June 2025 Committee Meeting

Date: 11/06/2025
Venue: Suite 6, Barlow House, Minshull Street, Manchester, M1 3DZ
Time: 9.15am – 4.30pm

Attendance

Committee member	Initials
Asif Adam	AA
Mohammed Anwar	MoA
Saghir Ahmed	SA
Ali Dalal	AD
Wesley Jones	Apologies (WJ)
Ifti Khan	Apologies (IK)
Aneet Kapoor	AKa*
Abdenour Khalfaoui	AKh
Fin McCaul	FMc
Mohamed Patel	MoP
Ian Strachan	IS
Elliott Patrick	EP

Joined virtually*

Team member	Initials
Janice Perkins (Exec Chair)	JP
Louise Gatley	LG
Luvjit Kandula	LK
Adrian Kuznicki	AKu
Rikki Smeeton	RS
Karishma Visram	KV

Welcome, introductions and apologies

Apologies received from IK, and WJ. AKa has joined virtually.

Minutes from April meeting were shared and approved.

Action Log Updates

IK has provided an email update on Action 14 regarding the Cohesion Menopause app LK to follow up to obtain GM's position on this.

PNA Update

No questions or issues regarding the PNA update.

Contraception Update

Update provided by LG* around re-purposing local authority monies.

It was agreed to setup a new dedicated steering group on a smaller scale. The group will report back to the main group if relevant.

LG will finalise setting up the group and initiate the first meeting.

CPGM Connect

Update provided by RS.

Purpose re-visited; creating a network of pharmacy ambassadors to use as a sounding board for feedback on specific topics.

The CPGM scoping meeting, outlined the following:

- People
- Operations
- Governance
- Finance
- Comms Plan

Goal is two F2F events a year around Nov/Dec and April/May. It is proposed to have a minimum of 8-10 contractors (1 per locality ideally) with a couple of the CPGM team/committee members supporting.

The content of the events will be a mixture of topics that are of importance to contractors and to CPGM. A good skill mix is essential i.e. pharmacists, technicians and support staff.

The planned comms was outlined including clear objectives, themes, content and expectations.

The planned governance and finance were discussed. An EOI selection process will be completed for each event to provide equal and fair opportunity for everyone to participate. The terms of reference will reflect this, identifying clearly what can be expected from the forums and what not to expect.

Travel time, parking and travel expenses will be paid on production of receipts. Clinician time will be paid for 8 hours. Pharmacist @ £30/hour and Pharmacy Technicians @ £15/hour.

Actions:

- Maximum costings to be re-calculated to reflect the fee change for registrant attendees.
- LK to ask other voting members of CPPB members to approve the new funding.
- KV to add a disclaimer about CPPB funding to all promo materials

Market Entry Update

Update provided by AKu.

Summary of recent volume of applications throughout past three months.

AKu highlighted the recent announcement that no new DSP applications would be allowed from the end of June. The CPGM Market entry subgroup expects an increased number of applications in the coming weeks/months as there may be a delay in them being processed by the NHS.

IP Pathfinder

Update provided by AS.

Context outlined about the programme which includes the clinical pathways, funding, operational feasibility and IT & digital considerations

The pathfinder programme is nationally funded with no cost to GM.

Role of independent prescribers in the NHS was already established and already delivering services for patients. CPGM involved throughout and supporting.

Ten IP pathfinder sites due to the size of GM. Nine of the ten sites are using GMCR to access patient medical records.

Three clinical models are being currently tested, MAS, Respiratory and Hypertension. AS will share further data and some updated slides.

Full go live is anticipated to be July 2025. CHL will be working on the PharmOutcomes modules.

The list of sites and a map was shared. PharmOutcomes data is now becoming available including access to the full consultation notes and drugs prescribed. CLEO solo data isn't currently available. This is all work in progress and AS is open to feedback and will build reports based on this.

Minor Ailments:

Monthly PharmOutcomes data for was including daily variations. Most patients accessed the service on Tuesdays and Wednesdays, with the average length of consultations lasting approximately 20 minutes. Consultation times should decrease once the IT systems are put in place and will be able to solve some of the issues and pressures.

Other patient data is available including age with the highest number of patients accessing the service aged 50+. A good spread of patients across all age groups including children was noted.

Respiratory:

Limited data available and more patients are required to build an accurate status report.

Hypertension:

This model isn't live yet.

Patient feedback and satisfaction ratings have been excellent so far.

Some challenges have been reported around difficulty in engaging local GP practices and wider patient awareness of the IP Pathfinder service still remains low.

It was requested that the data available was mapped to the index of deprivation.

Each site has funding for 26 sessions per month, which they can utilise as they wish to meet patient need. Most sites are offering planned appointments however there are some adhoc interventions.

The technology in use is quite clunky so the note taking is being completed after the consultation has finished to save the patient time.

Other systems are being reviewed by the programme team to bridge the gap.

The IP Pathfinder programme is due to finish on 31st December so there will need to be a transition period for patients where a follow up consultation may be needed. Some elements of the service may therefore need to finish around end Oct/early Nov.

Finance Report

Update provided on Finance by MoA.

Summary of accounts and budgets discussed and outlined for 2025-26.

The accounts for 2024-25 will be reviewed by the Finance & People subgroup and will then need approval from the board.

LMC Engagement

Update provided by Alan Dow a GP on West Pennine LMC

Alan highlighted that there were still a number of concerns about the GP contract and that whilst the collective action was paused this may continue if these aren't addressed. It was recognised that primary care was much stronger working together. CPGM was seen as being in a strong position as a combination of all previous LPCs whereas LMCs are still operating separately.

LMC concerns:

Writing to the GP Record – GPs colleagues are concerned this is the beginning of unrestricted access for lifelong confidential records never previously seen. GPs are required to be available digitally via the NHS app from 8.00am – 6:30pm however when appointments are booked this way there is no visibility of the significance and seriousness of the symptoms.

BMA position – there is a fundamental problem that the NHS has historically under invested into primary care in all forms. We are in the centre of the list for average spend compared to other countries however we are top in terms of spend in secondary care. We need to invest in preventing ill-health rather than fixing it.

Stock availability - significant challenge for patients, GPs and pharmacy teams. The LMC would like pharmacists/pharmacy teams to suggest alternative products that are available and to be clear whether it's just they don't have it in stock or it's a wider issue. It's a complicated issue and GPs cannot amend prescriptions that have been initiated by consultants in secondary care under a shared care protocol.

A committee member commented that there were no safeguards in the system when returning prescriptions to the spine and that patient the patient journey needed to be smoother as pharmacy teams don't always have the time to ring round other pharmacies.

JP shared that there are a number of support systems now available and that CPGM are starting a piece of work to review these. This may be a practical way that contractors and GP colleagues can be supported by the ICB however it would require everyone to engage.

CPGM will share a reminder of the stock availability top tips with contractors.

Private supply of GLP1s – this is becoming a challenge as GPs are being requested to advise on use of contraceptives and also other drug interactions. This is not sustainable going forward.

Feedback was shared that a GM Task and Finish group has been set up although GPs do not appear to be involved. It's a complicated issue and national guidance has been delayed. Only 900 patients will be eligible for an NHS funded service and this has to be agreed by end July. Primary Care modelling is underway and there's a consultation underway with a 2-week window for responses.

Prevention – it's important that money is allocated to make this happen. Acute trusts need to operate at under 50% of the total budget and work needs to move to primary care. An example was given where Wythenshawe Hospital offers world class, pioneering heart surgery and treatment of acute/emergency issues whereas data shows the Wythenshawe community to have the highest rates of CVD in GM.

A committee member suggested there could be some trade- offs and some work undertaken by GPs could transfer to community pharmacy e.g. vaccinations. Whilst this could happen Alan felt that it was more important to focus on increasing the total funding for primary care rather than moving work between sectors. More than the current 6% is required and he felt the minimum should be at least 10%. The review and guidance fee is seen as derisory by many GPs however it can also be seen as a positive first step.

Neighbourhoods and primary care – LMC's role is critical and GP and pharmacy unity at a local level is essential.

Feedback from the committee:

Branded generics – a question was asked about the ongoing challenge around branded generics as this takes more time for the pharmacy team and the GP to resolve any issues.

ARRS – a questions was asked about funding for ARRS. Alan shared this varied hugely in approach from locality to locality as everywhere tries to balance resource and funding availability. Alan reiterated that the goal isn't to move things round in primary care and that there's a risk of other solutions being set up which are just hospitals by another name.

Comms to be shared with contractors to remind them, keep Alan posted with any work CPGM is undertaking. Happy to have Alan back to retain the dialogue.

LK is happy to feed any comments from Alan back to the system.

Actions:

- Reminder comms to be shared with contractors, keep Alan posted with any work CPGM is undertaking.

Appointment – CHL Director

Quick overview of CHL provided by MoP.

Mutual agreement to appoint AA to fill the vacancy as an LPC director of CHL.

NHS Reform

ICB form and purpose outlined, diagram provided by LK.

Awaiting further NHS England guidance. ICB core functions outlined and functional changes explained.

ICB focus will be population health management, epidemiology, strategic planning and commissioning.

ICB will retain and adapt functions like quality management, governance and operational processes. Certain functions will be transferred e.g. provider performance oversight, workforce planning.

Focus is now on the three shifts, analogue to digital, hospital to community, sickness to prevention. GM ICB needs to reduce operating costs by 39% therefore their functions will be more focused. Not all changes can be done this year and full national guidance is not yet available. An ICB transition board has been set up.

Organisational design draft is currently under development. Standardisation is key with the aim to do things once across GM.

The next steps were outlined for system engagement and the initial PCB statement around the transfer of functions was shared via a comprehensive slide-deck.

The board discussed the potential implications for CP and agreed it was important to agree a position so that LK could feed this into ICB discussions. There are significant opportunities as well as some risks. All matters for ratification will need to be brought to CPPB/CPGM for discussion and engagement.

It was agreed that the board needs to identify what CPGM/CPPB/CHL need to do to scale up and ensure readiness/capacity/resource to take up responsibilities in the potential areas that arise. Strategic leadership/representatives from CPPB and CHL to be agreed to support future discussions re; representation and presentations.

Actions:

- LK to develop a positional paper for the board
- JP to organise a strategy day for the board (July/Aug) via doodle poll

Live Well & neighbourhoods

ICB form and purpose outlined, diagram provided by LK.

GM Live Well, led by Mayor Andy Burnham, is a commitment to ensure great everyday support is available in every neighbourhood. This scheme includes people being connected to a wide variety of activities, support and information.

Four core delivery components.

- Live Well centres, spaces and offers
- A resilient VCFSE Eco-System
- An optimum neighbourhood model
- A culture of prevention

The next steps on Primary Care engagement were outlined and LK requested

- the total number of public health services provided and a breakdown by locality
- case studies that demonstrated the great work that CP is undertaking around healthy living

Information on the Bolton Healthy Living Pharmacy collaboration to be shared with LKas well as case studies completed during the pandemic.

Important to develop services to challenge and address health inequalities and address life expectancy concerns, inconsistent service availability and share innovative and best practice. CP may have patients referred however will also need a directory of service providers and partners that they can refer into or signpost to.

It was highlighted that CPGM need information about contractors' premises and also information about the workforce. Sharing of locality information is essential and the committee were reminded to complete the report form after every meeting. The list of locality leaders has been updated and shared with the committee.

A committee member highlighted that funding was still required for pay rises and to address constitutional standards e.g. waiting time. There's a huge demand on the system and massive day to day pressures in primary care which means more work needs to be offloaded and traded off. It was suggested there was a good case to say CP could do this work cheaper e.g. £2bn/year could be saved by CP doing the basics and to go in strongly on a national basis around vaccination opportunities.

LK updated the committee on the GM plan for vaccination which differs from the national plan.

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It was felt that the CPGM structure was a position of strength and we need to leverage the opportunity this creates. Engagement in other ICBs is variable and GM is ahead of the game as provider collaboratives are already established.

Actions:

- An estate survey to be drafted. CPGM teak to pick up off-line
- Share any NHS reform events or opportunities being offered within any locality
- Create a Doodle poll to find a mutual date for all attendees to attend an NHS Reform/Live Well strategy day during the summer period.
- Develop a comms and engagement plan for contractors and MPs

CPE Report

The full committee last met in London on 30th April and 1st May 2025.

Implementation support focusing on driving actions, supporting delivery and monitoring progress. Margin explainer has been developed as a mechanism to explain the funding matters.

Progress in the area of services & PQS, including work to draft updates to service documentation. The majority of PQS guidance and resources has been published in a relatively short space of time. CPE led on the development of the PQS clinical audit paperwork, which will be released soon as possible so pharmacy owners can begin to prepare for the September start date.

Regulatory matters outlined – no new DSP applications after 23rd June 2025. Ongoing conversations at CPE to clearly define what constitutes a DSP. Great feedback so far from dedicated drop-in sessions for DSPs. Question of how we can support DSPs in delivering the services remotely to their patients. Briefing completed targeting DSPs only, highlighting changes and what they can and cannot do, will be released within the next few weeks. LG and RS highlighted the high number of dedicated calls to DSPs around bundling.

Looking ahead, continuing to focus on 10-year plan and spending review which is being prepared. Committee members discussed the tactics and approaches that may be beneficial in helping to further leverage CP's position.

Still ongoing support available for pharmacy owners in terms of helping them to understand the settlement. Engaging with pharmacy owners – importance highlighted on pharmacy 2025 pressures survey, continue to encourage further engagement.

Economic projects discussed, three workstreams initiated:

- Future of sector

- Evaluation of retained margin
- Evaluation of contracting and funding models

Some work completed on branded generics analysis. An analysis of prescription data on branded generics has been conducted to assess the scale of the problem and consider potential solutions.

18th June the first annual meeting of the forum of LPC chairs at the Houses of Parliament.

The 2025/26 Levy information has been published in the LPC Members area of the CPE website. Services team continues to publish services registrations data in the LPC Members area.

The CPE conference of LPC representatives is due to take place on Tuesday 25th November. It was agreed that that the three CPE representatives would attend to represent the CPGM committee alongside LK, LG, RS & JP.

Supporting Contractors

Update provided by KV.

Examples of briefings and publications provided from January 2025 were shared and it was noted that our newsletters had an average open rate of 95%.

24 drop-in sessions have also been provided to contractors over the last few months. This involved non-specific topic related, virtual-outcomes, PLO, DSPs, PQS regulatory changes and pharmacy technicians dedicated sessions. Engagement with these sessions is improving

The F2F pharmacy contraception service events were fully booked and the Patient Led Ordering webinar in conjunction with NHS GM was well attended. Numerous contractor support calls have been made focusing on bundling, PEM and PNA.

CPCF & PQS Plan

Update provided by RS.

Support provided to contractors regarding the new CPCF and regulatory changes to support the attainment of PQS domain criteria efficiently.

Full PQS and CPCF plan created and provided to contractors so all key information and guidance is in one place.

Lunch time and evening drop-in sessions are available to contractors or pharmacy owners focusing on some topic specific session and some general sessions to pick up on general queries and support.

WhatsApp polls have been created and provided on a more regular basis to increase and drive engagement amongst the CPGM WhatsApp community. This is an efficient way of testing demand for any promotional events or webinars.

Number of techs across GM, potential technician forum held by CPGM.

Positive feedback from committee regarding current approach by office team to contractors, to be maintained and continue targeting providing support for contractors.

PCARP Services

Overview of PCARP services by LG.

Service Working Group (SWG) held a strategy day to review the current workplan and priorities, noting it's the final year of programme funding. KPIs were developed with RAG ratings agreed for each service area. It was agreed to adopt a data-led approach now that performance information is becoming available.

Emphasis on delivering measurable outcomes to demonstrate return on investment. Defined a new KPI report with narrative to replace the checkpoint report. Objectives outlined for the services working group.

PCARP Data (based on 621 pharmacies)

600 pharmacies registered for PF (96%)

Hypertension 581 registered (94%)

Contraception 547 registered (88%)

80 pharmacies are not signed up for all 3 services, 28 of these are DSPs

14 of the 80 pharmacies are not signed up to any PCARP services including 5 DSPs, 2 x 100hour pharmacies plus 3 recent change of ownership

Next steps outlined; targeted calls for pharmacies, investigating reasons for non-participation and tailoring engagement based on pharmacy type.

Pharmacy First data comparing GM to other NW ICBs was shared. Data was also provided on Hypertension, Contraception. West Yorkshire appears to be performing really well for Contraception so it was suggested they were contacted to obtain some best practice around what is working well.

Challenges shown, changes to the number of ICBs over the next 12 months, may affect ranking of ICBs nationally. Low to no referrals from some general practices, ongoing work with the programme team to drive activity.

Challenges around AMR from GP. AMR data shared. GM is within lowest quartile for medicines supply which is great and within top % of ICBs.

AKu will identify which pharmacies need support with low PCARP engagement.

Data shown for pharmacies completing ABPM/clinic checks.

Action plan is being reviewed by SWG and will include follow up of feedback from GPs that some pharmacies do not have APBM machines. The data will be updated to reflect any pharmacies who rejected patients with high BP due to a lack of equipment. It was noted that this was also a patient safety risk.

Next steps for SWG:

- Continue with monthly data reviews
- Tracking of percentage conversion from clinical check to ABPM initiation, focusing on 0% conversion, then less than 5%, and less than 10%
- Beginning with monthly targeted mail merges, then advancing onto targeted calls
- CPGM supporting with monthly pharmacy visits

Future risks outlined. Programme team ending, leaving gaps in data & reporting, GP engagement, face-to-face engagement, complaint & issue resolution. Loss of the programme team to be added to the CPGM risk register and how it affects us going forwards.

Actions:

- Contraception data: understand and learn good practices from West Yorkshire
- AKu and LG to target low engaging pharmacies
- LG to confirm the best way to engage the multiple contractors
- Loss of Programme team to be added to CPGM Risk register and understand impact of this going forwards
- Programme team resource proposal to be provided by LK to September board meeting. LK to let it be known if assistance is needed with finalising this in time for September

Weight Management

Update provided by LK.

Initial funding in place but it is likely further funding will be provided.

LK will keep providing updates within future upcoming meetings with this.

Team Achievements

The reports from the team were noted and there were no questions

Future Agenda Items

Proposed agenda items:

- Update on NHS Reform (LK)
- Discussion on CPPB/CPGM ways of working (meeting outside of CPGM board)
- Social Media metrics (KV)

From 2026, it was agreed to hold our AGM in mid-July with a target date of July 8th so that information is shared with contractors sooner. JP also highlighted that the board meeting dates for 2026 would need reviewing and would be circulated to members with the minutes.

Meeting closed at 4.35pm