

# Primary Care Commissioning Committee Part 1

Wed 11 March 2026, 14:00 - 17:00

## Agenda

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

0 min

*Hein van den Wildenberg*

 2026 03 11 Item 00 ICB Primary Care Committee Agenda Pt 1.pdf (1 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

 2026 03 11 Item 03 Declarations of Interest.pdf (4 pages)

**14:00 - 14:00** **4. Review of Minutes and Action Log from the January 2026 meeting**

0 min

*Decision* *Hein van den Wildenberg*

 2026 01 14 Item 04 NWICB PCCC Minutes Part One.pdf (11 pages)

 2026 03 11 Item 04 PCCC Action Log Part One.pdf (1 pages)

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

0 min

*Information* *Sadie Parker*

 2026 03 11 Item 05 NWICB PCCC Forward Planner 2025 2026 Part One.pdf (1 pages)

**14:00 - 14:00** **6. Risk Register**

0 min

*Decision* *Sadie Parker/Sharon Gardner*

 2026 03 11 Item 06 Risk Register - front sheet.pdf (5 pages)

 2026 03 11 Item 06 Risk Register for Community Pharmacy Update.pdf (6 pages)

 2026 03 11 Item 06 Risk Register for Community Pharmacy Appendix A.pdf (3 pages)

 PCCC Risk Register 03.03.26 with dental pdf.pdf (8 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 03 11 Item 07 Director of Primary Care Report.pdf (6 pages)

**14:00 - 14:00** **8. Strategic Digital Report**

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0 min

Information *Anne Heath*

📄 2026 03 11 Item 08 Strategic Digital Report.pdf (3 pages)

**14:00 - 14:00 9. GP Action Plan - Practice Visit Report**

0 min

Information *Shepherd Ncube*

📄 2026 03 11 Item 09 GP Action Plan - Practice Visit Report.pdf (9 pages)

**14:00 - 14:00 Finance & Governance**

0 min

**14:00 - 14:00 10. Delivery Group Reports • General Practice & Community Pharmacy Delivery Group• Dental Services Delivery Group Report• Dental Development Group**

0 min

Information *Sharon Gardner / Fiona Theadom*

📄 2026 03 11 Item 10 DSDG Report.pdf (8 pages)

📄 2026 03 11 Item 10 Dental Development Group Report.pdf (3 pages)

📄 2026 03 11 Item 10 GPCP Delivery Group Report.pdf (6 pages)

**14:00 - 14:00 11. Reports from the Pharmaceutical Services Regulations Committee • Reports from the Pharmaceutical Services Regulations Committee • Optometry Services – contractual changes and other matters**

0 min

Information *Sharon Gardner*

📄 2026 03 11 Item 11 PSRC Front Sheet.pdf (2 pages)

📄 2026 03 11 Item 11 PSRC Quarterly Report.pdf (4 pages)

📄 2026 03 11 Item 11 GOS report.pdf (2 pages)

**14:00 - 14:00 12. Strategic Finance Report - M10**

0 min

Information *James Grainger*

📄 2026 03 11 Item 12 M10 Primary Care Commissioning Committee Finance Report.pdf (8 pages)

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

0 min

**14:00 - 14:00 13. Any Other Business• Questions from the public**

0 min

Cummins, Mary  
11/03/2026 13:32:39

Meeting of the Norfolk and Waveney ICB Primary Care Commissioning Committee  
Wednesday 11 March 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 January 2026 meeting</b> <i>For Approval</i>	Chair
5.		<b>Forward Planner</b> <i>For Noting</i>	SP
6.	14:10	<b>Risk Register</b> • <b>Community Pharmacy Risk update</b> <i>For Approval</i>	SP SG
<b>Service Development</b>			
7.	14:20	<b>Director of Primary Care Report</b> <i>For Noting</i>	SP
8.	14:25	<b>Strategic Digital Report</b> <i>For Noting</i>	AH
9.	14:30	<b>GP Action Plan – Practice Visit Report</b> <i>For Noting</i>	SN
<b>Finance &amp; Governance</b>			
10.	14:35	<b>Delivery Group Reports</b> • <b>General Practice &amp; Community Pharmacy Delivery Group</b> • <b>Dental Services Delivery Group Report</b> • <b>Dental Development Group</b> <i>For Noting</i>	SG/FT
11.	14:45	<b>Reports from the Pharmaceutical Services Regulations Committee</b> • <b>Reports from the Pharmaceutical Services Regulations Committee</b> • <b>Optometry Services – contractual changes and other matters</b> <i>For Noting</i>	SG
12.	14:50	<b>Strategic Finance Report ~ M10</b> <i>For Noting</i>	JG
<b>Any Other Business</b>			
13.	15:00	<b>Any Other Business</b> • <b>Questions from the public</b>	Chair
<b>Date, time and venue of next meeting</b> <b>TO BE CONFIRMED</b> <b>To be held by videoconference and You Tube</b>			
<b>Any queries or items for the next agenda please contact:</b> <a href="mailto:sarah.webb7@nhs.net">sarah.webb7@nhs.net</a> ; <a href="mailto:mary.cummins3@nhs.net">mary.cummins3@nhs.net</a>			
<b>Questions are welcomed from members of the public.</b> <b>Please send by email: <a href="mailto:nwicb.contactus@nhs.net">nwicb.contactus@nhs.net</a></b> <b>For a link to the meeting in real-time, please click <a href="#">here</a></b>			

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**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
Shepherd Ncube	Associate Director of Primary Care Commissioning	Nothing to Declare				N/A	N/A	N/A	N/A	N/A

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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) no work has been undertaken	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
		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

**Local Medical Committee Attendees**

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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>										
<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	N/A
<b>Other Primary Care Members</b>										
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

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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

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

**Minutes of the Meeting held on  
Wednesday 14 January 2026 at 14:00  
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 January 2026 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 ICB, 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 ICB, and Suffolk & North East Essex ICB)

In attendance

Name	Initials	Position and Organisation
Andrew Bell	AB	Vice Chairman Norfolk Local Dental Committee (LDC)
Mark Burgis	MB	Executive Director of Patients & Communities, Norfolk and Waveney ICB
Mary Cummins	MC	Primary Care Commissioning Support Officer, Norfolk and Waveney ICB
Michael Dennis	MD	Associate Director of Medicines Optimisation, Norfolk, and Waveney ICB
Lisa Drewry	LD	Executive Officer, Norfolk and Waveney Local Medical Committee
Sharon Gardner	SG	Head of Primary Care Commissioning Community Pharmacy and Optometry, Norfolk and Waveney ICB
Joni Graham	JGr	Executive Officer (Estates, Digital, Pharmacy & Prescribing) Norfolk & Waveney Local Medical Committee
Andrew Hayward	AHa	Trustee of Healthwatch Norfolk
Kirsty Hockley	KH	Commissioning Support Officer, Pharmacy and Optometry, Norfolk and Waveney ICB minute taker
Shepherd Ncube	SN	Associate Director, Primary Care Commissioning, Norfolk, and Waveney ICB
Helen Palmer	HP	Head of Pharmacy Workforce & Business Development, Medicines Optimisation, Norfolk and Waveney ICB
Sadie Parker	SP	Director of Primary Care, Norfolk and Waveney ICB
Jayde Robinson	JR	Head of Primary Care Workforce Transformation, Norfolk and Waveney ICB
Lauren Seamons	LS	Joint Chief Officer at Community Pharmacy Norfolk & Suffolk
Amanda Sear	AS	Head of Primary Care Strategic Planning, Norfolk & Waveney ICB
Nick Stolls	NS	Specialty Dental Advisor, 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
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 Norfolk & Waveney ICB and Suffolk and North East Essex ICB
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
Sally Watson	SWa	Healthwatch Suffolk – Community & Engagement Manager

No	Item	Action owner
1.	<b>Chair's introduction</b> The Chair welcomed attendees to the January 2026 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 November 2025 Committee</b> <i>For Approval</i> The minutes were agreed to be an accurate record of the November 2025 Committee meeting and minutes would be sent to the Chair for signing.  Action: SW to send signed minutes to the Chair for safekeeping.  Action Log 0204 0206 0213 0214 All closed	SW
5.	<b>Forward Planner</b> <i>For Noting</i> SP presented the forward planner for noting  SP highlighted the red 'N' indicator shown against the Pharmaceutical Services Regulation Committee related purely to timing of meetings, rather than any omission.  The Committee acknowledged no further discussion was needed and the Forward Planner was noted.	SP
6.	<b>Risk Register</b> <i>For Approval</i>	SP

	<p>SP presented the updated Risk Register for approval and confirmed the paper set out the key changes since the previous meeting.</p> <p>SP explained a deep dive review had recently been completed for the two workforce-related risks, with further detailed discussion scheduled later in the agenda. SP also noted the dental risk had been reframed following a structured programme of deep dives and indicated that FT would shortly provide a more detailed overview of the revised scoring and approach. SP further confirmed that deep-dive work had also taken place on the community pharmacy resilience risk, with the pharmacy team progressing actions ahead of a full update to be brought to the next Committee meeting in March.</p> <p>The SMI risk, scheduled for a review on 19th January 2026, was briefly highlighted by SN, who apologised for earlier scheduling confusion and confirmed performance in this area was broadly positive. SP added deep-dive planning was also underway for the general practice risk, with findings expected to return to Committee in March.</p> <p>The Committee approved the report.</p>	
7.	<p><b>Director of Primary Care Report</b> <i>For Noting</i></p>	SP
	<p>SP presented the Director of Primary Care report for noting</p> <p>SP emphasised the report demonstrated the dual nature of the team's current workload, balancing intensive operational delivery with an increasing shift toward strategic commissioning, aligned to the emerging ICB blueprint. SP described how a substantial proportion of team capacity had recently been directed toward planning requirements, including financial planning for the next year and beyond, mirroring pressures experienced across the wider ICB.</p> <p>SP highlighted the significant volume of ongoing procurements across primary care, all of which were consuming considerable staff time. SP also referenced forthcoming contract reform across general practice, dentistry, community pharmacy, and, in time, optometry, noting this as a major strategic focus shaping future work.</p> <p>SP explained that parallel efforts were underway to lay the foundations for future primary care resilience, including development of neighbourhood care models and support for primary care collaboratives across Norfolk and Waveney. SP further acknowledged the impact of the ongoing organisational change programme, expressing concern about capacity pressures, the potential loss of organisational memory, and the unsettling effect on staff as new structures were implemented. SP closed by formally recognising and appreciating the sustained efforts of the team during a period of system-wide change.</p> <p>MB reinforced SP's points, praising the team's resilience and highlighting that, despite a period of unprecedented organisational turbulence, the report demonstrated clear and measurable improvements for patients across primary care achievements he attributed to the hard work of staff across the system.</p> <p>Wi then raised a query regarding references in the report to primary care contractor development and the securing of expert support, sought clarification on the scope and intent of this activity.</p>	

	<p>AS responded, explaining that this work related to neighbourhood health development, an area still awaiting full national guidance, and clarified that funding had been secured through formal governance processes to obtain external expert facilitation to support system readiness.</p> <p>HW sought further clarity on the timing of national guidance, and MB confirmed that although more detail was expected, the system should continue planning based on core neighbourhood principles, which were unlikely to change significantly.</p> <p>With no further comments raised the paper was duly noted.</p>	
8.	<p><b>Primary Care Operational Plan Update</b> <i>For Noting</i></p>	AS
	<p>AS presented the Primary Care Operational Plan Update for noting, and AS confirmed that the first submission had already been made and NHSE had provided initial feedback late the previous week in the form of Key Lines of Enquiry (KLOEs).</p> <p>AS explained that, over the coming fortnight, work would be focused on responding to these KLOEs, which centred particularly on general practice appointment volumes, Pharmacy First consultation numbers, and urgent dental appointment capacity. AS noted, several of the technical queries from NHSE required detailed analytical input, with colleagues such as FT and SG supporting the process, and stressed that a degree of negotiation was expected especially where national ambitions needed to be balanced against local population growth, realistic productivity expectations, and fair-share allocations.</p> <p>AS highlighted the next submission was due on 12th February 2026, with an ICB Board meeting planned to undertake the required governance approval. AS explained that, because this was now a joint Norfolk–Suffolk plan, the total activity figures could no longer be separated, as performance from 1 April 2026 onward would be assessed as a single integrated system. AS emphasised the need to ensure the final operational plan aligned with the emerging ICB Strategy, the Population Health Improvement Plan, and the commissioning intentions, which together would shape the 2026–27 work programme for primary care.</p> <p>LD then raised concerns about ensuring the LMC was appropriately included in the constructive dialogue referenced in the report and stressed the importance of maintaining local flexibility across Norfolk, Waveney, and Suffolk, particularly given differing population needs and ongoing capacity pressures in general practice. LD also highlighted risks relating to staff burnout and the widening gap between demand and available workforce, urging the ICB to remain realistic about practice capacity.</p> <p>AS responded that these concerns would continue to be discussed in regular meetings and clarified that the high-level numbers represented overarching system totals rather than any forced alignment between the two geographies. HW acknowledged the points raised, emphasising the importance not only of the numerical targets submitted but also of the how the operational delivery mechanisms underpinning them.</p> <p>The paper was duly noted.</p>	

9.	<p><b>GP Action Plan Report</b> <i>For Approval</i></p>	SN
	<p>SN presented the GP Action Plan Report for approval, opening with contextual remarks to remind the Committee of the journey since the plan was originally signed off the previous year. SN explained the action plan had been deliberately ambitious, containing 15 priority areas, and acknowledged the substantial work undertaken by the team. SN described how the plan had been structured around three strategic priorities, contract oversight, commissioning and transformation, and tackling health inequalities and confirmed that the report sought the Committee's approval to close several actions that had now reached completion.</p> <p>SN began with the Primary Care Access Recovery Plan (PCARP) noting expected national guidance had not materialised and that most of the original objectives were now embedded within other strands of ongoing work; therefore, SN recommended this action be closed. Before SN moved on, KW requested clarification on what evidence demonstrated improvements in patient experience, prompting SN to outline the various data sources including PPG insights, GP Patient Survey trends, and increased activity volumes, showing improving trajectories, while acknowledging the need for continued focus.</p> <p>SN then recommended closure of the action relating to Enhanced Access, explaining a sustainable system for collecting activity and utilisation data had been successfully implemented through agreement with LMC colleagues and that only minimal support was still required for a small number of PCNs. SN proceeded to the commissioning and transformation self-assessment, facilitated by NHSE, noting two structured sessions had been completed with strong MDT participation and that action plans had already been shared and aligned with Suffolk colleagues; SN therefore recommended this action also be closed. SN additionally confirmed the Strategic Primary Care Framework, led by AS, had been completed to a point suitable for sign-off, recognising that it would remain a live document guiding long-term transformation work.</p> <p>LD raised two concerns: first, whether the target to expand the General Practice Improvement Programme from 31 to 49 practices by the end of March 2026 was realistic given current workload pressures; and second, the practice visit programme should more proactively support all practices by sharing trends and examples of high-performing models. SN responded that updated internal figures suggested the target was still achievable and emphasised practice visits were intended to build supportive relationships rather than to be solely data-driven; he welcomed further discussion with LD outside the meeting.</p> <p>MB endorsed this position, stressing practice visits should be collaborative and beneficial for practices above all else.</p> <p>SN then highlighted key areas where work should remain open, particularly Advice &amp; Guidance (A&amp;G), where new national flexibilities meant further work was needed to increase activity. SN also noted ongoing intensive monitoring of unwarranted variation, with improvements evident but continued focus required. After taking final questions, SN sought formal approval for closure of the completed actions.</p>	

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	HW confirmed Committee approval, noting no objections, and emphasised the importance of maintaining momentum across ongoing workstreams.	
10.	<p><b>Workforce</b></p> <ul style="list-style-type: none"> <li>• <b>Strategic Primary Care &amp; Workforce Recruitment and Retention Programme Report</b></li> <li>• <b>Strategic Pharmacy Workforce Report</b></li> </ul> <p><i>For Approval/For Noting</i></p>	JR/HP
	<p>JR presented the Strategic Primary Care &amp; Workforce Recruitment and Retention Programme Report for noting and approval, confirming the paper had been taken as read and highlighting the considerable progress achieved across general practice, dentistry, and optometry. JR reported 40% of all workforce programmes had fully met their KPIs, with a further 40% on track, supported by £3.3 million of investment across training capacity, workforce expansion, and development initiatives.</p> <p>JR announced Norfolk and Waveney had moved from third to second nationally for GP workforce growth, with ambitions to continue improving. JR also noted the first recorded increase in dental workforce numbers since 2019, describing this as a significant achievement. JR highlighted strong engagement in optometry, with 50% of schemes taken up, and confirmed 96% of general practices were now accredited as approved learning organisations, substantially increasing educational capacity and medical placements across the region. JR drew attention to progress in non-clinical workforce development, including volunteer integration and digital engagement.</p> <p>JR acknowledged ongoing challenges, particularly the impact of the organisational change programme, constraints on releasing staff for CPD, and the uncertainty surrounding physician associate workforce arrangements.</p> <p>JR then sought approval to close Workforce Risks 53 and 54, confirming both risks had now fallen within appetite and no longer required active monitoring.</p> <p>HP followed with the Strategic Pharmacy Workforce Report, confirming steady progress across the four pharmacy workforce pillars: attract, train, retain, and reform. HP reported the system now offered up to 39 foundation trainee pharmacist placements, nearly doubling capacity compared to previous years. HP highlighted the expansion of the Teach and Treat training programme for independent prescribing, with an additional nine student places secured across Norfolk, Waveney, and Suffolk.</p> <p>HP emphasised strengthened partnerships with UEA, including increased attendance at careers events to promote pharmacy roles. HP also noted ongoing challenges, including limited access to national training pathways due to short application windows, insufficient placement capacity, fragmented workforce data limiting system-wide planning, and lingering resistance to releasing staff for learning activity. Looking ahead, HP warned of potential reductions in pharmacy workforce capacity under the proposed new ICB structure, and highlighted the need to ensure that newly trained independent prescribers had appropriate pathways to use their skills locally, otherwise risking attrition to other sectors. HP asked the committee to note progress and endorse the proposed next steps for 2026–27.</p>	

	<p>LD raised strong concerns about ongoing difficulties in recruiting and retaining both clinical and non-clinical staff in general practice, citing rurality, poor transport links, public abuse toward reception teams, and financial pressures as recurring issues seen through GPAS reporting. LD urged continued monitoring to ensure workforce growth could be sustained.</p> <p>KW added her thanks to JR and HP, stressing the magnitude of their achievements and the importance of recognising progress in attracting dentists, supporting research activity, and making the region more appealing to clinicians.</p> <p>LS echoed this praise specifically for pharmacy but expressed deep concern about the impending loss of dedicated pharmacy workforce infrastructure in the new ICB, warning that the Norfolk and Waveney pharmacy workforce was at risk of being left without system-level support.</p> <p>MB assured members that these concerns had been heard and the consultation feedback would be reviewed as the structure was finalised.</p> <p>AS added national training hub design was currently under review and future commissioning was likely to address parity of esteem across all primary care contractor groups.</p> <p>MD reinforced that pharmacy workforce functions must not be left without a home, noting that system transformation could not be delivered without strong pharmacy workforce planning.</p> <p>HW confirmed the Committee’s approval of the recommendations, including closure of Workforce Risks 53 and 54.</p>	
11.	<p><b>Delivery Group Reports</b></p> <ul style="list-style-type: none"> <li>• <b>General Practice &amp; Community Pharmacy Delivery Group</b></li> <li>• <b>Dental Services Delivery Group Report</b></li> <li>• <b>Dental Development Group</b></li> </ul> <p><i>For Noting</i></p>	SN/FT
	<p>SN introduced the General Practice &amp; Community Pharmacy Delivery Group report, confirming the December 2025 meeting had covered a broad range of operational and strategic items. SN highlighted sustained focus on the risk register, noting that considerable time had been spent reviewing the approach to risk management, and particularly the workforce risks, which had now been escalated to the Committee for formal approval.</p> <p>SN reported positive progress against the Integrated Performance Report, emphasising that activity across general practice and community pharmacy continued to trend in the right direction. SN provided detailed updates on prescribing, where early signs showed improvement in antimicrobial stewardship, though further work was required in certain areas. SN noted constructive discussions around contract compliance for new service specifications, confirming that performance was generally strong, and he referenced a Chairs Action relating to estates, which had been formally noted.</p> <p>Financial updates showed the Directorate was under budget, which SN explained reduced financial pressure in-year but provided an opportunity to consider future resilience and action on health inequalities.</p>	

	<p>Turning to the Dental Services Delivery Group, FT summarised the report, highlighting the significant steps taken to strengthen oversight of dental commissioning. She noted that the group had adopted a more robust approach to underperformance, with active work underway to rebase contracts and reinvest freed-up resources into areas of need or new service capacity. FT confirmed that provider discussions were progressing positively and that revised contract arrangements were beginning to flow through. She also drew attention to the monitoring of Unscheduled Dental Care (UDC), reporting utilisation rates of 96–97%, though she flagged a slight but emerging increase in unused appointments, particularly in Norwich and King's Lynn, prompting further investigation into underlying causes.</p> <p>FT then presented the Dental Development Group update, explaining that this was a broad stakeholder forum designed to shape future commissioning intentions. The progress was reviewed on several developing dental pathways and considered how these aligned with long-term population needs. FT noted that, as Norfolk and Suffolk moved toward a single integrated ICB, the group would need to consider how to evolve its role within the new governance structure and how to support a joint forward plan for dental services.</p> <p>The item was duly noted.</p>	
12.	<p><b>Pharmacy Integration Project Final Outcome Report</b> <i>For Noting</i></p>	SG
	<p>SG presented the Pharmacy Integration Project Final Outcome Report for noting, summarising the conclusions of the joint Norfolk &amp; Waveney and Suffolk initiative designed to strengthen the integration of community pharmacy within local NHS systems. SG explained, following a competitive procurement process, Community Pharmacy Norfolk &amp; Suffolk (CPNS) had been selected as the delivery partner, and the project had focused on evaluating and improving referral pathways into Pharmacy First services and the Discharge Medicines Service (DMS).</p> <p>SG reported strong engagement with Pharmacy First across both ICBs, with significant growth in activity particularly within the contraception service, where Norfolk &amp; Waveney achieved the highest regional growth. SG highlighted that public awareness campaigns, including targeted social media promotion and the rollout of a new ICB Friends and Family Test, had led to an increase in self-referrals and generated 100% positive satisfaction feedback, which had been shared with contractors.</p> <p>Regarding DMS, SG noted progress had been more variable due to differences in acute trust readiness, workforce capacity constraints, and inconsistent digital processes. While the service was dependent on hospital referrals, the project had also focused on ensuring community pharmacies actioned referrals in a timely manner. SG confirmed DMS remained a key priority within the Medium-Term Planning Framework, and ongoing emphasis would be placed on improving uptake and standardising practice.</p> <p>SG outlined the significant training and engagement delivered during the project, including webinars, face-to-face events, and digital resources, which together had supported more than 300 pharmacy professionals. SG also noted emerging national developments recognising the role of pharmacy technicians within expanded clinical pathways, and she referenced an upcoming technician training event as part of this shift.</p>	

	<p>SG concluded the project had created a strong foundation for future strategic commissioning, generating clear learning on models that worked well and barriers requiring system-level resolution particularly around digital interoperability, consistent referral pathways, and cross-sector collaboration. Following SG's update, LS provided reflections from the provider perspective, emphasising the value of having dedicated capacity, funding, and analytical tools to explore workforce utilisation, data gaps, and system inconsistencies that community pharmacy normally lacked resources to analyse.</p> <p>LS highlighted the project surfaced critical insights into the need to strengthen secondary care-to-pharmacy referral flows, improve IT system connectivity, and better utilise the whole pharmacy team, especially in deprived areas where community pharmacies could substantially improve access and outcomes. LS urged the Committee to note the recommendations within the full report particularly those relating to interoperability and the need for clear system support to maintain the momentum gained.</p> <p>The item was duly noted. HW asked SP to include a section in the Chair of PCCC report to ICB Board on this Project Report.</p>	
13.	<p><b>Strategic Framework for Primary Care</b> <i>For Noting</i></p>	AS
	<p>AS presented the Strategic Framework for Primary Care for noting, beginning by acknowledging that the Committee had received feedback from the LMC earlier that day and emphasising, given the timing and the depth of the points raised, these would be fully considered outside the meeting to ensure they received the necessary attention.</p> <p>AS clarified references within the paper to primary care becoming a more unified and credible partner were not criticisms of any existing providers nor implications of under-performance; rather, this language reflected a system-wide recognition that greater collective, integrated primary care leadership would significantly strengthen system-level planning and strategic decision-making. AS explained operational delivery across general practice, dentistry, community pharmacy, and optometry was already strong, but there remained a gap at the strategic leadership level, where more coordinated primary care input would add considerable value.</p> <p>AS noted progress within the four thematic areas of the framework covering neighbourhood development, workforce, contracting, and strategic commissioning had not been linear due to the complexity and interdependencies across programmes. For this reason, instead of creating new standalone workstreams, the approach had been to embed the framework's ambitions within existing programmes to ensure sustainability and alignment with broader ICB transformation work.</p> <p>IWi welcomed AS's earlier clarification and highlighted the challenge that general practice comprised 103 independent small businesses without the corporate infrastructure of larger organisations. IWi stressed while general practice was committed to playing a full role within the wider system, meaningful engagement depended on adequate time, capacity, and realistic expectations. IWi noted the developing GP Collaborative, ongoing relationship-building work, and joint meetings with system partners such as NNUH, alongside the structural differences and constraints facing practices.</p>	

	<p>HW noted this framework was likely to reappear regularly at Committee due to the significant ongoing change across the system.</p> <p>The item was duly noted.</p>	
14.	<p><b>Strategic Prescribing Report</b> <i>For Noting</i></p>	MD
	<p>MD presented the Strategic Prescribing Report for noting, confirming the paper was extensive and began by outlining progress on antimicrobial resistance (AMR) indicators, explaining the three new national metrics were now embedded into performance reporting.</p> <p>MD reported the proportion of children aged 0–9 who had received at least one antibiotic in the previous 12 months had decreased from 40.3% a year earlier to 29.8%, bringing the system close to the national target of 27%. MD noted active work with partners particularly the walk-in centre to understand case mix differences and ensure appropriate prescribing. MD also confirmed strong progress on the Access, Watch and Reserve, with Norfolk &amp; Waveney achieving 81.7%, the highest performance in the East of England, well above the national threshold of 70%.</p> <p>MD reported further work was still required on the duration of antibiotic courses, highlighting that some clinicians especially in dispensing practices continued to prescribe seven-day courses despite national guidance now mandating five-day durations for most common infections. MD emphasised targeted engagement work was underway with these practices. MD also drew attention to an award recently received by the prescribing team at the Norfolk Fire and Rescue Awards, recognising extensive system-wide work to mitigate fire-related harm associated with paraffin-based emollients, which had been linked to several tragic fatalities in previous years.</p> <p>MD then highlighted a significant emerging concern regarding recent changes to the NHS App, drawing the Committee’s attention to risks associated with the newly introduced “Order All” button allowed patients to request every repeat medication at once. MD warned that this design feature risked generating conflict, unnecessary workload, and waste, because patients often assumed they had successfully reordered all medicines when, in fact, any items with no remaining repeats were removed silently from the request without explanation. As a result, patients were arriving at pharmacies and GP practices angry or confused when expected medicines were missing.</p> <p>MD explained the issue stemmed from the interaction between NHS App functionality and GP clinical systems, and stated that the matter had been escalated nationally, encouraging Committee members to reinforce this escalation through their own networks.</p> <p>The item was duly noted.</p>	
15.	<p><b>Strategic Finance Report</b> <i>For Noting</i></p>	JG
	<p>JG presented the Strategic Finance Report for noting, confirming the paper had been taken as read and highlighting the key financial movements since the previous month.</p> <p>JG reported the Primary Care and Prescribing Directorate was showing an underspend of £2.4 million against a total budget of £629.3 million, representing an improvement of approximately £400,000 from the month-</p>	

	<p>seven to month-eight position. JG explained the drivers of the underspend remained broadly consistent with the previous reporting period, with favourable variances across GP prescribing, Local Commissioned Services (LCS), primary care dental, optometry, and community pharmacy, all of which continued to deliver planned efficiencies that offset expenditure pressures elsewhere.</p> <p>JG also noted ongoing stranded costs within GPIT, which had been flagged in earlier reports. Importantly, JG advised that the position did not yet include any in-year dental performance adjustments, which were scheduled to be reflected in the month-nine figures and could further influence the overall financial outlook.</p> <p>JG directed members to the supporting sections in the pack, including the detailed financial analysis, efficiency delivery reporting, and LCS utilisation data, all of which supported the headline position.</p> <p>The item was duly noted.</p>	
16.	<b>Any Other Business</b>	Chair
	No other business was raised.	
	<b>Questions from the Public</b>	Chair
	There were no questions from the public, and the meeting closed at 15:35 hours.	

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

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

**Norfolk & Waveney IBC Primary Care Commissioning Committee - Part One Action Log**  
 11 March 2026

No	Meeting date added	Agenda Item	Owner	Action Required	Action Undertaken / Progress	Due date	Status	Date Closed
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.	GC provided an update on LCS in Part 2, JG made reference to this in his March update. Propose to close.	11-Mar-26		
0216	14 January 2026	4	SW	Minutes Send signed minutes to the Chair for safekeeping.	SW sent signed minutes to Chair.	11-Mar-26	Closed	14-Jan-26

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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 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 (P2)
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 - moved to P2
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

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**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>	11 March 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 January 2026.

**Executive Summary:**

**New risks identified and escalated:**

None identified

**Changes to held risks:**

None identified

**Risks de-escalated:**

No concerns have been raised to report since the changes in work force and dental risk was approved.

**Key highlights since the last meeting:**

- Deep Dive meetings for all the identified risks have been completed. A follow deep dive was done for both general practice and community pharmacy were completed since the last meeting. Follow up meetings have focussed on challenging the teams to further work on the risks to completely focus on meeting the needs of the population.
- Community pharmacy risk was presented, and a detailed discussion took place at the ICB Delivery Group in February. Less details is being provided in this paper as a separate update report is available to the committee meeting today.
- Approval of the General Practice and Community Pharmacy risks was scheduled for this meeting. However, following an internal review, it has been agreed that further work will be undertaken to strengthen the recommendations prior to submission to the

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Committee. This will ensure that proposals are robust and provide appropriate assurance when presented for approval.

**Recommendation to Committee:**

Committee members are invited to:  
The Committee is therefore asked to note the current position and ongoing work, with further updates and recommendations to be presented at a future meeting.

**Governance**

<b>Delivery Group Approval</b>	
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1. Board Assurance Framework (BAF) risks			2025-26 Monthly Risk Rating (April-March)											
Ref.	Risk Title	Tolerated	1	2	3	4	5	6	7	8	9	10	11	12
32	BAF02 - Primary Care Resilience and Transformation	12	20	20	20	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	N/A	N/A	N/A
	25	BORR09 Resilience of NHS General Dental Services in Norfolk and Waveney	DSDG	16	16	16	16	16	16	16	16	16	N/A	N/A	N/A
	71	Special Care Dental Services	DSDG	9	9	9	9	9	9	9	9	9	N/A	N/A	N/A
	TBC	Access to NHS Dental Services	DSDG										16	16	
	23	BORR11 The resilience of general practice	12	16	16	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	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	N/A	N/A	N/A
	54	ORR18 General Practice – Workforce (GPs and Nurses)	8	12	12	12	12	12	12	12	12	8	N/A	N/A	N/A
	55	ORR19 Severe Mental Illness (SMI) Annual Physical Health Checks	8	12	9	9	9	9	9	9	9	9	9	9	

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tbc	<b>PC06 Learning Disability Annual Physical Health Checks</b>	9	9	9	9	9	9	9	9	9	9	9	9	9
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**Appendix 1 – Risk management structures**

**Board Assurance Framework (BAF)**

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

**Board Operational Risk Register (BORR)**

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

**Operational Risk Register (ORR)**

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

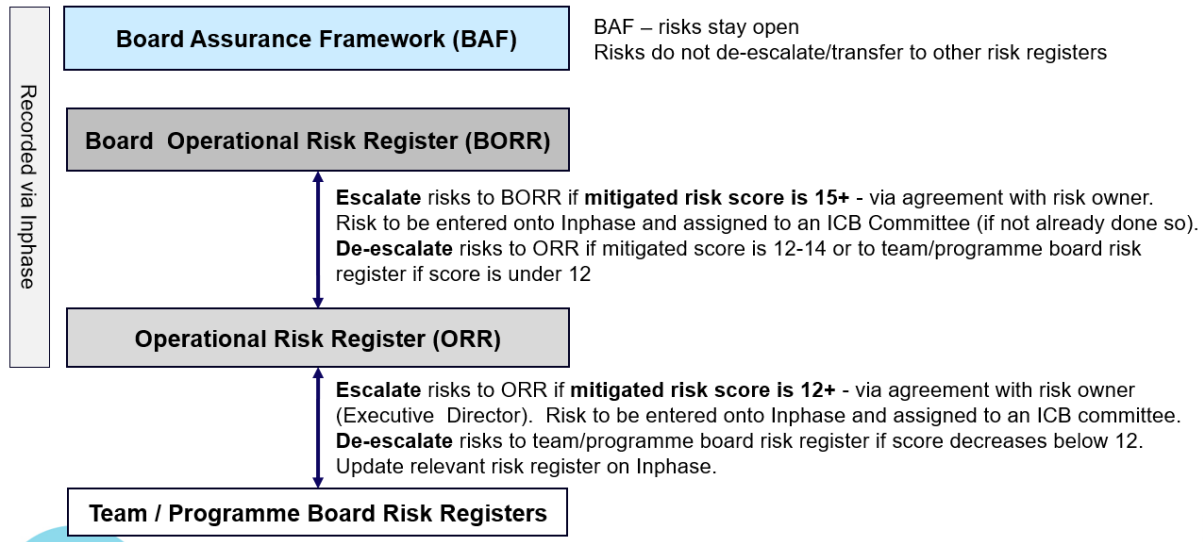
**BAF, BORR and ORR Risks are:**

- Recorded and reported on via inphase
- Owned by an Executive Director
- Aligned to an ICB Committee

**Team / Programme Board risk registers**

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

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Agenda item: 06

<b>Subject:</b>	<b>Risk Register – Community Pharmacy Risk Update</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 (PCCC)</b>
<b>Date:</b>	<b>11 March 2026</b>

**Purpose of paper:**

This paper provides an update on discussions held at the General Practice and Community Pharmacy Operational Delivery Group (GPCPODG) regarding the revised Community Pharmacy risk. It summarises the feedback received from members, outlines the implications for the risk description and scoring, and sets out the proposed next steps

The Community Pharmacy risk has been reframed to provide a clearer focus on population need and the potential impact on patient access should services be disrupted or compromised.

The purpose of this paper is to present the feedback received and, following an initial review, outline the ICB’s intended next steps to ensure the risk remains appropriately framed within the ICB’s responsibilities, areas of control, and governance requirements. The revisions required relate to refinement and clarification rather than further deep-dive review.

**Executive Summary:**

The ICB currently holds a single community pharmacy risk, titled “The Resilience of Community Pharmacy,” overseen by the Primary Care Commissioning Committee, with a current score of 20 and a mitigated score of 16.

As part of the wider review of primary care risks through the lens of a strategic commissioner, a reframed, patient focused version of the Community Pharmacy risk was presented to the General Practice and Community Pharmacy Operational Delivery Group (GPCPODG). The revised draft adopts a population health and patient access lens, emphasising areas where local mitigation is possible while acknowledging wider national pressures outside of the ICB’s direct control, such as medicines supply instability, workforce constraints and contractual funding limitations.

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Meeting attendees, including the Local Pharmaceutical Committee (LPC), Healthwatch and other stakeholders, provided detailed feedback. Key points included the distinction between access to essential medicines and access to clinical services; the importance of recognising medicines supply fragility as a key context driver; ensuring alignment with the Pharmaceutical Needs Assessment (PNA); and reflecting systemwide responsibilities for medicines access. Concerns were also raised about the need for clarity on what is within the ICB's control versus national or contractual factors.

Overall, members supported the value of the reframed, population focused approach. While the feedback does not necessitate a fundamental rewrite or deep dive, several refinements are required—particularly to the contextual narrative, scope and scoring—to ensure the risk remains aligned to the ICB's responsibilities, governance expectations and areas of influence.

The updated risk was initially scheduled for submission to the Primary Care Commissioning Committee for approval in March 2026. Following discussion, additional consideration and refinement of the wording, context and scoring are required. A full further deep dive is not anticipated; instead, targeted adjustments will be made before bringing the finalised risk to a future primary care governance meeting for approval, once the new ICB has been established.

Further information has been shared in Appendix A.

## Report

Community pharmacy plays a vital role in supporting patients to access essential medicines, urgent treatments, and a broad range of clinical services close to home. Across Norfolk and Waveney, the sector is experiencing increasing pressures, including permanent closures, short-notice temporary closures, and variation in service availability. These issues can disproportionately affect rural communities and areas with limited existing provision, contributing to inequitable access and reduced resilience.

National expectations of community pharmacy continue to grow as the sector expands its role in delivering clinical pathways, prevention-focused services and early access to care. However, national medicines supply challenges and ongoing workforce constraints, particularly involving pharmacists and pharmacy technicians, continue to impact continuity of care and patient experience.

The previous risk, centred on provider resilience, remains relevant, but many of its underlying drivers stem from national policy and funding issues beyond the ICB's influence. A population-focused reframing therefore enables the ICB to better articulate where it can meaningfully intervene to strengthen local system support and mitigate patient-level impact, without disregarding wider contextual pressures that affect the sector.

Neighbourhood health development remains central to delivering the NHS Long Term Plan. Ensuring that community pharmacy is fully integrated within emerging neighbourhood teams is key to improving accessibility and reducing inequalities.

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Limited integration risks reducing overall system resilience and widening variation in patient outcomes.

### **Feedback from GPCPDG and ICB Commentary**

During the discussion, members, including the Local Pharmaceutical Committee (LPC), raised several important points relating to the framing, interpretation and scope of the revised risk. These contributions were welcomed as part of constructive engagement.

#### **1. Separation and distinction between access to essential medicines vs access to services**

##### **Feedback:**

The LPC advised that risks relating to essential medicines access and those relating to clinical services should be separated given their different drivers.

##### **ICB Commentary:**

While the distinction is recognised, it is felt that the ICB must maintain a consolidated, population level risk to ensure clear oversight and alignment with the wider primary care risk approach.

It is currently recommended that medicines supply issues will continue to be acknowledged in the context section, which allows the formal risk to remain single and patient focused to reflect ICB accountability.

#### **2. National Pressures and Supply Chain Fragility**

##### **Feedback:**

The LPC and other members emphasised that medicines shortages and national funding pressures remain the most prominent drivers of reduced access.

##### **ICB Commentary:**

The risk will continue to reflect national pressure in the risk context. It is recommended that the scoring, mitigation and accountability should only reflect those factors within the ICB's remit. National drivers will therefore be described as context, not as the primary basis for the risk rating.

The Pharmacy commissioning team will also explore with the medicines optimisation team if a medicines shortages risk is already identified within the system through the governance of the medical directorate

#### **3. Alignment with the Pharmaceutical Needs Assessment (PNA)**

##### **Feedback:**

The LPC emphasised the importance of ensuring the risk does not conflict with PNA conclusions.

##### **ICB Commentary:**

We accept this principle. The revised wording will distinguish more clearly between statutory sufficiency (as defined by the PNA) and local access vulnerabilities, such as single-provider localities, which remain a legitimate population risk even when the PNA identifies no formal gaps.

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#### **4. Shared Responsibility for Medicines Access**

##### **Feedback:**

Members noted that risks relating to access to medicines also apply to GP dispensing practices as well as pharmacies.

##### **ICB Commentary:**

We acknowledge this and will ensure the risk description reflects the broader primary care landscape and responsibility for medicines access. However, it is still recommended the core purpose of the risk remains focused on population impact, rather than provider-specific ownership.

#### **5. Insights from Healthwatch**

##### **Feedback**

Healthwatch highlighted that:

- Public concern is strongly centred on access to medicines, particularly when prescriptions cannot be dispensed.
- Patients are less aware of newer services (e.g., Pharmacy First, contraception), which may be limiting their utilisation.
- Communication between GP practices and community pharmacies is a recurrent issue affecting patient experience.

##### **ICB Commentary:**

These insights reinforce the need to keep the risk centred on patient experience and access, ensuring that communication pathways are strengthened and that neighbourhood teams support clearer information-sharing and signposting. It is acknowledged that this forms a core part of the ICB's remit and will be reflected in mitigation actions.

#### **6. Variation in Service Awareness and Visibility**

##### **Feedback**

Some members commented that variation in uptake and awareness of advanced services is often linked to limited public understanding, rather than current provider capacity.

##### **ICB Commentary:**

The ICB can influence this through communication, promotion of pathways, and improving integration with general practice. These areas will be incorporated into localised mitigations.

#### **7. Scoring and Further Refinement**

##### **Feedback:**

Members noted that the proposed scoring required further review, particularly in relation to the mitigated score.

##### **ICB Commentary:**

The scoring will be revisited to ensure it reflects the likelihood and impact of population-level access issues and is consistent with the ICB's broader risk framework.

The tension between capturing nationally driven pressures and maintaining a local population health focus was acknowledged by the group. Members emphasised that the reframed risk must remain true to the ICB's statutory responsibilities while still accurately describing the real challenges patients face—particularly the interplay

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between workforce constraints, medicines access, and the capacity to provide enhanced services.

It was also acknowledged that the ICB, as a strategic commissioner, is required to frame risks through the lens of population health, access, and equity, which may differ from the local representative committees' remits.

### Proposed Changes

Following initial review, it is recommended that a consolidated, patient-focused risk will be retained. While several points of feedback will inform refinement, the fundamental structure of the risk will remain unchanged to ensure alignment with ICB responsibilities and governance expectations.

The revised risk will continue to focus on:

- Equitable access to community pharmacy services for the communities we serve
- Variation in provision, particularly in rural areas
- Workforce fragility at system level
- Medicines supply impacts on population access
- System resilience and neighbourhood-level integration

Mitigation will continue to be driven by data surveillance, targeted engagement with providers and neighbourhood teams, collaboration with NHS England, and ongoing monitoring of resilience issues. This approach supports the ICB to intervene where it can have the greatest effect and ensures the risk remains grounded in the areas legitimately within ICB control.

### Recommendations to the Group:

- Support the further refinement of the risk through engagement with system partners, ahead of formal submission through the appropriate governance for final approval
- Endorse the proposed approach and timelines for finalising the risk for submission to a future governance meeting (revised from March 2026) taking into consideration the establishment of Norfolk and Suffolk ICB from 1 April 2026

<b>Key Risks</b>	
<b>Clinical and Quality:</b>	Effective management of this risk will support improvements in patient access, safety and the quality of community pharmacy services. Strengthening system oversight and embedding pharmacy within neighbourhood models will help to reduce variation and improve clinical outcomes for residents.
<b>Finance and Performance:</b>	Not applicable
<b>Impact Assessment (environmental and equalities):</b>	A clear understanding of the risks associated with reduced or inconsistent access to community pharmacy services is essential for addressing

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	health inequalities and unwarranted variation across Norfolk and Waveney. The reframed risk enables a more targeted approach to ensuring equitable access for all populations.
<b>Reputation:</b>	Proactive and transparent management of this risk helps protect the ICB's reputation by supporting early identification of issues and timely escalation where required.
<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 GPCPODG community pharmacy risk paper Feb 2026
<b>NHS Constitution:</b>	N/A
<b>Conflicts of Interest:</b>	None identified
<b>Reference to relevant risk on the Board Assurance Framework</b>	The resilience of community Pharmacy BORR27

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## Item 06 - Appendix A

### Draft Revised Community Pharmacy Risk GPCPODG Feb 2026

#### Risk Title

Reduced patient access to essential medicines and clinical services, linked to variation and capacity issues within the community pharmacy network

#### Risk Description

There is a risk that patients living in specific areas in Norfolk and Waveney may not have equitable and reliable access to essential community pharmacy services, including supply and purchase of medication, urgent treatments, clinical services and self-care advice. Permanent closures of pharmacies, short-notice or unplanned temporary closures, and reduced availability of core and advanced services, could result in patients not being able to access care close to home, leading to delays in treatment, poorer health outcomes and a negative impact on their overall experience.

There is also a risk to patient safety, continuity of care and long-term health outcomes if community pharmacies are not fully involved as equal partners in neighbourhood health planning and service delivery. Community pharmacies play a vital role in supporting prevention, early intervention and accessible care, and the absence of meaningful engagement from local planning could weaken the ability of neighbourhood teams to meet the needs of their population.

Neighbourhood health development is fundamental to achieving the ambitions in the NHS's 10 Year health plan and the ICBs Population Health Improvement Plan. Ensuring that community pharmacy is embedded within this approach is essential to delivering safe, effective and equitable care for all residents.

#### Causes

Rurality, geographical isolation and absence of strong integration increases vulnerability in single-provider and non-pharmacy locations, enhancing the risk of reduced patient access to essential community pharmacy services.

Lack of community pharmacy integration in some localities, with local stakeholders and with wider Primary Care Networks. This not only increases the risk of community pharmacy isolation from future neighbourhood health development but reduces the use of current clinical pathways to support access, which may lead to delays in patient access to timely care.

Community pharmacy, not being fully involved or not being seen as an equal partner in neighborhood health planning and service delivery, will impact integration and future sustainability as the model is developed.

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Rapidly evolving clinical service expectations, including future prescribing models and expansion, without assured commissioning frameworks.

National medicines supply shortages which can add unnecessary complexity and delays to access essential medicines. This in turn can cause reputational damage to community pharmacies and may deter the population from using pharmacy services as their primary source of access for healthcare advice or clinical services.

Workforce shortages of registered pharmacy professionals, particularly pharmacy technicians, will restrict the ability to maximise clinical service delivery and future developments.

National funding complexities for pharmacy workforce training does not allow local developments to be funded in the numbers needed for a sustainable workforce, creating pipeline pharmacy technician challenges such as capacity to host training posts and post qualification attrition rates.

### **Impact on Patients**

Service constraints and variable availability may, at times, limit the ability to meet patient expectations, potentially impacting trust and confidence in pharmacy services

Delays or barriers in accessing medicines, urgent treatments, and clinical services and advice due to temporary suspension of pharmacy services, permanent closures and/or reduced clinical services

Variation in service provision impacting equitable access to clinical services such as Pharmacy First, contraception, and future prescribing services.

Disproportionate impact on patients in rural areas with, in some locations, no pharmacy presence leading to increased service demands on local healthcare providers potentially leading to delays in timely or alternative care.

### **Current Controls**

Collaborative working with the pharmacy contracting team, ICB complaints team and ICB quality team to enable regular monitoring of network resilience.

A triangulated approach, including operational and quality risk registers, utilising contract monitoring data, and ICB complaints data to inform the pharmacy commissioning and quality pharmacy visit plan.

Primary Care Commissioning Committee and General Practice and Community Pharmacy Operational Delivery Group (GPCPODG) assurance and oversight of commissioning decisions and contractual matters under the Delegation Agreement.

Active engagement with contractors, NHS England, Community Pharmacy Norfolk & Suffolk (Local Pharmaceutical Committee), and neighbourhood teams on workforce and sustainability issues to deliver a collaborative approach to commissioning.

Data-driven commissioning including mapping of high-risk geographies and service needs.

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### **Mitigated Actions**

Annual Contractual community pharmacy contractual framework (CPCF) survey to monitor adherence to contractual requirements

Local proactive monitoring of contracts and strengthening relationships between all local providers to maintain service continuity with reporting through the improvement and support register at GPCPODG

Assessing the risk of providers with multiple contracts establishing regular meetings with providers to mitigate risk of unplanned changes to service delivery

Pharmacy visit programme with the ICB quality pharmacist, which is informed by combined operational and quality risk registers, to provide support and guidance for providers

Annual review of national pharmacy workforce data generated from the pharmacy workforce survey to help inform workforce development initiatives to improve recruitment and retention.

Increased national Pre-registration trainee pharmacy technician (PTPT) funding levels for commissioned places from 26/27 onwards

Develop the concept of locality anchor pharmacies including learning pharmacy models for PTPT and foundation pharmacist training.

Develop pharmacy network vulnerability mapping to identify at-risk areas for pharmacy accessibility to help inform future strategic commissioning

National CPCF negotiations and outcome for 26/27 pharmacy contract

### **Current Risk Score**

<b>Overall risk score</b>	<b>20</b>
<b>Mitigated risk score</b>	<b>16</b>
<b>Target risk score</b>	<b>12</b>

### **Recommended Revised Risk Score**

<b>Overall risk score</b>	<b>16</b>
<b>Mitigated risk score</b>	<b>12</b>
<b>Target risk score</b>	<b>12</b>

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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	
			Mark Burgis	Primary Care Commissioning Committee	Amanda Sear	01 Sep 2020	31 Mar 2026	20	16	12			Shepherd Ncube	02 Feb 2026	31 Mar 2026	
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 Sep 2020	31 Mar 2026	20	16	12	Commencement of LMC General Practice Alert System sitreps	Deep dive of general practice risk, report to delivery group in February and PCCC in March				
											PCN ARRS (additional roles reimbursement scheme) funding has provided additional capacity but has not grown in this contract year. GPs have been added to the scheme.					
											Locality teams and strategic primary care teams structured around supporting the resilience of general practice. All practices have previously been supported to review business continuity plans.					
											Standard contract requirements on interface - gap analysis and action plans, including monitoring being reviewed by contracts team. New national requirement for providers to self-assess using national toolkit 6-monthly.					
											Primary care workforce and training team working closely with locality teams to ensure training available to support practices and PCNs in setting up and maintaining services					
											Contractual requirement for commissioners to have a 3 year rolling programme to review service quality and contractual compliance for the agreed medical services contracts.					
											Local interface groups have been established and commenced in an informal capacity from May 25. The system leads continue to meet quarterly. This aims to support the resilience of practice by establishing firm engagement with all provider leads.					

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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 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)		
							NHS Business Services Authority performance/quality management reporting and quality framework in place with regular meetings established with the ICB. Access to eDen dental data management reports and dashboard for ICB staff.		
							NHS England Long Term Workforce plan published June 2023		
							Clinical Dental Advisor role recruited for ICB in 2024 to replace NHS England roles		
							Dental Data Review being updated to inform commissioning plans.		
Dental Long Term Plan and local Primary Care Workforce Plan agreed 7 May 2024 sets out ambitions for primary care, Level 2 and secondary care service collaboration									
Primary care workforce and training team working closely with primary care commissioning team to ensure workforce retention programmes and training support is linked to the Dental Delivery Plans.									

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29	Secondary care dental services (Oral Surgery and Maxillo Facial Services, Orthodontic Services)	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 Burgess	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
											Dental Services Delivery Group established reporting to PCCC	31/7/2025: Additional funding agreed to support SNEE Programme team to end March 2026. 21/8/2025: projects continue to progress - Oral Surgery review to inform commissioning intentions from April 2026, TMJ pathway and sedation training programme. Analysis of oral surgery data underway 14/10/2025: joint workshops with SNEE ICB for paediatrics, TMJ and sedation being organised. 23/12/2025: workshops for TMJ & sedation not yet taken place. ICBs to review programme status & responsibilities Q4 from April 2026	Fiona Theadom	20 Feb 2025	31 Mar 2026
											NHS England Long Term Workforce plan published June 2023	To draw up an Equality Impact Assessment and Clinical Quality Risk Assessment with support from Quality team 20/03/2025 Baseline data has been requested from secondary care providers to inform EHIA completion. Date for completion revised to end May 2025 12/6/2025 Baseline data for 1 acute pending receipt. Limited resources within the dental team to complete EHIA may delay completion further. 21/8/2025: delay in drawing up EHIA due to lack of capacity within the dental team and conflicting priorities	Sadie Parker	01 May 2024	30 Oct 2025
											NHSE Recommendations for secondary care services in East of England 2024 published.				
											ICB primary care team recruited and in place working alongside newly recruited Quality Dental Nurse in Quality team and Finance colleagues to manage primary and community care contracts.				
Ring fenced dental budget for investment															

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32	Primary Care Resilience and Transformation	Under the Joint Forward Plan we have committed to integrating primary care services to deliver improved access (including digital tools and remote monitoring offers, etc.) to a wider range of services from multi-professional teams, focused on preventing illness and improving outcomes for our population within their communities. Our high-level outputs include: • Developing a vision for providing accessible enhanced primary care services • Improving patient outcomes and experience • Stabilise dental services and setting a strategic direction for the next five years Primary Care Services are the responsibility of the Integrated Care Board, including the recruitment and retention of healthcare professionals. There are particular risks to the resilience of general practice, access to NHS dentistry treatment and Level 2 dental services which are reflected in the risk scores. The community pharmacy and optometry landscape is less defined at the time of writing, but workforce and funding challenges are evident across community pharmacy which represent a risk, but could potentially be supported through greater integration and collaborative working with other primary care providers. Limitations of national contracts, collective action by General Practice, independent contractors 'handing back' NHS contracts, workload pressures, recruitment and retention and interface challenges are, together, impacting on access to high quality, sustainable primary medical, community pharmacy and dentistry services together with Level 2 dental services for our population. This may lead to delays in accessing care, unavailability of care (particularly dentistry), increased clinical harm because of delays in accessing services, failure to deliver the recovery of services adversely affected, and poor outcomes for patients due to pressured, and fragile services. As the cornerstone of healthcare, primary care resilience risks system ability to deliver against key workstreams, including the overall aim of moving towards a more population-based proactive community model of care which addresses prevention, health inequalities and improves outcomes. Reduced access in primary care may also impact on the resilience of other system providers	Mark Burgess	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	28 Oct	31 Aug
											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	Produce a joint SMI / LD report for board	Charles	14 Jan 2026	31 Mar											
A routine SMI HC Deep Dive session has been established to focus on developing a shared understanding, identify opportunities, and make progress on the achievement of SMI HCs across N&W. This meeting is attended by Commissioning, Inequalities, and Mental Health colleagues.															
A 2-year improvement trajectory has been agreed with NHS England taking into account the revised national target	Conduct quarterly SMI working group with appropriate stakeholders.	Charl	13	09											
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.	A multi-disciplinary approach to reviewing SMI HC data has taken place on 2nd February 2026, with additional follow ups to take place thereafter. Topics discussed include current position, anticipated forward achievement, opportunities for support and barriers to achievement. The goal of these meetings are to provide additional context, planning, and shared understanding of SMI HCs as a whole.	Charles Morrow	02 Feb 2026	02 Mar 2026											
Plan in place to increase uptake of SMI checks across N&W and regularly reviewed by PCCC and MH boards.															
Quarterly steering group has been established with input from Mental Health and Locality colleagues to review performance, risk and to discuss any challenges or service improvements.															
Regular assurance reports to NHSE/I & PCCC.															
Practice sign up to the SMI LES. This provides payment for enhanced checks (An additional payment for 3 extra checks).															

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56	The resilience of Community Pharmacy	The resilience of Community pharmacy is at risk due to several factors contained within this report, including workforce pressures which although workforce is led through a different directorate is incorporated within this risk due to its relevance The risk could ultimately lead to an increase in the number of permanent closures of pharmacies within our ICB which would reduce the accessibility of pharmacy services to our population. It could also lead to reduction to service provision including both core and advanced. The rurality of Norfolk and Waveney does mean that this risk is significantly projected due to geographical distance between existing providers.	Mark Burgis	Primary Care Commissioning Committee	Sharon Gardner	27 Dec 2024	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
											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												

Sharon Gardner
19 Aug 2025
20 Aug 2025

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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	Primary 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	20 Feb	31 Mar
											Dental Long-Term Plan and local primary care Workforce Plan agreed 7 May 2024 sets out ambitions for primary care, community dental services, Level 2 and secondary care service collaboration	Discussions taking place with ICB Primary Care workforce team, local provider and MCN Chairs to agree support from ICB schemes for recruitment 30/05/2025: CDS updated ICB at meeting on 28/5/2025 on successful appointment and advertisements for a number of clinical roles. Appointment to training posts have been paused. 31/7/2025: Recruitment for 3 clinical posts underway. Foundation trainee post unfilled. Discussions between CDS and NHSE WTE ongoing re training roles in 2026/2027. Successful recruitment of a Dental Officer 21/8/2025: recruitment to vacancies continues supported by ICB workforce schemes 14/10/2025: recruitment to vacancies in progress 23/12/2025: workforce recruitment remains a key challenge for the service resulting in waiting lists for assessment and treatment. Advertisements with ICB support live	Fiona Theadom	03 Jan 2025	20 Dec 2025
											Dental Services Delivery Group established reporting to PCCC				
											ICB primary care team recruited and in place working alongside Quality Dental Nurse in Quality team, ICB Clinical Advisor - Dentistry and Finance colleagues, and Commissioning Team (for secondary care dental services)				
NHS England Long Term Workforce plan published June 2023															
NHS Business Services Authority performance/quality management reporting and quality framework in place with regular meetings established with the ICB. Access to eDen dental data management reports and dashboard for ICB staff.															

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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>11 March 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](#), and to highlight key considerations as the system moves into the next phase of planning, assurance and organisational change.

**Executive Summary:**

This report provides context for the Committee as the system moves through a period of transition, with a particular focus on the months ahead rather than retrospective delivery.

Recent engagement with NHS England through the Quarterly Assurance Meeting (quarter three) has reinforced the importance of demonstrating clear grip on risk, prioritisation and delivery, while recognising the scale and pace of change currently being navigated nationally, and across the system.

In parallel, ongoing operational planning discussions continue to shape how national requirements for 2025/26 and beyond are translated into local delivery plans for primary care across Norfolk and Suffolk. These conversations have highlighted the expected cumulative impact of recent national initiatives and the need to maintain a realistic and sustainable approach to implementation.

This work is taking place alongside preparations for the new ICB operating model from 1 April, including the establishment of a combined Norfolk and Suffolk Primary Care team. This provides an opportunity to strengthen alignment, reduce duplication and support a more coherent approach to commissioning, assurance and transformation, while remaining mindful of transition risk and the need for continuity.

Overall, the Primary Care team remains focused on supporting delivery of national requirements, maintaining robust assurance on risk and performance, and creating the conditions for primary care to operate as a strong and effective partner within neighbourhood models, supporting sustainable delivery and improved outcomes for local populations as the system evolves.

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## **National assurance and system context**

The recent NHSE Quarterly Assurance Meeting provided an opportunity to reflect on progress, risk and readiness across primary care within the wider system context. Discussions reinforced the importance of:

- clear lines of sight from national requirements through to local delivery
- a coherent narrative on prioritisation and sequencing
- evidence of grip on risk, without driving unnecessary additional burden

The Primary Care team is working closely with colleagues across the ICB to ensure that intelligence, risks and mitigations are appropriately triangulated and reflected in both formal reporting and ongoing dialogue with NHSE.

## **Operational planning – looking ahead**

Operational planning remains a key focus as the system responds to national priorities and evolving planning guidance. The latest submission was made on 12 February, and at the time of writing, formal feedback has not yet been received. In parallel, work continues to maintain alignment of metrics across Norfolk and Suffolk as technical guidance evolves. Recent discussions have emphasised the need to:

- balance delivery of national commitments with local capacity and resilience
- recognise the expected cumulative impact of multiple initiatives introduced over recent cycles
- ensure that planning assumptions are grounded in realistic delivery trajectories

The medium-term planning checklist recently shared by NHS England is being used to review how effectively primary care is embedded within the ICB's integrated strategic commissioning plans and aligned to the Medium-Term Planning Framework and the three shifts set out in the 10Year Health Plan. The checklist emphasises clear governance and delegated commissioning arrangements, the use of data and population health management to inform planning, alignment of access and productivity metrics, and stronger integration across neighbourhood teams and the wider primary care system, including general practice, community pharmacy, dentistry and optometry. The next phase of work will focus on aligning primary care action plans more closely with integrated system plans, improving consistency of metrics and assumptions across Norfolk and Suffolk, and clarifying how primary care priorities will be delivered through neighbourhood models as organisational arrangements continue to evolve.

## **Strategic commissioning and neighbourhood working**

As the ICB moves to a new operating model from April, there is increasing focus on the role of strategic commissioning and what this means in practice for primary care.

Strategic commissioning reflects a shift in where system responsibilities sit, rather than an expectation that providers take on additional burden. Core primary care contracts across general practice, community pharmacy, dentistry and optometry remain nationally specified,

with statutory accountability for commissioning, assurance and oversight continuing to sit with the ICB.

The emphasis of strategic commissioning is on strengthening the ICB's role in setting direction, aligning resources and providing proportionate assurance, while reducing unnecessary duplication and transactional activity. This is intended to support greater coherence and equity over time, rather than introduce new requirements for providers.

The area where change is most likely to be felt is not within core contractual arrangements, but in the development of neighbourhood working alongside them. Neighbourhood working provides a space for collaborative, place-based approaches to shared challenges that cannot be addressed effectively by individual practices or services acting alone and sits alongside rather than instead of existing core contractual responsibilities.

### **Managing national contracts and transformation together**

As strategic commissioning develops, the Primary Care team will need to manage two distinct but complementary areas of activity.

Firstly, the ICB will continue to manage and assure delivery of national primary care contracts across all four primary care contractor groups, including access, performance and quality metrics, and delivery of any mandated support associated with these contracts, such as Training Hub and digital requirements.

Alongside this, the Primary Care Team is increasingly considering how its strategic commissioning role can best support enhanced services and neighbourhood health models. This work is intended to complement core contractual delivery and reflects the need to align investment more closely to population need, support collaborative approaches to prevention and population health, and enable integrated neighbourhood level working through commissioning design rather than reliance on informal or voluntary arrangements.

Balancing these approaches will be a defining feature of the Primary Care team's role during this transition and will require careful management to ensure clarity and stability, while creating the conditions for providers to work collaboratively in support of population outcomes as neighbourhood models develop.

### **Organisational change and the combined Primary Care team**

From 1 April, the move to a new ICB operating model and the establishment of a combined Primary Care team represents a significant change in how primary care commissioning and oversight will be delivered.

This provides opportunities to strengthen alignment across commissioning, planning and transformation, improve coherence in how primary care is supported and assured, and reduce fragmentation across teams. The transition also introduces risk, which is being actively managed through established assurance arrangements, with a focus on continuity of relationships, clarity of roles and a steady approach to change.

### **Looking forward**

Over the coming months, the Primary Care team will continue to focus on:

- supporting delivery of national priorities in a way that is locally sustainable
- maintaining clear grip on risk and assurance

- embedding new ways of working under the revised ICB structure
- providing clear, timely and proportionate information to support PCCC oversight

All work is taking place within a constrained operating context, reinforcing the importance of clear prioritisation and alignment across commissioning, planning and transformation. While there remains some capacity to invest in targeted development activity, this will need to be clearly linked to agreed population health priorities, the ICB's Population Health Improvement Plan, and the shared commissioning domains adopted across Norfolk and Suffolk, with a focus on demonstrable outcomes rather than short-term or isolated initiatives.

**Recommendation:**

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

<b>Key Risks</b>	
<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

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<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> <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>	Not applicable
<b>Process/Committee approval with date(s) (as appropriate)</b>	Not applicable

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## Appendix A

The 2026/27 **GP contract letter** (included [here](#) for information) marks a clear shift towards a capacity-led model of access, with funding and accountability moving decisively to practice level to support same-day care for clinically urgent patients. It tightens contractual expectations on responsiveness and transparency, embeds Advice and Guidance as core system infrastructure, and continues the reorientation of QOF towards evidence-based prevention and reducing inequalities, particularly in vaccination uptake. While PCNs remain integral to neighbourhood delivery, the contract emphasises clearer roles, greater workforce flexibility and pragmatic alignment with place. Collectively, the changes signal a move away from short-term access schemes towards more durable practice and neighbourhood capacity, with ICBs positioned as active partners in support and improvement rather than solely contract oversight.

**Dental contract reform** is progressing but is not yet complete. A detailed package of interim contract amendments has been confirmed and published, with implementation from April 2026, focusing on improving access to urgent and unscheduled care, better supporting patients with complex oral health needs, and strengthening prevention within the existing contractual framework. These changes rebalance incentives and introduce new nationally priced care pathways but do not constitute a new dental contract or replace the Unit of Dental Activity model. NHS England and the dental profession are clear that this represents a transitional step to stabilise NHS dentistry and address immediate access pressures, with more fundamental contract reform still outstanding.

**Community pharmacy** is currently operating under an agreed Community Pharmacy Contractual Framework covering 2024/25 and 2025/26, which provides a significant uplift in funding and expands the clinical service offer, including Pharmacy First, the New Medicine Service and national emergency contraception provision. The framework is explicitly intended to stabilise the sector and strengthen community pharmacy's role in improving access and supporting the shift of care closer to home. However, it is time-limited and does not represent a settled long-term contractual model. Negotiations on the next phase of the community pharmacy contract, including arrangements from 2026/27 onwards, have not yet concluded, and further reform is anticipated to support sustainability and deeper integration within neighbourhood and primary care models.

There is no single national contract reform for optometry equivalent to those for general practice, dentistry or community pharmacy. **General Ophthalmic Services** contracts continue to operate nationally, with updated fees and payments in place, while the expansion of eye care in primary care is being driven through locally commissioned optometry-led enhanced services. Nationally, there is a clear policy direction to shift elements of ophthalmology activity from hospital settings into community-based optometry, recognising ophthalmology as the busiest outpatient specialty and a significant contributor to waiting list pressures. Delivery remains locally commissioned and varies by ICB, but optometry is increasingly positioned as a core neighbourhood partner in managing eye care demand closer to home. There is a nationally recognised "Optometry First" approach, developed with NHS England, which supports a greater role for primary care optometry in managing eye care closer to home, although it is not a mandated national service and is being taken forward through locally commissioned models.

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<b>Subject:</b>	<b>Primary Care Digital Update</b>
<b>Presented by:</b>	<b>Anne Heath – Associate Director of Digital – NHS Norfolk &amp; Waveney ICB</b>
<b>Submitted to:</b>	<b>Primary Care Commissioning Committee</b>
<b>Date:</b>	<b>11 March 2026</b>

**The Digital Strategy for Primary Care is delivered in the following pillars:**

- 1) Infrastructure
- 2) Digital Access
- 3) Innovation
- 4) Productivity

**1) Infrastructure**

**GPIT Support**

Following the procurement exercise in 2025, GPIT support provision has now transferred from AGEM to NCHC. Along with the ICB, both organisations worked very well together to effect a smooth transition with no disruption to the practices. Initial feedback from practices on the new provider has been good, with benefits such as the VPN single sign on already being identified.

**GP Practice Infrastructure Upgrade Programme**

Following the change of IT provider, work will now begin on the final stage of cloud mobilisation for surgeries, removing the local domain controller servers and connecting practice devices to the Microsoft Azure Entra environment. This will provide more flexibility to the primary care workforce.

**2) Digital Access**

**NHS App**

65% of eligible residents in Norfolk & Waveney are registered for the NHS App, this is 635,971 people. There are over a million logins to the App every month. Many practices continue to run NHS App promotion events, either at the practice or as part of a PCN level Health & Wellbeing event, and the Digital Team supports these events where possible.

Healthwatch continue to evaluate the use of Digital tools, one focus this year being on groups who may be digitally excluded and barriers to using the NHS App.

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## **Digital Inclusion**

The rise in digital access methods leads us to look at groups of people who can't engage in this way through a lack of skills or digital poverty. Pioneered in Norfolk & Waveney, a scheme is being rolled out across the country, where the libraries service offers 1:1 coaching services. NCC also has Digital Skills coaches and can provide refurbished phones, laptops and tablets. There is a national data bank that will provide data SIMs for anyone in digital poverty. A toolkit of resources has been compiled and is available to GP Practices, Healthwatch and PPG groups, and also Integrated Neighbourhood Teams staff.

## **3) Innovation**

### **Copilot Chat**

Copilot Chat, part of the Microsoft 365 suite, has been made available to all GP Practice staff. It is an AI assistant that can help with meetings, such as by creating notes or action lists from meeting transcripts, it can draft emails or reports, and can summarise or explain documents. Practices have been provided with guidance around safe use of the AI tool, which includes always having a "human in the loop". A further safeguard is that Copilot Chat will access files on the user's personal OneDrive storage only.

### **AI and Ambient Voice Technology**

Nationally, the NHS is keen to make good use of technology such as AVT. At the moment, it is less useful in GP Practices for consultation purposes than other clinical areas, because of the need to clinically code entries on the practice clinical system. However, it is hoped that 2026 will see further tools released and funding made available.

### **National Document Repository**

This is a national initiative, to store and make accessible all digitised patient records. Access is controlled and secure, and records cannot be amended. As the records stay in a single location, patients and clinical staff do not have to wait until either a paper or digitised record arrives when a patient registers. There are also benefits in money saved transporting notes. 118,101 digitised records are now available for N&W residents, covering all GP Practices. This initiative has green benefits in saving manual collection of records and printing too. The national project estimates £21,285 annualised savings in the area, and 331kg of CO2 emissions avoided. This is the equivalent of using a typical home oven for around 300 hours, or driving a car 850 miles.

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#### **4) Productivity**

##### **Automations in Primary Care**

The automation for processing repeat prescriptions is now live in 50 sites, and has processed over 1,000,000 tasks, issuing 550,000 prescriptions.

A programme to help practices develop their own automations using Microsoft tools has been rolled out, and so far 10 practices have developed over 20 automations.

These are things like automation of subject access request management, or internal IT queries, back office tasks that improve productivity through automation.

#### **5) System Wide Projects**

##### **Shared Care Record**

All GP Practices in Norfolk & Waveney have access to the Shared Care Record as a contextual link from the clinical system. It is actively used by 82 GP Practices, mostly for access to information from social services and the mental health trust.

##### **EPR Programme – Acute Hospital Group**

The EPR programme is currently undertaking a replanning phase. The go live date has been pushed back and is likely to be April 2027. A Primary and Community Care workstream will be initiated to ensure that any interface with these areas is appropriately communicated and tested and that services have the ability to input.

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Agenda item: XX

<b>Subject:</b>	<b>Review of Norfolk and Waveney ICB Practice Visits</b>
<b>Presented by:</b>	<b>Jordan Bingley – Primary Care Commissioning Manager</b>
<b>Prepared by:</b>	<b>Jordan Bingley – Primary Care Commissioning Manager Charles Morrow – Primary Care Commissioning Manager Gemma Claridge – Primary Care Commissioning Manager Stuart White – Senior Primary Care Commissioning Manager Debbie Ebenezer – Senior Primary Care Commissioning Manager</b>
<b>Submitted to:</b>	<b>Primary Care Commissioning Committee</b>
<b>Date:</b>	<b>11<sup>th</sup> March 2026</b>

**Purpose of paper:**

The purpose of this paper is to provide the Primary Care Commissioning Committee with an overview of our General Practice Visit Programme, a key assurance and support workstream within our GP Action Plan 2026/7.

The programme is delivered in line with the Primary Care Policy and Guidance Manual assurance framework. This report summarises scope, delivery themes, and outcomes from visits undertaken across Norfolk and Waveney between June 2025 and the present date, and outlines how the programme is contributing to contractual assurance, risk identification and targeted practice support.

**Executive Summary:**

This paper provides an overview of our General Practice Visit Programme, a key assurance and support workstream within the GP Action Plan 2026/27. Delivered in line with the Primary Care Policy and Guidance Manual assurance framework, the programme supports the ICB’s delegated responsibilities for primary medical care commissioning.

Following its relaunch in July 2025, 33 practices across Norfolk and Waveney have received in-person visits. The programme provides contractual assurance, strengthens relationships with practices, and enables early identification of operational risks that may not be visible through routine performance data.

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Key themes include sustained demand and workforce pressures, estates constraints, variable PCN engagement, and challenges within mental health referral pathways. Visits have also highlighted strong innovation within practices, increasing adoption of digital tools, and opportunities to improve implementation of services such as Pharmacy First and Advice & Guidance.

The programme has improved awareness and uptake of ICB support offers and is contributing to more responsive, equitable commissioning. It will continue in 2026/27, with enhanced focus on demand and capacity management, care navigation training, and change support.

## Report

### 1. Background

A core part of the Delegated Primary Care Commissioning Team function on behalf of NHSE is to “manage the performance of the Primary Medical Services Provider[s] in order to secure the needs of people who use the services, improve the quality of services and improve efficiency in the provision of the services”<sup>1</sup>. Conducting in-person practice visits provides the opportunity for the Delegated Primary Care Commissioning team to carry out the delegated functions while also developing relationships with General Practice providers and understanding ways the ICB can support practices.

The Practice Visit Programme was paused during the pandemic, and despite being internally reviewed in 2022/23 wasn't relaunched until July 2025 due to capacity pressures within the Primary Care Delegated Commissioning team. Since July 2025, 33 practices have been visited by the team. With a breakdown by Place shown below (see Image 1 also):

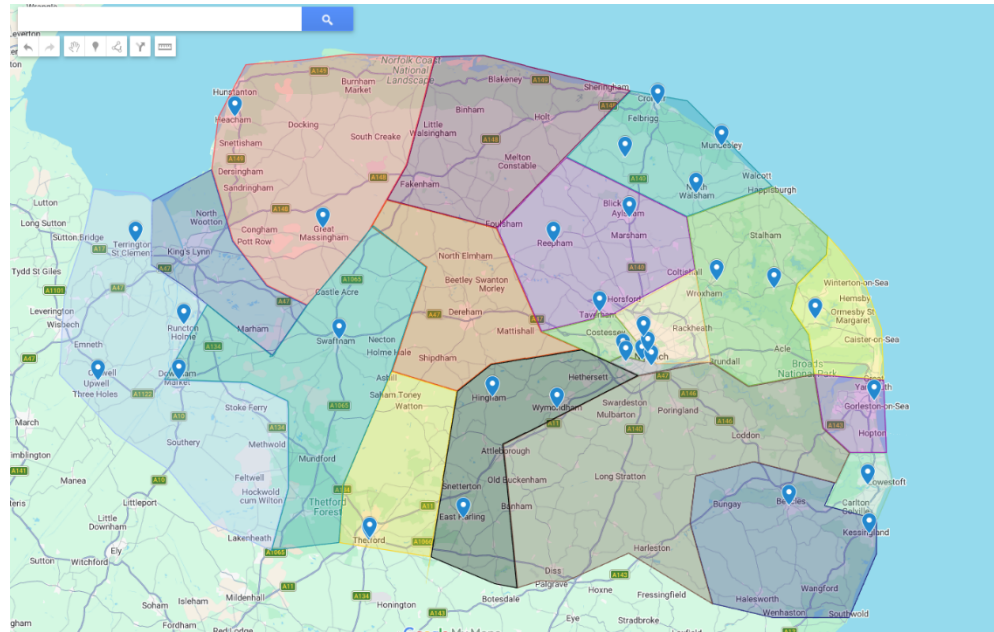
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<sup>1</sup> NHSE Delegation Agreement Primary Care and Dental (2023)

Image 1: Map of Practice Support Visits Undertaken in 25/26

- 6 in East (with another 1 booked in for 09/03/26)
- 8 in North
- 8 in Norwich
- 5 in South
- 7 in West



## 2. The Process

Delegated Primary Care Commissioning worked closely with the LMC and engaged several practice managers in 2022/23 to review the format and process of the practice visit programme with the aim of making the visits collaborative and supportive. An initial visit was undertaken in 2024 at Magdalene Medical Centre in Norwich who volunteered to trial the new format. Feedback from the visit was taken on board and incorporated into the finalised process laid out in the flow chart in Appendix 1.

The aim is that all practices will receive an in-person visit every three years, with commissioning managers aiming to undertake a minimum of one visit every month for their designated area.

## 3. Update on Visit Outcomes

The practice visits undertaken to date have created a valuable opportunity for open dialogue, developing relationships, enabling practices to share the high-quality care they continue to deliver and the innovative approaches being developed in response to ongoing challenges. Through these collaborative conversations, we have been able to capture examples of effective practice and reflect collectively on the key themes and outcomes emerging from the visits.

### 3.1. Strengthening relationships

Feedback from practices has highlighted the value of creating dedicated space for open and constructive dialogue. The visits have provided an opportunity for commissioners to better understand the day-to-day realities facing general practice

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and to hear directly about both the challenges and the solutions being developed locally.

Several common themes have emerged:

**Estates:** A number of practices described constraints within existing premises, including limited clinical space and parking capacity. These physical limitations can affect the ability to respond flexibly to rising demand and to implement service improvements aimed at enhancing access.

**Working within PCNs:** Experiences of PCN engagement vary. While many networks are working collaboratively at scale, some practices described opportunities to strengthen alignment and shared working to maximise the benefits of network delivery.

**Workforce:** Ongoing pressures relating to recruitment, retention, and managing long-term sickness continue to affect resilience across some practices.

**Mental Health Referrals:** Practices shared feedback on referral pathways to NSFT, particularly around clarity of thresholds and information requirements. These insights provide an opportunity for system partners to improve consistency and reduce avoidable administrative burden and have been shared with mental health commissioners.

Commissioners have also sought feedback on the implementation of **Pharmacy First** to better understand its impact. Practices with on-site or closely aligned pharmacies reported positive benefits in managing demand. Where community pharmacy access is less integrated, some practices noted that people can return to general practice, limiting the intended workload shift. Many practices also observed that patient awareness of the full scope of Pharmacy First remains variable. Where implementation challenges were identified, practices were signposted to the Pharmacy Commissioning Team for additional support.

Overall, these discussions are strengthening shared understanding and enabling collaborative solutions to be developed at both practice and system level.

### 3.2. Supporting General Practice

The practice visits have provided a valuable opportunity to strengthen awareness of the range of support services available to general practice. While these offers are routinely communicated through the GP Bulletin, the visits have enabled more detailed and bespoke conversations about how they can be accessed and tailored to meet individual practice needs.

Support highlighted during visits includes:

- Together for Mental Wellbeing SMI Outreach and Engagement support to improve uptake of SMI health checks, including provision of transport for patients where required.

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- Learning Disability Health Check support from the Health Improvement Team, including assistance with register validation and engagement of harder-to-reach patients.
- Succession planning support through the Primary Care Workforce Team.
- NHS App Champion training and support to help practices promote digital access and run engagement events.
- Support to enable automated Friends and Family Test (FFT) messaging via the NHS App following appointments.
- Peer Ambassador support for practice managers in relation to Modern General Practice and change management.
- Practice-level improvement support through GPIIP (general practice improvement programme) and Support Level Framework conversations.

Practices have also constructively identified areas where further support would be beneficial, particularly targeted care navigation training for reception and administrative teams. Strengthening confidence in managing and appropriately signposting patient queries was recognised as a practical step to support demand management and patient experience. This feedback has been shared with the workforce transformation team.

These conversations are helping to ensure that available support is aligned to practice priorities and that improvement activity is shaped collaboratively.

### 3.3. Hearing the Patient Voice

Engagement with Patient Participation Groups (PPGs) varies significantly across the practices visited. Several practices reported positive and constructive relationships with their PPGs, using them as a forum for meaningful discussion, co-design of improvements, and insight into patient priorities. In contrast, some practices described their PPGs as challenging to manage, with meetings often dominated by individual agendas rather than broader patient-focused issues. Across the system, PPG membership is predominantly drawn from older age groups, limiting the diversity of perspectives feeding into practice development.

Some practices had introduced or are introducing various ideas to engage a wider demographic by implementing the following:

- A practice in the south locality was now sending practice staff to attend local groups (such as parent and toddler groups, school youth groups etc) to gather feedback.
- A practice in the East which already has a large and active PPG was starting up a Youth PPG

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Practice managers consistently raised concerns about how accurately national patient survey feedback reflects the broader patient experience and so were engaging Healthwatch in local initiatives or undertaking their own practice survey.

### 3.4. Addressing Health Inequalities

Delivery of Learning Disability (LD) and Serious Mental Illness (SMI) Health Checks are discussed regularly and a number of practices reported how PCNs (such as Swaffham & Downham and Lowestoft PCNs) were working at scale to deliver these on behalf of practices. Support offers are highlighted (as mentioned in 3.2 above) and resources are provided (monthly LD leads group; printed pre-health check questionnaires or LD Health Check birthday card invites).

The visits have been a good opportunity to explain how practices can use the [ICB's Data Hub](#) for monitoring delivery or checking that national data sets align with practice data (as this affects PCN Investment and Impact Fund delivery targets). An example of this is the Diabetes Health Check Data which can identify which of the tests in the check are not routinely being undertaken. Sharing this data through the dashboard has enabled practices to identify gaps they may not previously have been aware of. This has provided the option for opportunistic urine sample collection, supporting improvement in albumin testing completion where patients were already attending for other care.

Visits have also provided the opportunity for discussions around the Local Enhanced Service (LES) Inclusion Health Outreach Clinics (Element 2) delivery and feedback on LES/ locally commissioned services in general.

### 3.5. Discussing Contractual Changes

Across the practices visited, there is clear and encouraging progress towards the implementation of the principles of Modern General Practice. Many teams are proactively adopting digital tools, including AI-supported summarising solutions and enhanced online workflows, to improve efficiency and support demand management. Some practices also shared learning from the implementation of AI receptionist solutions, such as EMMA and Jackie, outlining how they are managing patient engagement and refining internal processes to maximise benefit.

Feedback on the Advice & Guidance (A&G) enhanced service has been constructive and insightful. Many practices reported positive experiences, particularly in reducing unnecessary referrals and enabling timely access to specialist input. Where challenges were raised, such as response times, variation in advice, or perceived administrative burden, these discussions have provided valuable system-level learning. Practices highlighted that clearer criteria, consistent response standards, and strengthened communication with secondary care would further enhance A&G as a supportive clinical tool and this remains a key area of work for the ICB and hospitals into 2026/27.

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The visits have created a safe and informal space to discuss contractual requirements, including the October 2025 contract requirements relating to online consultation and access. This has enabled clarification of expectations and resolution of queries in a collaborative manner.

Demand and capacity pressures remain a consistent theme, particularly at the start of the week, with sustained high levels of patient flow. Practices shared reflections on how online booking systems can sometimes unintentionally increase perceived urgency. Despite significant efforts to implement required access changes, some practices continue to experience capacity constraints, particularly in maintaining clinical triage availability throughout the day. Where pressures were identified, commissioners have signposted practices to a range of free support offers available through the ICB and NHS England, aimed at strengthening operational processes, improving resilience, and supporting sustainable access models.

Overall, these conversations support shared understanding and continuous improvement across the system.

#### 4. Next Steps

Building on the outcomes achieved in 2025/26, the team intends to continue to deliver the Practice Visit Programme throughout 2026/27 as part of the new Norfolk and Suffolk ICB approach, to maintain assurance, strengthen relationships, and provide ongoing support to practices.

Feedback from visits has identified a clear need for enhanced support in change management, care navigation training, and the transition towards total triage and improved demand management. It is therefore recommended that these priorities are reflected in the 2026/27 support offer, with targeted training and practical assistance provided to help practices build resilience and operational sustainability.

#### Recommendation to the Board:

Board members are invited to review and note the update and progress being made in the practice support programme.

Key Risks	
<b>Clinical and Quality:</b>	Practice visits provide preemptive support to general practice and allow for changes to be made/ support offered before issues develop.
<b>Finance and Performance:</b>	Practice visits form an integral part of the undertaking the delegated functions required.
<b>Impact Assessment (environmental and equalities):</b>	If the ICB chooses not to undertake practice visits then we risk missing opportunities to address practice resilience and the impact this will have on

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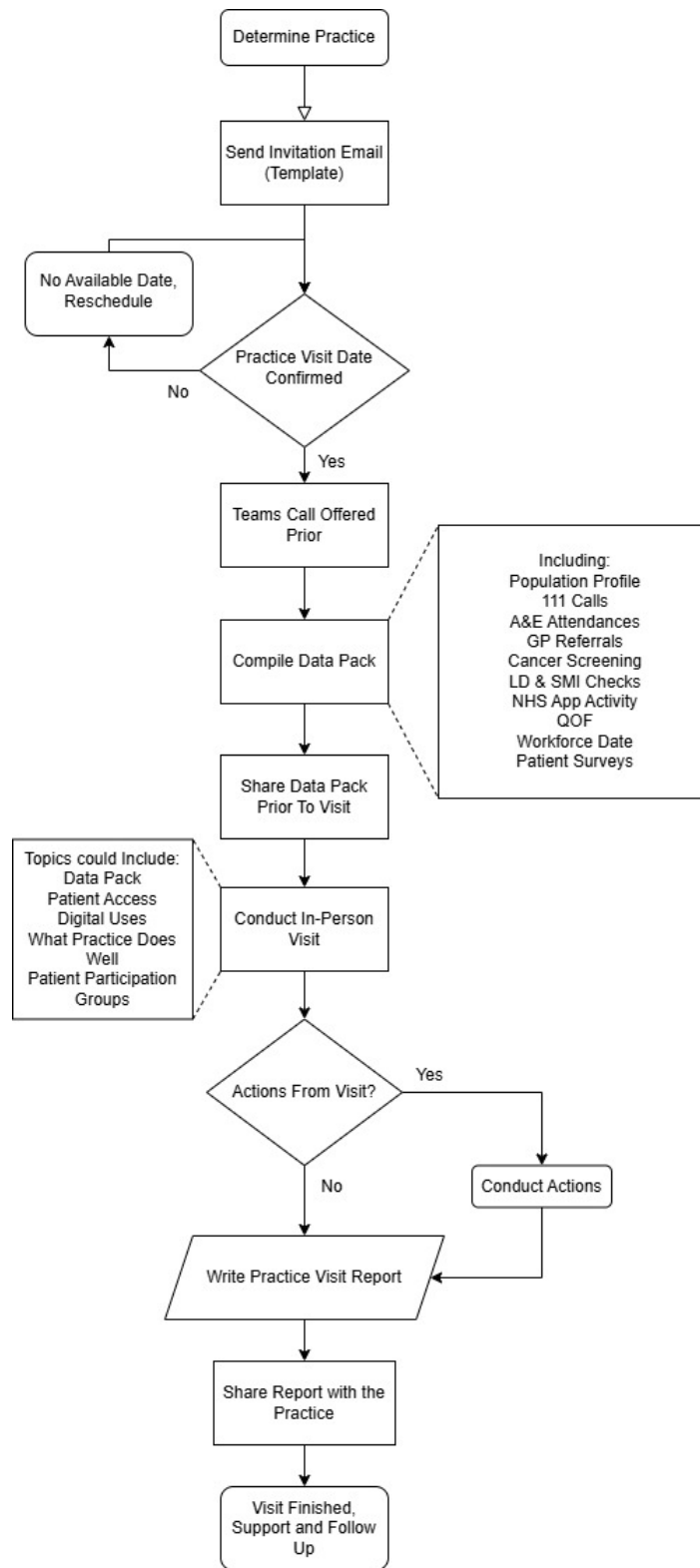
	vulnerable patient groups who rely on general practice.
<b>Reputation:</b>	Risk of being an outlier in the region and at a national level.
<b>Legal:</b>	Delegated commissioning agreement (and soon to be direct commissioning responsibility) from NHSE.
<b>Information Governance:</b>	N/A
<b>Resource Required:</b>	Business Intelligence Team Locality Teams Quality Team Practices
<b>Reference document(s):</b>	N/A
<b>NHS Constitution:</b>	Principle 3 – The NHS aspires to the highest standards of excellence and professionalism Principle 4 – The patient at the heart of everything the NHS does. Principle 6 – The NHS is committed to providing best value for taxpayers’ money.
<b>Conflicts of Interest:</b>	N/A
<b>Reference to relevant risk on the Board Assurance Framework</b>	PC14-BORR11 The Resilience of General Practice

## Governance

<b>Process/Committee approval with date(s) (as appropriate)</b>	Audit Committee for information.
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# Appendix 1: Norfolk & Waveney Practice Support Visit Process



Cummins, Mary  
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Agenda item: 10

<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>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>11 March 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.

The paper also includes an update on Year 2 plans and delivery of operational planning metrics in Appendix A

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 14 January 2026</b>	10 February 2026
<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.

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<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</p> <p>The following risks have been replaced by a new single risk for dental services. There were no critical updates to the risk score.</p> <p>BORR08 – Secondary Care Dental Services  BORR09 – Resilience and Stability of Primary Care Dental Services  BORR71 – Special Care Dental Services</p> <p>DSDG members asked that the ICB ensures that secondary care risks are captured going forward.</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>The Group noted the Finance report.</p> <p>A report on Unscheduled Care was made to the Group noting the upcoming changes to how urgent care will be provided under the new Contract Reforms from April 2026.</p> <p>The Group received a report on dental quality matters, including Green dentistry initiatives.</p> <p>A workforce update was provided to the Group highlighting that 12 programmes had either exceeded or met targets with 14% increase in uptake.</p> <p>The Group considered a case for improvements to NHS 111 triage pathway but asked that additional work be undertaken to look at all options and opportunities in light of upcoming changes from contract reform before a decision is made.</p>
<p><b>Items receiving formal approval from the Delivery Group</b></p> <p><i>To include any financial risks</i></p>	<p>The Group approved the extension of a sedation services contract for one year from April 2026</p>
<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 and all Voting Members (or nominated deputies for making decisions on behalf of Voting Member) present</b></p>	<p>The meeting was quorate. No declarations of interest were identified for the meeting.</p> <p>Voting Members present:</p> <p>Sadie Parker: Director of Primary Care  Lisa Read, Head of Place Quality (East &amp; West) (deputising for Karen Watts, Director of Nursing and Quality)  Fiona Theadom – Head of Primary Care Commissioning (Dental and GP) (deputising for Shepherd Ncube, Associate Director – Primary Care Commissioning)</p>

Cummins Mary  
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	Sarah Elliott, Finance Manager – Delegated Primary Care (deputising for James Grainger, Head of Finance – Primary Care and Corporate)
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**Recommendation to the Committee:**

To note the report and decisions taken by the Dental Services Delivery Group on 10 February 2026
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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 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 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.
<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/Personal 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 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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Cummins, Mary  
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## Update on Long Term Dental Plan

In May 2025, the ICB set out to achieve the following Year 2 plan, summarised below with key highlights:

Programme	Achievement
<p><b>Special Care Dental Services</b> – planning and review in light of Getting It Right First Time report (<a href="#">GIR FT-Community-Dental-Services-supplementary-report-FINAL-January-2025.pdf</a>) and East of England Paediatric vision, to support and improve service sustainability in the long term</p>	<p>Contract extension has been approved to 2029.</p> <p>Collaborative work continues with the provider to embed GIRFT and to deliver the EoE paediatric vision</p>
<p><b>Orthodontic Services</b> – long term sustainability of orthodontic services in Norfolk and Waveney</p>	<p>Long term contracts have been secured.</p> <p>Gaps in provision to be commissioned</p>
<p><b>Oral health prevention</b></p> <ul style="list-style-type: none"> <li>○ Children and young people (linked to the government’s commitment to introduce a national supervised toothbrushing scheme, targeted at 3, 4 and 5 year olds most in need) working with local authority public health.</li> <li>○ Older adults</li> </ul>	<p>Supervised Toothbrushing Scheme in place with 2 providers, led by Public Health team</p> <p>Review of domiciliary services and care home provision has commenced and will carry forward into 2026/2027 plans.</p> <p>Community Voices project in King’s Lynn and Great Yarmouth underway to better understand the barriers and challenges to oral health prevention and education. Norwich to commence shortly. Insight report due end June 2026 to inform ICB commissioning plans.</p>
<p><b>Level 2 services</b> – commissioning services and supporting workforce recruitment and retention plans through upskilling, training and professional</p>	<p>Work underway to develop Level 2 service provision and to accredit dental professionals to provide Level 2 services. ICB is leading this project on a regional basis. To continue programme into 2026/2027 plans</p>

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development. Support the national aim to shift care into the community	
<p><b>Access improvement</b></p> <ul style="list-style-type: none"> <li>○ Access to unscheduled care (national directive)</li> <li>○ Targeted programmes including areas of deprivation and Armed Forces families, areas of geographical need</li> <li>○ Pilots for targeting health inequalities in Norwich and West Norfolk working with Place teams</li> </ul>	<p>23 providers have been successfully delivering urgent care to the local population since Oct 2023. An additional 28 providers signed up under the national scheme in Oct 2025 to increase urgent care capacity. ICB is reviewing its commissioning plans from April 2026/27 to ensure population health needs for urgent dental care continue to be met.</p> <p>A new practice has been commissioned to open in early 2026/2027.</p> <p>Rebasing contracts to free up investment to improve access for new patients is underway with investment plans to be agreed early 2026/27</p> <p>Integrated neighbourhood project in North Norwich underway. Community Voices project commissioned (refer above)</p>
<b>Targeted UDA uplift</b> in rural and coastal areas, and in areas of high deprivation	A universal UDA uplift has been approved backdated to April 2025. Phase 2 to focus on rural and coastal areas and areas of high deprivation to carry forward in 2026/2027.
<b>Workforce</b> recruitment and retention plans	A separate report will be made to Committee
Looking at <b>digital technology and estates</b> to support and improve services for patients	Not progressed due to other priorities
Commitment to carry out a second patient and public engagement in February/March 2026	The ICB is undertaking a targeted Community Voices project which will report end June 2026 across 3 areas in Norfolk and Waveney. This will inform future public engagement.

### Unscheduled Care appointments

The ICB has delivered more than 51,000 urgent/unscheduled care dental appointments April 2025 – end February 2026. Arrangements are changing under the Contract Reform changes which come into effect from April 2026 however urgent

provision will continue to be available to individuals who need an urgent appointment and do not have a regular dentist.

### Shared Care Pathway

More than 70 referrals have been made to a Shared Care Practice since the service commenced in Oct 2025. The Clinical Advisor and Senior Fellow roles have been critical to successful development and learning to inform the evaluation. The patient’s immediate care and treatment is a priority for all involved in the pathway.

There is good engagement from all the practices and a close working relationship between triage, secondary and primary care with a fast, effective referral management process in place. The majority of referrals are made within 48 hours from initial referral and the patient is contacted within 3 days to book an appointment.

Learning is already reshaping the pathway however there is a risk as the triage infrastructure is a potential single point of failure and mitigating actions need to be identified and put in place. A peer review session is planned for March with key stakeholders involved. The ICB will need to undertake a formal evaluation to inform commissioning intentions from April 2027 when the pilot finishes.

### Child Focused Dental Practice Pathway

Over 500 referrals have been made to a Child Focused Dental Practice since April 2025, including a number of direct referrals to individual practices, e.g. Looked After Children, Mini Mouth Care Matters pathway which the ICB is looking to expand in the coming months. A formal evaluation will take place in the autumn supported by the ICB’s Research and Evaluation team to inform commissioning plans from April 2027 when the pilot finishes.

### Operational Planning Metrics

The ICB’s target and achievement to date for delivering operational planning metrics are set out below.

#### UDAs

	Quarter 1 2025/26	Quarter 2 2025/26	Quarter 3 2025/26	Quarter 4 2025/26
Quarterly Target	254,630	258,048	259,757	266,592
Quarterly total	341,785	341,785	341,785	341,785
% target	74.50%	75.50%	76.00%	78.00%
Quarterly achievement	255,042.4	262,323.6	231,524	
% achievement	74.62%	76.75%	67.80%**	

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\*\* delays in BSA processing led to lower than expected delivery. Average November 2025 – end January 2026 is 71.75%

**Adult unique dental patients**

	Quarter 1 2025/26	Quarter 2 2025/26	Quarter 3 2025/26	Quarter 4 2025/26
Target	318,295	324,326	330,325	336,378
Population	909,096	909,096	909,096	909,096
% target	35.01%	35.68%	36.34%	37.00%
Quarterly achievement	293,796	291,971	291,920	
% achievement	32.32%	32.12%	32.1%	

**Child unique dental patients**

	Quarter 1 2025/26	Quarter 2 2025/26	Quarter 3 2025/26	Quarter 4 2025/26
Target	115,407	116,708	118,049	119,421
Population	194,838	194,838	194,838	194,838
% target	59.23%	59.90%	60.59%	61.29%
Quarterly achievement	110,351	111,563	112,406	
% achievement	56.64%	57.26%	57.69%	

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Agenda item: 10

<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>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>11 March 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 14 January 2026</b>	20 January 2026
<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 relevant / aligned to this Committee.</b>	The work of the Dental Development Group aims to find solutions to mitigate the risks for primary care, community care and secondary care dental services however it is not the Group’s role to monitor risks.

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11/03/2026 12:39

<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>Shared Care Pathway update provided to DDG highlighting the referral and triage pathway in place with rapid turnaround to support early patient care. Discussion took place about potential improvements and changes to the pathway to build resilience, and the challenges of scaling up and need for broader training and upskilling the dental workforce and how continuity of the service may look beyond the end of the pilot. Details about the Community Voices project underway in King's Lynn and Great Yarmouth and being planned in Norwich to better inform oral health prevention and education messages and reduce health inequalities. The Group received a progress report on Child Focused Dental Practice pathway noting the Research and Evaluation report is due September 2026 to inform future commissioning intentions. A report on workforce recruitment and retention schemes provided an update noting that an outcome evaluation is underway. Details of the upcoming Contract Reform changes were shared. It was also noted that Norfolk and Suffolk teams are working closely together to develop a jointly agreed plan for the new ICB to take forward.</p>
<p><b>Items receiving formal approval from the Group</b></p>	<p>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.</p>
<p><b>Items for escalation to PCCC</b></p>	<p>None identified</p>
<p><b>Confirmation that the meeting was quorate and all Voting Members (or nominated deputies for making decisions on behalf of Voting Member) present</b></p>	<p>The Terms of Reference do not require the meeting to be quorate.</p>

**Recommendation to the Committee:**

To note the report from Dental Development Group members

**Key Risks**

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<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

Cummins, Mary  
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Agenda item: 10

<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>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>11 March 2026</b>

**Purpose of paper:**

To provide the Committee with an update on the work of the General Practice and Community Pharmacy Delivery Group including discussions and decisions that took place in February 2026. 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 10 <sup>th</sup> February 2026 meeting)
<b>Meetings since the previous update to PCCC on 14<sup>th</sup> January 2026</b>	10 <sup>th</sup> February 2026
<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.
<b>BAF and any Committee risks relevant / aligned to this Committee.</b>	<b>General Practice Resilience: 00000023 Community Pharmacy Resilience: 00000056</b>

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<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>Operational Risk Register</b></p> <p>It was noted that Workforce risks InPhase 53 and 54 had been formally removed from the register at PCCC in January 2026.</p> <p>There were no other changes to the existing risk profiles, but it was noted that the medical and pharmacy risk were under review in order to reframe them with an agreed focus on local access, population health and health inequalities.</p> <p>An updated draft community pharmacy risk was presented to the group seeking input and feedback in order to take a final draft to the PCCC in March for approval.</p> <p>Concerns were raised by the LPC that they were not consulted prior to submission, although conversations had taken place subsequently in advance of the meeting. National factors affecting pharmacy stability in particular supply chain issues were discussed. The LPC suggested separating the risk associated with access to essential medicines from the risk associated with access to services in general and scoring those areas separately.</p> <p>It was noted that patient concerns around the availability of essential medicines were a common theme heard by Healthwatch and feedback on clinical services were minimal which could either indicate smooth delivery or limited public awareness.</p> <p>It was acknowledged by voting members that a balance was required whilst remaining true to the ICB's statutory responsibilities and still accurately describing the real challenges patients face.</p> <p>The community pharmacy risk paper would be further reviewed and updated.</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>Integrated Performance Report</b></p> <p>All key performance indicators for general practice and community pharmacy were broadly in line with expectations, with community pharmacy performing ahead of original ICB targets.</p> <p>It was noted that the community pharmacy metrics on the integrated performance report had not been updated since August 2025 due to a change in the formatting of NHSE data. A detailed update of the figures was presented in the paper for reference.</p> <p>A query from the LPC on the use of the underspend of Pharmacy fair share allocations was raised which was taken away by the ICB finance team to respond to outside of the meeting.</p>

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The variability in appointment booking via the NHS App was discussed and it was noted that most practices required triage and did not offer direct booking via the App, but repeat prescriptions and other digital services were widely available via the App.

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

Updates were provided on learning disability (LD) and severe mental illness (SMI) health checks, with improved performance reported. Investment differences between Norfolk and Suffolk were discussed along with patient experience, and ongoing efforts to enhance quality and engagement.

It was reported that 48.9% of patients on LD registers received health checks in this financial year by December 2025, with increased activity in Norwich and South Norfolk in particular with practices using dedicated ARRS staff for improved quality.

The 8.64% increase in appointments delivered from December 2024 to December 2025 across Norfolk and Waveney was highlighted and noted to be 7.42% above the NHSE target for delivered appointments. The increase was linked with the GP contract changes which were implemented on 1<sup>st</sup> October 2025 and included online consultations. The LMC thanked the ICB for their support provided to practices with regard to the contract changes, whilst indicating that more support may be required to help practices meet the 8.6% increase in demand for appointments.

A 53.4% achievement for SMI health checks was reported, with a 10% increase expected by year-end. Ongoing support and engagement with practices was discussed.

There was a discussion about patient experience of the LD and SMI health checks. Feedback mechanisms which were in place such as ICB attendance at family and carer groups and an online feedback form were described. It was also noted that a member of the ICB LD team made visits to special schools and day centres to inform and gain feedback on the health checks.

### **GP Practice Protected Learning Time (PLT)**

A brief discussion took place regarding Protected Learning Time (PLT) for practices.

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	<p>An interim arrangement to support practice requests had been introduced to align with the new contractual requirements from 1<sup>st</sup> October 2025. A standardised email template and team review process, pending harmonisation with Suffolk's approach had been introduced. All requests received this year so far have been supported. A new process is yet to be agreed for the new organisation.</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>GP Branch Surgery Opening Hours Increase</b></p> <p>Changes to the opening hours of a GP practice branch site were approved, with assurance received that the surgery would comply with contractual requirements and the change would see an improvement in access to the branch for patients.</p> <p><b>GP Practice Boundary Increase</b></p> <p>The request to increase the boundary of a GP practice to include a new branch which would accommodate an increase in list size due to a new housing development was approved. Communication about the change to patients, pharmacy dispensing arrangements, and potential challenges were discussed. It was confirmed that local practices and stakeholders had been consulted and no challenges were anticipated.</p> <p><b>GP Practice Main Site / Branch Site Switch</b></p> <p>A request for an administrative change to switch the main and branch site designations for a GP practice was submitted and approved.</p> <p>It was outlined that the larger site would become the main site, reflecting current administrative functions and patient flow, with no expected impact on patients or staff.</p> <p>It was confirmed that the practice was aware of potential changes to Carr Hill weighting and global sum payments because of the switch and had accepted the associated risks.</p> <p><b>Pharmacy Essential Medicines Scheme Extension</b></p> <p>A three-month extension and additional funding for the essential medicine scheme to align with SNEE ICB's contract end date was requested and approved.</p> <p>It was explained that the scheme paid pharmacies to hold palliative care medicines for urgent access, and the extension would allow time for Norfolk and Waveney and SNEE to align for a future combined service.</p>
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	It was agreed to add the Pharmacy Essential Medicines Scheme Extension to the group forward planner in case further extensions are required.
<b>Items for escalation to PCCC</b>	There were no items requiring escalation to PCCC.
<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>The meeting was confirmed quorate. Attendance at the meeting is listed below:</p> <p>10<sup>th</sup> February 2026</p> <p><b>Voting members</b>  Sadie Parker, Director of Primary Care, NWICB - Chair  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

<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>	<p>Each proposal is accompanied by an Equalities Health Impact Assessment to inform the Group's decision making.</p> <p>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.</p>
<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)

Cummins, Mary  
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<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>
<b>Reference to relevant risk on the Board Assurance Framework</b>	<p>BAF02 – Primary Care Resilience and Transformation</p> <p>BORR11 – Resilience of General Practice</p> <p>BORR27 – Resilience of Community Pharmacy</p>

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Agenda item: 11

<b>Subject:</b>	<b>Pharmaceutical Services Regulation Committee (PSRC) – Decisions Made (October 2025 to December 2025)</b>
<b>Presented by:</b>	<b>Gregg Syder – Commissioning Manager – Pharmacy and Optometry</b>
<b>Prepared by:</b>	<b>Gregg Syder – Commissioning Manager – Pharmacy and Optometry in conjunction with ICB contracting team hosted by Herts and West Essex ICB</b>
<b>Submitted to:</b>	<b>Primary Care Commissioning Committee Part 1</b>
<b>Date:</b>	<b>11 March 2026</b>

## Summary of Paper

The attached paper contains the first quarter (Q3) report from the Pharmaceutical Services Regulation Committee (PSRC) relating to the market entry and fitness decisions made at the monthly PSRC meetings 1st October 2025 to 31<sup>st</sup> December 2025 in relation to Norfolk and Waveney matters.

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

## Recommendation

Note the decisions made at the PSRC meetings between 1st October 2025 to 31<sup>st</sup> December 2025

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

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<b>Legal:</b>	Pharmaceutical Services Regulations
<b>Information Governance:</b>	N/A
<b>Resource Required:</b>	Primary Care and Quality teams
<b>Reference document(s):</b>	Pharmacy Manual, Pharmaceutical Services Regulations
<b>NHS Constitution:</b>	N/A
<b>Conflicts of Interest:</b>	None identified
<b>Reference to relevant risk on the Board Assurance Framework</b>	The resilience of primary care

### Governance

<b>Process/Committee approval with date(s) (as appropriate)</b>	N/A
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<b>Meeting/Committee:</b>	<b>Primary Care Commissioning Committee</b>
<b>Venue:</b>	<b>Teams Meeting</b>
<b>Date:</b>	<b>11 March 2026</b>

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

### Executive Summary:

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

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

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

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

The following are the market entry and fitness decisions made at the monthly PSRC meetings between October 2025 – December 2025:

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

Application	Health and Wellbeing Board	Decision
None		

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

Application	Health and Wellbeing Board	Decision
None		

**Market Entry Applications under Appeal**

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

Application	HWB Area	Commissioner Decision	NHS Resolution Decision	Appeal Ref.

**Fitness Decisions (within scheduled PSRC meetings):**

Fitness Notifications / Concerns	Health and Wellbeing Board	Decision
None		

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### Fitness Decisions (via Delegated Decision Making):

Fitness Notifications / Concerns	Health and Wellbeing Board	Decision
Dereham Medical Supplies Ltd - Fitness accompanying market entry application	Norfolk	Fit and proper
Medpal Ltd - Fitness accompanying market entry application	Norfolk	Fit and Proper
Southend Pharma Ltd - Fitness accompanying market entry application	Norfolk	Fit and Proper
Universal Pharmacy Ltd - COSI	Norfolk	Remains Fit and Proper
Velvet Healthcare Ltd - COSICOD	Norfolk	Remains Fit and Proper

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

Fitness Notifications / Concerns	Health and Wellbeing Board	Decision
None		

### Fitness Decisions under Appeal:

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

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

### Regulatory Timescales:

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

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

For Q3, all completed applications were determined within the regulatory timescales.

**Recommendation(s):**

Note the decisions made at the PSRC meetings between October 2025 and December 2025.

**Next Steps:**

- Reporting will occur on a quarterly basis.

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<b>Meeting/Committee:</b>	<b>Primary Care Commissioning Committee</b>
<b>Venue:</b>	<b>Teams Meeting</b>
<b>Date:</b>	<b>11 March 2026</b>

<b>Title of Report</b>	<b>General Ophthalmic Services (GOS) Contracting – Quarter End Update Report (Q3 2025/26)</b>	
<b>Presented by</b>	Gregg Syder – Commissioning Manager – Pharmacy and Optometry	
<b>Author</b>	Jackie Bidgood, Senior Contract Manager, Pharmacy and Optometry	
<b>Commercially Sensitive</b>	No	
<b>Status</b>	For:	Information
<b>Finance Lead sign off (if required)</b>	Name: NA	Date: NA
<b>Conflict of Interest</b>	None known.	
<b>Governance and reporting</b> – at which other meeting has this paper already been discussed (or not applicable)	This paper has not been discussed at other meetings however an update report on GOS contracting was requested by ICBs following delegation on 1 April 2023.	Outcome of Discussion: NA
<b>ICS Engagement</b> (Describe engagement and co-creation with ICS colleagues)	The Pharmacy and Optometry Team is employed and hosted by NHS Hertfordshire and West Essex Integrated Care Board (HWE ICB) but works on behalf of the 6 ICBs in the East of England.  This is a standard report requested by ICBs following delegation.	

### Executive Summary:

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

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

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

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

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

This report produced for ICBs is reflective of Quarter 3 (Q3) position.

**GOS Contracting Overview**

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

**Table 1**

<b>Mandatory</b>	<b>Additional</b>
96	27

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

**Performer concerns:**

Update on TP7TL Post Payment Verification (PPV)

As a follow-up to the previous quarterly report, upon review of the clinical records for TP7TL, it was noted that the records were not within the last 12 months. The contractor was asked to provide a rationale for this and explained that they have not been providing NHS GOS services for more than a year. The contractor confirmed their intention to terminate the NHS GOS contract and instead continue providing dispensing services only. The termination process has been completed.

**Contractual Concerns:**

In the previous quarter, concerns were raised regarding a provider operating across multiple ICB areas.

The Optometry Contracting Team remains in active discussion with colleagues in the host region and are currently awaiting the findings from their investigation. Once these findings are known, it will be the responsibility of each ICB to review the outcomes and determine the appropriate course of action. ICBs will be updated in due course.

**Recommendation(s) and Next Steps:**

The Committee are to:

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

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Norfolk and Waveney Integrated Care System

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

## M10 2025

Primary Care Commissioning Committee 11<sup>th</sup> March 2026

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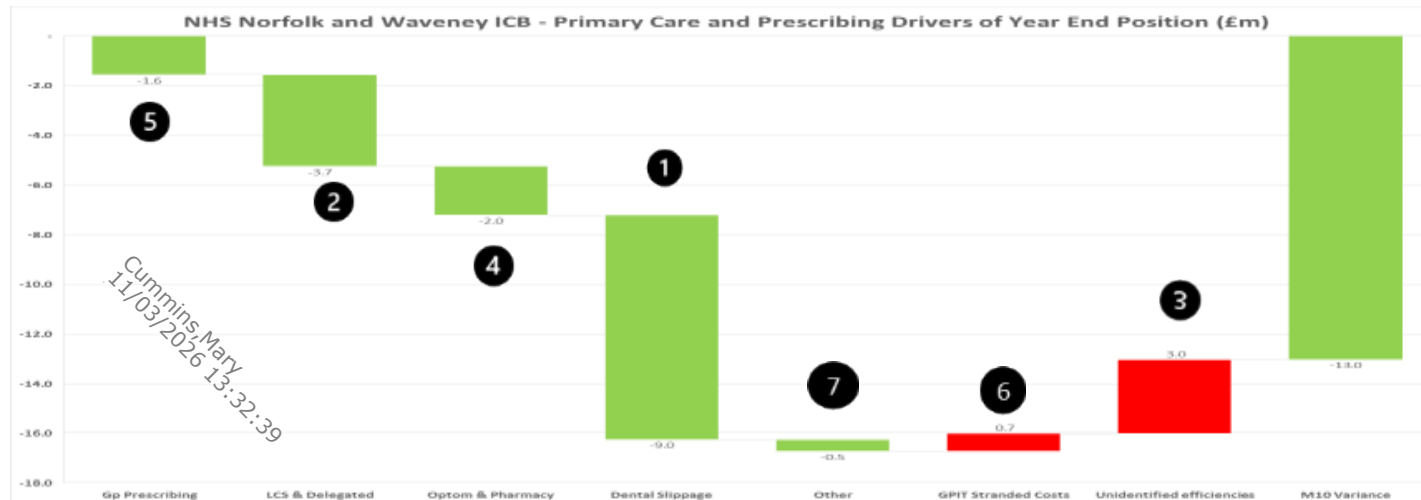
# 1.0 Executive summary – Reporting

**Reported Financial Position:** As of January (M10), the Primary Care & Prescribing reported position is £13m underspent due to underspends in Dental, GP Prescribing, LCS, Delegated PC, Optometry 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	630.6	518.0	505.7	(12.4)	617.5	(13.0)

## Variations:

The key operational variations are shown below:



The areas with significant variances are as follows.

- Dental is underspent because of potential activity claw back based on latest activity data. ①
- 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-Q3 for LCS. In addition, there are some allocation benefits for new schemes in 25/26 ②
- 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 ③
- 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 ④
- GP prescribing is under plan due to exceptional benefits to the ICB's financial position compared to previous years in Cat M & NCSO. ⑤
- 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. 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 being currently captured on 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 M10

Sub-Directorate (£m)	Full Year Variance (underspend) / overspend	Variance – significant items
GP Prescribing Budget £208	£(3.05) -1.5%	Year To Date Efficiencies delivered and exceptional year on year Cat M & NCSO benefits
Other Prescribing costs Budget £20	£1.47 7.2%	Increasing Mental Health Drugs costs and Weight Loss drugs both outside of FP10 transactions are leading to overspend.
Delegated Primary Care Budget £253	£(2.97) -1.2%	GP Procurement Savings (captured as efficiencies) and allocation benefits in new schemes for 25/26
Local Enhanced Services(LES) Budget £20	£(0.72) -3.5%	Q1-Q3 underspent on schemes creating an operational variance, needs to be monitored to see if spend increases in subsequent quarters.
Other Primary Care Incl GPIT Budget £13	£0.25 1.9%	GPIT Stranded costs less Other PC benefits
Dental Budget £72	£(9.04) -12.5%	Undersped due to estimated 25/26 clawbacks due to lower dental activity
Optom Budget £12	£(0.14) -1.1%	Small operational variance due to reduced activity in sight tests
Pharmacy Budget £33	£(1.8) -5.5%	CPCF Underspend, 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>£631</b>	<b>£(13.0)</b>

# 3. ICB Financial Position M10

Directorate Full Year Budget (£m)		Full year Variance (underspend) / overspend	Variance – significant items
Acute		£8.17	Sustainable commissioning QIPP
Budget	£1,445	0.6%	
Spec Comm		£(0.00)	On Plan
Budget	£225	0.0%	
Community and Better Care Fund (BCF)		£10.07	Sustainable commissioning QIPP
Budget	£258	3.9%	
Continuing Healthcare		£(4.11)	Patient levels and referrals have remained stable . Current efficiency plans, including new stretch commitment, are on target to deliver creating positive
Budget	£168	-2.5%	
Mental Health		£5.56	Sustainable commissioning QIPP
Budget	£335	1.7%	
Prescribing		£(1.58)	Cat M & NCSO benefits
Budget	£229	-0.7%	
Primary Care		£(11.46)	Procurement and Allocation benefits offset by GPIT Stranded costs
Budget	£402	-2.9%	
Other - Combined areas		£(3.01)	Sustainable commissioning QIPP
Budget	£26	-11.6%	
Planning		£(3.66)	Sustainable commissioning QIPP in above areas partially offset
Budget	£2	-146.6%	
Running Costs		£0.02	On Plan
Budget	£28	0.1%	
<b>Total</b>	<b>£3,118</b>	<b>£(0.00)</b>	

## 4.0 Prescribing Efficiencies M10

Prescribing Efficiencies Top Performing by value Budget (£000's)		Forecast (£000's)	Var (£000's) Fav (Adv)	Variance – significant items
OptimiseRx Budget	£2,100	£2,751	£651 31.0%	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	£2,495	£995 66.3%	Increased Savings than plan
Other Switches Budget	£1,250	£917	£(333) -26.6%	Savings lower than expected
Oral Nutritional Supplements Budget	£750	£217	£(533) -71.1%	Lower than plan
Deprescribing SMRs Budget	£750	£750	£0 0.0%	On Plan
Patent expirations Budget	£660	£812	£152 23.0%	Increased savings than plan
Sitagliptin Switch Budget	£600	£388	£(212) -35.3%	Lower than plan
Dressings Budget	£500	£0	£(500) -100.0%	On going Investigation, but overall Efficiency target of £14m met
Other Efficiencies Budget	£2,655	£2,020	£(635) -23.9%	Decreased savings than plan
<b>Sub-Total</b>	<b>£12,415</b>	<b>£12,049</b>	<b>£(366)</b>	
Dapagliflozin savings Budget	£1,585	£1,951	£366.00 23.1%	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	316,572	83.0%	Forecast based on Q3 submissions plus estimates for missing /rejected claims &Q4 budgets
Diabetes	655,787	569,770	86.9%	Forecast based on Q3 submissions plus estimates for missing /rejected claims &Q4 budgets
Eating Disorders	183,469	129,040	70.3%	Forecast based on Q3 submissions plus estimates for missing /rejected claims &Q4 budgets
Inclusion Health	428,280	265,958	62.1%	Forecast based on Q3 submissions plus estimates for missing /rejected claims &Q4 budgets
Mental Health SMI Health Checks	313,490	243,375	77.6%	Forecast based on Q3 submissions plus estimates for missing /rejected claims &Q4 budgets
Phlebotomy	6,597,102	6,407,959	97.1%	Forecast based on Q3 submissions plus estimates for missing /rejected claims &Q4 budgets
Proactive Healthcare	4,180,234	4,169,833	99.8%	Forecast based on Q3 submissions plus estimates for missing /rejected claims &Q4 budgets
PSA	476,468	497,860	104.5%	Forecast based on Q3 submissions plus estimates for missing /rejected claims &Q4 budgets
Shared Care	1,486,348	1,430,241	96.2%	Forecast based on Q3 submissions plus estimates for missing /rejected claims &Q4 budgets
Spirometry	453,256	400,947	88.5%	Forecast based on Q3 submissions plus estimates for missing /rejected claims &Q4 budgets
Treatment Room	4,005,914	3,855,436	96.2%	Forecast based on Q3 submissions plus estimates for missing /rejected claims &Q4 budgets
Warfarin	587,411	514,306	87.6%	Forecast based on Q3 submissions plus estimates for missing /rejected claims &Q4 budgets
MGUS	180,000	172,103	95.6%	Forecast based on Q3 submissions plus estimates for missing /rejected claims &Q4 budgets
Henoch-Schönlein purpura (HSP)	20,000	11,042	55%	Forecast based on Q3 submissions plus estimates for missing /rejected claims &Q4 budgets
<b>Total</b>	<b>19,948,986</b>	<b>18,984,444</b>	<b>95%</b>	

- Please note the separate paper & review on Locally Commissioned Services this month detailing a holistic review of the claims & activity made to date.

# Appendix A – Detailed Financial Position

Norfolk and Waveney ICB		N&W ICB Annual Budget	N&W ICB Position at Month 10 £000s			N&W ICB Forecast £000s	
Service Line	Description		Budget	Actual	Variance	Forecast	FOT Variance
Prescribing	Central Drugs	6,171,637	5,100,141	5,183,425	83,283	6,254,920	83,282
	GP Prescribing	208,224,822	171,096,830	171,096,878	48	205,174,891	(3,049,931)
	Medicines Management - Clinical	3,033,285	2,437,214	2,454,536	17,322	3,037,335	4,050
	Other Prescribing	7,170,253	5,652,100	7,381,942	1,729,842	8,813,256	1,643,003
	Oxygen	2,788,684	2,264,250	2,080,897	(183,353)	2,531,897	(256,787)
	Prescribing Incentives	1,318,877	0	0	0	1,318,877	0
<b>Prescribing Total</b>		<b>228,707,558</b>	<b>186,550,535</b>	<b>188,197,677</b>	<b>1,647,141</b>	<b>227,131,175</b>	<b>(1,576,383)</b>
Primary Care	Community Dental	3,607,334	3,006,110	2,839,097	(167,013)	3,400,643	(206,691)
	DOP Delegated pay	240,808	190,269	171,928	(18,340)	218,648	(22,160)
	GP Forward View	1,383,263	550,332	550,333	1	1,383,264	0
	Local Enhanced Services	20,349,304	16,714,898	16,077,380	(637,518)	19,632,786	(716,518)
	Optom	11,903,391	9,849,788	9,713,942	(135,846)	11,767,748	(135,642)
	Other Primary Care	4,426,497	3,408,589	2,993,018	(415,571)	3,948,048	(478,449)
	Pharmacy	33,436,252	25,354,103	24,104,030	(1,250,073)	31,612,219	(1,824,033)
	PMS to GMS Transition	0	0	0	0	0	0
	Primary Care Delegated Co-Commissioning	253,471,576	211,412,122	206,754,582	(4,657,541)	250,505,334	(2,966,243)
	Primary Care IT	7,437,620	6,280,351	6,578,866	298,515	8,169,366	731,746
	Primary Dental	53,195,009	44,321,422	34,885,391	(9,436,031)	44,385,171	(8,809,837)
	Secondary Dental	15,360,016	12,800,013	12,800,013	(0)	15,361,031	1,015
	Sustainable Commissioning QIPP	(2,964,849)	(2,404,691)	0	2,404,691	0	2,964,849
	Unidentified efficiencies	0	0	0	0	0	0
<b>Primary Care Total</b>		<b>401,846,220</b>	<b>331,483,307</b>	<b>317,468,580</b>	<b>(14,014,727)</b>	<b>390,384,257</b>	<b>(11,461,963)</b>
<b>Prescribing &amp; Primary Care Total</b>		<b>630,553,779</b>	<b>518,033,843</b>	<b>505,666,257</b>	<b>(12,367,586)</b>	<b>617,515,432</b>	<b>(13,038,347)</b>

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