

Agenda

NHS Greater Manchester Extraordinary Primary Care Commissioning Committee

Date: Thursday 26th March 2026

Time: 12:00 pm – 1:30 pm

Venue: Microsoft Teams

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Meeting ID: 362 966 648 297 40

Passcode: wh7sT9Lc

Item No.	Time	Duration	Subject	P / V	Presented by
1.	12.00	2 mins	Welcome, Introductions and Apologies	Verbal	Chair
2.			Declarations of Interest	Verbal	Chair
3.	12.02	3 mins	Virtual Decisions <ul style="list-style-type: none"> ▪ PMS Contract Decision (Shay Lane Medical Practice) ▪ Sight Testing in Special Education Settings Procurement Progress 	Verbal	Chair
4.	12.05	20 mins	Dental Contract Reforms 26/27 and relative impacts	Paper	Janna Rigby Jane Brooks
5.	12.25	20 mins	BeCCoR 2026/27 Scheme	Paper	Ben Squires Claire Lake
6.	12.45	10 mins	Community Pharmacy Independent Prescriber (IP) Pathfinder Programme Extension Proposal	Paper	Alison Scowcroft
7.	12.55	10 mins	Covid-19 delivery gaps – spring 26	Paper	Amy Ashton
8.	13.05	5 mins	Easter PC UEC Assurance – for info only	Paper	Ben Squires
For Information					
9.	13.10		Any Other Business	Verbal	Chair

National Dental Contract Reforms 2026: Overview and Impact

GM Primary Care Commissioning Committee

26 Marc 2026

Table 1 - core information relating to the content and creation of

Required information	Details
Title of report	National Dental Contract Reforms 2026: Overview and Impact
Author	Janna Rigby – Assistant Director of Primary Care Operations
Presented by	Janna Rigby
Contact for further information	Janna.rigby@nhs.net
Executive summary	<p>This paper is an expanded version of that presented to GM Primary Care Commissioning Committee on 9th February and provides an overview of the National Dental Contract changes for 2026/27, which represents a significant change to the current dental contract model.</p> <p>The recent detail provided by NHS England is provided for information and informs the considerations regarding potential impact on locally commissioned schemes, including urgent care and Patient Access Quality Scheme.</p>
The benefits that the population of Greater Manchester will experience.	Benefits and risks are set out in the paper.
How health inequalities will be reduced in Greater Manchester’s communities.	The national contract reforms will be implemented in all dental practices across Greater Manchester, making the NHS offer consistent to all.
The decision to be made and/or input sought	<ul style="list-style-type: none"> To note the National Dental Contract Reforms including the opportunities and potential risks To support the actions and next steps as set out in Section 5 of this paper
How this supports the delivery of the strategy and mitigates the BAF risks	<ul style="list-style-type: none"> Access to primary care Provision of urgent care within the community to mitigate attendance in other urgent care services.
Key milestones	<ul style="list-style-type: none"> Implementation of the dental contract changes to be in place from 1/4/26. Notification of future commissioning intentions to be confirmed to dental providers at the earliest opportunity during Q4 25/26.
Leadership and governance arrangements	<ul style="list-style-type: none"> GM Primary Care Commissioning Committee Blueprint Implementation Group
Engagement* to date	<ul style="list-style-type: none"> Dental Provider Board GM PCCC

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

Table 2 - checklist of engagement carried out, advice sought, conflict of interest and accessibility of report

1. INTRODUCTION

This paper is an expanded version of that presented to GM Primary Care Commissioning Committee on 9th February and provides an overview of the National Dental Contract changes for 2026/27, which represents a significant change to the current dental contract model.

There is a summary overview of the National Dental Contract changes provided, followed by a more detailed financial and service line analysis of the impacts and considerations.

The current contract is delivered in line with an agreed number of UDAs and 4 treatment bands. Section 2, below, summarises the reforms which are intended to:

- **Improve access:** Improved access for patients with unscheduled care needs
- **Better clinical care:** Enhanced treatment pathways for complex needs cases
- **Fairer payments:** Support dental teams with appropriate remuneration for complex care
- **Preventative focus:** Increased provision of fluoride varnish and preventative treatments for children
- **Reduce unnecessary recalls:** Minimises patient costs and frees capacity for those most in need
- **Quality Improvement:** Enhances patient care, safety and promotes continuous improvement
- **Appraisal:** Supports professional development and accountability through reflective practice
- **Discretionary payments:** Rewards innovation for exceptional service

Whilst the changes indicate the intent to improve provision and access nationally, it is noted that there are a number of potential areas of duplication or overlap with GM commissioned services or schemes, namely urgent care capacity and the Practice Access Quality Scheme. Analysis of the impacts in terms of activity and investment has been initiated in order to understand the detail of this and to enable review of the non-core commissioning (Beyond Core Contract – BeCCoR) for 2026/27 onwards.

2. SUMMARY OF CHANGES TO THE DENTAL CONTRACT FROM 1/4/26

A summary of the national contract reforms is set out below:

2.1 Urgent care

NHS dental contractors will be required to deliver 8.2% of their contract value as urgent/unscheduled activity in 2026/27.

At the increased remuneration level of £75 for each urgent/unscheduled course of treatment, which is being introduced as part of the reform package from April 2026, the 8.2% requirement is equivalent to 11 urgent/unscheduled care courses of treatment per £10,000 of contract value.

All urgent/unscheduled care patients seen under a practice's general dentistry contract, irrespective of whether or not they have been to that practice before and whether they have been referred (for example, from 111) or present as a walk-in, will contribute to the required number of courses of treatment.

Contracts meeting the following criteria are excluded and will not receive a mandated amount for unscheduled care:

- historic (pre-2006) child-only contracts
- separate contracts for additional unscheduled care capacity, for example contracts for out of hours unscheduled care services

- community dental services contracts
- contracts for services delivered in secure/detained estates

2.2 Complex care

The complex care element is set out as 3 defined pathways, each with a fixed value. This is a

- Pathway 1 (£284) – patients aged 16 and over with 5 or more teeth with caries into dentine
- Pathway 2 (£709) - patients aged 16 and over with 5 or more teeth with caries into dentine and unstable periodontitis
- Pathway 3 (£248)– patients aged 16 and over with a first diagnosis of Stage III or Grade C periodontal disease

2.3 Dentures, fissure sealants and Fluoride Varnish

- Denture modifications
- Fissure sealants (Band 2a or 2b)
- Fluoride varnish – qualified dental nurse application (0.5UDAs)

2.4 Quality Improvement

- Year 1 focus on managing recall intervals in with line with NICE guidance
- £3,400 per practice per year
- (CDS not eligible in year 1 due to topic applicability)

2.5 Appraisal

- £213 per appraisal per individual, converted to UDAs, in contract delivery

2.6 Discretionary Payments

- Rewards innovation for exceptional service to be extended to include dental performers who have transferred from a secondary care setting into primary care as part of their continuous service.

3. TIMELINES

- The contract changes come into effect from 1st April 2026, however with a phased implementation of the complex care pathways (from Q2) in acknowledgement of the time required to implement in a safe and managed way.
- The reforms represent significant change from the current way that dental contracts are set out and delivered, and as such significant engagement with dental practices will be required to ensure readiness for implementation from the 1st April 2026. The Dental Commissioning Team and Dental Provider Board continue to work collaboratively to support all dental practices affected by the contract reforms.

4. IMPACTS AND WIDER CONSIDERATIONS FOR GREATER MANCHESTER

4.1 Implementation

4.1.1 The timescales for implementation of the contractual reforms will be challenging during the month of March, for the Dental Commissioning Team and working with Dental Provider Board colleagues. Communications will be cascaded to dental practices as additional detail is made available b NHS England.

In addition, the team will need to adapt the contract and performance management processes to align with the new contractual requirements.

4.2 Financial

4.2.1 Existing contract values will remain the same and as such all changes will need to be managed within these parameters. This may impact access and capacity.

4.2.2 Analysis suggests that the financial impact of the National Contract Reforms may be significant with respect to the itemised values for each of the contract requirements and Patient Charge Revenue.

4.2.3 An in-depth analysis has been carried out to fully understand the scope and scale of the impacts and resulting actions.

4.2.4 Costing of price matching GM commissioned urgent care activity with the national pricing, as set out, will create additional financial pressure however will be a crucial action to ensure provision of urgent care appointments is able to be delivered equitably within practices.

4.2.5 The cost pressure to the dental budget is anticipated to be up to £2M.

4.3 Local (GM) non-core commissioned services

4.3.1 The current non-core commissioned services have been in place for a number of years and have served to improve patient access to both urgent and routine care.

4.3.2 Future commissioning decisions related to the national contract reforms will have a direct impact on the patient experience and access that have been improved across Greater Manchester over recent years; and the associated clinical and oral health improvement outcomes. These are key considerations for commissioning intentions and effective use of resources going forward.

4.4 Urgent Care Hubs

4.4.1 In response to the new requirement that (a minimum of) 8.2% of the contract is to be for urgent care provision, the locally commissioned dental urgent care hubs have been decommissioned. This prevents duplication of investment and perceived excess capacity within the system.

4.4.2 It is anticipated that there will be a period of unsettlement as the national contract is embedded in general dental practice; however the decision to decommission the urgent care hubs was taken on the balance of risk to patient access and financial affordability.

4.5 Patient Access Quality Scheme (PAQS)

4.5.1 The PAQS has continued to deliver increased access to dental care for both routine and urgent care since 2024/25 with demonstrable success. This scheme is commissioned on a non-recurrent basis with approval sought annually to recommission for a further 12-month period. As such, the current contracts will end on 31/3/26.

4.5.2 The current PAQS service specification has additional value built-in through quality elements relating to Healthy Living Dentistry and priority patient cohorts which include Veterans, Care Leavers and Cancer patients.

4.5.3 In order to ensure that the PAQS specification is aligned, and complementary, to the national dental contract in 26/27 a formal review is being undertaken. It is therefore proposed that to ensure that this work is carried out robustly and to enable the necessary service redesign, business case development and appropriate approvals to be sought that the *current* service specification is not continued beyond 31/3/26 however with the confirmed intention to commission an updated version of the PAQS during 2026/27.

5. ACTIONS AND NEXT STEPS

- i) Issue of National Contract Variations to be completed before 31/3/26
- ii) Continue with the work to review the current PAQ Schemes specification, identify duplication or overlap and refresh accordingly (as per 4.5.3) aligned to national contract requirements and financial affordability.

6. RECOMENDATIONS

- To note the National Dental Contract Reforms including the opportunities and potential risks, and the actions being taken to mitigate and manage these risks.
- To support the actions and next steps as set out in Section 5 of this paper.

BeCCoR: GM GP Incentive Scheme 2026/27

MEETING:	GM Primary Care Commissioning Committee
TITLE OF REPORT:	BeCCoR: GM GP Incentive Scheme 2026/27
DATE OF MEETING:	26 March 2026
FILE CLASSIFICATION:	Final
FILE VERSION NUMBER/DATE:	Final 20/3/26
AUTHOR/S:	Dr Claire Lake Ben Squires And BeCCoR Leadership team
WHICH GROUP HAS PRODUCED THIS PAPER (IF APPLICABLE):	BeCCoR Programme Team
PRESENTED BY:	Ben Squires, Director of Primary Care Claire Lake, Deputy Chief Medical Officer
HAS THERE BEEN PUBLIC OR CLINICAL ENGAGEMENT?	Yes – Clinical engagement
HAS AN EQUALITY IMPACT ASSESSMENT BEEN COMPLETED?	No
HAVE THE ENVIRONMENTAL SUSTAINABILITY IMPACTS BEEN CONSIDERED AND ADDRESSED?	Yes
ENGAGEMENT CARRIED OUT TO DATE	Triumverate approach with programme lead across Pan-GM function(s), Locality and Primary Care Provider Board Report to NHS GM Chief Officers and GM COG
HAS FINANCIAL OR LEGAL ADVICE BEEN OBTAINED? (IF YES, PLEASE STATE THE NAME OF THE FINANCE OFFICER WHO HAS PROVIDED THIS SUPPORT)	Ongoing input from NHS GM Finance colleagues throughout development
ARE THERE ANY POTENTIAL CONFLICTS OF INTEREST ASSOCIATED WITH THIS PAPER? (IF YES, HOW WILL THEY BE MANAGED?)	Co-design with general practice. Potential conflicts managed via strong primary care commissioning, DII and finance involvement in work to ensure value for money.

PURPOSE OF PAPER

Decision Requested: Yes No

For Discussion: Yes No

For Noting/Information: Yes No

Financial Implication: Yes No

This paper relates to the following BAF risks:	
Workforce challenges including shortage in many roles across the the whole health & care sector & staff wellbeing & efficiency	<input checked="" type="checkbox"/>
Demand exceeds available capacity to deliver services in a timely and effective way	<input checked="" type="checkbox"/>
Failure to deliver Financial Balance both for NHS GM organisationally and as an ICS	<input checked="" type="checkbox"/>
Widening health inequalities due to a reduced focus on prevention for the GM population	<input checked="" type="checkbox"/>
Sustaining a strong market for community based services (including adult social care and primary care	<input checked="" type="checkbox"/>
An emergency could overwhelm NHs GM's ability to respond effectively	<input type="checkbox"/>
There is a risk failure to comply with our statutory duties for quality assurance in Quality and Patient Safety within the NHS GM system	<input checked="" type="checkbox"/>

EXECUTIVE SUMMARY INCLUDING KEY MESSAGES:

Further to the successful implementation of BeCCoR Scheme in 2024/25 and 2025/26 the triumvirate collaborative approach has been sustained to further develop a consistent pan-GM commissioning of the Scheme for 2026/27.

There has been strong, positive evaluation of the impact and population outcomes resulting from delivery of the Scheme to date which has formulated the basis of a business case for further investment for 2026/27. This further investment is £15m - £7.3m from 2025/26 has been made recurrent and a further £7.5m investment for 2026/27.

This paper presents

- a. A commissioning overview of the 2026/2027 scheme
- b. The proposed final scheme specification document for publication and delivery by general practice (included as a separate document)

RECOMMENDATION

The GM PCCC is asked to:

- a. To acknowledge the collaborative and evidence based approach to developing the specification(s) for GP BeCCoR Scheme 2026/27
- b. Approve the GM GP Incentive Scheme 2026/27 Specification document for delivery 1st April 2026 -31st March 2027

CONTACT OFFICERS:

Dr Claire Lake, Deputy Medical Director, NHS GM

Ben Squires, Director of Primary Care, NHS GM

1. BACKGROUND

The ongoing work to review locally commissioned arrangements from Primary Care continues. This programme is known as “BeCCoR” – Beyond Core Contract Review, and fundamentally has taken a collaborative approach with triumvirate leadership across the GM primary care leadership, localities, and primary care providers from Primary Care Provider Board.

The basis of BeCCoR has been to utilise an improvement methodology to the development and delivery of primary care, ensuring an approach which is:

- **Fair:** the proposed scheme intentionally brings together the best practice from existing schemes, rather than replicates a single locality scheme
- **Coordinated:** a series of working groups have been established with a BeCCoR leadership group meeting weekly to ensure read across and connectivity across all areas
- **Transparent and Evidenced Based:** working groups have systematically explored current evidence, current GM and national best practices, evaluation and data and used these parameters as the basis for the proposals in the business case. A series of business case development workshops have been undertaken over September-October 2025.
- **Planned:** Underpinning the business case are a set of agreed design and delivery principles and outcomes framework.

The initial Scheme was introduced in 2024/25, with further development for 2025/26. In these years, the pan-GM consistent requirements were introduced into the 10 locality specifications. Evaluation of delivery of the scheme for 2024/25 is available, and 2025/26 outturn will be subject to similar scrutiny and evaluation.

In 2026/27 the commission will be through a single consistent pan-GM specifications with schedules to reflect retained elements of locality specific elements of the legacy arrangements.

2. SCHEME FOR 2026/27:

The following table provides a **commissioning** overview of the 2026/27 Scheme:

Commissioning Overview of BeCCoR 2026/27 Scheme
Agreement on scheme sign up
<p>The document sets of the expectations of both practices and NHS GM as part of the specification document. The key areas in this are:</p> <ul style="list-style-type: none"> - Engagement with GM and place partnership teams to enable scheme delivery and to improve place outcomes - To enable general practice to be a key partner within place based partnerships - To fulfil core access requirements as set out in GP contract <p>KPIs: Self declaration at sign-up to scheme; scheme subject to Post payment verification (PPV)</p>
Section 1: General Practice Quality and Sustainability

A quality and sustainability maturity matrix has been developed. 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
-

General practice are asked to self-assess and submit this self-assessment of their starting position.

Over the year, general practice will work to meet **all essential** criteria, and to meet a proportion of the **aspirational** areas (measured via a score) and then submit a further self-assessment to demonstrate progress made.

The **essential criteria** are:

1. All members of staff are aware of LFPSE and are encouraged to report all incidents via the system and this can be evidenced by the numbers of incidents reported and actions taken as a result (which have been discussed routinely at practice meetings)
2. The practice has processes in place to regularly review the GM Primary Care Quality Framework and other sources of intelligence regarding practice quality and safety. Based upon our review of the data, we:
 - understand the practice's strengths and areas for improvement
 - are actively working to deliver a practice quality development plan (see attached template) for making improvements and/or sharing good practice with peers.
3. The Practice completes the following safeguarding documents within the nationally mandated timelines:
 - Initial child protection conference report
 - Review child protection conference report
 - Any report requested by statutory partners regarding Looked after Children and Care Leavers (note: foster carer medicals and adoption medicals are funded privately)
 - Any Rapid Review brief chronology & analysis as requested
4. The practice business continuity plan:
 - Specifically considers how the practice will cope during periods of extremely high demand (in addition to other business continuity issues e.g. IT outage or no access to practice building).
 - Considers how support will be sought from neighbouring practices.
 - Is reviewed at least annually and updated to reflect changes in circumstances/learning from incidents (both internal, but also at other practices in the PCN or locality).
5. The practice has a Freedom To Speak Up Policy that:
 - all staff are aware of and encouraged to follow
 - includes a list of internal and external escalation routes, including regulators such as NHS England
6. All practice staff receive annual appraisals where there is joint reflection on performance; discussion regarding areas for development; and aspirations for career development. The appraisal results in an agreed personal development plan and protected time for learning and development.

KPIs: 2 x self-assessment submissions; post payment verification audit of practices to ensure can evidence the work described in the self-assessments

This section supports general practice to respond to national and GM changes to the elective care pathway; to deliver a reduction in unwarranted variation in referrals by adopting an advice first approach and use of elective SPOASs and to be key partners in elective transformation through engagement and participation.

This area builds on the 2025/26 BeCCoR Elective scheme, and retains focus on quality improvement. Practices are asked to nominate a practice champion for elective care, to attend a quarterly GM Learning and Improvement network and to ensure sign up and use of Consultant Connect.

Through practice quality improvement plans, practices are asked to shift to an advice first approach across 10 high impact specialities – increasing the use of A+G (by trust A+G or consultant connect or use of SPOA) with a corresponding reduction in directly generated referrals.

The 10 High Impact Specialities:

- Cardiology
- Gastroenterology
- Respiratory
- Dermatology
- Gynaecology
- Urology
- ENT
- Trauma and Orthopaedics
- Paediatrics
- Neurology

KPIs:

1. Evidence practice has adopted an ‘advice first’ approach:

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)

2. Evidence of impact:

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. Achievement is for a 2-5% reduction with payment on a sliding scale.

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.

(Baseline – year to date comparison 31st March 2026 compared to 31st March 2025)

ROI: reduction of 22,493 referrals over 2026/26 with a financial cost avoided of £4,498,575

Section 3: Prevention, Population Health and Neighbourhoods: Cohort-Based Multimorbidity Reviews

The first component of this section is an expansion of the current BeCCoR approach to CVD and Diabetes. Through digital population health management tools, a population with high and very high unmet need has been identified across the following clinical areas. Unmet need is defined either via a set of clinical parameters OR by not having been seen in practices for >18m, thereby having gaps in care. There is a weighting applied for demographics, SMI, anxiety and depression as well to ensure that inequalities are addressed through this approach and are not widened.

Practices are asked to undertake unmet need reviews – holistic clinical reviews that meet gaps in clinical care for this population.

The expanded cohorts are as follows:

Cohort - Prevention and Pop Health	How the cohort is defined	Associated review type	Cohort Size
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)	139,997
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)	139,997
Primary Prevention - High QRISK	Estimated QRISK3 >10% and no lipid-lowering medication.	Primary Prevention Lipid Risk Review	133,160
Respiratory - COPD	High-risk COPD cohort (RespNeed risk stratification).	Enhanced COPD Review	38,355
Respiratory - Asthma (adult)	High-risk asthma cohort (RespNeed risk stratification).	Enhanced Asthma Review (adult)	114,314
Respiratory - Asthma (CYP)	High-risk asthma cohort in children and young people (same criteria as adult asthma for cohort selection).	Enhanced Asthma Review (CYP)	16,790

KPIs: % of high and very high risk population having had an unmet need review

System Outcomes: GM evaluation of impact on outcomes, system utilisation and population health

Clinical outcomes

1. Improved disease control for BP, Lipids, Hba1c, AF
2. Reduced number of patients with QRISK >10% not on lipid lowering therapy
3. Increased completion of 'diabetes 8 care processes' with reduced variation across GM
4. Reduced numbers of exacerbations of asthma and COPD
5. increased flu/RSV/pneumococcal vaccination uptake in COPD and asthma cohort
6. Reduced rates of heart attacks and strokes
7. Reduced avoidable mortality heart attacks, strokes and respiratory illness

Addressing Health Inequalities Outcomes

1. Higher rate of improvement in groups who have worst outcomes e.g. when analysed by ethnicity and deprivation
2. Reduction in those who are exception reported from OF and
3. Reduction in those in high risk group due to not having been 'seen' by general practice for >18m
4. Improved patient experience (measured by neighbourhood surveys)

Reduction in Demand Outcomes

1. Reduced A+E attends due to asthma and COPD exacerbations
2. Reduced demand on UEC pathways in relation to diabetes, coronary heart disease and stroke
3. Over time, reduced non elective admissions and reduced LOS for adults with COPD
4. Increase hospital utilisation of virtual ward pathways for BeCCoR cohort

ROI: the modelled ROI is >£10million in avoided costs over 12months

The second component is for general practice to work with neighbourhood teams to develop and enact a neighbourhood action plan to address the wider needs of this cohort (and wider cohorts). This is supported by a neighbourhood prevention allocation.

Oversight of this component will be at place level to ensure alignment with place demand management and neighbourhood plans. An evaluation framework with qualitative and quantitative data has been developed.

It is anticipated that embedding this clinical approach within neighbourhood working will maximise the impact, outcomes and ROI described above. This section is also one of the components of the GM Prevention Demonstrator work which will add further opportunity, focus and rigorous evaluation approaches.

KPIs: neighbourhood action plans and GM wide evaluation

Section 4: Medicine Optimisation

Antimicrobial Stewardship

This specification works to deliver improvements in AMS through prescribing optimisation across total antibiotic usage, broad spectrum antibiotic usage and antibiotic usage in children.

As well as improving quality of care, the KPIs below support NHS GM to meet the National Oversight Framework AMS targets and support medicines CIP through reduced prescribing.

KPIs:

- Reduction in overall antibiotic items per STAR-PU to ≤0.871.
- 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 ≤10%

AND

- ≥70% of broad-spectrum antibiotic prescriptions issued between April 1st 2026 and March 31st 2027 must have a coded indication.
- Percentage of registered children aged 0–9 years prescribed ≥1 antibiotic in last 12 months ≤ 25% (national target) by March 31st 2027

CIP: this has been built into Meds Opt CIP plans for 2026/27

<p>Shared Care of Medicines</p>	<p>A single Shared Care of Medicines service for all GP practices to ensure safe, equitable and sustainable delivery of shared care activity.</p> <p>This supports the ongoing work of the SCOM taskforce.</p> <p>KPI: this is activity based with payment for shared care of medicines prescribing and monitoring.</p>
<p>DOAC Optimisation</p>	<p>DOACs are anticoagulant medications that are widely used but need to be monitored to reduce the risk of medicines related harms.</p> <p>There is also a variation in agents prescribed with considerable cost implication of this variation.</p> <p>This aspect asks general practice to:</p> <ol style="list-style-type: none"> 7. Undertake safe monitoring of DOACs (bloods, BMI and calculating creatine clearance at least annually) 8. To do a direct switch to a more cost effective DOAC where not on one <p>KPIs:</p> <p>%age DOAC patients who have had a complete annual review</p> <p>Active switch to cost effective agent where clinically appropriate</p> <p>CIP: this has been built into Meds Opt CIP plans for 2026/27</p>
<p>Low Priority Prescribing</p>	<p>This part of the scheme will 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> <p>KPIs: Reduction in practice level actual LPP spend either by maintaining or reducing on previous year spend</p> <p>CIP: this has been built into Meds Opt CIP plans for 2026/27</p>
<p>Population Health Approach to Medicine Safety</p>	<p>This is a novel component to add to BeCCoR 2026/27. It builds on the population health management approach laid out in section 3, and applies this to medicines.</p> <p>It uses digital tool to identify problematic polypharmacy which can lead to patient harm (such as confusion, falls, delirium) and unplanned hospital attends/admissions. It also supports general practice to deliver targeted interventions to embed safer prescribing.</p> <p>Practices will be asked to undertake structured medication reviews (SMRs) for their patients in the high and very high unmet need category (based on SaferPrescriingNeed scores).</p> <p>Practices are also asked to collaborate at PCN level to implement coordinated approaches for the high and very high unmet need cohorts, so as to bring about sustainable reductions in harm. These plans will focus around:</p>

	<p>a. Polypharmacy and Anticholinergic Burden b. Opioids and Dependence Forming Medication</p> <p>KPIs: SMR completion for “very high” and “high” unmet need population cohort. And submission of a Q1 and Q4 QI plan from each PCN.</p> <p>System Impact: reduced hospital admissions from medicine related harm – e.g. falls, accidental overdoses, delirium</p>
<p>Tirzepatide Clinical Data Quality</p>	<p>The aim is 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>The ask is to retrospectively and prospectively apply a consistent set of clinical codes to tirezepatide prescriptions, and then undertake a clinical audit in Q2 to identify – and address – and clinical coding gaps.</p> <p>KPIs: a complete set of clinical codes where tirzepatide has been prescribed</p> <p>System Impact: will enable clarity of tirzepatide related spend so as to differentiate weight management costs from diabetes costs; and to differentiate private from nhs prescribing.</p>
<p>Section 5: Locally retained elements</p>	
<p>Retaining key elements of existing locality schemes to sustain stability of local arrangements</p>	<p>Examples:</p> <ul style="list-style-type: none"> • Health Checks for those with Severe Mental Illness

A comprehensive proposed scheme specification accompanies this paper. This is yet to be published, awaiting formal sign-off through NHS GM governance. Therefore PCCC members are requested to restrict distribution of this document until formal publication.

3. RECOMMENDATION

3.1. The Primary Care Commissioning Committee is asked to:

- a. To acknowledge the collaborative and evidence based approach to developing the specification(s) for GP BeCCoR Scheme 2026/27
- b. Approve the GM GP Incentive Scheme 2026/27 Specification document for publication and delivery 1st April 2026 -31st March 2027

Community Pharmacy Independent Prescriber Pathfinder Programme Extension Proposal

March 2026

GM Primary Care Commissioning Committee

DATE

Required information	Details
Title of report	Community Pharmacy Independent Prescriber (IP) Pathfinder Programme Extension Proposal
Author	Alison Scowcroft, Community Pharmacy Integration and Commissioning Portfolio Lead Ben Squires, Director of Primary Care Lara Shah, Deputy Chief Pharmacist
Presented by	Alison Scowcroft, Community Pharmacy Integration and Commissioning Portfolio Lead
Contact for further information	Alison.scowcroft@nhs.net
Executive summary	This document details a proposal to extend the commissioning of Independent Prescribing (IP) services in up to 10 community pharmacies in Greater Manchester in 2026/27, as an interim position between the end of the Community Pharmacy Independent Prescriber Pathfinder Programme on 31 st March 2026 and any national solutions for commissioning which are developed as part of the national Community Pharmacy Contractual Framework (CPCF) and contractual settlement for 2026/27, negotiations for which commenced early March 2026.
The benefits that the population of Greater Manchester will experience.	Patients visiting up to 10 pathfinder site pharmacies with minor illness are receiving their full episode of care in community pharmacy, rather than having to be referred to their GP if a prescription is needed.
How health inequalities will be reduced in Greater Manchester’s communities.	Community pharmacies are positioned and embedded into our GM communities, and they are easily accessible with 99% of the population able to reach a pharmacy within 20 minutes by car and 96% by walking or using public transport. Community pharmacy teams are an integral, trusted part of the NHS, delivering high quality clinical services as a partner within local primary care networks. Over 80,000 people visit a community pharmacy every day across Greater Manchester.



	<p>In addition, 64% of GM community pharmacies are in areas of GM with the highest levels of deprivation (IMD 1-3).</p> <p>Pathfinder sites were selected considering (among many other aspects) opening hours and deprivation. 7 of the 10 sites are located in areas with an index of multiple deprivation 4 or less (Manchester, Salford, Rochdale, Wigan and Withington), the remaining 3 sites are rated 6,9 and 10 (Manchester and Trafford).</p>
<p>The decision to be made and/or input sought</p>	<p>PCCC is requested to support the proposal to request the utilisation of programme funding slippage by extending the commissioning of IP in community pharmacy into 2026/27.</p>
<p>How this supports the delivery of the strategy and mitigates the BAF risks</p>	<p>The extension of this service helps NHS GM to deliver the 10 Year Health Plan for England: fit for the future - GOV.UK by ensuring patients are seen in the most appropriate place, by the most appropriate professional and supports GM's obligations in the NHS England » Medium Term Planning Framework – delivering change together 2026/27 to 2028/29 This will support the ICB to deliver services in line with constitutional targets and standards.</p>
<p>Key milestones</p>	<ul style="list-style-type: none"> • National programme designed to establish a framework for IP services in community pharmacy, patient-facing activity commenced in February 2025 and nationally funded to December 2026. • Programme management funding provided by NHS England as ring-fenced SDF allocations. • 10 community pharmacies commissioned across GM delivering 3 clinical models – Minor Illness, Respiratory, and Hypertension. • Additional national funding received in January 2026 secured an extension for January to March 2026, with activity by site limited to remain within the available funding. • Slippage in programme management funding is proposed to be utilised to

	extend commissioning into 2026/27 on a small scale to ensure continuity of service provision in those sites where IP has become embedded and where discontinuation would have a significant negative impact on patients and general practice.
Leadership and governance arrangements	Governance through: PCCC December 2023 CEG October 2023 (Minor Illness clinical model), April 2024 (Respiratory clinical model) and June 2025 (Hypertension clinical model). IP Pathfinder Steering Group monthly
Engagement* to date	Director of Primary Care and Deputy Chief Pharmacist Jan 25 NW Region Deputy Chief Pharmacist and NHSE Pharmacy Transformation Team Jan 25 IP Pathfinder Steering Group Feb 25 CPGM Feb 25 Pharmacy LPN Feb 25

Table 1 - core information relating to the content and creation of paper

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

Table 2 - checklist of engagement carried out, advice sought, conflict of interest and accessibility of report

Area of Primary Care Commissioning	General Primary Care	Primary Ophthalmic Services	Dental Services	Primary Medical Services	Pharmaceutical Services
Compliance with mandated guidance					Y
Service provision and planning					Y
Contracting					Y
Contractor / Provider compliance and performance					

Table 3 – Checklist against Delegated Primary Care Functions Assurance Framework – contribution to self-certification declaration

Community Pharmacy Independent Prescriber Pathfinder Programme: Extension Proposal

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1. Executive Summary

- National programme designed to establish a framework for IP services in community pharmacy, patient-facing activity commenced in February 2025 and nationally funded to December 2026.
- Programme management funding provided by NHS England as ring-fenced SDF allocations.
- 10 community pharmacies commissioned across GM delivering 3 clinical models – Minor Illness, Respiratory, and Hypertension.
- Additional national funding received in January 2026 secured an extension for January to March 2026, with activity by site limited to remain within the available funding.
- Slippage in programme management funding is proposed to be utilised to extend commissioning into 2026/27 on a small scale to ensure continuity of service provision in those sites where IP has become embedded and where discontinuation would have a significant negative impact on patients and general practice.

2. Introduction

This document details a proposal to extend the commissioning of Independent Prescribing (IP) services in up to 10 community pharmacies in Greater Manchester in 2026/27, as an interim position between the end of the Community Pharmacy Independent Prescriber Pathfinder Programme on 31st March 2026 and any national solutions for commissioning which are developed as part of the national Community Pharmacy Contractual Framework (CPCF) and contractual settlement for 2026/27, negotiations for which are due to commence in February 2026.

3. Background

NHS GM currently commissions 10 community pharmacy pathfinder sites as part of the NHS England Community Pharmacy Independent Prescriber Pathfinder Programme. The 10 sites have provided NHS prescribing for patients through 3 commissioned clinical models to GM patients since February/March 2025. See [Appendix 1](#) for a list of the sites.

a. National Pathfinder Programme

The strategic aim of the community pharmacy IP pathfinder programme was to establish a framework for the future commissioning of NHS community pharmacy clinical services incorporating independent prescribing for patients in primary care. More detail on the aims and objectives of the national programme can be found in [Appendix 2](#).

b. Commissioning and Funding Arrangements

NHS GM commissioned the 10 pathfinder sites as a Local Enhanced Service (LES); the programme was nationally funded with programme management and sessional fees reimbursed by NHS England.

NHS England provided 3 ring-fenced SDF allocations of programme management funding for each of the financial years in which the programme ran: 2023/24, 2024/25 and 2025/26. In addition, activity funding for the pathfinder sites was reimbursed by NHS England up to a maximum of 240 4-hour sessions per month for the 10 pathfinder sites up to 31st December 2025.

Programme management arrangements were outsourced to CPGM Healthcare Ltd (CHL), the LPC provider company for 2024/25 and 2025/26, funded by the ring-fenced SDF allocations and in partnership with NHS Cheshire and Merseyside and NHS Lancashire and South Cumbria.

Electronic prescribing is managed through an electronic platform called 'Cleo Solo', which was nationally procured and contracted until 31st March 2026.

c. Governance

The commissioning for the GM pathfinder programme was signed off through GM governance at Primary Care Commissioning Committee (PCCC) in December 2023. Clinical design of the programme was approved by Clinical Effectiveness and Governance Committee (CEG) in October 2023 (Minor Illness clinical model), April 2024 (Respiratory clinical model) and June 2025 (Hypertension clinical model).

Operational oversight of the programme is managed through a programme steering group with multi-disciplinary membership which meets monthly and regular reporting to the operational Community Pharmacy Services Group (CPSG), PCCC, and CEG.

Clinical oversight of the programme is provided by a clinical mentor who is funded through programme funding for 1 4-hour session per week to provide clinical mentorship to the community pharmacy Independent Prescribers and operational support is provided through weekly drop-in calls with the programme manager and programme lead.

At a regional level, oversight is provided through the Northwest Deputy Chief Pharmacist through a weekly meeting with colleagues from NHS Cheshire and Merseyside and NHS Lancashire and South Cumbria, with regular updates from the NHSE Pharmacy Integration team. This support was intended primarily to support with the set-up and implementation of the programme, appropriate reporting and data capture, and to support the evaluation of the programme and will cease from April.

d. Greater Manchester position and further information

The uptake of the programme has varied across the 10 pathfinder sites, with some sites delivering significant activity levels which has led to material and sustained changes in patient behaviour and ways of working between general practice and community pharmacy. A summary of the activity, an overview of patient feedback, and feedback from a general practice which has been working closely with an IP pathfinder site can be found at [Appendix 3](#).

e. Extension 1st January 2026 to 31st March 2026

Reimbursement for site sessional fees from NHS England ended on 31st December 2025.

A decision was taken at the programme steering group in December 2025 to extend and sustain the programme delivery to 31st March 2026 due to:

- the positive impact of the programme on patients,
- the positive impact of the programme on general practice resource and capacity (see section f),

- the risks in some areas of a hard stop adversely impacting patient care during the winter period,
- the anticipated future of IP in community pharmacy confirmed in the NHS 10 Year health plan and the Medium-Term Planning Framework,
- a budgetary review of programme funding.

This extension for January to March 2026 has been funded through budgetary slippage of £90,000 comprising one-off allocations received from NHS England for the programme implementation (at £1500 per site) and further allocations received to support lipid management (which has been delivered as part of the hypertension clinical model).

Due to the fixed financial envelope, a review of activity was undertaken in November to ensure that activity January to March 26 could be covered by the available funding. The number of sessional fees claimed by site was compared to the number of patient consultations recorded and each site was given a revised allowance of sessions they can claim per month, based on their actual activity in the programme. This approach was signed off by Community Pharmacy Greater Manchester (CPGM - the Local Pharmaceutical Committee, LPC, representative body for community pharmacy contractors in GM) and the programme steering group.

f. Moving into 2026/27

The [10 Year Health Plan for England: fit for the future - GOV.UK](#) and [NHS England » Medium Term Planning Framework – delivering change together 2026/27 to 2028/29](#) mandate that ICBs must commission IP services from community pharmacy in 2026/27. Any national solutions for commissioning which are developed will be part of the national Community Pharmacy Contractual Framework (CPCF) and contractual settlement for 2026/27, negotiations for which are due to commence in February 2026. This framework agreement is anticipated to describe and inform the commissioning of IP services from community pharmacy by ICBs from 2026/27 onwards but is not anticipated to be in place and available to start from 1st April 2026.

The current IP services in community pharmacy will cease from 1st April 2026 until such a national arrangement for ICBs to commission service is in place, leaving a significant gap.

Identified risks of an abrupt cessation of service on 1st April 2026 include:

- Reputational risk to community pharmacy – discontinuing services may be viewed as the ICB / NHS England not having “faith” in community pharmacy IP services.
- Pharmacy services viewed as temporary, inconsistent or non-reliable.
- Relationship issues where primary care systems have been working together to deliver a local integrated offer to patients.
- Risks to capacity and patient care in general practices where IP has become embedded into their ways of working.
- Patients not understanding the changes and viewing the discontinuation as withdrawal of services.
- IP workforce leaves the community pharmacy system – this could lead to difficulty for recruitment processes for providers in the future when trying to relaunch services.
- Community pharmacies reluctant to sign up to future services.
- Significant work and resource required to restart IP services once national arrangements are confirmed in 2026/27.

g. Proposal summary

There is slippage within the SDF programme management allocations as of February 2026, which is due to efficiencies realised. This proposal is therefore to request the utilisation of this programme funding by extending the commissioning of IP in community pharmacy into 2026/27.

Service continuity is preferable to ceasing provision due to financial recovery of remaining funds, impacting on integration as part of local system delivery where services have embedded IP into their ways of working, changing patient behaviour and creating significant capacity in general practice which is now being routinely utilised for more complex care. Furthermore, it is anticipated that ICBs will be required to commission services incorporating IP in 2026/27 as part of the medium-term planning framework, so maintaining a service from 1st April 2026 would prevent services having to stop and restart where activity levels are impactful on the local system.

Until the activity in January, February and March 2026 is claimed, there will not be a final figure available, however it is likely that programme slippage held by CHL will be around £50-£75k.

The proposed rationale is to retain this national programme funding and use it to act as a bridging arrangement to continue to commission and fund a lower level of patient-facing activity, from sites who have delivered the most impactful activity until such time as national arrangements are clarified with a managed and phased exit strategy if appropriate.

h. Proposal considerations

Although the pathfinder programme was nationally funded and supported, the governance sat with NHS GM, and therefore moving to local arrangements will not have a material impact on the governance of the pathfinder sites.

Other considerations include:

- An extended arrangement should continue until September 2026, by which time the national arrangements should be clear.
- Only the sites who have delivered significant levels of patient activity throughout the duration of the pathfinder programme will be commissioned to continue.
- Funding of Cleo Solo needs to be included, and the recommendation from NHS England is that sites contract directly with Cleo Solo.
- It is recommended that the clinical lead role is also funded to ensure appropriate clinical oversight of prescribing activity in community pharmacy.

4. Next Steps

The next steps proposed are:

- Confirm the funding available and propose modelling for how best to continue commissioning, considering:
 - Number of pathfinder sites to commission in 2026/27, and which sites present greatest benefit to sustain.
 - Which clinical models to commission to ensure greatest impact on patient care and system working.
 - Number of sessions each site can claim per month, balanced between available funding and maximum impact.
 - Confirm Cleo Solo licensing costs per site per month.

- Gain approval through NHS GM governance to fully utilise programme funding to continue to commission and fund IP services in community pharmacy into 2026/27.
- Discuss with pathfinder sites their appetite to continue to deliver IP services into 2026/27, including contracting directly with Cleo Solo.
- Agree what governance and oversight will be required for the sites who continue to provide IP services into 2026/27. Consideration of capacity requirement is such that it is proposed to commission the clinical lead supervision for 1 session per fortnight.
- Extend contracting arrangements into 2026/27.

5. Recommendations

The recommendation is to approve the full utilisation of programme funding, of circa £50k-£75k to support the continued commissioning and funding of Independent Prescribing services in community pharmacy in 2026/27.

6. Contact Officer

Alison Scowcroft, Community Pharmacy Integration and Commissioning Portfolio Lead, NHS GM.
Alison.scowcroft@nhs.net

Appendix 1 – Pathfinder Site List

ODS code	Pharmacy Name & Address	Locality	Commissioned clinical models
FL885	Didsbury Pharmacy, 676 Wilmslow Rd, Manchester. M20 2DN	Manchester	Minor Illness Hypertension Respiratory
FX146	Manley Pharmacy, 207 Clarendon Rd, Whalley Range. M16 0EH	Manchester	Minor Illness Hypertension Respiratory
FTP04	Wilmslow Pharmacy, 480 Wilmslow Rd, Withington, Manchester. M20 3BG	Manchester	Minor Illness Hypertension Respiratory
FGK90	Well Pharmacy, 17 Mellor St, Lees, Oldham. OL4 3BS	Oldham	Minor Illness Hypertension
FKJ16	Everest Pharmacy, 57 Manchester Rd, Oldham. OL8 4LN	Oldham	Minor Illness Hypertension Respiratory
FMD75	Drugmart Pharmacy, 78 Spotland Rd, Rochdale. OL12 6PQ	Rochdale	Minor Illness Hypertension Respiratory
FDH13	Vincent Smith Pharmacy, Monton Medical Centre, Canal Side, Eccles, Manchester. M30 8AR	Salford	Minor Illness Hypertension Respiratory
FPM98	Boots the Chemist, 1 Stamford Quarter, George St, Altrincham. WA14 1RH	Trafford	Minor Illness Respiratory
FJJ51	Timperley Pharmacy, 250 Stockport Rd, Timperley, Cheshire. WA15 7UN	Trafford	Minor Illness Hypertension Respiratory
FPC22	Hollowood Chemists, 11 Mesnes St, Wigan. WN1 1QP	Wigan	Minor Illness Hypertension Respiratory

Appendix 2 – National Pathfinder Programme Aims and Objectives

Greater Manchester

Community Pharmacy Independent Prescribing Programme

Pathfinder strategic aim: establish a framework for the future commissioning of NHS community pharmacy clinical services incorporating independent prescribing for patients in primary care.

Purpose

- Recognition that harnessing the skills and workforce capabilities of pharmacist prescribers and enhanced pharmacy technician roles would enable independent prescribers to support patients with access to treatment.
- To support the Fuller Stocktake report's vision for transforming access to services, improving experience for patients with long term conditions and preventing ill health through integration with neighbourhood teams.
- To build on the investment set out in the [Delivery Plan for recovering access in primary care](#) that sets the ambition to introduce a community pharmacy Common Conditions Service and expand the BP Check and Contraception services.

Benefits include

- Improved patient access to healthcare across the system
- Ensuring community pharmacists are working to their full clinical potential
- Supporting General Practice
- Better enables ICB level service delivery planning

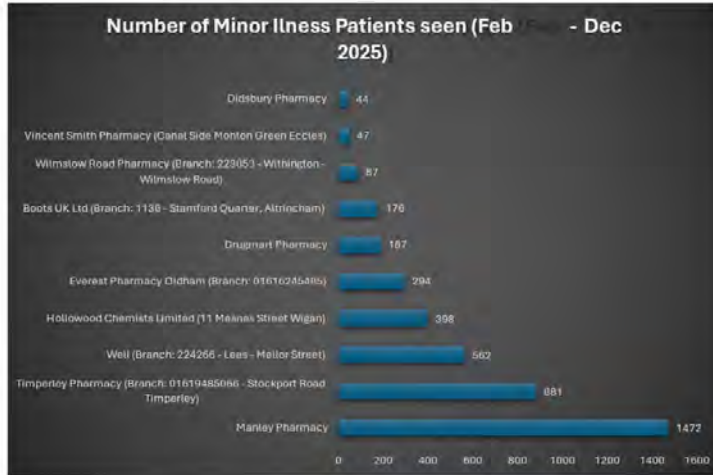
Greater Manchester

Pathfinder objectives

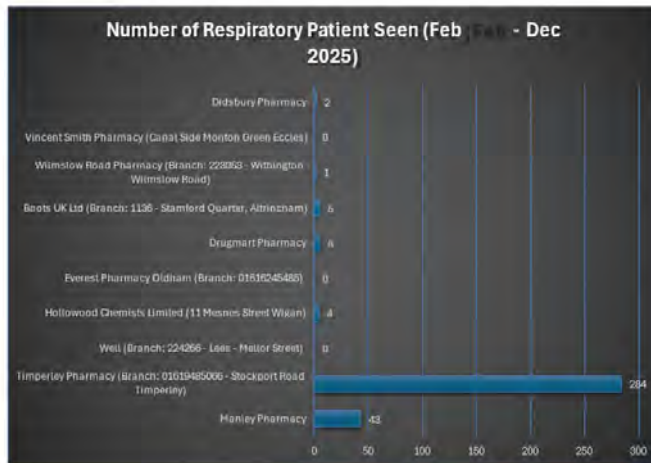
1. To establish Pathfinder sites to test the delivery of IP in community pharmacy across all NHSE regions aligning with general practice
2. To **identify the optimum processes including governance, reimbursement and IT requirements** required to enable independent prescribing in community pharmacy
3. To inform the **development of professional and clinical service standards** that support assurance of IP activities in the context of NHS community pharmacy services
4. To inform the **professional development** needs of community pharmacists and wider **workforce strategy** for pharmacy professionals in primary care
5. To inform the **post 2019- 2024 community pharmacy contractual framework strategy**
6. To inform the **ICB delegation responsibilities** necessary to support national and local commissioning of clinical services
7. To undertake appropriate local and national **quantitative and qualitative evaluation / research**, including patient experience and the experience of community pharmacy, general practice, community services and secondary care teams.

Appendix 3 – IP Pathfinder Activity Data, Patient and General Practice Feedback

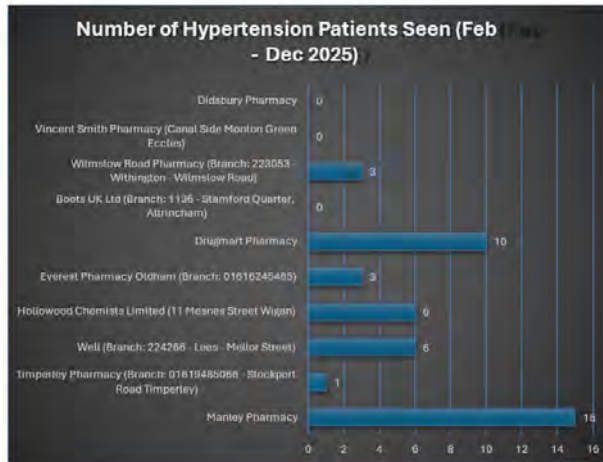
IP Pathfinder Programme - Minor Illness Summary Activity 2025



IP Pathfinder Programme – Respiratory Summary Activity 2025



IP Pathfinder Programme – Hypertension Summary Activity 2025



Patient Feedback Highlights – December 2025

- 91 patients have given their feedback about the service.
- 92% of patients said the service met their needs
- 91% of patients rated the skills of pharmacist as **very good**
- 91% of patients said they are **very likely** to use the service again
- 95% of patients said they would recommend the service to other people



Feedback from a GP in Manchester locality:

“The extended service [the] pharmacy delivers has become an integral part of how we deliver primary care. Over the last month alone, our practices have referred more than 1000 patients via the 'Pharmacy First' and 'IP pathway', with 94% successfully managed. These figures represent hundreds of patients who were managed safely, promptly, and appropriately without requiring a GP appointment, allowing GPs and their colleagues in practices to deliver a better, faster, safer service to the rest of their patients.

This service has been key in enabling redesign of how we use our clinical capacity. The ability to rely on a funded prescribing community pharmacist has allowed us to refocus GP appointments toward patients with complex, long-term, and higher-risk conditions. Removing this service would result in an immediate surge in demand returning to general practice, with a direct negative impact on access, waiting times, patient experience, and staff wellbeing.

...

Even within its pilot period this service has moved beyond the impact of a pilot — it is already providing critical operational capacity within our local primary care system.

We cannot overstate the importance of this matter, continuing and extending this service is part of how we save the NHS! A loss of funding would not simply pause innovation; it would dismantle a proven model that is already delivering safer, more efficient, and more patient-centred care.”

Gap in COVID-19 Spring 26 vaccination offer to eligible cohorts and proposed mitigation within Greater Manchester

GM Primary Care Commissioning Committee

Thursday 26th March 2026

Required information	Details
Title of report	Gap in COVID-19 Spring 26 vaccination offer to eligible cohorts and proposed mitigation within Greater Manchester
Author	Alistair Rutherford – Winter Vaccinations Manager GM ICB
Presented by	Amy Ashton – Assistant Director – Lead for Screening and Immunisations (Greater Manchester)
Contact for further information	Alistair Rutherford – Alistair.rutherford@nhs.net
Executive summary	<p>This paper seeks to update and gain approval from the Primary Care Commissioning Committee (PCCC) on a significant service delivery gap in providing Spring 2026 COVID-19 vaccinations for housebound and older adults living in care homes. It describes the scale of the shortfall, the underlying causes, and the proposed actions to mitigate this.</p> <p>The paper seeks Committee approval to progress the recommended commissioning approach.</p> <p>For 2026, the enhanced service contract shifts responsibility for COVID-19 vaccinations from Primary Care Networks (PCNs) to individual GP practices. In Greater Manchester, NHS England’s S7a Access & Inequalities (A&I) funding supports the strengthened delivery of s7a vaccination programmes. Under the proposal, NHS England (NHSE) Greater Manchester would allocate £60,000 from the 2026–27 NHSE S7a A&I fund (£750,000 total) to commission four community pharmacy providers to deliver COVID-19 vaccinations specifically for housebound and older adults residing in care homes during the spring Covid-19 vaccination programme.</p>
The benefits that the population of Greater Manchester will experience.	<p>Improvements in access to vaccinations, specifically COVID-19, alongside other relevant opportunistic health interventions.</p> <p>Utilisation of available ringfenced funding within GM system to meet population health needs.</p>
How health inequalities will be reduced in Greater Manchester’s communities.	<p>There are substantial disparities in uptake of vaccinations within GM communities, both based on economic deprivation as well as ethnic background. This has an onward impact on incidence of severe illnesses that</p>

	<p>would ordinarily be preventable (or greatly reduced) by vaccination.</p> <p>Housebound and care home patients cannot access practices for healthcare support or vaccination and need to be vaccinated by home visits.</p>
The decision to be made and/or input sought	PCCC is requested to approve the proposed expenditure and support the extension of contracts to four Community Pharmacy (CP) providers to commission delivery of the enhanced vaccination outreach scheme in GM to housebound and older adults resident in a care home.
How this supports the delivery of the strategy and mitigates the BAF risks	<p>Improving both the uptake of vaccinations as well as reducing disparities in uptake rate between different communities aligns with key population health strategies, embracing the ‘left shift’ from treatment to prevention, and from hospital to community services.</p> <p>Improved uptake of vaccinations reduces the incidence of severe illness and protects essential urgent and emergency care ‘front doors’ from excess attendances associated with preventable disease.</p>
Key milestones	
Leadership and governance arrangements	The proposals have been reviewed by a tripartite working group prior to recommendation to PCCC to ensure they align with strategic objectives and offer value-for-money to the system.
Engagement* to date	Discussion with primary care and clinical directorate leads.

1.0 Background

1.1 NHS England issued an Enhanced Service (ES)¹ for COVID-19 and adult Influenza vaccination to all GP practices in January 2026, including the delivery of the COVID-19 spring vaccination programme.

1.2 Because the ES is non-mandated, a substantial number of practices have either opted out or not responded to the offer to deliver the spring campaign. Analysis indicates that approximately 126 GP practices have not signed up to the ES currently. The number of practices that sign up to the ES is expected to increase towards the A/W seasonal vaccinations campaign, this will be monitored and close work with primary care will be undertaken.

1.3 The Joint Committee for Vaccination and Immunisation (JCVI) recommends that a seasonal Covid-19 vaccination is offered to all individuals:

- Adults aged 75+

¹ [NHS England » General practice enhanced service specification – COVID-19 and adult influenza vaccination programmes: 1 April 2026 to 31 March 2027](#)

- Individuals aged 6 months–74 years with severe immunosuppression
- Residents of older adult care homes

1.4 Mobile, non-housebound patients may attend a local Community Pharmacy (CP), but housebound patients and older adult care home residents cannot, due to their dependency on roving, domiciliary delivery of care. The gap in GP provision results in approximately 10,000 housebound and older adult care home residents not being able to access the COVID-19 spring vaccination programme.

1.5 Although housebound patients are not a formal JCVI cohort, GM must ensure all eligible patients receive an equitable offer. The commissioning of a roving provider is the best option.

1.6 Historically, a national additional payment of £10 per housebound vaccination was provided to primary care. This payment has been removed for 2026, reducing the incentive for providers to undertake domiciliary delivery.

2.0 Key Themes and the Data-Informed Approach

2.1 National guidance indicates that Community Pharmacies should deliver to housebound patients where GP practices are not participating; however, the removal of the additional housebound payment means that no providers have been willing to do so under the current funding structure.

2.2 GM analysis confirms large areas have no GP-led COVID-19 domiciliary offer. To deliver to housebound and older adult care home cohorts, providers must be able to:

- Contact and invite patients
- Have real-time recording of vaccinations via Point of Care IT systems:
- Input vaccinations for *any* patient, (like flu workflow)
- Cold chain management for roving teams
- Consent and capacity assessment
- Compliance with GM/NHSE assurance for home visits

2.3 Community Pharmacies are the only provider group able to meet the full technical, IT, clinical, and regulatory requirements for safe and compliant domiciliary delivery. Other provider types (e.g. Trusts, VCSE, independent contractors) cannot be mobilised within the required timeframe or lack the necessary system access.

2.4 To maintain full programme coverage, NHSE (GM) proposes to extend the contracts of a small number of Community Pharmacy providers that have already been procured via tender. The contracts can be extended with minor modification.

2.5 It is proposed that four Community Pharmacy providers are commissioned to deliver vaccinations to an estimated 6,000 housebound patients and 4,000 older adult care home residents, with activity weighted to locality population size and completed within an eight-week period.

2.7 Additional funding will be provided to cover the enhanced operational workload beyond business as usual, with the deduction of item of service for an estimated number of

vaccinations.

2.8 CPs face significant additional activity beyond the standard vaccination delivery to meet the needs of these patients:

- Liaison with non-participating practices to gather patient information
- Home visits across non-participating practice footprints
- Scheduling and coordination
- Mileage and travel time
- Data entry and administrative handling
- Liaison with care home teams and families
- Complex consent/capacity assessments

2.9 GM has no alternative provider model that can travel, meet safety and IT requirements within the timeframe.

3.0 Commercial and Governance Approach

3.1 Governance will take place via the winter vaccinations team to ensure that providers have suitable support to successfully deliver vaccinations. Performance management will be replicated for all providers.

4.0 Local Scheme Proposals & Finance

4.1 The North West regional NHSE team has developed a standardised funding model (Appendix 1), for use and consistency across all 3 ICBs to enable providers to be commissioned to fulfil the service delivery gaps. The funding proposed provides a fixed administration fee of £3,000 per provider and delivery costs of £18,000 for an eight-week intensive period. After deducting the estimated IOS income (£6,036), the net funding requirement per provider is circa £15,000 per 2,500 patients. The providers will have pro rata payments to ensure the funding is distributed fairly;

Table 1 – Documents the 4 proposed CP providers in GM, with the expected funding per cohort:

CP	Proposed Payment	Patient Numbers
Formans	£20,400	3,756
Imman	£6,600	1,190
Rupert Street	£19,200	3,477
Wellfield	£13,800	2,460

4.2 The total estimated funding requirement to commission four providers is £60,000, to be met from NHSE (GM) S7a A&I allocation, which totals £750,000 in 2026/27. There is sufficient funding within the S7a A&I funding to commission these services.

4.3 All providers will be expected to deliver appropriate Making Every Contact Count intervention to ensure each patient receives the greatest possible benefit and is supported to

access the most suitable services. This could be hypertension case finding service or blood pressure checks working with the patient's practice to ensure correct eligibility.

5.0 Risks

5.1 Failure to commission an alternative provider to deliver Spring COVID-19 Vaccinations:

- **Patient Safety:** Vulnerable patients may not receive timely vaccination, increasing risk of severe illness or hospitalisation.
- **Time:** Ability to find alternative providers or delivery models is unlikely when programme starts on the 13th April.
- **Equity:** Localities with high GP opt-outs could see significantly lower coverage among at-risk cohorts.
- **Programme Delivery:** Failure to meet NHSE deadlines for care home and housebound vaccination completion could affect regional assurance.
- **Reputational Risk:** GM ICB is responsible for ensuring universal coverage regardless of provider participation.

6.0 Recommendations

Public Health Commissioners request PCCC approve the following recommendations:

6.1 Approve the commissioning of the four proposed Community Pharmacy providers to deliver Spring 2026 COVID-19 vaccinations to all housebound and older adult care home patients in areas without a GP ES offer.

6.2 Approve the allocation of £60,000 from GM's NHSE Access & Inequalities budget to meet the additional operational costs from providers, in line with the Northwest regional funding methodology.

6.3 Support timely mobilisation to ensure providers are operational in advance of programme launch on 13 April 2026.

7.0 Appendix

From NHS England: The proposed funding methodology is proposed for providers supporting housebound and older adults resident in a care home capacity gaps. The approach below is intended to be simple, transparent and consistent across ICBs.

Proposed funding model

1. Fixed administration fee

Flat fee: £3,000 (one-off)

2. Delivery cost

- £40 per hour for 9 hours per day = £360 per day

- On-costs applied at 25% = £450 per day
- Delivery period: 5 days per week for 8 weeks (40 days)

Total delivery cost:

£450 × 40 days = £18,000

Gross funding (before offsets):

£3,000 (admin) + £18,000 (delivery) = £21,000

Offset for existing IOS income

Providers will continue to receive income via the IOS fee, which will be deducted from the above amount to avoid double funding.

IOS calculation:

15 patients per day × £10.06 = £150.90 per day

£150.90 × 40 days = £6,036

Net funding payable

£21,000 (gross funding)

less £6,036 (IOS income)

= Round this up to £15,000 per provider.

Key assumptions and scope:

This funding model assumes of one pharmacist delivering HB activity per day. We recognise that some providers may deploy more than one pharmacist on certain days; however, this is not expected to be sustained across the full period and the funding is therefore not uplifted beyond the agreed daily rate.

Funding is limited to an 8-week period only, despite the overall programme running for 12 weeks. This reflects the intention to prioritise completion of housebound activity early in the programme.

Summary this methodology:

- Covers administration and delivery costs
- Applies a consistent daily rate with on-costs
- Transparently offsets existing IOS income
- Focuses funding on early completion of HB activity
- Results in a net payment of £14,964 per provider for the 8-week period

We would welcome confirmation that ICBs are content with this methodology so that we can proceed at pace and I'm happy to work through where you may have some providers who require additional funding based on an increased workload.

Please also remember we can review this during the Spring season, and this agreement is only for the 26/27 Spring programme only at this time.

Greater Manchester (April 2026) Easter Primary Care - Urgent Emergency Care Assurance

MEETING:	GM Primary Care Commissioning Committee
TITLE OF REPORT:	Easter (2026) Primary Care UEC Assurance
DATE OF MEETING:	26 March 2026
AUTHOR/S:	Ben Squires
PRESENTED BY:	Ben Squires, Director of Primary Care
HAS THERE BEEN PUBLIC OR CLINICAL ENGAGEMENT?	Yes – Clinical engagement
HAS AN EQUALITY IMPACT ASSESSMENT BEEN COMPLETED?	No
HAVE THE ENVIRONMENTAL SUSTAINABILITY IMPACTS BEEN CONSIDERED AND ADDRESSED?	No
ENGAGEMENT CARRIED OUT TO DATE	Provider engagement
HAS FINANCIAL OR LEGAL ADVICE BEEN OBTAINED? (IF YES, PLEASE STATE THE NAME OF THE FINANCE OFFICER WHO HAS PROVIDED THIS SUPPORT)	N/A
ARE THERE ANY POTENTIAL CONFLICTS OF INTEREST ASSOCIATED WITH THIS PAPER? (IF YES, HOW WILL THEY BE MANAGED?)	N/A
PURPOSE OF PAPER Decision Requested: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> For Discussion: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> For Noting/Information: Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Financial Implication: Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

This paper relates to the following BAF risks:	
Workforce challenges including shortage in many roles across the the whole health & care sector & staff wellbeing & efficiency	<input type="checkbox"/>
Demand exceeds available capacity to deliver services in a timely and effective way	<input checked="" type="checkbox"/>
Failure to deliver Financial Balance both for NHS GM organisationally and as an ICS	<input checked="" type="checkbox"/>
Widening health inequalities due to a reduced focus on prevention for the GM population	<input type="checkbox"/>
Sustaining a strong market for community based services (including adult social care and primary care	<input type="checkbox"/>
An emergency could overwhelm NHs GM's ability to respond effectively	<input checked="" type="checkbox"/>
There is a risk failure to comply with our statutory duties for quality assurance in Quality and Patient Safety within the NHS GM system	<input checked="" type="checkbox"/>

EXECUTIVE SUMMARY INCLUDING KEY MESSAGES:

Confirmation of arrangements in place for primary care services over the Easter Bank Holiday period forms part of the NHS GM Assurance return to NHS England. These details pertaining to primary care are provided within this report to the Committee for information and assurance.

Addition details of opening hours for Community Pharmacies over the Bank Holiday period are also provided.

RECOMMENDATION

The GM PCCC is asked to:

- a. Note the arrangements in place for provision of primary care services over the Easter Bank Holiday period.

CONTACT OFFICERS:

Ben Squires, Director of Primary Care, NHS GM

1. BACKGROUND

NHS England routinely requests assurances from NHS Greater Manchester regarding capacity and planning to meet UEC demand.

As part of the assurance processes for the Easter Bank Holiday 2026, request has been made for a summary of each NW ICS' assessment of the plans in place across its footprint to manage the expected Urgent and Emergency Care (UEC) pressures over the Easter Bank Holiday period (including plans for both the week preceding and succeeding the Easter BH weekend – Monday 30 March to Sunday 12th April 2026).

Within this assurance are specific requirements in respect to provision of Primary Care services.

2. GM PRIMARY CARE ARRANGEMENTS FOR EASTER BANK HOLIDAY:

Attached to this paper are the following the following:

- i. NHS GM primary care response to risks and mitigations identified within NHS England assurance template providing heading into the Bank Holiday period.
- ii. Confirmation of primary care service opening and capacity over the Easter Bank Holiday period 2026, provided through the GM UEC team to form part of the ICB assurance return to NHS England.
- iii. Details of Community Pharmacy opening hours across GM during the period. These opening arrangements have been agreed with branches, based upon previous capacity requirements and considerations of service need. Other pharmacies may be open, but have not confirmed this to the NHS Greater Manchester team and are therefore not included in this list. These details are confirmed on the DOS and with 111, and all primary care contractors have been notified of these opening hours.

3. RECOMMENDATION

3.1. The Primary Care Commissioning Committee is asked to:

- b. Note the arrangements in place for provision of primary care services over the Easter Bank Holiday period.

North West Region

Easter Delivery Position

30 March – 12 April 2026

This Easter Bank Holiday assurance document is intended to provide a summary of each NW ICS' assessment of the plans in place across its footprint to manage the expected Urgent and Emergency Care (UEC) pressures over the Easter Bank Holiday period (including plans for both the week preceding and succeeding the Easter BH weekend – Monday 30 March to Sunday 12th April 2026)

The completed document should be returned to **england.nw-roc@nhs.net** by **1700 Monday 23rd March 2026**

Primary Care Provision (NHS Greater Manchester)

Please consider the questions below relating to primary care provision, heading into the bank holiday period and the mitigations you have or need to put in place

Risk Description		Response
1.	What admission avoidance services are in place and accessible (i.e. GPs, WICs/UTCs) over the bank holiday period and do any services have extended opening hours. If so, please identify?	<ul style="list-style-type: none"> Urgent Treatment Centres and Walk-In Centres ATT/+ (Alternative to Transport) / PAS (Patient Assessment Services) Community Pharmacy provision / Pharmacy First Urgent dental provision accessed via GM Dental Helpline (0333 332 3800 – also via 111) CUES (Community urgent eyecare services)
2.	What options are in place to support streaming/signposting away from the ED?	<ul style="list-style-type: none"> As above
3.	What Primary Care pressures/concerns are expected over the Easter bank holiday period? How will these pressures/concerns be managed/mitigated?	<p>Anticipating increased levels of demand prior to and following bank holiday weekend. Increased requests for medicines on Friday and Monday via OOH, as seen in previous years.</p> <p>Enhanced access hours will be redistributed in the 2 weeks following the bank holiday to offer more capacity.</p> <p>OOH provision increases capacity during this time.</p> <p>Urgent dental provision provided via OOH</p>
4.	Have PCN Enhanced Access hours (on routine working) days been agreed/confirmed?	Yes – all PCNs will ensure capacity is redistributed within 2 weeks
5.	If any changes to PCN Enhanced Access hours are required due to falling on a bank holiday, has the change and new dates for delivery been agreed in line with the Network Contract DES?	Yes
6.	Has the local primary care access commissioner assessed overall primary care capacity?	We have assessed overall access and there is provision in place for GP OOH, Dental and pharmacy.

Extended Primary Care (NHS Greater Manchester)

	NHS 111	DoS	GP OOH	
Confirmation is required that the following have been informed of opening arrangements for all general practice and community pharmacy services	Yes	Yes	Yes	
Can the ICB confirm there is reasonable access to community pharmacy services in all of the ICB footprint on the bank holidays?				Yes
<p>Has the ICS considered/commissioned other urgent primary care services provision to support over the Easter Bank Holiday period (e.g. urgent eye care services)?</p> <ul style="list-style-type: none"> • Supplementary Urgent Dental access capacity has been commissioned across GM over the Easter period, despite requirements for national additional appointments having been stood down. • Community Urgent Eyecare Services will be available over the Easter Bank Holiday weekend 				
<p>How has information about access and availability of primary care services over the Easter Bank Holiday period been communicated to patients across the ICS?</p> <ul style="list-style-type: none"> • GM GTKWTG – Get To Know Where To Go communications • Information on ICB website and additionally on partner websites, such as pharmacy opening hours available on CPGM website. 				