

Agenda

Place Based Primary Care Commissioning Committee

Date: 30 March 2026

Time: 3.30pm until 4.45pm

Venue: Microsoft Teams

Chair: Adrian Crook

Item No.	Time	Duration	Subject	Paper/ Verbal	For Approval/ Discussion/ Information	By Whom
1.	3.30 - 3.35	5 mins	Welcome, Apologies and Quoracy	Verbal	Information	Chair
2.			Declarations of Interest	Paper	Information	Chair
3.			Minutes of previous meeting held on 26 January 2026	Minutes	Approval	Chair
4.			Matters arising and update on actions	Actions	Discussion	Chair
5.			Public Questions	Verbal	Information	Chair
6.	3.35 – 3.40	5 mins	General Practice Leadership Collaborative Update	Verbal	Information	Mark Beesley
7.	3.40 – 3.50	5 mins	Primary Care Programme Highlight and Risk Report	Paper	Information	Zoe Alderson
8.	3.50 – 4.00	10 mins	APMS Reprourement	Paper	Information	Zoe Alderson
9.	4.00 – 4.10	10 mins	BeCCoR	Paper	Information	Zoe Alderson
10.	4.10 – 4.20	10 mins	GP Contract Changes for 2026/2027	Paper	Information	Zoe Alderson
11.	4.25 – 4.35	10 mins	Practice Learning Times	Paper	Information	Zoe Alderson
12.	4.35 – 4.40	5 mins	Finance Update	Verbal	Information	Simon O'Hare
13.	4.45		Any Other Business	Verbal	Information	Chair
			Date and time of next meeting: Monday 18 May 2026 at 3.30pm			

If you wish to attend this meeting, please contact the Bury Corporate Office: gmicb-bu.corporateoffice@nhs.net

If you would like to ask a question of the Bury Place Based Primary Care Commissioning Committee (PCCC) please submit it by **email to gmicb-bu.corporateoffice@nhs.net by no later than Friday, 27 March 2026 at 12 noon.**

Please note that due to the limited time we have, we cannot respond to public questions within the PCCC meeting. We will acknowledge all the questions we receive and will respond to them formally in writing within 20 days.

MEETING: Place Based Primary Care Commissioning Committee

ITEM NUMBER: 2

DATE: 30 March 2026

REPORT TITLE:	Declarations of Interest
REPORT AUTHOR:	
<p>EXECUTIVE SUMMARY:</p> <p>NHS GM has responsibilities in relation to declarations of interest as part of their governance arrangements (details of which can be found outlined in the NHS Greater Manchester Integrated Care Conflict of Interest Policy version 1.2).</p> <p>NHS GM (Bury Locality) therefore, has a requirement to keep, maintain and make available a register of declarations of interest for all employees and for a number of boards and committees.</p> <p>The Local Authority has statutory responsibilities detailed as part of Sections 29 to 31 of the Localism Act 2011 and the Relevant Authorities (Disclosable Pecuniary Interests) Regulations 2012. For other partners and providers, we understand that conflicts of interest are recorded locally and processed within their respective (employing) NHS and other organisations as part of their own governance and statutory arrangements too.</p> <p>Taking into consideration the above, a register of Interests has been included detailing Declaration of Interests for the Primary Care Commissioning Committee.</p> <p>In terms of agreed protocol, the Primary Care Commissioning Committee members should ensure that they declare any relevant interests as part of the Declaration of Interest Standing item on the meeting agenda or as soon as a potential conflict becomes apparent as part of meeting discussions.</p> <p>The specific management action required as a result of a conflict of interest being declared will be determined by the Chair of the Primary Care Commissioning Committee with an accurate record of the action being taken captured as part of the meeting minutes.</p> <p>There is a need for Primary Care Commissioning Committee members to ensure that any changes to their existing conflicts of interest are notified to NHS GM (Bury Locality) Corporate Office within 28 days of a change occurring to ensure that the Declarations of Interest register can be updated.</p>	

RECOMMENDATIONS:	<p>The Primary Care Commissioning Committee is asked to;</p> <ul style="list-style-type: none"> • Receive the latest Declarations of interest Register; • Consider whether there are any interests that may impact on the business to be transacted at the meeting on the 30 March 2026; and • Provide any further updates to existing Declarations of Interest within the Register. 			
OUTCOME REQUIRED <i>(Please Indicate)</i>	Approval <input type="checkbox"/>	Assurance <input type="checkbox"/>	Discussion <input checked="" type="checkbox"/>	Information <input type="checkbox"/>
CONSIDERATIONS				
<p>Please include a brief synopsis of any considerations or implications should be made aware of:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Risk implications; <input type="checkbox"/> Financial implications; <input type="checkbox"/> Clinical implications; <input type="checkbox"/> Impact on Inequalities; <input type="checkbox"/> Communication/Public Engagement; <input type="checkbox"/> Legal Implications; <input type="checkbox"/> Workforce Implications; 				

Committees and Sub-Committees

Place Based PCCC

Declaration of interest as per policy:
 - Declare in meetings where relevant
 - Not to be sent papers where conflicted
 - Not to be involved in any decision making where conflicted (which may then also involve the following action to be taken at a meeting)
 - Remaining present at the meeting but withdrawing from the discussion and voting capacity
 - Remaining present at the meeting and participating in the discussion but not involved in any voting capacity

Name	Current Position	Declared Interest- (Name of organisation and nature of business)	Type of Interest			Is the Interest direct or indirect?	Nature of Interest	Date of Interest		Comments		
			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests			From	To			
Voting Members												
Blandamer	Will	Deputy Place Based Lead & Executive Director Health and Adult Care	Ashton on Mersey Football Club Trafford			X	Direct	Chairman	2024	Present	As per policy - see details above (Y,Y,Y,Y,Y)	
			Manchester Football Association			X	Direct	Non Exec Director (Board Champion for	2018	Present		
			Francis House Hospice (Manchester)				Indirect	Spouse is a Registered Nurse	2024	Present		
			University Hospital of Wales				Indirect	Daughter is a Foundation Year 1 Doctor	2024	Present		
			Stockport NHS Trust				Indirect	Daughter is a Foundation Year 1 Doctor	2025	Present		
Crook	Adrian	Director of Adult Social Care and Community Services	Bolton Hospice			X	Direct	Trustee	Jul-05	Present	As per policy - see details above (Y,Y,Y,Y,Y)	
Jackson	Catherine	Associate Director of Nursing, Quality & Safeguarding	Northern Care Alliance				Indirect	Partner is a Director at the Northern Care Alliance	2019	Present	As per policy - see details above	
Alderson	Zoe	Head of Primary Care	None Declared					Nil Interest	Oct-23	Present	As per policy - see details above. (Y,Y,Y,Y,Y)	
Schofield	Rachele	Primary Care Manager	None Declared					Nil Interest	Oct-23	Present	As per policy - see details above. (Y,Y,Y,Y,Y)	
O'Hare	Simon	Locality Finance Lead	Simkat Shore Holdings LTD	X			Direct	Director	Apr-19	Present	As per policy - see details above. (Y,Y,Y,Y,Y)	
Ridsdale	Lynne	Chief Executive for Bury Council	Bury Council		X		Direct	Chief Executive	Mar-23	Present	As per policy - see details above (Y,Y,Y,Y,Y)	
Non Voting Members												
Beesley	Mark	Chief Officer	Bury GP Practices Limited	X			Direct	Chief Officer & Director	Jul-21	Present		
			Greater Manchester GP Federation	X			Direct	Director	Oct-21	Present		
Dalal	Ali	GLMPC Independent Contractor / Bury Locality Lead	Almaz Limited	X			Direct	Owens and operates Formans Chemist which trades from the following address: 12 Park Hill, Bury Old Road, Prestwich, M25 0FX	01/10/2011	Present	As per policy - see details above (Y,Y,Y,Y,Y)	
Hobday	Jon	Director of Public Health	None Declared					Nil Interest	Nov-23	Present	As per policy - see details above	
Passman	Ruth	Chair of Bury Healthwatch	None Declared					Nil Interest		Present	As per policy - see details above	
Craven	Wendy	Primary Care Provider Representative - Optometry	GM East Local Optical Committee		X		Direct	Vice Chair	2020	Present	As per policy - see details above. (Y,Y,Y,Y,Y)	
			Primary Eyecare Services Ltd	X			Direct	Clinical Performance Lead	2021	Present		
			Craven & Murray Opticians	X			Direct	Owner	2007	Present		
			Craven & Murray Opticians				Indirect	Husband - Lewis Craven Director	2007	Present		
In attendance												
Dr	Fines	Cathy	Associate Medical Director and Named GP	GP Federation	X			Direct	Practice is a member	2013	Present	Declaration of interest as per policy as detailed above (Y,Y,Y,Y,Y)
				Tower Family Health Care	X			Direct	Partner in a member practice in Bury Locality	2017	Present	
				Horizon Clinical Network	X			Direct	Practice is a member	2019	Present	
				Greater Manchester Foundation Trust				Indirect	Husband is employed		Present	
Dr	Patel	Kiran	Member of the Locality Board	Tower Family Health Care - Primary Care General Practice	X			Direct	GP Partner	Jul-18	Present	As per policy - see details above (Y,Y,Y,Y,Y)
				Bury GP Federation - Enhanced Primary Care Services	X			Direct	Medical Director	Apr-18	Present	
				Laserase Bolton - Provider of a range of cosmetic laser and injectable	X			Direct	Medical Director	1994	Present	
				Laserase Bolton - Provider of a range of cosmetic laser and injectable				Indirect	Spouse is a Shareholder	2012	Present	
				Tower Family Health Care - Primary Care General Practice				Indirect	Spouse is a Director	Jul-18	Present	
Waller	Shirley	Engagement Officer, Healthwatch Bury	Healthwatch Bury			X	Direct	Staff Member	July 2021	Present	Temp Attendee	
Poldkivi	Anneman	Acting Chief Officer, Healthwatch Bury	NCA Fairfield Hospital, Bury			X	Direct	Volunteer	Apr-20	Present	Temp Attendee	
			None Declared					Nil Interest		Present		

MEETING: Place Based Primary Care Commissioning Committee

ITEM NUMBER: 3

DATE: 30 March 2026

REPORT TITLE:	Minutes of the previous meeting held on 26 January 2026			
REPORT AUTHOR:				
<p>EXECUTIVE SUMMARY:</p> <p>The minutes of the Primary Care Commissioning Committee meeting in public held on 26 January 2026 are presented as an accurate reflection of the meeting, reflecting the discussion and any actions agreed.</p> <p>An action log of those actions captured at the meeting has been included for review and update.</p>				
RECOMMENDATIONS:	<ul style="list-style-type: none"> • Receive the minutes of the previous meeting held on 26 January 2026 as an accurate record of the meeting. • Review and update the actions recorded on the log accordingly. 			
OUTCOME REQUIRED <i>(Please Indicate)</i>	Approval <input checked="" type="checkbox"/>	Assurance <input type="checkbox"/>	Discussion <input type="checkbox"/>	Information <input type="checkbox"/>
CONSIDERATIONS				
<p>Please include a brief synopsis of any considerations or implications PCCC should be made aware of:</p> <p><input type="checkbox"/> Risk implications;</p> <p><input type="checkbox"/> Financial implications;</p> <p><input type="checkbox"/> Clinical implications;</p> <p><input type="checkbox"/> Impact on Inequalities;</p> <p><input type="checkbox"/> Communication/Public Engagement;</p> <p><input type="checkbox"/> Legal Implications;</p> <p><input type="checkbox"/> Workforce Implications;</p>				

Minutes

Place Based Primary Care Commissioning Committee

Date: 26 January 2026

Time: 3.30pm

Venue: Microsoft Teams

Title	Minutes of the Primary Care Commissioning Committee		
Author	Faith O'Brien		
Version	V 0.2		
Target Audience	Place Based Primary Care Commissioning Committee		
Date Created	26 January 2026		
Date of Issue	30 March 2026		
To be Agreed	30 March 2026		
Document Status (Draft/Final)	Final		
Description	Place Based PCCC		
Document History:			
Date	Version	Author	Notes
2 February 2026	v 0.1	Faith O'Brien	Draft minutes produced. Sent to Zoe Alderson for review and asked for any updates to be shared with the Chair.
3 February 2026	v 0.2	Zoe Alderson	Chair approved final minutes, with some small amendments from Zoe Alderson.
Approved:			Adrian Crook
Signature:		 Add name of Committee/Chair

Primary Care Commissioning Committee

MINUTES OF MEETING
<p>Place Based Primary Care Commissioning Committee Monday 26 January 2026 via Microsoft Teams Chair – Mr Adrian Crook</p>

ATTENDANCE

Members
<p>Voting Members: Adrian Crook, Director of Adult Services, Bury Council (Chair) Will Blandamer, Deputy Place Based Lead for NHS GM (Bury) Zoe Alderson, Head of Primary Care, NHS GM (Bury) Carolyn Trembath, Head of Quality, NHS GM (Bury) Simon O'Hare, Locality Finance Lead, NHS GM (Bury)</p> <p>Non-Voting Members: Dr Cathy Fines, Associate Medical Director for NHS GM (Bury) Rachele Schofield, Primary Care Lead, NHS GM (Bury) Jon Hobday, Director of Public Health, Bury Council (<i>Joined the meeting at 4pm</i>)</p>
Others in attendance
<p>Clare Toomey, Head of Operations, BARDOC Dr Zahid Chauhan OBE, Chief Executive, BARDOC Lorna Reilly, Executive Director of Contracting & Finance, BARDOC Katie Heslewood, Primary Care Manager, NHS GM (Bury) Faith O'Brien, Governance Support Officer, NHS GM (Bury) (minutes)</p>

MEETING NARRATIVE & OUTCOMES

1	Welcome, Apologies and Quoracy
1.1	<p>The Chair welcomed all to the meeting. Apologies were received from:</p> <ul style="list-style-type: none"> Lynne Ridsdale, Place Based Lead for NHS GM (Bury) Catherine Jackson, Associate Director for Nursing, Quality and Safeguarding, NHS GM (Bury) David Latham, Senior Programme Manager, NHS GM (Bury) Wendy Craven, Primary Care Provider Representative - Optometry Mark Beesley, Chair of Bury GP Board
1.2	<p>For the meeting to be quorate, there is a requirement for five individual voting members to be present. The meeting was declared as quorate.</p>
2	Declarations of Interest

2.1	The Chair reminded the Primary Care Commissioning Committee members of their obligation to declare any interest they may have on any issues arising from agenda items which might conflict with the business of the Place Based Primary Care Commissioning Committee.		
2.2	Declarations made by members of the Primary Care Commissioning Committee are listed in the Register of Interests which is presented under this agenda.		
2.3	Declarations of interest from today's meeting Will Blandamer noted an updated Declaration of Interest, relating to the employment of his daughter. The committee Declaration of Interest register is to be updated.		
ID	Type	The Primary Care Commissioning Committee:	Owner
D/01/01	Decision	Noted the register and declarations of interest.	

3	Minutes of The Last Meeting		
3.1	The minutes of the Place Based Primary Care Commissioning Committee meetings held on 24 November 2025 were agreed as a correct record.		
ID	Type	The Primary Care Commissioning Committee:	Owner
D/01/02	Decision	Agreed the minutes from the meeting held on 24 November 2025 as a correct record.	

4	Matters Arising and Update on Actions		
4.1	The action log was updated, and new actions recorded as shown on the action log.		
ID	Type	The Primary Care Commissioning Committee:	Owner
D/01/03	Decision	Noted the updates provided in relation to the Matters Arising.	
D/01/04	Decision	Noted the updates provided in relation to the Action Log.	

5	Public Questions		
5.1	There were no public questions submitted.		

6	General Practice Board Update		
6.1	Mark Beesley was not present at the meeting and so there was no update provided.		
ID	Type	The Primary Care Commissioning Committee:	Owner

7	Primary Care Highlight and Risk Report		
7.1	The committee noted the Primary Care Highlight and Risk report, presented by Zoe Alderson. Zoe advised that a number of key areas will be picked up as separate agenda items.		
7.2	Zoe did highlight the ongoing risks regarding self-referrals to community services.		
7.3	The committee was made aware that confirmation regarding PCN cover for Highbank had not yet been confirmed, despite repeated attempts.		
7.4	The Chair, Zoe, Will Blandamer and Dr Cathy Fines discussed the general practice strategy and the need for a potential refresh, and the importance of maintaining strategic focus amidst business-as-usual reporting.		

7.5	Carolyn Trembath highlighted the need to coordinate with the GM quality team regarding the Priory's move from hospital to care home designation, the Chair asked Carolyn to facilitate contact between the GM quality team and the Bury Primary Care Team.		
7.6	Will discussed the new Performance & Quality Committee and thanked Zoe for her work on this.		
ID	Type	The Primary Care Commissioning Committee:	Owner
D/01/05	Decision	Noted the report.	
D/01/06	Decision	Noted the risk log provided.	
A/01/01	Action	Carolyn Trembath to facilitate contact between GM Quality Team and Bury Primary Care Team regarding the Priory.	CT

8	Out Of Hours Contract Monitoring		
8.1	Dr Cathy Fines, in the absence of David Latham introduced colleagues Dr Zahid Chauhan OBE, Clare Toomey and Lorna Reilly from BARDOC to discuss Out of Hours contract monitoring.		
8.2	Clare summarised October and November activity, noting a significant increase in 111 calls, Clare also fed back the challenges with triage performance, workforce flexibility, and the impact of staff sickness and flu outbreaks, while maintaining acute patient care performance near targets.		
8.3	Dr Cathy Fines questioned the high volume of medication requests with Dr Chauhan explaining that most requests are for repeat prescriptions, attributing the issue to patient education and digital uptake, and describing ongoing efforts to use digital communication for behavioural change.		
8.4	Clare and Dr Chauhan described ongoing work to analyse practice level variation in out of hours usage, with governance processes in place to address high-intensity users and ensure feedback and safeguarding are monitored through regular audits and integrated governance structures.		
8.5	Will Blandamer discussed increased A&E referrals, with Dr Chauhan detailing internal audit processes, the impact of changing patient cohorts, and the need for better integration with community services; Zoe Alderson and Dr Chauhan agreed on the importance of triangulating data across services and improving pathway coordination.		
8.6	Rachele Schofield was requested to discuss with the GP Federation why BARDOC cannot currently book into winter schemes (Acute Respiratory Hub/Surge).		
8.7	The Chair thanked colleagues from BARDOC for attending and providing such detailed data. <i>Jon Hobday joined the meeting during this agenda item.</i>		
ID	Type	The Primary Care Commissioning Committee:	Owner
D/01/07	Decision	Noted the update provided.	
A/01/02	Action	Rachele Schofield to discuss with the GP Federation why BARDOC cannot currently book into winter schemes.	RS

9	Quarter 3 Contracting Report		
9.1	Rachele Schofield presented the Quarter 3 Contracting Report to the committee, at quarter 3 there are some practices within each neighbourhood meeting targets and others not. As reward payments depend on all practices achieving, it is essential to prevent year-end non-compliance and potential appeals. Practices have been asked to address this collectively through their established forums.		

9.2	Whilst overall progress is satisfactory, work will be undertaken to review the transactional indicators, which operate as a block without targets or reward payments. If practices are not delivering the activity they are funded for, assurance will be required about where patients are receiving these services. The Primary Care Team will follow up with practices reporting little or no activity and where there is genuinely no patient demand, this must be clearly evidenced.
9.3	Regarding the Respiratory Diagnostic Service, the PCCC's approval is required for short-term bridge funding. Spirometry has been agreed as the GM-wide standard. Rachele requested the group consent to provide bridge funding for the respiratory diagnostic service beyond 31 March 2026 to prevent service gaps and staff loss before BeCCoR contract arrangements are finalised.
9.4	Rachele advised the recommendation would be to roll over the Paediatric Phlebotomy contract with Rock for 2026-2027, including enhancements to referral criteria and shared care.
9.5	Improvements were reported in enhanced access utilisation and the transition to a new reporting system for minor surgery, noting the need for timely claims submission and ongoing provider engagement.
9.6	Whilst the committee were supportive of the commissioning recommendations for 2026/2027, the committee acknowledged that this would be subject to sufficient funding being received (specifically Paediatric Phlebotomy, Special Allocation Scheme and the Respiratory Diagnostic Service). Will Blandamer confirmed that he does not have the authority to approve these. Will advised that he escalate this report to those responsible for the post April budget.

ID	Type	The Primary Care Commissioning Committee:	Owner
D/01/08	Decision	Noted the report provided.	
A/01/03	Action	Will Blandamer to escalate the concerns regarding funding, post April 2026, for the commissioning recommendations specifically for Paediatric Phlebotomy, Special Allocation Scheme and the Respiratory Diagnostic Service.	WB

10	Bury LCS/ Beyond Core Contract Review (BeCCoR) 2026/2027		
10.1	Zoe Alderson described the implementation of phase 3 of the BeCCoR Contract 2026/207, from April 2026 and the introduction of six pillars covering local service delivery, medicines optimisation, transformation, urgent/elective care, health inequalities, and neighbourhood transformation.		
10.2	Two scenarios were presented to the PCCC, scenario one is dependant on GM securing additional funding and assuming contracting responsibility for pillars 2-6, while scenario two would maintain current arrangements with minor amendments. Both scenarios may result in underfunding of existing service delivery.		
10.3	The committee discussed several concerns regarding programme timings and associated funding which is to be formally raised with central GM colleagues on the committee's behalf by the Deputy Place based lead, Associate Director of Finance and Head of Primary Care. The Chair stressed the legal requirement for public consultation if services are to be stopped, and recommending continuation of current services if no concrete outputs are available from GM.		
10.4	Zoe raised concerns about the funding methodology and the risk of exacerbating health inequalities due to differences in how neighbourhood and PCN achievements are rewarded, and the potential for non-outcome-based funding in GM's plans.		

ID	Type	The Primary Care Commissioning Committee:	Owner
D/01/09	Decision	Noted the updates provided.	

A/01/04	Action	Concerns regarding programme timings and associated funding to be raised with central GM colleagues.	WB, SOH, ZA
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11 Workforce Strategy and Delivery Plan			
11.1	Katie Heslewood presented the Workforce Strategy and Delivery plan, Katie outlined the strategic priorities including strengthening recruitment and retention, expanding training and career development, enhancing leadership and succession planning, and supporting workforce wellbeing to address identified challenges.		
11.2	The delivery plan includes actions, responsibilities, and timelines across workforce intelligence, recruitment, learning, leadership, wellbeing, integration, digital transformation, and equality, diversity & inclusion.		
11.3	Katie emphasised the need for input from practices, PCNs, and the GP Federation. The importance of promoting Bury as an attractive place to work and live was also discussed by the group, leveraging existing research and communications resources, and addressing barriers such as the location of the medical school, in South Manchester. Jon Hobday offered to share narrative materials used for public health recruitment, and the Chair suggested preparing a comprehensive communications pack highlighting Bury's strengths.		
ID	Type	The Primary Care Commissioning Committee:	Owner
D/01/10	Decision	Noted the update provided.	

12 Finance Update			
12.1	Simon O'Hare provided a brief finance update, confirming that the main financial priority is to ensure Additional Roles Reimbursement Scheme (ARRS) funding is utilised appropriately to avoid overspending.		
ID	Type	The Primary Care Commissioning Committee:	Owner
D/01/11	Decision	Noted the update provided.	

13 Any Other Business			
13.1	Will Blandamer wished to thank Carolyn Trembath for her outstanding contribution to this committee over the years as Carolyn will be leaving NHS Greater Manchester.		
ID	Type	The Primary Care Commissioning Committee:	Owner

14 Date and time of next meeting			
15.1	Date and time of next meeting: Monday, 30 March 2025, 3.30pm – 4:45pm via Teams		

Place Based Primary Care Commissioning Committee

Status Rating



- In Progress



- Completed



- Not Yet Due



- Overdue

Date	Reference	Action	Lead	Status	Due Date	Update
24 November 2025	A/11/01	Future reporting should include NHS app benchmarking against other GM areas	Zoe Alderson/ Stephanie Farr		October 2026	Zoe Alderson reported following meetings with Stephanie from the BI team, no additional data requests for NHS app benchmarking will be supported due to NHS reforms; Zoe will revisit this in nine months.
24 November 2025	A/11/07	Meeting to be organised with lowest achieving practice under the remit of the Peer Ambassador programme	Zoe Alderson/Cathy Fines		March 2026	Dr Fines and Zoe Alderson have contacted the practice identified, but have struggled to receive a response. A more formal approach will likely be required going forward.
26 January 2026	A/01/01	Carolyn Trembath to facilitate contact between GM Quality Team and Bury Primary Care Team regarding the Priory.	Carolyn Trembath		March 2026	Carolyn Trembath has emailed the GM Quality Team and the Bury Primary Care Team.
26 January 2026	A/01/02	Rachele Schofield to discuss with the GP Federation why BARDOC cannot currently book into winter schemes.	Rachele Schofield		March 2026	Rachele Schofield reported that neither BARDOC or ED streaming can book appointments as the GP Federation cannot have two profiles on CAS. This has been flagged with GM for response/resolution.
26 January 2026	A/01/03	Will Blandamer to escalate the concerns regarding funding, post April 2026, for the commissioning recommendations specifically for Paediatric Phlebotomy, Special Allocation Scheme and the Respiratory Diagnostic Service.	Will Blandamer		March 2026	
26 January 2026	A/01/04	Concerns regarding programme timings and associated funding to be raised with central GM colleagues.	Will Blandamer, Simon O'Hare & Zoe Alderson		March 2026	

PROGRAMME HIGHLIGHT REPORT

Programme / Project:	Primary Care	SRO:	Mark Beesley as GPLC Chair	Lead:	Zoe Alderson	Month	March 2026	RAG Status¹:	
Key achievements / deliverables completed this period:					Key deliverables / milestones planned for next period:				
<p>Prog.1 - Alternative at Scale Solutions</p> <ul style="list-style-type: none"> Winter schemes continue to support practices and are well utilised, in place till 31 March 2026 <p>Prog.2 – Communications and Engagement</p> <ul style="list-style-type: none"> GM Portal – limited number of registrations of concern given this will be the main method of communication moving forward. We will continue to signpost people rather than repost articles where possibly to encourage sign up. <p>Prog.3 – Data and Digital Ambition</p> <ul style="list-style-type: none"> Continue to promote NHS App usage through PLO work. <p>Prog.4 – Effective Pathway Navigation</p> <ul style="list-style-type: none"> Risk - Community Services <ul style="list-style-type: none"> Self-referrals no further progress made No examples received where internal referrals had been requested or where A&G have advised a community services referral to be made which is subsequently rejected. <p>Prog.5 – Current and Future Estate</p> <ul style="list-style-type: none"> UMF schemes for both 25/26 and 26/27 continue to progress Successful visit to Radcliffe PCCC with the aim of seeking funding from CHP to convert unused rooms in support of PC clinical space <p>Prog.6 – Integration (Wider PC/Neighbourhoods/PSR)</p> <ul style="list-style-type: none"> Neighbourhood data packs discussed, further considerations needed as to how these are used. Patient-led ordering on set to go live in Whitefield practices 1st April. Comms & engagement with Whitefield community pharmacies complete. <p>Prog.7 – Quality and Assurance</p> <ul style="list-style-type: none"> Quality Visits – Outstanding action plans from Fairfax, Longfield and Greyland PCN DES: <ul style="list-style-type: none"> Q3 assurance return received only from Horizon (deadline was 13th Feb) ARRS 24/25: Bury PCN March 24 claims outstanding finance ratification and payment ARRS 25/26: All PCNs submitted claims to October 25 for ratification and payment: <ul style="list-style-type: none"> Bury PCN will be paid for first 6 months of 2526 HPW PCN Claims paid to August 26 Enhanced Access data received up January for HPW and December for Bury PCN Confirmation received that Bury PCN will cover Highbank Care Home Bury LCS <ul style="list-style-type: none"> Additional requested PCN/MOT meetings completed –quarterly data sets due March (continued significant improvements made with AMS targets). Another round of reminders for GM AMS & locality submissions LTI/PLT changes discussed with GP Board in February however, group did not support. Feedback given to DMOG reflecting this <p>Prog. 8 – System Leadership</p> <ul style="list-style-type: none"> Awaiting outcome of GM discussions regarding which scenario will be implemented and feedback regarding Pillar 1 funding value. <p>Prog.9 – Workforce (recruitment/development and retention)</p> <ul style="list-style-type: none"> Draft strategy and delivery plan shared with PCN CDs / INT GP Leads for feedback 					<p>Prog.1 - Alternative at Scale Solutions</p> <ul style="list-style-type: none"> GM have approved QAS PSR which is now with Sam Evans for final approval before contracts can be issued GM have approved Bury LCS PSR which is now with Sam Evans for final approval before contracts can be issued Paediatric Phlebotomy – Current provider issued notice on 25/26 contract in December 2025. Awaiting decision re 26/27 funding before STAR/PSR progresses SAS – 25/26 PSR form to be submitted once STAR form approved. QAS – awaiting BeCCoR outcome in order to consider 26/27 requirements <p>Prog.2 – Communications and Engagement</p> <ul style="list-style-type: none"> Sharepoint – We will work to reduce the level of information on Sharepoint in order to reduce duplication, signposting to the portal where possible. MO sharepoint reviewed to ensure Bury specific messages/information only – all other comms via the primary care portal. <p>Prog.3 – Data and Digital Ambition</p> <ul style="list-style-type: none"> Practices to be asked to support amendment to DSA for EMIS Enterprise access to include NHS Health Checks data Primary Care access deep dive at the next Quality and Performance meeting <p>Prog.4 – Effective Pathway Navigation</p> <ul style="list-style-type: none"> Community Self referral – audit to commence. Evidence from practices will be needed to support any change. <p>Prog.5 – Current and Future Estate</p> <ul style="list-style-type: none"> Ongoing discussions with various practices re UMF schemes for both 25/26 and 26/27 <p>Prog.6 – Integration (Wider PC/Neighbourhoods/PSR)</p> <ul style="list-style-type: none"> Continue PLO roll-out in Whitefield. Engagement & plan for roll out in Bury East (WR & Knowsley) <p>Prog.7 – Quality and Assurance</p> <ul style="list-style-type: none"> Bury LCS 25/26 <ul style="list-style-type: none"> LTI/PLT changes to be discussed with PCCC in March PCN DES <ul style="list-style-type: none"> Enhanced Access - Conversations on going re utilisation with all PCNS with action plans in place (attendance at Bury PCN Board in January did not take place at request of Chair, awaiting an alternate date) 26/27 PCQV format to be discussed/planned ARRS 25/26 <ul style="list-style-type: none"> WTE ratification taking place across March to ensure information tallies with information held in Finance Team Bury PCN - Evidence requested to support claims made across 2526, outstanding payments will be made upon submission of that evidence HPW PCN - Further evidence requested to support claims made from Sept 25 onwards before payments can be made <p>Prog. 8 – System Leadership</p> <ul style="list-style-type: none"> Bury LCS/BeCCoR 26/27 - Locality discussions will commence on receipt of communications from GM Review General Practice Strategy and delivery programmes in the context of the new Operating Model (paused during consultation period) <p>Prog.9 – Workforce (recruitment/development and retention)</p> <ul style="list-style-type: none"> Workforce Strategy: <ul style="list-style-type: none"> Test of change – confirm with identified practice participation in improvement project and start date Workforce experience survey to be shared 				

Priorities / Projects / Workstreams:			
Programme	Project	Key milestones / deliverables completed this period against plan	RAG Status ¹
Prog.1 - Alternative at Scale Solutions	Integration of Paediatric Phlebotomy Service	25/26 contact monitoring	
		Side issue regarding bloods required by other providers e.g. Discussions taking place with PCFT re solution moving forward	
		For 26/27 it has been agreed that a small number of changes will be made with the existing service specification and the same provider commissioned, with the view that a wider GM approach will then be considered at a later date	
	Winter Resilience	Analysis of data currently being undertaken (DNA and triangulation of utilisation)	
	Respiratory Diagnostic Service	Discussions ongoing with GM regarding future commissioning/funding model – potential to fund from additional GM funding	

Programme / Project Highlight Report

		RDS has been varied into the Bury LCS 2526 contract however, the PSR has been approved by GM but is at final sign off stage with Sam Evans before contract can be issued	
	Minor Surgery	STAR form in train (sent to GM but awaiting confirmation of approval) CQRS Local – need to establish a GM position regarding claiming process to ensure consistency	
	Special Allocation Scheme	26/27 STAR and PSR to be completed to continue with same provider SAS – Quarterly contract meetings taking place with a view to reducing numbers Wider discussions needed about future GM plans – not progressed due to capacity in GM, continuing with local model at present STAR form submitted 25/26 (awaiting confirmation)	
Prog.2 – Communications and Engagement	Routine Comms and Engagement	Topics for webinars planned and sessions facilitated	
	Future Comms and Engagement	Reduce sharepoint content following go live of GM portal	
	Patient Feedback	Ensure contractual compliance with Friends and Family Test process	
	Champion Programmes	Continue to promote and increase sign up to various champion programmes	
Prog.3 – Data and Digital Ambition	Reducing Unwarranted Variation	Data and progress continue to be reviewed Outstanding action plans from Fairfax (disputing data), Longfield and Greyland	
	Maximising QoF Achievement	No Practices responded to outreach for support or to offer support QoF data only available as at May 2025	
Prog.4 – Effective Pathway Navigation	Utilising Wider Providers	Continue to monitor adoption and uptake of Pharmacy First options and raise with those not using it	
	Recovering Access	Increased number of self-referral options for patients within Community Services	
Prog.5 – Current and Future Estate	New Developments	Ongoing development meetings regarding Whitefield Health Centre	
	PCN Toolkit Implementation	Utilisation and modernisation fund – supporting practices with PIDs for 25/26 Utilisation and modernisation fund – development of PIDs for 26/27 round of bids	
	Current Estate (Maximising usage/lease issues etc)	Supporting lease discussions with practices	
Prog.6 – Integration (Wider PC, Neighbourhoods/PSR)	Bury LCS 25/26	Alignment of GM PLT principles with locally agreed LTI options to be agreed by practices and approved by PCCC however potential cost implication to align with GM standardisation. GP Board raised concerns regarding the requirements put forward, further work is needed to address this.	
	BeCCoR	Ongoing development of Phase 3 scheme	
	Schedule 7	Review of schedule 7 within the PCN agreements to clearly articulate how system partners will work together, particularly where the PCN and Neighbourhood do not align	
	GP/Pharmacy Interface Principles	Roll-out Patient Lead Ordering in Whitefield neighbourhood.	
Prog.7 – Quality and Assurance	PCN Networks	Q3 outstanding returns expected Outstanding Enhanced Access Claims and payments expected to be resolved Attendance at Bury PCN Board to discuss and address utilisation concerns	
	CQC Improvement	No inspections planned for immediate future for Bury	
	Care Homes	Working with practices and wider stakeholder to address specific issues around Fast Track Discharges The Priory - Conversations with provider required around move from Hospital to Care home designation inc roles and responsibilities of GP for patients inc PCN alignment	
	Prescribing Quality	Ongoing savings work & continued support for LCS indicators	
Prog.8 – System Leadership	Wider PC Collaborative	Forum to discuss wider PC collaboration active (2nd meeting planned 7 th October cancelled) – Paused whilst outcome of GM reforms are known	
Prog.9 – Workforce (recruitment/development and retention)	Development of Workforce Strategy	Workforce Strategy - Retention survey changed to Workforce Experience to gain wider insight. Will go to PM meeting this month (meeting got cancelled last month)	
	Implementation of Workforce Strategy	Implementation Plan to support delivery of the workforce strategy Test of change – practice to be identified for improvement project	

Current highest scoring risks / Issues:

Risk/Issue	Current Mitigation / Controls	Gaps in control	If being escalated to the programme Board, IDC Board or Locality Board state where and what is the reason for escalation – <i>what needs to happen?</i>
IF: the apportionment of delegated PC monies is not sufficient enough to cover local elements unique to Bury (dementia diagnosis, ring pessaries, bloods etc) THEN: services may need to be stopped limiting what general practice support/deliver LEADING TO: Wider provider pathway pressures which cost more and possible poorer outcomes for the patients of Bury	<ol style="list-style-type: none"> Ongoing discussions via phase 3 BeCCoR to secure equitable/sufficient funding from 26/27 (including further benchmarking) System partners fully engaged in difficult decisions which may need to be taken as a result GM/Locality discussion planned for 10th Feb 2026. (confirmation of figures provided to GM following that meeting but not yet reflected in latest documents) 	Awaiting outcome from GM PCCC and Board regarding likely expectations on financial split e.g. GM standardisation versus local need.	Concerns remain regarding the funding being suggested against the transactional elements of the LCS (e.g. Dementia Diagnosis, phlebotomy etc) This has been flagged through various committees both locally and centrally in GM and a locality meeting planned for 10th Feb 2026.

Programme / Project Highlight Report

<p>IF: There is no clear roadmap for increasing community self-referral pathways as per NHS England's Delivery plan for recovering access to primary care</p> <p>THEN: practices ability to triage and deflect/direct appropriately to other more appropriate services will be limited</p> <p>LEADING TO: delays in patients being seen by the appropriate service, more general impact on GP access and potentially poorer outcomes for everyone as a result.</p>	<ol style="list-style-type: none"> 1. A roadmap was requested from the commissioning and community services team (Nina Parekh, Jennifer Davies and Joanne Howard) back in Sep 2024, and the last information received was in May 2025 advising that the plan was to work towards self-referral for falls and podiatry, though as services had seen an increase in demand without additional capacity the team could not take on the further additional work which self-referrals would generate. 2. Further update re plans and timeframes have been requested again in August 2025. 3. Initial workshop undertaken and several actions agreed 	<p>A key element of practices being able to offer sufficient access to their patients is their ability to triage and deflect/direct appropriately to other more appropriate services.</p> <p>Without a clear understanding of what self-referral community service options are available (both now and planned timeline) patients options are limited</p>

Decisions required:

Project / Workstream	Decision Required	At what level <small>[programme board, IDC Board, Locality Board, other?]</small>	Impact if no decision

Performance:

<p>Performance [against targets / outcomes] Attached as Appendix 1 - Data quality issues are highlighted bright yellow</p> <p>Positive key items to note are:</p> <ul style="list-style-type: none"> ○ 14.11% of diabetic patients are signed up to access the My Way Diabetes platform as at Jan 26 (GM 12.7%) ○ 72% of Bury registered patients aged 13+ now have the NHS APP (GM 68%) ○ The total no. of prescriptions ordered using the repeat prescribing function on the NHS App as at Jan'26 is 371,575 (48,248 more than in 24/25 with two more months' worth of activity still to come) <p>Room for improvement:</p> <ul style="list-style-type: none"> ○ % of SMI patients receiving all 6 checks in preceding 12mths. Whilst we have improved performance on 54.0% in Dec 25 to 58.9% in Jan'26 we remain 10th in GM ○ Our WTE staff numbers are at the lowest they have been all 25/26. Currently 200.33 (24/25 baseline was 207.90) ○ We continue to have the lowest number of appointments per 10,000 patients recorded through GPAD 3,791 in Jan'26 (4,512 GM Average) 	<p style="background-color: #C8E6C9; padding: 2px;">Finance:</p> <p>Financial Tracker for programme</p>
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One key takeaway message for IDC and Locality Board:

<p>A decision is still awaited regarding the additional funding required to proceed with scenario 1 of the GM Beyond Core Contract (a fully standardised contract with retained and locally specific elements)</p> <ol style="list-style-type: none"> 1. the locality funding associated with retained/local elements is not sufficient to continue to fund all currently commissioned activity and despite meeting with GM colleagues and subsequently restating financial value required we have yet to receive confirmation of funding 2. Practice have not yet seen any details associated with this contract other than high level discussions regarding its structure and content, nor do they know the funding methodology or value for their specific practice. This presents significant risk regarding effective implementation from 1st April.
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STATUS¹

ON TRACK
COMPLETE
AT RISK
OVERDUE

02. General Practice 2022 and beyond delivery plan 2526

Measurable Indicators	Lead	Target 25/26	22/23	23/24	24/25 Baseline	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Sparkline
GOAL 1 – DEVELOP & PROMOTE A NEW MODEL OF GENERAL PRACTICE																		
100% of our practices rated as Good or Outstanding by CQC	KH	100%	96%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	
Cloud based telephony across all practices	DS	100%	45%	83%	92%	92%	92%	92%	92%	92%	92%	96%	96%	96%	96%	100%	100%	
Increase in the uptake of the NHS App (13+)	ZA	↑	55%	59%	65%					64%	65%	70%	71%	71%	72%			
The no. of prescriptions ordered using the online repeat prescription function	ZA	↑	N/A	214,956	323,327	34,115	69,144	104,339	141,493	178,374	216,055	254,452	291,973	331,640	371,575			
	Monthly			Average	26,944	34,115	35,029	35,195	37,154	36,881	37,681	38,397	37,521	39,667	39,935			
% of practices signed up to DSA for Myway Diabetes	LL	↑	N/A	N/A	48%	48%	52%	52%	68%	76%	76%	76%	76%	76%	76%			
% of practices with bulk activation	LL	↑	N/A	N/A										60%	60%			
Bury MyWay Diabetes Reach (% of Diabetes Population Registered)	LL	↑	N/A	N/A						13.3%				13.86%	14.11%			
Bury MyWay Diabetes Reach (No.of patients)	LL	↑	N/A	N/A	1,074	1,078	1,083	1,093	1,109	1,117	1,166	1,175	1,180	1,191	1,815			
GOAL 2 - A RESILIENT WORKFORCE AND AN ATTRACTIVE PLACE TO WORK																		
All practices/PCNs check and update the NWRS each month	RM	↑	24%	40%	54%	68%	68%	88%	68%	76%	64%	88%	92%	68%	60%			
Increase no. of WTE staff per 100,000 patients	RM	↑	175	203.31	207.90	207.40	205.90	204.51	200.36	202.19	203.66	202.83	203.75	204.28	200.33			
• Admin/Non-clinical	RM	↑	100	116.7	119.8	120.18	119.20	118.23	115.96	116.35	116.75	115.73	116.14	116.72	115.62			
• Direct patient care (non-ARRS)	RM	↑	14	20.4	20.8	21.39	21.63	21.27	21.06	21.06	21.37	21.85	22.35	22.07	19.64			
• GP	RM	↑	38	43.6	42.5	41.71	41.32	40.74	39.53	40.65	41.20	40.90	41.35	41.18	41.41			
• Nurses	RM	↑	23	22.6	24.8	24.12	23.75	24.27	23.81	24.13	24.34	24.35	23.91	24.31	23.66			
Maximize no. of WTE ARRS staff working across general practice (Bury)	RS	110.98	135.01	103.82	160.27	105.71	102.51	106.74	111.52	108.61	104.72	71.77	87.61	88.21	89.35	109.32		
• Bury	RS	25.05	49.27	24.40	54.50	34.70	34.50	32.50	39.17	33.28	29.18							
• Horizon	RS	44.75	40.29	47.62	59.17	39.81	37.81	40.85	40.52	40.35	41.24	39.90	55.50	55.50	55.50	74.20		
• Prestwich	RS	21.85	25.58	16.60	27.32	15.18	15.18	16.18	15.83	17.98	16.90	16.59	16.94	17.45	18.82	19.28		
• Whitefield	RS	19.33	19.88	15.20	19.28	16.02	15.02	17.21	16.00	17.00	17.40	15.28	15.17	15.26	15.03	15.84		
Increase in the uptake of the Active Practice Charter	LL	↑	N/A	N/A	16%	16%	24%	24%	32%	32%	32%	36%	36%	36%	36%	36%	36%	
Increase in the uptake of the Good Employment Charter	LL	↑	0%	0%	4%	4%	4%	4%	4%	8%	8%	8%	8%	8%	8%	8%	8%	
Increase in the % of practices accredited as a Unified Learning Environment	LL	↑	0%	16%	56%	56%	56%	56%	56%	56%	56%	56%	56%	56%	56%	56%	56%	
Increase in % of staff booked onto CPD courses (25 courses from hub)	LL	↑	88%	63%	63%	34%	56%	59%	64%	64%	64%							
Increase in the number of places on CPD courses booked	LL	↑	117	96	80	68	77	83	88	88	88							
Increase in the number of places attended CPD courses	LL	↑	78	80	66	12	34	55	71	71	71							
GOAL 3 - INCREASE CAPACITY WITHIN GENERAL PRACTICE AND MEET APPROPRIATE DEMAND																		
Increase the number of appointments available in general practice (ED19)	ZA	↑	870,372	986,925	1,017,349	75,024	150,514	231,245	317,489	390,923	476,608	581,613	661,049	739,718	820,012			
	Monthly	Ave	72,531	82,244	84,779	75,024	75,490	80,731	86,244	73,434	85,685	105,005	79,436	78,669	80,294			
Increase the number of appointments available per 10,000 patients (S001a)		↑ Ave	3,464	3,921	4,000	3,542	3,564	3,812	4,072	3,467	4,045	4,958	3,750	3,714	3,791			
	GM Ranking	1 best - 10 worst				10	10	9	9	9	9	9	10	10	10			
Reduce the No. of DNAs	ZA	↓	N/A	50,513	49,446	3,839	7,741	11,778	16,191	19,916	24,508	31,191	35,811	40,209	44,034			
	Monthly	Ave		4,121	3,839	3,902	4,037	4,413	3,725	4,592	6,683	4,620	4,398	3,825				
% of regular appointments within 14days (S129a)	ZA	↑	Ave	81.5%	78.8%	78.5%	80.2%	79.8%	79.9%	79.2%	79.0%	71.2%	76.6%	79.5%	78.6%			
	GM Ranking	1 best - 10 worst				9		10	9	9	10	10	8	10				
Reduction in the % of patients waiting over 28days all modes all HCPs	ZA	↓	3.2%	4.0%	6.5%	7.0%	6.3%	5.1%	5.6%	6.8%	6.6%	9.1%	7.1%	6.0%	7.1%			
Reduction in % of unmapped appointments	ZA	↓	0.1%	12.6%	4.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%			
Reduction in % of inconsistent mapping of appointments	ZA	↓	11.8%	4.2%	4.8%	4.4%	4.7%	4.7%	4.6%	4.5%	5.1%	5.3%	5.1%	4.8%	4.5%			
Increase the number of referrals via Pharmacy First (Cumulative figure)	LL	↑	1475	2,193	6,418	519	1,009	1,490	1,994	2,342	2,809	3,371	3,898	4,403	4,870	5,301		
	Monthly 'Pharmacy First' figures	Ave	N/A	40.8	472	519	490	481	504	348	467	562	527	505	467	431		
Required number of hours to be offered against the Enhanced Access DES (Total)	RS	11177.88	5395.00	11429.04	11170.72	931.49	931.49	931.49	931.49	931.49	931.49	931.49	931.49	931.49	931.49	931.49	931.49	931.49
No. of hours offered against the Enhanced Access DES (Total)	RS	11177.88	5760.00	9584.67	11217.00	928.89	919.00	927.00	933.00	955.42	931.10	929.75	961.08	935.00	708.00			
Increase utilisation of Enhanced Access appointments across Bury (inc DNAs)	RS	85%	70%	69%	70%	66.30%	68.24%	62.80%	55.52%	69.00%	69.22%	67.67%	74.34%	63.54%				
Increase utilisation of Enhanced Access appointments across Bury (exc DNAs)	RS	85%	N/A	N/A	82%	76.00%	77.00%	70.00%	71.00%	77.00%	77.44%	79.00%	84.00%	70.00%				
	Bury - Required	RS	2687.88	1303	2899.62	2792.76	223.99	223.99	223.99	223.99	223.99	223.99	223.99	223.99	223.99	223.99	223.99	223.99
• Bury - Hrs Offered	RS	2687.88	1403	2727.00	2835.00	224.00	231.00	221.00	231.00	228.00	224.00	227.00	227.00	227.00				
• Bury - Utilised of appointments (inc DNAs)	RS	85%	50%	51%	52%	46.09%	50.32%	47.51%	57.57%	60.53%	46.87%	56.84%	64.35%	45.81%				
• Bury - Utilised of appointments (exc DNAs)	RS	85%	N/A	N/A	57%	52.35%	56.39%	51.93%	60.53%	64.91%	53.36%	62.69%	72.91%	50.00%				
	Horizon/Prestwich and Whitefield - Required	RS	8490.00	4092	8529.42	8377.96	707.50	707.50	707.50	707.50	707.50	707.50	707.50	707.50	707.50	707.50	707.50	707.50
• Horizon/Prestwich and Whitefield - Hrs Offered	RS	8490.00	4357	6857.67	8382.00	704.89	688.00	706.00	702.00	727.42	707.10	702.75	734.08	708.00	708.00			
• Horizon/Prestwich and Whitefield - Utilised appointments (inc DNAs)	RS	85%	74%	77%	77%	72.84%	74.39%	67.80%	54.92%	71.70%	69.22%	71.32%	77.61%	69.45%	75.40%			
• Horizon/Prestwich and Whitefield - Utilised appointments (exc DNAs)	RS	85%	N/A	N/A	90%	83.00%	84.00%	76.00%	74.06%	81.14%	77.74%	84.49%	87.00%	77.22%	82.31%			
Reduce the number of patients on the SAS	KH	20	41	41	41	41	41	41	41	41	45	42	43	42				

02. General Practice 2022 and beyond delivery plan 2526

Measurable Indicators	Lead	Target 25/26	22/23	23/24	24/25 Baseline	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Sparkline
GOAL 4 – STRENGTHEN RELATIONSHIPS BETWEEN PROVIDER PARTNERS ACROSS THE BURY SYSTEM																		
Increase sit rep reporting informed system resilience discussions	RS	↑	N/A	27.00%	86.24%	90.00%	88.00%	92.00%	87.56%	91.40%	92.00%	86.22%	88.50%	89.20%	96.00%	94.00%		
GOAL 5 – IMPROVE OUTCOMES FOR PATIENTS BY REDUCING INEQUITY AND VARIATION IN ACCESS AND QUALITY OF CARE																		
% of patients identified as having >20% 10yr risk of developing CVD are treated with statins (proxi measure CVDP003CHOL being used)	KH	60%	N/A	63.06%	65.00%		64.58%	64.33%			64.54%							
% of patients with hypertension who are treated to target as per NICE guidance S053b (proxi measure CVDP007HYP being used)	KH	80%	54.70%	66.60%	70.00%		67.10%				68.13%							
Increase in the uptake of cervical screening	LL/RM																	
• 80% of patients, 25-49, attending cervical screening within target period (3.5 year coverage)	LL/RM	80%	N/A	71.21%	68.90%	69.10%	69.10%	69.10%	68.90%	68.70%	68.40%	68.10%	68.00%	68.00%	68.20%			
• 80% of patients, 50-64, attending cervical screening within target period (3.5 year coverage)	LL/RM	80%	N/A	74.87%	74.10%	74.10%	74.00%	74.20%	74.10%	74.00%	73.90%	74.20%	74.50%	74.60%	74.60%			
Average Vaccination Uptake Childrens (All vaccines)	LL/RM	95%	N/A	N/A	80.70%			81.70%	82.30%	82.70%	82.90%	83.10%	82.90%	82.90%	83.20%			
Locality Ranking (based ave uptake all childhood vaccines)	LL/RM	1 worst-10 best	N/A	N/A	5th			6	6	6	5	6			7			
MMR 1 Uptake	LL/RM	95%	N/A	N/A	93.20%			93.40%	93.40%	93.40%	93.40%	93.40%	93.20%	93.20%				
MMR 2 Uptake	LL/RM	95%	N/A	N/A	87.80%			88.10%	88.10%	88.20%	88.20%	88.20%	88.00%	88.00%				
Increase the dementia diagnosis rate to 66.7% by March 2025	RS	66.7%	77.0%	76.2%	75.1%	76.20%	76.50%	76.40%	76.40%	76.30%	76.60%	76.80%	76.70%	76.80%	76.60%			
Increase in the % of patients diagnosed with Dementia whos care plan has been reviewed in the proceeding 12mths	RS	↑	74.26%	75.15%		100.00%	100.00%	75.00%	83.30%	85.70%	80.00%	80.00%	90.90%	91.70%	92.30%	87.50%		
Increase the number of patients on Learning Disability registers	RS	↑	1171	1199	1209	1267	1264	1262	1259	1254	1253	1252	1248	1246	1246	1248		
Increase the number of patients on LD register with reasonable adjustment recorded (1 of 5 specified codes)	RS	↑	320	548	850	903	905	907	910	908	907	915	922	934	954	963		
% of patients on LD register with reasonable adjustment recorded	RS	↑	27%	46%	70%	71.30%	71.60%	71.90%	72.30%	72.40%	72.6%	73.1%	73.9%	75.0%	76.6%	77.2%		
(IIF) Increase % of patients aged over 14 on QoF LD registers receiving an annual health check & health action plan in addition to a recording of ethnicity by Mar'25	LL/RM	LT60% UT80%	N/A	74.96%	88.81%	3.03%	7.15%	13.28%	20.44%	26.35%	32.15%	39.05%	47.72%	54.35%	66.81%			
• Bury	LL/RM	LT60% UT80%	N/A	85.17%	88.56%	1.86%	2.23%	9.02%	16.35%	23.08%	32.42%	43.31%	49.02%	52.12%	65.23%			
• Horizon	LL/RM	LT60% UT80%	N/A	84.33%	85.92%	4.47%	10.89%	16.15%	22.88%	28.11%	30.99%	37.88%	47.61%	55.56%	66.48%			
• Prestwich	LL/RM	LT60% UT80%	N/A	71.82%	86.85%	3.64%	6.39%	10.05%	17.67%	24.30%	34.11%	37.85%	48.13%	57.01%	73.49%			
• Whitefield	LL/RM	LT60% UT80%	N/A	58.50%	93.89%	0.00%	4.81%	15.14%	22.58%	28.34%	32.80%	37.97%	45.79%	51.06%	62.23%			
(IIF) Increase % of lower gastrointestinal urgent suspected cancer referrals accompanied by a FIT result within the 21 days leading up to the referral	LL/RM	LT65% UT 80%	N/A	65.91%	84.20%	83.33%	82.43%	84.07%	84.19%	84.83%	85.60%	85.92%	85.86%	86.30%	87.55%			
• Bury	LL/RM	LT65% UT 80%	N/A	63.50%	82.90%	65.00%	72.00%	74.68%	78.07%	79.17%	80.57%	82.46%	82.86%	84.07%	86.56%			
• Horizon	LL/RM	LT65% UT 80%	N/A	77.33%	88.40%	82.09%	83.33%	85.64%	85.29%	87.20%	87.25%	87.47%	87.14%	87.38%	87.99%			
• Prestwich	LL/RM	LT65% UT 80%	N/A	58.36%	81.40%	94.12%	86.84%	87.27%	83.75%	83.00%	82.64%	82.76%	83.13%	84.62%	86.14%			
• Whitefield	LL/RM	LT65% UT 80%	N/A	64.46%	84.48%	95.45%	88.37%	88.24%	88.66%	86.61%	89.51%	88.75%	88.52%	87.50%	88.80%			
Increase in the % of patients having had all 8 Diabetes Care Processes Age >=17 (QoF)	LL/RM	56.9% GM 24/25	N/A	46.80%	53.60%	51.50%	49.80%	49.20%	49.60%	50.30%	51.30%	53.00%	54.10%	56.00%				
GM Ranking	LL/RM	<	N/A					7			7	5	4	3				
Increase in the % of patients offered Structured Education Age >=17 (QoF)	LL/RM	70.6% GM 24/25	N/A	70.40%	71.70%	73.50%	71.90%	70.70%	69.20%	68.80%	69.00%	70.30%	68.70%	70.02%				
GM Ranking	LL/RM	<	N/A					7			6	4	6	5				
Increase in % of people with SMI receiving all 6 checks in preceeding 12mths	LL/RM	60%	N/A	64.9%	60.6%	58.0%	56.0%	53.9%	53.7%	53.1%	53.6%	54.5%	54.4%	54.0%	58.9%			
GM Ranking	LL/RM	<	N/A	10	10	10	10	10	10	10	10	10	10	10	10			
Increase in uptake of the Military Veterans RCGP accreditation	LL	↑	12%	80%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	
Increase in uptake of the Homeless Friendly accreditation across practices	LL	↑	72%	72%	72%	72%	72%	72%	72%	72%	72%	72%	72%	72%	72%	72%	72%	
Increase in uptake of the Pride in Practice accreditation across practices	LL	↑	48%	64%	64%	64%	64%	64%	64%	64%	64%	64%	64%	64%	64%	64%	64%	
Increase in uptake of the Gambling Harms GP Practice Accreditation	LL	↑	N/A	0%	0%	0%	12%	12%	16%	16%	16%	20%	20%	20%	20%	20%	20%	

Meeting: Primary Care Commissioning Committee			
Meeting Date	30 March 2026	Action	Receive
Item No.	8	Confidential	No
Title	APMS Reprourement Bury		
Presented By	Rachele Schofield, Primary Care Lead (Bury)		
Author	Rachele Schofield, Primary Care Lead (Bury)		
Clinical Lead	Dr Catherine Fines		

Executive Summary
The following paper has been written to seek approval to extend two Bury Alternative Provider Medical Services (APMS) General Practice contracts by one year as they are reaching the end of their term.
Recommendations
The Primary Care Commissioning Committee is asked to: <ul style="list-style-type: none"> Note the contents of the paper Approve the request to commence with the STAR and PSR process to reprocore both APMS contract for 1 year

OUTCOME REQUIRED (Please Indicate)	Approval <input type="checkbox"/>	Assurance <input type="checkbox"/>	Discussion <input type="checkbox"/>	Information <input type="checkbox"/>
APPROVAL ONLY; (please indicate) whether this is required from the pooled (S75) budget or non-pooled budget	Pooled Budget <input type="checkbox"/>	Non-Pooled Budget <input type="checkbox"/>		

Links to Locality Plan priorities	
Scale our work on Population Health Management - Improve population health and reduce health inequality of those in the most disadvantaged areas	<input type="checkbox"/>
Drive prevention, reducing prevalence and proactive care – supporting Demand Reduction through primary intervention, secondary preventions and tertiary prevention	<input type="checkbox"/>
Transforming Community Care in Neighbourhoods - fully realising the benefit of neighbourhood team working with a focus on the assets of residents and communities and providing proactive care	<input type="checkbox"/>
Optimise Care in institutional settings and prioritising the key characteristics of reform.	<input type="checkbox"/>

Links to Locality Plan priorities						

Implications						
Are the risks already included on the Locality Risk Register?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
Are there any risks of 15 and above that need to be considered for escalation via an NHS GM Statutory Committee or Board in line with the Risk Escalation process ?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
Are there any quality, safeguarding or patient experience implications?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
Have any departments/organisations who will be affected been consulted ?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
Are there any financial Implications?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>

Governance and Reporting		
Meeting	Date	Outcome
N/A		

Reprocurement of APMS Contracts

1. Introduction

- 1.1 The following paper has been written to seek approval to extend two Bury Alternative Provider Medical Services (APMS) General Practice contracts by one year as they are reaching the end of their term.

2. Background

- 2.1. APMS contracts are time limited flexible contracts for primary care services, allowing non-traditional providers (like private firms or charities) to offer GP-like services. Bury locality has 2 APMS contract holders in place, Rock Healthcare based in Bury East and Garden City Medical Practice based in the North of the borough.
- 2.2. APMS contracts are legally flexible in length and must be re-procured at term end. Whilst these contracts were procured at a different time, their length of contracts were agreed to coincide with each other, this means that both contracts are due to expire on 31 March 2027, and the notice period date set as 31 May 2026. Written notice is required to be served by the GM Head of Primary Care regarding the future of the contracts by this time.

3. One Year APMS Extension Recommendation

- 3.1 As part of the current ongoing NHS Reform, it has been signalled that Contracting will become part of the GM primary care function, this means that the locality will no longer lead re-procurements from 1 April 2026. It is however recognised that, the shift of responsibility is likely to take longer.
- 3.2 It is therefore recommended that PCCC support a 1-year APMS GP Practice re-procurement exercise retaining both current providers to ensure continuity of statutory primary medical services during this time of transition. This will also allow a GM-wide re-procurement exercise of all GM APMS contracts to take place at one time providing a more effective use of resources centrally.

4. Associated Risks

- 4.1 Due to the current NHS reforms, resource is limited at Place to conduct a full and thorough APMS reprocurement exercise given the short mobilisation window available to us. If the one-year APMS extension is denied or delayed, then it is likely to lead to service disruption which will impact patient care.

5 Actions Required

- 5.1 The Primary Care Commissioning Committee is asked to:
- Note the contents of the paper
 - Approve the request to commence with the STAR and PSR Direct Award C process to reprocurse both APMS contracts for 1 year

Rachele Schofield

Primary Care Lead (Bury)
racheleschofield@nhs.net
February 2026

Meeting: Primary Care Commissioning Committee			
Meeting Date	30 March 2026	Action	Receive
Item No.	9	Confidential	No
Title	BeCCoR/LCS 2026/27 Update		
Presented By	Zoe Alderson, Head of Primary Care		
Author	Zoe Alderson, Head of Primary Care		
Clinical Lead	Dr Catherine Fines – Associate Medical Director		

Executive Summary

The purpose of this paper is to present Primary Care Commissioning Committee with the final version of the GM Quality Contract which has been developed through the BeCCoR (Beyond Core Contract Review) group including the retained services for the Bury Locality.

The paper is heavily caveated in that its content and recommendations are subject to approval from GM Board.

Recommendations

The Bury Place Based Primary Care Commissioning Committee (PCCC) is asked to:

- Receive the specifications being presented
- To discuss and agree some recommendations and next steps to mitigate the highlighted risks.

OUTCOME REQUIRED (Please Indicate)	Approval <input checked="" type="checkbox"/>	Assurance <input type="checkbox"/>	Discussion <input type="checkbox"/>	Information <input type="checkbox"/>
APPROVAL ONLY ; (please indicate) whether this is required from the pooled (S75) budget or non-pooled budget	Pooled Budget <input type="checkbox"/>	Non-Pooled Budget <input type="checkbox"/>		

Links to Locality Plan outcomes

To support a local population that is living healthier for longer and where healthy expectancy matches or exceeds the national average by 2025.	<input type="checkbox"/>
To achieve a reduction in inequalities (including health inequality) in Bury, that is greater than the national rate of reduction.	<input type="checkbox"/>
To deliver a local health and social care system that provides high quality services which are financially sustainable and clinically safe.	<input type="checkbox"/>
To ensure that a greater proportion of local people are playing an active role in managing their own health and supporting those around them.	<input type="checkbox"/>

Implications						
Are the risks already included on the Locality Risk Register?	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
Are there any risks of 15 and above that need to be considered for escalation via an NHS GM Statutory Committee or Board in line with the Risk Escalation process ?	Yes	<input type="checkbox"/>	No	<input checked="" type="checkbox"/>	N/A	<input type="checkbox"/>
Are there any quality, safeguarding or patient experience implications?	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
Have any departments/organisations who will be affected been consulted ?	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	<input type="checkbox"/>	No	<input checked="" type="checkbox"/>	N/A	<input type="checkbox"/>
Are there any financial Implications?	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input checked="" type="checkbox"/>
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input checked="" type="checkbox"/>
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>

Governance and Reporting		
Meeting	Date	Outcome

2026/27 BeCCoR / Bury LCS

1. Introduction

- 1.1. The purpose of this paper is to present Primary Care Commissioning Committee with the final version of the GM Quality Contract which has been developed through the BeCCoR (Beyond Core Contract Review) group including the retained services for the Bury Locality.
- 1.2. The paper is heavily caveated in that its content and recommendations are subject to approval from GM Board.

2. Background

- 2.1. BeCCoR (Beyond Core Contract Review) is a Greater Manchester (GM) programme of work which was established in June 2023 to review existing GP quality schemes (the Bury LCS) and to recommend a way forward to move from 10 locality commissioned schemes to a single GM scheme.
- 2.2. BeCCoR Phase 1 was launched in April 2024 when two GM-wide 'areas of consistency' were incorporated into all locality schemes. In April 2025, Phase 2 increased the number of areas of consistency to four (a QI project for Elective Care and a forerunner scheme for Shared Care of Medicines). Bury also received some additional investment allowing neighbourhoods to widen the number of priorities they focused on.
- 2.3. Phase 3 (a GM-wide GP quality incentive scheme) will run from April 2026 to March 2027 focuses on 6 'pillars':

Pillar 1 – Local Service Delivery

Pillar 2 – Medicines Optimisation

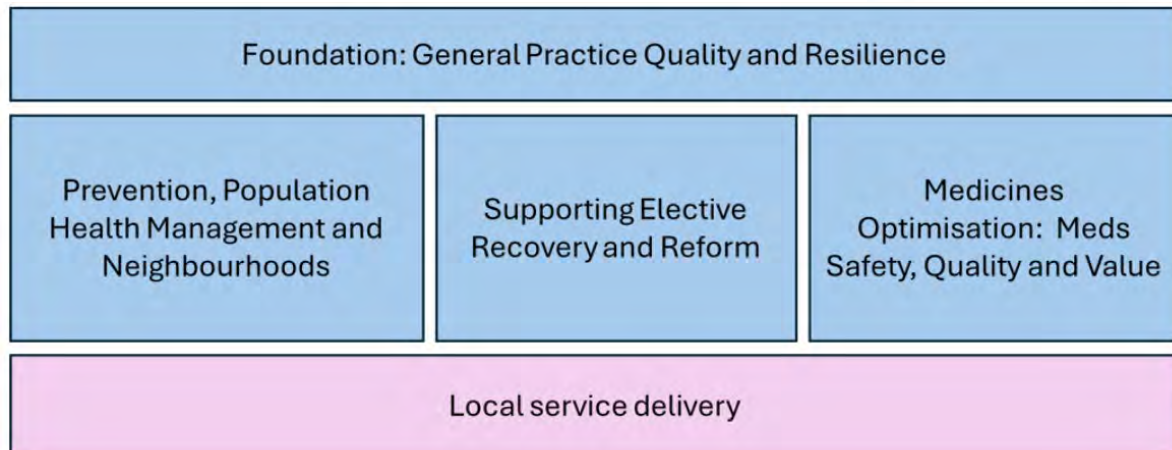
Pillar 3 – General Practice Quality and Resilience

Pillar 4 – Supporting System Priorities

Pillar 5 – Prevention, Tackling Health Inequalities and Population Health

Pillar 6 – General Practice at The Heart of Neighbourhood Transformation

- 2.4. Delivery structure as follows:



- 2.5. Full details of the GM requirements and intended deliverables can be found in Appendix 1.
- 2.6. Local Service Delivery
- 2.6.1. There is a significant volume of work still to be undertaken in order to fully rationalise and standardise requirements across GM. Each locality will therefore retain a level of funding for services previously delivered at part of their Locally Commissioned Service.
- 2.6.2. For Bury this includes:
- Dementia Diagnosis
 - Diagnostics e.g. ECGs, Venepuncture
 - Ear Irrigation (in line with local guidelines only)
 - Ring Pessaries
- 2.6.3. Full service specification details can be found within Appendix 2

3. Wider Remaining LCS agreements

- 3.1. As the committee will be aware, our current LCS contract is commissioned via the GP Federation with them receiving a management fee for processing practice level claims in addition to providing hands on support in terms of searching/reporting and demonstrating delivery.
- 3.2. It has been indicated that the locality will have sufficient funding with which to continue this arrangement. Indications have also been received regarding wider locally commissioned services including the Respiratory Diagnostic Service, Care Home Outbreaks and Paediatric Phlebotomy.
- 3.3. Following Board approval work will take place to formalise these requirements through the STAR/PSR process.

4. Risks and Mitigations

- 4.1. Unlike in previous years, practices have not been part of the development of the GM specification meaning that the 1st of April will be the first time they have seen what could be seen as a significant amount of work. As requirements are largely based on the previous phases and new asks are generally focused on end of Q1 delivery, this is not seen as risk. There will be various webinars to support scheme launch which practices are encouraged to attend.
- 4.2. There are several self assessments required as part of the GM Scheme, this therefore will mean that a post payment verification process will be necessary. Practices will be encouraged to put in processes which mean they capture and save evidence to support these claims as they progress throughout the year.
- 4.3. Neighbourhood plans are expected at the end of Q1. Further work is needed to understand the risks associated with this change in approach.

5. Recommendations

- 5.1. The Bury Place Based Primary Care Commissioning Committee (PCCC) is asked to:
 - Consider the content of this paper
 - To discuss and agree some recommendations and next steps to mitigate the highlighted risks.

Zoe Alderson

Head of Primary Care (Bury)

March 2026

Greater Manchester GP Incentive Scheme 2026/2027

Proposed document.

Foreword

We are delighted to launch the BeCCoR Greater Manchester GP Incentive Scheme for 2026/27.

Firstly, this scheme comes at an important time for the NHS. The publication of the 10 Year Health Plan in July 2025 set out the direction for the NHS over the next 10 years. The ambition described in the plan to shift from sickness to prevention; hospital to community; and analogue to digital is one that we can all support.

In Greater Manchester, we are able to build on our foundation of devolution to work with partners to make this ambition a reality – through integration and collaboration with our 10 GM places, commissioning for the outcomes we want to achieve and accelerating and maturing integrated neighbourhood working as the means to deliver proactive and preventative care, closer to home.

General practice is at the heart of this. The transformational approaches of the Prevention, Population Health and Neighbourhoods component of this incentive scheme are included in Greater Manchester's Prevention Demonstrator programme. This national accelerator for prevention will give Greater Manchester the chance to demonstrate the impact and success of the approaches we are taking and the achievements of Greater Manchester General Practice to improve the health of our population – working as part of the Live Well neighbourhood health model.

Secondly, this scheme is built on evidence and learning. Evidence that has been generated from identifying best practice, scaling it up and then undertaking robust evaluation to evidence the benefits and impacts. This approach is crucial because it will not only clearly demonstrate the successes that General Practice can deliver as a key system partner, but will also support system decisions about investment. For 2026/27, this evidence based approach has enabled the investment of a further £15million into the BeCCoR GM GP Incentive Scheme at a time when NHS finances are still very challenged.

We recognise that the launch of a GM scheme reflects a new approach to previous years where GP incentive schemes were commissioned locally. This has built on the 2 previous years where GM areas of consistency were added into locality schemes. This approach of a consistent GM scheme allows for a consistency of the outcomes achieved for the health of our population and a move towards consistency of investment across all GM general practices. Alongside this consistent GM approach, there do remain 'retained' local elements and local services which should be familiar

to you as areas of delivery from last year's scheme that remain important for your place.

Finally, this scheme has been developed through trimumvirate leadership and working, meaning that colleagues from NHS GM pan-GM and place teams have worked together with GM GP Board colleagues to develop this scheme. We would like to acknowledge the importance of this approach and the commitment that this will continue moving forwards.

Acknowledgements

With thanks to the BeCCoR Core Leadership team who have led the development of this scheme.

Co-Chairs:

Dr Claire Lake – Deputy Chief Medical Officer, NHS GM

Dr Tim Dalton – Chair, GM GP Board and Deputy Chair GM Primary Care Board

Ben Squires – Director of Primary Care, NHS GM

Section Leads:

Anna Ganotis – Head of Service Transformation (Primary Care) – NHS GM (Salford)

Dr Aseem Mishra – Clinical Lead CVD Prevention, NHS GM

Caroline Bradley - Associate Director of Primary Care – NHS GM (Manchester)

Janna Rigby – Assistant Director Primary Care Operations, NHS GM

Khalada Abdullah, Strategic Lead, Population Health, NHS GM

Lara Shah – Deputy Chief Pharmacist, NHS GM

Matthew Conroy – Analytical Service Lead (Primary Care), NHS GM

Dr Viren Mehta – Vice Chair, GM GP Board

Zoe Porter – Associate Director: Live Well and Neighbourhoods, NHS GM

Finance Leads:

Anthony Ashworth – Finance Business Partner – Primary Care , NHS GM (Manchester)



Greater Manchester

Ben Galbraith – Strategic Financial Advisor, GM Primary Care Board

Elaine Vermeulen – Associate Director of Finance, NHS GM (Salford)

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	• Section 3: Population Health Management and Neighbourhoods	21
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Summary Overview

This document lays out the full details of the GM BeCCoR Scheme for 2026/27. The scheme runs from 1st April 2026 -31st March 2027.

Schedule 1 is the GM BeCCoR Scheme. It is made up of 5 sections: sections 1-4 are consistent across Greater Manchester and section 5 is specific to your locality. For each section there is a table that sets out the requirements and the indicators against which achievement will be measured. Schedule 2 of this document outlines locally retained general practice delivered services specific to each GM locality.

To ensure all information relating to the scheme is accessible as possible, a [GM BeCCoR webpage](#) has been developed, and all scheme materials will be hosted on this site. This will include a copy of this document, access to dashboards, recordings of webinars and submissions portal. Please use the BeCCoR webpage as your first point of reference for all information related to the scheme.

A **summary timeline** that encompasses all the deadlines and key dates for the scheme has been included on page 9.

Recognising that this 2026/27 scheme represents new arrangements, expectations of both NHS GM and of general practices have been set out to aid clarity:

Expectations of Practices:

- Upon sign up to the scheme, review the documentation and webpages and ensure access to supporting resources
- Attend launch webinars and other scheme related sessions
- Become familiar with the contractual requirements, highlighting queries and issues early in the financial year
- Fully engage with place partnership and GM teams to enable scheme delivery and improved place outcomes. This is to support general practice to be a key partner in place partnerships and neighbourhood teams. Engagement includes participation at place partnership meetings, practice manager forums, place hosted webinars/training sessions and within place and neighbourhood focussed partnership working arrangements.
- This contract is commissioned and funded at practice level, however there are some areas where practices will need to, or may benefit from, working together with GP federation/primary care network/neighbourhood partners. NHS Greater Manchester would encourage practices to seek opportunities to work together where this brings benefits for practices and patients.

- We expect practices to fulfil access requirements, throughout core hours (8am-6.30pm) as set out in the national GP contract. Noting that any subcontracting arrangements require prior approval of commissioners
- Share examples of good practice with ICB and place partnership teams to support scheme delivery, improved outcomes for patients, reduction in unwarranted variation and a reduction in health inequalities
- Implement GM Care Record Digital Care Plans
- Complete the NHS GM Sit Rep monthly or by exception if there is an immediate change

Expectations of NHS GM teams (pan GM and place teams):

- Provide clear leadership in relation to the scheme and its development
- To implement an evidence based and outcome driven scheme
- To host launch webinars and communicate clearly regarding scheme launch
- To provide tools and materials required for practices to be able to deliver scheme in a timely manner, and where not immediately available, to provide a clear timeline for when they will be
- To utilise expertise from across the GM system to support practices to deliver the scheme, such as Elective and Safeguarding expertise as examples.
- Clear communication that encourages feedback from General Practice, responds to practice / scheme queries, hosts additional training sessions as required and engages early on future developments
- Ensure value for money that demonstrates transparency and that funding is linked to workload and outcomes
- To have clear governance in place so issues that can't be resolved informally can be escalated and responded to in a timely manner

Self-Declaration:

Practices will be asked to complete a self-declaration at the start of the scheme. This will include:

- Confirmation practice will sign up to deliver all elements of the BeCCoR GP Incentive Scheme
- Confirmation practice has read this document and agrees with the expectations set out in the overview section

- Confirmation that where submission is not required and/or where specifically stated in this document, the practice will retain evidence of work undertaken, and the impact, in case required for post payment verification (PPV) purposes

Document Submission:

All submissions will be made via the [BeCCoR webpage](#) unless otherwise stated.

Data Sharing

Data sharing agreements to be in place for the purposes of the direct care components of the scheme.

It is the responsibility of the practice to ensure data reporting is available to evidence and support delivery and performance achievement. This may be through automation and tools provided by NHS GM resulting from data sharing arrangements. If data sharing is not in place for secondary uses, then it is incumbent upon the practice to manually report their position. This may include baseline evidence. Early discussion is encouraged.

Contract arrangements

Contracting and delivery of this commissioned practice activity is recognised to be under association of delivery of the practice's core contract for primary medical care services. NHS GM reserves the right to suspend this contract in the event that there are material concerns relating to the practice which have not been resolved through other means.

Contact details:

For scheme related queries, please contact: enhancedserviceses1@nhs.net

Any queries specifically relating to the Medicines Optimisation specifications should be directed to: nhsgm.beccormedsopt@nhs.net

Schedule 1 – Greater Manchester GP Incentive Scheme 2026/27

There are 5 sections that make up the Greater Manchester GP Incentive Scheme 2026/27.

These are:

Section 1: General Practice Quality and Sustainability (Page 12)

Section 2: Elective Transformation (Page 16)

Section 3: Prevention, Population Health and Neighbourhoods (Page 21)

Section 4: Medicines Optimisation (Page 27)

Section 5: Locality Retained Elements (Tackling Inequalities, Neighbourhoods and Supporting Demand Management in Place) (Page 49)

These are described in detail in the following pages.

Scheme Summary Timeline

The following table summarises key dates for the BeCCoR GP Incentive Scheme 2026/27. <https://curator.gmtableau.nhs.uk/gp-quality-scheme-gm-areas-consistency-beccor> To support practice planning, a summary timeline in date order has also been developed, please see the BeCCoR webpage.

All submissions are made via [BeCCoR webpage](#) unless otherwise stated.

Section	Submission	Deadline
Sign-up to scheme		
Self-declaration	Self-declaration	29.05.2026
Scheme launch webinars	Attendance	02.04.2026
Section 1: General Practice Quality and Sustainability		
Requirement 1a	Quarter 1 Self-assessment summary	30.06.2026
Requirement 1b	No submission: delivery will be assessed via Req 1c	
Requirement 1c	Quarter 4 Self-assessment summary	31.03.2027
Section 2: Elective Transformation		
Requirement 2a	Self-declaration (as above)	29.05.2026
Requirement 2b Using consultant connect	No submission: data will be extracted from consultant connect	
Requirement 2c Nominate elective lead	Self-declaration (as above)	29.05.2026
Requirement 2d Attendance at LIN	Attendance	Quarterly – dates to be shared
Requirement 2e Adoption of elective pathway improvements	No submission: engagement with comms, practice emails and webinars outlining changes to elective pathway	
Requirement 2f QI approach and Adoption of Advice First Approach	No submission: achievement assessed via data led KPIs	
Section 3: Prevention, Population Health and Neighbourhoods		
Requirement 3a Identify cohorts and undertake reviews	No submission: achievement assessed via data led KPIs	
Requirement 3b Neighbourhood Action Plan	Attendance	Quarterly - dates to be agreed by practice/PCN with neighbourhood team
Requirement 3b Neighbourhood Action Plan Q1	Quarter 1 neighbourhood action plan	30.06.2026 – submit to place teams

Requirement 3b Neighbourhood Action Plan Q4	Quarter 4 neighbourhood action plan update with outcomes	31.03.2027 – submit to place teams
Requirement 3c Neighbourhood Prevention Allocation	No additional submission: neighbourhood delivery of neighbourhood action plan with GM level evaluation against core and optional metrics	

Section continued	Submission	Deadline
Section 4: Medicines Optimisation		
MO1: Antimicrobial Stewardship		
Requirement 1 Nominate AMS Champion	Self-declaration (as above)	29.05.2026
Requirement 1 QI Plan Quarter 1	Submission practice or PCN level QI plan	30.06.2026
Requirement 1 QI Plan Quarter 4	Submission of practice or PCN QI plan updated with outcomes	31.03.2027
Requirement 2 Reduction in total antibiotic prescribing	No submission: achievement assessed via data led KPIs	
Requirement 3 Reduction in broad spectrum antibiotics	No submission: achievement assessed via data led KPIs	
Requirement 4 Antibiotic prescribing in children	No submission: achievement assessed via data led KPIs	
MO2: Shared Care of Medicines		
SCOM	No submission: achievement assessed via data led KPIs	
MO3: DOAC Optimisation		
Annual DOAC Review	No submission: achievement assessed via data led KPIs	
Active switch to cost-effective DOAC	No submission: achievement assessed via data led KPIs	
MO4: Low Priority Prescribing		
Review Prescribing of Low Priority Products	No submission: achievement assessed via data led KPIs	
MO5: Safer Prescribing Need		
Cohort Identification and Structured Medication Reviews	No submission: achievement assessed via data led KPIs	
PCN QI Plan – Q1	Submission of PCN level QI plan	30.06.2026

PCN QI Plan – Q4	Submission of PCN QI plan updated with outcomes	31.03.2027
MO6: Tirzepatide Prescribing – Clinical Data Quality		
Clinical coding and clinical audit	No submission: achievement assessed via data led KPIs or practice level assurance discussion	
Section 5: Locally Retained Elements		
<i>For each locality team to add local arrangement into</i>		

Section 1: General Practice Quality and Sustainability

Background To General Practice Quality and Resilience Section

The General Practice Quality and Resilience Section is a new addition to the 2026/27 BeCCoR Locally Commissioned Service (LCS) contract. It has been included to standardise the breadth of quality improvement activity that was already happening across Greater Manchester GP practices as part of locality LCS schemes. A review of existing locality contractual requirements was the starting point for the development of this section. By scaling up this best practice across GM, unwarranted variation will be reduced, and practices will be well placed to successfully deliver the requirements of the full BeCCoR scheme.

General Practice Quality and Resilience	
Aim	Recognising the pivotal importance of primary medical care providers to the Greater Manchester (GM) health and care system, the overarching aim of the General Practice Quality and Resilience requirements is to make available funding which will support GM GP contract holders to enhance their resilience and to embed continuous quality improvement.
Rationale	<p>By delivering elements of a 'General Practice Quality and Resilience Framework', unwarranted variation will be reduced, and Greater Manchester general practices will:</p> <ul style="list-style-type: none"> - Improve the quality of patient care and service delivery, optimising: patient safety; patient experience; and service efficiency - Be more resilient and better able to maintain business continuity - Create an organisational culture that is open and honest, with all staff feeling confident to raise issues and make suggestions for improvement. Knowledge, skills and wellbeing of practice staff will also be enhanced <p>By actively resourcing general practice quality and resilience, NHS Greater Manchester will enable GM GP practices to have enhanced capacity and capability to be able to successfully deliver against the requirements of the other sections of the BeCCoR scheme. This will facilitate general practices' contribution to the delivery of some key ICB strategic priorities.</p> <p>Delivering the framework elements will also support practices to maximise their achievement and income from other contract revenue streams, such as QoF and enhanced services, thus further supporting provider viability and sustainability. There will also be an added benefit of practices increasing their 'CQC readiness'.</p>
Delivery	<p>General Practice Quality and Resilience Framework</p> <p>Contractual delivery of the General Practice Quality and Resilience Framework is subdivided into three requirements:</p>

Requirement 1a (Quarter 1 Self-Assessment)

All practices signing up to deliver the BeCCoR contract are required to complete a 'General Practice Quality and Resilience Self-Assessment' at the start of the financial year. This **Excel document is shared on the BeCCoR landing page** so that practices can start to complete it from April 2026.

The self-assessment tool requires practices to evaluate whether or not they are delivering against a number of elements under the following domains:

- Quality and Service Improvement
- Practice Resilience
- Practice Culture and Skills

When completing the self-assessment, practices are encouraged to make an honest assessment, informed by a wide range of practice staff. Whilst practices will not routinely be asked to submit evidence of compliance with the framework elements, they should be ready to share it if requested as part of a post payment verification audit, or in response to commissioner queries (e.g. as part of a routine practice quality assurance visit).

Some self-assessment framework elements are classed as '**Essential**'. All participating practices must commit to ensuring that they remain or become compliant with all of the essential elements by the end of the financial year.

Other elements of the framework are '**Aspirational**'. Practices are asked to choose aspirational elements adding up to a weighting of at least 5 that they weren't compliant with when they undertook the self-assessment in Q1. Practices must commit to delivering these self-selected aspirational elements by the end of the financial year. Practices will have choice to select the elements that they feel will be most beneficial to their patients and staff. Practices are encouraged to select aspirational elements across the three different domains, but this is not mandatory.

Weightings have been assigned to each aspirational element which factor in work/effort required, but also strategic importance.

In the unlikely event that a practice is already compliant with all of the framework elements, please contact the BeCCoR team to discuss and agree any actions required.

Requirement 1b (Delivery)

This requirement reflects the work that practices will be undertaking over the course of the financial year to:

- Maintain or become compliant with **ALL essential** framework elements
- Become compliant with the self-selected **aspirational** elements, which total a **weighting of at least 5**.

Requirement 1c (Quarter 4 Self-Assessment)

	<p>All practices should complete the Q4 columns of the Excel self-assessment tool towards the end of Q4 to consider and demonstrate the progress that they have made.</p>
<p>Key Performance Indicators</p>	<p>A % of the practice funding available for the delivery of the General Practice Quality and Resilience Framework will be assigned to achievement of each component. The requirements will be performance managed as follows:</p> <p><u>Requirement 1a (Quarter 1 Self-Assessment)</u> (20% of available funding) At the end of Quarter 1, practices will be expected to submit a summary of their self-assessment results and to list the elements that they commit to implementing/delivering over the year via a simple Airelogic form (which will be shared by May 2026). This will be a digitalised summary of the completed Excel self-assessment document. Submission Date 30 June 2026.</p> <p>A fully completed submission within the submission timescales = payment achieved.</p> <p><u>Requirement 1b (Delivery)</u> (60% of available funding) Payment achieved where: The 2nd self-assessment demonstrates that the practice has:</p> <ul style="list-style-type: none"> - Maintained or become compliant with ALL essential framework elements - Become compliant with the self-selected aspirational elements, which total a weighting of at least 5. <p>This requirement will be subject to some additional assurance checks (see below).</p> <p><u>Requirement 1c (Quarter 4 Self-Assessment)</u> (20% of available funding) By the end of Quarter 4, practices will be expected to submit a summary of their updated self-assessment via a simple Airelogic form.</p> <p>A fully completed submission within the submission timescales = payment achieved. Submission Date 31 March 2027.</p> <p><u>Assurance of delivery:</u> Compliance will largely be based upon the outcomes of the self-assessment submissions; however, additional assurance may be obtained in the following ways:</p> <ol style="list-style-type: none"> 1. GP Practice Quality Visits (where these are routinely undertaken) may incorporate some questions to assess whether practices are complying with some of the key framework requirements. 2. A year-end 'Post Payment Verification' (PPV) process will undertake random 'spot-checks' with some practices being asked to provide evidence in relation to the delivery of their self-declarations. The intent of PPV is that NHS Greater Manchester will be looking to ensure that practices delivered what they committed to/declared. In the first year of delivery this will be

	<p>undertaken in a supportive way. There are no set standards for delivery of the elements and as long as practices can evidence that they have complied with the spirit of the requirements, then this will be deemed acceptable.</p> <p>3. In addition to the above, evidence may come to light during the year (e.g. from practice incidents or feedback from system partners) which results in commissioners asking further questions of the practice/s concerned to ascertain compliance.</p> <p>NHS Greater Manchester reserves the right to withhold all, or a %, of Requirement 1b funding where the above processes result in it being determined that self-assessments were inaccurate.</p>
Key Dates	<p>30 June 2026 – Airelogic submission deadline for Requirement 1a</p> <p>31 March 2027 – Airelogic submission deadline for Requirement 1c</p> <p>April 2027 – some practices will be asked to submit Post Payment Verification evidence</p>
NHS GM Support available	<p>The self-assessment Excel tool contains a number of links and embedded documents/templates to support practices with undertaking the self-assessment and then delivering the required elements. The templates and guidance documents are also available on the BeCCoR landing page.</p> <p>The Greater Manchester Training Hub runs a 'Primary Care Integrated Development Programme' which includes many training topics that would support the delivery of the quality and resilience requirements.</p>
References	<p>The Health Foundation (2021) Quality Improvement Made Simple: What everyone should know about health care quality improvement</p> <p>NHS England (2019) An Introduction to Quality Improvement in General Practice</p>

Section 2: Elective Transformation 2026/27

Background

Elective care, and the recovery of waiting times for elective care, remains a key priority for the NHS as we enter 2026/27. The publication of the [10 Year Health Plan for England](#) in July 2025 reaffirmed the national ambition to recover and reform elective care for patients. The National Reforming Elective Care for Patients plan mandated the expansion of Specialist Advice & Guidance (A&G). The plan's central directive is for a system shift from a "referral by default" model to an "advice-first" model and for general practice to continue to prioritise the use of A+G. In response to this, and to ensure that all general practices in Greater Manchester have a comprehensive pre-referral A&G service, NHS GM commissioned the Consultant Connect offer.

The recently published [Medium Term Planning Framework](#) marks a fundamental shift from elective recovery to systemic reform, nationally mandating an 'Advice-First' approach for planned care. The expectation is for all ICBs to establish digital Single Points of Access (SPoA) for at least 10 high-volume specialties over 2026.

For General Practice, this national context signals a significant shift in the elective pathway. Through this section, the intention is to support GM General Practice respond to this national shift and resultant changes in the elective care pathway.

<u>Elective Transformation 2026/27</u>	
Aim	<p>For 2026/27, the aim is to build on the 2025/26 BeCCoR Elective Quality Improvement approach to:</p> <ol style="list-style-type: none"> 1. Support GM general practice to respond to the national changes and local GM improvements in the elective care pathway; including the introduction of a national 'advice first' approach 2. Recognise GM general practice as key partners in the elective care pathway and support meaningful engagement and opportunities to shape local improvements 3. Deliver improvements in the reduction of unwarranted variation in referrals generated by general practice, with a corresponding rise in the proportion of 'Advice First' referrals compared to direct referrals generated through A+G and through utilising SPoAs (Single points of access) once rolled out across GM (roll-out to start in 2026)
Rationale	<p>In Greater Manchester, the GM Elective Recovery and Reform Programme is working with partners across the system to improve the experiences of GM residents awaiting elective care, to drive recovery of waiting lists and to lead transformation in elective care aligned to national plans.</p> <p>The programme recognises and values the role of general practice – and wider primary care – as key partners in this transformation. This specification will support delivery of this transformation in elective care for GM residents.</p>
Delivery: Supporting and Enabling General Practice as Key System Partners in Elective Recovery and Reform	

Req	Activity	Rationale	
Req 2a	Self-declaration to confirm the practice will undertake all the activities laid out in this table (Req 2b-2f) and the practice will retain evidence of these activities	Self-declaration approach to reduce reporting burden for practices. Evidence retained for payment verification purposes.	
Req 2b	The practice is signed up to, and utilising, Consultant Connect	Patients and practices are able to benefit from timely access to specialist A+G	
Req 2c	Nominate an elective lead within your practice to: <ul style="list-style-type: none"> - Champion the Quality Improvement methodology for the delivery of this work within your practice - Lead peer-to-peer discussion regarding progress of this work at regular practice meetings - Represent the practice in PCN or neighbourhood discussions regarding elective transformation - Bring the learning and outputs of the GM LIN (see 2d) into the practice to share and embed 	To reduce variation in the practice of individual clinicians and practices through peer-to-peer interactions and benchmarking	
Req 2d	Evidence of practice attendance at, and contribution to, a GM Elective Learning and Improvement Network (LIN) by a member of the practice team (ideally your elective lead)	To enable learning and sharing of best practice to drive further improvements across general practice, neighbourhoods, place and across the GM system.	
Req 2e	Adoption of new national and GM referral processes as they are rolled out – for example, enhanced clinical triage models and SPOAs (Single Points of Access)	Recognition that as elective referral pathways improve and change over 2026/27, general practice may need to review and adapt internal practice referral processes	
Req 2f	Participation in education, training and engagement – For example: attendance at BeCCoR elective webinars; engagement in place and neighbourhood work to improve elective care for patients; engagement with local acute provider via local primary care-secondary care training or discussion sessions	General practice is supported to be an active partner in driving local improvements in elective care	
Delivery continued: Quality Improvement Approach to Referral Management			
Req 2g	Continue to take a Quality Improvement (QI) approach to referral management for your practice across 10 'high impact' specialities: <ul style="list-style-type: none"> - Review your practice data regularly - Undertake clinical audit - Agree a practice-level improvement plan to increase the proportion of your A+G referrals 	General practice is adopting a QI methodology to achieve transformation in elective care through referral management approaches and adoption of new models of elective care The 10 High Impact Specialities: <ul style="list-style-type: none"> o Cardiology 	

	<p>compared to direct referrals across the 10 high impact specialities; <u>this plan should focus on how the practice will adopt an 'advice first' approach and will maximise alternatives to referral whilst also maintaining clinical safety and appropriateness</u></p> <ul style="list-style-type: none"> - Monitor your data and modify your improvement plan accordingly based on what is working well and what isn't <p>Please keep evidence of the QI work undertaken but note that routine submissions will not be required. An elective template is available on BeCCoR landing page for you to use and keep as evidence, although submission is NOT required.</p>	<ul style="list-style-type: none"> o Gastroenterology o Respiratory o Dermatology o Gynaecology o Urology o ENT o Trauma and Orthopaedics o Paediatrics o Neurology
	<p>Please build on your 2025/26 practice quality improvement actions plans. <u>Examples of elements to consider including within your practice improvement plan include:</u></p> <ul style="list-style-type: none"> o Utilise SPoA/Advice First approach to all referrals to 10 high impact specialities o Where SPoA is not available, use Consultant Connect or available Advice & Guidance services e.g. develop practice protocols to guide the use of Consultant Connect and A+G o Maximise the usage of appropriate available primary and community services as alternative to referral, including utilising care navigation; use of 'watch & wait' approach & manage patient expectations; standardised clinical pathways for common conditions across specialities o Work with the practice admin team to update referral workflow within the practice to ensure alignment with the practice improvement plan o Ensure practice staff have completed relevant training / education & sharing of appropriate resources and support tools (e.g. guidelines) o Utilise a clinician within a practice or PCN with a special interest within the identified specialties to support decision making, e.g. use of dermatoscopy in practice ahead of dermatology referral o Discuss referrals at regular practice meetings and undertake regular clinical audit of referrals o Provide information in locum / hub packs & protocols to support locum GPs 	
<p>KPIs</p>	<p>Achievement is based on 3 elements</p> <ul style="list-style-type: none"> • Requirement 2a-2f: £0.30php for these elements AND • Requirement 2g (1): £0.35php based on achievement thresholds AND • Requirement 2g (2): £0.35php based on achievement thresholds <p>Please note, exceptionality is described in the table below</p>	
<p>Req 2a-2f</p>	<p>Self-declaration completed And Evidence from CC platform of practice utilising Consultant Connect And</p>	<p>Payment of £0.30php if all of these elements are achieved</p>

	Practice attendance at LIN (minimum 2 sessions)		
Req 2g (1)	<p>Evidence practice has adopted an ‘advice first’ approach:</p> <p>Increase in Advice and Guidance referrals equivalent to 10% of referrals in the 10 high impact specialities from practice baseline (Baseline – 2025/26 referrals generated across 10 high impact specialities; includes trust A+G and consultant connect)</p>	£0.35php	
Req 2g (2)	<p>Evidence of impact:</p> <p>By increasing proportion of referrals generated via ‘Advice First’, there is expected to be a corresponding (and clinically appropriate) reduction in generated referrals per head of population across the 10 high impact specialities – i.e. by increasing the use of A+G or SPOAs as an advice first route to referrals, there will be a corresponding reduction in directly generated referrals; as well as clinically appropriate reductions due to using Consultant Connect or alternatives to referral.</p> <p>A note on clinical appropriateness: 2ww referrals on suspected cancer pathways are not included in this KPI and should continue unchanged. For non-2WW referrals, the shift described here is to adopt an advice first approach to referrals so that patients can access timely specialist advice or diagnostics. This is not about rationing referrals and clinically appropriate referrals should continue to be made.</p> <p>(Baseline – year to date comparison 31st March 2026 compared to 31st March 2025)</p>	<p>£0.35php</p> <p>70% of payment for 2% reduction in generated referrals/head population, increasing on sliding scale to 100% for achievement of a 5% reduction in generated referrals/head population</p> <p>e.g. 2% reduction = 70% payment 3% reduction = 80% payment 4% reduction = 90% payment 5%+ reduction = 100% payment</p>	
	<p>Exceptionality:</p> <p>It is anticipated that these KPIs are achievable by adopting an advice first approach and without compromising clinical care.</p> <p>In the exceptional circumstance where a practice has already adopted a fully advice first approach and therefore does not believe a further 10% increase in A+G utilisation is possible, please contact NHS GM in Quarter 1 (by 30th June 2026) to review baseline position.</p> <p>Where these KPIs Req 2g (1) and (2) are not met due to exceptional circumstances on clinical or patient safety grounds, practices can request a discussion with NHS GM to present evidence of work done and evidence of impact. A decision-making process will then be applied to determine whether presented evidence will lead to payment. Please do this as early as possible.</p>		
Key Dates	<p>Quarter 1 – work through Reqs 2a-2g</p> <p>Quarter 1-4 – deliver improvement plan to work towards achieving KPIs. Use QI template to retain evidence of work undertaken.</p>		

	<p>Quarter 1-4 – partake in training webinars; at least quarterly attendance at Learning and Improvement Network; practice lead to engage in place based elective workshops/system events. Retain evidence.</p> <p>Achievement of KPIs will be assessed as of 31st March 2027</p> <p>April 2027 – some practices will be asked to submit Post Payment Verification evidence</p>	
<p>NHS GM Resources</p>	<p>Supporting Resources</p>	
	<p>Self-Declaration</p>	<p>To be undertaken at scheme sign up</p>
	<p>Consultant Connect</p>	<p>User Guide will be shared via BeCCoR webpage</p>
	<p>Quarterly GM Elective Learning and Improvement Network (LIN)</p>	<p>Dates will be shared</p>
	<p>Data Dashboards: 1) GP Referrals Generated Dashboard 2) A+G Dashboard</p>	<p>These dashboards have been developed to support this specification and a link to the dashboards is on the BeCCoR landing page.</p> <p>Training webinars will also be available.</p>
	<p>Searches within GP IT systems</p>	<p>Searches for the 10 high impact specialities will be available within GP IT systems to enable practice audit</p>
	<p>QI Template</p>	<p>A simple QI based template will be available for practices to use to evidence this activity has been undertaken.</p> <p>Please note, routine submission is not required, but please retain for payment verification and appeal purposes.</p>
	<p>Webinars</p>	<p>This elective specification will be included as part of the series of BeCCoR launch and data webinars. Additional sessions will be communicated by NHS GM teams. These may be pan-GM events or locality specific in conjunction with acute providers.</p>

Section 3: Prevention, Population Health and Neighbourhoods

Prevention, Population Health and Neighbourhoods: Cohort-Based Multimorbidity Reviews	
Aim	<p>Implement at scale a combined Population Health Management and Neighbourhood/Live Well model that:</p> <ul style="list-style-type: none"> • Identifies and prioritises people with high unmet clinical need across selected long-term condition cohorts, leading to optimised clinical care • Supports completion of high-impact cohort-based reviews and optimisation actions to prevent worsening ill health and reduce avoidable urgent care use (including avoidable ED attendances) • Further strengthens existing neighbourhood partnerships and Live Well pathways to improve engagement and holistic support for people who are not engaging and/or have additional non-medical needs that impact health outcomes. <p><i>This section builds on the learning, evidence and evaluation from BeCCoR 2024/25 and 2025/26 population health and prevention schemes.</i></p>
Rationale	<p>This section focuses on conditions that drive significant morbidity, avoidable urgent and emergency care use, and health inequalities, and where there is a strong evidence base for proactive optimisation in General Practice.</p> <ul style="list-style-type: none"> • Cardiovascular disease (CVD), related risk factors (hypertension, hyperlipidaemia and atrial fibrillation) and diabetes are core priorities within the Greater Manchester prevention approach. • Respiratory disease (COPD and Asthma) is a major driver of high symptom burden, time out of school/employment, preventable hospital admissions and avoidable deterioration in health outcomes. • These conditions are experienced at higher rates by people experiencing socio-economic disadvantage and other inequality groups, who may also be less likely to engage effectively with health services: To maximise impact, General Practice will work with neighbourhood partners as part of a Live Well approach to better engage people and connect them to wider support that will improve outcomes. This benefit will be felt by the BeCCoR cohorts, plus is anticipated to positively impact a wider population. • The drivers of unmet need are heavily influenced by wider social determinants and cannot be addressed by General Practice in isolation. Integrated neighbourhood models support a more sustainable system by enabling teams and services to work together (NHSE 2022¹).
Delivery Requirements	<p><u>Requirement 3a: Cohorts and corresponding reviews</u></p> <p>The table below summarises the BeCCoR eligible cohorts and the required review type for each cohort. Appendix B outlines how the cohorts have been identified and the clinical components of each review.</p>

¹ [Microsoft Word - FINAL 003 250522 - Fuller report\[46\].docx](#)

BeCCoR cohort	Required review
CVD and Diabetes (CVNeed) high-need cohort	CVD/Diabetes High-Need Review (core)
CVD and Diabetes (CVNeed) high-need cohort	CVD/Diabetes High-Need Review + ACR (stretch)
Primary Prevention – High QRISK cohort	Primary Prevention Lipid Risk Review
Respiratory – COPD high-need cohort	Enhanced COPD Review
Respiratory – Asthma (adult) high-need cohort	Enhanced Asthma Review (adult)
Respiratory – Asthma (children and young people) high-need cohort	Enhanced Asthma Review (CYP)

Additional information to support delivery of Requirement 3a:

Digital access to cohorts and dashboards

- Practices will access their full BeCCoR cohorts using Re-identification (ReID) and a dashboard available via BeCCoR webpage.
- Practices can view the full cohort list, filter as required, and download named lists to support recall and delivery.
- Training will be provided as part of the BeCCoR launch webinars.

Cohort definitions and measurement rules

- Unless otherwise stated, cohorts will be *defined as of 1st April 2026* for the purpose of measurement and payment.
- In general, these cohorts should be fixed but may fluctuate dependant on patients registering or deregistering from the practice – following QOF business rules
- No exception reporting applies to BeCCoR cohorts. Patients who register with the practice in the last 3 months of the financial year will be excluded if they do not already have a coded review – as per QOF.
- Patients who are coded as GSF Red, Amber or Yellow are also excluded if they do not already achieve.
- Cohort definitions, completion criteria and any patient movement rules are provided in the appendices.

Sociodemographic lens and prioritisation

- Once cohorts are defined for the practice by accessing the ReID and Curator tools, patients will be presented to the practice via a list that is prioritised within cohorts to support practices to focus first on those with the greatest unmet need and highest barriers to care.
- The analytic tools allow each practice to further understand cohorts, as each cohort can be filtered using deprivation (IMD), frailty (as a vulnerability indicator), mental health (anxiety or depression), multiple sick notes (as a proxy for being out of work) and previous non-attendance/missed reviews. This will be demonstrated via the launch webinars.
- This prioritised view should be used to support practice recall planning, delivery and neighbourhood discussion; it does not change cohort eligibility or review requirements.

Requirement 3b: Agreeing a 'BeCCoR Neighbourhood Action Plan' with Neighbourhood Partners

Following practice engagement with neighbourhood teams, practices are expected to participate in the development of a 'BeCCoR neighbourhood action plan' with neighbourhood teams, including voluntary, community, faith and social enterprise (VCFSE) partners. The plan should include:

- Description of the BeCCoR cohorts in Req 3a (or groups within cohorts) have been agreed for neighbourhood focussed interventions
- Strategies to overcome identified barriers to accessing clinical care for the agreed cohort(s)
- Opportunities as part of broader 'Live Well' working for both clinical and non-clinical interventions that address wider determinants of health and support behaviour change
- Aims and expected outcomes
- SMART activities and working arrangements to achieve these over 2026-2027
- It is expected that many of these activities and working arrangements will by their nature, reach and benefit wider populations as well as the BeCCoR target cohorts – this is actively encouraged

Additional information to support delivery of Requirement 3b:

Building relationships and understanding Cohorts as part of Shared Neighbourhood Priorities

GP practices (and/or PCNs where locally agreed) will be expected to attend neighbourhood forums and work collaboratively with key neighbourhood partners to develop a shared action plan. This plan is aimed at better reaching the non-engaged BeCCoR cohort, addressing broader needs that impact health and wellbeing, or supporting healthy lifestyle and behaviours. This could include approaches that have a benefit for a broader population in addition to the identified BeCCoR cohort, but should result in better engagement with, and outcomes for, people within the BeCCoR cohort as a minimum.

The action plan will be informed by neighbourhood priorities, insights and opportunities, along with non-identifiable General Practice insights, including demographic data. It will be developed through neighbourhood engagement and co-production activities. It could consider:

- Groups experiencing health inequalities, including inclusion groups
- Emerging clinical and non-clinical needs (e.g. debt/finances, housing, lifestyle related health issues etc)
- Barriers to accessing general practice via routing recall processes
- Barriers to addressing health and wellbeing needs that could be overcome through partnership with neighbourhood partners and communities

Local Ownership of the BeCCoR Neighbourhood Action Plan

	<p>The BeCCoR Neighbourhood Action Plan will be agreed through an identified, and in most places an already established, neighbourhood forum. The plans will include agreed actions to:</p> <ul style="list-style-type: none"> • Engage groups and communities that general practice is finding it most challenging to reach – to include people within the BeCCoR cohort • Identify opportunities for both clinical and non-clinical interventions that address wider determinants of health and support behaviour change • Map and strengthen referral pathways to 'Live Well' - wider neighbourhood offers and VCFSE and community-based advice, lifestyle and wellbeing support, again ensuring this includes pathways for the BeCCoR cohort <p>Where neighbourhood forums already exist that align with general practice or PCN populations, these should be utilised. Where they do not, pragmatic alignment should be made, with support from place-based partnerships. Please identify instances where neighbourhood structures are not available to your practice/PCN early to NHS GM and place partnership teams.</p> <p>An evaluation framework has been developed by NHS GM to support each neighbourhood team to demonstrate and evaluate the impact of the neighbourhood work. This will be published on the BeCCoR webpage at the launch of the scheme and should be considered and built into neighbourhood action plans.</p> <p><u>Requirement 3c: Neighbourhood Prevention Allocation</u></p> <p>Each place partnership (locality) will have a Neighbourhood Prevention Allocation (a financial allocation) available through NHS Greater Manchester to fund additional costs for partnership activities in the action plans.</p> <p>The oversight of this allocation will sit within place partnership teams, who will provide a steer early in the year on the content of the action plans, to support their alignment with strategic priorities including place neighbourhood plans.</p> <p>The use of the Neighbourhood Prevention Allocation will be overseen by Place through place based partnership governance. Funding decisions will take place at Place and must be in collaboration and agreement with the local GP board (or equivalent mechanism where there is no GP board), to align with strategic priorities, including Neighbourhood Health Plans. For the purposes of financial flows, the default position will be that Neighbourhood Prevention Funding will flow to GP practices. Where this is not the case, e.g. funding to PCNs or wider partners, this must be formally communicated by place teams to NHS GM by end of Quarter 1 (30th June 2026).</p> <p>An evaluation framework has been developed by NHS GM to support each place team to demonstrate and evaluate the impact of the Neighbourhood Prevention Allocation. This will be published on the BeCCoR webpage at the launch of the scheme.</p>
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	<p>NHS GM will agree a process with place teams by which to ratify the locality plans and ensure clarity of financial flows, and to agree evaluation timelines.</p> <p>To support this work further, examples of activities that could be considered as part of neighbourhood action plans can be found in Appendix C.</p>
<p>Key Performance Indicators</p>	<p>Requirement 3a: Clinical delivery (cohort-based)</p> <ul style="list-style-type: none"> • Primary measure: Number of complete BeCCoR reviews recorded in-year (by review type) • A review is counted as complete when all required elements for that review type are recorded for an individual within the financial year (completion criteria in Appendix B). • Achievement will be extracted from clinical codes and surfaced via Curator dashboards; there is no separate manual reporting requirement for this part of the scheme. <p><u>Achievement thresholds:</u></p> <p>Clinical payment is based on the number of reviews completed, with a minimum threshold of 30% achievement before any payment is earned. The different reviews receive different payments based on the activity required to complete that review. A financial allocation will be calculated for each type of review in every practice based on the size of the relevant cohort.</p> <p>Payment will be made on a sliding scale as below:</p> <p>0-29.9% of reviews completed – no payment 30% of reviews completed – 30% of financial allocation plus 10%, and thereafter up to 79.9% of reviews completed – 79.9% of financial allocation plus 10% 80% of reviews completed – 100% of financial allocation</p> <p>Requirement 3b: Neighbourhood and Live Well delivery</p> <ul style="list-style-type: none"> • Each practice will identify 1–2 leads from the practice team for the Prevention, Population Health and Neighbourhoods scheme (as a minimum 1 lead must be a clinical prescriber). • Each practice will proactively engage with neighbourhood teams/relevant fora (minimum 1 formal engagement session per quarter, plus additional working meetings as required to develop and co-ordinate delivery of the Plan), with support from PCNs where agreed locally. • Agree a joint neighbourhood delivery plan (SMART objectives) including identification process and impact metrics to support in-year evaluation. A template for documenting your neighbourhood action plan has been developed and is available on BeCCoR webpage. Neighbourhood action plan to be submitted to place based teams by 30 June 2026. • Note: the names of practices involved in plan will be listed on this document so it can be a joint submission. • Delivery of the neighbourhood action plan to take place over 2026-27 (supported by neighbourhood prevention allocation)

	<ul style="list-style-type: none"> • Update the Neighbourhood Action Plan template to reflect the progress made and impact. Template available on BeCCoR webpage. Submit to place teams by 1st March 2027. • Record non-clinical interventions on the practice clinical system using appropriate SNOMED/social prescribing codes (coding guidance in appendices) to help to evidence work done • Ensure the wider practice team (including care navigation/front of house) is aware of the practice's agreed neighbourhood/Live Well offer and local referral/signposting routes to maximise utilisation <p>Retain evidence of these activities for payment verification purposes.</p> <p><u>Achievement thresholds:</u></p> <ul style="list-style-type: none"> • A flat fee will be paid for neighbourhood engagement and submission of an approved Q1 and Q4 joint neighbourhood action plan <p>Requirement 3c: Neighbourhood Prevention Allocation As described in the delivery section above, there is a Neighbourhood Prevention Allocation to fund aspects of plan delivery.</p> <p>This will be coordinated by place teams, and the submission of your neighbourhood action plans will inform this use of this fund, with the intention of supporting mobilisation of delivery of actions from Q2.</p> <p>A place level evaluation of impact will be undertaken to demonstrate the impact.</p>
<p>Key Dates</p>	<ul style="list-style-type: none"> • Neighbourhood element: quarterly engagement and Q1 and Q4 plan reporting to Place (submission dates 30th June 2026 and 31st March 2027)

Section 4: Medicines Optimisation

The BeCCoR Medicines Optimisation (MO) requirements align to Greater Manchester’s ambition to deliver safer, more effective, and sustainable use of medicines across primary care.

MO is defined as a person-centred approach to safe and effective medicines use, ensuring that individuals receive the right medicines, at the right time, and are actively engaged in decisions about their care. This approach requires a system-wide commitment, embedding best practice across all clinical pathways and interfaces, and supporting continuous improvement in prescribing and medicines management.

This section is split into the following components for delivery:

- MO1: Antimicrobial Stewardship (AMS)
- MO2: Shared Care of Medicines (SCOM)
- MO3: Value: Direct Oral Anti Coagulation (DOAC) Optimisation
- MO4: Value: Low priority prescribing
- MO5: A Population Health Approach to Medicine Safety: GM SaferPrescribingNeed
- MO6: Tirzepatide Prescribing: Clinical Data Quality

Any queries specifically relating to the Medicines Optimisation specification should be directed to: nhsqm.beccormedsopt@nhs.net

MO1: Antimicrobial Stewardship (AMS)	
Aim	To deliver measurable improvements in AMS across GM primary care, focusing on leadership, prescribing optimisation (including paediatric prescribing), and documentation.
Rationale	<p>Antimicrobial resistance (AMR) is a global public health crisis that threatens the effectiveness of essential antibiotics. The emergence and spread of drug-resistant bacteria not only undermine modern medicine but also pose a substantial economic burden on healthcare systems worldwide.</p> <p>The 2024-2025 ESPAUR Report details the overall burden of resistance continues to grow, with a 9.3% increase from 2023 to 2024. London and the Northwest continue to experience the highest AMR burden, a trend that has been observed since national reporting began.</p> <p>The scheme builds on the 2025/26 AMS scheme, retaining Domains 1–3 and replacing Domain 4 with a new paediatric prescribing target to address high rates of antibiotic use in children aged 0–9 years.</p>

<p>Delivery</p>	<p>Delivery of this specification will be driven through 4 requirements:</p> <ol style="list-style-type: none"> 1. Requirement 1 (Drivers for AMS): <ul style="list-style-type: none"> • Nominate an AMS Champion. • Participate in World AMR Awareness Week (WAAW). • Submit a Quality Improvement (QI) plan with outcomes. 2. Requirement 2 (Reduction in total antibiotic prescribing): <ul style="list-style-type: none"> • Reduction in overall antibiotic items per STAR-PU to ≤ 0.871. The 12-month rolling figure on March 31st 2027, will be compared to the baseline figure on March 31st 2026, to calculate achievement. 3. Requirement 3 (Reduction in broad spectrum antibiotic prescribing and increased coding): <ul style="list-style-type: none"> • The 12-month rolling figure on March 31st 2027, for the proportion of antibiotics prescribed from broad spectrums (cephalosporins, co-amoxiclav and quinolones) to be $\leq 10\%$ <p style="text-align: center;">AND</p> <ul style="list-style-type: none"> • $\geq 70\%$ of broad-spectrum antibiotic prescriptions issued between April 1st 2026, and March 31st 2027 must have a coded indication. 4. Requirement 4 (Antibiotic prescribing in Children 0-9 Years): <ul style="list-style-type: none"> • Percentage of registered children aged 0–9 years prescribed ≥ 1 antibiotic in last 12 months $\leq 25\%$ (national target) by March 31st 2027 														
<p>Key Performance Indicators</p>	<table border="1"> <thead> <tr> <th data-bbox="491 1205 778 1249">Indicator</th> <th data-bbox="778 1205 1449 1249">Description</th> </tr> </thead> <tbody> <tr> <td data-bbox="491 1249 778 1344">AMS Leadership & Engagement</td> <td data-bbox="778 1249 1449 1344">Nomination of an AMS Champion and evidence of participation in World AMR Awareness Week (WAAW)</td> </tr> <tr> <td data-bbox="491 1344 778 1438">QI Plan</td> <td data-bbox="778 1344 1449 1438">Submission of a QI plan at the beginning of the year followed by a final evaluation of outcomes and reflections at the end of the year</td> </tr> <tr> <td data-bbox="491 1438 778 1532">Total Antibiotic Prescribing / STAR-PU</td> <td data-bbox="778 1438 1449 1532">12-month rolling antibiotic items per STAR-PU. Achievement is measured as a reduction from baseline (March 2026) with a target of ≤ 0.871</td> </tr> <tr> <td data-bbox="491 1532 778 1626">Broad-Spectrum Prescribing</td> <td data-bbox="778 1532 1449 1626">Proportion of total antibiotics prescribed that are broad spectrum must be maintained below or reduced to $\leq 10\%$</td> </tr> <tr> <td data-bbox="491 1626 778 1720">Broad-Spectrum Indication Coding</td> <td data-bbox="778 1626 1449 1720">$\geq 70\%$ of broad-spectrum antibiotic prescriptions must have a coded clinical indication entered at the time of prescribing</td> </tr> <tr> <td data-bbox="491 1720 778 1803">Paediatric Prescribing Target</td> <td data-bbox="778 1720 1449 1803">Percentage of registered children aged 0–9 years prescribed ≥ 1 antibiotic in the last 12 months (National Target: $\leq 25\%$)</td> </tr> </tbody> </table>	Indicator	Description	AMS Leadership & Engagement	Nomination of an AMS Champion and evidence of participation in World AMR Awareness Week (WAAW)	QI Plan	Submission of a QI plan at the beginning of the year followed by a final evaluation of outcomes and reflections at the end of the year	Total Antibiotic Prescribing / STAR-PU	12-month rolling antibiotic items per STAR-PU. Achievement is measured as a reduction from baseline (March 2026) with a target of ≤ 0.871	Broad-Spectrum Prescribing	Proportion of total antibiotics prescribed that are broad spectrum must be maintained below or reduced to $\leq 10\%$	Broad-Spectrum Indication Coding	$\geq 70\%$ of broad-spectrum antibiotic prescriptions must have a coded clinical indication entered at the time of prescribing	Paediatric Prescribing Target	Percentage of registered children aged 0–9 years prescribed ≥ 1 antibiotic in the last 12 months (National Target: $\leq 25\%$)
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Achievement																
Indicator	Payment Threshold															
AMS Leadership & Engagement & QI plan	<p><u>Requirement 1: Maximum reward of £0.30 php</u></p> <p>All the following are required for payment:</p> <ul style="list-style-type: none"> Nominate an AMS Champion. Participate in World AMR Awareness Week (WAAW). Submit an approved Q1 Quality Improvement (QI) plan and Q4 QI plan with outcomes and next steps. (See Appendix F for guidance) 															
Total Antibiotic Prescribing / STAR-PU	<p><u>Requirement 2: Maximum reward of £0.30 php</u></p> <p>Payment will be based on performance against antibiotic prescribing data:</p> <ul style="list-style-type: none"> GP practice maintains or meets national target ≤ 0.871 antibiotic items per STAR-PU – 100% award (£0.30php) For GP practices who are above the national target, a sliding scale methodology will be applied. Therefore, if a GP practice is >0.871 but they reduce antimicrobial prescribing (from their March 2026 baseline) via the following sliding scale, payment will be as a % as per the below. NOTE: If your practice is tied to additional services (e.g., a walk-in centre), prescribing may be recorded against the main practice and distort the data. Where this applies, request a separate cost centre code to keep prescribing activity separate. Please contact your local NMP lead to arrange this. <table border="1" style="width: 100%; text-align: center;"> <thead> <tr> <th style="width: 25%;">Items reduced</th> <th colspan="4">*based on individual GP practice</th> </tr> </thead> <tbody> <tr> <td>Items per STAR-PU</td> <td><0.871</td> <td>0.872-0.961</td> <td>0.962 - 1.050</td> <td>1.051-1.140</td> </tr> <tr> <td>Payment percentage (%) based on achievement</td> <td>100%</td> <td>75%</td> <td>50%</td> <td>25%</td> </tr> </tbody> </table>	Items reduced	*based on individual GP practice				Items per STAR-PU	<0.871	0.872-0.961	0.962 - 1.050	1.051-1.140	Payment percentage (%) based on achievement	100%	75%	50%	25%
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Broad-Spectrum Prescribing	<p><u>Requirement 3: Maximum reward of £0.20 php</u></p> <p>Payment based on performance:</p>															

	<p>and coding indication</p>	<ul style="list-style-type: none"> • GP practice meets national target $\leq 10\%$ for co-amoxiclav, cephalosporins and quinolones prescriptions AND • 70% of all co-amoxiclav, cephalosporins and quinolones are coded with an indication when prescribed OR • For practices where the percentage of co-amoxiclav, cephalosporins and quinolones prescriptions is $> 10\%$ but a reduction in the 12-month rolling figure of $\geq 10\%$ from baseline can be seen by March 2027, 80% reward will be given. The requirement for 70% of broad-spectrum antibiotic prescriptions with a coded indication must also be met.
	<p>Paediatric Prescribing Target</p>	<p><u>Requirement 4: Maximum reward of £0.20 php</u></p> <p>Percentage of registered children aged 0–9 years prescribed ≥ 1 antibiotic in last 12 months $\leq 25\%$ (national target) by March 2027</p> <ul style="list-style-type: none"> • 100% reward if score is $\leq 25\%$ • 80% reward if score $> 25\%$ but there was a 10% reduction from March 2026 baseline figure
<p>Key Dates</p>	<p>End of Q1 submission – 30th June 2026</p> <p>Nominate AMS lead Submission of QI plan at a PCN or GP practice level (outcomes and next steps to follow in Q4),</p> <p>End of Q4 submission – 31st March 2027</p> <p>Submission of QI plan outcomes and next steps Submission of evidence of participation in WAAW</p> <p>*Note: all submissions to be done via online airelogic forms</p>	
<p>NHS GM Support available</p>	<p>Launch webinar GM Tableau dashboard for domain, 2, 3, and 4 QI and evaluation templates GMMMGM antimicrobial guidance and resources antimicrobial guidance and resources WAAW support materials to be hosted on the BeCCoR landing page.</p>	

MO2: Shared Care of Medicines (SCOM)	
Aim	<p>To establish a single, standardised approach to delivery of SCOM services across all GM general practices, ensuring safe, equitable and sustainable delivery of shared care activity through shared care protocols and consistent commissioning.</p> <p>This is to accompany the wider system work on SCOM, that is being led by the SCOM Taskforce.</p>
Rationale	<p>Shared care of medicines (SCOM) is a nationally recognised pathway to enable seamless prescribing and monitoring of higher risk medicines and allowing patients to receive care closer to home in an integrated and convenient manner.</p> <p>The Greater Manchester (GM) SCOM programme – overseen by the GM SCM Taskforce - aims to address the long-standing <i>system</i> issues faced with SCOM pathways through a quality improvement (QI) approach, and in turn, transform them into an offer that is safe, equitable and affordable for the GM population. The programme is led by a multi-disciplinary and cross-sector taskforce group including representatives from LMC, Primary Care Board, Trusts and the ICB. The work of the taskforce is ongoing and includes commissioning appropriate SCOM services with secondary care.</p> <p>For 2026/27, this BeCCoR scheme builds on the previous QI SCOM forerunner scheme and transitions to a standardised cohort tariff-based specification reflecting local service delivery.</p> <p>The SCOM Programme acknowledges there remain '<i>shared care pathways still under review</i>' (see Appendix D). The SCOM programme will continue to work with the SCOM taskforce and specialist services at pace to address the barriers to these arrangements with the aim to embed refreshed pathways during 26/27.</p>
Delivery	<p>The Greater Manchester Medicines Management Group (GMMM) has identified medicines suitable for shared care and published drug-specific shared care protocols.</p> <p>Where shared care is agreed to or continued for these medicines by the GP practice, under this scheme delivery constitutes the practice prescribing and monitoring medicines as per the shared care arrangement.</p> <p>Core Requirements for GP Practices Practices delivering this service must:</p> <ul style="list-style-type: none"> • Review and respond to new shared care of medicines requests within 14 days of receiving the request to confirm acceptance or refusal of shared care. • Code all decisions (accepted, declined, or “accepted with concerns” *) using agreed SNOMED codes (see SNOMED code section) for new and historical shared care prescribing. • Maintain an up-to-date register of shared care patients. • Ensure prescribing and monitoring are undertaken as per the relevant SCP requirements.

**This scheme acknowledges that GP practices may continue to accept shared care requests when concerns remain with the associated pathway, although the practice continues to manage these concerns and any associated risks in the best interests of the individual patient over 2026/2027 whilst the ongoing work by the GM SCOM taskforce continues at pace to resolve and address these concerns. The decision to accept in this instance will be made by the GP practice.*

In addition, GP practices will:

- Access and follow GMMMGM shared care protocols (SCPs).
- Comply with local commissioning policies on the prescribing of shared care of medicines.
- Produce and maintain an up-to-date register of all patients prescribed medicines under a SCP, including patient name, date of birth, NHS number and the medicines prescribed. Details of the indication and planned duration (including indefinite) of treatment should be easily identifiable from each patient's computerised medical records within the GP practice.
- Operate effective call and recall of patients to ensure review takes place either in a hospital or general practice setting so that patients are not lost from follow-up and relevant monitoring is undertaken. The level and frequency of review will be appropriate to the shared care protocol and can include opportunistic reviews.
- Maintain an effective repeat prescribing system to support safe prescribing.
- When necessary, refer patients promptly to other relevant services and/or support agencies using locally agreed guidelines and referral policies, where they exist.
- Feedback to NHS GM where shared care has been declined via MS Forms to escalate challenges with pathways.
The form should only be completed once communications have been made with the specialist service and a final decision has been made to decline sharing the care of medicines.
[Please note, declining shared care agreements with specialist services must be done with due regard to professional and clinical responsibilities and in the best interests of the individual patient. If considering cessation of established treatment, please contact specialist services and local medicines optimisation teams for support.](#)
- Record all relevant patient safety incidents related to delivery of this service or to treatment with the medicine that is prescribed and monitored under this service using the Learning from Patient Safety Events (LFPSE) portal.

Inclusion Criteria

This service applies to patients who:

- Are registered with a general practice within NHS GM** and either attend the practice for monitoring or receive monitoring at home (including temporarily or permanently housebound patients).

And

- The practice is taking responsibility for prescribing and/or monitoring and/or administering a Shared-Care eligible medicine, defined as:
 - Adult medicines: listed within the GMMMGM Formulary with Amber (shared care) RAG status

	<p>- Paediatric medicines: included within the GMMMG Paediatric Amber List.</p> <p>**Patients newly registered in GM who are already receiving an Amber/shared-care medicine and are awaiting first specialist contact may be included.</p> <p>Exclusion Criteria</p> <p>The following patients are not included within this specification:</p> <ul style="list-style-type: none"> • Patients prescribed an eligible shared-care medicine where no prescribing or monitoring activity has been provided by the GP practice within the 26/27 financial year. • Patients prescribed a medicine that is not eligible for shared care under this specification, including where: <ul style="list-style-type: none"> • NHS GM does not commission the medicine for the indication • NHS GM has not yet confirmed a commissioning position — GMMMG should be notified • A Shared Care Protocol (SCP) is not yet available or approved • Shared care activity cannot be claimed for medicines without a GMMMG-approved SCP, even if the medicine holds (or is expected to hold) an Amber RAG status. <p>The GP practice can decline to accept prescribing responsibility, but in doing so will be out of scope of this service specification.</p> <p>Reporting</p> <p>Reporting will be automated through GP data flow to the Analytics and Data Science Platform (ADSP) based on appropriate coding.</p> <ul style="list-style-type: none"> • Number of qualifying patients in each banding (see appendix D for definition of banding) • Number of qualifying patients on each medicine (see appendix D for drug list associated with each band). <p>The Provider will qualify for one payment per patient, per qualifying medicine. If a patient is on more than one qualifying medicine, the above reported numbers should include each drug. This will be automated through GM Tableau.</p> <p>Escalation of Issues</p> <p>An escalation process is being developed to support general practice where issues with SCOM arrangements arise. This is in response to feedback from general practice. This sits within the work of the GM SCOM taskforce and further information will be communicated with practices. Please also use A+G where available to communicate with acute providers particularly around physical health pathways where issues arise.</p>
<p>Achievement</p>	<p>Cohort based reimbursement for practices based on number of patients prescribed shared care medicines.</p> <p>Payment will be banded cohort fees based on monitoring intensity, plus a specific item of service fee for depot administration.</p>

	<p>(Banded cohorts identified as “a” are for those localities and associated GP practices who do not have additional funding for phlebotomy services in place as part of an LCS)</p> <table border="1" data-bbox="491 443 1406 1057"> <thead> <tr> <th>Medication Band</th> <th>Payment per annum per patient</th> </tr> </thead> <tbody> <tr> <td>Band 1</td> <td>£103.46</td> </tr> <tr> <td>Band 1a</td> <td>£130.41</td> </tr> <tr> <td>Band 2</td> <td>£77.59</td> </tr> <tr> <td>Band 2a</td> <td>£97.80</td> </tr> <tr> <td>Band 3</td> <td>£51.72</td> </tr> <tr> <td>Band 3a</td> <td>£65.19</td> </tr> <tr> <td>Band 4</td> <td>£37.25</td> </tr> <tr> <td>Band 4a</td> <td>£43.99</td> </tr> <tr> <td>Depot Administration Fee</td> <td>£10.71</td> </tr> </tbody> </table> <p>Payment will be based on coded shared care.</p> <p>In the first instance, due to current coding being very varied, we will use EPACT2 data to calculate the potential funding that each practice could earn. This will form the basis of interim payments in Q1 and Q2. We will then assess the actual coded Shared Care during Q3 and will adjust the payment accordingly, making any reconciling payments or reductions as necessary.</p> <p>See Appendix D for Banding.</p>	Medication Band	Payment per annum per patient	Band 1	£103.46	Band 1a	£130.41	Band 2	£77.59	Band 2a	£97.80	Band 3	£51.72	Band 3a	£65.19	Band 4	£37.25	Band 4a	£43.99	Depot Administration Fee	£10.71
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<p>NHS GM Support available</p>	<p>NHS GM Shared Care Task Force – an FAQ document will be produced to address some the key queries raised about SCOM and the ongoing work of the GM SCOM taskforce GMMMM Approved Shared Care Protocols</p> <p>GMMMM is responsible for:</p> <ul style="list-style-type: none"> • determining the RAG classification of medicines • approving Shared Care Protocols (SCPs) and associated monitoring requirements • reviewing existing RAG classifications when new evidence or pathways change • maintaining publication of SCPs and formulary designations • determining Banding of Amber medicines (subject to GM CEG approval) 																				
<p>Applicable Service Standards</p>	<p>Applicable Professional & Clinical Standards GP practices must deliver care in line with national professional standards including:</p>																				

	<ul style="list-style-type: none"> • General Medical Council, Good practice in prescribing and managing medicines and devices • British Society for Rheumatology guidelines • British Society of Gastroenterology guidelines • Specialist Pharmacy Service, Drug Monitoring
SNOMED Codes	<ul style="list-style-type: none"> • Accept - 'Shared care prescribing' – SNOMED ID: 2534089011 • Accept however concerns remain with the SCOM pathway - management plan for shared care - SNOMED Concept ID 8803310000000106 • Declined: shared care prescribing declined' – SNOMED Concept ID 415523003 (Note: where prescribing of shared care medicines remains with the specialist service, GP practices must ensure this medicine is added to the patient's medication list as 'hospital only' or 'drugs prescribed by others' to ensure an up-to-date medication history is available) • Shared care ended - High risk treatment stopped - SNOMED Concept ID 170912005 • Patients on shared care medicines have monitoring undertaken - High Risk Drug Monitoring – Shared Care SNOMED 20581010000109

MO3: Value: Direct Oral Anti Coagulation (DOAC) Optimisation	
Aim	To ensure all patients prescribed a DOAC undergo regular screening in accordance with NICE guidance and to consider the most cost-effective use of DOACs tailored to individual patient needs.
Rationale	<p>MHRA released a Drug Safety Update in October 2019 stating that issuing DOACs and other drugs where the dosage is determined by renal function should calculate Creatinine Clearance (CrCl) using the Cockcroft-Gault formula as the most accurate marker of renal function, not eGFR.</p> <p>A GM-wide clinical system data search has revealed significant gaps in the monitoring of renal function for patients prescribed direct oral anticoagulants (DOACs). Specifically, it was found that 69.5% of patients across Greater Manchester who are being prescribed a DOAC did not have an up-to-date CrCl. 8% of patients receiving a DOAC have never had a CrCl level calculated and documented in their medical records.</p> <p>Additionally, there is currently variation in DOAC prescribing across GM and there are multiple reasons that sit behind this. GM GP practices range from 30% to 100% of their total DOAC patients using one of the most cost effective DOAC, i.e. either Apixaban or Rivaroxaban. There is an opportunity, to address both the variation in the monitoring of DOACs and the agents prescribed to reduce this variation across GM.</p>
Delivery	<p>Annual DOAC Review</p> <ol style="list-style-type: none"> 1. Every patient using a DOAC should have at least annual monitoring (some individual patients will require more) which should include up to date: <ul style="list-style-type: none"> • Full blood count • Liver function tests • Urea and electrolytes • Serum creatinine (for creatinine clearance) • Weight (for creatinine clearance)

	<ol style="list-style-type: none"> 2. Contemporaneous Creatinine Clearance levels should be calculated using the MDCalc Creatinine Clearance (Cockcroft-Gault Equation) and input into the patient notes within a maximum of 3 months following their creatinine results. 3. Once the CrCl score has been entered into the patient records by practice staff, the DOAC choice should be reviewed to ensure continued appropriateness against the CrCl score for each patient. 4. Use GMMM document to guide changes based on CrCl levels DOAC-review-of-NVAF-patients FINAL FOR WEB-v1.0 SEPTEMBER-2024.pdf 5. All patients who are identified to not be on an optimal DOAC or dose following their CrCl calculation or due to a change in weight, should have their DOAC reviewed to ensure safe prescribing and be invited for a DOAC review – this is in line with safe prescribing guidance and in many practices often takes place via an annual review. 6. This annual DOAC review should be recorded on clinical system by using recording each of the elements: <ul style="list-style-type: none"> • Full blood count • Liver function tests • Urea and electrolytes • Serum creatinine (for creatinine clearance) • Weight (for creatinine clearance) • Creatinine Clearance <p>Active DOAC Switch</p> <ol style="list-style-type: none"> 7. In addition, where patients are <i>not</i> prescribed apixaban or rivaroxaban as their DOAC (so are prescribed Dabigatran or Edoxaban), these patients should be consulted about switching to apixaban or rivaroxaban. This can take place during their annual review or via a separate interaction to discuss a switch in medication. This discussion should be recorded in the clinical system using the following codes: <ul style="list-style-type: none"> • Treatment changed SNOMED CT: 445528004 • If patient declined the switch use: Drug declined by patient – alternative therapy SNOMED CT: 182901005 • If the review leads to a dose change: SNOMED CT: 1364161000000108 - Direct-acting oral anticoagulant dose changed (situation) • If the review is complete but nothing was changed, then: 1364181000000104 - Direct-acting oral anticoagulant dose not changed (situation) 8. The guidelines for DAOC switched are included here. Patients newly commencing on a DOAC should also be initiated on DOACs in line with these guidelines. DOAC-review-of-NVAF-patients FINAL FOR WEB-v1.0 SEPTEMBER-2024.pdf and GM's commissioning statement. 				
<p>KPIs</p>	<table border="1"> <thead> <tr> <th data-bbox="376 1720 683 1760">Indicator</th> <th data-bbox="683 1720 1447 1760">Description</th> </tr> </thead> <tbody> <tr> <td data-bbox="376 1760 683 1984">Annual DOAC review (some patients will require more frequent monitoring – please see here)</td> <td data-bbox="683 1760 1447 1984"> % of all DOAC patients who have had an annual DOAC review which includes full screening: <ul style="list-style-type: none"> • Full Blood Count (FBC) • Liver Function Tests (LFTs) • Urea and Electrolytes (U&Es) • Serum Creatinine (for creatinine clearance) • Weight (for creatinine clearance) </td> </tr> </tbody> </table>	Indicator	Description	Annual DOAC review (some patients will require more frequent monitoring – please see here)	% of all DOAC patients who have had an annual DOAC review which includes full screening: <ul style="list-style-type: none"> • Full Blood Count (FBC) • Liver Function Tests (LFTs) • Urea and Electrolytes (U&Es) • Serum Creatinine (for creatinine clearance) • Weight (for creatinine clearance)
Indicator	Description				
Annual DOAC review (some patients will require more frequent monitoring – please see here)	% of all DOAC patients who have had an annual DOAC review which includes full screening: <ul style="list-style-type: none"> • Full Blood Count (FBC) • Liver Function Tests (LFTs) • Urea and Electrolytes (U&Es) • Serum Creatinine (for creatinine clearance) • Weight (for creatinine clearance) 				

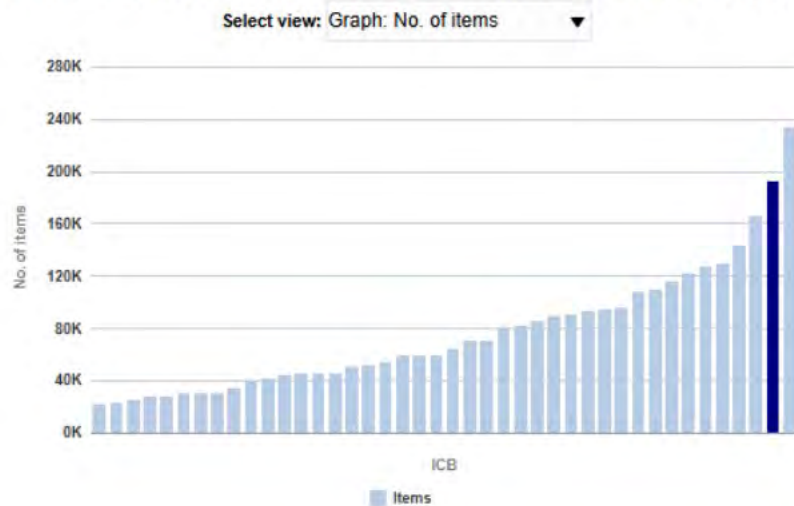
		<ul style="list-style-type: none"> Record results and CrCl calculation within 3 months of the serum creatinine being measured in the patient's clinical record <p>Monitoring will be undertaken using new DOAC Dashboard (available via BeCCoR landing page)</p> <p>AND</p> <p>Optimising DOAC type or dose where clinically appropriate</p>				
	Active switch to a cost-effective DOAC	Discuss and consent patient to switch from either dabigatran or edoxaban to apixaban or rivoroxaban and update prescribed medications aligned with DOAC-review-of-NVAF-patients_FINAL_FOR_WEB-v1.0_SEPTEMBER-2024.pdf				
Achievement						
	<table border="1"> <thead> <tr> <th data-bbox="368 896 687 929">Indicator</th> <th data-bbox="687 896 1447 929">Payment schedule</th> </tr> </thead> <tbody> <tr> <td data-bbox="368 929 687 1632">Annual DOAC review</td> <td data-bbox="687 929 1447 1632"> <p>Practices can earn funding for fully completing one annual review for each of their DOAC patients. Some patients will require more frequent monitoring based on clinical best practice. These additional reviews will not be subject to additional funding.</p> <p>The average number of DOAC patients in each practice during November 2025 -January 2026 will be used as a baseline. Each practice can earn funding equal to their share of the overall GM DOAC cohort e.g. if a practice has 1% of GM DOAC patients, they can earn 1% of the total funding for this section.</p> <p>Payment thresholds will apply: Lower threshold = 50% of patients reviewed, Upper Threshold = 80% of patients reviewed.</p> <p>Below the Lower Threshold payment is £0. At the Lower Threshold 50%, 50% of funding is payable. Payment will then rise in line with % of DOAC patients having a completed review up to 79.9%. At the Upper Threshold of 80%, 100% of funding is payable.</p> </td> </tr> </tbody> </table>	Indicator	Payment schedule	Annual DOAC review	<p>Practices can earn funding for fully completing one annual review for each of their DOAC patients. Some patients will require more frequent monitoring based on clinical best practice. These additional reviews will not be subject to additional funding.</p> <p>The average number of DOAC patients in each practice during November 2025 -January 2026 will be used as a baseline. Each practice can earn funding equal to their share of the overall GM DOAC cohort e.g. if a practice has 1% of GM DOAC patients, they can earn 1% of the total funding for this section.</p> <p>Payment thresholds will apply: Lower threshold = 50% of patients reviewed, Upper Threshold = 80% of patients reviewed.</p> <p>Below the Lower Threshold payment is £0. At the Lower Threshold 50%, 50% of funding is payable. Payment will then rise in line with % of DOAC patients having a completed review up to 79.9%. At the Upper Threshold of 80%, 100% of funding is payable.</p>	<p>Switch of patients currently on Edoxaban or Dabigatran Practices can earn funding for completing switches for DOAC patients currently prescribed Edoxaban or Dabigatran.</p> <p>For each practice, the patient cohort will be determined using November 2025-January 2026 EPACT data as a baseline. Each practice can earn funding equal to their share of the overall GM cohort on Edoxaban/Dabigatran. Total funding available is £224,365 (equivalent to approximately £21.68 per patient currently on Edoxaban/Dabigatran).</p> <p>Payment thresholds will apply: Lower Threshold = 30%.</p>
	Indicator	Payment schedule				
Annual DOAC review	<p>Practices can earn funding for fully completing one annual review for each of their DOAC patients. Some patients will require more frequent monitoring based on clinical best practice. These additional reviews will not be subject to additional funding.</p> <p>The average number of DOAC patients in each practice during November 2025 -January 2026 will be used as a baseline. Each practice can earn funding equal to their share of the overall GM DOAC cohort e.g. if a practice has 1% of GM DOAC patients, they can earn 1% of the total funding for this section.</p> <p>Payment thresholds will apply: Lower threshold = 50% of patients reviewed, Upper Threshold = 80% of patients reviewed.</p> <p>Below the Lower Threshold payment is £0. At the Lower Threshold 50%, 50% of funding is payable. Payment will then rise in line with % of DOAC patients having a completed review up to 79.9%. At the Upper Threshold of 80%, 100% of funding is payable.</p>					
Active switch to a cost-effective DOAC						

	<p>Upper Threshold = 70%. Below Lower Threshold payment is £0. At the Lower Threshold 30%, 50% of funding is payable (i.e. LT%+20%). Payment will rise in line with % of cohort reviews completed +20% up to 69.9% (i.e. at 69% achievement 89% funding is payable). At UT of 70%, 100% of funding is payable.</p>
Key Dates	<p>Baseline data will be available when March 2026 data is released.</p> <p>Ongoing monitoring of patient numbers being prescribed apixaban plus rivaroxaban as a % of all DOACs will be carried out on a quarterly basis via ePACT data.</p> <p>Final payments will be based on the achievement against thresholds noted above after the March 2027 data is available (May 2027).</p>
NHS GM Support available	<ul style="list-style-type: none"> • GMMMG DOAC commissioning statement is available here to identify preferred DOAC options in GM • The GMMMG document DOAC-review-of-NVAF-patients FINAL FOR WEB-v1.0 SEPTEMBER-2024.pdf • GM DII team will make a DOAC dashboard available. This will identify patients who have not had their Creatinine Clearance score calculated and coded • Engagement: Locality Medicines Optimisation Teams and GM ICB DII team will support practices through data provision, guidance, and peer comparison.

MO4: Value: Low Priority Prescribing

Aim	<p>To reduce the prescribing and associated expenditure of Low Priority Prescribing (LPP) across Greater Manchester by 31 March 2027, lowering the annual spend of £2.9 million through consistent, evidence based prescribing practices that improve quality, safety, and equity of care.</p>
Rationale	<p>NHS England Items which should not routinely be prescribed in primary care: policy guidance sets out items that are considered low priority for prescribing. These items may be ineffective, unsafe or not- cost effective. The aim is to reduce unwarranted variation in prescribing practices and to improve overall patient care.</p> <p>NHS GM ICB are the second highest prescribers of Low Priority Products in England based on ePACT2 data.</p>

ICB Comparison (Overall): ICB within National
NHS GREATER MANCHESTER INTEGRATED CARE BOARD against all ICBs (Oct-24 -



Source: ePACT2

Table: Items not for routine prescribing: GM Data

Prescribers are advised that no new patients should be started on these items, that they should be deprescribed for current patients and that, where possible, suitable alternatives should be identified for patients.

Below is a summarised extract of the guidance. This summary is intended to support safe, consistent and value-based prescribing across GM and **does not replace the NHSE policy or GMMMG formulary** but presents the information in a quick reference format aligned to the expectations of this specification.

The policy recommendations are grouped under two categories:

1. Items where no prescribing is appropriate (no exceptions apply).
2. Items where prescribing may be appropriate in some exceptional circumstances.

The following policy recommendations apply to all items in both categories:

- do not initiate in primary care
- deprescribe in patients currently prescribed this item.

The following policy recommendations apply to some items in the second category due to one or more exceptions:

- prescribe only if no other item or intervention is clinically appropriate.
- prescribe only if no other item or intervention is available.
- prescribe only if the item is for an indication named in this guidance.

Additional prescribing guidance is provided for some items, including alternatives and where a multidisciplinary approach is required. Prescribers should also follow GMMMG guidance.

Category 1 – Items where no prescribing is appropriate - no exceptions apply

- Co-proxamol

	<ul style="list-style-type: none"> • Glucosamine & Chondroitin • Herbal Treatments and other natural products • Homeopathy • Minocycline for Acne • Omega-3 fatty acid compounds (Excluding icosapent ethyl) • Silk garments <p>Category 2 - Items where prescribing may be appropriate in some exceptional circumstances</p> <p>For all items, if no other item is clinically appropriate or available it may be appropriate to prescribe following a shared decision-making conversation between the prescriber and patient, based on evidence-based good quality information, clinical judgement and the patient's values and preferences.</p> <ul style="list-style-type: none"> • Aliskirin • Bath and shower preparations for dry and pruritic skin conditions: <ul style="list-style-type: none"> ○ substitute with 'leave-on' emollients. • Dosulepin: <ul style="list-style-type: none"> ○ prescribing decision should be made after a multidisciplinary team discussion • Doxazosin (prolonged release) • Lutein and antioxidants • Oxycodone and naloxone combination product: • Prescribing decision should be made after a multidisciplinary team discussion • Paracetamol and tramadol combination product • Perindopril arginine • Rubefacients, benzydamine, mucopolysaccharide and cooling products (excluding NSAIDs and capsaicin) • Trimipramine. <p>Items where prescribing may be appropriate in some exceptional circumstances – NAMED EXCEPTIONS – see official guidance for specific exceptions and details</p> <ul style="list-style-type: none"> • Amiodarone • Dronedarone • IR Fentanyl • Lidocaine Plasters • Liothyronine • Needles for pre-filled and reusable insulin pens • Travel Vaccines <p>The scheme supports the NHS England Low Priority Prescribing (LPP) guidance by discouraging prescribing of medicines with limited clinical effectiveness, poor cost-effectiveness, or safety concerns.</p>
<p>Delivery</p>	<p>Practices are required to:</p> <ul style="list-style-type: none"> • Review prescribing of Low Priority Products in line with NHS England » Items which should not routinely be prescribed in primary care: policy guidance and PrescQipp Low priority prescribing • Use provided searches to identify patients prescribed LPP medicines. • Undertake reviews, including shared decision-making discussions with patients where changes or deprescribing are indicated. • Implement agreed actions to reduce, stop or switch LPP medicines to clinically appropriate alternatives where suitable.




Key Performance Indicators	Indicator	Description
	Engagement	Baseline eact data of actual cost of LPP items in the 12m period April 2025 to March 2026. Data source: ePACT2 prescribing data; GM ICB Tableau dashboards Population: All practices within Greater Manchester Definition: Weighted list size as at Jan 26.
	Performance: Reduction in practice level actual LPP spend of Actual Cost	Data source: ePACT2 prescribing data; GM ICB Tableau dashboards Population: All practices within Greater Manchester Definition: Actual Cost between April 2026 and March 2027.
Payment Thresholds	Indicator	Payment threshold
	Engagement	Each Practice can earn £0.08 per weighted list size as an engagement payment. This payment will be payable where a practice does not increase their spend on LPP during the year 2026/27 (compared to the 2025/26 baseline period).
	Performance: Reduction in practice level actual LPP spend of Actual Cost	Each practice can earn 30% of the amount by which LPP cost is reduced between the baseline (April 2025 to March 2026) and the measured period (April 2026 to March 2027).
Key Dates	<p>Baseline Data will be made available 1.4.2026</p> <p>Monitoring points. Quarterly (30/6/26, 30/9/26, 31/12/26 and 31/3/27) via eact2 in Tableau dashboard.</p> <p>Final verification and payment – 2 months post year-end (approx. June 2027) subject to completion of any PPV checks.</p>	
NHS GM Support available	<ul style="list-style-type: none"> • Data will be available via GM Tableau dashboard • Clinical system searches will be provided so practices can obtain real time practice data (Tableau data has a 3-month delay) 	

MO5: A Population Health Approach to Medicine Safety: GM SaferPrescribingNeed	
Aim	To reduce avoidable harm from high risk prescribing in GM by using a population health approach to identify those with greatest need via the new GM SaferPrescribingNeed dashboard and delivering targeted interventions like structured medication reviews. The specification embeds safer prescribing into routine care, strengthens systemwide collaboration, aligns with national priorities, and reduces unwarranted variation.

<p>Rationale</p>	<p>GM faces significant challenges with problematic polypharmacy, opioid prescribing and anticholinergic burden which are key drivers of adverse drug events, hospital admissions and widening health inequalities. Evidence shows that targeted medication safety interventions improve patient safety, reduce workload and deliver cost savings. A population health approach ensures resources are focused where they have the greatest impact, supporting both clinical effectiveness and equity.</p> <p>This scheme is expected to improve medicines safety and population health by reducing avoidable harm from high-risk prescribing, lowering adverse drug events and decreasing hospital admissions linked to polypharmacy, SMASH/PINCER indicators, opioids and dependence forming medicines use. It also aims to narrow health inequalities by targeting cohorts with the greatest unmet need.</p>					
<p>Delivery</p>	<p>A two-fold delivery approach will be expected for this specification:</p> <ol style="list-style-type: none"> 1. Practices will be expected to invite all patients from the GM SaferPrescribingNeed (SPN) Dashboard with “very high” and “high” unmet SaferPrescribingNeed scores and prioritise these cohorts for structured medicines reviews. Practices will be provided a list of their “very high” and “high” unmet population cohorts via Re-id. 2. Practices will be expected to collaborate at a PCN level with other practices, wider primary care, community teams, voluntary sector partners and others to develop quality improvement plans* focusing on either a) or b) below. The aim of the QI plan is to take a proactive approach through implementing coordinated population-level interventions that prevent patients moving into higher unmet need cohorts and support sustainable reductions in harm across the PCN: <ol style="list-style-type: none"> a. Polypharmacy and Anticholinergic Burden b. Opioids and Dependence Forming Medication <p>Where practices in a PCN come together and cannot reach agreement on which area to focus on due to varying needs of the practice populations within the PCN, please raise and discuss this with NHS GM early in Q1 to agree an approach – please refer to Appendix F</p>					
<p>Key Performance Indicators</p>	<table border="1"> <thead> <tr> <th data-bbox="472 1529 721 1581">Indicator</th> <th data-bbox="727 1529 1433 1581">Description</th> </tr> </thead> <tbody> <tr> <td data-bbox="472 1585 721 2018"> % of “very high” and “high” unmet population cohort to be invited to a Structured Medication Review (SMR) </td> <td data-bbox="727 1585 1433 2018"> <p>Practices will be provided a list* of their “very high” and “high” unmet population cohorts from the GM SaferPrescribingNeed Dashboard.</p> <p>Practices must invite all patients for a SMR and apply the following code:</p> <p>136320100000103 Invitation for structured medication review (procedure) </p> <p>Patient Lists on GM SaferPrescribingNeed Dashboard will be frozen on 1st April 2026 to enable performance tracking. This will follow same rules as QOF for patients joining/leaving the practice.</p> </td> </tr> </tbody> </table>		Indicator	Description	% of “very high” and “high” unmet population cohort to be invited to a Structured Medication Review (SMR)	<p>Practices will be provided a list* of their “very high” and “high” unmet population cohorts from the GM SaferPrescribingNeed Dashboard.</p> <p>Practices must invite all patients for a SMR and apply the following code:</p> <p>136320100000103 Invitation for structured medication review (procedure) </p> <p>Patient Lists on GM SaferPrescribingNeed Dashboard will be frozen on 1st April 2026 to enable performance tracking. This will follow same rules as QOF for patients joining/leaving the practice.</p>
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	<p>SMR completion for “very high” and “high” unmet need” population cohort</p>	<p>SMR completion for “very high” and “high” unmet need population cohort.</p> <p>SMRs should be carried out by appropriately trained clinicians such as clinical pharmacists, GPs or advanced nurse practitioners. SMRs should be completed on the clinical system template that will be provided.</p> <p>The following SNOMED codes should be used for all SMRs successfully delivered:</p> <table border="1" data-bbox="740 658 1417 1155"> <thead> <tr> <th>Description</th> <th>SNOMED Code</th> </tr> </thead> <tbody> <tr> <td>All completed SMRs</td> <td>Structured medication review (procedure) 1239511000000100</td> </tr> <tr> <td>Review of Opioids/Dependence Forming Medication</td> <td>287031000000100 Review of opioid medication (procedure) </td> </tr> <tr> <td>ACB Score review</td> <td>763242009 Assessment using Anticholinergic Cognitive Burden Scale (procedure) </td> </tr> <tr> <td>Polypharmacy review including any deprescribing</td> <td>870661000000100 Polypharmacy medication review (procedure) </td> </tr> <tr> <td>SMASH/PINCER indicators review</td> <td>268525008 High risk drug monitoring (regime/therapy) </td> </tr> </tbody> </table> <p>Practices should utilise the resources outlined in ‘NHS GM Support available’ to holistically review all patients in line with the GMMMG formulary.</p>	Description	SNOMED Code	All completed SMRs	Structured medication review (procedure) 1239511000000100	Review of Opioids/Dependence Forming Medication	287031000000100 Review of opioid medication (procedure)	ACB Score review	763242009 Assessment using Anticholinergic Cognitive Burden Scale (procedure)	Polypharmacy review including any deprescribing	870661000000100 Polypharmacy medication review (procedure)	SMASH/PINCER indicators review	268525008 High risk drug monitoring (regime/therapy)
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	<p>Submission of PCN QI Plan – (Quarter 1 - June 30th 2026)</p>	<p>Practices will be expected to collaborate at a PCN level with other practices, wider primary care, community teams, voluntary sector partners and others to develop a PCN-wide quality improvement plan focusing on either a) or b).</p> <p>a) Polypharmacy and Anticholinergic Burden b) Opioids and Dependence Forming Medication</p> <p>Frailty, Age, Ethnicity and Deprivation should also be considered as part of the QI plan.</p> <p>A few examples that PCNs may focus on, but not limited to: Specialist MDT reviews, deprescribing initiatives, group sessions, non-pharmacological pathways, and strengthened patient support through education, awareness campaigns and voluntary sector services. Prescribed opioids >3 months, On Oral Morphine Equivalence >120mg/day, Co-prescribed opioids + gabapentinoids or benzodiazepines/Z-drugs >12 weeks</p> <p>Prevention must be considered as part of the PCN QI plan, including the population inside and outside the ‘very high’ and ‘high’ unmet need cohorts. Working with</p>												

		<p>their PCNs, practices must identify and implement proactive, population level safety interventions that minimise the risk of patients moving into higher unmet need cohorts.</p> <p>All PCN QI plans must align to the QI standards outlined in Appendix F. The PCN practices can determine the innovative QI project with multiple planned interventions and clear demonstrable outcomes. All QI plans should have named project lead/s who will be responsible for oversight of the delivery of outlined QI plan.</p> <p>QI template submitted via Airelogic by 30th June 2026</p> <p>Please note only 1 QI plan per PCN will need to be submitted</p>				
	<p>Submission of QI Evaluation, Outcomes, Reflections and Supporting Evidence- (Quarter 4 – 31st March 2027)</p>	<p>Practices are expected to complete end of QI project evaluation and submit this using the template provided by the end of Q4.</p> <p>The QI evaluation form template will be provided and will aim to capture:</p> <ul style="list-style-type: none"> • Summary of results • Lessons learned • Next steps following completion of the QI Plan <p>QI template submitted via Airelogic by 31st March 2027</p> <p>Please note only 1 QI evaluation per PCN will need to be submitted</p>				
	<p>Reductions in number of people within “very high” and “high” unmet SPN population cohorts</p>	<p>As one of the key outcomes from both the SMR delivery and PCN QI plan, all practices will need to demonstrate a reduction in the number of people within the very high and high unmet need cohort.</p> <p>A sliding scale reduction will be used to measure performance against a recorded baseline on 1st April 2026. Patient Lists on GM SaferPrescribingNeed Dashboard will be frozen on 1st April 2026 to enable performance tracking</p>				
	<p>All performance will be measured using GM Tableau and this will be available to practices.</p>					
<p>Achievement</p>	<p>All payments will be made at practice-level irrespective of the expectation of practices to work collaboratively at PCN level.</p>					
	<table border="1"> <thead> <tr> <th data-bbox="470 1901 697 1933">Indicator</th> <th data-bbox="703 1901 1423 1933">Funding breakdown and schedule</th> </tr> </thead> <tbody> <tr> <td data-bbox="470 1933 697 2020">100% of “very high” and “high” unmet</td> <td data-bbox="703 1933 1423 2020">£1.30 per invite based on full cohort invited</td> </tr> </tbody> </table>	Indicator	Funding breakdown and schedule	100% of “very high” and “high” unmet	£1.30 per invite based on full cohort invited	
Indicator	Funding breakdown and schedule					
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	<p>population cohort to be invited to a Structured Medication Review</p>	<p>Final payments will be calculated following data verification after the end of quarter 4</p>															
	<p>SMR completion for "very high" and "high" unmet need population cohort</p>	<p>£25 per SMR completed</p> <p>Final payments will be calculated following data verification after the end of quarter 4</p>															
	<p>Submission of PCN QI Plan – Quarter 1</p>	<p>Submission of an approved Q1 Plan</p>															
	<p>Submission of QI Evaluation, Outcomes, Reflections and Supporting Evidence – Q4</p>	<p>Submission of an approved Q4 plan</p>															
	<p>Reductions in very high and high unmet need population cohorts</p>	<p>Very high unmet need population cohort – 0.12php High unmet need population cohort – 0.25php</p> <p>Final payments will be calculated following data verification after the end of quarter 4</p> <p>A sliding scale will be used to determine final payment:</p> <table border="1" data-bbox="719 1211 1417 1402"> <tr> <td>0% reduction</td> <td>2.5% reduction</td> <td>5% reduction</td> <td>7.5% reduction</td> <td>10%+ reduction</td> </tr> <tr> <td colspan="5" style="text-align: center;">  </td> </tr> <tr> <td>0% payment</td> <td>25% payment</td> <td>50% payment</td> <td>75% payment</td> <td>100% payment</td> </tr> </table> <p><i>Payment will be made proportionally — e.g., a 6.2% reduction equates to receiving 62% of the payment.</i></p> <p><i>These threshold targets will be reviewed in-year and maybe reduced dependent on achievement levels. Any amendments in target thresholds will be communicated to all practices</i></p>	0% reduction	2.5% reduction	5% reduction	7.5% reduction	10%+ reduction						0% payment	25% payment	50% payment	75% payment	100% payment
0% reduction	2.5% reduction	5% reduction	7.5% reduction	10%+ reduction													
																	
0% payment	25% payment	50% payment	75% payment	100% payment													
<p>Key Dates</p>	<p>Please note for the PCN QI plan, practices can collectively decide on how to utilise and distribute their allocated funding to deliver on the specification requirements and planned interventions.</p> <ul style="list-style-type: none"> • Submission of PCN QI Plan – 30th June 2026 • Submission of QI Evaluation – 31st March 2027 																
<p>NHS GM Support available</p>	<ul style="list-style-type: none"> • SMR Clinical System Template • Access to GM Tableau dashboards and GM SaferPrescribingNeed Dashboard 																

	<ul style="list-style-type: none"> • Named locality contacts for escalation, troubleshooting and queries around additional tools for the QI project • OptimiseRx message integration. • Engagement and Educational webinars on clinical domains highlighted above • GMMMG-Polypharmacy-resource-pack-v-4.0-for-GMMMG-website.pdf • 268. IMPACT 2021 2.0 – PrescQIPP Improving Medicines and Polypharmacy Appropriateness Clinical Tool • Clinical Guidance and Pathways - GMMMG • The mechanics of tackling overprescribing and problematic polypharmacy • Greater Manchester Pain Management Resources Hub - GMMMG
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MO6: Tirzepatide Prescribing - Clinical Data Quality	
Aim	<p>To improve the accuracy and completeness of tirzepatide-related coding in GP patient records across Greater Manchester in order to support safe prescribing and to ensure continued roll-out of tirzepatide for weight management.</p> <p>Improved data quality will enable NHS GM to better understand the scale and pattern of tirzepatide prescribing across the system, including the distinction between prescribing for diabetes and weight management where this can be identified through clinical coding.</p>
Rationale	<p>Tirzepatide prescribing has increased significantly across Greater Manchester for both diabetes and weight management indications.</p> <p>ePACT prescribing data provides a system-wide view of prescribing activity, including estimated patient numbers and overall expenditure for tirzepatide. Current prescribing spend across Greater Manchester is approximately £1.4–£1.5 million per month. However, ePACT data does not distinguish between prescribing for type 2 diabetes and prescribing for weight management.</p> <p>As a result, the system currently does not have a clear view of how much of this expenditure relates specifically to the NHS England weight management programme compared with diabetes prescribing. Understanding this split is essential in order to understand activity associated with NHS England commissioning arrangements for tirzepatide and to be able to proceed to offering the drug to additional eligible weight management cohorts.</p> <p>The outcomes of this component are twofold:</p> <ul style="list-style-type: none"> • A consistent set of codes for tirzepatide prescribing utilised across GM GP practices • Improvement of clinical data quality via clinical audit
Delivery	<p>The following activities will be required:</p> <p>1. Use of consistent clinical coding Practices should:</p> <ul style="list-style-type: none"> - Retrospectively review patient records and ensure that relevant clinical coding associated with tirzepatide prescribing is accurate and complete (using practice initiated searches)

- Prospectively ensure that relevant clinical codes associated with tirzepatide prescribing are recorded appropriately by practice clinicians.

Tirzepatide for weight management

Where tirzepatide is prescribed as part of the weight-management pathway, national SNOMED codes should be used consistently to support accurate reporting.

To maintain GM-wide reporting consistency, practices should ensure the appropriate national SNOMED codes are recorded at key stages of the pathway:

- Where a patient meets commissioning eligibility criteria but is not suitable for treatment (e.g. contraindications or other clinical factors), the following SNOMED code should be recorded: **Unsuitable for NHS obesity medication pathway** (SCTID: 2386221000000103)
- Where an eligible patient declines treatment and/or mandatory wraparound care, the following SNOMED code should be recorded: **NHS obesity medication pathway declined** (SCTID: 2386241000000105)
- Where an eligible patient consents to treatment and mandatory wraparound care, the following two SNOMED codes should be recorded: **Referral to NHS obesity medication wraparound support pathway** (SCTID: 2386201000000107) AND **NHS obesity medication pathway started** (SCTID: 2386231000000101)

Practices can also refer to national [Tirzepatide SNOMED Coding Flowchart](#). These codes are expected to align with QOF 2026/27 indicators for weight management.

Tirzepatide for diabetes

Where tirzepatide is prescribed for diabetes, appropriate diabetes diagnosis codes should be recorded in line with diabetes QOF coding requirements.

Recording privately supplied tirzepatide

Where patients obtain tirzepatide privately, practices should ensure this is recorded appropriately within the medication record using the appropriate SNOMED CT codes:

- **EMIS SNOMED Concept ID: 394828003 (Prescription by another organisation)**
- **SystemOne SNOMED CT Concept ID: 394828003 (Prescription by another organisation)**

Practices should:

- Record a start date where available
- Update records if treatment changes or is discontinued

The processes for recording privately prescribed medicines in the patient’s clinical record are set out in the appendices:

- **Appendix Ea – EMIS**
- **Appendix Eb – SystemOne**

	<p>Note - Local codes or free text should be avoided wherever possible, as this limits the ability to extract consistent data for central reporting and monitoring progress through the phased weight-management eligible cohorts.</p> <p>2.Clinical audit Practices are asked to carry out a clinical audit in Quarter 2 2026/27 (July-September 2026).</p> <p>Searches will be provided for practices to support this.</p> <p>The aim of the clinical audit is to:</p> <ul style="list-style-type: none"> • Identify any gaps in clinical coding and to address these through a clinical review of records and addition of appropriate codes (as outlined above) and • To identify any gaps in clinical care in relation to tirzepatide prescribing with appropriate clinical actions to address these <p>Note, for practices who have applied the consistent set of codes as set out in section 1 above, there may be very few/no patients to review via a clinical audit.</p> <p>Support for practices Locality Medicines Optimisation teams may support practices, where capacity allows, by identifying potential data-quality issues within practice systems.</p>
<p>Key Performance Indicators (KPIs)</p>	<p>The aim of this work is to improve the quality and consistency of coding associated with tirzepatide prescribing across Greater Manchester. The following indicators will be used to monitor delivery of the data-quality review.</p> <p>KPI 1 – Adoption of consistent set of clinical codes for tirzepatide prescribing All tirzepatide prescribing has relevant clinical coding recorded, including:</p> <ul style="list-style-type: none"> • use of national SNOMED codes where tirzepatide is offered, started, or declined within the weight-management pathway • appropriate recording of privately supplied tirzepatide within medication records • accurate recording of diabetes status where applicable <p>KPI 2 – Completion of tirzepatide clinical audit GP practices have undertaken an audit of patients prescribed tirzepatide within their clinical systems to identify clinical coding gaps. Where gaps are identified, a review of the patient records and addition of appropriate clinical codes (as described above) has been undertaken.</p> <p>Completion of the data-quality KPIs will be confirmed through a complete set of clinical coding and where necessary practice-level assurance discussions with Medicines Optimisation team.</p>
<p>Achievement</p>	<p>Practices will be considered to have achieved the requirements of this specification where the data-quality work described in the Delivery section has been completed as evidenced by a complete set of consistent codes applied for tirzepatide prescribing.</p>
<p>Key Dates</p>	<p>April -June 2026: Adoption of consistent set of coding to improve historic and prospective data quality</p> <p>July-September 2026: Undertake clinical audit to improve clinical data quality by addressing any residual clinical coding gaps.</p>

Section 5 - Locality specific retained elements 2026/27

To maintain stability for 2026/27, a small proportion of locality elements within established locality schemes, identified via the recent review, will be retained. The retained elements vary by locality depending upon the existing offer. Locality colleagues have reviewed the retained elements prior to their submission in this document to ensure they are effective, up to date, value for money and do not duplicate other areas of the scheme.

The BeCCoR programme of work will continue its ambition to move to a more consistent population offer through a phased review. This will enable delivery of evidence based and outcome focused primary care provision.

Future developments of this scheme will identify opportunities to establish further impact and benefit for the local population through the delivery of primary care services.

Please find below the locality retained elements for delivery in 2026/27 in {insert locality}

{LOCALLY RETAINED DETAILS – INSERT}

Schedule 2 - Local Service Delivery

Currently there is significant variation across localities in the services that are being delivered beyond core contract within a primary care setting.

A recent review, and baseline data capture, demonstrated that despite a large number of services being delivered beyond core contract, no one service is common to all NHS GM localities.

The local services being delivered across localities will remain under review within the scope of the BeCCoR programme of work. Future opportunities and plans will be identified for 2027/28 and beyond via NHS GM commissioning intentions with the aim of growing the consistent GM elements of the scheme over time and reducing locally retained elements.

Please find below the local services that are included for delivery within 2026/27 for **{insert locality}**

{SCHEDULE OF LOCAL SERVICE SPECIFICATIONS – INSERT}

Finances, Payment Schedule and Appeals

Total Indicative funding of the Greater Manchester Incentive Scheme

Section 1 General Practice Quality and Sustainability	£17,245k
Section 2 Elective Transformation	£3,449k
Section 3 Prevention, Population Health Management and Neighbourhoods	£21,713k
Section 4 Medicines Optimisation	£13,281k
Section 5 Locality Retained Elements (Tackling Inequalities, Neighbourhoods and Supporting Demand Management in Place)	£15,040k
Total financial opportunity (GM)	£70,728k

Individual Practice Financial Schedule

As part of contractual sign-up process, each practice will receive an individualised financial schedule outlining the available finances for your practice based on the practice population. This is to lay out the financial *opportunity* for your practice to aid planning, workforce requirements and to support delivery prioritisation.

Practice *achievement* will be based on the parameters laid out in this document and the level of achievement will then inform financial reconciliation as per the schedule laid out below.

Schedule of Payments for 2026/27

Quarter 1 April 2026	Quarter 2 July 2026	Quarter 3 Oct 2026	Quarter 4 Jan 2027	Quarter 1 2027	% Paid in Year	% Paid in Following Year
20%	20%	20%	20%	20%*	80%	20%*
*A final 20% payment of up to 20% will be made once financial reconciliation of practice achievement has taken place. If practice achievement is less than 80% a claw back of funding will be undertaken.						

Post Payment Verification

Practices should retain evidence of work undertaken.

Post-payment verification will be carried out during Q1 of the following financial year. The PPV process and parameters will be clearly defined and communicated

with practices prior to commencement, however for note it will include audit of a number of elements from across non-data led elements of the scheme. If you have any queries regarding contractual compliance during the 2026/27 year, please contact enhancedserviceses1@nhs.net at the earliest opportunity.

Appeals

Once financial reconciliation of contractual achievement has been undertaken and notified, practices will have a period of 4 weeks to lodge an appeal. The appeal should describe the grounds for appeal and the supporting evidence.

Any appeals will be considered in line with NHS GM Quality Incentive Scheme Contracts LCS Appeals process and governance via Primary Care Commissioning Committee, and the outcome will be communicated with the practice.

Appendices

Appendix A: Prevention, Population Health and Neighbourhoods: Cohort-Based Multimorbidity Reviews

BeCCoR cohorts and corresponding reviews

The table below summarises the proposed cohorts and the review type required for each cohort.

Cohort	How the cohort is defined	Associated review type
CVD and Diabetes (CVNeed) - core	Known hypertension, hyperlipidaemia, atrial fibrillation or diabetes with highest clinical need (CVNeed risk stratification).	CVD/Diabetes High-Need Review (core elements)
CVD and Diabetes (CVNeed) + ACR (stretch)	As above, with an additional ACR completion requirement for the same cohort.	CVD/Diabetes High-Need Review + ACR (stretch)
Primary Prevention - High QRISK	Estimated QRISK3 >10% and no lipid-lowering medication.	Primary Prevention Lipid Risk Review
Respiratory - COPD	High-risk COPD cohort (RespNeed risk stratification).	Enhanced COPD Review
Respiratory - Asthma (adult)	High-risk asthma cohort (RespNeed risk stratification).	Enhanced Asthma Review (adult)
Respiratory - Asthma (CYP)	High-risk asthma cohort in children and young people (same criteria as adult asthma for cohort selection).	Enhanced Asthma Review (CYP)

Cohort definitions

Cohorts will be provided to practices through GM shared analytics and surfaced via ReID and Curator. Unless otherwise stated, cohorts will be defined as of 1st April 2026 for the purpose of measurement and payment. In general, these cohorts should be fixed but may fluctuate dependant on patients registering or deregistering from the practice

[Appendix B: Prevention, Population Health and Neighbourhoods: High-need cohort definitions and Clinical Review Criteria](#)

CVD and Diabetes (CVNeed) - high-need cohort

The CVNeed cohort identifies patients with known hypertension, hyperlipidaemia, atrial fibrillation or diabetes who are at highest risk for review and remains the same cohort

High-risk criteria (copied from the 2025/26 specification):

Patients who are high risk are defined as any patients who meet the below criteria:

2.3 Hypertension:

- 1 Clinic BP \geq 180/120 mmHg
- 2 Clinic BP \geq 160/110 mmHg
- 3 No BP reading in the last 18 months

2.4 Diabetes:

- 1 HbA1c $>$ 86 mmol/mol
- 2a Moderate / Severe Frailty, HbA1c $>$ 75 mmol/mol
- 2b Mild Frailty / No Frailty, HbA1c $>$ 75 mmol/mol
- 3 No HbA1c reading in the last 18 months

2.5 Atrial Fibrillation:

- 1a Not on Anticoagulant, Female and CHADS \geq 2
- 1b Not on Anticoagulant, Male and CHADS \geq 1
- 1c Not on Anticoagulant, Age \geq 65
- 1d Not on Anticoagulant, No CHADS ever

2.6 Secondary Prevention of CVD: Coronary Heart Disease, Peripheral Arterial Disease, Stroke or TIA:

- 1a No lipids ever
- 1b No lipids in the last 12 months
- 2a Not on statin therapy and eligible
- 2b Statin declined or contraindicated, not on alternative lipid lowering therapy

2.7 Chronic Kidney Disease:

- 1a eGFR decrease > 25% and category change in 12 months
- 1b eGFR decrease > 15 ml/min/1.73m² in 12 months
- 2 ACR >= 70 mg/mol

2.8 CVD and Diabetes (CVNeed) + ACR (stretch)

This stretch cohort uses the same CVNeed high-need cohort as section 1.1. The difference is in the review completion criteria: an ACR element is required for review completion (see section 3.2).

2.9 Primary Prevention - High QRISK cohort

This cohort is intended to support primary prevention through lipid optimisation in those at highest estimated cardiovascular risk who have not had a QRISK calculation coded recently and are not on lipid-lowering medication.

Proposed inclusion criteria (draft - to be confirmed in final specification):

- Estimated QRISK3 10-year CVD risk >= 10% (calculated centrally via GM analytics using available GP record data).
- No current lipid-lowering medication (statin or alternative lipid-lowering therapy).
- No existing diagnosis of CVD (secondary prevention cohort exclusions).
- Age range and clinical exclusions aligned to GM and national guidance.

2.10 Respiratory - Asthma (adult) high-need cohort

Patients who are 18+ and meet one or more of the following criteria as of 31st March 2026:

- 1a: 6+ SABA prescriptions in the last 12 months AND no ICS in the last 6 months.
- 1b: 6+ SABA prescriptions in the last 12 months AND no MART / AIR in the last 6 months.
- 1c: 6+ SABA prescriptions in the last 12 months and currently on concurrent MART / AIR and SABA over the last 3 months
- 2: 2+ courses of oral steroids in the last 12 months
- 3: 2+ antibiotic prescriptions in the last 12 months
- 4: 3 - 5 SABA prescriptions in last 12 months

- 5: LABA prescribed in the last 6 months AND no ICS in last 6 months
- 6a: No ICS in last 6 months and exacerbation in last 12 months
- 6b: No ICS in last 6 months
- 7: No complete QOF review in the last 18 months

2.11 Respiratory - Asthma (children and young people) high-need cohort

Patients who are aged 6 - under 18 and meet one or more of the following criteria as of 31st March 2026:

- 1a: 6+ SABA prescriptions in the last 12 months AND no ICS in the last 6 months.
- 1b: 6+ SABA prescriptions in the last 12 months AND no MART (6 and over) / AIR (12 and over) in the last 6 months.
- 1c: 6+ SABA prescriptions in the last 12 months and currently on concurrent MART (6 and over) / AIR (12 and over) and SABA over the last 3 months
- 2: 2+ courses of oral steroids in the last 12 months
- 3: 2+ antibiotic prescriptions in the last 12 months
- 4: 3 - 5 SABA prescriptions in last 12 months
- 5: LAMA prescribed in the last 6 months AND no ICS in last 6 months
- 6a: No ICS in last 6 months and exacerbation in last 12 months
- 6b: No ICS in last 6 months
- 7: No complete QOF review in the last 18 months

2.12 Respiratory - COPD high-need cohort

Patients who meet one or more of the following criteria:

- 01a: 2+ courses of oral steroids in last 12 months AND no elements of triple therapy in last 6 months
- 01b: 2+ courses of oral steroids in last 12 months AND no element of double therapy in last 6 months
- 02: FEV1 < 50% and no LAMA or LABA in last 6 months
- 03: MRC 3 to 5, never attended pulmonary rehab
- 04: Current smoker, no smoking cessation advice in last 12 months
- 05: No complete QOF review in the last 18 months

Reviews and completion criteria

A review is counted as complete when all required elements are recorded for an individual within the financial year. Where a person is in multiple cohorts, practices are encouraged to combine work into a single holistic contact; however, the required elements for each review type must be coded to count as complete.

CVD/Diabetes High-Need Review (core elements)

A streamlined high-risk review is defined as the following 6 criteria below are undertaken within the financial year:

- Blood pressure
- BMI (Body Mass Index)
- eGFR (estimated Glomerular Filtration Rate)
- HbA1c (Haemoglobin A1c)
- Smoking status
- Cholesterol

Practices are strongly recommended to complete full long-term condition / QOF reviews at the same time, in addition to the minimum criteria.

CVD/Diabetes High-Need Review + ACR (stretch)

A streamlined high-risk review + ACR is defined as:

- Blood Pressure
- BMI
- eGFR
- HbA1c
- Smoking status
- Cholesterol
- Urinary AC

Primary Prevention Lipid Risk Review

A Primary Prevention Lipid Risk Review is defined as completion of the following elements:

- Calculate and code QRISK3 (QRISK2 acceptable until within clinical systems)
- Lipid lowering medication offer if QRISK \geq 10% (as clinically appropriate)
- Record of outcome of the offer (e.g., started, declined, contraindicated)

Enhanced COPD Review

Defining the 5 Elements Required for an Enhanced COPD Review:

- Review of inhalers within the last 6 months as clinically appropriate as per GMMMG Guidelines [GMMMG COPD GUIDELINE 2021](#)
- Record of smoking status in the financial year.
- Record of pulmonary rehabilitation status, either:
 - Attendance at pulmonary rehabilitation ever.
 - Offer of pulmonary rehabilitation in the financial year.
 - Declined offer of pulmonary rehabilitation in the financial year with reason for decline.
- Record of flu vaccination status, either:
 - Flu vaccination received in the financial year.
 - Flu vaccination declined in the financial year.
 - Permanent contraindication to flu vaccination ever.
 - Temporary contraindication to flu vaccination in the financial year.

If the patient is at high risk and requires pneumococcal vaccination every 5 years (asplenia, splenic dysfunction or chronic renal disease), either:

- Pneumococcal vaccination received in the last 5 years.
- Pneumococcal vaccination declined in the last 5 years.
- Contraindication to Pneumococcal vaccination ever

Enhanced Asthma Review (adult)

Defining the 5 Elements Required for an Enhanced Asthma Review:

- Prescription for MART / AIR (Combined ICS and LABA with Formoterol) within the last 6 months as clinically appropriate as per GMMMG Guidelines [GMMMG Adult Asthma Guideline 2024](#)
- Record of inhaler technique in the financial year.
- Record of smoking status in the financial year
- Recording of vaping status in the financial year
- Record of either:
 - Flu vaccination received in the financial year.
 - Flu vaccination declined in the financial year.
 - Permanent contraindication to flu vaccination ever.
 - Temporary contraindication to flu vaccination in the financial year.

Enhanced Asthma Review (children and young people)

This review mirrors the enhanced asthma review elements for adults, with any CYP-specific adjustments to be confirmed in the final specification and supporting clinical guidance.

Proposed elements:

- Asthma self-management plan completed.
- Record of inhaler technique in the financial year.
- Record of smoking status / smoke exposure in the financial year.
- Recording of vaping status in the financial year
- Review of inhalers and optimise as per NICE Guidelines [NICE Asthma Guideline 2024](#)
- Record of either:
 - Flu vaccination received in the financial year.
 - Flu vaccination declined in the financial year.
 - Permanent contraindication to flu vaccination ever.
 - Temporary contraindication to flu vaccination in the financial year.

[Appendix C: Prevention, Population Health and Neighbourhoods:](#) Neighbourhood Prevention Allocation

Each locality will have access to a **Neighbourhood Prevention Allocation** to fund additional costs for partnership activities. Where there are costed elements of the Practices' BeCCoR Neighbourhood Plan, these will be considered at a Place level through locality governance. Funding decisions will take place at Place level, to align with strategic priorities.

Examples of activities/interventions that can be commissioned/locally sourced are:

1. Agreed attendance at MDTs for specific identified cohorts identified as high need through multimorbidity reviews.
2. The development and maintenance of pathways for people from Very High Need cohort identified through multi-morbidity reviews or broader need identification through engagement, to be supported by a wider Neighbourhood team offer, alongside general practice support.
3. Development and maintenance of peer support and community champion groups
4. Practice roles to be trained, paid (i.e. grades uplifted) and supervised to operate through a focused care approach.
5. Training for staff in coaching, motivational interviewing and trauma informed practice approaches
6. Additional support (training, networking time plus supervision) for reception/front of house staff to enable them to develop relationships with communities and wider public services, and to support people with those wider offers.
7. Enabling outreach into community spaces and centres to work on joint initiatives and projects (for all practice staff).
8. Resourcing complementary VCFSE support for patients to support prevention, and health and wellbeing improvement outcomes.
9. Income maximisation activities undertaken (e.g. Attendance allowance case finding and communication).
10. Participation on an accredited programme for awareness and upskilling around inclusion health cohorts.
11. CYP relevant scheme– *considering* engagement with schools
12. Dementia Care support
13. Integration of physical activity into health & care e.g. GM Moving Active Practices
14. Existing/previous LCS schemes supporting Integrated Neighbourhood working and LiveWell

Process to develop and access funding will be available through local Place leads

[Appendix D: Medicines Optimisation: SCOM](#)

MO2: SCOM: Banding Criteria

Criteria	Band 1	Band 2	Band 3	Band 4
Intensity of monitoring	High intensity	Moderate to high intensity	Moderate intensity	Low intensity
Frequency	Monthly to every 2 months or more frequently	Less frequently than 2 months but more frequently than 6 months (e.g. 3 monthly checks)	Every 6 months to annually	On a “when required” basis, very little monitoring required
Blood Tests	Regular monitoring, including U&Es, LFTs, FBC and /or other relevant tests	Periodic monitoring including U&Es, LFTs, FBC and /or other relevant tests	Periodic monitoring including U&Es, LFTs, FBC and /or other relevant tests	None
Physical Checks	During monitoring sessions	During monitoring sessions	During monitoring sessions	Annually or as clinically indicated
Additional Tests	>1 ECG per year	Annual ECG (if required)	None	None
Examples of the Amber medicines	<ul style="list-style-type: none"> • Methotrexate (po) (adults) • Patiromer (po) (adults) 	<ul style="list-style-type: none"> • Azathioprine (po) (paediatrics) • Disulfiram (po) (adults) • Ibandronic acid (po) (adults) 	<ul style="list-style-type: none"> • Atomoxetine (po) (adults) • Apomorphine (injection/infusion) (adults) 	<ul style="list-style-type: none"> • Citalopram (po) (paediatrics) • Colistimethate (nebules) (adults) • Somatotropin (injection self-admin) (paediatric)

GP practices can claim additional fee for administration of injections

Banding criteria was developed by a Shared Care of Medicines Programme Task and Finish Group, which sought to cost associated activity utilising the skill mix of the Primary Care Workforce in General Practice. A benchmarking activity was undertaken against other NHS ICS Shared Care of Medicines schemes.

Banding of Amber Medicines for 26/27 SCOM Service Specification

*For up to date full list of medicines and protocols please see [Approved Shared Care Protocols - GMMMG](#)

Band 1	Band 2	Band 3	Band 4	Injections/ Implants/ Depots
Azathioprine (po, adults)	Amiodarone (po, adults)	Apomorphine (inj/inf, adults)	Citalopram (po, paediatrics)	Aripiprazole (depot inj, adults)
Ciclosporin (po, adults)	Amisulpride (po, adults)	Aripiprazole (po, adults)	Colistimethate (nebules, adults)	Flupenthixol decanoate (depot inj, adults)
Dronedarone (po, adults)	Aripiprazole (depot inj, adults)	Aripiprazole (po, paediatrics)	Domperidone (po, paediatrics)	Goserelin (implant, adults)
Hydroxycarbamide (po, adults)	Azathioprine (po, paediatrics)	Atomoxetine (po, adults)	Ethinylestradiol (po, paediatrics, BP 6m only)	Haloperidol decanoate (depot inj, adults)
Leflunomide (po, adults)	Cinacalcet (po, adults)	Atomoxetine (po, paediatrics)	Fluoxetine (po, paediatrics)	Leuprorelin (SC/IM inj, adults/17+)
Mercaptopurine (po, adults)	Disulfiram (po, adults)	Denosumab (SC inj, adults)	Hydroxychloroquine (po, adults)	Paliperidone palmitate (depot inj, adults)
Methotrexate (po, adults)	Flupenthixol decanoate (depot inj, adults)	Degarelix (SC inj, adults)	Melatonin (po, paediatrics)	Risperidone (depot inj, adults)
Mycophenolate (po, adults)	Goserelin (implant, adults) 2 or 3 (depending on indication)	Dexamfetamine (po, adults)	Sertraline (po, paediatrics)	Triptorelin (SC/IM inj, adults/17+)
Patiromer (po, adults)	Guanfacine (po, paediatrics)	Dexamfetamine (po, paediatrics)	Somatotropin (inj, paediatrics, self-admin)	Zuclopenthixol decanoate (depot inj, adults)
Penicillamine (po, adults)	Ibandronic acid (po, adults)	Estradiol (po/transdermal, Indigo 17+)		Apomorphine (inj/inf, adults)
Riluzole (po, adults)	Leuprorelin (SC/IM inj, adults/17+) 2 or3 (depending on indication)	Guanfacine (po, adults)		Denosumab (SC inj, adults)
Sodium Zirconium Cyclosilicate (po, adults)	Lurasidone (po, adults)	Haloperidol decanoate (depot inj, adults)		Degarelix (SC inj, adults)

Sulfasalazine (po, adults)	Olanzapine (po, adults)	Lisdexamfetamine (po, adults)		Testosterone (Sustanon) (IM injection, Indigo 17+)
	Paliperidone (po, adults)	Lisdexamfetamine (po, paediatrics)		Testosterone (Nebido) (IM injection, Indigo 17+)
	Paliperidone palmitate (depot inj, adults)	Methylphenidate (po, adults)		
	Quetiapine (po, adults)	Methylphenidate (po, paediatrics)		
	Quetiapine (po, paediatrics)	Risperidone (depot inj, adults)		
	Risperidone (po, adults)	Zuclopenthixol decanoate (depot inj, adults)		
	Risperidone (po, paediatrics)	Testosterone (gel/transdermal, Indigo 17+)		
	Triptorelin (SC/IM inj, adults/17+) 2 or 3(depending on indication)	Testosterone (Nebido) (IM injection, Indigo 17+)		
	Lithium (po, adults)			
	Olanzapine (po, paediatrics)			
	Testosterone (Sustanon) (IM injection, Indigo 17+)			

Shared care medicines pathways where further development is underway:

there are a number of medicines that are on GMMMG and rated 'AMBER' (appropriate for shared care) that have been identified by the SCOM programme as requiring further work in collaboration with specialist services to improve pathways across the interface. Work will continue on these pathways as part of the SCOM programme.

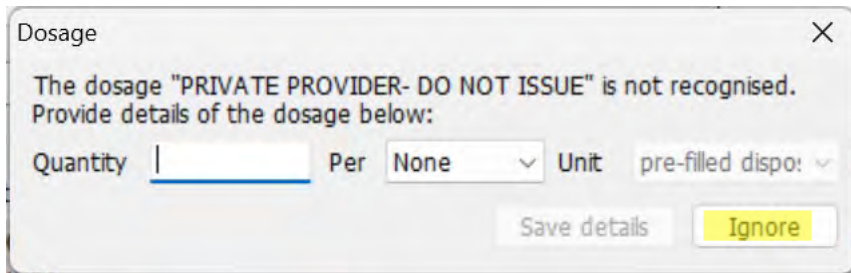
Shared care medicines pathways where ongoing pathway development is underway
Amisulpride
Aripiprazole Depot
Aripiprazole Oral
Atomoxetine hydrochloride
Dexamfetamine sulfate
Flupentixol decanoate
Guanfacine
Haloperidol decanoate
Lisdexamfetamine
Lurasidone
Methylphenidate hydrochloride
Olanzapine
Quetiapine
Paliperidone
Paliperidone (Injection)
Risperidone (Parenteral)
Risperidone (Systemic)
Tacrolimus
Zuclopenthixol decanoate
Shared care requests from private providers

Appendix Ea: Medicines Optimisation: Management of medications supplied by private providers on EMIS Web system

1. Go to the medication tab of the patient, then 'Add Drug'.



2. This will launch the drug browser where the clinician must select the drug prescribed by a private provider.
 3. Complete the other required details of the drug on prescription section.
- **Dose: PRIVATE PROVIDER - DO NOT ISSUE**
 - You will get a 'dosage not recognised' message. Select Ignore

A screenshot of a 'Dosage' dialog box. The title bar says 'Dosage' and has a close button (X). The main text reads: 'The dosage "PRIVATE PROVIDER- DO NOT ISSUE" is not recognised. Provide details of the dosage below:'. Below this text are several input fields: 'Quantity' followed by a text box, 'Per' followed by a dropdown menu showing 'None', 'Unit' followed by a dropdown menu, and 'pre-filled dispo:' followed by a dropdown menu. At the bottom of the dialog are two buttons: 'Save details' and 'Ignore'.

- **Quantity:** Enter lowest quantity i.e. 0.001
- **RX Types:** Amend to **Repeat**
- **Patient Info** details can be entered to reference provider if required

Add a Drug
×

Generic / Trade Switch
Online Visibility
Drug Information
Medication Review
Local Mixtures
My Record

MOUSE, Mickey (Mr)

 Born **25-Dec-1960 (65y)** Gender **Male**
 EMIS No. **500000**

Name:

Dosage:

Quantity: pre-filled disposable injection Duration: Day(s)

Rx Types:

Authorising Clinician:

Pack Details

Optional Prescription Information

Pharmacy Info:

Review Date: 19-May-2026

Days Before Next Issue: Min Max

Warnings
 Drug Information
 Current Medication
 Past Medication
 Allergies
 Problems

Selected Drug - **Mounjaro KwikPen 5mg/0.6ml solution for injection 2.4ml pre-filled pens (Eli Lilly and Company Ltd)**

▼ Report All Adverse Reactions To The MHRA

Contains - Tirzepatide 5 mg/0.6 ml

High Severity Warnings (2)

- ⚠ **Similar drug: Tirzepatide**
Mounjaro KwikPen 5mg/0.6ml solution for injection 2.4ml pre-filled pens (Eli Lilly and Company Ltd)
- ⚠ **Similar drug: Tirzepatide**
Mounjaro KwikPen 2.5mg/0.6ml solution for injection 2.4ml pre-filled pens (Eli Lilly and Company Ltd)

Medium Severity Warnings (4)

- ⚠ **Caution: Use Tirzepatide with caution in renal impairment (potential risk of metabolic acidosis due to accumulation of benzyl alcohol excipient over**

Add Another
Issue
Issue Later
Cancel

4. Proceed to issue and select **'Change All'** from the top selection. Select as issued by **'Record Hospital (No Print)'** as per screen shot below. Then Approve and Complete.
Whilst there are other prescription issue options within the 'change all' tab these will result in the medication appearing within the patients acute or repeat medication list with the potential risk of being issued in error.

Issue

Authoriser Medication Regime Review **Change All** Change Selection Pharmacy Message Patient Message

MOUSE, Mickey (Mr) Born **25-Dec-1960 (65y)** Gender **Male**
EMIS No. **500000**

Last regime review has expired

NHS Printed Script (non-EPS)

To Be Signed By: **AH-WENG, Frank (DF)**

Mounjaro KwikPen 5mg/0.6ml solution for injection 2.4ml pre-filled pens (Eli Lilly and Company Ltd) PRIVATE PROVIDER- DO NOT ISSUE, 0.01 pre-filled disposable injection Issue 1 of 1
Patient Text - prescribed by private provider- 'chemist' 18.02.26

Total Approximate NHS Cost: £1.80

Printer Store Postdate 18-Feb-2026 Separate Non-GP

Request Approve and Complete Cancel

- This enables the drug to be placed in a different section of the medication screen and be visible to all clinicians who access the patients record.

Active **MOUSE, Mickey (Mr)** Born **25-Dec-1960 (65y)** Gender **Male** EMIS No. **500000** Usual GP

Current

Drug / Dosage / Quantity

Acute

- A **Apixaban 5mg tablets** One To Be Taken Twice A Day, 56 tablet
- B **Desogestrel 75microgram tablets** One Tablet Daily At The Same Time Each Day, 336 tablet
- C **Ramipril 2.5mg capsules** One To Be Taken Each Day, 28 capsule

Repeat

- D **Amitriptyline 10mg tablets** One To Be Taken At Night, 14 tablet
- E **Aspirin 75mg dispersible tablets** One To Be Taken Each Day, 28 tablet
- F **Atorvastatin 80mg tablets** One To Be Taken Each Day, 28 tablet
- G **Bisoprolol 2.5mg tablets** take one daily, 28 tablet
- H **Finetest Lite testing strips (Neon Diagnostics Ltd)** Use as directed, 50 strip

Variable use repeat

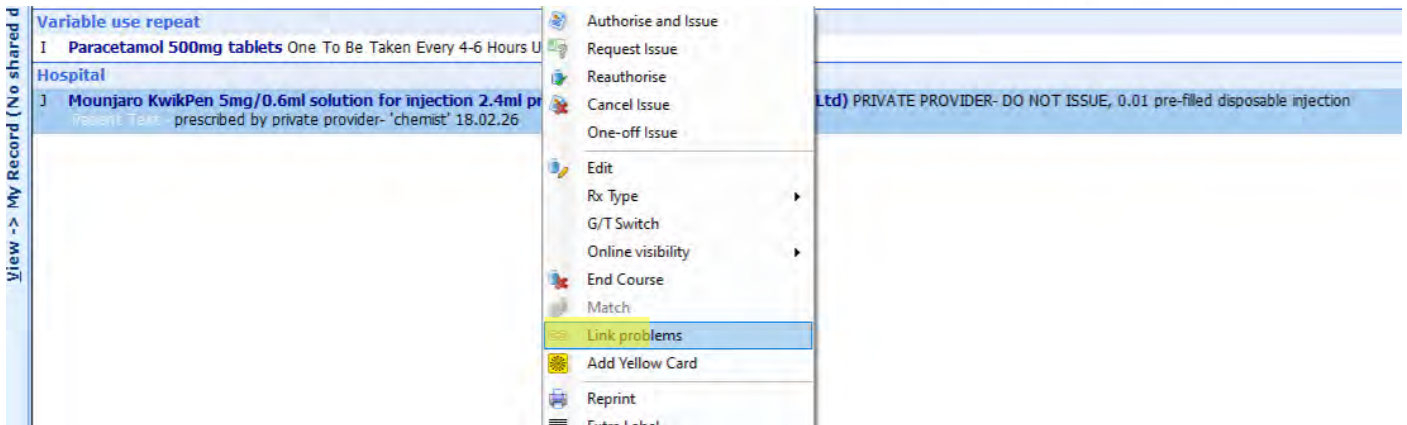
- I **Paracetamol 500mg tablets** One To Be Taken Every 4-6 Hours Up To Four Times A Day, 100 tablet

Hospital

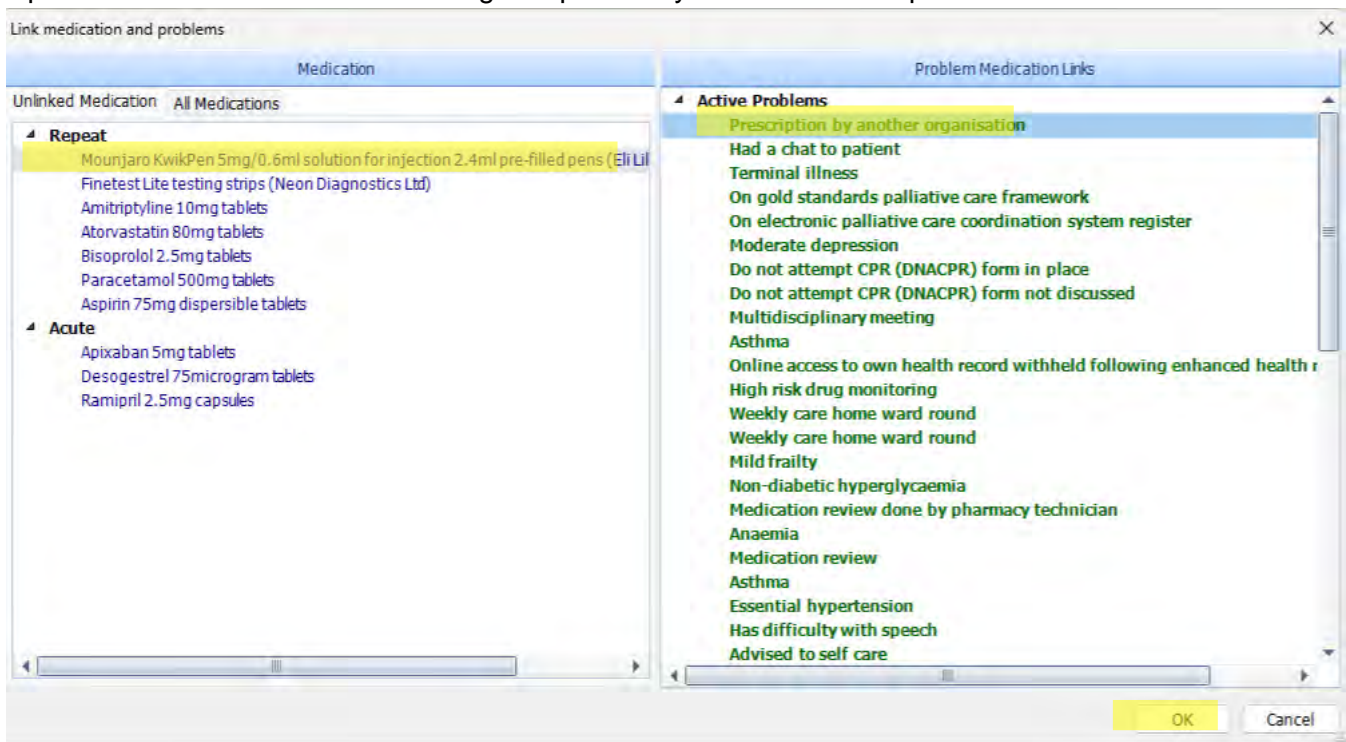
- J **Mounjaro KwikPen 5mg/0.6ml solution for injection 2.4ml pre-filled pens (Eli Lilly and Company Ltd) PRIVATE PROVIDER- DO NOT ISSUE, 0.01 pre-filled disposable injection**
Patient Text - prescribed by private provider- 'chemist' 18.02.26

ord (No shared data.)

- The medication can be linked to the SNOMED code 394828003 (prescription by another organisation) added to the clinical record, by right clicking on the item and selecting Link problems



Upon the new screen- select the drug and problem you wish to link & press OK




- If the practice tries to issue the drug a warning would appear upon the 'prescription request' task for approval to inform it is a 'hospital medication'- as this could be missed it is important that the above prescription entry instructions are adhered to.

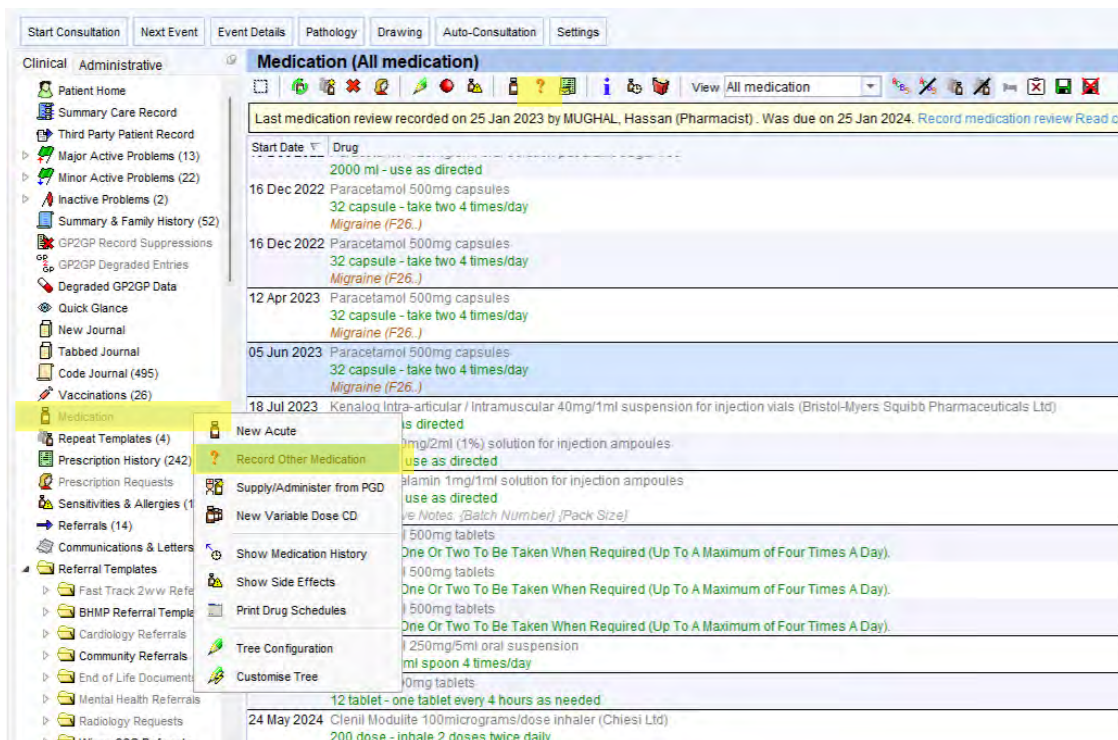
Additional Information:

- Potential interactions will be flagged when the medication is initially added as a 'hospital medication' or when any other medications are added onto the system.
- Medications added as a 'hospital medication' will appear as 'Repeats' when a search via 'Population Reporting' is completed- by following the suggested prescription entry instructions these can be flagged within an auto-report when 'dose' or 'issue method' has been added to the presented report data.

- Medications added as a 'Hospital medication' **will not be printed on the right-hand side of the repeat prescription** ensuring the patient will not be able to order as a repeat prescription from their repeat slip. However, this also poses a risk in that repeat slips are commonly used for medicines reconciliation when patients are admitted into hospital and therefore this does not provide information on the non-practice medication that the patient is also taking. Practice provided 'summaries will list the Hospital medications within the repeat medication section- dosage will also be listed providing information that the medication is prescribed outside of primary care.
- Medications added as an acute **are not retained on the Summary Care Records (SCRs) beyond 12 months** after they were initially recorded, therefore it is recommended to add privately prescribed medications as a 'repeat'.

Appendix Eb: Medicines Optimisation: Management of medications supplied by private providers on TPP-SystemOne

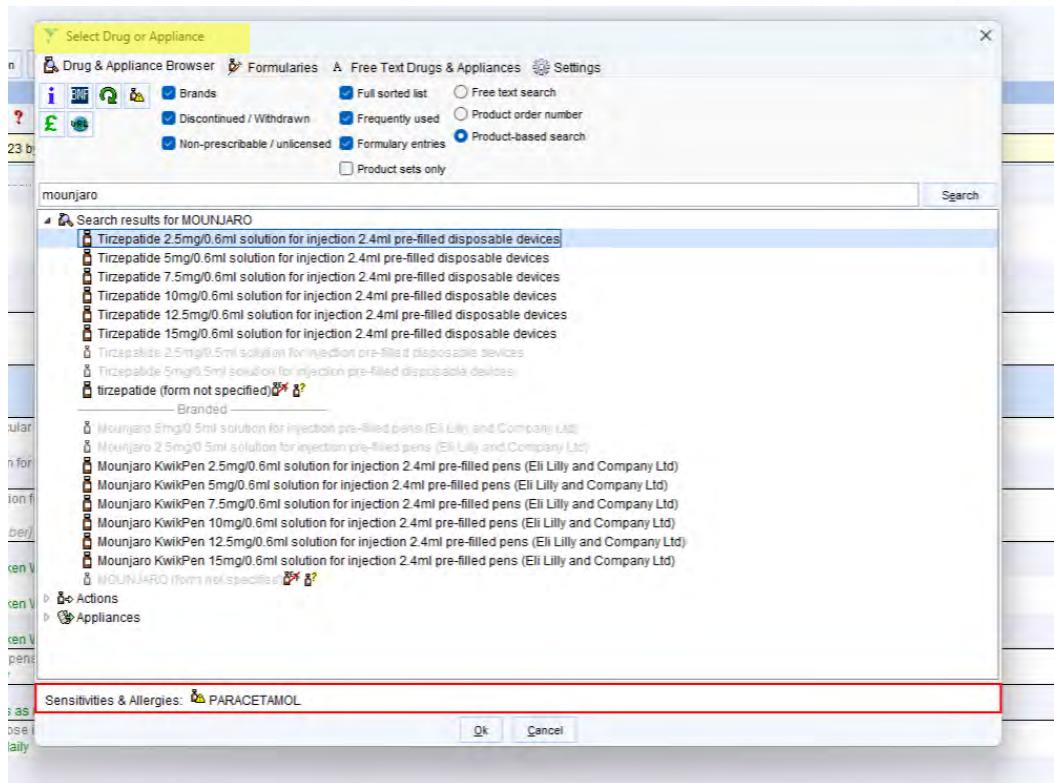
1. Right-click on '**Medication**' node listed in clinical tree or by selecting the 'record a non-printable dental or hospital prescription' symbol  on the medication banner.
2. Select '**Record other medication**' – the medication will appear in a separate box at the bottom of the repeat template screen.



The screenshot shows the TPP-SystemOne Medication management interface. The main window displays a list of medications with columns for Start Date and Drug. The 'Record Other Medication' option is highlighted in the left-hand menu. The main window displays a table of medications with columns for Start Date and Drug. The 'Record Other Medication' option is selected, showing a list of available drugs for selection.

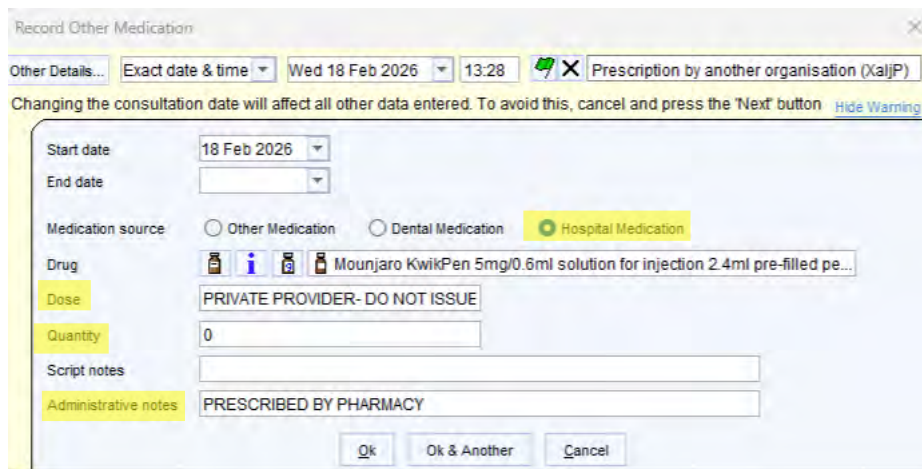
Start Date	Drug
16 Dec 2022	Paracetamol 500mg capsules 32 capsule - take two 4 times/day Migraine (F26.)
16 Dec 2022	Paracetamol 500mg capsules 32 capsule - take two 4 times/day Migraine (F26.)
12 Apr 2023	Paracetamol 500mg capsules 32 capsule - take two 4 times/day Migraine (F26.)
05 Jun 2023	Paracetamol 500mg capsules 32 capsule - take two 4 times/day Migraine (F26.)
18 Jul 2023	Kenalog Intra-articular / Intramuscular 40mg/1ml suspension for injection vials (Bristol-Myers Squibb Pharmaceuticals Ltd)
	is directed
	1mg/2ml (1%) solution for injection ampoules.
	use as directed
	1mlamin 1mg/1ml solution for injection ampoules
	use as directed
	Use Notes: (Batch Number) (Pack Size)
	500mg tablets
	One Or Two To Be Taken When Required (Up To A Maximum of Four Times A Day).
	500mg tablets
	One Or Two To Be Taken When Required (Up To A Maximum of Four Times A Day).
	500mg tablets
	One Or Two To Be Taken When Required (Up To A Maximum of Four Times A Day).
	250mg/5ml oral suspension
	ml spoon 4 times/day
	10mg tablets
	12 tablet - one tablet every 4 hours as needed
24 May 2024	Clenil Modulite 100micrograms/dose inhaler (Chiesi Ltd)
	200 dose - inhale 2 doses twice daily


3. This will launch the drug browser where the clinician selects the drug prescribed by the private provider.



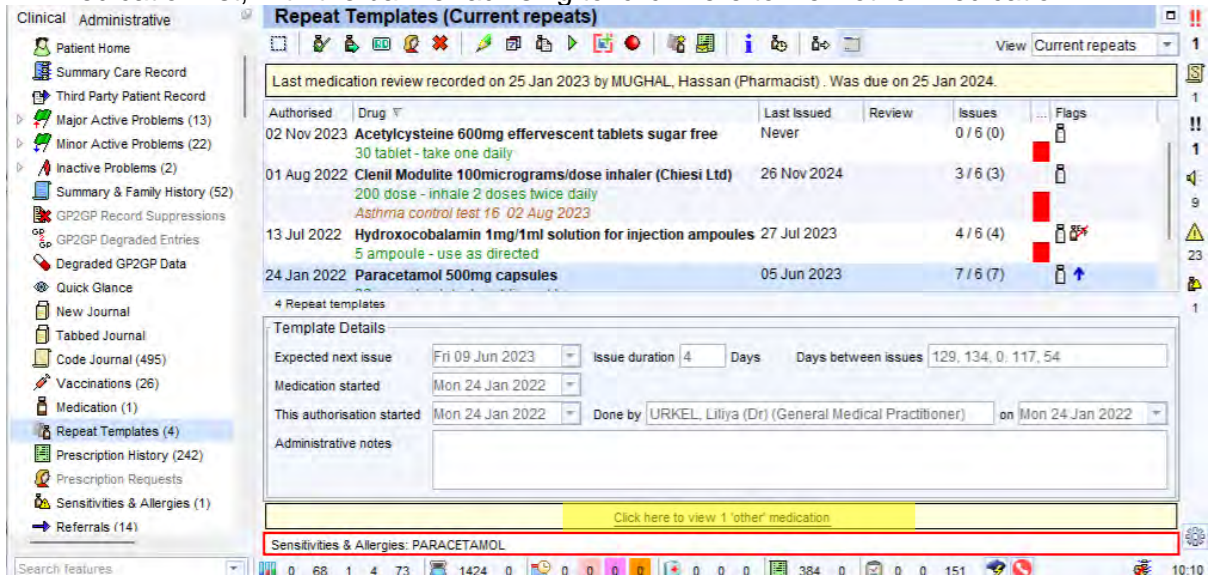
4. Once the drug is selected complete the other required details on the **'Record Other Medication'** dialog. Note: Ensure rules are adhered to minimise risk of the privately prescribed drug(s) being supplied even if prescription is inadvertently printed in error.

- **Medication source:** select **'Hospital Medication'**
- **Dose:** **PRIVATE PROVIDER- DO NOT ISSUE**
- **Quantity:** Enter lowest quantity i.e. **'0' (Zero)**
- **Administrative notes:** **Prescribed by (provider)**

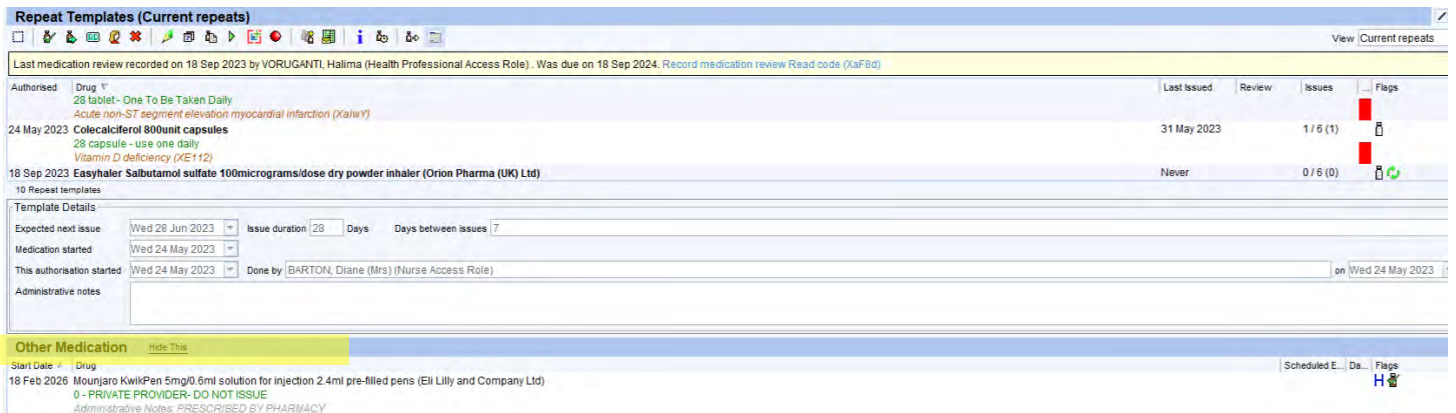


- The medication can also be linked to the SNOMED coded problem 'prescription by another organisation' using the Flag symbol  at the top right of the pop up.

5. The drug will be displayed in a separate section of the 'Repeat Template' medication list, with the banner advising to 'click here to view other medication'



6. Once selected the list of 'other medication' will be visible along with all details completed as above prescription entry instructions.



7. It is also highlighted in the 'Medication' template as a 'Hospital' medicine(s).

Start Date	Drug	Scheduled E...	Da...	Medication Type	Flags
Administrative Notes: Prescribed by hospital					
12 Aug 2025	Amoxicillin 500mg capsules 15 capsule - take one 3 times/day	17 Aug 2025	5	NHS medication	
12 Aug 2025	Bambhaler Budesonide 100microgram/step dry powder inhaler (Orion Pharma (UK) Ltd) 200 dose - inhale ONE dose TWICE a day (Please return your empty or unwashed inhalers to a pharmacy for disposal)	20 Nov 2025	100	NHS medication	
12 Aug 2025	Evorel Sequi patches (Theramix HD UK Ltd) 24 patch - apply ONE Evorel 50 patch twice weekly for 2 weeks, within 5 days of onset of period, followed by ONE Evorel Comb patch twice weekly for 2 weeks. Repeat this 28 day cycle without a break	04 Nov 2025	84	NHS medication	
13 Aug 2025	Amlodipine 5mg tablets 28 tablet - take one daily	10 Sep 2025	28	NHS medication	
18 Aug 2025	Amoxicillin 500mg capsules 15 capsule - take one 3 times/day	23 Aug 2025	5	NHS medication	
18 Aug 2025	Co-amoxiclav 500mg/125mg tablets 21 tablet - take one 3 times/day	25 Aug 2025	7	NHS medication	
18 Aug 2025	Neroburanton 100mg modified-release capsules 14 capsule - take one twice daily	25 Aug 2025	7	NHS medication	
12 Sep 2025	Spondonidone 25mg tablets 28 tablet - use as directed	13 Sep 2025	1	NHS medication	
02 Feb 2020	Doxicloine 100mg capsules 6 capsule - two now then one daily	07 Feb 2020	5	NHS medication	
02 Feb 2020	Epimax excetra cream (Aspire Pharma Ltd) 500 gram - use as directed	02 Mar 2020	28	NHS medication	
16 Feb 2020	Amoxicillin 500mg capsules 15 capsule - take one 3 times/day	21 Feb 2020	5	NHS medication	
18 Feb 2025	Moujano KwikPen 5mg/0.5ml solution for injection 2.4ml pre-filled pens (Eli Lilly and Company Ltd) 0 - PRIVATE PROVIDER- DO NOT ISSUE			Hospital	
Administrative Notes: PRESCRIBED BY PHARMACY					

Additional information:

- Potential interactions with acute or repeat medication commenced after the recording of the 'other medication' will be flagged up when a new medication is prescribed but will not flag when the 'other medication' is entered onto the system.
- Medications recorded as 'Other Medications' will only show in searches completed on SystmOne when 'Report on all issues' is selected within Medication.
- If a medication summary is printed from the clinical system the medication will show within the list of current medications- only drug names are listed
- Within the Summary Care Record (SCR) the medication will show under the heading of 'Current Repeat Medications' within the medication type of 'Repeat Prescribed Elsewhere', text stating 'This medication could either be Acute or Repeat Medication' will also be endorsed on the record.
Discontinued medications will continue to show on SCR for 6 months.

[Appendix F: Medicines Optimisation: Quality Improvement Requirements](#)

Overview

There are 2 medicines optimisation specifications (MO1 & MO5) that require practices to submit Quality Improvement (QI) plans and evaluations. Practices are encouraged to work collaboratively across their PCN to submit 1 QI plan per PCN.

There are 2 submission deadlines within 2026/2027

- **End of Q1 (30th June 2026) – QI Plan Submission**
- **End of Q4 (31st March 2027) – QI Evaluation Submission**

Please note that performance monitoring and payments will still be made at a practice level. Practices can collectively decide on how to utilise and distribute their allocated funding to deliver on the specification requirements and planned interventions.

Please refer to the QI guidance that has been put together to support practices / PCNs formulate their QI plans.

See [Quality Improvement Guide \(page 77\)](#)

Payments linked to QI plan and evaluation submissions are intended to support planned interventions in addition to developing the QI plan and completing the evaluation.

In exceptional circumstances, a practice may request permission to submit its own QI plan and QI evaluation independently of the PCN submission. All requests must first be sent to nhsgm.beccormedsopt@nhs.net, outlining the extenuating circumstances. Practices should await formal approval from NHS GM before proceeding with a practice-level QI plan and evaluation submission.

QI plan submissions will be assessed for the following domains:

- Relevance & Rationale
- Alignment
- Avoidance of exclusion criteria
- SMART Aims
- Intervention Quality
- Health Inequalities consideration
- Measurement plan
- Governance

All QI plans will be provided scores against the domains above and the overall score will determine an outcome which will be communicated with named QI project leads.

- ≥ 80 Approved.
- 65–79 Approved with conditions.
- < 65 Revise and resubmit

All QI plans should consider the following specification standards:

MO1: Antimicrobial Stewardship Standards

- Each PCN must submit one QI plan as per the service specification
- Must include baseline data review of antimicrobial prescribing patterns. Evidence is to be submitted via online Airelogic forms and data will be accessible via GM tableau dashboard.
- All plans are required to have the following as 1 of the outcomes:
 - Reduction in inappropriate prescribing of antimicrobials contributing to reducing total volume, in line with national targets detailed in service specification.

MO5: A population health approach to medicines safety: GM Safer Prescribing Need Standards

1. QI projects must not duplicate SMR delivery (invitations, completions, coding).
2. Each PCN must submit one QI Plan (confirmed in specification).
3. Must select either A or B:
 - A: Polypharmacy & ACB
 - B: Opioids & DFM
4. Must align with national and GMMMG medicines optimisation standards.
5. Must incorporate inequality considerations (frailty, age, ethnicity, deprivation).
6. Must incorporate prevention strategies for the wider population
7. Must use baseline data and evidence-based problem identification.
8. Must include a SMART aim, measurement plan, and defined outcomes across practice and PCN level.
9. Interventions must demonstrate system improvement, not individual SMR delivery.
10. All plans are required to have the following as outcomes
 - Reduction in unwarranted variation
 - Improvement in the selected domain (polypharmacy or opioids)
 - System & process change (not SMR driven)

Exclusion Standards

- SMR count-based activity
- Work solely generating SMR SNOMED codes
- Case-finding only for SMR purposes

Data & Evidence Standards

- Must use SPN Dashboard
- Supplement with ePACT2, SMASH, audits and other practice data
- Must report QI plan outcomes at PCN and practice level

BeCCoR Medicines Optimisation 2026/27

Quality Improvement Guidance

Quality improvement (QI) is an ongoing cyclical process.

This template has been adapted from a behavioural change approach to AMS and is underpinned by four important **principles** which support quality improvement:

- Attending to emotions
- Supporting people to take control
- Being curious
- Keep cycling/repeat the process

All the way through the quality improvement project, aim to foster an *appreciative* and *participatory* approach, by being curious and attending to / being aware of people's emotions.

Whilst ensuring that you stick with the principles, you will be going through a cycle in which you plan, do, study and act. This is called the PDSA cycle and is a typical way that people approach quality improvement.



This approach to QI draws on four important **approaches**:

- The PDSA (plan, do, study, act) cycle
- The Behaviour Change Wheel
- Participatory approaches
- Appreciative Inquiry

Further Information about these four approaches is included at the end of this document for additional reading. To find out more about the study of behaviour, how it relates to change of health professional behaviour and organisational change, see www.thechangeexchange.org

P lan

Specifying the vision: The vision is what you want to achieve. This is going to be something *everyone can agree with* and will be the long term, important aim of your activities. Having the vision written down, means that you are all aiming for the same thing and will also influence how you might be able to ‘study’ the impact of your QI.

Gather the people: It is important that people who need to change are involved in change from the outset. There are so many examples where people reject changes when they are seen as imposed from above. Identifying who needs to be involved in the process is a crucial step.

Hold meetings: Organise a meeting with the relevant stakeholders about the quality improvement activities. The meeting will have five main activities: 1) share the vision; 2) identify who needs to do what; 3) get it out in the open; 4) plan how to intervene; 5) specify how you will know you’ve been successful.

Template Meeting Structure
<p>1. Share the vision</p> <p>The vision should not be a contentious topic and so you can get agreement with the vision at the outset. This starts people with a good sense of shared purpose and attends to emotions.</p>
<p>2. Identify who needs to do what</p> <p>This is where you show your curiosity. <i>Ask rather than tell people: Who needs to do what for us to realise our shared vision?</i> <i>What would the people who do your job need to do differently?</i></p> <p>Try to be <u>specific</u> and identify Who needs to do what, how, with / to whom, when and where</p>
<p>3. Get it out in the open</p> <p>Here’s a chance to identify all the strengths that people have to take the changes forward. It is often tempting to start with the barriers to change, but take an</p>

appreciative approach by asking: ***What strengths do people have to make this change happen?***

People will identify barriers as part of this process but then ask the group to develop solutions – the ones that they have done before and have worked. You are looking to identify the capability, opportunity, and motivation of people about each of the behaviours.

- **Capability** – what do they know and know how to do that will help them and what would be helpful to know more about?
- **Opportunity** – when they imagine doing the new behaviour, what is around them that makes it possible / easier? This can be equipment, other people, time or so on.
- **Motivation** – why do they think this is a good idea? What would remind them to do this at the right time (e.g., prompts and cues).

4. Plan how to intervene

Armed with all the new information you have about who needs to do what and their capability, opportunity and motivation to do that, plan how you will intervene as a group. These can be very small changes that help you and others to do what's important for the project. This can include elements that address each of capability, opportunity and motivation:

- **Capability** – this is usually training in what to do and how to do it
- **Opportunity** – *make the right thing the easy thing* thinking through what happens around the behaviours and making the path smooth for the new behaviours – this might be equipment or paperwork or processes. Remember that opportunity is also social – if there are people who might get in the way, can they be brought into the shared vision?
- **Motivation** – are people already motivated? If not, you might want to share the underpinning reasons for the shared vision – why is this the right thing to do. You could have some information about the future consequences of not changing versus changing. Don't forget that we do lots of things automatically too – so think about whether reminders in places might help.

5 Specify how you will know it has been successful and by when

Make some simple plans for how you will know if you have been successful. This can include assessments of outcome, for example if a point prevalence survey has been conducted. it also might be assessment of the process, for example do people know about the shared vision? are people doing the new behaviours? How are you going to feedback to leadership and those that have been involved?

D_o

This is where you do what you have planned. Make some records about what you did and how those activities were linked to the behaviours and the things you knew about the capability, opportunity and motivation of people to do those behaviours.

S_{tudy}

At the predefined point, review the information you've collected together.

What evidence do you have about

- Whether the interventions were acceptable
- That we changed capability, opportunity or motivation of any of the groups/stakeholders
- Changed the behaviour of any of the groups/stakeholders
- Antimicrobial used changed

A_{ct}

What's next? You can continue your cycle if there are still improvements to be made. Every time you go through a cycle you find out more about yourselves and the teams, so every cycle is worthwhile. If it has worked then you can decide what to work on next, but also perhaps how to monitor the changes to make sure they are sustained.

QI: Further Supporting information.

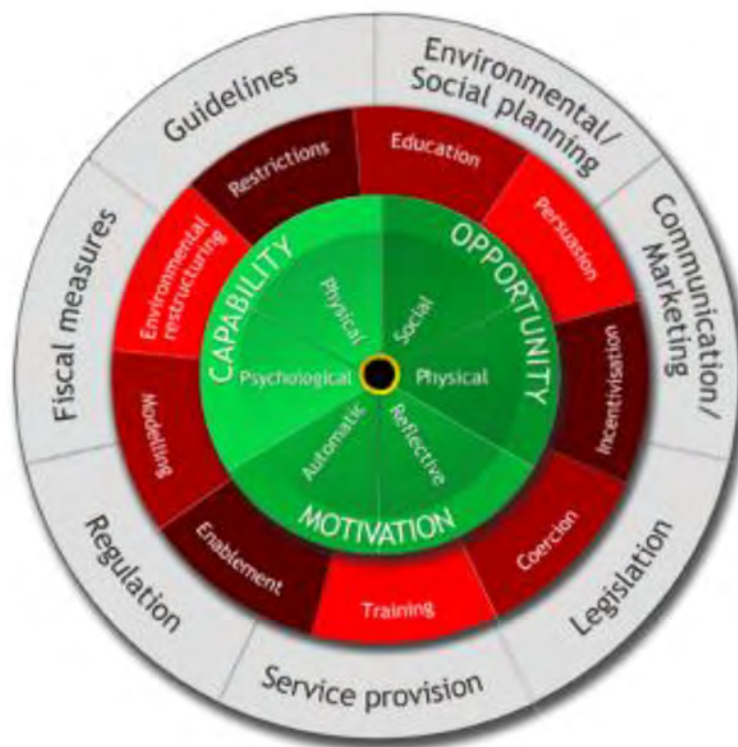
1. The PDSA Cycle: The PDSA cycle provides a framework for developing, testing and implementing changes to improve services. You can read more about the PDSA cycle here:

- <https://www.england.nhs.uk/wp-content/uploads/2022/01/qsir-pdsa-cycles-model-for-improvement.pdf>
- To learn about some of the potential difficulties in applying PDSA see here: <https://qualitysafety.bmj.com/content/25/3/147>

2. Participatory approaches: You can read an example of using the Behaviour Change Wheel using a participatory approach here: <https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-019-3885-8#article-info>

3. Appreciative Inquiry: Appreciative inquiry is a shift from identifying and working on people's deficits to identifying and working on their strengths. Based on an ancient idea that we create the sense of ourselves and others through the stories we tell about our actions, this is a positive move away from improvement projects feeling like they are showing us how we are failing. In our QI workbook, we take an appreciative stance by asking people to first identify what is going well and to think about what could be. There is a lot written about appreciative inquiry as a development approach, and if you want to know more you can start your reading here <https://www.davidcooperrider.com/ai-process/>

4. The Behaviour Change Wheel: The Behaviour Change Wheel is a framework that seeks to draw together what is known about the influences and interventions. In the centre of the wheel is the COM-B framework, which says that the influences on behaviour (B) can be usefully categorised into capability, opportunity and motivation (COM). The red ring is the different functions that interventions can have e.g., they can educate or enable or restrict in order to cause behaviour. Finally, the grey ring are the different types of policy that can be enacted, including publishing guidelines, legislating or marketing.



We draw on the Behaviour Change Wheel to try to deeply understand what drives people to act in the way that they do and what we can do to support change in ourselves and others.

You can learn more about the Behaviour Change Wheel with these free guides <https://www.ucl.ac.uk/behaviour-change/resources/achieving-behaviour-change-guides-local-and-national-government-and-partners> or from this book (available as an ebook) <http://www.behaviourchangewheel.com>.

Service Specification

Service Specification No.	001
Service	Bury Locally Commissioned Service
Commissioner Lead	Zoe Alderson, Head of Primary Care
Provider Lead	GP Practices
Period	1 st April 2026 – 31 March 2027
Date of Review	Quarterly

1. Population Needs

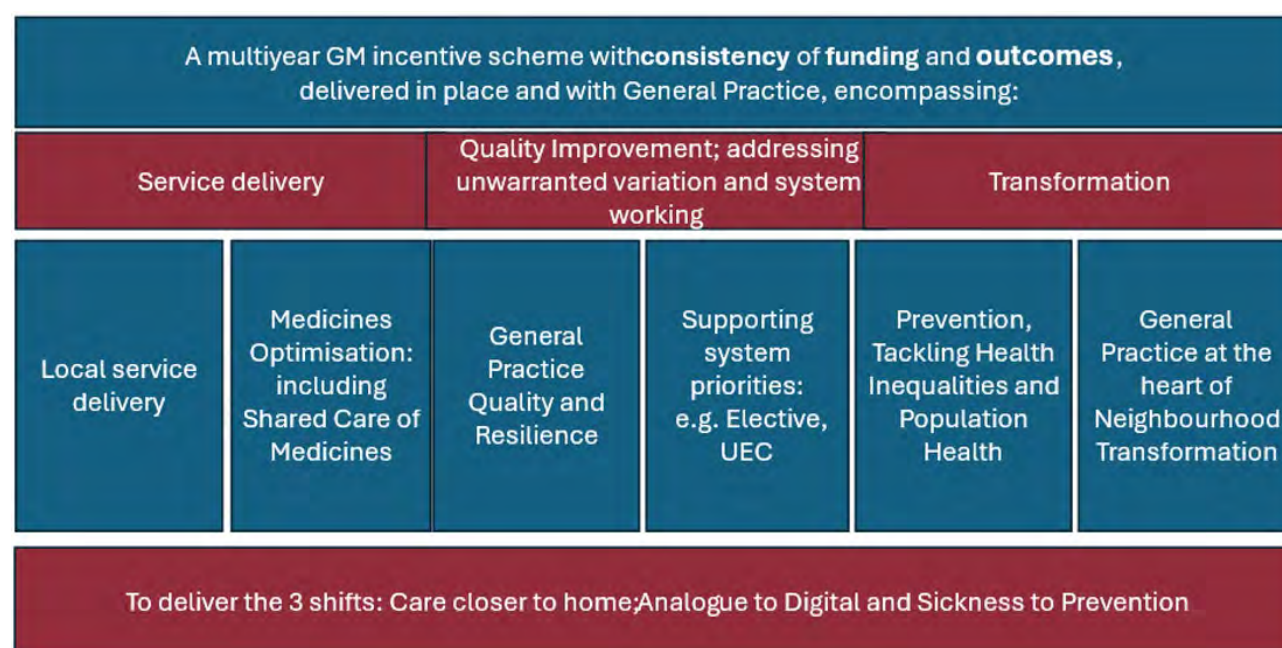
1.1 National/local context and evidence base

Requirements commissioned from general practice varies significantly across the 10 Greater Manchester (GM) localities due to legacy Clinical Commissioning Group (CCG) arrangements.

A GM wide programme of work referred to as the Beyond Core Contract Review (BeCCoR) was established in 2023 aimed at review existing schemes and develop a consistent and standardised approach across GM moving forward.

This is a phased piece of work; phase 1 was launched in April 2024 when Antimicrobial Stewardship and review of high risk patients with CVD and Diabetes were incorporated into all locality schemes. In April 2025, phase 2 introduced a QI project for Elective Care and a forerunner scheme for Shared Care of Medicines along with some additional local neighbourhood requirements for Bury.

For Phase 3, 1st April 2026 – 31st March 2027, localities will continue to commission Pillar 1 services (Local service delivery) with Pillars 2 to 6 instead now forming part of a GM-wide GP quality incentive scheme:



This specification therefore describes the services remaining within Pillar 1 Local Service Delivery Requirements.

1.2 Population of Bury

As of January 2025, Bury had a weighted population of 213,395 registered across 25 Practices working (28 sites, across 5 neighbourhoods).

Practices continue to work together to not only ensure the local population has high quality healthcare services which are sustainable, but also working alongside wider neighbourhood colleagues to target and address areas of variation in terms of care or outcomes for patients.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	✓
Domain 2	Enhancing quality of life for people with long-term conditions	✓
Domain 3	Helping people to recover from episodes of ill-health or following injury	✓
Domain 4	Ensuring people have a positive experience of care	✓
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	✓

The overall aim of this service specification is to provide clinically safe and effective services that will improve the outcomes for patients.

Table 1 – List of indicators

Work Area	Indicator
Diagnosis	<p>Continue to support the local Dementia Diagnosis Pathway by:</p> <ol style="list-style-type: none"> 1 Identifying a Dementia Clinical Lead 2 Providing a first assessment 3 Providing a second assessment to carry out diagnostic tests 4 Providing a third assessment for further medical assessment 5 Referring patients with a new diagnosis and their carers for support 6 Providing newly diagnosed patients with a 3 month follow up 7 Patients with suspected complex dementia should be referred to MAS 8 Recording information re care for each patient using provided SNOMED codes <p>Please see full required delivery criteria for points 1 – 8 in section 4.1</p>
Diagnostics	Undertake and record PC diagnostics as appropriate
Diagnosics	<p>Undertake venepuncture as appropriate, including hospital requested phlebotomy (outside of the NCA footprint) when a fully completed card has been provided by the requester. This does not preclude any practice from undertaking hospital requested bloods within the NCA footprint should they see fit.</p> <p><i>Children between the ages of 5 and 12 years old may be referred to the Paediatric Phlebotomy Service who will test only for conditions that can be managed within primary care e.g. suspected menorrhagia, anaemia or coeliac disease or undertake bloods for patients in that age range who are on shared care agreements:</i></p> <ul style="list-style-type: none"> • Any bloods for the above conditions required on patients 12 years and over can be done in practice

	<ul style="list-style-type: none"> • Any children outside of these conditions (age 5-12), must go through Consultant Connect to seek paediatric advice & guidance first to determine which bloods might be needed and can then be referred to Rock (this must be detailed on the bloods request form and accompanying TQuest labels provided) • Any patient under 5, consider referral to Paediatrics (not for blood tests but for management advice) and not dealt with in Primary Care
Ear wax	Only perform ear wax removal where clinically necessary and in line with local guidance ≥18 Please see full details of guidance embedded within section 4.1
Ring Pessaries	Undertake the fitting, change and removal of ring pessaries. Work continues in regard to the commissioning of community based GM wide gynae services (which includes ring pessaries). It is envisaged that once this service is in place this requirement may be dropped from this specification. There is no available timeframe around this.

3. Scope

1.1 Aims and objectives of the service

- Delivery of transactional type activity which all relevant registered patients must have access to
- Data will be collected from all practices using EMIS enterprise

1.2 Service description/care pathway

The provider will determine the most appropriate care pathways when delivering the requirements articulated within this specification.

Leads identified as a requirement within this specification should as a minimum:

- Be the most suitably skilled person for the role
- Engage in meetings specific to the work area
- Contribute to finding agreeable solutions
- Implement actions as a result of discussions
- Disseminate information and influence wider work colleagues

Training to support ongoing dementia diagnosis will continue to be supported and communicated.

1.3 Population covered

All patients must be registered with a Bury General Practice

1.4 Protected Learning Time

There will be 12 whole practice based Protected Learning Time (PLT) sessions in the year, the content of which may be directed by the ICB. In order to comply with the GM policy for PLT, practices are to ensure that telephones are diverted to BARDOC and Online Consultation Platforms remain switched on. All other core contractual responsibilities during LTI sessions remain the responsibility of the Practice to maintain.

Monthly sessions will continue to be covered by BARDOC with Practices having a choice of 1 from 3 set days/times, as follows:

Dates: The 3rd Tue of each month
The 2nd Thursday of each month, OR
The 4th Wed of each month

Duration: 13:00 - 15:30 (2.5 hours)

- Practices are required to maintain their chosen session throughout the year and only by prior negotiation with the locality may consideration be given to this being changed. This is to ensure that effective communication with patients can be maintained.
- Practices wishing to undertake LTIs outside of these standard days/times must do so whilst remaining open to their patient population.
- If requested, Practices will submit a summary of LTI's undertaken which details key learning from the session.

1.5 Interdependencies with other services/providers

- Northern Care Alliance
- Community Services
- Integrated Neighbourhood Teams
- BARDOC
- Voluntary Community Faith Alliance
- Bury Hospice
- Memory Assessment Service
- Dementia United

4. Applicable Standards & Quality Requirements

4.1 Applicable national/local standards

The following pathway should be followed when diagnosing those with Mild Cognitive Impairment or Dementia



Mild Cognitive
Impairment Dementiz

Ear Wax removal should only be carried out in line with the follow pathway



Draft criteria Ear Wax
Removal v3.docx

5. Reimbursement

As part of contractual sign-up process, each practice will receive an individualised financial schedule outlining the available finances for your practice based on the practice population.

Reimbursement for this specification will form part of that individualised schedule.

6. Contract Monitoring

All work undertaken as part of this specification is auditable and subject to post payment verification, therefore every effort should be made to use the business rules provided to record activity in accordance to this specification. Any omissions or errors within those business rules should be reported to gmss.dataqualitygm@nhs.net at the earliest opportunity.

Practices should continue to use the coding specification already in place for these transactional requirements.

Monthly performance reviews will be carried out in order to highlight any contracting concerns which must be addressed to avoid financial clawback.

7. Disputes

Once financial reconciliation of financial achievement has been undertaken, practices will have a period of 4 weeks to lodge an appeal. The appeal should describe the grounds for appeal and the supporting evidence.

Any appeals will be considered through Greater Manchester Primary Care Contracting processes and governance, and the outcome communicated with the practice.

8. Duration & Notice Period

These requirements are to be delivered from the 1st April 2026 until 31st March 2027.

Should it be necessary to amend the service requirements mid-year, it will be done following further engagement and a contract variation subsequently issued in line with previous iterations of this contract.

Termination outside of the dates of this agreement by either party will be in writing with a minimum notice period of 3 months.

9. Future Developments

During 2026/27 the services delivered by localities under the Pillar 1 umbrella will continue to be reviewed and a decision taken as to whether:

- A. They should continue and be commissioned across GM and therefore become part of the GM BeCCoR scheme
- B. They should continue and are unique to the locality and therefore will continue to be commissioned separately
- C. They should be decommissioned and therefore the appropriate actions taken to allow this to happen.

The first service to be considered will be Quality Assured Spirometry/Feno. As Bury already has a separately commissioned service via the Bury GP Federation which meets the GM specification requirements, this is unlikely to have any impact on practices in Bury, however updates will be provided as and when available.

Meeting: Primary Care Commissioning Committee			
Meeting Date	30 March 2026	Action	Receive
Item No.	10	Confidential	No
Title	GP Contract Changes 2026/27		
Presented By	Zoe Alderson, Head of Primary Care (Bury)		
Author	Zoe Alderson, Head of Primary Care (Bury)		
Clinical Lead	Dr Catherine Fines, Associate Medical Director (Bury)		

Executive Summary
<p>This report summarises the confirmed changes to the General Practice (GP) Contract for 2026/27 as outlined by NHS England. The changes aim to strengthen GP capacity, enhance clinical outcomes, modernise quality frameworks, and improve access and patient experience across primary care. The contract introduces new financial uplifts, revised clinical requirements, adjustments to the Quality and Outcomes Framework (QOF), and stronger expectations of integrated working with primary care networks (PCNs) and integrated care boards (ICBs).</p>
Recommendations
<p>The Primary Care Commissioning Committee is required to:</p> <ul style="list-style-type: none"> Receive the 2026/27 GP Contract Changes being presented and note the risks associated

OUTCOME REQUIRED <i>(Please Indicate)</i>	Approval <input type="checkbox"/>	Assurance <input type="checkbox"/>	Discussion <input type="checkbox"/>	Information <input type="checkbox"/>
APPROVAL ONLY; (please indicate) whether this is required from the pooled (S75) budget or non-pooled budget	Pooled Budget <input type="checkbox"/>	Non-Pooled Budget <input type="checkbox"/>		

Links to Locality Plan outcomes	
To support a local population that is living healthier for longer and where healthy expectancy matches or exceeds the national average by 2025.	<input type="checkbox"/>
To achieve a reduction in inequalities (including health inequality) in Bury, that is greater than the national rate of reduction.	<input type="checkbox"/>
	<input type="checkbox"/>

Links to Locality Plan outcomes	
To deliver a local health and social care system that provides high quality services which are financially sustainable and clinically safe.	
To ensure that a greater proportion of local people are playing an active role in managing their own health and supporting those around them.	<input type="checkbox"/>

Implications						
Are the risks already included on the Locality Risk Register?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
Are there any risks of 15 and above that need to be considered for escalation via an NHS GM Statutory Committee or Board in line with the Risk Escalation process ?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
Are there any quality, safeguarding or patient experience implications?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
Have any departments/organisations who will be affected been consulted ?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
Are there any financial Implications?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>

Governance and Reporting		
Meeting	Date	Outcome
GP Board	18/03/2026	Not known at the time of writing this paper

GP Contract Changes 2026/27

1. Introduction

- 1.1. This report summarises the confirmed changes to the General Practice (GP) Contract for 2026/27 as outlined by NHS England. The changes aim to strengthen GP capacity, enhance clinical outcomes, modernise quality frameworks, and improve access and patient experience across primary care. The contract introduces new financial uplifts, revised clinical requirements, adjustments to the Quality and Outcomes Framework (QOF), and stronger expectations of integrated working with primary care networks (PCNs) and integrated care boards (ICBs).

2. Background

- 2.1. General practice remains the gateway to the NHS, with recent reforms seemingly demonstrating improved GP access. Building on these reforms, the 2026/27 contract consultation has concluded, embedding a further shift toward preventative care, streamlining pathways, and enabling system-wide collaboration. National investment will rise by £485 million, raising the total contract value to £13.863 billion (3.6% cash uplift). Priorities include GP capacity, clinically urgent same-day access, vaccination improvements, and modernised QOF indicators aligned with updated NICE guidance.

3. Key Changes

- 3.1 A full detailed list of contracts and QoF changes are available in Appendix 1 attached. Key changes for the committee to note include:
 - Practices will have access to a new practice-level GP reimbursement scheme to enable them to recruit new GPs or increase the number of sessions from GPs already working in the practice. (repurposed from Primary Care Network (PCN) Capacity and Access Payment (CAP) fund)
 - The PCN DES is being changed to allow PCNs to claim for GPs at any stage in their career and increase the maximum reimbursement for GPs (up to the top of the range for salaried GPs) - removing the previous restriction that ARRS funding can only be claimed for recently qualified GPs.
 - PCNs will be allowed to recruit to other non-patient facing roles (roles that are not set out in the role specifications in the DES), with commissioner agreement.
 - Patients identified as clinically urgent will be dealt with on the same day.
 - Patients whose needs are assessed as non-urgent, will receive an appropriate response by the end of the next core hours period.
 - There will be changes to the core contract to clarify that patients should not be asked to call the practice back and to explicitly require that online consultation systems must not cap the number of requests.

- A range of QOF changes including:
 - A new diabetes indicator requiring delivery of all 8 NICE recommended care processes.
 - Two new obesity related indicators to support referrals into structured weight management programmes and medicines optimisation (the existing weight management enhanced service will be retired)
 - Additional improvement thresholds for the three childhood vaccination indicators intended to recognise and reward practices, particularly those in more deprived areas that may not meet the existing achievement thresholds but demonstrate meaningful and sustained improvement in vaccination uptake.
- Practices will be required to engage with support from their integrated care board (ICB) where unwarranted variation has been identified.
- Practices will be required to use Advice and Guidance prior to or in place of a planned care referral where clinically appropriate and to follow locally agreed referral pathways, including single point of access models once introduced. (Funding from the existing enhanced service will be moved into core)
- Practices will be required to have a dedicated, monitored email address for pharmacy communications.
- The General Practice Staff Survey will be extended to all practice and PCN staff.
- It will become a core requirement for PCNs to identify and prioritise cohorts for continuity of care using risk stratification tools as part of their core activities.
- The Network Contract DES will be amended to require PCNs to work with their ICB to achieve greater alignment between the PCN registered list and the neighbourhood, where an ICB works with the local authority to define a neighbourhood around a natural community that does not match current PCN geography.

4 Associated Risks

4.1 The BMA has emphasised within its response to these changes that it **was not permitted to negotiate** the 2026/27 GP contract in the usual way. Instead, the Government used a *group consultation* model involving multiple stakeholders, breaking with long-established process and side-lining the BMA's traditional role as the sole negotiating body for GPs. A further response is therefore anticipated from the BMA regarding these imposed contract changes which may or may not result in further collective action.

4.2 In addition to this, the following area risks should be noted:

Area	Risk	Mitigation
Workforce	Same-day urgent care requirements may strain	The new GP reimbursement scheme should be used to

	practices with already high demand and limited staffing.	strengthen local workforce, prioritising same-day access capacity.
		GPAD Coding support is recommended to ensure robust consistent recording
		Linked to above
	Mandatory online registration, uncapped online consultations, and expanded monitoring metrics could increase administrative workload.	Wider link to lack of community services self-referral options which if resolved would remove a level of unnecessary demand from general practice.
	The new practice level GP reimbursement is funded from repurposed CAP funding, meaning PCNs will have less to spend on PCN wide improvements.	No mitigations
Estates	The ability to increase GP sessions is limited where estates capacity is already stretched.	Work with practices and estates colleagues to make best use of buildings/space available.
PCN / Neighbourhood Alignment	Requirements to ensure alignment with neighbourhood footprints may create organisational friction	Awaiting further information

5 Recommendations

- 5.1 The Primary Care Commissioning Committee is required to:
- Receive the 2026/27 GP Contract Changes being presented and note the risks associated.

Zoe Alderson

Head of Primary Care (Bury)

March 2026

Meeting:			
Meeting Date	30 March 2026	Action	Approve
Item No.	11	Confidential	No
Title	GM Policy for Protected Learning Time		
Presented By	Zoe Alderson, Head of Primary Care (Bury)		
Author	Rachele Schofield, Primary Care Lead (Bury)		
Clinical Lead	Dr Catherine Fines, Clinical Lead		

Executive Summary
The purpose of this paper is to outline the approach and principles of creating a Greater Manchester wide protected learning policy and process for general practice. This includes the approach to arranging, agreeing, and covering protected learning time and the required changes to align Burys current Learning Time Initiative Programme to this.
Recommendations
The Primary Care Commissioning Committee are asked to: <ul style="list-style-type: none"> • Note the requirement to for Protected Learning Times to be delivered in line with GM policy from 1 April 2026 • Note the intention to continue with Bury LTIs Programme across 2026/27, adopting a clear approach to Practice responsibilities relating to subcontracting arrangements for the LTI cover • Note the intention for further GM standardisation across 2026/27 to ensure equitable access to PLT and funding from 1 April 2027

OUTCOME REQUIRED <i>(Please Indicate)</i>	Approval <input type="checkbox"/>	Assurance <input type="checkbox"/>	Discussion <input type="checkbox"/>	Information <input type="checkbox"/>
APPROVAL ONLY ; (please indicate) whether this is required from the pooled (S75) budget or non-pooled budget	Pooled Budget <input type="checkbox"/>	Non-Pooled Budget <input type="checkbox"/>		

Links to Locality Plan outcomes	
To support a local population that is living healthier for longer and where healthy expectancy matches or exceeds the national average by 2025.	<input type="checkbox"/>
	<input type="checkbox"/>

Links to Locality Plan outcomes	
To achieve a reduction in inequalities (including health inequality) in Bury, that is greater than the national rate of reduction.	
To deliver a local health and social care system that provides high quality services which are financially sustainable and clinically safe.	<input type="checkbox"/>
To ensure that a greater proportion of local people are playing an active role in managing their own health and supporting those around them.	<input type="checkbox"/>

Implications						
Are the risks already included on the Locality Risk Register?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
Are there any risks of 15 and above that need to be considered for escalation via an NHS GM Statutory Committee or Board in line with the Risk Escalation process ?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
Are there any quality, safeguarding or patient experience implications?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
Have any departments/organisations who will be affected been consulted ?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
Are there any financial Implications?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	<input type="checkbox"/>	No	<input checked="" type="checkbox"/>	N/A	<input type="checkbox"/>
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>

Governance and Reporting		
Meeting	Date	Outcome
GP Board	18/03/2026	Verbal update given. Outputs will be communicated within the 26/27 local pillar of BeCCoR specification

GM Policy and Process for Protected Learning Time

1. Introduction

- 1.1 The purpose of this paper is to outline the approach and principles of creating a Greater Manchester wide protected learning policy and process for general practice (Appendix 1). This includes the approach to arranging, agreeing, and covering protected learning time and the required changes to align Burys current Learning Time Initiative Programme to this.

2 Background

- 2.1 Historically across NHS Greater Manchester (NHS GM) there have been different approaches in localities regarding protected learning time (PLT), with some localities not having any PLT in place at all.
- 2.2 Protected learning time for general practice has been very much valued in the localities where it has been supported. Enabling practices to take time out for training and development has benefitted both patients and staff and supported system transformation and collaboration.
- 2.3 NHS GM, through the Direct Management Operational Group (DMOG) has taken the steps to consider a new approach to PLT, initially aiming to achieve consistency of policy and application across Greater Manchester for general practice and provide an initial framework to GM PCCC for consideration.
- 2.4 In developing these principles, it is also recognised that opportunities and funding for PLT should be equal across all the localities. Funding for PLT is currently managed within each locality, with a varied model currently in place. A core levelling up provision will also need to take account from a financial context, what the ICB can and will directly fund in relation to PLT. Whilst this work is underway to review, the initial principles as described below are not intended to interrupt existing locality financial provision.

3 What is Protected Learning Time (PLT)

- 3.1 Protected learning time is not mandatory, but it is advised as good practice, for taking opportunities to improve services, quality and patient safety. PLT may take the form of:
- Practice learning, where members of the GP practice team take time outside usual activity to learn and develop and collaborate together.
 - Learning across providers, that could be across a PCN or across a number of different disciplines of primary care.

- Locality-wide learning for one discipline of primary care or a combination of primary care disciplines.

3.2 Learning can happen in different ways from organised events to less formally designed and delivered events led by a practice or group of practices. PLT requires time out of usual activities, and it is therefore important that arrangements are made for cover and stability of access for patients, including the proactive communication of any changes to accessing care.

4 Principles of Protected Learning Time for Adoption across GM

4.1 PLT is recommended and important, both for general resilience and ensuring high quality clinical care. PLT sessions may be focussed on individual contractors, or contractor groups, or be a broader system session, supporting provider partnership and collaboration. It may be used in response to changes in evidence, GM or national policies and may be used for transformation of models of care.

4.2 In agreeing the outline principles for PLT in Greater Manchester the aim is as follows, noting that no localities in GM meet these criteria in full at present with work ongoing across 2627 to determine how to implement the policy in full:

- Ensure a consistent and equitable approach for general practices to notify NHS GM of their proposed PLT event(s) and the cover arrangements for delivering essential services during core hours (08:00am – 18.30pm).
- Provide a single standardised set of requirements for all GM GP practices and provide a standardised application process that provide assurance regarding cover arrangements.
- Ensure GP practices or via their sub-contracting arrangements provide appropriate access to primary medical services during PLT for all modes of access, including online consultation submissions, telephone or walk in.
- Provide clarity for providers and commissioners with the required level of information upon which to make a consistent assessment for determination of assurance.
- Provide a process of appeal to the commissioner via the central NHS GM Primary Care Commissioning Team. It is anticipated that escalation would be infrequent and that decisions to agree assurance of a notifications will be made promptly by locality commissioner.
- Acknowledge there may be other 'extenuating circumstances' which require a GP practice to put cover arrangements in place for delivering their essential services and clarity on process for notifying these directly to the commissioner.

- 4.3 The process for protected learning time is made jointly between providers and commissioners. Where GP Practices wish to appeal the outcome, a formal appeal should be made to the Direct Commissioning Contracting Panel (DCCP). It is anticipated that escalation would be unlikely and that decisions to agree PTL will continue to be made locally with GP practices in discussion with commissioning teams.
- 4.4 When making a decision about agreeing protected learning time, the following should be taken into consideration:
- I. Timeliness with regard to system pressures, including winter pressures.
 - II. Funding availability to support the session and cover required, if applicable.
 - III. Equal opportunity across practices.
 - IV. The length of time of the PLT proposed (max 5hrs or less).
 - V. Only one PLT occurrence per month (GP practices are not permitted to be fully closed for half a day on a weekly basis)
 - VI. Provider resilience
 - VII. Details of any sub-contracting arrangements and how they meet GP contractual requirements
- 4.5 Although there are no set rules of the frequency of PLT requests, principles of proportionality and use of PLT balancing workforce need and patient need, and of system collaboration need should be considered by providers and commissioners.

5 Subcontracting Cover Arrangements

- 5.1 Subcontracting or cover arrangements are to be established prior to agreement of protected learning time. The length of the proposed PLT and cover may also determine the extent to which alternative provision is required and therefore there may be some flexibility in shorter periods such as the 2.5-hour LTI sessions that currently take place in Bury.
- 5.2 The commissioner should ensure that practices have explored all options before making use of networks, federations and any inter-practice arrangements. Subcontracting or cover arrangements must meet the reasonable needs of patients and be capable of providing the same level of services throughout core hours, which would include:
- Ability to attend a pre-bookable appointment (face to face)
 - Ability to book/cancel appointments
 - Ability to collect/order a prescription
 - Ability to access urgent appointments/advice as clinically necessary
 - Ability to receive a home visit (where clinically necessary)
 - Ability to ring for telephone advice
 - Ability to be referred to other services were clinically urgent
 - Ability to access urgent diagnostics and take action in relation to urgent results
 - Ability to submit an online consultation request for non-urgent appointment

requests, medication queries and admin requests.

- 5.3 The model of access for the practices proposed during PLT should demonstrate reasonable needs of how the above can be met and be clear of any gaps and mitigations if appropriate. Sub-contracting and cover arrangements should be clearly advertised and communicated to patients in advance by the practice, via practice websites and other methods of communication. Local Community Pharmacies would also ideally be informed to support patients in accessing services appropriately.

6 Bury Current LTI Arrangements

- 6.1 Bury's LTI sessions are currently all practice-led. The current model allows practices to close once per month for 2.5 hours, with telephone cover provided by BARDOC with the requirement for Online Consultation platforms to remain switched on.
- 6.2 Practices are required to maintain their chosen session throughout the year and only by prior negotiation with the locality may consideration be given to this being changed. This ensures effective communication with patients is maintained. These parameters are stipulated within the Bury Locally Commissioned Service (LCS) and practices wishing to undertake PLTs outside of these standard days/times must do so whilst remaining open to their patient population. Sessions take place as follows:
- Dates: The 3rd Tue of each month, OR the 2nd Thursday of each month, OR the 4th Wed of each month
 - Duration: 13:00 - 15:30 (2.5 hours)
- 6.3 Current subcontracting cover for Bury's LTI sessions is funded via the locality budget at a cost of £15, 986.62 pa. Other PLT models in place across GM vary as does funding which ranges from £0 to £33K. It is important to note that localities are not required to fund PLTs and, like Bury, none of the GM localities meet the current set of GM principles or are likely to have additional funding to support the increased subcontracting arrangements to meet expectations.
- 6.4 Work will take place across 2627 via the BeCCoR Group to establish how the full GM Policy for PLTs can be implemented as standard across GM, including how this can be funded equitably likely signalling a move towards this model in Bury as we progress.

7 Practice requests to close outside of agreed PLT

- 7.1 GM have also implemented a process by which practices can apply to close outside of their normal PLT timeslot. As this is currently prohibited under the terms of the Bury Locally Commissioned Service Contract, this is something that has only been permitted in extenuating circumstances. Practices wishing to undertake PLTs outside

of their chosen standard days/times must do so whilst remaining open to their patient population remain.

- 7.2 Despite this, GM feel there are opportunities for general practice to apply for PLT and exceptional reason variation and that these should be equal across all the localities across GM. The impact of practice variations in opening hours on patient access is the primary driver for the consistent process across GM.
- 7.3 Unless mandatory, we do not wish to adopt this in Bury given this is not part of our historical model. Should GM insist, then for any practice requested closures outside of the agreed PLT times, practices must evidence that their contractual requirements and expectations as outlined will be achieved. Practices will also be expected to fund the subcontracting arrangements in place. Where the ICB declines the practice application to close, practices can dispute formally via the Direct commissioning Contracting Panel (DCCP).

8 Risks

- 8.1 GM has asked that GM PCCC support the implementation of the PLT Policy and Process across GM from 1 April 2026, however, Bury locality has no further funding to support the adoption of GM principles against our current commitment of once a month for each practice.
- 8.2 Concerns were raised by Bury GP Board regarding the extent of the subcontracting arrangements for the relatively short 2.5-hour LTI window currently in place in Bury. In order to comply with the GM policy for PLT, practices are to ensure that telephones are diverted to BARDOC and Online Consultation Platforms remain switched on. All other core contractual responsibilities during LTI sessions remain the responsibility of the Practice to maintain.
- 8.3 The expectation for Practices to meet the full subcontracting arrangements listed in the GM Policy for PLTs in Bury in 2627 will therefore be as follows:

Subcontracting Requirement	Bury Requirements
Ability to attend a pre-bookable appointment (face to face)	The practice will not schedule appointments for patients during their LTI session
Ability to book/cancel appointments -	Patients can book/cancel appointment via the NHS App or practice alternative
Ability to collect/order a prescription	The practices LTI and alternative options during that time will be well publicised to patients in advance
Ability to access urgent appointments/advice as clinically necessary	General Practice is not an emergency service there, Patients will be able to speak to BARDOC via telephone and contact the

	practice via the online consultation platform during LTI sessions
Ability to receive a home visit (where clinically necessary)	Home visits will be scheduled outside of the LTI time
Ability to ring for telephone advice	Telephone calls will be taken by BARDOC during LTI sessions
Ability to be referred to other services were clinically urgent	These will be done by the practice following the LTI session
Ability to access urgent diagnostics and take action in relation to urgent results	General practice is not an emergency service and any actions required will be picked up by the practice following the LTI session
Ability to submit an online consultation request for non-urgent appointment requests, medication queries and admin requests	Online consultation platforms will remain on during LTI sessions

9 Recommendations

- 9.1 It is recognised that the subcontracting arrangements for PLTs varies significantly across GM. The GM Policy aims to reinforce the core contractual requirements which should be maintained throughout. It was agreed following discussion with GM Central Colleagues that Burys LTI arrangements are sufficient and meet the subcontracting arrangements therefore, the LTI programme will continue as is across 26/27 with telephone cover provided by BARDOC with the practice Online Consultation platforms will remain switched on.
- 9.2 Practices will be advised of these requirements ahead of 1 April 2026 with clear guidance issued as to delivery of the subcontracting arrangements, practice responsibilities and the application process for any closures outside of the defined LTI times.
- 9.3 There is further work required to truly standardise the PLT offer across all Primary Care Disciplines moving forward.

10 Actions Required

- 10.1 The Primary Care Commissioning Committee are asked to:
- Note the requirement to for Protected Learning Times to be delivered in line with GM policy from 1 April 2026
 - Note the intention to continue with Bury LTIs Programme across 2026/27, adopting a clear approach to Practice responsibilities relating to subcontracting

- arrangements for the LTI cover
- Note the intention for further GM standardisation across 2026/27 to ensure equitable access to PLT and funding from 1 April 2027

Rachele Schofield
Primary Care Lead
racheleschofield@nhs.net
March 2026

Appendix 1



NHS Greater
Manchester policy an

NHS GREATER MANCHESTER POLICY AND PROCESS FOR PROTECTED LEARNING TIME (PLT) – DEVELOPING AN ICB APPROACH

GM Primary Care Commissioning Committee

DATE 9th February 2026

Required information	Details
Title of report	NHS Greater Manchester policy and process for protected learning time (PLT)
Author	<p>Gail Henshaw - Senior primary Care Programme Manager.</p> <p>Jason Bamford Swift – Head of Delivery and Transformation (Trafford)</p> <p>Stephanie Pearson - Service Transformation Manager Primary Care, (Salford)</p> <p>Anna Ganotis - Head of Service Transformation (Primary Care) – Salford</p> <p>Pina Renzulli - Primary Care Lead (Manchester)</p> <p>Tori O’Hare – Assistant Director Primary Care, Communities & Neighbourhoods (Tameside)</p>
Presented by	Gail Henshaw / Janna Rigby
Contact for further information	Gail.henshaw@hs.net / Janna.rigby@nhs.net
Executive summary	<p>The purpose of this paper is to outline the approach and principles of creating a Greater Manchester wide protected learning time (PLT) policy and process for general practice. This includes the approach to arranging, agreeing, and covering protected learning time.</p>
The benefits that the population of Greater Manchester will experience.	<p>The benefits of GP Protected Learning Time (PLT) to patients include:</p> <ul style="list-style-type: none"> - Improved patient care: PLT sessions are designed to enhance the quality of care provided to patients by ensuring that members of the GP practice team are up-to-date with the latest clinical developments and best practices. - Enhanced communication: PLT sessions foster better communication and shared understanding among members of the GP practice team, leading to more consistent and effective patient care. - Resilient primary care: PLT sessions contribute to the resilience and future-proofing of primary care by ensuring that members of the GP practice team have the necessary time and resources to develop and maintain their skills.

	These benefits highlight the importance of PLT in supporting the professional development of healthcare professionals and ultimately improving patient care.
How health inequalities will be reduced in Greater Manchester's communities.	To reduce inequalities between patients with respect to their ability to access health services during PLT; and reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services.
The decision to be made and/or input sought	GM PCCC is asked to:- <ul style="list-style-type: none"> - Acknowledge the NHS Greater Manchester policy and process for protected learning time (PLT) - Support the implementation of PLT policy and process across Greater Manchester from 1st April 2026. - Offer further reflection and points of consideration to be taken into account
How this supports the delivery of the strategy and mitigates the BAF risks	<ul style="list-style-type: none"> - Strengthen our communities - Recover core health and care services - Support our workforce and carers - Achieve financial sustainability - Meet our statutory obligations
Key milestones	Proposed plan to implement the NHS Greater Manchester PLT policy and process by the 1 st April 2026
Leadership and governance arrangements	Update on the proposed PLT policy and process to be notified to Primary Care Commissioning Committee (PCCC), Direct Management Oversight Group (DMOG), Greater Manchester Local Medical Committee.
Engagement* to date	<ul style="list-style-type: none"> - Delegated Management Oversight Group (DMOG – Primary Care locality commissioners) • Primary Care Access Group meetings – the process has been drafted with support of locality colleagues • Manchester Practice Managers Reference Group

Public engagement	Clinical engagement	Sustainability impact	Financial advice	Legal advice	Conflicts of Interest	Report accessible
N	N	N	N	N	N	Y

Table 1 - checklist of engagement carried out, advice sought, conflict of interest and accessibility of report

Table 2 - core information relating to the content and creation of paper

1. INTRODUCTION

The purpose of this paper is to outline the approach and principles of creating a Greater Manchester wide protected learning policy and process for general practice. This includes the approach to arranging, agreeing, and covering protected learning time.

2. BACKGROUND

Historically across NHS Greater Manchester (NHS GM) there have been different approaches in localities regarding protected learning time (PLT), with some localities not having any PLT in place at all.

Protected learning time for general practice has been very much valued in the localities where it has been supported. Enabling practices to take time out for training and development has benefitted both patients and staff and supported system transformation and collaboration.

NHS GM, through the Direct Management Operational Group (DMOG) has taken the steps to consider a new approach to PLT, initially aiming to achieve consistency of policy and application across Greater Manchester for general practice and provide an initial framework to GM PCCC for consideration.

In developing these principles, it is also recognised that opportunities and funding for PLT should be equal across all the localities. Funding for PLT is currently managed within each locality, with a varied model currently in place. A core levelling up provision will also need to take account from a financial context, what the ICB can and will directly fund in relation to PLT. Whilst this work is underway to review, the initial principles as described below are not intended to interrupt existing locality financial provision.

3. WHAT IS PROTECTED LEARNING TIME

Protected learning time is not mandatory, but it is advised as good practice, for taking opportunities to improve services, quality and patient safety. PLT may take the form of:

- Practice learning, where members of the GP practice team take time outside usual activity to learn and develop and collaborate together.
- Learning across providers, that could be across a PCN or across a number of different disciplines of primary care.
- Locality-wide learning for one discipline of primary care or a combination of primary care disciplines.

Learning can happen in different ways from organised events to less formally designed and delivered events led by a practice or group of practices.

PLT requires time out of usual activities, and it is therefore important that arrangements are made for cover and stability of access for patients, including the proactive communication of any changes to accessing care.

4. PRINCIPLES OF PROTECTED LEARNING TIME FOR ADOPTION ACROSS GREATER MANCHESTER

PLT is recommended and important, both for general resilience and ensuring high quality clinical care. PLT sessions may be focussed on individual contractors, or contractor groups, or be a broader system session, supporting provider partnership and collaboration. It may be used in response to changes in evidence, GM or national policies and may be used for transformation of models of care.

In agreeing the outline principles for PLT in Greater Manchester the aim is to:

- Ensure a consistent and equitable approach for general practices to notify NHS GM of their proposed PLT event(s) and the cover arrangements for delivering essential services during core hours (08:00am – 18.30pm).
- Provide a single standardised set of requirements for all GM GP practices and provide a standardised application process that provide assurance regarding cover arrangements.
- Ensure GP practices or via their sub-contracting arrangements provide appropriate access to primary medical services during PLT for all modes of access, including online consultation submissions, telephone or walk in.
- Provide clarity for providers and commissioners with the required level of information upon which to make a consistent assessment for determination of assurance.
- Provide a process of appeal to the commissioner via the central NHS GM Primary Care Commissioning Team. It is anticipated that escalation would be infrequent and that decisions to agree assurance of a notifications will be made promptly by locality commissioner.
- Acknowledge there may be other 'extenuating circumstances' which require a GP practice to put cover arrangements in place for delivering their essential services and clarity on process for notifying these directly to the commissioner.

The process for protected learning time is made jointly between providers and commissioners. Where parties are in disagreement, this should be managed through local dispute resolution. Where GP Practices wish to appeal the outcome, a formal appeal should be made to the Direct Commissioning Contracting Panel (DCCP). It is anticipated that escalation would be unlikely and that decisions to agree PTL will continue to be made locally with GP practices in discussion with commissioning teams.

When making a decision about agreeing protected learning time, the following should be taken into consideration:

- I. Timeliness with regard to system pressures, including winter pressures.
- II. Funding availability to support the session and cover required, if applicable.
- III. Equal opportunity across practices.
- IV. The length of time of the PLT proposed (max 5hrs or less).
- V. Only one PLT occurrence per month (GP practices are not permitted to be fully closed for half a day on a weekly basis)
- VI. Provider resilience
- VII. Details of any sub-contracting arrangements and how they meet GP contractual requirements

Although there are no set rules of the frequency of PLT requests, principles of proportionality and use of PLT balancing workforce need and patient need, and of system collaboration need should be considered by providers and commissioners.

5. ANTICIPATED PROCESS FOR INITIATING PROTECTED LEARNING TIME

Notification for protected learning time may come from the locality commissioning team/ GM commissioning team or from practices/groups of practices.

Information/Notice should be made in advance, as soon as reasonably practicable before the date of the proposed PLT, ideally the aim is for GP practices to set out the dates of their planned / proposed PLT at least 6 to 12 months in advance through the application form process. It is acknowledged there are times where this may not be met, as a minimum GP practices would be expected to provide at least 28 days' notice in advance of their PLT.

When a need for protected learning time is established, the following process should be put into place initiated by a discussion between the locality commissioning team and practices. All information to be captured on a template:

- The date and time of protected learning time.
- Which practices and staff are involved.
- Learning objectives and the intended improvements that will be delivered.
- Funding source of session, including funding for subcontracting/cover arrangements
- Details of subcontracting/cover arrangements

Although requests are made and considered within the locality for general practice, all information should be collated and regular consistency reviews and across locality commissioners and the providers in line with ensuring local need and fairness of opportunity across practices and localities. To do this locality commissioning teams will keep a log of notifications to support fair access to opportunity as well as sharing opportunities across localities for joint sessions and learning.

6. SUBCONTRACTING/ COVER ARRANGEMENTS

Subcontracting or cover arrangements are to be established prior to agreement of protected learning time. The length of the proposed PLT and cover may also determine the extent to which alternative provision is required and therefore there may be some flexibility in shorter periods.

The commissioner should ensure that practices have explored all options before making use of networks, federations and any inter-practice arrangements.

Subcontracting or cover arrangements must meet the reasonable needs of patients and be capable of providing the same level of services throughout core hours, which would include:-

- Ability to attend a pre-bookable appointment (face to face)
- Ability to book/cancel appointments
- Ability to collect/order a prescription
- Ability to access urgent appointments/advice as clinically necessary
- Ability to receive a home visit (where clinically necessary)

- Ability to ring for telephone advice
- Ability to be referred to other services were clinically urgent
- Ability to access urgent diagnostics and take action in relation to urgent results
- Ability to submit an online consultation request for non-urgent appointment requests, medication queries and admin requests.

The model of access for the practices proposed during PLT should demonstrate reasonable needs of how the above can be met and be clear of any gaps and mitigations if appropriate.

Sub-contracting and cover arrangements should be clearly advertised and communicated to patients in advance by the practice, via practice websites and other methods of communication. Local Community Pharmacies would also ideally be informed to support patients in accessing services appropriately.

7. ENGAGEMENT

As part of our engagement process, the draft GM Policy and Process for PLT has been shared with Manchester Practice Managers Reference Group to obtain some initial thoughts and feedback (as per attached slides appendix 1).

Initial feedback has been positive with practices noting that the principles/process does not unduly differ from current arrangements and provides a consistent framework.

As part of the engagement process the ICB also intends to engage the Greater Manchester Local Medical Committee and Primary Care Provider Board.

8. RECOMMENDATIONS

The GM PCCC is asked to:

- Acknowledge the NHS Greater Manchester policy and process for protected learning time (PLT)
- Support the implementation of PLT policy and process across Greater Manchester from the 1st April 2026.
- Offer further reflection and points of consideration to be taken into account

9. APPENDACIES

Appendix 1 - PowerPoint presentation describing the process for protected learning time

10. ACKNOWLEDGEMENTS

Jason Bamford Swift – Head of Delivery and Transformation (Trafford)

Stephanie Pearson - Service Transformation Manager Primary Care, (Salford)

Anna Ganotis - Head of Service Transformation (Primary Care) – Salford

Pina Renzulli - Primary Care Lead (Manchester)

Tori O'Hare – Assistant Director Primary Care, Communities & Neighbourhoods (Tameside)

Meeting:			
Meeting Date	30 March 2026	Action	Approve
Item No.	11	Confidential	No
Title	GM Policy for Protected Learning Time		
Presented By	Zoe Alderson, Head of Primary Care (Bury)		
Author	Rachele Schofield, Primary Care Lead (Bury)		
Clinical Lead	Dr Catherine Fines, Clinical Lead		

Executive Summary
The purpose of this paper is to outline the approach and principles of creating a Greater Manchester wide protected learning policy and process for general practice. This includes the approach to arranging, agreeing, and covering protected learning time and the required changes to align Burys current Learning Time Initiative Programme to this.
Recommendations
The Primary Care Commissioning Committee are asked to: <ul style="list-style-type: none"> Note the requirement to for Protected Learning Times to be delivered in line with GM policy from 1 April 2026 Note the intention to continue with Bury LTIs Programme across 2026/27, adopting a clear approach to Practice responsibilities relating to subcontracting arrangements for the LTI cover Note the intention for further GM standardisation across 2026/27 to ensure equitable access to PLT and funding from 1 April 2027

OUTCOME REQUIRED <i>(Please Indicate)</i>	Approval <input type="checkbox"/>	Assurance <input type="checkbox"/>	Discussion <input type="checkbox"/>	Information <input type="checkbox"/>
APPROVAL ONLY ; (please indicate) whether this is required from the pooled (S75) budget or non-pooled budget	Pooled Budget <input type="checkbox"/>	Non-Pooled Budget <input type="checkbox"/>		

Links to Locality Plan outcomes	
To support a local population that is living healthier for longer and where healthy expectancy matches or exceeds the national average by 2025.	<input type="checkbox"/>
	<input type="checkbox"/>

Links to Locality Plan outcomes	
To achieve a reduction in inequalities (including health inequality) in Bury, that is greater than the national rate of reduction.	
To deliver a local health and social care system that provides high quality services which are financially sustainable and clinically safe.	<input type="checkbox"/>
To ensure that a greater proportion of local people are playing an active role in managing their own health and supporting those around them.	<input type="checkbox"/>

Implications						
Are the risks already included on the Locality Risk Register?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
Are there any risks of 15 and above that need to be considered for escalation via an NHS GM Statutory Committee or Board in line with the Risk Escalation process ?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
Are there any quality, safeguarding or patient experience implications?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
Have any departments/organisations who will be affected been consulted ?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
Are there any financial Implications?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	<input type="checkbox"/>	No	<input checked="" type="checkbox"/>	N/A	<input type="checkbox"/>
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>

Governance and Reporting		
Meeting	Date	Outcome
GP Board	18/03/2026	Verbal update given. Outputs will be communicated within the 26/27 local pillar of BeCCoR specification

GM Policy and Process for Protected Learning Time

1. Introduction

- 1.1 The purpose of this paper is to outline the approach and principles of creating a Greater Manchester wide protected learning policy and process for general practice (Appendix 1). This includes the approach to arranging, agreeing, and covering protected learning time and the required changes to align Burys current Learning Time Initiative Programme to this.

2 Background

- 2.1 Historically across NHS Greater Manchester (NHS GM) there have been different approaches in localities regarding protected learning time (PLT), with some localities not having any PLT in place at all.
- 2.2 Protected learning time for general practice has been very much valued in the localities where it has been supported. Enabling practices to take time out for training and development has benefitted both patients and staff and supported system transformation and collaboration.
- 2.3 NHS GM, through the Direct Management Operational Group (DMOG) has taken the steps to consider a new approach to PLT, initially aiming to achieve consistency of policy and application across Greater Manchester for general practice and provide an initial framework to GM PCCC for consideration.
- 2.4 In developing these principles, it is also recognised that opportunities and funding for PLT should be equal across all the localities. Funding for PLT is currently managed within each locality, with a varied model currently in place. A core levelling up provision will also need to take account from a financial context, what the ICB can and will directly fund in relation to PLT. Whilst this work is underway to review, the initial principles as described below are not intended to interrupt existing locality financial provision.

3 What is Protected Learning Time (PLT)

- 3.1 Protected learning time is not mandatory, but it is advised as good practice, for taking opportunities to improve services, quality and patient safety. PLT may take the form of:
- Practice learning, where members of the GP practice team take time outside usual activity to learn and develop and collaborate together.
 - Learning across providers, that could be across a PCN or across a number of different disciplines of primary care.

- Locality-wide learning for one discipline of primary care or a combination of primary care disciplines.

3.2 Learning can happen in different ways from organised events to less formally designed and delivered events led by a practice or group of practices. PLT requires time out of usual activities, and it is therefore important that arrangements are made for cover and stability of access for patients, including the proactive communication of any changes to accessing care.

4 Principles of Protected Learning Time for Adoption across GM

4.1 PLT is recommended and important, both for general resilience and ensuring high quality clinical care. PLT sessions may be focussed on individual contractors, or contractor groups, or be a broader system session, supporting provider partnership and collaboration. It may be used in response to changes in evidence, GM or national policies and may be used for transformation of models of care.

4.2 In agreeing the outline principles for PLT in Greater Manchester the aim is as follows, noting that no localities in GM meet these criteria in full at present with work ongoing across 2627 to determine how to implement the policy in full:

- Ensure a consistent and equitable approach for general practices to notify NHS GM of their proposed PLT event(s) and the cover arrangements for delivering essential services during core hours (08:00am – 18.30pm).
- Provide a single standardised set of requirements for all GM GP practices and provide a standardised application process that provide assurance regarding cover arrangements.
- Ensure GP practices or via their sub-contracting arrangements provide appropriate access to primary medical services during PLT for all modes of access, including online consultation submissions, telephone or walk in.
- Provide clarity for providers and commissioners with the required level of information upon which to make a consistent assessment for determination of assurance.
- Provide a process of appeal to the commissioner via the central NHS GM Primary Care Commissioning Team. It is anticipated that escalation would be infrequent and that decisions to agree assurance of a notifications will be made promptly by locality commissioner.
- Acknowledge there may be other 'extenuating circumstances' which require a GP practice to put cover arrangements in place for delivering their essential services and clarity on process for notifying these directly to the commissioner.

- 4.3 The process for protected learning time is made jointly between providers and commissioners. Where GP Practices wish to appeal the outcome, a formal appeal should be made to the Direct Commissioning Contracting Panel (DCCP). It is anticipated that escalation would be unlikely and that decisions to agree PTL will continue to be made locally with GP practices in discussion with commissioning teams.
- 4.4 When making a decision about agreeing protected learning time, the following should be taken into consideration:
- I. Timeliness with regard to system pressures, including winter pressures.
 - II. Funding availability to support the session and cover required, if applicable.
 - III. Equal opportunity across practices.
 - IV. The length of time of the PLT proposed (max 5hrs or less).
 - V. Only one PLT occurrence per month (GP practices are not permitted to be fully closed for half a day on a weekly basis)
 - VI. Provider resilience
 - VII. Details of any sub-contracting arrangements and how they meet GP contractual requirements
- 4.5 Although there are no set rules of the frequency of PLT requests, principles of proportionality and use of PLT balancing workforce need and patient need, and of system collaboration need should be considered by providers and commissioners.

5 Subcontracting Cover Arrangements

- 5.1 Subcontracting or cover arrangements are to be established prior to agreement of protected learning time. The length of the proposed PLT and cover may also determine the extent to which alternative provision is required and therefore there may be some flexibility in shorter periods such as the 2.5-hour LTI sessions that currently take place in Bury.
- 5.2 The commissioner should ensure that practices have explored all options before making use of networks, federations and any inter-practice arrangements. Subcontracting or cover arrangements must meet the reasonable needs of patients and be capable of providing the same level of services throughout core hours, which would include:
- Ability to attend a pre-bookable appointment (face to face)
 - Ability to book/cancel appointments
 - Ability to collect/order a prescription
 - Ability to access urgent appointments/advice as clinically necessary
 - Ability to receive a home visit (where clinically necessary)
 - Ability to ring for telephone advice
 - Ability to be referred to other services were clinically urgent
 - Ability to access urgent diagnostics and take action in relation to urgent results
 - Ability to submit an online consultation request for non-urgent appointment

requests, medication queries and admin requests.

- 5.3 The model of access for the practices proposed during PLT should demonstrate reasonable needs of how the above can be met and be clear of any gaps and mitigations if appropriate. Sub-contracting and cover arrangements should be clearly advertised and communicated to patients in advance by the practice, via practice websites and other methods of communication. Local Community Pharmacies would also ideally be informed to support patients in accessing services appropriately.

6 Bury Current LTI Arrangements

- 6.1 Bury's LTI sessions are currently all practice-led. The current model allows practices to close once per month for 2.5 hours, with telephone cover provided by BARDOC with the requirement for Online Consultation platforms to remain switched on.
- 6.2 Practices are required to maintain their chosen session throughout the year and only by prior negotiation with the locality may consideration be given to this being changed. This ensures effective communication with patients is maintained. These parameters are stipulated within the Bury Locally Commissioned Service (LCS) and practices wishing to undertake PLTs outside of these standard days/times must do so whilst remaining open to their patient population. Sessions take place as follows:
- Dates: The 3rd Tue of each month, OR the 2nd Thursday of each month, OR the 4th Wed of each month
 - Duration: 13:00 - 15:30 (2.5 hours)
- 6.3 Current subcontracting cover for Bury's LTI sessions is funded via the locality budget at a cost of £15, 986.62 pa. Other PLT models in place across GM vary as does funding which ranges from £0 to £33K. It is important to note that localities are not required to fund PLTs and, like Bury, none of the GM localities meet the current set of GM principles or are likely to have additional funding to support the increased subcontracting arrangements to meet expectations.
- 6.4 Work will take place across 2627 via the BeCCoR Group to establish how the full GM Policy for PLTs can be implemented as standard across GM, including how this can be funded equitably likely signalling a move towards this model in Bury as we progress.

7 Practice requests to close outside of agreed PLT

- 7.1 GM have also implemented a process by which practices can apply to close outside of their normal PLT timeslot. As this is currently prohibited under the terms of the Bury Locally Commissioned Service Contract, this is something that has only been permitted in extenuating circumstances. Practices wishing to undertake PLTs outside

of their chosen standard days/times must do so whilst remaining open to their patient population remain.

- 7.2 Despite this, GM feel there are opportunities for general practice to apply for PLT and exceptional reason variation and that these should be equal across all the localities across GM. The impact of practice variations in opening hours on patient access is the primary driver for the consistent process across GM.
- 7.3 Unless mandatory, we do not wish to adopt this in Bury given this is not part of our historical model. Should GM insist, then for any practice requested closures outside of the agreed PLT times, practices must evidence that their contractual requirements and expectations as outlined will be achieved. Practices will also be expected to fund the subcontracting arrangements in place. Where the ICB declines the practice application to close, practices can dispute formally via the Direct commissioning Contracting Panel (DCCP).

8 Risks

- 8.1 GM has asked that GM PCCC support the implementation of the PLT Policy and Process across GM from 1 April 2026, however, Bury locality has no further funding to support the adoption of GM principles against our current commitment of once a month for each practice.
- 8.2 Concerns were raised by Bury GP Board regarding the extent of the subcontracting arrangements for the relatively short 2.5-hour LTI window currently in place in Bury. In order to comply with the GM policy for PLT, practices are to ensure that telephones are diverted to BARDOC and Online Consultation Platforms remain switched on. All other core contractual responsibilities during LTI sessions remain the responsibility of the Practice to maintain.
- 8.3 The expectation for Practices to meet the full subcontracting arrangements listed in the GM Policy for PLTs in Bury in 2627 will therefore be as follows:

Subcontracting Requirement	Bury Requirements
Ability to attend a pre-bookable appointment (face to face)	The practice will not schedule appointments for patients during their LTI session
Ability to book/cancel appointments -	Patients can book/cancel appointment via the NHS App or practice alternative
Ability to collect/order a prescription	The practices LTI and alternative options during that time will be well publicised to patients in advance
Ability to access urgent appointments/advice as clinically necessary	General Practice is not an emergency service there, Patients will be able to speak to BARDOC via telephone and contact the

	practice via the online consultation platform during LTI sessions
Ability to receive a home visit (where clinically necessary)	Home visits will be scheduled outside of the LTI time
Ability to ring for telephone advice	Telephone calls will be taken by BARDOC during LTI sessions
Ability to be referred to other services were clinically urgent	These will be done by the practice following the LTI session
Ability to access urgent diagnostics and take action in relation to urgent results	General practice is not an emergency service and any actions required will be picked up by the practice following the LTI session
Ability to submit an online consultation request for non-urgent appointment requests, medication queries and admin requests	Online consultation platforms will remain on during LTI sessions

9 Recommendations

- 9.1 It is recognised that the subcontracting arrangements for PLTs varies significantly across GM. The GM Policy aims to reinforce the core contractual requirements which should be maintained throughout. It was agreed following discussion with GM Central Colleagues that Burys LTI arrangements are sufficient and meet the subcontracting arrangements therefore, the LTI programme will continue as is across 26/27 with telephone cover provided by BARDOC with the practice Online Consultation platforms will remain switched on.
- 9.2 Practices will be advised of these requirements ahead of 1 April 2026 with clear guidance issued as to delivery of the subcontracting arrangements, practice responsibilities and the application process for any closures outside of the defined LTI times.
- 9.3 There is further work required to truly standardise the PLT offer across all Primary Care Disciplines moving forward.

10 Actions Required

- 10.1 The Primary Care Commissioning Committee are asked to:
- Note the requirement to for Protected Learning Times to be delivered in line with GM policy from 1 April 2026
 - Note the intention to continue with Bury LTIs Programme across 2026/27, adopting a clear approach to Practice responsibilities relating to subcontracting

- arrangements for the LTI cover
- Note the intention for further GM standardisation across 2026/27 to ensure equitable access to PLT and funding from 1 April 2027

Rachele Schofield
Primary Care Lead
racheleschofield@nhs.net
March 2026

Appendix 1



NHS Greater
Manchester policy an

NHS GREATER MANCHESTER POLICY AND PROCESS FOR PROTECTED LEARNING TIME (PLT) – DEVELOPING AN ICB APPROACH

Required information	Details
Title of report	NHS Greater Manchester policy and process for protected learning time (PLT)
Author	<p>Gail Henshaw - Senior primary Care Programme Manager.</p> <p>Jason Bamford Swift – Head of Delivery and Transformation (Trafford)</p> <p>Stephanie Pearson - Service Transformation Manager Primary Care, (Salford)</p> <p>Anna Ganotis - Head of Service Transformation (Primary Care) – Salford</p> <p>Pina Renzulli - Primary Care Lead (Manchester)</p> <p>Tori O’Hare – Assistant Director Primary Care, Communities & Neighbourhoods (Tameside)</p>
Presented by	Gail Henshaw / Janna Rigby
Contact for further information	Gail.henshaw@hs.net / Janna.rigby@nhs.net
Executive summary	<p>The purpose of this paper is to outline the approach and principles of creating a Greater Manchester wide protected learning time (PLT) policy and process for general practice. This includes the approach to arranging, agreeing, and covering protected learning time.</p>
The benefits that the population of Greater Manchester will experience.	<p>The benefits of GP Protected Learning Time (PLT) to patients include:</p> <ul style="list-style-type: none"> - Improved patient care: PLT sessions are designed to enhance the quality of care provided to patients by ensuring that members of the GP practice team are up-to-date with the latest clinical developments and best practices. - Enhanced communication: PLT sessions foster better communication and shared understanding among members of the GP practice team, leading to more consistent and effective patient care. - Resilient primary care: PLT sessions contribute to the resilience and future-proofing of primary care by ensuring that members of the GP practice team have the necessary time and resources to develop and maintain their skills.

	These benefits highlight the importance of PLT in supporting the professional development of healthcare professionals and ultimately improving patient care.
How health inequalities will be reduced in Greater Manchester's communities.	To reduce inequalities between patients with respect to their ability to access health services during PLT; and reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services.
The decision to be made and/or input sought	GM PCCC is asked to:- <ul style="list-style-type: none"> - Acknowledge the NHS Greater Manchester policy and process for protected learning time (PLT) - Support the implementation of PLT policy and process across Greater Manchester from 1st April 2026. - Offer further reflection and points of consideration to be taken into account
How this supports the delivery of the strategy and mitigates the BAF risks	<ul style="list-style-type: none"> - Strengthen our communities - Recover core health and care services - Support our workforce and carers - Achieve financial sustainability - Meet our statutory obligations
Key milestones	Proposed plan to implement the NHS Greater Manchester PLT policy and process by the 1 st April 2026
Leadership and governance arrangements	Update on the proposed PLT policy and process to be notified to Primary Care Commissioning Committee (PCCC), Direct Management Oversight Group (DMOG), Greater Manchester Local Medical Committee.
Engagement* to date	<ul style="list-style-type: none"> - Delegated Management Oversight Group (DMOG – Primary Care locality commissioners) • Primary Care Access Group meetings – the process has been drafted with support of locality colleagues • Manchester Practice Managers Reference Group

Public engagement	Clinical engagement	Sustainability impact	Financial advice	Legal advice	Conflicts of Interest	Report accessible
N	N	N	N	N	N	Y

Table 1 - checklist of engagement carried out, advice sought, conflict of interest and accessibility of report

Table 2 - core information relating to the content and creation of paper

1. INTRODUCTION

The purpose of this paper is to outline the approach and principles of creating a Greater Manchester wide protected learning policy and process for general practice. This includes the approach to arranging, agreeing, and covering protected learning time.

2. BACKGROUND

Historically across NHS Greater Manchester (NHS GM) there have been different approaches in localities regarding protected learning time (PLT), with some localities not having any PLT in place at all.

Protected learning time for general practice has been very much valued in the localities where it has been supported. Enabling practices to take time out for training and development has benefitted both patients and staff and supported system transformation and collaboration.

NHS GM, through the Direct Management Operational Group (DMOG) has taken the steps to consider a new approach to PLT, initially aiming to achieve consistency of policy and application across Greater Manchester for general practice and provide an initial framework to GM PCCC for consideration.

In developing these principles, it is also recognised that opportunities and funding for PLT should be equal across all the localities. Funding for PLT is currently managed within each locality, with a varied model currently in place. A core levelling up provision will also need to take account from a financial context, what the ICB can and will directly fund in relation to PLT. Whilst this work is underway to review, the initial principles as described below are not intended to interrupt existing locality financial provision.

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- Practice learning, where members of the GP practice team take time outside usual activity to learn and develop and collaborate together.
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Learning can happen in different ways from organised events to less formally designed and delivered events led by a practice or group of practices.

PLT requires time out of usual activities, and it is therefore important that arrangements are made for cover and stability of access for patients, including the proactive communication of any changes to accessing care.

4. PRINCIPLES OF PROTECTED LEARNING TIME FOR ADOPTION ACROSS GREATER MANCHESTER

PLT is recommended and important, both for general resilience and ensuring high quality clinical care. PLT sessions may be focussed on individual contractors, or contractor groups, or be a broader system session, supporting provider partnership and collaboration. It may be used in response to changes in evidence, GM or national policies and may be used for transformation of models of care.

In agreeing the outline principles for PLT in Greater Manchester the aim is to:

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- Provide a single standardised set of requirements for all GM GP practices and provide a standardised application process that provide assurance regarding cover arrangements.
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- I. Timeliness with regard to system pressures, including winter pressures.
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Notification for protected learning time may come from the locality commissioning team/ GM commissioning team or from practices/groups of practices.

Information/Notice should be made in advance, as soon as reasonably practicable before the date of the proposed PLT, ideally the aim is for GP practices to set out the dates of their planned / proposed PLT at least 6 to 12 months in advance through the application form process. It is acknowledged there are times where this may not be met, as a minimum GP practices would be expected to provide at least 28 days' notice in advance of their PLT.

When a need for protected learning time is established, the following process should be put into place initiated by a discussion between the locality commissioning team and practices. All information to be captured on a template:

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Although requests are made and considered within the locality for general practice, all information should be collated and regular consistency reviews and across locality commissioners and the providers in line with ensuring local need and fairness of opportunity across practices and localities. To do this locality commissioning teams will keep a log of notifications to support fair access to opportunity as well as sharing opportunities across localities for joint sessions and learning.

6. SUBCONTRACTING/ COVER ARRANGEMENTS

Subcontracting or cover arrangements are to be established prior to agreement of protected learning time. The length of the proposed PLT and cover may also determine the extent to which alternative provision is required and therefore there may be some flexibility in shorter periods.

The commissioner should ensure that practices have explored all options before making use of networks, federations and any inter-practice arrangements.

Subcontracting or cover arrangements must meet the reasonable needs of patients and be capable of providing the same level of services throughout core hours, which would include:-

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- Ability to book/cancel appointments
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- Ability to access urgent appointments/advice as clinically necessary
- Ability to receive a home visit (where clinically necessary)

- Ability to ring for telephone advice
- Ability to be referred to other services were clinically urgent
- Ability to access urgent diagnostics and take action in relation to urgent results
- Ability to submit an online consultation request for non-urgent appointment requests, medication queries and admin requests.

The model of access for the practices proposed during PLT should demonstrate reasonable needs of how the above can be met and be clear of any gaps and mitigations if appropriate.

Sub-contracting and cover arrangements should be clearly advertised and communicated to patients in advance by the practice, via practice websites and other methods of communication. Local Community Pharmacies would also ideally be informed to support patients in accessing services appropriately.

7. ENGAGEMENT

As part of our engagement process, the draft GM Policy and Process for PLT has been shared with Manchester Practice Managers Reference Group to obtain some initial thoughts and feedback (as per attached slides appendix 1).

Initial feedback has been positive with practices noting that the principles/process does not unduly differ from current arrangements and provides a consistent framework.

As part of the engagement process the ICB also intends to engage the Greater Manchester Local Medical Committee and Primary Care Provider Board.

8. RECOMMENDATIONS

The GM PCCC is asked to:

- Acknowledge the NHS Greater Manchester policy and process for protected learning time (PLT)
- Support the implementation of PLT policy and process across Greater Manchester from the 1st April 2026.
- Offer further reflection and points of consideration to be taken into account

9. APPENDACIES

Appendix 1 - PowerPoint presentation describing the process for protected learning time

10. ACKNOWLEDGEMENTS

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