.	1. Create 4 role specific career specific pathways in dentistry and general practice by 31/12/25.	1. Delivered on target	
Workforce Planning	Dental First Five	Dental	19, 20	To support dentists throughout the first five years of Dental Core Training (DCT). Incorporating the N&W Dental Fellowship Model, offering tailored levels of support specific to each year of the training. The initiative emphasises professional development and ensures dentists are prepared for the next stages of their career. By addressing the unique needs of each year, the programme aims to foster progression and strengthen the dental workforce.	1. Develop new "First Five Programme" offer for Dental Practices in Norfolk and Waveney by 01/08/25. 2. Recruit 5 new Dental "Fellows" by 31/03/26. 3. Deliver 1 "Dental First Five" event by 31/03/26. 4. Offer First Five package to 100% of Dental Practices in Norfolk and Waveney by 31/12/25.	1. Delivered on target 2. Delivered on target 3. Not delivered 4. Delivered on target	3. Dental First Five event will not be delivered due to resourcing capacity within the ICB PCWT and dental fellows clinical capacity
Workforce Planning	Community Voice Programme	All	9, 10	To Engage with the Health Inequalities and Voluntary, Community and Social Enterprise (VCSE) team to determine how dentistry can engage with service users through the Community Voice programme.	1. Deliver 2 Community Voices projects with key recommendations to improve patient engagement and accessibility for each primary care sector by 31/03/26.	1. On track to be delivered	
Workforce Planning	Practice Workforce Planning Support	GP	1, 19, 20	To engage with and visit each individual practice identified in the GP Action Plan as requiring support, in order to understand workforce needs at Place level and tailor appropriate interventions.	1. Support the 5 practices that have been identified in the GP action plan to improve their negative workforce variation by 31/12/25.	1. On track to be delivered	
Workforce Planning	Volunteering Development	Dental	1, 19	To collaborate with the Health Inequalities and Voluntary, Community and Social Enterprise (VCSE) team to explore opportunities for dentistry to integrate volunteers into its workforce.	1. Identify and pilot two new volunteering roles in General Practice by 31/12/25. 2. Identify and pilot one new volunteering role in Dentistry by 31/03/26.	1. On track to be delivered 2. On track to be delivered	

Webb Sarah  
07/01/2026 14:56:21

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

Webb, Sarah  
07/01/2026 14:56:21

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

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

Webb Sarah  
07/01/2026 14:56:21

Agenda item: 11

<b>Subject:</b>	<b>General Practice &amp; Community Pharmacy Delivery Group Report</b>
<b>Presented by:</b>	<b>Sharon Gardner, Head of Primary Care Commissioning Pharmacy and Optometry</b>
<b>Prepared by:</b>	<b>Shepherd Ncube, Associate Director of Primary Care Commissioning Sharon Gardner, Head of Primary Care Commissioning Pharmacy and Optometry Mary Cummins, Primary Care Commissioning Support Officer</b>
<b>Submitted to:</b>	<b>Primary Care Commissioning Committee</b>
<b>Date:</b>	<b>14 January 2026</b>

**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 including discussions and decisions that took place in December 2025. this paper is for noting.

<b>Delivery Group:</b>	General Practice & Community Pharmacy Delivery Group
<b>Delivery Group Chair</b>	Mark Burgis, Executive Director of Patients and Communities (Sadie Parker, Director of Primary Care – Chair for 9 December 2025 meeting)
<b>Meetings since the previous update to PCCC on 1<sup>st</sup> October 2025</b>	9 December 2025
<b>Overall objectives of the Delivery Group:</b>	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").
<b>Main purpose of meeting:</b>	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.

Webb, Sarah  
07/01/2026 14:56:21

<p><b>BAF and any Committee risks relevant / aligned to this Committee.</b></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><b>Operational Risks</b></p>	<p><b>General Practice Resilience: 00000023</b>  <b>Community Pharmacy Resilience: 00000056</b></p> <p>There were no significant changes to the risks around resilience in general practice and community pharmacy and the scores remained the same.</p> <p>A focus was placed on good progress within the primary care workforce risks, and the group noted that Norfolk and Waveney were now ranked third nationally for positive variation in primary care workforce. There was a discussion regarding issues around recruitment of doctors and it was suggested that this could be raised with practice staff at practice visit meetings led by the delegated commissioning team for medical.</p> <p>A recommendation to reduce the risk scores and to reframe the risks as part of the overall shift towards a patient-focused risk approach was discussed and supported by the group and will form part of the risk report to the PCCC in January 2026.</p> <p>It was noted that a review of all risks would be completed by end of January and will be reported to the committee in line with the updated forward planner.</p> <p><b>Operational Risk Register</b></p> <p>Significant improvements in the primary care workforce risks were highlighted and the group approved the proposal to take these risks to committee for formal approval of a reduction in scoring as follows and the closure of these risks at committee level. It was recommended that these risks be monitored at standard level going forward.</p> <p>General Practice – Allied Health Professionals Workforce including PCN Additional Roles – risk to be reduced from 12 to 8.</p> <p>General Practice - Workforce (GPs and Nurses) – risk to be reduced from 12 to 8.</p>
<p><b>Key items for Committee to take note of</b></p> <p><i>To highlight if any items include:</i></p> <ul style="list-style-type: none"> <li>• <i>Changes to national policy/strategy</i></li> <li>• <i>Quality &amp; safety matters</i></li> </ul>	<p><b>Chair's Action</b></p> <p>A paper was presented which comprised a summary of recent schemes led by the Estates team. Offline approval had been granted by voting members for schemes involving Utilisation and Modernisation Funding (UMF) proposals, allowing the progression of work on these schemes in a timely fashion.</p> <p>A premises scheme for a particular practice had been transferred from business as usual (BAU) to UMF, a national funding initiative for primary care announced last year, at the suggestion of NHS England. Negotiations were underway</p>

Webb Sarah  
07/01/2026 14:56:21

with the landlord for a premises scheme at another practice to achieve value for money for the NHS.

The Local Medical Committee (LMC) were thanked for their support with The Building Safety Act Advice Note following training with NHS England Property Services.

### **Integrated Performance Report**

The Integrated Performance Report paper was presented to the group for noting which highlighted performance data in key areas such as GP appointments and access, the growth of community pharmacy services and learning disability health checks.

Positive trends in same-day and short-wait GP appointments compared to the previous year were reported, with analysis ongoing to identify key drivers behind the improvements.

The group noted record numbers of learning disability annual health checks and action plans completed, with targeted outreach to hard-to-reach groups and collaboration with Suffolk to improve coverage.

The paper highlighted significant growth in pharmacy contraception services, steady hypertension service uptake, and ongoing efforts to increase referrals. Work with the ICB place teams, GP practices and IC24 to increase awareness of the functions and capacity of community pharmacy including 111 referrals continued to take place. One potential risk was raised by the LPC around staff workload and funding pressures which they believed could decrease Pharmacy First growth in future years.

### **General Practice Contract Update**

The General Practice Contract Update paper was presented to the group for noting and outlined levels of compliance of general practices against the new requirements of the GMS contract which had been introduced on 1 October 2025.

All practices had completed the annual electronic self-declaration for the first time. However, one practice encountered technical issues, and their submission was not visible on the national system. NHS England were provided with evidence confirming that the submission was completed and the ICB were awaiting their consideration.

100% compliance was reported for online consultations, with ongoing operational learning and monitoring of system usage nationally and locally. Areas for monitoring included core opening hours, the provision of the link to You and Your GP

Webb, Sarah  
07/01/2026 14:56:21

(YYGP) on practice websites home pages, and practice engagement with GP Connect. All practices had been offered support with achieving contract compliance in the above areas if required.

### **GP Survey**

A detailed GP Patient Survey report was shared with the group and increased patient satisfaction following clinical contact was highlighted, as well as significant variation between PCNs.

It was noted one of the key elements of neighbourhood health development for general practice was improving access via the embedding of the Modern General Practice Model and the survey data was a key area to support the ongoing work programme.

### **Prescribing Report**

Practices with high rates of dependence-forming medication prescribing were listed in the Prescribing Report which was presented to the group for noting. It was recommended that primary care and quality teams address the over-prescribing issues during practice visits. Positive trends in antibiotic prescribing were noted.

Methods of communication to practices raising awareness regarding the overprescribing of dependence-forming medication were discussed and clarified at the meeting.

It was suggested colleagues from the medicines optimisation team could be invited to join primary care commissioning colleagues on practice visits to support collaborative working.

### **TIAA Audit Action - Establishment of goals for ARRS**

A verbal update on the TIAA Audit ARRS Action covered the introduction of a monthly business intelligence report tracking ARRS role appointment activity within the primary care network. Ongoing monitoring enabled the demonstration of value for money represented by the ARRS roles as required by the audit. As part of their monthly report the finance department reported on the ARRS scheme so that the level of utilisation of ARRS roles could be seen in each primary care network. It was advised that appointment activity and financial calculations were triangulated and shared with relevant ICB colleagues on a monthly basis.

In view of the progress made, the TIAA audit ARRS action was closed by the group.

### **Finance Report M07**

Webb, Sarah  
07/01/2026 14:56:21

	<p>The Finance Report for M07 was presented for noting and highlighted a net forecast underspend of £1.7 million against the 12-month plan for primary care excluding dental and optometry. The forecast underspend was mainly due to delegated commissioning savings, offset by unidentified efficiencies linked to sustainable commissioning. The figure was based on October 2025 data.</p>
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<p><b>Items receiving formal approval from the Delivery Group</b></p> <p><i>To include any financial risks</i></p>	<p><b>Forward Planner 2025/2026</b></p> <p>It was noted that the Local Enhanced Services (LES) and the Alternative Provider Medical Services (APMS) Updates had been deferred. The Forward Planner was approved by the group.</p> <p><b>Estates – Proposed Sale and Leaseback</b></p> <p>The Estates team presented the proposed sale and leaseback for one practice. It was confirmed the District Valuer Service had assessed the terms of the lease and considered them value for money for the NHS. The lease term would be fifteen years, with lease rent commencing at the same level as the existing notional rent. Appropriate and timely advice notes had been shared with the practice.</p> <p>A discussion took place regarding reasons for the increase in proposed sale and leasebacks of GP practices. It was noted the increasing difficulties of obtaining substantial personal loans and the risks involved for GPs was affecting the number who were prepared to take on this type of arrangement.</p> <p>The sale and leaseback was approved by the group with the following conditions:</p> <ul style="list-style-type: none"> <li>i) There is a condition that the practice should in due course either agree a schedule of improvement and repair works with their prospective landlord before leases are signed or confirm that such provision has been agreed by practice and landlord as not being required.</li> <li>ii) The preferences on certain lease terms as highlighted by the District Valuer should be considered.</li> </ul> <p><b>Estates – Revised Proposed Premises Scheme</b></p> <p>Following a previous premises scheme approval by the ICB and NHS England, a practice sold their premises to NHS Property Services and the scheme put on hold. The sale had completed but had impacted the proposed scheme. A revised scheme for refurbishment and reconfiguration was presented and in reflection of time passed and increased costs the value was indicated to be just under £101k including GP IT and VAT costs. Under the 2024 directions the practice was exercising its right to request 100% funding for the scheme.</p>
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07/01/2026 14:56:21

	<p>Approval was granted by the group for the approach to NHS England to be made in respect of the revised estates scheme. It was agreed that a plan towards the practice becoming a learning organisation was required.</p> <p><b>Covid Service Development</b></p> <p>The Covid Service Development paper proposed that selected pharmacies permanently stock a limited supply of oral antivirals for vulnerable patients to ensure direct and timely access over weekend and bank holidays. Upfront payments to pharmacies to mitigate financial risk and ensure timely access were also requested.</p> <p>The group approved the proposal for service enhancements for weekends to fund six strategically located pharmacies across Norfolk and Waveney to stock two boxes of Paxlovid, for the duration of their contract, in addition to their essential medicines list.</p> <p>The group approved the proposal for service enhancements for Bank Holidays to fund selected pharmacies that are commissioned to be open on winter bank holidays, to hold one box of Paxlovid mitigating risks caused by restricted wholesaler opening times.</p>
<p><b>Items for escalation to PCCC</b></p>	<p>There were no items requiring escalation to PCCC.</p>
<p><b>Confirmation that the meeting was quorate and all Voting Members (or nominated deputies on making decisions on behalf of Voting Member) present</b></p>	<p>The meeting was confirmed quorate. Attendance at the meeting is listed below:</p> <p>9 December 2025</p> <p><b>Voting members</b>  Sadie Parker, Director of Primary Care, NWICB - Chair  Shepherd Ncube, Associate Director, Primary Care Commissioning  Rashmi Balakrishnan, Primary Care Finance Reporting Manager (deputising for James Grainger, Head of Primary Care Finance),  Karen Watts, Director of Nursing and Quality</p>

**Recommendation to the Committee:**

The committee is asked to:

- Note the content of the report
- Approve the delivery group recommendation to reduce the scores of workforce risks 54 and 55 and transfer these risks to standard level monitoring.

Webb Sarah  
07/01/2026 14:56:21

<b>Key Risks</b>	
<b>Clinical and Quality:</b>	The Group will be monitoring quality improvement and development of a performance dashboard and overall assurance framework
<b>Finance and Performance:</b>	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.
<b>Impact Assessment (environmental and equalities):</b>	Each proposal is accompanied by an Equalities Health Impact Assessment to inform the Group's decision making. Papers to 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.
<b>Reputation:</b>	Healthwatch Norfolk and Healthwatch Suffolk, Local Professional Network and the Local Representative Committee are all represented on the Group
<b>Legal:</b>	Terms of reference, General Practice Contracts, NHS (pharmaceutical and local pharmaceutical services) regulations 2013 (the 2013 regulations)
<b>Information Governance:</b>	Information Governance matters will be highlighted as and when appropriate
<b>Resource Required:</b>	Primary Care Commissioning Team
<b>Reference document(s):</b>	Primary medical services regulations, statement of financial entitlements, premises directions and policy guidance manual, delegation agreement with NHS England.
<b>NHS Constitution:</b>	N/A
<b>Conflicts of Interest:</b>	<p>To note any specific Conflicts of Interests from Delivery Group meeting here and how managed are described above under each item, where appropriate.</p> <p>Arrangements are in place to manage conflicts of interest at each meeting and to accurately record and manage them.</p> <p>At the meeting held on 9<sup>th</sup> December 2025 conflicts of interest were noted and managed as follows:</p> <p>Item 1 and Item 7 – papers were restricted in circulation.</p> <p>Item 1: Advice had been sought from the ICB Governance team on how to manage this conflict in relation to the information provided in the paper. As the reference to the item for which a member held a conflict of interest was brief and concerned a decision that had already been made, the advice was that the individual</p>

Webb, Sarah  
07/01/2026 14:56:21

	<p>could remain in the meeting for this item but should not take part in the discussion.</p> <p>Item 7: Four conflicts of interest had been identified in advance of the meeting. As the paper was for approval, it was deemed appropriate that the individuals with declared conflicts of interest would be requested to leave the meeting for this item and return afterwards. The other two attendees identified with conflicts of interest in this item were unable to attend the meeting therefore no action was required in respect of those individuals.</p> <p>Two additional conflicts of interest were declared at the meeting but both were historical and therefore it was agreed that no action was required.</p>
<p><b>Reference to relevant risk on the Board Assurance Framework</b></p>	<p>BAF02 – Primary Care Resilience and Transformation  BORR11 – Resilience of General Practice  BORR27 – Resilience of Community Pharmacy</p>

Webb, Sarah  
07/01/2026 14:56:21

Agenda item: 11

<b>Subject:</b>	<b>Dental Services Delivery Group report</b>
<b>Presented by:</b>	<b>Fiona Theadom, Head of Primary Care Commissioning (Dental and GP)</b>
<b>Prepared by:</b>	<b>Sarah Johnson, Senior Primary Care Commissioning Manager (Dental)</b>
<b>Submitted to:</b>	<b>Primary Care Commissioning Committee</b>
<b>Date:</b>	<b>14 January 2026</b>

**Purpose of paper:**

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

This paper is for noting.

<b>Delivery Group:</b>	Dental Services Delivery Group
<b>Delivery Group Chair</b>	Mark Burgis, Executive Director – Patients and Communities
<b>Meetings since the previous update to PCCC on 19 November 2025</b>	9 December 2025
<b>Overall objectives of the Delivery Group:</b>	The purpose of the meeting is to provide a framework for effective decision making in relation to certain contractual matters for primary care, community care and secondary care dental services under delegated authority from the ICB’s Primary Care Commissioning Committee (“PCCC”).
<b>Main purpose of meeting:</b>	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.

Webb, Sarah  
07/01/2026 14:56:21

<p><b>BAF and any Committee risks relevant / aligned to this Committee.</b></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>BAF02 – Primary Care Resilience and Transformation          BORR08 – Secondary Care Dental Services          BORR09 – Resilience and Stability of Primary Care Dental Services          BORR71 – Special Care Dental Services</p> <p>A proposed new consolidated dental risk was reviewed by DSDG members and is being presented to Primary Care Commissioning Committee in January 2026 for approval.</p>
<p><b>Key items for Committee to take note of</b></p> <p><i>To highlight if any items include:</i></p> <ul style="list-style-type: none"> <li>• <i>Changes to national policy/strategy</i></li> <li>• <i>Quality &amp; safety matters</i></li> </ul>	<ul style="list-style-type: none"> <li>• The Group received an update report on End of Year and Mid-Year for noting. DSDG members were informed that productive discussions with underperforming providers had been taking place which will lead to improved performance and/or contractual changes. Papers will be presented to the Group for approval in relation to contractual changes.</li> <li>• The Group received an update on Unscheduled Care performance reporting high utilisation rates of over 96% for urgent care appointments. Potential options for commissioning additional urgent care were outlined noting that contract reform proposals effective from April 2026 may influence plans.</li> <li>• Annual Survey Results were raised for noting, highlighting the increased satisfaction amongst dental patients compared to the previous year, whilst acknowledging that the results are still below the national average so still work to be done.</li> </ul>
<p><b>Items receiving formal approval from the Delivery Group</b></p> <p><i>To include any financial risks</i></p>	<ul style="list-style-type: none"> <li>• Finance report and forecast spend was received and approved.</li> <li>• A proposal for additional commissioning of Out of Hours Christmas and New Year Provision was received and approved.</li> <li>• Proposal for the consolidation of services in Kings Lynn for two dental contracts 0.3 miles apart was received and approved. A communications plan to inform key stakeholders to be finalised.</li> <li>• Proposal for funding for the continuation of a care home dental service in West Norfolk was received and approved.</li> <li>• A proposal to extend the Trauma Pathway pilot for six months in order to allow for procurement of the service was received and approved.</li> </ul>
<p><b>Items for escalation to PCCC</b></p>	<p>No items for escalation to Committee</p>
<p><b>Confirmation that the meeting was quorate</b></p>	<p>The meeting was quorate. No declarations of interest were identified for the meeting.</p>

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07/01/2026 14:12:21

<p><b>and all Voting Members (or nominated deputies for making decisions on behalf of Voting Member) present</b></p>	<p>Voting Members present:</p> <p>Mark Burgis, Executive Director – Patients and Communities  Sadie Parker: Director of Primary Care  Karen Watts, Director of Nursing and Quality  Shepherd Ncube, Associate Director of Primary Care Commissioning  James Grainger, Head of Finance – Primary Care and Corporate/Reporting  Sarah Elliott, Finance Manager – Delegated Primary Care (attending part of the meeting for James Grainger, Head of Finance – Primary Care and Corporate)</p>
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**Recommendation to the Committee:**

<p>To note the report and decisions taken by the Dental Services Delivery Group on 9 December 2025.</p>
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<p><b>Key Risks</b></p>	
<p><b>Clinical and Quality:</b></p>	<p>The Group will be monitoring quality improvement and development of a performance dashboard and overall assurance framework</p>
<p><b>Finance and Performance:</b></p>	<p>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.</p>
<p><b>Impact Assessment (environmental and equalities):</b></p>	<p>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.</p>
<p><b>Reputation:</b></p>	<p>Healthwatch Norfolk and Healthwatch Suffolk, Local Professional Network and the Local Representative Committee are all represented on the Group</p>
<p><b>Legal:</b></p>	<p>Terms of reference, general dental services contracts, regulations and Dental Policy Handbook</p>
<p><b>Information Governance:</b></p>	<p>Information Governance matters will be highlighted as and when appropriate</p>
<p><b>Resource Required:</b></p>	<p>Primary Care Commissioning Team</p>
<p><b>Reference document(s):</b></p>	<p>General/Personal dental services contracts, regulations and Dental Policy Handbook</p>
<p><b>NHS Constitution:</b></p>	<p>N/A</p>

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07/01/2026 14:56:21

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

Webb, Sarah  
07/01/2026 14:56:21

Agenda item: 11

<b>Subject:</b>	<b>Dental Development Group report</b>
<b>Presented by:</b>	<b>Fiona Theadom, Head of Primary Care Commissioning (Dental and GP)</b>
<b>Prepared by:</b>	<b>Sarah Johnson, Senior Primary Care Commissioning Manager (Dental)</b>
<b>Submitted to:</b>	<b>Primary Care Commissioning Committee</b>
<b>Date:</b>	<b>14 January 2026</b>

**Purpose of paper:**

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

This paper is for noting.

<b>Dental Development Group:</b>	Dental Development Group
<b>Group Chair</b>	Sadie Parker, Director of Primary Care
<b>Meetings since the previous update to PCCC on 1 October 2025</b>	18 <sup>th</sup> November 2025
<b>Overall objectives of the Dental Development Group:</b>	The Group enables the prioritisation of dental strategy work and workforce planning alongside identification and support for wider system projects which aim to improve dental access for children and adults, practice resilience and development of services.
<b>Main purpose of meeting:</b>	The purpose of the meeting is to provide a “safe space” for stakeholders to come together to discuss and drive delivery of Norfolk and Waveney dental ambitions. To share information, soft intelligence and to agree actions as to how best to work together and enable a joined up approach to solution finding under delegated authority from the ICB’s Primary Care Commissioning Committee (“PCCC”).
<b>BAF and any Committee risks</b>	The work of the Dental Development Group aims to find solutions to mitigate the risks for primary care,

Webb, Sarah  
07/01/2026 11:56:23

<b>relevant / aligned to this Committee.</b>	community care and secondary care dental services however it is not the Group's role to monitor risks.
<b>Key items for Committee to take note of</b>  <i>To highlight if any items include:</i> <ul style="list-style-type: none"> <li>• <i>Changes to national policy/strategy</i></li> <li>• <i>Quality &amp; safety matters</i></li> </ul>	The Group had a number of in-depth discussions focusing on a number of key areas of development within the ICB plan with constructive feedback from attendees to help inform ICB thinking: <ul style="list-style-type: none"> <li>• Supervised Toothbrushing Scheme update, presented by Norfolk County Council Public Health confirming aims of the scheme, targeted age group, number of settings and the split of service provision across Norfolk and Waveney between the 2 providers.</li> <li>• Child Focused Dental Practices update. Overview of the service being provided and current challenges being faced. Discussion around integrating with other projects such as Supervised Toothbrushing Scheme.</li> <li>• Workforce update given in relation to work progressing with the Level 2 Endodontics and Periodontic services with a needs analysis being undertaken for Norfolk, Waveney and Suffolk.</li> <li>• Commissioning Intentions 2026/2027 - 2028/2029 were reviewed. Draft joint commissioning intentions were shared with the group which focused on broad priorities of improving access to oral health care, underpinned by workforce plans, and the shift to providing oral health services in the community, closer to home.</li> <li>• UDA uplift review update, progress report given to the group following a working group discussion.</li> <li>• Unscheduled Care update given of the progress with the local scheme and the introduction of the new October national scheme. Performance against targets discussed.</li> </ul>
<b>Items receiving formal approval from the Group</b>	The role of the Dental Development Group is to make recommendations to the Dental Services Delivery Group and Primary Care Commissioning Committee; it is not a decision making forum.
<b>Items for escalation to PCCC</b>	None identified
<b>Confirmation that the meeting was quorate and all Voting Members (or</b>	The Terms of Reference do not require the meeting to be quorate.

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<b>nominated deputies for making decisions on behalf of Voting Member) present</b>	
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**Recommendation to the Committee:**

To note the report from Dental Development Group members
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<b>Key Risks</b>	
<b>Clinical and Quality:</b>	The Group will be monitoring quality improvement and development of a performance dashboard and overall assurance framework
<b>Finance and Performance:</b>	Finance is represented within the membership of the Group. Performance and potential spend against the relevant budget is monitored in detail and reported to the Committee. Any potential financial risks are highlighted to the Committee in this report.
<b>Impact Assessment (environmental and equalities):</b>	Each proposal is accompanied by an Equalities Health Impact Assessment to inform the Group's decision making. Papers to Dental Development Group seek to identify potential impact on equalities and mitigating actions required. Action will be taken to draw up Equality Health Impact Assessments for all new projects, pathway or service developments and proposals.
<b>Reputation:</b>	Healthwatch Norfolk and Healthwatch Suffolk, Local Professional Network and the Local Representative Committee are all represented on the Group
<b>Legal:</b>	Terms of reference, general dental services contracts, regulations and Dental Policy Handbook
<b>Information Governance:</b>	Information Governance matters will be highlighted as and when appropriate
<b>Resource Required:</b>	Primary Care Commissioning Team
<b>Reference document(s):</b>	General dental services contracts, regulations and Dental Policy Handbook
<b>NHS Constitution:</b>	N/A
<b>Conflicts of Interest:</b>	To note any specific Conflicts of Interests from Delivery Group meeting here and how managed are described above under each item, where appropriate.  Arrangements are in place to manage conflicts of interest at each meeting and to accurately record and manage them.
<b>Reference to relevant risk on the Board Assurance Framework</b>	BAF02 - Primary Care Resilience and Transformation

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07/01/2024 16:21

Agenda item: 12

<b>Subject:</b>	<b>Norfolk and Waveney (N&amp;W) / Suffolk and North East Essex (SNEE) ICB Collaborative Community Pharmacy Project Final Summary</b>
<b>Presented by:</b>	<b>Sharon Gardner Head of Primary Care Commissioning Pharmacy and Optometry</b>
<b>Prepared by:</b>	<b>Sharon Gardner Head of Primary Care Commissioning Pharmacy and Optometry</b>
<b>Submitted to:</b>	<b>Primary Care Commissioning Committee</b>
<b>Date:</b>	<b>14 January 2026</b>

**Purpose of paper:**

This paper provides a summary of the final report for the Community Pharmacy Integration Project, delivered by Community Pharmacy Norfolk and Suffolk (CPNS) as the commissioned provider during 2024-2025. The report highlights key outcomes, challenges, system learning and presents CPNS recommendations for consideration with future commissioning and integration.

**Executive Summary:**

Following approval at the GPCPDG meeting on 14 May 2024 the community pharmacy integration project was jointly commissioned by NHS Norfolk and Waveney ICB (N&W) and NHS Suffolk and North East Essex ICB (SNEE).

It was agreed that NHS allocated integration funding would be used to commission project management support to expand and strengthen community pharmacy referral pathways. Community Pharmacy Norfolk and Suffolk were appointed as the commissioned provider through a procurement process conducted in line with the Provider Selection Regime (PSR) regulations, with the project commencing on 1<sup>st</sup> October 2024.

The project aimed to strengthen the integration of community pharmacy within local NHS systems in line with the NHS Long Term Plan, Primary Care Access Recovery Plan (PCARP), and later in the project the NHS 10 Year Health Plan for England.

The project focused on national clinical services central to primary care reform which included the recently introduced Pharmacy First Service, the expansion of both the Hypertension Case Finding Service and Pharmacy Contraception Service and the Discharge Medicines Service (DMS)

Across these areas, the project delivered strong engagement, improved clinical activity, and strengthened partnerships with GP practices and hospital pharmacy teams. Over 300

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07/01/2025 14:55:27

pharmacy professionals received training, and promotional campaigns reached more than 50,000 residents, contributing to significant service uptake.

Notable achievements documented include:

- **Pharmacy First:** 94% local sign-up (vs 87% nationally), improved confidence and delivery, though digital referral pathways remain inconsistent.
- **Hypertension Case Finding:** As part of this service pharmacies are required to fit patients who meet the criteria with an Ambulatory Blood Pressure Measurement (ABPM) device, through targeted, data-driven support we saw an increase to this conversion %, ensuring contractors felt confident and knowledgeable to have this conversation.
- **Pharmacy Contraception Service:** Substantial growth, particularly in Norfolk & Waveney, aligning with national and regional trends.
- **Discharge Medicines Service:** Strengthened relationships with Trusts and improved referral completion in some locations where data was available, although IT interoperability remains a barrier.

The project confirmed the growing readiness of community pharmacy to deliver clinically integrated care but also highlighted ongoing challenges around digital interoperability, workforce pressure, estates limitations, and data sharing.

## Report

### Background

The integration project was commissioned as part of an NHSE initiative to accelerate the practical integration of community pharmacy into NHS primary care pathways, recognising pharmacy's role in improving access, supporting prevention and ensuring patients to receive the right healthcare advice, by the right clinician, in the right place, in a timely manner

During 2024–25, additional Community Pharmacy Contractual Framework contractual requirements—including the bundling of Pharmacy First, Hypertension Case Finding, and Contraception services—strengthened the need for whole system integration in line with the NHS long term plan, PCARP and the Fuller Stocktake report of 2022.

During 2025 the release of the government's 10-year health plan for England aligned the project to the role of community pharmacy in supporting the shift from hospital to community and the prioritisation of prevention over treatment

The project used:

- Targeted contractor engagement
- Data informed support and intervention
- Joint work with Primary Care Networks (PCNs), GP practices, and acute trusts
- Training (Centre of Postgraduate Pharmacy Education (CPPE), webinars, on-site visits)
- Communications and social media campaigns

Webb, Sarah  
07/01/2026 14:56:21

This approach ensured delivery that was responsive to both system needs and contractor feedback. Whilst there was no direct contact with patients, contractors and national statistics allowed us an insight into barriers and concerns from service users.

## **Summary of Key Findings**

### **Pharmacy First Services**

There was strong sign up and engagement across both ICBs with the Pharmacy contraception service showing the strongest growth. Norfolk and Waveney saw the highest regional growth in the contraception service at +293%

Delivery of services improved as confidence increased. This was built through training and promotion, which was supported by a toolkit, visits, face-to-face training sessions, and webinars. Also, manufacturer led training sessions for the hypertension service helped support clinical accuracy and improved referral quality.

Public awareness of the service was also key, and this grew through targeted promotion, confirmed by the increase in patients' self-referring to community pharmacy during the project period. Norfolk and Waveney ICB also launched Pharmacy First Friends and Family test during the same period, this has shown 100% patient satisfaction in the service and allowed the ICB the opportunity to share successes with contractors.

It was noted service delivery varied between pharmacies and that workforce capacity and operational variability remained barriers to further referral growth. Long term sustainability requires continued system support and PCN alignment.

### **Discharge Medicines Service (DMS)**

Engagement with five acute/mental health Trusts highlighted variability in readiness. However, where there were embedded technician led models, this proved effective.

Loss of data access in early 2025 limited monitoring and targeted improvement concluding that IT and data sharing challenges remain the principal barrier to scaling DMS impact.

### **Training and Engagement**

Over 300 pharmacy professionals were supported through a combination of webinars, CPPE events, and digital resources. This evidenced strengthened system-wide confidence and capability through service activity growth.

Through data led intervention it was highlighted that a quality focus on the hypertension case finding service was required. Training focus for this service was aimed at device training and service specification understanding.

Following expansion of the Pharmacy First service to include the use of suitably trained technicians and colleagues, a new focus concentrated on increasing engagement from the wider pharmacy team which in turn would demonstrate broadened reach. A technician focused training day is due to take place in January 2026

### **Patient, Stakeholder, and Contractor Feedback**

Through feedback, it was noted that patients consistently rated Pharmacy First highly, praising accessibility and professionalism.

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07/01/2026 14:56:21

Stakeholders across general practice and Trusts also reported improved collaboration and understanding. However, it was noted that there was geographical variation in reports and in some areas continued focus on the benefits of collaborative working are required

Contractors valued CPNS support but highlighted ongoing challenges: workforce, admin burden, and service variability.

### **CPNS Conclusions and Recommendations**

It was recognised across both systems that partnerships have strengthened, digital pathways have begun to take shape, and contractors are increasingly confident in their clinical delivery.

The project has also underlined that true integration depends on continued collaboration, interoperability of IT, shared data, and sustained investment in workforce development, both within commissioning teams and in embedding the skills of pharmacy teams in service delivery.

The success of the project has directly contributed to the regional performance of the ICB. Over the six month period of March - August, Norfolk and Waveney ICB recorded the highest year-on-year regional increase in clinical conditions, averaging 64% per month. It also led the region in overall year-on-year growth across all Pharmacy First elements, with an average monthly increase of 63.70%. Norfolk and Waveney ICB is on track to significantly exceed last year's activity levels. Based on data from April to July, projected year-end figures suggest a 24.3% increase in hypertension, a 137.7% rise in contraception, and a 32.7% uplift in clinical pathway activity compared to the previous 12 months.

A key priority agreed by both the ICB and CPNS is to maintain a shared understanding of community pharmacy's role in system delivery. This reflects the learning from a successful way of working during the project, which was commissioned to bring together resources from two ICBs, promoting local ownership, and draw on established, local expertise. This collaborative approach enabled CPNS to lead delivery while remaining aligned to ICB direction and provides a strong foundation for informing and influencing the ICB's future primary care and neighbourhood strategies.

While the CPNS recommendations are recognised, they will be reviewed by the Committee within the context of the ICB's evolving role as a strategic commissioner, the commissioning blueprint, and the future direction of neighbourhood health.

The Committee is invited to consider what enablers are needed to deliver a broader, collective strategy, where responsibility for delivery should sit as projects move into business-as-usual, and what support may be required for transition. Feedback is sought on how these recommendations should shape the wider commissioning and market development strategy and align with priorities such as Pharmacy First.

### **Recommendation to the Board:**

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07/01/2026 14:56:21

- Note the findings of the report and acknowledge the positive impact the project had on pharmacy first services.
- Provide feedback on CPNS recommendations considering the ICBs current commissioning blueprint and the future direction of neighbourhood health.
- Note the successful collaborative structure of the N&W and SNEE project model and ensure lessons are retained as the two organisations come together in April.
- Note the need for further work to reduce geographic inequity in access to pharmacy services.

<b>Key Risks</b>	
<b>Clinical and Quality:</b>	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
<b>Finance and Performance:</b>	Pharmacy First Services are a key focus within the ICB operational planning document and within our commissioning intentions to ensure focus remains on performance against expectations
<b>Impact Assessment (environmental and equalities):</b>	Future consideration needs to include a data driven approach with focus on communities underserved by community pharmacy. We will review those with only one community pharmacy within a 5 mile radius to help ensure provision of Essential Pharmacy Services for those communities by utilising any existing funding and a strategic commissioning approach.
<b>Reputation:</b>	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
<b>Legal:</b>	Community Pharmacy Contractual Framework (CPCF) 2025/2026
<b>Information Governance:</b>	Information Governance matters will be highlighted as and when appropriate. None are applicable on this paper
<b>Resource Required:</b>	N&W Pharmacy and Optometry Primary Care Commissioning team
<b>Reference document(s):</b>	<p><a href="https://www.england.nhs.uk/publication/delivery-plan-for-recovering-access-to-primary-care/">NHS England » Delivery plan for recovering access to primary care</a> https://www.england.nhs.uk/publication/delivery-plan-for-recovering-access-to-primary-care/</p> <p><a href="https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/">NHS England » Next steps for integrating primary care: Fuller stocktake report</a> https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/</p> <p><a href="https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future">10 Year Health Plan for England: fit for the future - GOV.UK</a> https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future</p>

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07/01/2026 14:56:21

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<b>NHS Constitution:</b>	NHSE/ICB Delegation Agreement
<b>Conflicts of Interest:</b>	ICB master register checked and no conflict apparent . Arrangements are in place to manage conflicts of interest as they arise.
<b>Reference to relevant risk on the Board Assurance Framework</b>	BAF02 Primary Care Resilience and Transformation. BORR 27 The Resilience of Community Pharmacy

## Governance

<b>Process/Committee approval with date(s) (as appropriate)</b>	
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07/01/2026 14:56:21



# Community Pharmacy Integration Project

October 2024 – September 2025

# Community Pharmacy Integration Project Report (2024–2025)

## Community Pharmacy Norfolk & Suffolk (CPNS)

### Contents

Executive Summary .....	3
Introduction .....	5
Planning and Methodology .....	7
Delivery & Outcomes.....	9
Training and Events.....	9
Pharmacy First .....	10
Pharmacy Contraception Service .....	15
Discharge Medicines Service (DMS).....	17
Service Promotion and Communications.....	20
Patient feedback.....	20
Stakeholder feedback.....	21
Contractor Feedback.....	22
2024 vs. 2025 Contractor Survey.....	22
Next Steps.....	23
Conclusions.....	24
Recommendations .....	26

Webb, Sarah  
07/01/2026 14:56:21

# Executive Summary

The Community Pharmacy Integration Project was jointly commissioned by NHS Norfolk and Waveney ICB and NHS Suffolk and North East Essex ICB and delivered by Community Pharmacy Norfolk & Suffolk (CPNS) during 2024–2025. The project aimed to strengthen the practical integration of community pharmacy within local NHS systems, supporting national ambitions to shift care from hospital to community, from analogue to digital, and from sickness to prevention, as set out in the NHS Long Term Plan, PCARP, and the Government’s 10-Year Health Plan for England.

Rather than claiming full system integration, the project demonstrates how community pharmacy can operate as a credible and scalable primary care partner when supported through targeted engagement, training, promotion, and system leadership. Across Norfolk, Suffolk, and North East Essex, the work delivered measurable improvements in service delivery, professional confidence, and partnership working, while also exposing the structural and digital barriers that continue to limit the pace and consistency of integration.

**The project focused on four nationally commissioned services central to current primary care reform: Pharmacy First, Hypertension Case Finding, the Pharmacy Contraception Service, and the Discharge Medicines Service. Delivery was underpinned by contractor engagement, data-led targeting of support, structured training programmes, public-facing promotion, and sustained liaison with ICBs, PCNs, GP practices, and Trust pharmacy teams.**

Pharmacy First emerged as the most visible and system-facing workstream. Local promotion, training, and contractor support improved confidence and consistency of delivery, with 94% of pharmacies locally signed up to all required PCARP services, compared with 87% nationally. Activity increased across both ICBs during 2025, aligning with regional growth trends and exceeding them in Norfolk & Waveney. However, efforts to embed routine electronic referrals from general practice and urgent care were constrained by IT interoperability, variable workflows, and mutual confidence issues around capacity and responsiveness. The project reinforces that referral behaviour will not scale without seamless digital pathways and shared operational expectations.

Hypertension Case Finding activity strengthened through targeted data analysis, focused communications, and practical training aimed at improving conversion from clinic checks to Ambulatory Blood Pressure Monitoring (ABPM) in line with NICE guidance. ABPM delivery increased significantly across both ICBs during 2025, rising by 125% in Norfolk & Waveney and 109% in Suffolk & North East Essex, with sustained growth following periods of targeted training and support. This demonstrated the value of using local data to direct intervention and improve clinical appropriateness.

The Pharmacy Contraception Service showed the strongest relative year on year growth (293% N&W, 224% SNEE). Following training, professional development events, and targeted digital promotion, activity increased substantially across both ICBs, exceeding regional and national growth rates. This provides strong evidence that confidence-building, visibility, and clear

positioning of community pharmacy services translate directly into patient uptake when services are framed as accessible and routine.

Discharge Medicines Service activity highlighted both the potential and fragility of hospital-to-community integration. Engagement with acute and mental health Trusts improved understanding, referral quality, and completion rates in some areas, particularly where technician-led models were embedded within Trust pathways. However, inconsistent data access and IT limitations significantly constrained the ability to monitor, target, and sustain improvement, underlining the importance of robust data-sharing agreements and system-wide digital alignment.

**Across all workstreams, communications and training were critical enablers. Over 300 pharmacy professionals were supported through webinars, CPPE events, on-site visits, and digital resources, while social media promotion reached more than 50,000 local residents at low cost. Contractor feedback indicates a clear shift toward whole-team engagement, with growing demand for short, practical, and digitally delivered support.**

In conclusion, the Community Pharmacy Integration Project has delivered measurable progress against its aims and provides a strong foundation for future commissioning and integration. It demonstrates that community pharmacy can contribute meaningfully to access, prevention, and system resilience when supported through coordinated leadership and partnership. Sustaining this progress will require continued joint working between ICBs and the LPC, clearer data-sharing arrangements, investment in workforce development, and a long-term strategic approach to embedding community pharmacy within integrated neighbourhood teams.

Webb, Sarah  
07/01/2026 14:56:21

# Introduction



The Community Pharmacy Integration Project (hereafter “The Project”) was jointly commissioned by NHS Norfolk and Waveney ICB and NHS Suffolk and North East Essex ICB, and delivered by Community Pharmacy Norfolk & Suffolk (CPNS), in close partnership with the Community Pharmacy teams at both ICBs, between 2024 and 2025. The project aimed to strengthen the integration of community pharmacy within local NHS systems, ensuring that pharmacies play a full and active role in delivering clinical services and supporting population health priorities.

The project was developed to accelerate alignment between community pharmacy and wider NHS primary care systems, building directly on the ambitions set out in the **NHS Long Term Plan (2019–2029)** and subsequent national strategies such as the **Delivery Plan for Recovering Access to Primary Care (PCARP, 2023)**. The Long Term Plan established the foundation for integrated neighbourhood care, focusing on dissolving boundaries between primary, community and hospital-based services, improving patient access, and empowering local health systems to deliver care closer to home. PCARP reaffirmed these aims in practical terms—identifying community pharmacy as a core partner in improving timely access, reducing GP workload, and tackling inequalities in primary care capacity.

Within this policy framework, the **Pharmacy Integration Programme** and the **Community Pharmacy Contractual Framework (CPCF)** serve as the operational levers for change. Both were designed to shift community pharmacy from a primarily supply-based function to a more clinically integrated model of patient care. Services such as **Pharmacy First**, the **Discharge Medicines Service (DMS)**, **Hypertension Case-Finding**, and the **Pharmacy Contraception Service** exemplify this evolution. Together, they represent the transition envisioned in the Long Term Plan—from episodic treatment to continuous, prevention-focused care embedded within local systems.

The project also responds to the **Fuller Stocktake Report (2022)**, which called for Integrated Neighbourhood Teams capable of addressing population health needs across traditional professional and organisational boundaries. That report, echoed by PCARP, positioned community pharmacy as a key enabler of equitable access—particularly for patients who find it difficult to engage through traditional GP routes. By embedding pharmacy services within local care pathways, the project sought to strengthen resilience across the systems while supporting the NHS goal of “right care, first time.”

## Four national services formed the focus of the project:

1. Pharmacy First (PF)
2. The Hypertension Case-Finding Service (HCFS)
3. The Pharmacy Contraception Service (PCS)
4. The Discharge Medicines Service (DMS)

During the lifetime of the project, further significant developments were incorporated into the national Community Pharmacy Contractual Framework (CPAF), following national negotiations and agreement. These introduced additional requirements on service sign up and delivery. A key change which affected

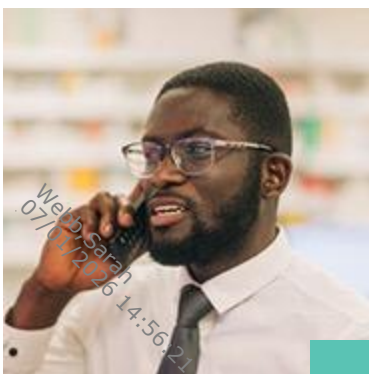
project work was the 'bundling' of the PCARP services (PF, HCFS and the PCS). This "bundling" incentivises pharmacies to be signed up to and delivering all 3 services, by making this a "gateway" requirement for the additional monthly payment previously dependent only on PF activity.

Accompanying CPCF updates to service specifications, pathways and regulations, were introduced, which developed and strengthened the delivery models, such as the scope and delivery of the New Medicines Service. Some fundamental changes were also introduced which impacted on how Distance Selling pharmacies (DSPs) are regulated and can delivery services.

The Government also published 'Fit for the Future: 10-Year Health Plan for England' (2025), which reinforced three national priorities:

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

All of the above changes provided additional opportunities for contact with our pharmacies, but clearly the "ever-developing picture" also posed additional challenges which affected many aspects of project prioritisation, planning and execution, requiring the project team to be extremely nimble and adaptable to developments.



# Planning and Methodology

The planning phase of the Community Pharmacy Integration Project took place during November and December 2024, following the contract award and establishment of the project team. This stage focused on confirming project priorities, developing communication plans, and stakeholder mapping across both Norfolk & Waveney and Suffolk & North East Essex Integrated Care Boards (ICBs), to shape the programme of work for early 2025.

A structured consultation process was undertaken with local pharmacy contractors, Primary Care Network (PCN) Pharmacy leads, ICB representatives, and Trust pharmacy teams. Feedback gathered through meetings, surveys, and online forms (as summarised in the [Winter 2024/25 Feedback Report](#)) highlighted several consistent themes:

- The need for clearer communication of service updates, particularly for Pharmacy First and the Pharmacy Contraception Service.
- Requests for more practical, locally relevant promotional materials that could be easily adapted by pharmacies for use in their communities.
- A desire for additional face-to-face and virtual training opportunities — both refresher sessions for existing staff and induction-level support for new pharmacy teams.
- Concerns about referral pathways and interoperability between Trust systems and community pharmacy platforms, particularly for DMS.
- Strong encouragement for joint working with GP practices, especially around referral prompts and signposting for Pharmacy First and Hypertension Case Finding.



This consultation period also informed the design of the social media advertising campaign and broader communication plan, launched later in 2024. The campaign strategy prioritised the three “walk-in” services; Pharmacy First, Hypertension Case Finding, and the Pharmacy Contraception Service. This aligned with feedback that highlighted the need to raise public awareness and reinforce the clinical role of community pharmacy.

The project team responded proactively to stakeholder input by:

- **Developing a suite of free-to-access digital resources hosted on the CPNS website, including posters, service explainer videos, and downloadable promotional templates.**
- **Planning a series of webinars and virtual workshops for early 2025 to support confidence and consistency across all participating pharmacies.**
- **Coordinating with ICB communication leads to ensure campaign messaging was consistent with national NHS branding while reflecting local patient priorities.**

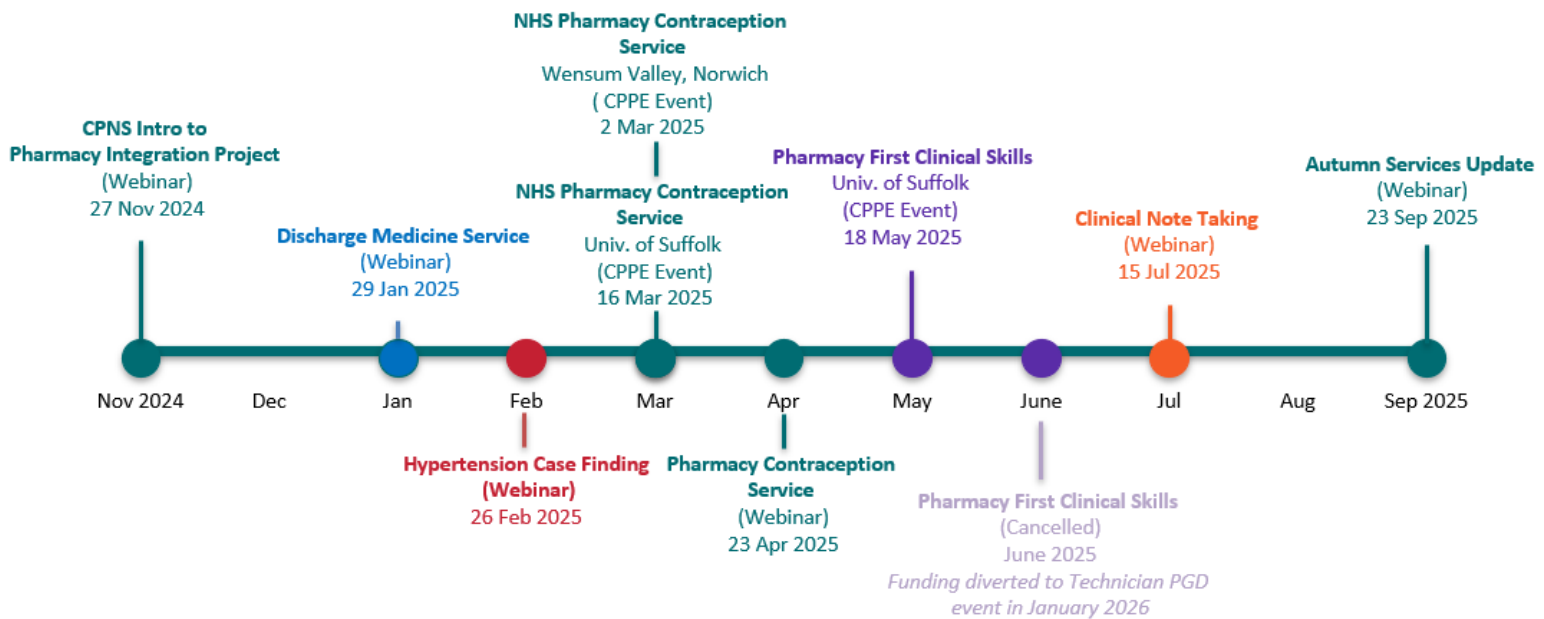
By the close of December 2024, the project had a clearly defined delivery plan, underpinned by strong stakeholder engagement and data-informed priorities. This collaborative approach ensured that implementation in 2025 was responsive, evidence-based, and aligned with both national NHS policy and local system needs.

Webb, Sarah  
07/01/2026 14:56:21

# Delivery & Outcomes

## Training and Events

Across the project year, 169 attendees engaged with CPNS-hosted webinars, with a further 40+ accessing recordings of the sessions. Each service webinar included a guest speaker, blending guidance with case-based discussion and live Q&A, encouraging two-way engagement.



Attendance was strongest in early 2025 as service specific sessions aligned with pharmacy visits and promotion of specific services by the CPNS team. National announcements to changes in the Community Pharmacy Contractual Framework (see above) diverted attention for the remainder of the year to service sign up and delivery, but built on the knowledge base and resources already provided.

Engagement feedback (through surveys, phone calls and visits) indicated that participants valued the focused, practical nature of sessions and the mix of live and recorded access. Over time, these webinars established a digital learning model that complemented on-site visits, promotional materials and newsletters, embedding a more interactive, inclusive approach to communication across the community pharmacy network. Recordings and digital materials remain accessible on the CPNS website alongside links to national service guidance and CPD resources.

Combined with CPPE and partnership events, the programme of training directly supported more than 300 pharmacy professionals across Norfolk and Suffolk & North East Essex. Attendance patterns show consistent engagement across both ICB areas, with representation from independents, multiples, and supermarket-based pharmacies.

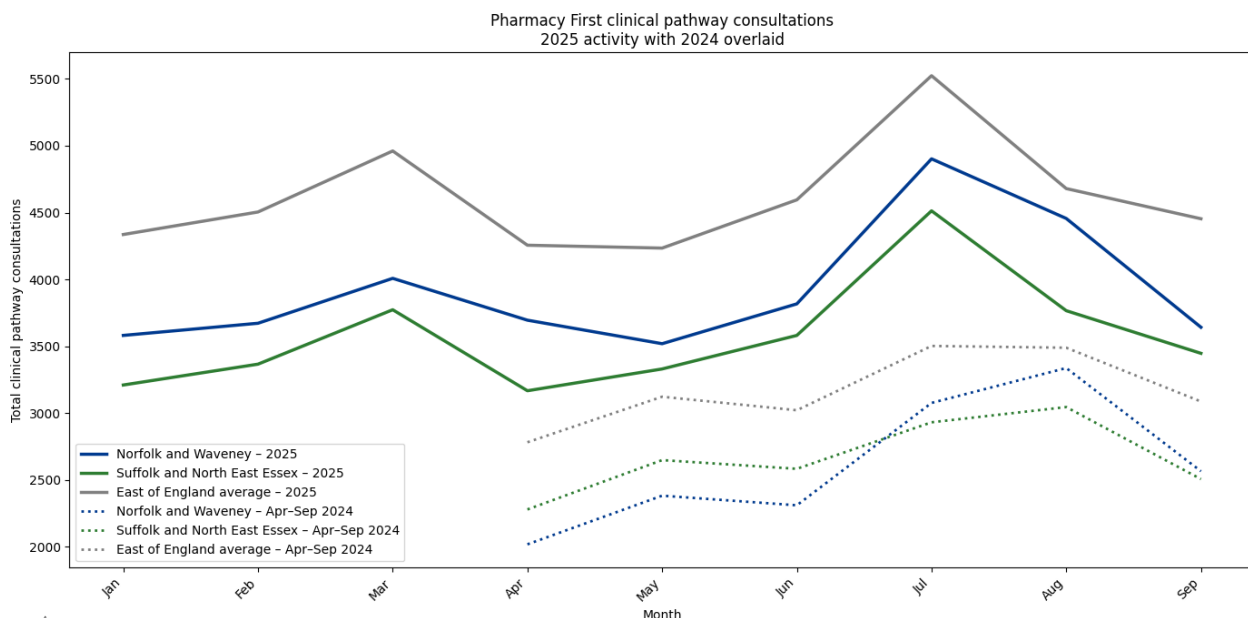
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# Pharmacy First

Pharmacy First became the project’s most visible and public-facing workstream. Engagement included a national awareness campaign, local promotion through newsletters and posters, and targeted social media boosting. Stakeholder support focused on encouraging GP, urgent care, and NHS 111 referrals; clarifying eligibility; and building public trust in the clinical role of Pharmacists.

Our support focused on upskilling staff, investigating and sharing best practice, embedding delivery into “business as usual models” and ensuring promotional materials were available and visible within the pharmacies and in some partner organisations, such as within the Norfolk County Council building, and Secondary Care sites.

Both Norfolk & Waveney and Suffolk & North East Essex showed a significant increase in overall Pharmacy First clinical pathway activity between April and September 2025 compared with the same period in 2024. N&W recorded the strongest growth, with a 53.2% uplift, exceeding the East of England average increase of 46.0%. SNEE also demonstrated clear growth over the period, delivering a 36.3% increase, in line with the regional pattern but at a more moderate rate. This indicates that while both systems benefited from a significant uplift in Pharmacy First delivery, N&W in particular outperformed the regional trend, suggesting more rapid embedding and scaling of the service during 2025 following a slower start in 2024.



## Electronic Referrals from Other Healthcare Professionals

Efforts to increase electronic referrals into the Pharmacy First service from GP practices and other healthcare settings were met with mixed success. Despite strong engagement from both ICB colleagues,

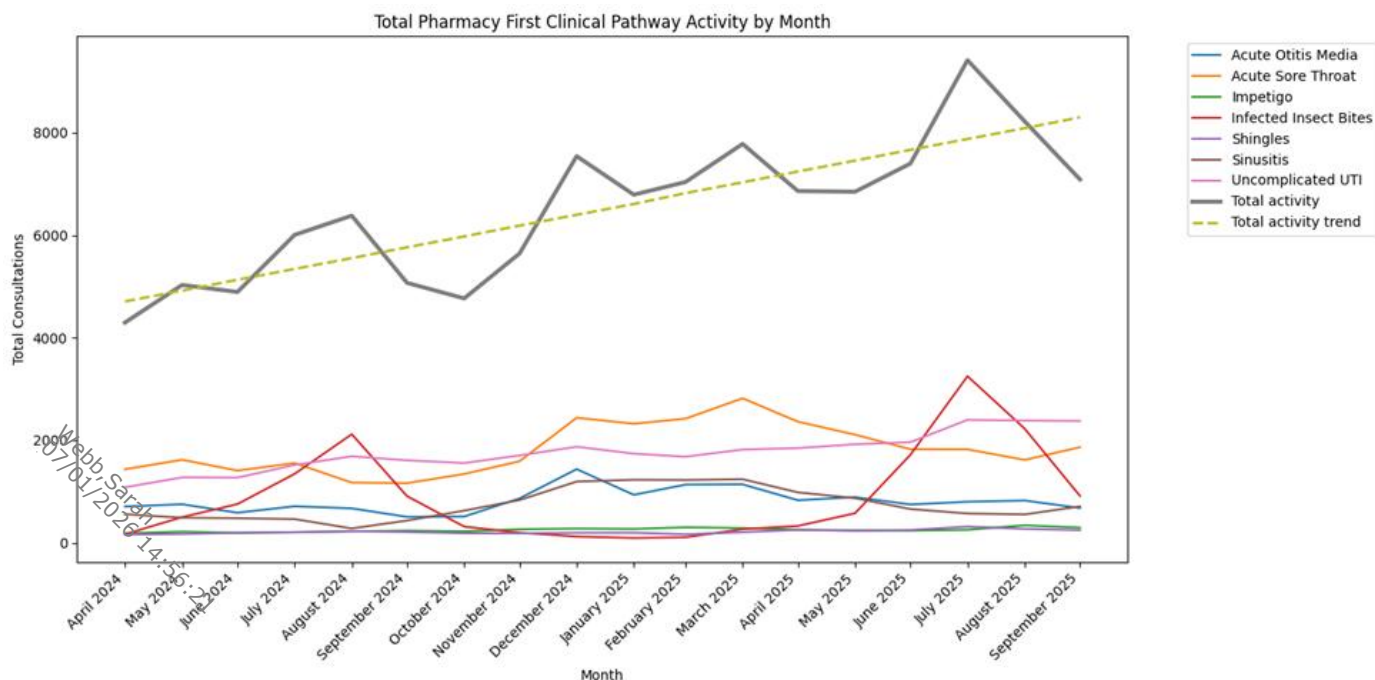
PCN Pharmacy leads and the CPNS team, progress was constrained by the relatively weaker interoperability (at the time) between the most commonly deployed primary care IT systems and pharmacy IT systems. In practice, this meant that referral processes were often manual, inconsistent, and dependent on individual staff confidence rather than embedded workflow.

GP practices reported limited confidence both in their own ability to make referrals efficiently and in pharmacies' capacity to consistently pick up and complete them, perhaps a reflection of the extreme workforce challenges which so badly affected pharmacies services here until quite recently. This perception was reinforced by differing local approaches and variable understanding of the Pharmacy First offer. Pockets of success were evident in Norfolk and Waveney, where proactive local engagement and practical referral toolkits supported better communication between practices and pharmacies. However, these remain isolated examples rather than a consistent regional pattern.

A focused collaboration between CPNS and SNEE ICB in Ipswich sought to test a Urgent and Emergency Care (UEC) referral pathway early in 2025. Despite significant time invested by ICB colleagues and the CPNS team, including staff shadowing and workflow analysis, the project failed to generate referrals. Barriers identified included parking and access issues for patients, perceived duplication of effort, and the availability of same-day GP appointments reducing the need to refer externally.

These experiences underline a core theme for future integration: that meaningful referral activity depends not only on awareness or willingness but on seamless digital pathways and mutual confidence in service capacity robustness and capabilities. Building that confidence and managing expectations will remain critical as Pharmacy First continues to embed, and signposting (rather than electronic referrals) remains focused on the seven clinical conditions which can be treated following walk-in patient requests.

Reported plans for IT system improvement may soon present new opportunities to support electronic referrals for self care and minor illness management, but will need to be balanced with wider workforce and capacity issues, particularly with seasonal patient and healthcare system challenges, such as vaccination demand, Winter pressures and the increased pressures from holiday tourism seen especially in our coastal areas. Demand for advice and treatment also fluctuated with clear demand for support for Insect bites peaking in the summer and winter illnesses increasing between November-March, as demonstrated in the chart below.



### Support for Changing requirements

Another challenge to consistency of service was supporting Pharmacies to meet the required thresholds in order to access the underpinning funding for the Pharmacy First service. Pharmacies were reminded through newsletters, update webinars, and postal letters of the sign up requirements for inclusion of Contraception and Hypertension case finding in the Threshold payment requirements, alongside the addition of an intermediary monthly payment band in July 2025.

By the end of the project both Norfolk & Waveney and Suffolk & Norfolk East Essex based pharmacies show strong sign up figures compared to the England average.

Area	Pharmacy First	Hypertension Case-Finding	Pharmacy Contraception	Bundling requirements met
England average	89.7%	88.0%	88.0%	86.7%
Norfolk and Waveney ICB	98.3%	94.8%	94.2%	94.2%
Suffolk and North East Essex ICB	97.0%	95.2%	94.5%	93.9%

Webb, Sarah  
07/01/2026 14:56:21

# Hypertension Case Finding

**This workstream was driven by close analysis of data to direct a variety of interventions, including direct mail, personalised email, phone calls and pharmacy visits by both the CPNS support officers and ICB colleagues. The main aim was to improve conversion of higher clinic checks into ABPM acceptance, to improve patient access to the most clinically appropriate diagnostic pathways prior to GP referral and potential treatment.**

A training webinar, live and later available on demand, included a manufacturer-led session on best practice for ABPM was held to promote confidence and accuracy. The project team used up to date claims data to call visit and encourage those who were struggling with delivering ABPM. Targeted communications were also sent by post to advise each pharmacy on their performance against upcoming requirements for claiming threshold payments.

## *Hypertension Case Finding totals:*

Area	Apr–Oct 2024	Apr–Oct 2025	Absolute Change	% Change
England	1,791,151	2,153,372	+362,221	+20.2%
East of England	163,747	206,933	+43,186	+26.4%
Norfolk & Waveney ICB	23,633	29,080	+5,447	+23.0%
Suffolk & North East Essex ICB	32,376	38,927	+6,551	+20.2%

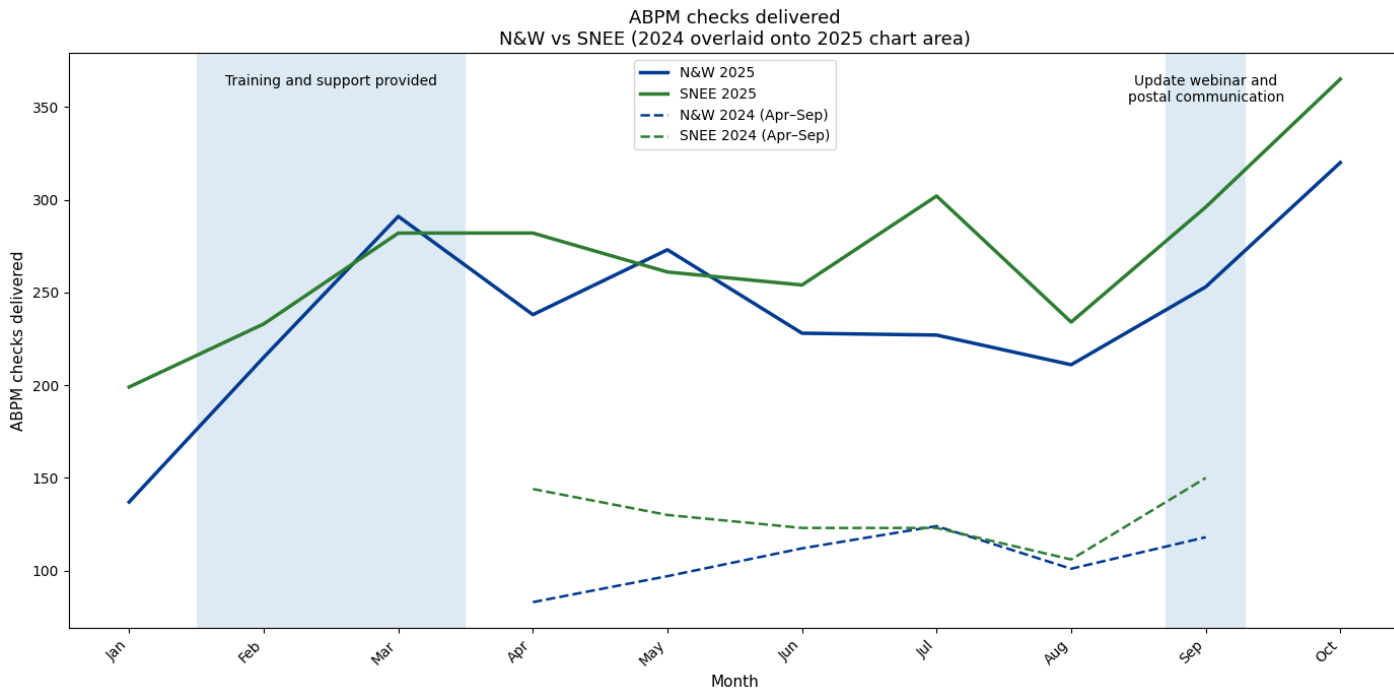
## *Hypertension Case Finding ABPM figures:*

Area	Apr–Oct 2024	Apr–Oct 2025	Absolute Change	% Change
England	114,806	183,990	+69,184	+60.3%
East of England	7,629	14,069	+6,440	+84.4%
Norfolk & Waveney ICB	782	1,761	+979	+125.2%
Suffolk & North East Essex ICB	954	1,994	+1,040	+109.0%

As shown in the figures above, total Hypertension Case finding checks delivered demonstrated similar growth to the national average, while conversion to ABPM achieved a significant uplift in provision for both ICB areas.

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07/11/2026 14:56:21

Clear correlation between project support activities and ABPM increases can also be seen in the chart below:



However, a number of barriers remain. Delivery is still uneven between pharmacies, indicating that capacity, workflow integration, and confidence with ABPM continue to vary locally. Seasonal dips and reliance on periods of focused support highlight that the service is not yet fully self-sustaining in all areas. Practical issues such as staff time, competing service pressures, access to equipment, and variable referral flows from general practice continue to limit consistency. Addressing these challenges will require continued system support, better integration with general practice pathways, and sustained reinforcement rather than one-off interventions, to ensure that Hypertension Case Finding becomes a routine and resilient part of primary care delivery rather than an intermittently high-performing service.

Webb, Sarah  
07/01/2026 14:56:21

# Pharmacy Contraception Service

**This workstream expanded significantly following national rollout in 2024. CPNS supported pharmacies to initiate and continue oral contraception safely and confidently through promotion of CPD events and a follow up webinar.**

Two in-person CPD events hosted by CPPE in Ipswich and Norwich, reached over 100 Pharmacists. These were supplemented by CPNS online follow-up webinars featuring local experienced Pharmacists who shared their knowledge and practical advice for providing the service. Branded materials and paid digital advertising in June 2025 reached up to 45,000 women aged 18–40 (Targeted to the Norfolk, Suffolk and Colchester areas).



Pharmacies across England recorded an increase from around 185,000 consultations in April–October 2024 to over 538,000 in the same period of 2025, an uplift of 191 percent.

Growth in the East of England region was even steeper, increasing from just under 16,000 consultations to over 53,000 (+233%). Pharmacies in Norfolk & Waveney delivered an increase of 293%, the strongest relative growth in the region. Suffolk & North East Essex increased by 234% in the same period, closely aligning with the wider regional pattern and substantially above the England average.

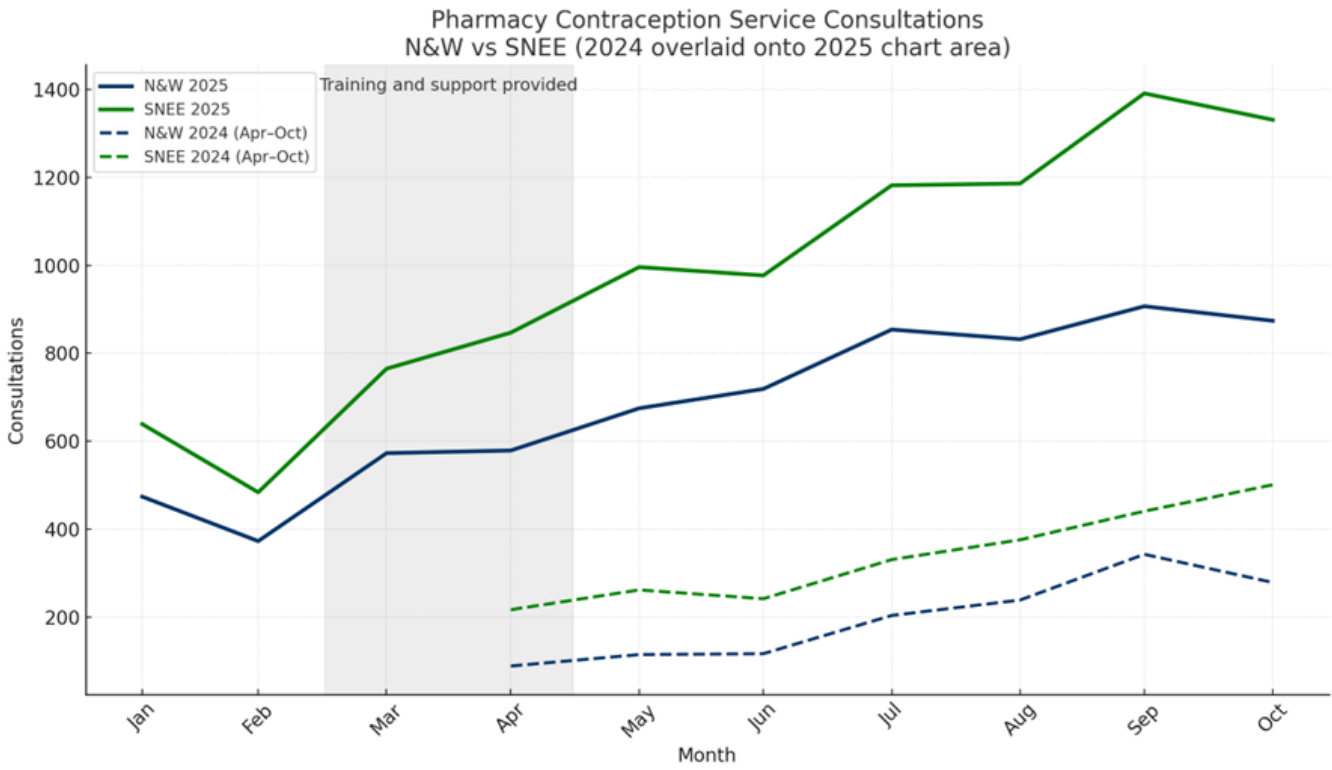
This pattern suggests that local training, confidence-building activity, and targeted promotion have translated into meaningful increases in service uptake, with particular growth N&W, which started from a lower baseline level than SNEE.

Area	Apr–Oct 2024	Apr–Oct 2025	Absolute Change	% Change
England	185,074	538,240	+353,166	+190.8%
East of England	15,960	53,132	+37,172	+232.9%
Norfolk & Waveney	1,386	5,440	+4,054	+292.5%
Suffolk & North East Essex	2,370	7,910	+5,540	+233.8%

The chart below illustrates a sustained increase in Pharmacy Contraception Service consultations across both Norfolk & Waveney and Suffolk & North East Essex during 2025, with activity consistently exceeding the equivalent months of 2024. The shaded period in mid-March to mid-May marks the window in which targeted training, CPPE events, and practical support were delivered to pharmacy teams, and the subsequent uplift in consultations aligns closely with this intervention. Both ICBs show steeper growth

curves after this training phase, suggesting that the focused support increased service confidence, consistency, and patient uptake.

The boosted social media promotion as well as an awareness raising of the “bundling” requirement for all three PCARP services may have also had an impact in June 2025.



Webb, Sarah  
07/01/2026 14:56:21

# Discharge Medicines Service (DMS)

**The Discharge Medicines Service (DMS) continues to play a vital role in ensuring continuity of medicines use and patient safety during transfer from hospital to community settings. It is an Essential Service, meaning it is a mandatory part of the Community Pharmacy Contractual Framework. The publication of the NHS 10 year plan Cleary presents an opportunity linking to the key theme of Hospital to Community care.**

## **Integrating safer transfers of care between hospital and community pharmacy**

Across Norfolk, Suffolk, and North East Essex, this strand of the project focused on supporting Trusts to embed DMS referral processes, increase awareness among staff, and strengthen collaboration with community pharmacies.

The DMS workstream built on previous success in SNEE, where a similar DMS project was delivered by Suffolk LPC in 2023/24, focused on increasing referrals from Trusts and uptake/completion by pharmacies.

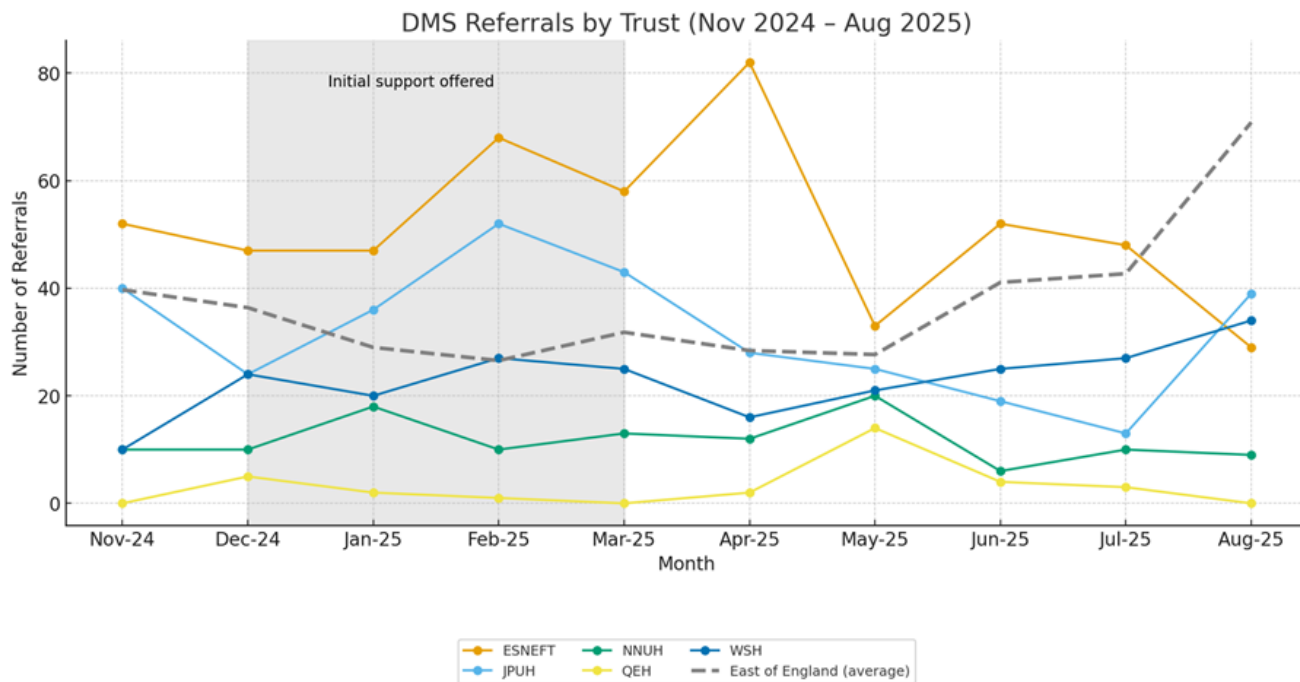


The original **SNEE Pharmacy Integration Project Report (May 2024)** highlighted that while all three SNEE acute trusts were live for the DMS, referral numbers remained low and delivery across community pharmacies was somewhat inconsistent. The report demonstrated that locally coordinated support from the LPC significantly improved referral completion rates and patient outcomes, showing the importance of direct facilitation, clear communication between hospital and pharmacy teams, and access to robust data. It also identified several priorities for future work: increasing referral volumes through ongoing engagement with Trusts, improving data visibility via PharmOutcomes, using population health insights to target patient groups most likely to benefit, and embedding the service as a routine part of discharge care. These findings directly shaped the next phase of work; continuing focused support within SNEE while extending the approach into Norfolk and Waveney.

Commissioning Teams at both ICBs were integral to making introductions between Trust lead pharmacists and CPNS, providing constructive challenge, and reinforcing expectations with Trust Chief Pharmacists. Their involvement helped maintain momentum, unlock engagement, and ensure that DMS remained a shared system priority rather than community pharmacy teams alone.

Webb, Sarah  
07/01/2026 14:56:21

Data and feedback continued to demonstrate a need for active engagement and liaison between Community Pharmacies and Trust in order to strengthen hospital-to-pharmacy referral pathways, improve acceptance and completion rates, and develop technician-led models. Engagement with five acute and mental health Trusts showed varying readiness but clear progress.



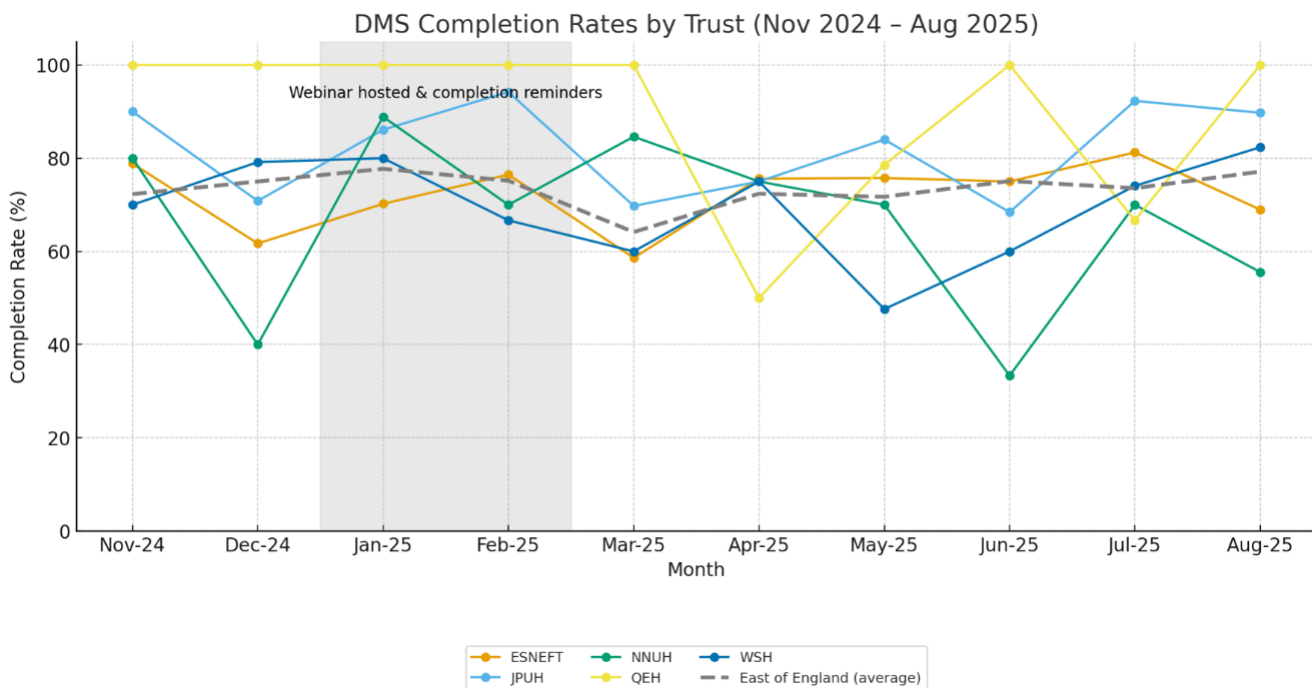
Recurring barriers surrounded access to data by the project team, workforce constraints at the trusts, and IT interoperability between Trust systems and the Pharmacy Referral system, meaning there was variance in the way referrals were sent, with some methods more time consuming. Pharmacies were not always aware of referrals, as many did not receive them often enough to be part of their routine business, nor did some understand if and how feedback on referrals were viewed at the Trusts.

Examples of positive impact from the discussions and support to the Trusts include: West Suffolk Foundation Trust retaining its PharmOutcomes license and expanding technician roles; ESNEFT refreshing SOPs and increasing referrals; EPUT integrating DMS into mental health teams; and JPUH maintaining a national best-practice technician-led model.

A webinar was hosted in January 2025, which was well attended and included Guest Speaker Kelly Pryke, from James Paget University hospital, who explained the service value from Trust, and patient safety perspectives, as well as covering the practicalities for pharmacies on how to complete referrals through all stages. Following this training and awareness session, where data on referrals was available, pharmacies were prompted to pick up and complete referrals. An improvement in completion level of the referrals was seen during this time (as shown on the chart below) but unfortunately access to data on referrals made was lost during spring 2025, meaning outcome data was not available, and further support to the pharmacies was thence limited.

Webb, Sarah  
07/01/2026 14:56:21

The loss of access to data highlighted a fundamental issue around data sharing agreements and how ICBs and Trusts could improve digital access and monitoring.



As the chart above shows, Pharmacies showed an improved completion rate during the support period, however variability in number of referrals and regularity still remains a barrier to incorporating DMS referrals into day to day processes.

Outcome: Improved medicines reconciliation, fewer unaccepted referrals, and greater understanding by both Trust and Community Pharmacy teams of the value of DMS in safer transitions of care.

Webb, Sarah  
07/01/2026 14:56:21



# Service Promotion and Communications

**A key goal of the project was to raise public and partner awareness of the services offered by community pharmacy.**

A coordinated communications plan combined printed and digital promotion, event branding, social media advertising, and direct engagement through newsletters and webinars. This reflected contractor feedback emphasising the need for accessible communications and high-visibility materials.

Printed and Event Materials included A2 posters, A4 leaflets, counter cards, pull-up banners for CPPE and ICB events, and GP referral prompt cards. Visual branding was consistent across both ICBs.

## Social Media Advertising

Between March and May 2025, CPNS ran six “boosted” Facebook campaigns promoting Pharmacy First, Hypertension, and Contraception services. Combined reach was 51,730 people, with 94,598 total views and cost-efficiency of £0.014 per person reached. The ‘All Conditions’ Pharmacy First advert was most successful, reaching 44,847 people. This provided some clear learnings on funded social media advertising which will help inform future promotion of pharmacy services.

## Patient feedback

Patient feedback on Pharmacy First remains highly positive, both nationally and locally. The June 2025 Healthwatch England report, *One Year On – How Pharmacy First is Working for Patients*, found that around 86 percent of patients rated their experience positively, praising the speed, accessibility, and professionalism of pharmacists. However, awareness of the service was often low before patients attended, and about one in ten patients expressed concerns about privacy or lack of follow-up advice. Similar themes appear in Norfolk and Waveney, where limited Friends and Family Test responses reflect high satisfaction with pharmacist care.

Comments posted to the *Community Pharmacy Norfolk & Suffolk (CPNS) Facebook page* show strong public support for Pharmacy First, with many comments praising quick access and friendly, knowledgeable staff. A few noted uncertainty about which pharmacies were participating or what to do if their chosen site could not provide treatment.

Representative comments included:

- “I went into my local pharmacy for a sore throat and was seen within minutes – no GP appointment needed.” (CPNS Facebook comment, March 2025)
- “Great service – pharmacist was thorough and I got the medicine I needed straight away.” (CPNS Facebook comment, April 2025)

- “Didn’t know this service existed until I saw your post – really useful!” (CPNS Facebook comment, February 2025)

Overall sentiment expressed on social media seems to mirror national findings- patients value the accessibility and professionalism of Pharmacy First, while highlighting the need for clearer signposting and consistent service availability across all pharmacies.

The combination of national survey data, local qualitative feedback, and social media commentary has provided a more rounded understanding of patient experience. Together, these sources highlight both areas of strong performance—such as awareness and confidence in pharmacy services—and continuing challenges around privacy in consultation spaces and the consistency of safety-netting advice. The emerging picture shows that triangulating national and local data gives commissioners and CPNS a clearer view of equity of access and demonstrates the growing public confidence in pharmacy-led clinical care.

## Stakeholder feedback

Feedback from GP practices and system partners shows increasing understanding and appreciation of Pharmacy First and other integrated pharmacy services. Practices with established relationships reported that referrals to community pharmacies have “*drastically reduced appointments, especially for UTIs,*” and found the service “*extremely beneficial*” when communication was good (feedback from West Norfolk PCNs). Where joint training sessions were held, practice staff were positive about the referral process and confident to implement it, though follow-up and feedback loops were often limited. Practices valued clear guidance on eligibility and referral criteria but identified barriers such as variable pharmacist availability, complex electronic referral systems, and uncertainty about which pharmacies were live.

PCN pharmacy leads, who attended meetings with the CPNS team, expressed strong support for the service’s aims, noting improved collaboration and growing confidence among independent prescribers. They also emphasised the importance of continuing to promote hypertension and contraception referrals, even though these PCN roles are no longer formally commissioned they acted as an important feedback source during the first half of the project.

Hospital pharmacy teams, particularly within the acute trusts, reported a better understanding and appreciation of DMS following targeted engagement sessions. They noted that relationships with community pharmacies had strengthened, with improved clarity on referral pathways and patient follow-up. ICB colleagues were supportive, recognising the service as aligning with PCARP ambitions and reducing pressure on urgent care, but emphasised the importance of continued workforce development and interoperability improvements to sustain growth.

Collectively, the feedback across the system shows a clear cultural shift toward shared ownership of pharmacy integration, balanced by recognition that administrative processes, awareness, and data connectivity still require coordinated local action.



# Contractor Feedback

Contractor feedback was gathered via visits, calls and follow-up phone calls with pharmacies, targeted using activity data to ensure a wide range of views and service delivery models were explored. Over 50 pharmacies received visits or calls with later follow-up. These visits and calls provided valuable insight into how Pharmacy First and wider integration initiatives are working in practice. Most contractors reported growing confidence in delivering clinical services, particularly as familiarity with referral systems and pathways has improved.

Pharmacists and their teams consistently praised the accessibility of CPNS support and the clarity of training materials, noting that resources such as webinars and digital guides had made implementation smoother. Many emphasised the positive impact on patient relationships, with one pharmacist describing the service as “a chance to show what we’re capable of beyond dispensing.” However, recurring challenges were identified: time pressures, limited staffing, and the administrative workload associated with referrals remain the main barriers to further expansion.

Contractors concerns highlighted variation in referral quality and frequency from GP practices, resistance of patient to use ABPM monitors and issues with transferring data, with some expressing frustration that systems interoperability still prevents seamless collaboration.

Overall, feedback reflected a constructive and forward-looking attitude, with pharmacies keen to sustain and grow their clinical offer provided that support, communication, and operational stability continue to improve. Many barriers identified will require continued systemic change to operating models or national support (in particular around IT and service specifications) or were more fundamental, such as development of estates and workforce alongside long-term funding sustainability.

## 2024 vs. 2025 Contractor Survey

The 2025 Norfolk and Suffolk Pharmacy Team Survey received 53 responses, compared with 44 in 2024, representing 47 unique pharmacies this year against 37 last year—a 27% increase in reach. Responses came from a wider mix of providers, with a notable rise in independent and small-chain participation. Duplication from single branches reduced, showing broader geographical and organisational coverage of feedback across Norfolk and Suffolk.

The respondent profile also widened, with more non-pharmacist roles responding, particularly dispensers, checking technicians, and non-pharmacist managers, indicating that LPC communications and project activity are now reaching beyond the usual Pharmacist and contractor roles. This broader engagement reflects the increased visibility and accessibility of the LPC’s work during the past year thanks to the project funding, and the growing recognition of the support offer among all members of the pharmacy team.

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07/01/2026 14:56:21



# Next Steps

CPNS has committed to supporting the following actions beyond the life of this project:

## Discharge Medicines Service support

Continue to liaise with Secondary care Trusts on quality and consistency of Discharge Medicines referrals and pharmacy completion. This falls within the remit of our statutory duties as a representative body.

## Patient awareness and communications

Continue to work alongside ICB comms teams to develop and support patient messaging and awareness of PCARP services, exploring which methods have most impact while providing value for money and time from our Committee resources.

Alongside the 'Help us Help You' communications theme, we will increasingly provide Community Pharmacy Teams and key stakeholders with the resources, knowledge and encouragement to better promote their own services within their own communities and neighbourhoods.

## Workforce – Technicians

Deliver a Pharmacy Technician CPD session in partnership with CPPE and the N&W Pharmacy commissioning team. Additional events are expected as a core CPPE offer in SNEE which will also be promoted. Both events represent and reinforce a CPNS aim to develop the Pharmacy Technician workforce and highlight future opportunities to develop the skill-mix of the whole pharmacy team.

## Workforce – Independent Prescribing

Although Independent prescribing (IP) has not so far been utilised in the services included in the project, it would be remiss not to mention the future opportunities that IPs may present for future nationally and locally commissioned pharmacy services. The growing proportion of pharmacists with an IP qualification and the prospect of newly qualified pharmacists graduating with prescribing capabilities offers a major opportunity to expand clinical care capacity across primary care networks. However, realising this potential depends on system-level coordination. Local workforce plans led by the ICB pharmacy and workforce teams will need to align commissioning opportunities with structured supervision and mentorship arrangements, ensuring an adequate supply of Designated Prescribing Practitioners (DPPs) across both community and primary care settings. In parallel, there remains an interdependency with the upskilling of the existing workforce, supporting experienced pharmacists to gain prescribing qualifications and to practice safely within new service frameworks. Embedding IP capability within community pharmacy contracts will require careful planning but offers transformative benefits for patients, enabling timely access to clinical decision-making and more seamless continuity of care within integrated neighbourhood teams.

Webb, Sarah  
07/01/2026 14:56:21

# Conclusions

**The Community Pharmacy Integration Project has demonstrated both the appetite and the capacity for community pharmacy teams to play a central contribution to the delivery of the ambitions of the NHS Long Term Plan and the Primary Care Access Recovery Plan.**

Across Norfolk, Suffolk and North East Essex, partnerships have strengthened, digital pathways have begun to take shape, and Contractors are increasingly confident in their clinical delivery. The project has also underlined that true integration depends on continued collaboration, interoperability of IT, shared data, and sustained investment in workforce development, both within commissioning teams and in embedding the skills of pharmacy teams in service delivery. Digital interoperability in particular remains a national as well as a local challenge, and continues to sit firmly at the forefront of system planning.

Service readiness and participation were strong. By the end of the project, 94% of pharmacies locally were signed up to all required PCARP services, exceeding the England average of 87%, indicating that pharmacy participation was not a limiting factor to delivery.

**Pharmacy First** clinical pathway activity increased significantly year on year. Between April and September 2025, activity increased by 53.2% in Norfolk and Waveney and 36.3% in Suffolk and North East Essex compared with the same period in 2024. This compared favourably with the East of England average increase of 46.0%, with Norfolk and Waveney in particular outperforming the regional trend.

**Hypertension Case Finding** delivery support focused on conversion of clinic checks to Ambulatory Blood Pressure Monitoring (ABPM). During 2025, BP clinic checks maintained a stable growth pattern (20-23%) while ABPM activity increased by 125% in Norfolk & Waveney and 109% in Suffolk & North East Essex, following targeted training and data-led support, supporting more clinically appropriate diagnostic pathways.

**The Pharmacy Contraception Service** demonstrated the strongest relative growth of all workstreams. Nationally, consultations increased by 191% between April–October 2024 and the same period in 2025. Growth in the East of England reached 233%, while Norfolk and Waveney recorded a 293% increase and Suffolk and North East Essex a 234% increase, placing both systems well above the England average.

**Discharge Medicines Service** activity showed more variable quantitative progress, reflecting system constraints. Where data was available, referral completion rates improved during periods of focused Trust engagement and training, particularly within technician-led models. However, inconsistent referral volumes and loss of data access during 2025 limited sustained measurement of outcomes.

The feedback provided from ICB stakeholders, General Practice, Pharmacy teams and patient feedback provide a strong foundation for supporting the development and future commissioning of clinical services in a Community pharmacy setting. Time and support will be needed to facilitate the continued evolution of community pharmacy from a supply function into a fully integrated Primary Care partner within the NHS. Maintaining this momentum will be essential to ensuring that pharmacy continues to deliver accessible, preventative, and high-quality care for the communities it serves.

Over the project year, more than 300 pharmacy professionals were supported through webinars, CPPE events, on-site visits, and digital resources, with increasing engagement from non-pharmacist roles, indicating a shift toward whole-team service delivery.

Public awareness activity achieved a high reach at relatively low cost. Targeted social media campaigns promoting Pharmacy First, Hypertension, and Contraception services reached over 51,700 local residents, generating 94,598 views at a cost of approximately £0.014 per person reached, demonstrating value for money in population-level promotion.



Webb, Sarah  
07/01/2026 14:56:21



# Recommendations

As the Community Pharmacy Integration Project draws to a close, it is clear that the progress made this year must not mark the end of collaborative pharmacy integration efforts. The project has shown what can be achieved when local leadership, consistent communication, and shared ambition align. However, the work of embedding community pharmacy fully within integrated care pathways remains ongoing. Sustained progress will require an ongoing commitment, underpinned by strong leadership, from both Integrated Care Boards (ICBs) and the Local Pharmaceutical Committee (LPC) to maintain and expand upon the progress built through this project.

Without ongoing coordination, there is a risk that momentum will dissipate, particularly in areas such as data alignment, technician workforce development, and cross-sector communication, all of which are vital to achieving the ambitions of the NHS 10-Year Plan.

The opportunities and challenges presented by moving to an Integrated Neighbourhood Team model inevitably includes questions around consistency and deliverability of services.

## Priorities for Future Delivery

The priorities set out below are intended to support a pragmatic, phased approach to future commissioning of community pharmacy services. They reflect learning from delivery over the past year, emerging system pressures, and the need for consistency as Integrated Neighbourhood models develop. Collectively, they highlight where commissioning levers, provider engagement, and representative insight can most effectively align to sustain momentum, reduce variation, and embed community pharmacy as a routine part of integrated care pathways.

### Short-term priorities (0–6 months)

- Maintain targeted training and data-led contractor support across priority services, focusing on Pharmacy First, Hypertension Case Finding, and Contraception.  
*Risk if not implemented:* Recent gains in delivery may plateau or regress, particularly in services that remain confidence- or workflow-dependent.
- Continue structured engagement with GP practices and urgent care settings to clarify referral expectations and capacity assumptions.  
*Risk if not implemented:* Community pharmacy capacity will remain underutilised, and inconsistent referral behaviour will continue to limit investment as well as system impact.
- Develop and implement a joint community pharmacy communications strategy with the LPC, aligning patient-facing promotion, professional messaging, and system communications across priority services.  
*Risk if not implemented:* Messaging will remain fragmented, reducing the impact of future service launches and limiting public and professional understanding of community pharmacy's clinical role.

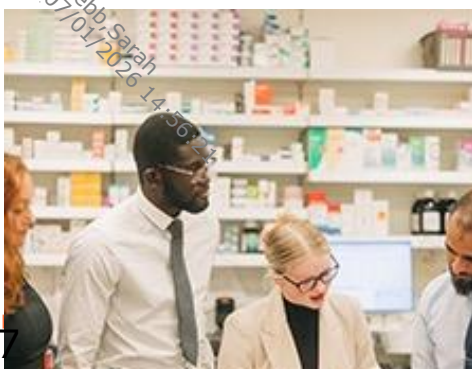
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## Medium-term priorities (6–18 months)

- Embed routine, interoperable digital referral pathways across Pharmacy First and Discharge Medicines Service workflows.  
*Risk if not implemented:* Manual workarounds will increase variation of activity, constraining scale, increasing administrative burden, and undermining confidence in pharmacy responsiveness.
- Establish and maintain regular joint system forums to review community pharmacy service delivery data, share outcomes, and identify new opportunities for integration across primary and secondary care.  
*Risk if not implemented:* Learning will remain siloed, opportunities for scaling successful models will be missed, and integration activity will continue to rely on informal relationships rather than system-wide mechanisms.
- Encourage DMS technician-led and team-based delivery models, within hospital referral pathways.  
*Risk if not implemented:* Workforce capacity constraints will continue to limit DMS expansion and resilience.

## Long-term priorities (18+ months)

- Secure robust data-sharing arrangements and system-wide reporting visibility for community pharmacy services.  
*Risk if not implemented:* Commissioning decisions will continue to be made with partial insight, limiting the ability to target investment, evaluate impact, or sustain improvement.
- Align future commissioning with a long-term strategy for embedding community pharmacy within integrated neighbourhood teams.  
*Risk if not implemented:* Community pharmacy will remain positioned as an adjunct rather than a core primary care partner, limiting its contribution to prevention, access, and system resilience.



### Next steps and enquiries

The LPC welcomes further discussion on the findings of this report and their application to future commissioning and service development. Enquiries can be directed to:

**Norfolk & Suffolk Local Pharmaceutical Committee**

Email: [info@CPNS.org.uk](mailto:info@CPNS.org.uk)

<b>Subject:</b>	<b>Primary Care Strategic Framework Priorities</b>
<b>Presented by:</b>	<b>Amanda Sear, Head of Primary Care Strategic Planning</b>
<b>Prepared by:</b>	<b>Amanda Sear, Head of Primary Care Strategic Planning</b>
<b>Submitted to:</b>	<b>Primary Care Commissioning Committee</b>
<b>Date:</b>	<b>14 January 2026</b>

**Purpose of paper:**

This paper provides an overview of progress against the four strategic priorities for the 2025/26 financial year, as set out in the Primary Care Strategic Framework adopted in July 2025:

- Primary Care Input into System Planning and Decision Making
- Understanding Resource, Demand and Capacity
- Role of Primary Care in Tackling Health Inequalities
- Future Models of Primary Care

These priorities were designed to ensure confident and credible primary care leadership as part of a whole-system approach aligned with the evolving Integrated Care System (ICS) landscape and to support the shift toward ICB-led strategic commissioning and provider-led operational and transformational leadership.

The update reflects how these priorities are being delivered in the context of significant system changes.

**Executive Summary:**

Since July 2025, significant system developments, many of which are well documented elsewhere, have influenced how these priorities are being delivered.

As a result, progress is being achieved through integration of the four areas into wider primary care and system initiatives rather than through independent workstreams.

This paper provides an update and looks ahead for each priority area.

**Primary Care Input into System Planning and Decision Making**

The system ambition is to create a collaborative model that brings together all primary care as a confident, unified and credible system partner. Experience and emerging evidence suggest provider collaboration is key to enabling primary care contractors to respond

effectively to national expectations and ICB priorities for resource use. Our aim is to give primary care contractors the best opportunity to work together in responding to these changes. We hope that the tone and content of the dialogue we have been fostering with them will help shape a shared vision - grounded in partnership and aligned with the needs of our local population.

Engagement within and with primary care happens through existing forums and programme workstreams, but there is recognition that a more structured collaborative approach could be beneficial, particularly in areas including:

- strengthening the foundations for neighbourhood health and making primary care collaboration central
- aligning shared primary care priorities with system goals
- supporting better resource and workforce planning
- providing independent contractors with a platform for joint decision-making and sustainability

For patients and communities, confident, unified and credible primary care input could mean more proactive, equitable care and better-integrated pathways that promote health and wellbeing.

One of the challenges is that evidence suggests the most effective collaboratives are built from the ground up. However, the current reality reflects the pace of change, including the shift to strategic commissioning, combined with limited maturity of collaboration across primary care providers. There is also a potential tension where independent contractors balance collective goals with the need to sustain their individual business interests.

Initial engagement by the ICB sought to involve all primary care pillars at once, but on reflection we recognise the practicalities involved so the priority now is to ensure we work with all sectors in a connected and coordinated way. This will include learning from our collaboration with Suffolk as part of our journey toward a more integrated approach.

A group discussion planned in January will focus on hearing from those in paid leadership positions within general practice, the LMC, and Norfolk Primary Care. This reflects a practical sequencing decision rather than a prioritisation of one sector over others. This work must be inclusive of all primary care providers, given the immaturity of current provider structures and the need to move beyond siloed thinking.

### **Next Steps**

In January, we have invited general practice clinical leaders together with the LMC and Norfolk Primary Care so they can share their consensus with us on:

- the purpose of a collaborative and how it will differ from current arrangements
- the top practical priorities for the first year (such as resilience, neighbourhood models, tackling inequalities, and estates/digital)
- the approach and topics for future sessions

This work is part of our ICB role in developing primary care providers and builds on previous engagement work.

We will also continue working with contractors to make the most of existing opportunities (such as Pharmacy First and the PCN DES) and explore new ones (including Left Shift and

the development of Neighbourhood Health), through a commissioning approach focused on population outcomes rather than individual organisations.

At this stage, we cannot commit to specific timelines or outcomes, as these will need to be shaped and led by primary care itself.

## **2. Understanding Resource, Demand and Capacity**

A clearer, shared picture of demand and capacity is needed to underpin sustainable neighbourhood health models and ensure that investment decisions promote equity and improve outcomes for our local populations.

Recent developments, including the launch of, and enhancements to, the national GP dashboard and focus on addressing unwarranted variation and contractual management alongside transformation, are shaping the way we understand resource use and demand. This approach aligns with how other primary care contracts are managed as well as providing a useful foundation for local investment decisions.

Much of the ongoing work sits under Primary Care Operational Delivery Plan for 2025/26 and has been helpful in myth-busting and building confidence in the data collected and analysed across a range of outcomes, including quality, workforce and appointments across primary care settings.

What we need to focus on, is to strengthen confidence in a shared view of this data, so that we can respond collectively and make informed decisions together. Local insight remains critical, and we are bringing together parts of the ICB with primary care contractors, local committees, and member organisations to combine collective knowledge and expertise in understanding demand more effectively.

This work will be shaped by the recent Norfolk and Suffolk needs assessment and our commissioning intentions, which together provide the strategic context for investment and transformation.

We will use existing levers to maximise the impact of current local investment on outcomes, ensuring that resources are deployed where they make the greatest difference over and above what is contracted nationally.

### **Next Steps**

Ongoing conversations, rooted in robust data but guided by local insight, bringing these discussions to a neighbourhood level to ensure relevance and impact.

Building transparency, trust, and openness that is still developing; noting this can sometimes feel at odds with a transactional commissioning approach and that neither perspective is wrong; rather, we need space to explore these issues together with an open mind and encourage flexible thinking.

Over time, this could be an area where a primary care collaborative plays a key role in supporting shared understanding and decision-making.

## **3. The Role of Primary Care in Tackling Health Inequalities**

Primary care is often at the heart of our communities. With its presence on the high street and trusted relationships, it reaches people in ways few other services can. Many patients engage through GP practices, but others connect via community pharmacies, dental

surgeries, and optometry - often without an appointment. These everyday touchpoints offer opportunities to promote health, prevent illness, and intervene early. Everyone has a part to play, and primary care's breadth - from treatment to prevention and health promotion - makes it central to reducing inequalities.

Our long-term dental plan led the way in commissioning to tackle health inequalities. By prioritising access in areas of greatest need and introducing services for vulnerable groups, we are moving away from traditional investment models based on population size and activity. Instead, we are focusing on outcomes - ensuring resources flow to where they make the biggest difference.

We have created opportunities and protected time to look at data and learn together as a directorate, supported by expert guidance from our Health Inequalities colleagues who are part of the team. This has been a two-way process, looking at how we can best align the complexities of the primary care landscape with the ethos of health inequalities: *"everybody needs something, some people need more."* By combining insight and expertise, we are starting to ensure that equity is embedded in all decision-making.

We have worked closely with other teams, such as Planned Care colleagues as part of their secondary prevention programme, so that their engagement with primary care contractors mirror ours. This joined-up approach means that funding decisions are increasingly informed by identified need, ensuring resources go where they will make the greatest impact.

Across our Primary Care Commissioning Directorate, we are continuing to strengthen confidence to talk about health inequalities and link meaningfully with initiatives such as *Community Voices*. This work, less visible because it takes place internally, is designed to ensure that tackling inequalities is not just a policy commitment but a shared responsibility across primary care commissioners and contractors.

## **Next Steps**

We are now looking at strategic commissioning and changing the way we invest - shifting from funding based on provider activity to investing for outcomes for populations.

This means using data and local insight to direct resources where they will have the greatest impact, bringing a consensus to how and why every pound spent should improve health and reduce inequalities.

Over time, developing this approach will help us move beyond siloed thinking and create a system where equity is embedded in every decision. This will be evident in our review and future investment in local primary care services and strengthened both in our procurement and contract management.

## **4. Future Models of Primary Care**

The future of primary care is about care that feels local, personal, and connected. Neighbourhood health puts services where people live - on the high street, in community spaces, and through trusted relationships. It means integrated teams of GPs, pharmacists, dentists, optometrists, and community partners working together to deliver joined-up care that meets real-life needs.

Independent contractors delivering primary care are in many respects, free to operate as they choose - provided they deliver against their national contracts. However, the NHS 10-Year Health Plan sets out a clear ambition: moving towards Integrated Health

Organisations\*\* that work as true system partners. To play a meaningful role in planning and designing neighbourhood health, primary care will need to think beyond national contracts and embrace an outcomes agenda.

Remaining focused only on contractual obligations risks isolation and missed opportunities. The rewards for engaging - greater influence, access to transformation funding, and a stronger voice in shaping care - are significant. But staying as things are is unlikely to be an option in a system moving towards collaboration and shared accountability.

Transforming how care is delivered will be underpinned by:

- Population health management: Using data and local insight to identify need and target interventions for those who need more support.
- Integrated working: Breaking down silos and working across organisational boundaries so that primary care, community services, and voluntary partners collaborate seamlessly.
- Digital and data integration: Shared systems and interoperable platforms to enable proactive planning and continuity of care.
- Outcome-based commissioning: Shifting from activity-based funding to investment that delivers measurable improvements in population health.

Neighbourhood models are expected to be more than a structural change - they are about creating a system that feels accessible and responsive. They enable early intervention, tackle wider determinants of health, and reduce pressure on hospitals by supporting people closer to home. By embedding primary care at the heart of neighbourhood health, we can build resilience, improve outcomes, and make equity a reality.

*\*\*Integrated Health Organisations are described in the 10-year health plan as a population-based contracting model whereby an Integrated Care Board (ICB) awards a capitated budget for a defined population to a host provider - typically a high-performing NHS Foundation Trust. That trust manages the full spectrum of services, either directly or via sub-contracts with partner providers - spanning primary, community, mental health, acute, and social care. They are intended to:*

- *improve patient care by integrating services across sectors.*
- *facilitate investment in capital and digital infrastructure.*
- *empower small providers and local business ecosystems.*
- *drive care integration, particularly shifting resources from hospitals to communities.*
- *enhance population health outcomes and reduce health inequalities.*
- *evolve into the default model for provider contracting in the future*

## Next steps

We are in the process of appointing a strategic delivery partner to work alongside us to support the next phase of transformation, focusing on how primary care can best engage with neighbourhood health and integrated care models.

The scope of the work has not yet been finalised, but is likely to include:

- facilitating engagement across primary care leaders to co-design neighbourhood health models
- building capability and confidence among primary care leaders to operate as system partners

- helping prioritise actions for strategic commissioning, outcome-based contracting, and integrated neighbourhood teams

Working to the underlying principles of:

- aligning primary care transformation with the ethos of population health and equity
- moving from activity-based to outcome-based delivery
- supporting integrated neighbourhood teams to deliver care closer to home

**Recommendation:**

Committee members are asked to note the update and are invited to provide feedback on areas of particular interest or future updates they would like to see

Key Risks	
<b>Clinical and Quality:</b>	The continuous quality improvement cycle benefits from collaboration and a shared agenda across primary care
<b>Finance and Performance:</b>	Understanding and matching care capacity to meet clinical need across primary care will contribute positively to system finance and performance
<b>Impact Assessment (environmental and equalities):</b>	Increased collaboration and integrated working across all primary care services could increase the ability to ensure resources are used to address health inequalities
<b>Reputation:</b>	Integrated care boards (ICBs), through delegation for primary care, lead provide assurance for planning and arranging services for contractors to deliver in ways which best meet population needs, address health inequalities. Primary care access will be key to the shift to <a href="#">neighbourhood health services</a> , which is in central to delivering locally on the ambitions in the 10-year health plan for integrated, sustainable health and care
<b>Legal:</b>	None identified
<b>Information Governance:</b>	None identified
<b>Resource Required:</b>	Primary Care Workforce Transformation and Primary Care Delegated Commissioning Teams alongside Medical, Locality, Digital, Health Inequalities, and Commissioning teams all support contractual delivery and transformation

Webb, Sarah  
07/01/2026 14:56:21

<b>Reference document(s):</b>	<p>NHSE Neighbourhood Health Guidelines 2025-26</p> <p><a href="https://www.england.nhs.uk/long-read/neighbourhood-health-guidelines-2025-26/">https://www.england.nhs.uk/long-read/neighbourhood-health-guidelines-2025-26/</a></p> <p><a href="#">ICB Model Blueprint</a> - update published on 28 May 2025</p> <p><a href="#">Fit for the Future</a> - 10-Year Plan published on 3 July 2025</p> <p><a href="#">Model Region Blueprint</a> - article published 11 September 2025</p> <p><a href="#">Planning Framework</a> - published 24 October 2025</p> <p><a href="#">Strategic Commissioning Framework</a> - published 5 November 2025</p>
<b>NHS Constitution:</b>	<p>The four pillars of primary care operate under distinct contractual frameworks and guidance: the Primary Care Policy and Guidance Manual (general practice), the Drug Tariff and Pharmaceutical Services Regulations (pharmacy), the Dental Policy Book and GDS/PDS Regulations (dentistry), and the Optical Policy Book and GOS Regulations (optometry). Collectively, these form the Primary Care Contractual Frameworks.</p> <p><a href="https://www.england.nhs.uk/publication/primary-medical-care-policy-and-guidance-manual-pgm/">https://www.england.nhs.uk/publication/primary-medical-care-policy-and-guidance-manual-pgm/</a></p> <p><a href="#">NHS England » Policy book for primary dental services</a></p> <p><a href="#">NHS England » Pharmacy Manual</a></p> <p><a href="#">NHS England » Policy Book for Eye Health</a></p>
<b>Conflicts of Interest:</b>	Declarations of interest are held on record; there were no conflicts of interest noted for this report
<b>Reference to relevant risk on the Board Assurance Framework</b>	Risk to resilience of primary care and transformation, on BAF and monitored through Primary Care Commissioning Committee, current score of 20
<b>Governance</b>	The Primary Care Strategic Framework workstreams were adopted by the PCCC during July 2025
<b>Process/Committee approval with date(s) (as appropriate)</b>	Not applicable

Webb, Sarah  
07/01/2026 14:56:21

Agenda item: 14

<b>Subject:</b>	<b>Strategic Medicines Optimisation report</b>
<b>Presented by:</b>	<b>Michael Dennis, Associate Director of Pharmacy and Medicines Optimisation</b>
<b>Prepared by:</b>	<b>Jessica Adcock, Head of Pharmacy and Medicines Optimisation (Quality and Safety)</b>
<b>Submitted to:</b>	<b>Primary Care Commissioning Committee</b>
<b>Date:</b>	<b>14 January 2026</b>

**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 within our pillars are highlighted and discussion on implementation and the workstreams are welcomed.

- 2.1 The prescribing team is focused on supporting the prescribing quality scheme and an additional switch scheme monitoring.
- 2.2 We continue to work with SNEE (Suffolk and North East Essex) ICB colleagues to plan alignment of policies etc.
- 2.3 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](#).
- 2.4 Our five are.
  - Addressing problematic polypharmacy
  - Addressing low priority prescribing
  - Best value biologics in line with NHSE commissioning recommendations
  - Improving valproate safety
  - Switching IV antibiotics to oral (hospital in-patients)

Webb, Sarah  
07/01/2026 14:56:21

## 2 MO Pillar highlight report – Quality and Safety

### 2.1 Medicines Safety

After the successful partnership working with the formation of the Valproate working group the Medicines Safety and Quality group (MSQG) has been formed. The group's purpose is to promote the best possible health outcomes for our local population through working collaboratively with our partners and local communities to provide organisational oversight and assurance on patient safety and quality improvements around the safe use of medicines in primary care and at the interface with our partners and other stakeholders across the integrated care system.

The group will provide assurance for Medicines Safety across Norfolk and Waveney in primary care and at the interface with other stakeholders and act as a forum to discuss and implement a seamless process to identify, escalate, communicate and share learning from medicines safety related issues at the interface. The group will report to the Medicines Optimisation Programme Board

As part of the Prescribing Quality Scheme practices have been asked to nominate a Medicines Safety Lead and a Dependency Forming Medicines (DFM) Lead. The clinical Medicines Safety Lead is responsible for ensuring medicines are managed safely within the practice, including ensuring relevant policies and procedures and national safety alerts are dealt with in a timely manner. The DFM lead is an existing role, they should ensure that the practice has a current drug-seeking behaviour policy and approach to management that is followed by practice staff.

### 2.2 Dietetics

The Medicines Optimisation Dietetic team continue to develop guidelines, SOPs, and education sessions for primary care, care home and domiciliary care staff, and ICS dietetic teams to improve the quality of prescribing of nutrition borderline substances (NBS) such as oral nutritional supplements (ONS), enteral feeds, infant formulae, and some vitamins and minerals. They continue to provide support to primary care and ICS colleagues via the dietetic queries mailbox.

The team have completed new patient information resources to target those affected by rising food prices, those with poor kitchen facilities, and those needing to access community support for food provision. These resources provide information on sourcing and preparing nutritious meals on a budget using simple cooking facilities. Translated versions of these resources will also be available. These are awaiting formal publication and will be shared with local VCSE organisations and ICS teams who are in contact with Norfolk and Waveney residents requiring support with access to nutritious, affordable food. The team are also developing a new policy managing home enteral feeding supplies for teams who look after patients requiring artificial enteral nutrition at home. This is being developed to improve sustainability, reduce the use of single-use plastics, and manage the high cost of some items. This includes producing some patient information leaflets to support washing and reusing of suitable equipment such as enteral syringes and gastrostomy extension sets.

The team continue to meet with SNEE prescribing support dietitian colleagues to plan for future projects.

Webb, Sarah  
07/01/2026 11:56:21

## 2.3 Antimicrobial Stewardship (AMS)

Combatting antimicrobial resistance – the UK second five-year national action plan continues to promote optimal use of antimicrobials in humans to ensure safe and effective patient care by strengthening antimicrobial stewardship programmes which should include the review of dose and duration of antimicrobial prescriptions. There is also an ambition to reduce UK antimicrobial use in humans by 5% by 2029.

The national metrics for AMR have been reviewed and updated with a shift to population health metrics

The metrics being monitored for 2025-26 are

- a. Percentage of children aged 0-9 years who have been prescribed at least one antibiotic in primary care in the last 12-month period at or below 27%
- b. Proportion of total items in UK Access classification for antibiotic prescribing in primary care – 70% of items
- c. Reduced course length of amoxicillin and doxycycline prescribing to 5 days – 75% and 60% of items

### **a) Percentage of children aged 0-9 years who have been prescribed at least one antibiotic in primary care in the last 12-month period at or below 27%**

The metric for children is included in the NHS Oversight Framework for 2025-26 This patient safety metric is supporting delivery of both the UK second five-year action plan and the NHS delivery of high-quality, safe care.

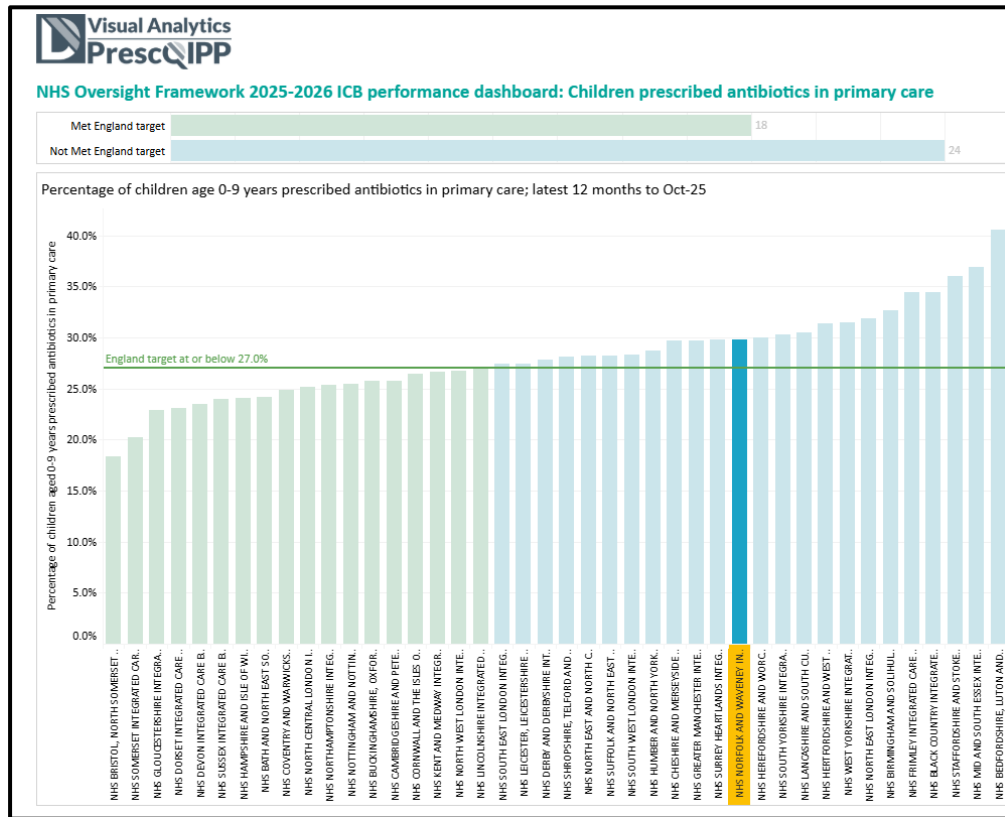
ICB performance is assessed as Met or Not Met against a fixed national England target: at or below 27.0%

The ICB performance for 12 months to October 2025 is Not Met with a percentage of 29.8% (40.3% in October 2024) – Table 1

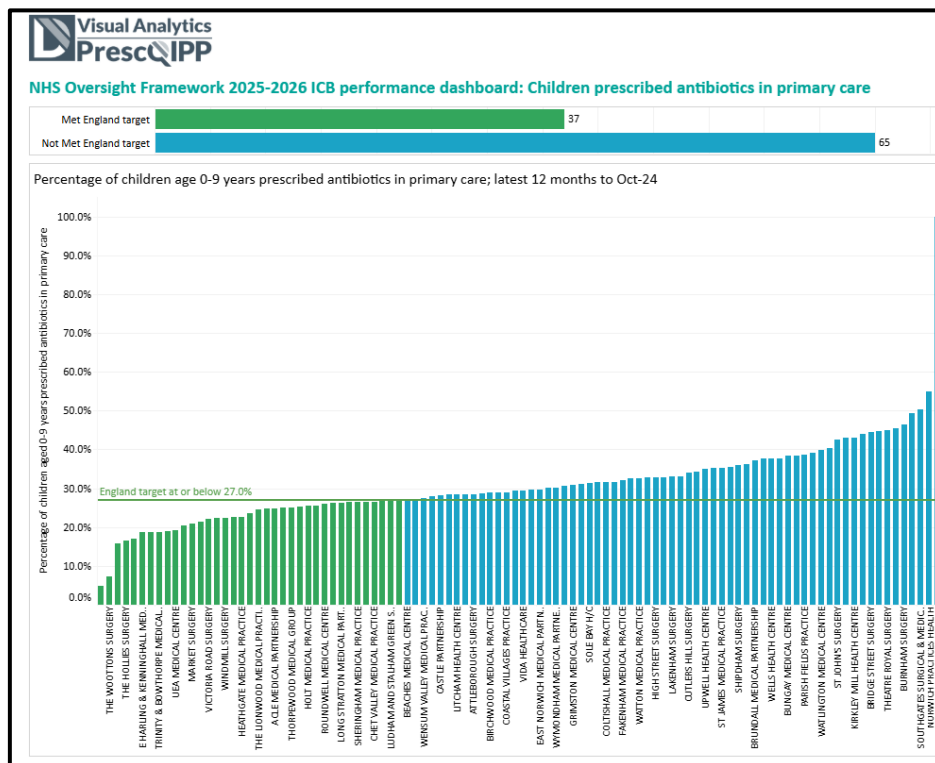
79 practices are meeting this performance target in August 2025 (37 practices in October 2024) - Table 2

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07/01/2026 14:56:21

**Table 1: NHS Oversight Framework 2025-26 ICB Performance Dashboard: Children prescribed antibiotics in primary care – ICB level**



**Table 2: NHS Oversight Framework 2025-26 ICB Performance Dashboard: Children prescribed antibiotics in primary care – Practice level**



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## **Focus work with Norwich Walk in Centre**

Analysis confirmed that Norwich OOH prescribing and the walk-in centre showed the highest prescribing rates per child, leading to the decision to direct a pilot project in the Norwich area.

A multidisciplinary working group was established within the N&W ICB, including Infection Prevention and Control nurses, secondary care pharmacists, a paediatric community nurse, a health visitor, and a public health lead, to review findings and develop solutions.

Direct engagement was initiated with the Norwich walk-in clinic clinical team to understand prescribing practices and obstacles to appropriate paediatric antibiotic use.

Educational materials (leaflets and videos) developed by the working group have been shared with the clinic for follow-up and implementation.

## **Community and Stakeholder Outreach**

Engaged with the Just One Norfolk Health Visitors team and School Nursing Immunisation Teams to agree upon sharing educational materials and communication content with their clinicians and stakeholders.

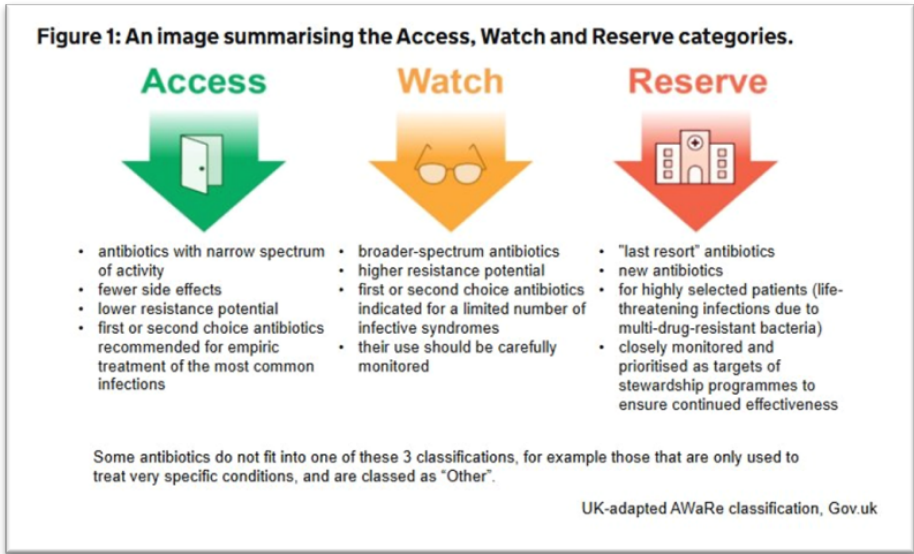
Coordinated with school nurses to integrate AMS messaging into school immunisation visits.

Liaised with NCC school liaison to distribute AMS content to parents/carers via school newsletters during World Antimicrobial Awareness Week (WAAW).

### **b) Proportion of total items in UK Access classification for antibiotic prescribing in primary care – 70% of items**

In the UK second five-year National Action Plan there is a new target to achieve 70% of total antibiotics prescribed from the Access category

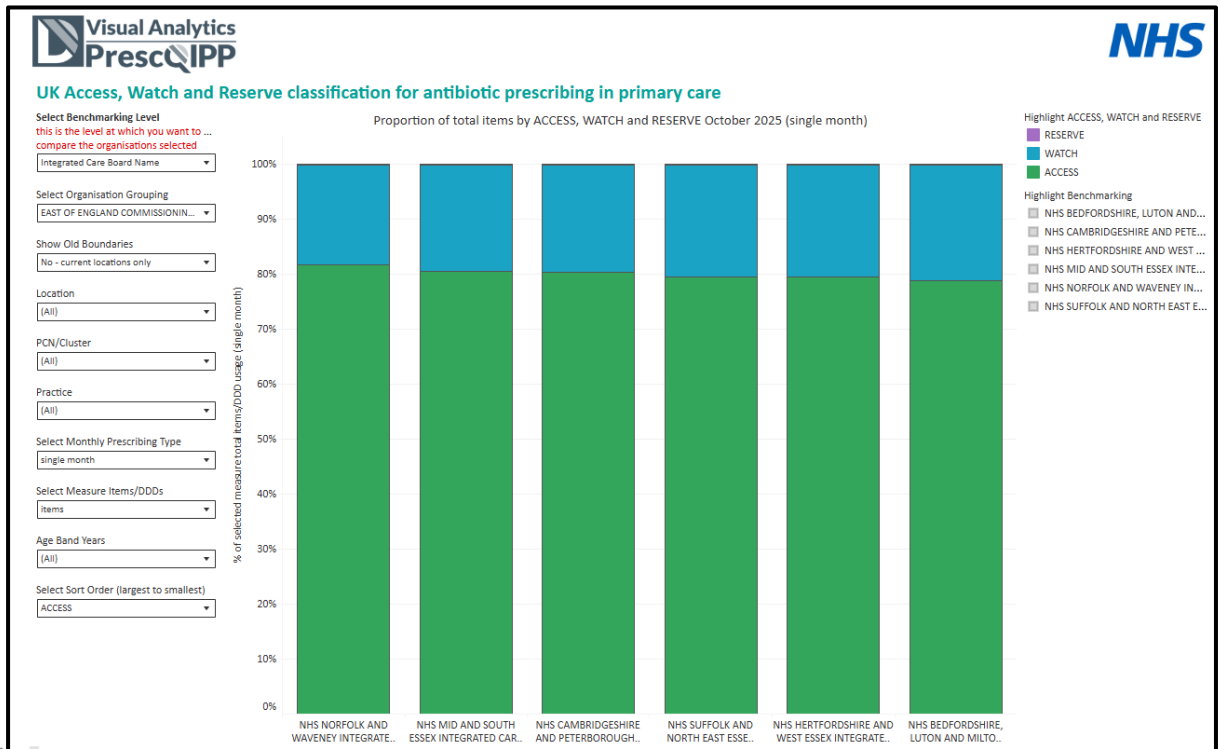
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07/01/2026 14:56:21



<https://www.gov.uk/government/publications/uk-aware-antibiotic-classification/uk-access-watch-reserve-and-other-classification-for-antibiotics-uk-aware-antibiotic-classification>

Norfolk and Waveney are leading this indicator in the EoE with 81.66% (target 70%) – Table 3. This is a huge achievement and has been driven by the work our team do with practices to ensure selecting an appropriate antimicrobial drug either follows formulary guidelines or microbiology sensitivities.

**Table 3 UK Access, Watch and Reserve classification for antibiotic prescribing in primary care – East of England**



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**c) Reduced course length of amoxicillin and doxycycline prescribing to 5 days – 75% and 60% of items**

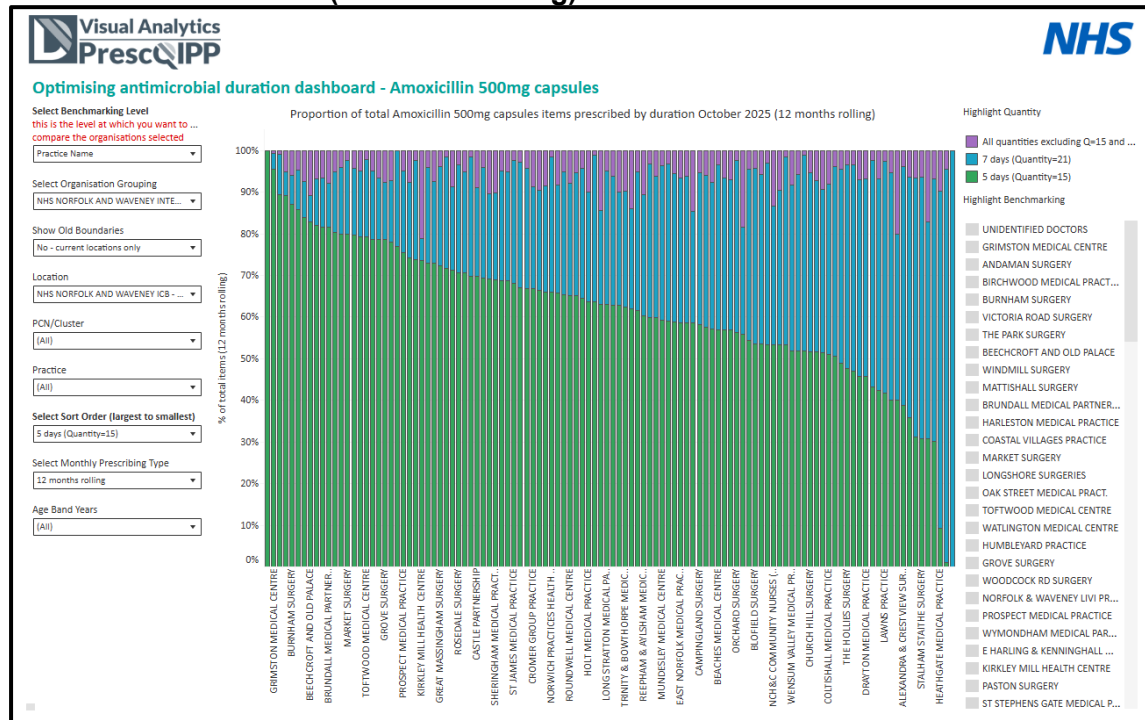
Optimising antimicrobial prescribing duration is a continuing focus for our outlier practices, improvement is being facilitated through the prescribing quality scheme 2025-26.

**Amoxicillin 500mg capsules**

The ICB is third for the Amoxicillin Optimising indicator – 62.35% over a 12-month period to October 2025

Table 4 shows the Norfolk and Waveney practice performance for prescribing Amoxicillin 500mg capsules as a 5-day duration.

**Table 4 Proportion of total Amoxicillin 500mg capsules items prescribed by duration October 2025 (12-month rolling)**



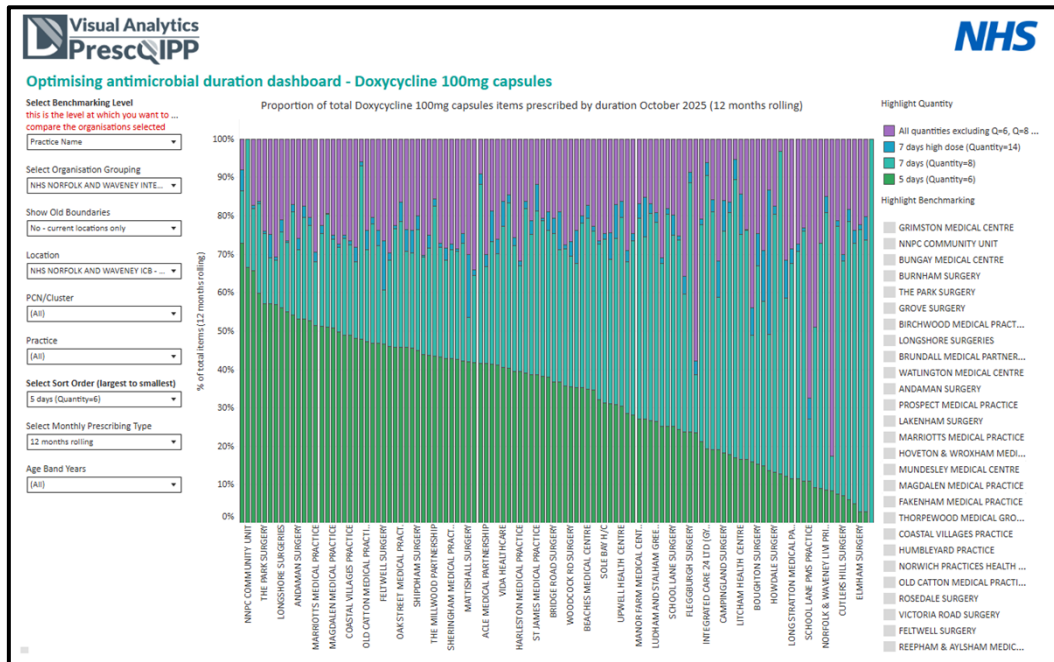
**Doxycycline 100mg capsules**

The ICB is fifth in EoE for the Doxycycline Optimising indicator – 37.13% over a 12-month period to October 2025

Table 5 shows the Norfolk and Waveney practice performance for prescribing Doxycycline 100mg capsules as a 5-day duration. There is still a large variation in performance, improvement is being supported through the Prescribing Quality Scheme and individual practice visits.

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07/01/2026 14:56:21

**Table 5 Proportion of total Doxycycline 100mg capsules items prescribed by duration October 2025 (12-month rolling)**



**2.4 MO Quality and Safety Team – Triple Award winners**

**NHS East of England Antibiotic STAR Award 2025 Winner**

Norfolk and Waveney ICB Antimicrobial Stewardship prescribing team and Infection Prevention and Control team - winners of the Primary Care Team award.

We are pleased to recognise this team for achieving a reduction in C.difficile infections through targeted interventions in broad spectrum antibiotic prescribing in primary care.

**Norfolk Fire and Rescue Awards**

The MO Quality and Safety team working in partnership with Norfolk Safeguarding Adults Board and the West Norfolk Learning Disabilities Team and the National Fire Chiefs Council, won the Norfolk Fire and Rescue Partnership award.

'Their expertise has helped us educate the public on the fire risks when using these medical moisturisers for conditions such as eczema and psoriasis and together we have produced a video on the subject which has been shared with professionals across the country. This has been a fantastic example of true partnership working to benefit both our communities and those further afield and help save people's lives.'

You can watch the video via the link <https://orlo.uk/KfQ0Z> under the heading Reducing Risk: Information for Carers and Support Workers

**National Fire Chiefs Council annual awards**

The project was also nominated and won a National Fire Chief Council annual award - 'Partnership Working Award'.

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### **3 MO Pillar highlight report – Clinical Experience and Delivery**

#### **3.1 Delivering prescribing efficiencies:**

The pillar continues to deliver targeted prescribing meeting reviews, both in-person and online, with a clear focus on reducing unwarranted prescribing variation. Regular collaborative meetings with all PCN Pharmacist teams across Norfolk & Waveney, have ensured alignment of priorities and strengthened delivery of medicines optimisation workstreams.

Engagement with GP Prescribing Leads has been maintained on request and when working with priority GP spend outlier practices, which has facilitated additional leadership support where it is most needed, to those practices not signed up to the Prescribing Quality Scheme

Between July and December 2025, most identified outlier practices demonstrated reductions in spend per ASTRO-PU, with notable improvement in practices that are outliers when compared to both ICB and national averages.

Another key achievement during this period has been the reduction in unlicensed prescribing, with licensed alternatives promoted wherever possible. This has delivered an 11.61% year-on-year reduction in the total number of unlicensed medicines prescribed in general practice, directly supporting patient safety and compliance with national guidelines. There is ongoing work focused on GP practices with high-volume prescribing to individual patients, undertaken in close alignment with ICS and prescribing teams to ensure the safe reduction of prescribing volumes or the amendment of inappropriate quantities where clinically appropriate. Particular attention has been directed towards single high-quantity items, notably immediate-release Fentanyl (exceeding 2,000 lozenges per month), phosphate enemas, and Hyoscine patches.

Training for GP Practices on patient administration of Staladex (leuprorelin) implant injection, supported by Aspire Ltd, was delivered in October 2025 for practices administering LHRH antagonists. Further sessions are scheduled for February and March 2026 to support the administration of low-acquisition-cost LHRH injections, promoting safe, value-based care within GP practices.

The pillar recorded 74 facilitated interventions on Co-ordinate Rx between July and December, generating annualised savings of £66,048.

#### **Home Oxygen Service**

The team continues to support General Practice in managing issues that may arise for patients receiving home oxygen therapy, working collaboratively with ICS clinicians to ensure treatment modalities are appropriately optimised. Patient queries are addressed promptly to maintain safe and effective care.

It has been noted that a small number of GP Practices have ordered large quantities of static and ambulatory cylinders for patients. In response, the team has been working closely with the GP Practices, Baywater, and the Home Oxygen Assessment Service to transition patients from cylinders to home concentrators, thereby improving both safety and efficiency.

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## **4 MO Pillar highlight report – Interface and Formulary (I&F)**

Collaboration with ICB colleagues and N&W system partners continues; exploring best value opportunities through the introduction of biosimilars and the development of High-Cost Drugs guidance and pathways in collaboration with the Acute Trusts, aiming for a “do it once approach” across the system. I& F Pillar continue to review and update the Norfolk and Waveney netFormulary platform, ensuring evidence based best value medicines are highlighted for our local prescribers.

### **4.1 Knowledge NoW and Netformulary**

Netformulary and KNoW are considered valuable resources to healthcare professionals as the Norfolk and Waveney Formulary pages continue to be the most popular on KNoW. Its popularity has raised the potential for expansion of the platform to host Acute Trust resources and provide an accessible repository of information for clinicians supporting patient care at the interface. This is in accord with the NHSE and DHSC aim to achieve the most seamless care for patients while ensuring the most effective use of NHS resources; to provide timely communication and appropriate commencement of medication.

Netformulary is built and managed in collaboration with our system partners. I&F team continue to work with NSFT colleagues to populate Mental Health Chapter 4; ensuring all previously agreed TAG decisions are clearly documented. The formation of the Acute Trust Group model, and the imminent closure of the Medicines Complete formulary platform within the Trusts has necessitated a rapid review of formulary provision in N&W and future access for the Trusts; there will be a single net formulary platform provided across N&W.

Work is progressing at pace to deliver this before closure of Medicines Complete in July 2026. I&F are leading the task and finish group facilitating this mammoth task. Although a digital solution for populating net formulary is being explored there are several hundred formulary entries to evaluate, align and upload in a very short time frame.

The work towards a National Formulary will also be a factor in the approach and content of the new integrated formulary. Initial work already conducted across the 6 current ICBs in EoE within the Medicines Collaborative Group has provided some reassurance that most of our N&W traffic lights are already in line with other ICBs.

### **4.2 Therapeutics Advisory Group (TAG)**

The Therapeutics Advisory Group (TAG) as N&W area prescribing committee, continues to provide informed, professional advice and recommendations for medicines, dressings and other prescribable items.

In preparation for the new organisation, both Medicines Optimisation Teams are working closely to manage the transition and address areas of disparity with commissioning decisions, clinical guidelines and policies. Governance for decision making will be priority for January to April 2026, aligning Area Prescribing Committees TAG (N&W) and IMOC (SNEE), meeting in common where possible e.g NICE TA recommendations.

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Priority will also be given to alignment of National NHSE policy guidance; *Conditions for which over the counter items should not routinely be prescribed in primary care* and *Items which should not be routinely prescribed in primary care*. This will be followed by a full review of East of England Priorities Advisory Committee Guidance produced in collaboration with ICB Medicines Optimisation leads. High priority will also be given to items which support local incentives, commissioning intentions and best value projects; particularly where biosimilars and NHSE Frameworks are agreed.

## 5 MO Pillar highlight report – Repeat Prescribing and Support

### 5.1 Introduction

The purpose of the RP&S Team is to facilitate improvement in repeat prescribing processes within practices and aims to:

- Improve safety and reduce waste,
- Support practices with practical tools and training,
- Align with ICS sustainability and Medicines Optimisation priorities.

This report provides an update on the Repeat Prescribing and Support Pillar's activities and outcomes since June 2025 - highlighting project updates, data insights, practice engagement, and ongoing development of initiatives.

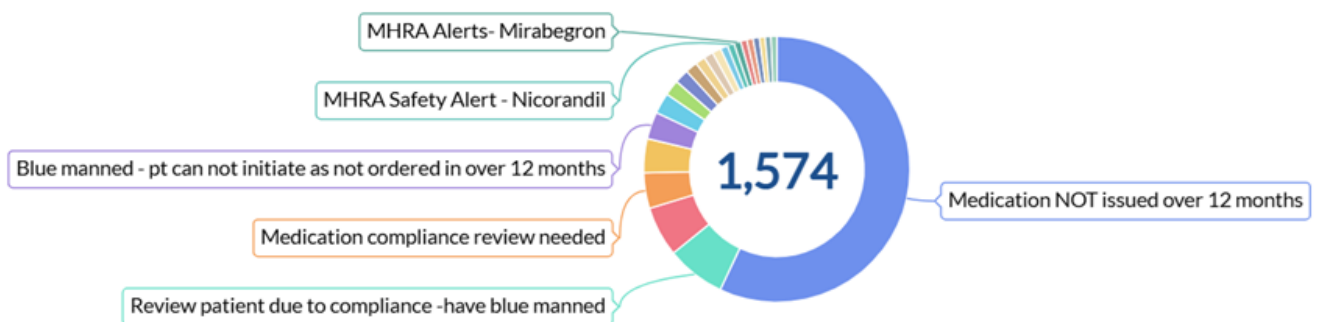
### 5.2 Project updates

#### 5.2.1 Housekeeping and Direct Support

Engagement with practices remains consistent supporting numerous areas of repeat prescribing. The team continues to support practices, including those where historically direct engagement has been difficult, and has led to positive relationship building.

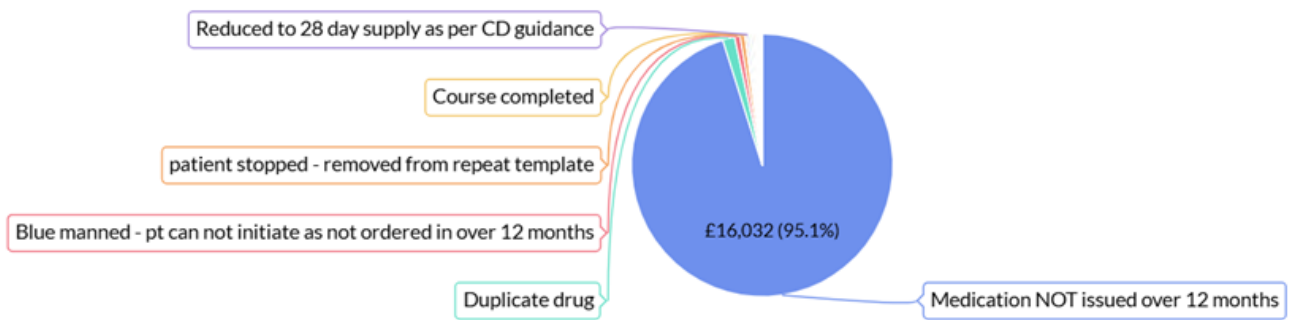
Support has been provided for multiple practices, including MHRA alert updates, eRD and Housekeeping.

The graphic below shows the total number of interventions recorded by the team since March 2025, split into categories.



And the corresponding cost-savings for the period March-November 2025.

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By implementing good practices within the GP practice, further savings will be made directly and sustainably by the practice staff and pharmacy teams.

### 5.2.2 Repeat Prescribing Toolkit

Completion of the Repeat Prescribing Toolkit has been incentivised through the Prescribing Quality Scheme 2025/26. The toolkit audit has now been sent to 77 practices (74% of total Norfolk and Waveney practices). 45 practices are actively working through the audit, with action plans returned from 13. It has been interesting to note practices implementing quality improvement methodologies with a multi-disciplinary approach to audit completion.

Themes are being collated from the audit returns and remain consistent around:

- Understanding of roles and responsibilities of the repeat prescription process
- A requirement for training of Prescription Clerks
- Inconsistencies in policies and procedures and staff awareness

Webinars to support practices in approaching completion of the Toolkit were hosted in September and October.

### 5.2.3 eRD

Work continues around the implementation of electronic Repeat Dispensing with several practices requesting additional training.

Prescribing data shows little movement in the usage of eRD, although this is complicated within Norfolk and Waveney due to the use of RPA (robotic process automation) and more patients using the NHS App for ordering.

The team continue to provide support as and when required.

### 5.2.4 Training

The team have identified through the previously mentioned audit returns, that prescription for training clerks is an identified need. There is currently no defined training standard for non-clinical staff who usually receive “on the job” training. This can lead to poor practice when processes are passed down to newer members of staff.

The Primary Care Workforce Team were consulted to identify whether this had been highlighted through the General Practice Training Needs Analysis. Responses did not

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indicate this area as a need, however the specific question about this function had also not been asked. There remains no commercially available training package to develop medicines management for non-clinical staff beyond an introductory level.

Discussions have been undertaken with SNEE colleagues to identify work undertaken in their area with a view of bringing together any future offering. A Training Needs Analysis is in development and will be offered across Norfolk and Suffolk practices.

PrescQIPP offer an introductory level Medicines Co-ordinator course, which has been added as a requirement in the Prescribing Quality Scheme. Funding for this course has been obtained through Primary Care Workforce. To date 99 licence codes have been distributed to practices.

### 5.2.5 Medication waste reduction campaign

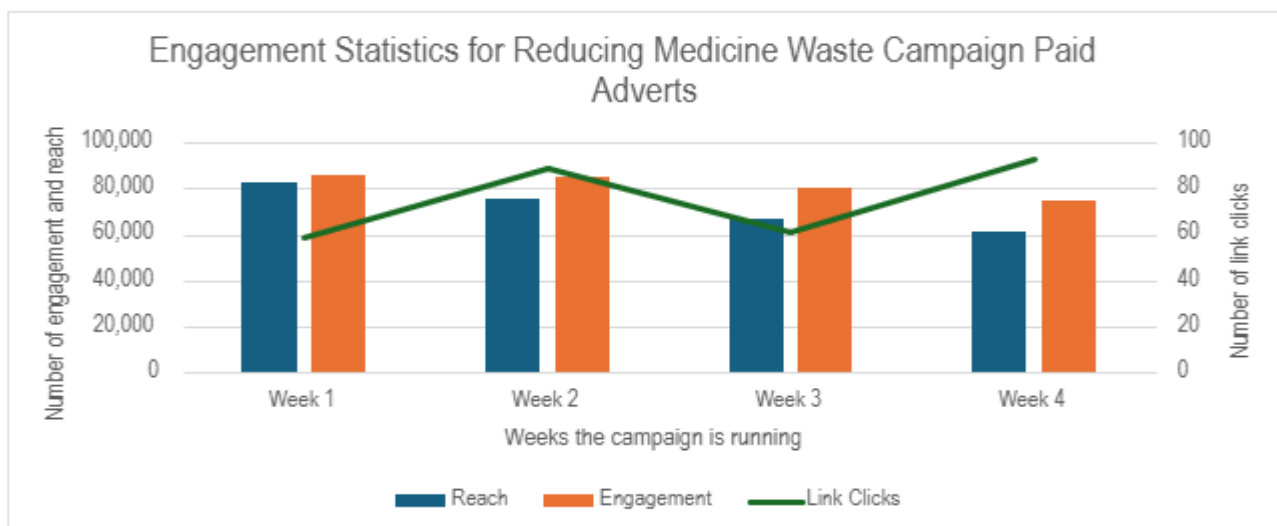
The medication waste reduction campaign commenced in September 2025 with social media messaging along 4 weekly themes:



Additionally, presentations were made at the ICB Staff Briefing, radio interview with Dr Frankie Swords on Heart Radio, three waste webinars for 22 primary care staff, and two Patient Participation Groups to highlight the issue. The practice webinars provided a further opportunity to highlight the Repeat Prescribing Toolkit.

Reach and engagement for the four-week period was as shown below:

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This shows a consistent level of engagement across the four weeks, generating awareness of the cost to the NHS.

Further to this campaign, the materials were shared with Primary Care Commissioning colleagues who implemented one of the mandatory annual health campaigns for community pharmacy to display posters within pharmacies – continuing the reach of this important message.

### 5.3. Additional Practice Support (outside set team scope)

Long Stratton Medical Practice received additional support with their Emis to SystmOne clinical system switch, both with leading up to the transfer and on Go-Live day.

Prior to the switch, data checking was completed to ensure all data transferred accurately, and on the day were able to support queries with the issuing of prescriptions and adding medication stock onto the live system.

### 5.4. Risks and Challenges

Utilisation of the NHS App by patients to order their medication continues to grow. A recent app development has given the option to “Order All” medication. This is a potential area of risk to prescribing items and costs if patients use this routinely, rather than ordering what is required. In addition, there is a risk that items are missed as only items due for order are displayed. Patients may not realise this, increasing the likelihood of blaming practice or pharmacy staff for missing items. We would like to feed these concerns back to the NHS App development team.

### 5.5. Planning 2026/27

Further ideas continue to be worked up for the 2026/27 workplan in conjunction with work undertaken as business as usual.

- Training – continue to develop training needs and scope for prescription clerk / non-clinical staff around repeat prescribing good practice.
- Digital Expansion - broadening knowledge of the NHS App into community pharmacy

Webb, Sarah  
07/01/2026 14:56:21

- Managed repeats – to further reduce medication waste, produce materials to enable pharmacies and practices to remove managed repeat services; encouraging patients to order their own medicines, and improve efficiency through removal of an unfunded service.

**Recommendation to Committee:**

The committee is asked to note this report.

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

**GOVERNANCE**

<b>Process/Committee approval with date(s) (as appropriate)</b>	Monthly report to PCCC
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07/01/2026 14:56:21



Improving lives **together**

Norfolk and Waveney Integrated Care System

# 2025/26 Primary Care Commissioning Committee Finance Report Norfolk & Waveney ICB

## M8 2025

Primary Care Commissioning Committee 14<sup>th</sup> January 2026

Webb, Sarah  
07/01/2026 14:56:21

# Contents

Section	Description	Page Number(s)
1.0	Executive Summary - Reporting	3
2.0	Primary Care and Prescribing Reporting	4
3.0	ICB Financial Position	5
4.0	Prescribing Efficiencies	6
5.0	LCS Activity Tracker	7
App A	Detailed Financial Position Prescribing and Primary Care	8

Webb, Sarah  
07/01/2026 14:56:21

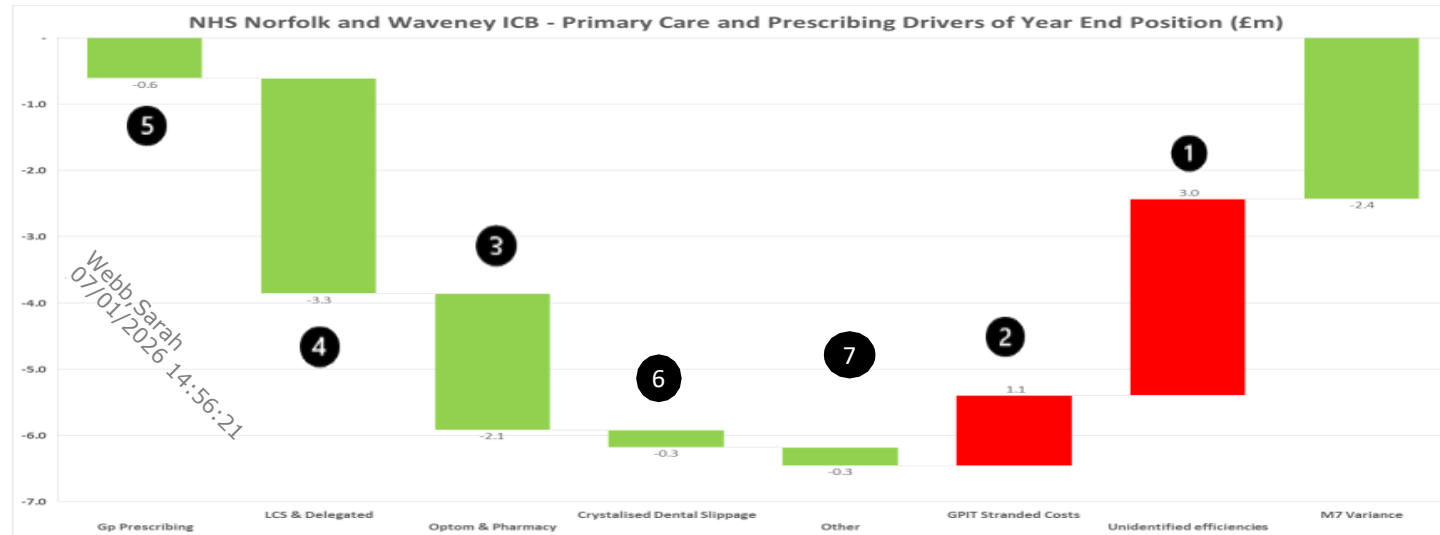
# 1.0 Executive summary – Reporting

**Reported Financial Position:** As of November 2025 (M8), the Primary Care & Prescribing reported position is £2.4m underspent due to underspends in GP Prescribing, LCS, Delegated PC, Optom and Pharmacy driven by the budgeted efficiencies within this area reduced partly by the budgeted unidentified efficiencies and GPIT stranded costs.

	Annual Budget	Budget	Actual	Variance	Forecast	FOT Variance
	£m	£m	£m	£m	£m	£m
Reported	629.3	413.8	413.7	(0.1)	626.8	(2.4)

## Variations:

The key operational variations are shown below:



The GP & Prescribing forecast position is now under plan. The areas with significant variances are as follows.

- The budgeted unidentified Efficiencies in Primary Care amount to approx. £3m. There are now schemes identified and are showing benefits outside of this sub-directorate **1**
- Within GPIT the termination of the GPIT contract with AGEM CSU will be require the agreement of stranded costs including 3<sup>rd</sup> party contracts, redundancy and corporate overhead. Circa £1m has been currently provided for this. **2**
- Optometry is under plan due to an operational benefit for reduced sight test activity £0.1m. Pharmacy is also under plan due to CPCF allocation distributed on a fair share basis **3**
- LCS and Delegated under plan due to GP Procurement savings which are shown as efficiency achievement offset, and an operational benefit from reduced claims in Q1 for LCS. In addition, there are some allocation benefits for new schemes in 25/26 **4**
- GP prescribing is under plan due to exceptional benefits to the ICB's financial position compared to previous years in Cat M & NCSO (no cheaper stock obtainable). **5**
- Dental broadly on plan with some Part Year adjustment, but this is before any adjustment for activity claw back. **6**
- Primary Care Other is underspent due to prior year benefits. **7**

## Managing In-Year Risks:

### Efficiencies

The unidentified efficiency requirement is partly identified and there are some efficiencies that are being currently captured with regards to the conversion of APMS contracts to GMS and the reduction of some contracts by circa 6% on their expiry in lieu of their conversion to GMS. Other savings with Pharmacy slippage have been identified

## 2. Primary Care and Prescribing reporting M8

Sub-Directorate (£m)	Full Year Variance (underspend) / overspend	Variance – significant items
GP Prescribing Budget £208	£(1.82) -0.9%	Year To Date Efficiencies delivered and exceptional year on year Cat M & NCSO
Other Prescribing costs Budget £20	£1.20 5.9%	Increasing Mental Health Drugs costs and Weight Loss drugs both outside of FP10 transactions and leading to overspend.
Delegated Primary Care Budget £253	£(2.79) -1.1%	GP Procurement Savings (captured as efficiencies) and allocation benefits in new schemes for 25/26
Local Enhanced Services(LES) Budget £20	£(0.46) -2.3%	Q1 underspent on schemes creating an operational variance, needs to be monitored to see if soend increases in subsequent quarters.
Other Primary Care Incl GPIT Budget £13	£0.78 6.0%	GPIT Stranded costs less Other PC benefits
Dental Budget £72	£(0.26) -0.4%	Broadly on plan this is before any under activity claw back
Optom Budget £12	£(0.23) -1.9%	Small operational variance due to reduced activity in sight tests
Pharmacy Budget £32	£(1.8) -5.6%	CPCF Underspent, due to fair shares distribution of allocation centrally.
Sustainable Commissioning QIPP Budget -£3	£3.0 -100.0%	Delivered in Pharmacy and Delegated PC
<b>Total</b>	<b>£629</b>	<b>£(2.4)</b>

# 3. ICB Financial Position M8

Directorate Full Year Budget (£m)		Full year Variance (underspend) / overspend	Variance – significant items
Acute		£8.09	Sustainable commissioning QIPP
Budget	£1,409	0.6%	
Spec Comm		£0.00	On Plan
Budget	£225	0.0%	
Community and Better Care Fund (BCF)		£5.12	Sustainable commissioning QIPP
Budget	£258	2.0%	
Continuing Healthcare		£(4.17)	Patient levels and referrals have remained stable up to M08. Current efficiency plans, including new stretch commitment, are on target to deliver creating
Budget	£168	-2.5%	
Mental Health		£4.97	Sustainable commissioning QIPP
Budget	£334	1.5%	
Prescribing		£(0.61)	Cat M & NCSO benefits
Budget	£229	-0.3%	
Primary Care		£(1.82)	Procurement and Allocation benefits offset by GPIT Stranded costs
Budget	£401	-0.5%	
Other - Combined areas		£(2.60)	Sustainable commissioning QIPP
Budget	£25	-10.4%	
Planning		£(8.96)	Sustainable commissioning QIPP in above areas partially offset
Budget	£10	93.9%	
Running Costs		£(0.02)	On Plan
Budget	£17	-0.1%	
<b>Total</b>	<b>£3,055</b>	<b>£0.00</b>	

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## 4.0 Prescribing Efficiencies M8

Prescribing Efficiencies Top Performing by value Budget (£000's)		Forecast (£000's)	Var (£000's) Fav (Adv)	Variance – significant items
OptimiseRx Budget	£2,100	£2,673	£573 27.3%	Increased savings than plan as more surgeries use Optimise Rx
Rivaroxaban savings Budget	£1,650	£1,699	£49 3.0%	Increased savings as more patients prescribed Rivaroxaban
Low Risk, cost effective switching programme Budget	£1,500	£2,115	£615 41.0%	Increased Savings than plan
Other Switches Budget	£1,250	£1,051	£(199) -15.9%	Savings lower than expected
Oral Nutritional Supplements Budget	£750	£450	£(300) -40.0%	Lower than plan
Deprescribing SMRs Budget	£750	£750	£0 0.0%	On Plan
Patent expirations Budget	£660	£726	£66 10.0%	Increased savings than plan
Sitagliptin Switch Budget	£600	£484	£(116) -19.3%	Slightly lower than plan
Dressings Budget	£500	£300	£(200) -40.0%	Slightly lower than plan
Other Efficiencies Budget	£2,655	£3,067	£412 15.5%	Increased Savings than plan
Sub-Total	£12,415	£12,776	£488	
Dapagliflozin savings Budget	£1,585	£1,224	£(361.00) -22.8%	Stretch Target
<b>Grand Total</b>	<b>£14,000</b>	<b>£14,000</b>	<b>£0</b>	Net delivery on 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	381,226	299,692	78.6%	Forecast based on Q2 submissions plus estimates for missing /rejected claims
Diabetes	655,787	568,236	86.6%	Forecast based on Q2 submissions plus estimates for missing /rejected claims
Eating Disorders	183,469	129,040	70.3%	Forecast based on Q2 submissions plus estimates for missing /rejected claims
Inclusion Health	428,280	261,325	61.0%	Forecast based on Q2 submissions plus estimates for missing /rejected claims
Mental Health SMI Health Checks	313,490	241,844	77.1%	Forecast based on Q2 submissions plus estimates for missing /rejected claims
Phlebotomy	6,597,102	6,381,940	96.7%	Forecast based on Q2 submissions plus estimates for missing /rejected claims
Proactive Healthcare	4,180,234	4,151,942	99.3%	Forecast based on Q2 submissions plus estimates for missing /rejected claims
PSA	476,468	496,103	104.1%	Forecast based on Q2 submissions plus estimates for missing /rejected claims
Shared Care	1,486,348	1,423,558	95.8%	Forecast based on Q2 submissions plus estimates for missing /rejected claims
Spirometry	453,256	397,509	87.7%	Forecast based on Q2 submissions plus estimates for missing /rejected claims
Treatment Room	4,005,914	3,821,106	95.4%	Forecast based on Q2 submissions plus estimates for missing /rejected claims
Warfarin	587,411	512,280	87.2%	Forecast based on Q2 submissions plus estimates for missing /rejected claims
MGUS	180,000	198,537	110.3%	Forecast based on Q2 submissions plus estimates for missing /rejected claims
Henoch-Schönlein purpura (HSP)	20,000	11,042	55%	Forecast based on Q2 submissions plus estimates for missing /rejected claims
<b>Total</b>	<b>19,948,986</b>	<b>18,894,154</b>	<b>95%</b>	

- Eating disorders, Inclusion Health & SMI are the largest variances to budget based on Q2 submissions plus estimates for missing or rejected claims.
- Eating disorders has lower patient activity compared to budget assumptions, SMI health check's we believe is a budget phasing issue and the percentage will increase over subsequent quarters. Finally, inclusion health has a slightly lower sign-up rate compared to previous years (85% compared to 90%). The same applies to Eating disorders.
- The finance team work closely with practices to ensure that any missing claims are investigated, and late claims go through a fair process of assessment for payment.

# Appendix A – Detailed Financial Position

Norfolk and Waveney ICB		N&W ICB Annual Budget	N&W ICB Position at Month 8 £000s			N&W ICB Forecast £000s	
Service Line Description			Budget	Actual	Variance	Forecast	FOT Variance
Prescribing	Central Drugs	6,171,637	4,028,657	4,113,743	85,086	6,256,722	85,085
	GP Prescribing	208,224,822	138,298,045	138,287,942	(10,103)	206,408,542	(1,816,280)
	Medicines Management - Clinical	3,024,571	1,951,302	1,947,063	(4,239)	3,002,186	(22,385)
	Other Prescribing	7,170,253	4,443,616	5,529,770	1,086,154	8,460,204	1,289,951
	Oxygen	2,788,684	1,798,250	1,738,960	(59,290)	2,639,394	(149,290)
	Prescribing Incentives	1,318,877	0	0	0	1,318,877	0
<b>Prescribing Total</b>		<b>228,698,844</b>	<b>150,519,870</b>	<b>151,617,478</b>	<b>1,097,608</b>	<b>228,085,925</b>	<b>(612,919)</b>
Primary Care	Community Dental	3,607,334	2,404,888	2,344,316	(60,572)	3,467,408	(139,926)
	DOP Delegated pay	253,294	152,215	137,604	(14,611)	231,043	(22,251)
	GP Forward View	1,074,263	257,323	285,483	28,160	1,014,594	(59,670)
	Local Enhanced Services	20,349,304	13,482,277	13,018,128	(464,149)	19,885,155	(464,149)
	Optom	11,903,391	7,870,703	7,690,452	(180,251)	11,671,727	(231,664)
	Other Primary Care	4,556,734	2,754,073	2,529,435	(224,638)	4,337,791	(218,943)
	Pharmacy	32,464,252	20,303,705	19,269,751	(1,033,954)	30,638,523	(1,825,729)
	PMS to GMS Transition	0	0	0	0	0	0
	Primary Care Delegated Co-Commissioning	253,304,576	166,566,167	164,850,615	(1,715,552)	250,518,703	(2,785,874)
	Primary Care IT	7,450,682	5,654,685	5,645,608	(9,077)	8,513,010	1,062,329
	Primary Dental	53,206,282	35,460,109	36,057,748	597,639	53,108,620	(97,662)
	Secondary Dental	15,360,016	10,240,011	10,240,011	0	15,360,016	0
	Sustainable Commissioning QIPP	(2,964,849)	(1,844,630)	0	1,844,630	0	2,964,849
Unidentified efficiencies	0	0	0	0	0	0	
<b>Primary Care Total</b>		<b>400,565,278</b>	<b>263,301,525</b>	<b>262,069,151</b>	<b>(1,232,373)</b>	<b>398,746,590</b>	<b>(1,818,688)</b>
<b>Prescribing &amp; Primary Care Total</b>		<b>629,264,122</b>	<b>413,821,395</b>	<b>413,686,630</b>	<b>(134,765)</b>	<b>626,832,515</b>	<b>(1,401,605)</b>