



# January 2026 Committee Meeting

Date: 21/01/2026

Venue: Suite 6 Barlow House, Minshull Street, M1 3DZ

Time: 9.30am – 4.30pm

## Attendance

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

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

## Guests:

Jainil Patel (JPa) and James Wood (JW)



## Welcome, apologies

Jainil Patel (contractor) was welcomed to the meeting as an observer.

James Wood, Director of Member and LPC Support at CPE attended for the morning session to share in our discussions.

FMc sent apologies and EP will join at lunch time.

A reminder of the CPGM Code of Conduct was shared and JP confirmed that JPa was aware of the governance that applied to Committee meetings. JP welcomed contributions from both guests as appropriate and reminded them that whilst the sessions were open there may be confidential information shared and no comments were attributable in line with CPGM policy. A summary of the meeting will be available on the CPGM website for contractors to read.

## Approval of Minutes

Minutes were shared for November the board meeting and the nomination issues meeting held on 5<sup>th</sup> January. Both sets of minutes were approved.

## Action Log

All actions are complete or in progress. A decision log is now in place to support with continuity of conversations. The same is also in place for PCB.

## Pharmacy Manifesto

Update provided by LK.

Version 7 currently worked on, final version will be finalised in the coming weeks.

A draft manifesto slide deck has been shared with Manisha Kumar to help inform decision making and this will be refined with stakeholders over the next few weeks.

Other assets to sit alongside the detailed narrative include a short 2/3page summary and an infographic for contractor engagement and social media.

Suggestions were shared around tightening the financial information and clarifying the local and national elements of the offer.

A communications and engagement strategy has been developed to build public, political and system awareness of the community pharmacy offer and asks.

The manifesto will be used to inform GM Commissioning intentions led by Katherine Sheeran. This will happen via PCB.

Other primary care providers are developing similar documents though not as a multi-angle manifesto.

It was suggested that Neighbourhood team integration should be mentioned. It would be helpful to show how much money community pharmacy has saved the NHS through a reduction in hospitalisations etc.

MPs need some stand out statistics to capture attention and prompt action locally and nationally.

LK to review which stats should be used in the infographic.

It was noted that NHS data was not ideal to provide such statistics, very transactional, difficult to prove that the statistics made a tangible difference.

LK highlighted some of the key data from the paper itself about walk-ins. Data to go into the executive summary, need paper to be confirmed before collating the executive summary together. Once finalised it will be reviewed by a number of committee members and Jainil.

Key areas to include are how community pharmacy is involved in

- Keeping people in work
- Prevention
- Reducing no. of days of illness
- Core20PLUS5 and support for those in deprived communities across GM.

We're embedded into all communities with pharmacy being within 20 minutes of each patient in GM. It was agreed some storytelling to bring the statistics and data to life would be valuable.

Low engagement achieved on the NHS 10-year plan survey; to be redistributed again.

Sequencing, what are we doing in what order, what stakeholders are and how we influence them.

Drive national service delivery; bring in new services. Survey to be recirculated but low engagement. More effective approach to reach out to specific localities for some case study examples.

Finance stakeholders really important who hold the money and make final authorisation decisions.

### Actions:

- LK to share manifesto with Nick Thayer (CCA), Saghir Ahmed (IPA), Mo Patel (Ind) and James Wood (CPE) for review and feedback by end of January.
- LK to review which stats should be used in the infographic.
- KV will export all data information from the manifesto to a separate document to highlight for contractors
- LK to create an explainer video, aiming to launch manifesto from mid-February onwards
- 3 versions of manifesto (LK & KV):
  - Storytelling/human interest version for the Mayor linked to Live Well
  - Finance version showing financial outcomes and deliverables
  - Exec Summary of the long narrative – NHS stakeholders
- AKu to redistribute NHS 10-year plan survey to contractors again to drive up engagement, liaise with LK.
- LK to collate examples of good practice for neighbourhood stories.

## Nomination Issues

Minutes were previously shared from the 5<sup>th</sup> January meeting.

Further update provided by LG.

Contractor feedback received over the last few weeks. Overall, prescription nomination issues has improved. Affected contractors are seeking assurance that there will be accountability and consequences, rather than the issue simply being resolved without explanation.

Some answers received regarding patient safety incidents, in general very few reports have been submitted via LFPSE – further work required with contractors around using LFPSE.

LFPSE – doesn't have a patient nomination issue category, so may have been reported and not be visible in the data. It would require someone to check the free text. Request to be sent to NHS GM to review this as CPGM can't access these reports.

Conclusion is that issues are still ongoing and CPGM and NHS GM will continue to work closely on this. CPE have escalated to NHS England and our evidence and data is being used to support a change to the terms of service.

Committee suggested that contractors should escalate the lack of action by the GPhC to the PSA.

### Actions:

- Highlight that LFPSE does not have a category to capture nomination issues
- Request NHS GM review LFPSE data for any reported patient safety nomination issues
- Pick up with Roy Blair regarding temporary suspension of smartcards and how the process works for removal of suspension
- Escalate regulatory concerns to the PSA

## Managing Levy Expectations

JW slides will be shared after the meeting.

Income from CPE exclusively raised from pharmacy owners via a levy on LPCs in England.

The levy is apportioned according to the % share of total NHS income available to pharmacy owners in each LPC area.

Before it was different, based on shared of items, now focused on total of income which includes any national and local services included in FP34. This is the fair share model that was signed off by the CPE Committee and approved at the LPC Conference.

Proposals for 2026/27 outlined.

Calculations outlined. The latest 12 months' available pharmacy owner income data (using drug and appliance reimbursement plus fees and service income from contractors' FP34 data).

LPCs are responsible for agreeing their own budgets and setting levy, although they are required to use a standard template, publish and send copies to NHS ICBs.

Levy justification outlined. A new section on the CPE website describes the vision, strategy and objectives along with the plan for the year ahead and the Feb 2026 levy letter.

Reserves guidance changed in 2025 to provide more flexibility. This has been implemented by CPGM.

Questions outlined for clarity on what the increased levy paid to CPE is funding.

The recent Treasurer webinar was attended by MoA and LK. Advanced planning is crucial as is MP engagement so more notice would be helpful.

The value of LPCs was discussed. LPCs sometimes become the recipient of what NHS England is not doing as the contract is negotiated nationally leading to local system resistance. Implementation and embedding of services need to be separate and appropriately funded to ensure engagement and sustainability.

NHS 10year plan in GM is moving towards local & other funding streams that come through mayor so we need time and funding to engage and maximise the opportunity.

JW shared how the levy increase is being used to influence, create a vision and strategy for the sector, and develop strategy skills and capacity. This is manifested in numerous ways including consultancy projects. This is outlined in various CPE infographics which JW will share with JP. It was also noted that there's a cost to protecting the income we already have in place against a backdrop of significant financial pressure from the Treasury and DHSC.

IK highlighted the CPE should confirm that all LPCs have implemented the reserves policy and provide support if needed

CPGM will be discussing levy finance at the AGM so contractors have advance notice of future increases and can plan accordingly.

It was suggested that CPGM committee could discuss other ways of calculating the levy and feed into CPE noting there is no perfect way to do this that all contractors would be happy with.

The current system does mean large DSPs pay their fair share and was reviewed in 2022. This would need to be an agenda item at the Nov LPC Conference.

The committee were reminded that the Economic Review highlighted the overall funding challenges in the sector. There is £8bn debt spread over 9500 contractors. With inflation currently at 3.4% contractor pressure will continue to increase which is why a different model is needed. Whilst not an immediate priority all LPCs and CPE should be reviewing their reserves policy.

## Medicines Shortages

Issues discussed around price concessions for contractors.

The timing of when price concessions are released was discussed. LG to share the price concessions infographic with the committee. This is a complex issue with multiple competing factors.

It was agreed at least 5days notice is needed for contractors to claim effectively and minimise any financial losses.

Discussions about a potential paper to the system – this is the level of the current problem. To manage strategically it's critical to collate case studies to showcase financial impact and patient experience.

IPA modelling has indicated that rather than retained margin being £900m it should be £1.4m. It's believed access to margin has decreased and contractor experiences are negative and very concerning. Tinkering with the model will not solve this issue.

The concessions model was not designed for this level of medicines shortages it was set up as an emergency measure.

This is a key priority for CPE in their negotiations with DHSC and needs wider discussion at the CPE committee meeting.

### Actions:

- Remind contractors to report shortages via CPE webform
- LG to share the CPE price concessions infographic with the committee
- LG to draft a standard contractor statement to manage patient expectations and GP relationships
- CPGM to send communication to MPs to place pressure whilst it's a hot issue
- Add price concessions to the "Understanding the Basics" session at the CPGM Connect event on 8<sup>th</sup> February

## NHS Reform Structure

LK shared the updated NHS Chief Officer structure.

Discussions and outcomes shared from meeting with Manisha.

Before Christmas, the NHS GM board agreed to move into transitional arrangements to focus capacity on NHS Reform and other key priorities. This will ensure capacity is focused in the right areas between now and the end of financial year.

The ICB is now working on a new committee structure for April 2026. Future ICB governance arrangements are being shaped. Currently engagement is still via PCB.

Once stakeholder mapping exercise has been completed, should place focus on a lot of meetings that don't really bring value. CPGM needs to work on helping stakeholders understand that not attending all meetings, which would be impossible, does not mean we aren't engaged in the change agenda.

## Neighbourhoods

Update provided by LK.

Actions completed to date outlined.

Paper presented in June and December 2025. The GM Mayor has endorsed and recognised the value of PC inclusion in GM Live Well.

GM Live Well board and neighbourhood integration subgroup is now setup – PCB are now members. This is led by the Mayor.

GM Live Well was outlined and it was clarified that the prevention demonstrator is about testing what works. Population health intelligence will be used to identify cohorts though everyone needs to get smarter on how data is used, what the result is and its impact. There will be some money flowing through to primary care and we need to ensure community pharmacy gets its fair share. The Mayor wants to get an evidence base to secure additional government funding. This needs to include stories, backed up with data on impact and outcomes which is challenging to collate in community pharmacy. Anything we do will be visible nationally as GM is a trailblazer.

We need to define our neighbourhood offer and highlight the CPCF services as fundamental to prevention and care.

The challenge is around how we support local neighbourhood working and ensure attendance by the right people at the right meetings supported by the right governance.

A workshop may be needed to scope this out and also to update our stakeholder mapping.

CPGM Connect Forum attendees could potentially be involved, realities of what we can do, what's achievable and realistic.

We need to develop leadership capabilities in different pharmacies. Parallel thinking how we develop contractors' confidence as ultimately this will drive business.

### **Actions:**

- CPGM team to scope what we need to do to facilitate committee members having effective conversations
- LK to develop a leave piece for committee members and contractors
- JP set up a workshop outside of the committee meeting cycle

## **Services & Dashboard Development**

Update provided by LG and AKu.

Severe challenge outlined regarding advanced service data accessibility; new format introduced by NHSBSA without announcement. Some of the metrics we previously relied on as a result are no longer directly available or comparable.

AKu with support of Ali have been working on developing a new service dashboard that aligns with the updated data set.

AKu presented a demo of the currently working on service dashboard. Positive feedback. Some comments made regarding whether use of AI can assist with the dashboard.

It was raised that CPGM could be in the same situation again if NHSBSA decide to revert back their decision around data structure. It was suggested this might be avoided by using PowerBI or a SQL database rather than Excel.

It was also suggested that a conversation with PharmData may be beneficial as they may enhance their dashboard to meet CPGM needs.

CCA and CPE have also recently launched dashboards though again none fully meet our requirements.

### Actions:

- LG and AKu to scope all requirements and match all external databases to these
- LG and AKu to assess costs of developing what CPGM requires
- JP to take a recommendation to the Finance & People Group

## Programme Team Resource

Update provided by LK.

Progress update provided on CPGM discussion at strategy meeting in December 2025 as per paper and slide deck.

A new proposal was submitted and the board agreed funding and duration for the Programme Team role.

It was suggested there was an opportunity to do more social media activity and raise the profile of the valuable work being done.

The proposed transition plan for SWG transition plan was outlined with next steps.

### Actions:

- LK to update the title, job description and job requirements to reflect new ways of working
- LK to speak with the Programme Team members
- LK to seek further HR advice on the proposal

## Finance Report & Budget

Accounts and budgets for 2026–27 summarised and outlined by MoA.

The committee were asked to feed in any suggestions prior to the Finance and People subgroup meeting to discuss the detail. The final draft will be brought back to the full committee for approval.

### Actions:

- AKu to review and provide comments on elements of budget highlighted by MoA
- JP to feed in team requirements
- MoA to pursue office lease renewal
- MoA to look at 6+6 or 8+4 forecasting in 2026-27
- Revisit the reserves annually so the total retained always equals 6 months in line with the policy

## CPE Report

Update provided by IK.

Full Committee met in London on 19<sup>th</sup> and 20<sup>th</sup> November 2025.

Subcommittee updates were provided and a summary is available on the CPE website.

Key areas discussed at the CPE meeting included:

- Recent service changes
- Branded generics
- Reimbursement reforms
- LPC Conference
- Case for investment in the sector
- NHS Reform
- Negotiating principles
- Roadmap for next 3 – 10 years
- Funding gap
- Neighbourhood Health

## Team Achievements

CPGM team highlighted key achievements that the committee needed to be aware of.

LK highlighted the current challenge around lack of support for newly qualified IPs and the risk associated with the 10 pathfinder sites stopping on 31<sup>st</sup> March. This has been raised with Manisha Kumar.

## Obesity Bid

Update provided by LK.

The approach to the bid was summarised; understanding the health economic analysis on the cost and impact of obesity in GM. Re-imagining could create a new pan-GM model of care for obesity, involving 40+ people from across the system. It's been agreed that the new approach shouldn't overlap with NICE eligibility criteria

Outstanding issues to resolve:

- Meds optimisation governance support to write the PGD
- Resolution of the tariff pricing anomaly between PGD and FP10 supply
- Availability of CLEO – other systems may need to be considered to progress at pace
- Confirm availability of indemnity insurance

AKa suggested some innovative ways the pricing issue might be addressed and will support LK with this.

OPIP implementation group being set up. Money is limited so model may be impacted

Will know by end of January if the bid is successful and it will need to be deployed by 1s August.

### Actions:

- Set up a clinical reference group involving – WJ, LG, HR, LK, AKa
- Ascertain current baseline data to assess progress (LK)

## Chair update

Reminder about CPGM Connect Maximising NHS Income event on 8<sup>th</sup> February.

CPGM policies are being reviewed in line with the agreed governance process and will be recirculated for reading and sign off before the new financial year.

CPGM self- assessment is being updated along with the Finance Checklist.

Future meetings outlined and potential attendees.

### Actions:

- Invite Andy Burnham to a committee meetings/arrange additional off- site meeting (LK)

## Contingency

LK term as Chair of PCB ends August 2026. If CPGM want this extending to end March 2027 to align with the financial year end a letter will need sending to Tracey Vell (CEO)

### Actions:

- JP to discuss at the Finance and People Subgroup and get a decision

## Meeting closed at 4.30pm

