NHS
Greater Manchester

Agenda

NHS Greater Manchester Primary Care Commissioning Committee (Part 1)

Date: Monday 13th April 2026
Time: 3:00 pm – 5:00 pm
(Part 2 to commence after part 1)
Venue: Microsoft Teams
Join the meeting now
Meeting ID: 381 238 799 311
Passcode: xm6ac6R3

Item No.	Time	Duration	Subject	P / V	Presented by
1.	3:00	2 mins	Welcome, Introductions and Apologies	Verbal	Chair
2.			Declarations of Interest	Verbal	Chair
3.	3:02	3 mins	Minutes of Previous Meetings and Matters Arising ▪ Extraordinary PCCC Meeting (26.03.2026)	Paper	Chair
Corporate Reports					
4.	3:05	5 mins	Place Based PCCC Chair's Reports	Paper	Jonathan Kerry
Service and Contract Developments					
5.	3:10	10 mins	APMS Contract Review and Extension Proposal – Hope Citadel Practices HMR Locality	Paper	Jackie Woodall
6.	3:20	10 mins	Community Pharmacy Independent Prescriber (IP) Pathfinder Programme Evaluation	Paper	Alison Scowcroft
7.	3:30	5 mins	AOB		Chair

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Minutes
Greater Manchester Primary Care Commissioning Committee – (PART 1)

Date: 09th February 2026
Time: 3:00 pm to 4:00 pm

Venue: Microsoft Teams

Members		
Katherine Sheerin	KS	(Chair) Chief Officer for Commissioning - NHS GM
Manisha Kumar	MK	Chief Medical Officer - NHS GM
Sam Evans	SE	Corporate Director of Finance – Commissioning & Financial Assurance - NHS GM
Ben Squires	BS	Director of Primary Care - NHS GM
Jonathan Kerry	JK	Interim Deputy Place Lead, Wigan - NHS GM
Martin Ashton	MA	Deputy Director, Delivery - Bolton
Anita Rolfe	AR	Deputy Chief Nursing Office
In Attendance		
Don McGrath	DMc	Don McGrath, GM Dental Provider Board Chair
Stuart Allan	S Allan	Chair, Greater Manchester Federation of LDCs
Janna Rigby	JR	Assistant Director Primary Care Operations - NHS GM
Julia Maiden	JM	Optometry Provider Board and Chair of Wigan LOC
Caroline Bradley	CB	Associate Director of Primary Care (Manchester)
Salimata Jarra	SJ	(Minutes) Primary Care Admin Support – NHS GM
Jim Rochford	JiR	Senior Primary Care Programme Manager – Dental
Chris Nortcliff	CN	Chief Clinical Information Officer & GP Digital Lead Greater Manchester Primary Care Provider Board Delivery Team
Alison Scowcroft	AS	Community Pharmacy Integration and Commissioning Portfolio Lead - NHS GM
Steph Fernley	SF	Assistant Director - GM Primary Care Development
Gail Henshaw	GH	Senior Primary Care Programme Manager - NHS GM
Luvjit Kandula	LK	Chair - Community Pharmacy Provider Board & Primary Care Board
Barry McCann	BMc	Strategic medicines optimisation pharmacist Community pharmacy integration and commissioning - NHS GM
Saquib Ahmed	SA	Senior Medicines Optimisation Pharmacist Community Pharmacy Integration and Commissioning Medical Directorate - NHS GM
Jim Ritchie	JiRi	Chief Clinical Information Officer - NHS GM
Apologies		
Jane Brooks		Assistant Director of Finance (Direct Commissioning) - NHSGM
Amy Ashton		Head of s7a Public Health Commissioning and Operations (Screening and Immunisations)
Will Blandamer		Deputy Place Lead - NHS GM (Bury)

Item No.	Topic	Action
1.	**Welcome, Introduction and Apologies:** Katherine Sheerin (KS) welcomed attendees and apologies were noted	
2.	**Declarations of Interest:** None	
3.	**Minutes of Previous Meetings** • Minutes of 8th December Committee meeting approved **Action Log** **GP Out of Hours Review - BS & SE updated:** • GM-wide strategic review initiated - kick off meeting held • 10 existing OOH contracts vary significantly - mapping underway (services, funding routes, visiting models, alternatives to conveyance) • Contracts requiring extension will progress through a single GM STAR form, to streamline governance • Strategic scope expanding to include non-GP urgent primary care (dental helpline, optometry urgent services) • **KS** - requested for the full scope document once available • Funding governance to be clarified once funding sources mapped **Primary - Secondary Interface Work - JiRi** • Workplan updated and aligning with: o Bridging the Gap work o National contractual shifts o Red Tape Challenge • **JiRi** will share through interface governance and return to PCCC in April 2026	PDF 2. GM Primary Care Commissioning Comr
4.	**Place Based Primary Care Commissioning Committee Chair's Reports – presented by Jonathan Kerry (JK)** **Key issues:** • Quoracy challenges across several localities • Continued work on: o Local Commissioned Services o Online consultation o Quality schemes o BeCCoR 26/27 development • Need to finalise what sits where between GM and Place - committee to receive full update next meeting in April 2026 **Risk Reporting** • Several localities missing mitigations or risks entirely • Concerns raised especially for: o HMR and Oldham (no risks submitted) o Tameside (mitigations not fully articulated) • Agreement to strengthen consistency Action: Localities to update risk mitigations - **JR** and **CB** to support	PDF 3. Place Based PCCC Chair Highlight Repor

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	BeCCoR 26/27 and Locality Issues Tameside LCS Paper • Engagement underway - Tameside final locality to be met • Commissioning paper for BeCCoR will come to PCCC in extraordinary March meeting • Risk in Bury LCS expected to be resolved through BeCCoR redesign	
5.	**Primary Care Digital Strategy – Presented by Chris Nortcliff (CN) & Jim Ritchie (JiRi)** **Overview** • A 10-year GM-wide Primary Care Digital Strategy covering: o All primary care disciplines (GP, pharmacy, optometry, dentistry) o Integrated digital architecture • Aims to support strategic investment, avoid siloed purchases, and build an innovation-ready system **Feedback from Committee** **Key concerns:** • Deliverability and investment requirements unclear • Governance pathway for digital approval still ambiguous • Align with What Good Looks Like national framework • Include baseline GM digital spend • Strategy arrived same day - request for review time **Outcome** • Committee supports strategy in principle • **CN** to incorporate feedback and share revised version by email • **MK** to support route to ICB Board	4. PCCC Committee Report_GM_Primary_(
6.	**NHSE S7A Screening & Immunisations – 2026/27 Commissioning Programme Changes (for information only)** • **JM** highlighted that Children's Vision Screening was missing from the documentation and queried where this sits within the screening element **Action: MK** to confirm with **Amy Ashton** where Children's Vision Screening is positioned within the overall screening programme and report back to committee	5. PRN02205 -Section 7A public hea
7.	**Standardisation of Palliative Care (and other community pharmacy services) – Presented by Alison Scowcroft (AS) and Saquib Ahmed (SA)** **Proposal** • Standardise all pharmacy LCS/LES across GM • Move funding to single GM budget line • Commission once at GM level with: o Single service spec o Standard fees o Reduction in unwarranted variation o Improved equity and access **Feedback from Committee** • Strong support from committee • Need clarity on: o Transitional costs o Engagement with Deputy Place Leads o Local discretionary funding impacts	6. PCCC Committee GM CP LES-LCS 0302

	Decision **Approved - subject to:** • Further engagement with localities • Detailed financial modelling • Clear transitional plan Action: **AS, SA and Finance team** to refine finances and re-engage places	
7.	**Capacity Access and Improvement Payments (CAIP) 2025/26 and approach to Post Payment Verification (PPV) – Presented by Steph Fernley (SF)** **Proposal** • PPV sampling: 1 PCN per locality (15% sample) • Desktop review and DCCP for evidence assurance • Outcomes to return to PCCC in June **Risks Discussed** • System One search failures (particularly Wigan & Bolton) • Capacity constraints during April - June • Online consultation procurement impact • Data limitations in GM Intelligence Hub • Need for system-wide prioritisation due to reduced workforce capacity **Decisions** • PPV process approved • DMOG to produce system-wide commissioning priorities for Q1 26/27 **Actions:** • **SF** to run PPV process as proposed • DMOG to develop prioritisation paper - return to PCCC	7. 2026_02_09 GM PCCC CAIP 25_26 PPV

8.	**NHS Greater Manchester Protected Learning Time (PLT) Policy & Process – Presented by Gail Henshaw (GH)**
	
	• The committee reviewed the proposal for a GM-wide PLT policy to ensure consistency and equity across localities, aiming for implementation from 1st April 2026
	• Significant variation in funding across GM was highlighted as the major barrier to implementation
	  o Some localities fund PLT - others (e.g., Wigan) do not
	  o Committee agreed this must be resolved before a GM-wide approach can be enacted
	• Concerns were raised about the impact on capacity and appointment loss, with modelling showing potentially large reductions in available appointments if monthly 5-hour PLT is applied uniformly
	• Committee agreed PLT is valuable, but unnecessary bureaucracy must be avoided given future reduced ICB capacity
	• Consensus that PLT should not be centrally funded, except where part of a mandatory BeCCoR QI session
	• Need to consider wider primary care disciplines and ensure equitable access to learning opportunities for all practices
		8. 251209 NHS GM Commissioning Policy
		
		8a. NHS Greater Manchester policy and

	• Operational considerations identified, including ensuring safe management of online consultations during PLT • Committee supported the principles, but further work is required before agreeing the operational model **Actions** 1. Undertake detailed financial modelling, including appointment/capacity impacts and options to address funding inequity across localities Owner: GH 2. Refine PLT proposals with the DEMOG working group, drawing on colleagues with historical knowledge Owner: GH and DEMOG colleagues 3. Develop a phased implementation plan to support transition from locality variation to a standard GM model Owner: GH 4. Return a revised proposal to PCCC with options and recommendations Owner: Gail	
9.	**National Dental Contract Reforms - Presented by Janna Rigby (JR)** • National guidance expected late February / early March for April 1st start • Significant changes to: o Provider activity o Patient-facing models o ICB commissioning responsibilities • Potentially large financial pressures for GM • Some discretionary schemes may become unviable • Risk of reduced access - may create a new dental access crisis • Risk to ICB planning requirements: o Urgent dental care o Child & adult access **Feedback from Committee** • Finance modelling underway • Concern national model will override or undermine successful GM schemes • Need early comms if disinvestment required • Proposal to hold: o 1-hour BeCCoR o 1-hour Dental Contract deep dive in March extraordinary PCCC meeting **Decisions** • Committee noted significant risk • Work to continue with Dental Finance and GM Dental team • Include risk on ICB Risk Register	PDF 9. National Dental Contract Reforms ove

	Action: • **JR** and Dental Finance to bring detailed modelling to March extraordinary PCCC meeting	
10.	**AOB** None	
	Next Meeting Date and Time: **Monday 13th April from 3pm – 5pm (Via MS Teams)** **Monday 8th June from 3pm – 5pm (Via MS Teams)**	

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Minutes
Extraordinary Primary Care Commissioning Committee – (PART 1)

Date: 26th March 2026
Time: 12:00 pm to 1:30 pm

Venue: Microsoft Teams

Voting Members (Part 1 & 2)		
Katherine Sheerin	KS	(Chair) Chief Officer for Commissioning - NHS GM
Manisha Kumar	MK	Chief Medical Officer - NHS GM
Sam Evans	SE	Corporate Director of Finance – Commissioning & Financial Assurance - NHS GM
Ben Squires	BS	Director of Primary Care - NHS GM
Jonathan Kerry	JK	Interim Deputy Place Lead, Wigan - NHS GM
Amy Ashton	AA	Head of s7a Public Health Commissioning and Operations (Screening and Immunisations)
Anita Rolfe	AR	Deputy Chief Nursing Office
Non-Voting Members / Provider Representatives (Part 1 only)		
Luvjit Kandula	LK	Primary Care Provider Representative (Community Pharmacy), GM Community Pharmacy Provider Board Chair
Mohammed Bhuta	MB	Attending on behalf of Dharmesh Patel - Primary Care Provider Representative (Optometry), GM Optometry Provider Board Chair
Viren Mehta	VM	Attending on behalf of Tracy Vell - Primary Care Provider Representative (General Practice), GM Primary Care Provider Board Chief Officer
Don McGrath	DMc	Don McGrath, GM Dental Provider Board Chair
Jim Rochford	JiR	Member of Primary Care Provider Board & Dental Provider Board
Stuart Allan	S Allan	Chair, Greater Manchester Federation of LDCs
In attendance		
Janna Rigby	JR	Assistant Director Primary Care Operations - NHS GM
Caroline Bradley	CB	Associate Director of Primary Care (Manchester) NHS GM
Claire Lake	CL	Deputy Chief Medical Officer, NHS GM
Lindsey Bowes	LB	Senior Primary Care Programme Manager – (Dental) GM
Salimata Jarra	SJ	(Minutes) Primary Care Admin Support – NHS GM
Alison Scowcroft	AS	Community Pharmacy Integration and Commissioning Portfolio Lead - NHS GM
Steph Fernley	SF	Assistant Director - GM Primary Care Development
Gail Henshaw	GH	Senior Primary Care Programme Manager - NHS GM
Alistair Rutherford	AR	Senior Programme Manager - NHS GM
Apologies		
Martin Ashton		Deputy Director, Delivery - Bolton
Will Blandamer		Deputy Place Lead - NHS GM (Bury)

Item No.	Topic	Action
1.	**Welcome, Introduction and Apologies:** Katherine Sheerin (KS) welcomed attendees and apologies were noted	
2.	**Declarations of Interest:** **Manisha Kumar** - declared a potential conflict of interest relating to the procurement for sight testing in special education settings, due to her husband's role. **Viren Mehta** - declared an interest in Item 5 – BeCCoR paper, due to his status as a GP Partner. **Claire Lake** - declared an interest in Item 5 – BeCCoR as a GP Partner & presenter	
3.	**Virtual Decisions** **a. PMS Contract Decision (Shay Lane Medical Practice)** • The Committee did not approve the requested variation to the PMS contract • As PMS variations require mutual agreement, the request could not proceed Agreed Next Steps / Mitigation: • The ICB will offer a review with the practice to explore alternative support options going forward Status: Decision noted by Committee **Actions:** • ICB to engage with Shay Lane Medical Practice to undertake a review and explore support options **b. Sight Testing in Special Education Settings - Procurement Progress** • The Committee approved the procurement strategy for GOS sight testing in special education settings Key Points: • The procurement addresses a vulnerable patient cohort • The process is live and progressing Status: Decision noted by Committee **Actions:** • Officers to progress procurement and bring future updates back to Committee	
4.	**Dental Contract Reforms 26/27 and relative impacts: Presented by Janna Rigby (JR) & Jane Brooks (JB)** **Key Issues Discussed:** • National dental contract reforms effective 1 April 2026, including: o Mandated urgent care provision (minimum 8.2% contract value)	 4. National Dental Contract Reforms ove

	o Introduction of complex care pathways (from Quarter 2) • Estimated £2m financial risk to the GM dental envelope for 2026/27 (subject to DDRB funding clarity) • Proposed end of the Patient Access Quality Scheme (PAQS) at 31 March 2026 raised significant concern from providers • Strong feedback that ending PAQS in Quarter 1 risks: o Destabilising access o Reversing gains in routine and preventative care o Knock-on pressure to GP and A&E services Committee Position: • The Committee did not reach a final decision on PAQS at this meeting • Strong consensus that further work and dialogue is required urgently Outcome: Decision deferred **Actions:** • Officers to: o Hold urgent discussions with dental colleagues outside Committee o Re-examine financial assumptions and transitional risks o Bring an updated, revised proposal back to Committee within days • No immediate change to PAQS pending further consideration	
5.	**BeCCoR 2026/27 Scheme: Presented by Ben Squires (BS) & Claire Lake (CL)** **Summary:** • Committee considered the GM-wide BeCCoR scheme for general practice for 2026/27 • Scheme developed over 18 months with extensive engagement • Represents: o Greater GM-wide consistency o A phased 20% increase in GP investment over two years o Clear KPIs, ROI, and evaluation framework • Practice-level modelling undertaken to identify impact and mitigation needs **Key Themes Raised:** • Tension between GM consistency vs locality flexibility • Capacity of place teams to support delivery • Risk of duplication with neighbourhood, elective, and future provider models • Need to protect practice development and learning time • Strong recognition of BeCCoR as a success story, with request for adaptive implementation **Decision:** Committee approved the BeCCoR 2026/27 scheme specification, with pragmatic implementation approach Conditions / Assurances: • Financial sign-off to follow through ICB governance • Implementation to proceed while approvals complete (as per previous year) • Active monitoring and agility agreed	 5. BECCOR 2026-27 - Cover Sheet.pdf  5a. BeCCoR 2026-27 Full Scheme Documer  5b. BeCCoR GP Quality & Resilience S

	Actions: • Officers to: o Incorporate any minor re-wording (notably neighbourhood framing) if provided swiftly o Finalise communications to practices o Deliver launch webinars (early April and later in April) o Monitor delivery and escalate material issues back to PCCC	
6.	**Community Pharmacy Independent Prescriber (IP) Pathfinder Programme Extension Proposal: Presented by Alison Scowcroft (AS)** **Summary:** • National IP Pathfinder funding ended 31 Dec but extended to 31 March via slippage • Further slippage available, but insufficient to continue all 10 sites • NW Region confirmed unused slippage would be clawed back if not utilised • Proposal to extend 2 - 3 high-performing sites for 6 - 9 months as a bridging arrangement **Decision:** Committee supported the proposal in principle **Key Conditions:** • Site selection criteria must be clear, transparent and defensible, including: o Quality o ROI o Throughput o Consideration of equity and GM coverage • Alignment required between this paper and the STAR panel paper **Actions:** • Officers to: o Align Pathfinder and STAR paperwork o Finalise site selection rationale o Progress extension via STAR governance o Use learning to inform future pharmacy commissioning	PDF 6. PCCC Committee CP IPPPP extension pr
7.	**Covid-19 delivery gaps – spring 26: Presented by Amy Ashton (AA) & Alistair Rutherford (AR)** **Summary:** • Shift from PCN-led to practice-level opt-in for Spring COVID delivery • Resulted in 126 sites not covered • All alternatives explored - community pharmacy identified as only viable route under current rules • Proposal to commission four community pharmacy providers, funded via NHSE Access & Inequalities funding **Decision:** Committee approved the proposed approach	PDF 7. Spring Covid19-S7a AI funding to miti

	Key Assurances: • This is a time-limited, pragmatic solution • Does not set a default model for future campaigns • Commitment to reset delivery planning for Autumn/Winter **Actions:** o Implement Spring 2026 arrangements immediately o Monitor uptake and equity o Review delivery models (including GP/federation options) for future campaigns o Engage Primary Care Provider Board ahead of Winter planning	
8.	**Easter PC UEC Assurance (For Information): Presented by Ben Squires (BS)** **Summary:** • Committee noted the UEC assurance submission to NHS England • Covers: o Primary care access arrangements o Community pharmacy opening o Easter bank holiday coverage	PDF 8a. Easter Assurance Return 2026 (NHS GM PDF 8. Easter (2026) Primary Care UEC Ass 8c. GM Pharmacy Opening Hours Easter 8b. GM PC Hours Assurance Return Eas
9.	**AOB** No additional items raised	

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Locality Primary Care Commissioning Committee Highlight Reports February / March 2026 Meetings

Part of Greater Manchester Integrated Care Partnership

Presented by: Jonathan Kerry,

Interim Deputy Place Lead (Wigan)
Date: 13th April 2026

All Localities Primary Care Commissioning Committee (PCCC) Highlight Report – February / March 2026

This report updates / informs the NHS Greater Manchester PCCC on key themes, actions and risks from all localities. Individual locality reports included within appendices.

Key Themes:

- The system communicated to primary medical providers to sign up to the COVID vaccination service for Spring.
- The Quality Contract for 2026/27 is being developed at GM / Primary Care Quality Updates
- 25-26 Winter Access Schemes
- Practices are registered on the LFPSE system and upload any relevant incidents where system learning could be identified.
- OOH Contracting – Monthly reporting received for information only.
- BeCCoR 26/27
- GM Policy Practice Learning Times – The committee received and supported the policy
- Enhanced Access
- Primary Care Finance Updates
- Primary Care Risks

Priority actions in next 2 months:

- GM winter planning
- Linking in with GM Vaccs Team to ensure provision of the Covid and Flu vaccinations for all eligible patients.
- To ensure all GP Practices are compliant with any contract changes as a result of MGPA.
- Locality colleagues continue to work with GM primary care colleagues to clarify BeCCoR asks for 26/27.
- PCNs - Ongoing work to improve Enhanced Access utilisation and ensure maximum ARRS spend
- Continue to support and maximise achievement of the Manchester Locality PQRRS and NHS GM BeCCoR Quality Scheme across General Practice in Manchester for 2025/26

Top Risks:

Locality	Risk Identified	Mitigating Actions	Likelihood	Impact	Score
Bury ICB	IF: the apportionment of delegated PC monies is insufficient to cover local elements unique to Bury (such as dementia, ring pessaries, bloods etc) THEN: services may need to be stopped limiting what gps support/deliver LEADING TO: Wider provider pathway pressures which cost more & may lead to poorer outcomes for patients	1. Ongoing discussions via phase 3 BeCCoR to secure equitable/sufficient funding from 26/27 onwards 2. System partners fully aware of position and risks associated	4	4	16
Manchester ICB	**Hawthorn Medical Centre** - risk to business continuity associated with the potential closure of Hawthorn Medical Centre and co-located Walk in Centre due to lease break clause being exercised by landlord. Although an extension has been agreed by the landlord, build difficulties are being experienced that could take the build period over the agreed lease extension deadline that has been agreed.	Programme Team progressing permanent build for July/August 26 completion. The landlord has offered a lease extension to 31 Aug 26, with an additional 8 week commissioning period to enable safe transition of the service to new premises. Build was expected to be completed on 31 Aug 26. Deadlines remain very tight / no margin for delay across the programme. Planning application is in progress. Recent updates indicate that build difficulties are being experienced, with an expected delay that runs beyond the extended lease agreement, this means that the programme team is exploring interim estates options to ensure business continuity.	**4**	**4**	**16**
Manchester ICB	**Limited resource within the Primary Care Team -** due to organisational restructure & requirement for efficiency running cost savings. The team has lost staff that have not been replaced, has been holding vacancies, has had several members of staff on long term sickness (currently being phased back into work) & have staff on fixed term contracts. Morale & productivity in the team is being adversely impacted because of the NHS reform, expected ICB running cost savings and increasing workload. This is affecting the locality PC teams ability to deliver against its significant work programmes. As additional work continues to come into the primary care team this means a constant re-prioritisation of work programmes & engagement / negotiation with the PC team & with wider teams. Risk of further pressure through asks for mutual aid where localities / NHS GM has lost resource.	Regular meetings across the PC team to discuss the primary care programme plan with a constant re-prioritisation of work to match available resource and knowledge / expertise. This includes identifying work that can be deferred / stopped. The team / locality is engaged with transition planning & NHS GM business continuity work including development of RACI matrices to support future working arrangements aligned to the operating model. High level discussions continue with NHS GM primary care colleagues to explore economies of scale / mutual aid / peer support across localities – although due to resource implications across other NHS GM localities, the benefits of this are currently limited. HR processes are being followed where staff are on sickness absence. NHS GM Health & Wellbeing resources are being shared regularly; together with all information on managing change, exploring opportunities. Staff are being advised to engage with the offers and with trade union resources / meetings as applicable. The locality has set up a staff engagement group to provide peer to peer support and a space for locality staff to discuss the reform and wider issues.	**4**	**4**	**16**
Manchester ICB	**Lack of resource to deliver a proportionate infrastructure / estates response to population growth -** This includes team resource & capital funding to support the increasing Manchester population requirement. The increasing population & planned future housing developments across the Locality mean that additional Primary Care services & workforce are required. These will need estates to enable delivery. The current Manchester estate does not offer enough space to support future delivery therefore, funding is required to develop, build, refurbish & reconfigure to deliver the estate the population needs.	Discussions are on-going with Manchester system partners via SEG and with NHS GM colleagues to identify resource (financial and physical) to support the delivery of an effective Health infrastructure plan for Manchester.	**4**	**4**	**16**

All Localities Primary Care Commissioning Committee (PCCC) Highlight Report – February / March 2026

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Key Themes:

- The system communicated to primary medical providers to sign up to the COVID vaccination service for Spring.
- The Quality Contract for 2026/27 is being developed at GM / Primary Care Quality Updates
- 25-26 Winter Access Schemes
- Practices are registered on the LFPSE system and upload any relevant incidents where system learning could be identified.
- OOH Contracting – Monthly reporting received for information only.
- BeCCoR 26/27
- GM Policy Practice Learning Times – The committee received and supported the policy
- Enhanced Access
- Primary Care Finance Updates
- Primary Care Risks

Priority actions in next 2 months:

- GM winter planning
- Linking in with GM Vaccs Team to ensure provision of the Covid and Flu vaccinations for all eligible patients.
- To ensure all GP Practices are compliant with any contract changes as a result of MGPA.
- Locality colleagues continue to work with GM primary care colleagues to clarify BeCCoR asks for 26/27.
- PCNs - Ongoing work to improve Enhanced Access utilisation and ensure maximum ARRS spend
- Continue to support and maximise achievement of the Manchester Locality PQRRS and NHS GM BeCCoR Quality Scheme across General Practice in Manchester for 2025/26

Key escalations for NHS Greater Manchester PCCC:

Locality	Escalation
Bury ICB	The funding currently earmarked to be retained/pillar 1 services is insufficient to continue with all transactional requirements of the Bury LCS. This has been flagged with various colleagues within the central teams
Manchester ICB	The impact of the NHS Reform programme, and the on-going uncertainty, on staff health and wellbeing, morale and overall productivity against a backdrop of increasing workload and expectation.

All Localities Primary Care Commissioning Committee (PCCC) Highlight Report – February / March 2026

This report updates / informs the NHS Greater Manchester PCCC on key decisions from all localities. Individual locality reports included within appendices.

Locality	Decision Detail	Meeting Period
Bolton ICB	• Bolton PCCC Stood down	
Bury ICB	• APMS Contracts - The committee supported the recommendation to award both APMS providers with a 12 mth contract rather than undertake a procurement exercise given the changes currently taking place due to the reforms • Enhanced Access (part b) – The committee supported the recommendation to change the delivery models as proposed for Horizon, Prestwich and Whitefield.	March 2026
HMR ICB	• Meeting only took place on the 27th March – awaiting Final Sign Off	
Manchester ICB	• Brooklands Medical Practice Contract Novation - approved • Barlow Medical Centre boundary extension - approved • NHS GM BeCCoR and Manchester PQRRS - revised local services / locally retained indicators (previously known as PQRRS) agreed for 2026/27 – to be incorporated into the overarching NHS GM BeCCoR scheme	Feb / March 2026
Oldham ICB	• Oldham PCCC Stood down	
Salford ICB	• Salford PCCC meeting has been stood down	
Stockport ICB	• APPROVED a 1-year direct award for Go To Doc to deliver the Stockport Special Allocation Scheme	January 2026
Tameside ICB	• Tameside PCCC meeting has been stood down	
Trafford ICB	• None	March 2026
Wigan ICB	• Approval of the updated Primary Care Risk Register	March 2026

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Appendices – Locality Highlight Reports

Bury Primary Care Commissioning Committee (PCCC) Highlight Report

Chair: Will Blandamer
Reporting period: March 2026
Attendance: ~~Excellent / Acceptable /~~ Unacceptable

This report updates / informs the NHS Greater Manchester PCCC on the Bury PCCC work to date. It also provides an opportunity to raise any issues and inform of any changes that may affect the progression of work.

Part A

OOH Contracting – Monthly reporting received for information only.

Primary Care Programme – A high-level overview of progress against the GP Strategy programmes was presented to the committee. The highlight report contained several performance indicators being used to monitor delivery against the programme.

BeCCoR 26/27 (including retained/pillar 1 Bury Specification) – The committee received the draft specification which has been submitted to GM PCCC for approval. The committee recognised the 26/27 scheme as a real opportunity to standardise and care and investment across GM however concerns remain regarding confirmation of funding for retained and pillar 1 services.

APMS Contracts - The committee received and supported the recommendation to award both APMS providers with a 12 mth contract rather than undertake a procurement exercise given the changes currently taking place due to the reforms

GM Policy Practice Learning Times – The committee received and supported the policy

The committee has been stood down in line with new operating model however priorities for the forth coming period include:

BeCCoR 26/27 – Launch

Bury General Practice Strategy – a review and refresh in line with the new 10year plan

PCNs - Ongoing work to improve Enhanced Access utilisation and ensure maximum ARRS spend

MOT – Continue to roll out patient led ordering in addition to supporting CIP delivery

Decisions made: (this committee was not quorate and therefore several papers will be submitted to GM PCCC for ratification)

- **APMS Contracts** - The committee supported the recommendation to award both APMS providers with a 12 mth contract rather than undertake a procurement exercise given the changes currently taking place due to the reforms
- **Enhanced Access (part b)** – The committee supported the recommendation to change the delivery models as proposed for Horizon, Prestwich and Whitefield.

Top 3 Risks:

Risk Identified	Mitigating Actions	Likelihood	Impact	Score
IF: the apportionment of delegated PC monies is insufficient to cover local elements unique to Bury (such as dementia, ring pessaries, bloods etc) THEN: services may need to be stopped limiting what gps support/deliver LEADING TO: Wider provider pathway pressures which cost more & may lead to poorer outcomes for patients	1. Ongoing discussions via phase 3 BeCCoR to secure equitable/sufficient funding from 26/27 onwards 2. System partners fully aware of position and risks associated	4	4	16
IF: The locality does not have a clear roadmap for increasing community self-referral pathways as per NHS England's Delivery plan for recovering access to primary care THEN: practices ability to triage and deflect/direct appropriately to other more appropriate services will be limited 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.	1. Repeated attempts have been made to engage with the Community Services Provider 2. Follow up workshop to be arranged	4	3	12

Any other information:

Key escalations for NHS Greater Manchester PCCC: The funding currently earmarked to be retained/pillar 1 services is insufficient to continue with all transactional requirements of the Bury LCS. This has been flagged with various colleagues within the central teams

Manchester Primary Care Commissioning Committee (PCCC) Highlight Report

Chair: Tom Hinchcliffe Reporting period: Feb / Mar 26 Attendance: ~~Excellent~~ / Acceptable / ~~Unacceptable~~

This report informs NHS GM PCCC on the Manchester PCCC work to date.

Key updates:

Brooklands Medical Practice Contract Novation – Formal request from the practice to novate the GMS contract to a limited company. Paper provided the relevant background info, engagement to date and current position.

Barlow Medical Centre – proposed boundary change – request from the practice to extend their current boundary. Paper outlined the rationale, engagement with patients/ practices/ PCNs and next steps

NHS Greater Manchester BeCCoR and Manchester PQRRS update – Overview of the NHS GM BeCCoR scheme 2026/27 and a request for Manchester PCCC to ratify the local services / locally retained elements for 2026/27 (for inclusion within the overarching NHS GM BeCCoR scheme for 2026/27.

Manchester PQRRS Quarterly Assurance (Quarter 3) – Summary of Q3 assurance questions to General Practice and the responses. Responses shared with relevant locality / system colleagues for info and action.

Primary Care Quality – updates provided on the Manchester Locality MDT process, CQC liaison and the 2025/26 Quality Scheme for General Practice

Finance Report – Month 11 overview provided

Primary Care Risks – presented to the PCCC for information, awareness and discussion re: impact and mitigating action

Priority actions in coming period:

- Liaison with Brooklands MP re: outcome of Manchester PCCC and next steps
- Engagement with Barlow Medical Centre re: outcome of Manchester PCCC and next steps
- Work with NHS GM colleagues to finalise the NHS GM BeCCoR scheme 2026/27, and associated resources, for implementation from 1 April 2026. This includes the revised Manchester locally retained elements and local services that were ratified at March Manchester PCCC.
- Continue to support and maximise achievement of the Manchester Locality PQRRS and NHS GM BeCCoR Quality Scheme across General Practice in Manchester for 2025/26

Decisions made:

Brooklands Medical Practice Contract Novation - approved

Barlow Medical Centre boundary extension - approved

NHS GM BeCCoR and Manchester PQRRS - revised local services / locally retained indicators (previously known as PQRRS) agreed for 2026/27 – to be incorporated into the overarching NHS GM BeCCoR scheme

Top 3 risks

Risk Identified	Mitigating Actions	Likelihood	Impact	Score
Hawthorn Medical Centre - risk to business continuity associated with the potential closure of Hawthorn Medical Centre and co-located Walk in Centre due to lease break clause being exercised by landlord. Although an extension has been agreed by the landlord, build difficulties are being experienced that could take the build period over the agreed lease extension deadline that has been agreed.	Programme Team progressing permanent build for July/August 26 completion. The landlord has offered a lease extension to 31 Aug 26, with an additional 8 week commissioning period to enable safe transition of the service to new premises. Build was expected to be completed on 31 Aug 26. Deadlines remain very tight / no margin for delay across the programme. Planning application is in progress. Recent updates indicate that build difficulties are being experienced, with an expected delay that runs beyond the extended lease agreement, this means that the programme team is exploring interim estates options to ensure business continuity.	4	4	16
Limited resource within the Primary Care Team - due to organisational restructure & requirement for efficiency running cost savings. The team has lost staff that have not been replaced, has been holding vacancies, has had several members of staff on long term sickness (currently being phased back into work) & have staff on fixed term contracts. Morale & productivity in the team is being adversely impacted because of the NHS reform, expected ICB running cost savings and increasing workload. This is affecting the locality PC teams ability to deliver against its significant work programmes. As additional work continues to come into the primary care team this means a constant re-prioritisation of work programmes & engagement / negotiation with the PC team & with wider teams. Risk of further pressure through asks for mutual aid where localities / NHS GM has lost resource.	Regular meetings across the primary care team to discuss the primary care programme plan with a constant re-prioritisation of work to match available resource and knowledge / expertise. This includes identifying work that can be deferred / stopped. The team / locality is engaged with transition planning and NHS GM business continuity work including development of RACI matrices to support future working arrangements aligned to the operating model. High level discussions continue with NHS GM primary care colleagues to explore economies of scale / mutual aid / peer support across localities – although due to resource implications across other NHS GM localities, the benefits of this are currently limited. HR processes are being followed where staff are on sickness absence. NHS GM Health and Wellbeing resources are being shared regularly; together with all information on managing change, exploring opportunities. Staff are being advised to engage with the offers and with trade union resources / meetings as applicable. The locality has set up a staff engagement group to provide peer to peer support and a space for locality staff to discuss the reform and wider issues.	4	4	16
Lack of resource to deliver a proportionate infrastructure / estates response to population growth - This includes team resource & capital funding to support the increasing Manchester population requirement. The increasing population & planned future housing developments across the Locality mean that additional Primary Care services & workforce are required. These will need estates to enable delivery. The current Manchester estate does not offer enough space to support future delivery therefore, funding is required to develop, build, refurbish & reconfigure to deliver the estate the population needs.	Discussions are on-going with Manchester system partners via SEG and with NHS GM colleagues to identify resource (financial and physical) to support the delivery of an effective Health infrastructure plan for Manchester.	4	4	16

Any other information: None

Key escalations for NHS Greater Manchester PCCC:
The impact of the NHS Reform programme, and the on-going uncertainty, on staff health and wellbeing, morale and overall productivity against a backdrop of increasing workload and expectation.

Stockport Primary Care Commissioning Committee (PCCC) Highlight Report

Chair: David Dolman (Associate Director of Finance, GM ICS (Member) (Acting Chair)
Reporting period: Jan 2026
Attendance: ~~Excellent~~ / Acceptable / ~~Unacceptable~~

This report updates / informs the NHS Greater Manchester PCCC on the Stockport PCCC work to date. It also provides an opportunity to raise any issues and inform of any changes that may affect the progression of work.

Key updates:

Approval was requested for a 1-year contract for Go To Doc Health to deliver the Special Allocation Scheme for 2026/2027

An update was provided on discussions held at NHS Greater Manchester Primary Care Commissioning Committee including:

- Terms of reference (Oldham PCCC)
- Primary care risk register

An overview of the proposals for the 2026/2027 Beyond Core Contract (BeCCoR) with relevant draft papers shared with the group, highlighting the focus areas proposed and required governance to secure final sign off

An update was provided on primary care estates with 3 key areas highlighted:

- Primary care utilisation and modernisation funding – 3 schemes approved for 2025/2026 all nearing completion. It was noted that contact has been made with practices requesting proposals for 2026/2027 with 4 responses received to date from practices interested in applying for funding
- Working with planning council colleagues to ensure within local plan that developers are required to contribute to health infrastructure
- 8000 dwellings due to be developed in town centre – business case to be drafted for town centre health hub

The Primary Care Commissioning Committee NOTED the Delegated Commissioning Finance Update for the period ending 31st December 2025 (Month 9).

Priority actions in coming period:

- Determine requirements for a place based Primary Care Commissioning Committee due to NHS reforms and a change of operating model
- Continue to monitor contractual compliance for all Stockport practices

Decisions made:

APPROVED a 1-year direct award for Go To Doc to deliver the Stockport Special Allocation Scheme

Top 3 Risks:

Risk Identified	Mitigating Actions	Likelihood	Impact	Score

Any other information: None

Key escalations for NHS Greater Manchester PCCC: None

Trafford Primary Care Commissioning Committee (PCCC) Highlight Report

Chair: N/A
Reporting period: Feb/March 2026
Attendance: Excellent / Acceptable / Unacceptable - Trafford PCCC cancelled, updates from Operational Group and SLT members.

This report updates / informs the NHS Greater Manchester PCCC on the Trafford PCCC work to date. It also provides an opportunity to raise any issues and inform of any changes that may affect the progression of work.

Key updates: General Practice Update

- The system communicated to primary medical providers to sign up to the COVID vaccination service for the coming Spring, which will be a practice level service as opposed to PCN.
- A GP practice has been commissioned to provide primary medical services to the residents of Trafford Waters.
- The Quality Contract for 2026/27 is being developed at GM. Trafford hopes to retain the 25-26 HIU & SMI schemes, should this be approved by GM.
- All 26 GP practices in Trafford have confirmed their intention to continue contracting arrangements with PCIT in 26-27, either on a PCN or practice footprint.
- Trafford GP Learning Events have commenced, with the first face to face one being held on 12 March 2026.
- ICB VR process has resulted in 3 members of the Primary Care Team leaving the organisation this is having significant impact on the teams capacity
- 25-26 winter access schemes are in progress and utilisation is positive we will be providing a summary and analysis post Q4.
- Intention to extend SMOC for another two years with STAR application submission.
- Intention to extend TPAS for a further year.

General Practice Quality Update

- Trafford currently working in re-active way to support any quality issues due to capacity in the PC team. Weekly MDT's in place to discuss issues and resolve as they arise. Pro-active quality monitoring on hold until NHS reform arrangements are in place.
- Practices are registered on the LFPSE system and have started to upload any relevant incidents where system learning could be identified.
- CQC meetings are in the diary quarterly and we are aware of their inspection schedule in Trafford which is based around aged ratings and risk which is the same across GM. For Trafford, we were assured that there are currently no significant risks that would expedite an inspection, but we are aware that a number of practices have aged ratings (going back as far as 2016) that would require inspections in the coming months.
- Trafford ICB Quality Visits are on hold until capacity and remit for the team following reform has been clarified.

Priority actions in coming period:

- Analysis of winter schemes following end of Q4 to consider impact and value for money of investment over the winter period.
- Locality and GM winter planning meetings in place.
- Linking in with GM Vaccs Team to ensure provision of the Covid and Flu vaccinations for all eligible patients.
- To ensure all GP Practices are compliant with any contract changes as a result of modern general practice requirements.
- Digital Facilitator continues to work with practices to ensure compliance with Modern General Practice.
- Locality colleagues continue to work with GM primary care colleagues to clarify BeCCoR asks for 26/27.

Decisions made:

None

Top 3 Risks:

Risk Identified	Mitigating Actions	Likelihood	Impact	Score
Trafford Waters development outside of practice boundary and lack of primary care provision.	Engagement with provider of home and engagement with Primary Care providers across Trafford, Salford and Manchester. Controls around PCN enhanced health in care home DES.	4	3	12
3 senior positions within Trafford commissioning that have gaps within the Trafford PC ICB team	There has been further reductions in workforce due to planned retirements and restrictions on recruitment from an ICB level for the locality. This means the risk has increased. It is currently unknown when the restrictions will be lifted	3	3	9
There are a number of issues/queries in relation to Primary Care estates/buildings being reviewed.	Meetings with GM senior primary care colleagues to support with advice and guidance to resolve.	3	3	9

Any other information:

Key escalations for NHS Greater Manchester PCCC:

Wigan Primary Care Commissioning Committee (PCCC) Highlight Report

Chair: Jonathan Kerry, Interim Deputy Place Lead (Wigan)
Reporting period: March 2026
Attendance: ~~Excellent~~ / Acceptable / ~~Unacceptable~~

This report updates / informs the NHS Greater Manchester PCCC on the Wigan PCCC work to date. It also provides an opportunity to raise any issues and inform of any changes that may affect the progression of work.

Key updates:

- A report was presented that provided an update the financial position for NHS GM - Wigan Locality Primary Care as at February 2026 (M11).
- A report was presented that outlined the progress of the Primary Care Quality Improvement Programme, detailing the key priority areas including GP Provider Contract updates, Changes to Contracts, GP Survey Results, Protected Learning Time Approvals, Service Users Experience and Care Quality Commission (CQC)
- An update on General Practice, this included the ongoing discussions around the 2026-27 GP Contract
- An update was presented on the progress against the NHS Greater Manchester - Wigan Borough Pharmacy Programme this included an update against the Pharmacy First programmes and Medicine Shortages.
- An update on the progress against the NHS Greater Manchester – Primary Eye Care Service.
- The committee approved the updated Primary Care Risk Register.
- An update was provided regarding the Homeless Specification and the future direction. This will be a system wide service review of all elements of the health Inclusion pathway and commissioned providers.

Priority actions in coming period:

- Issue the 2025/2026 Local Commissioned Services Specifications & contracts
- Continue to support implementation, and increased achievement against the NHS GM BeCCoR Quality Scheme programme of work across General Practices.
- Continue to work with GM primary care colleagues to clarify BeCCoR asks for 26/27
- To ensure all GP Practices are compliant with contract changes
- To review Local Commissioned Services 2026/27
- Analysis of winter schemes following end of Q4 to consider impact and value for money of investment over the winter period.

Decisions made:

- Approval of the updated Primary Care Risk Register

Top 3 Risks:

Risk Identified	Mitigating Actions	Likelihood	Impact	Score
Lack of funding available to support premise developments could hinder the ability to adapt to new models of care, supporting patients close to home.	Maintain strong working relationships with the locality SEG and GM SEB to utilise any capital funding opportunities and support from partners in the delivery of estates across Wigan Borough.	4	3	12
Continuing shift from NHS to Private Dental works could result in health inequalities across the Borough.	Maintain awareness of national position to understand implications and potential support options required for local contractors.	4	3	12
Failure to deliver on QIPP targets results in additional financial pressures on locality budgets.	Maintain regular reporting through to SLT and Finance colleagues through the year to forecast any increasing risk and mitigate where possible.	4	3	12

Any other information:

Key escalations for NHS Greater Manchester PCCC:

NHS
Greater Manchester

APMS Contract Review and Extension Proposal – Hope Citadel Practices (HMR Locality)

Part of Greater Manchester Integrated Care Partnership

GM Primary Care Commissioning Committee

DATE 13th April 2026

Required information	Details
Title of report	APMS Contract Review and Extension Proposal – Hope Citadel Practices HMR Locality
Author	Jackie Woodall Transformation and Delivery Lead, HMR Locality
Presented by	Jackie Woodall Transformation and Delivery Lead, HMR Locality
Contact for further information	Jacqueline.woodall@nhs.net
Executive summary	The four Alternative Provider Medical Services (APMS) contracts in Heywood, Middleton and Rochdale, held by Hope Citadel CIC, are approaching the end of their initial 10-year term on 31 March 2027. An options appraisal was undertaken to determine the future delivery model for these practices. The three options considered were: 1. List dispersal, 2. Competitive re-procurement, and 3. Extension of the existing contracts to the full 10 + 5-year term. Following detailed due diligence and review of quality, access, financial sustainability, community impact, and governance, the HMR Locality Primary Care Commissioning Committee approved Option 3 (contract extension) on 16 January 2026. Key findings supporting the recommendation include: • Strong quality performance across CQC, QOF, and locality quality improvement schemes. • Effective access models aligned with NHS England priorities. • Positive community impact, particularly in high-deprivation areas. • Stable financial position and workforce growth trajectory. • Robust governance with no material contractual concerns. GM PCCC is asked to note the locality

	decision and endorse progression of Option 3, recognising that onward approval via STAR and the GM Finance Board is required due to the contract value (>£100m).
The benefits that the population of Greater Manchester will experience.	By extending the Hope Citadel APMS contracts, Greater Manchester's population, especially its most vulnerable communities, will benefit from continuity, quality, improved access, financial stability, and a model of care tailored to tackling inequalities. The proposal avoids unnecessary disruption, protects established community services, and strengthens the GM primary care system.
How health inequalities will be reduced in Greater Manchester's communities.	Continuing the Hope Citadel APMS contracts ensures that those facing the greatest health, social and economic inequalities continue to receive targeted, high-quality, accessible and holistic care. This approach directly reduces preventable illness, improves long-term health outcomes, and supports Greater Manchester's commitment to reducing health inequalities across its communities.
The decision to be made and/or input sought	GM PCCC is asked to: • Note and endorse the decision of HMR Locality PCCC to approve Option 3 (contract extension). • Approve progression to STAR and GM Finance Board as required under GM governance. • Support the proposed contractual timeline, ensuring extension notice deadlines can be met (notice period June 2026 to terminate). Note the due-diligence findings confirming that Hope Citadel meets quality, performance, financial and compliance requirements.
How this supports the delivery of the strategy and mitigates the BAF risks	By endorsing the extension of the Hope Citadel APMS contracts, GM PCCC supports the delivery of the GM strategy by strengthening continuity, reducing inequalities, modernising access, and protecting quality and workforce stability. At the same time, it mitigates critical BAF risks relating to service disruption, capacity, financial sustainability, primary care stability, patient safety, and population health inequality.
Key milestones	**1. Initial Locality Review & Due Diligence**

	• **November 2025** – Initial options appraisal presented to HMR Locality PCCC. • **Late 2025** – Detailed due diligence completed covering quality, access, finance, governance, and strategic alignment. **2. Locality Decision** • **16 January 2026** – HMR Locality PCCC formally approves Option 3: extension of existing APMS contracts. **3. GM Governance Process** • **13 April 2026** – GM PCCC considers and is asked to endorse the locality recommendation. • **April–May 2026** – Submission to **STAR Panel** for detailed assessment (required due to contract value >£100m). • **May–June 2026** – GM Finance Board approval for extension decision and contract value sign-off. **4. Contractual Deadlines** • **June 2026 (latest)** – Deadline for serving formal contract extension notice, meeting the 9-month contractual requirement prior to current 31 March 2027 expiry. **5. Implementation & Transition** • **2026–2027** – Contract management actions, mobilisation of extension period, and continuation of monitoring processes (quality visits, dashboards, performance reviews). **6. Contract Continuity** • **1 April 2027** – Start of the extended contract term (final 5 years of the 10+5 arrangement).
Leadership and governance arrangements	The leadership and governance arrangements for Hope Citadel demonstrate a mature, safe, and well-functioning system, characterised by strong organisational leadership, effective quality and safety governance, robust contract compliance, and meaningful patient engagement. These arrangements provide assurance that the provider is well equipped to deliver the extended contract term and continue supporting high-need communities across Greater Manchester.

Engagement* to date	Engagement activity has taken place throughout the options appraisal and due-diligence process, spanning patients, practices, PCNs, Healthwatch, local and GM committees, and provider leadership. This engagement has provided strong evidence to support the locality recommendation to extend the APMS contracts and has shaped the due-diligence findings presented to GM PCCC.

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

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

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

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

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

Introduction

1.0 Background

1.1 Alternative Provider Medical Services (APMS) Contract

The Alternative Provider Medical Services (APMS) contract is one of the nationally directed primary medical care contracting routes, alongside General Medical Services (GMS) and Personal Medical Services (PMS). Unlike GMS and PMS, which are restricted to NHS bodies and traditional General Practice (GP) partnerships, APMS contracts allow a wider range of providers, including independent sector organisations, community trusts, and voluntary sector organisations, to deliver primary medical services.

APMS was introduced in 2004 to provide commissioners with flexibility in securing primary care services, particularly where:

- New services are required in response to population growth, new housing, or workforce challenges.
- Additional capacity is needed in areas where there are no GP Practices located or underserved areas.
- Targeted services are required for specific groups (e.g. homelessness, asylum seekers, or other vulnerable populations).
- There is a need to secure continuity of a GP Practice following the termination or withdrawal of a GMS/PMS contract.

APMS contracts are time-limited and competitively procured by the ICB. They are often in place for periods of 5–10 years, though shorter contracts can be used in specific circumstances eg for caretaking arrangements. Providers are selected through a procurement process based on their ability to deliver high-quality, safe, and accessible primary medical services in line with the NHS Constitution and local commissioning priorities.

The contract terms are defined nationally but allow for local tailoring, including:

- Service specifications reflecting local population health needs.
- Quality and performance requirements, often aligned with Primary Care Networks and ICB objectives.
- Contract monitoring arrangements, including key performance indicators, patient experience, and clinical outcomes.

APMS contracts are sometimes seen as a way of introducing innovation and competition into primary care delivery. There are also concerns about continuity, sustainability, and value for money compared with the traditional GMS contracts. The ICB has to balance these considerations carefully when deciding whether to procure services through APMS or seek alternative contractual models.

NHS GM ICB currently holds four APMS contracts with Hope Citadel across Heywood,

Middleton and Rochdale (HMR). These practices collectively serve highly deprived populations with significant health inequalities.

1.2 APMS Contracts Expiring

The following four Hope Citadel APMS practices were awarded contracts under a 10+5 year arrangement, meaning a total duration of 15 years, subject to a formal review at the 10-year point. While the contract includes a break clause at year 10, this was intended as a safeguard to allow for reassessment in the event of any significant issues.

P Code	Practice	Company	List Size	PCN	Contract Date	Contract End	Termination Notice
Y02718	Birtle View Medical Practice	Hope Citadel Community Interest Company (06560148)	4628	Heywood	1 April 2025	31 March 2027	9 months
Y02720	The Kingsway Practice	Hope Citadel Community Interest Company (06560148)	4640	Canalside	1 April 2025	31 March 2027	9 months
Y02721	Kirkholt Medical Practice	Hope Citadel Community Interest Company (06560148)	5089	Canalside	1 April 2025	31 March 2027	9 months
Y02795	Middleton Surgery	Hope Citadel Community Interest Company (06560148)	5274	Canalside	1 April 2025	31 March 2027	9 months

All four practices are now approaching the 10-year milestone on 31 March 2027, and are therefore subject to a formal review through the due diligence process. The potential extension of the contracts for the final 5 years falls within the originally approved contractual envelope.

Any decision to extend these contracts for the remaining 5 years is based on local determination. Clause 2.3 of the contract states...

“The Commissioner may, no later than [nine (9) months] prior to the Expiry Date, serve notice on the Contractor to extend the Contract by a maximum of [five (5) year], such extension commencing on the day after the Expiry Date”.

While the Commissioner may not wish to agree the 5 year extension, this clause gives the ability to do so, however, it would depend on obtaining the relevant GM ICB governance approvals including but not limited to STAR approval. The first step in this process has been for the locality to review all options available regarding the management of the APMS contracts and approve recommendation for next steps via GM Governance.

For all the above 4 Hope Citadel Practices, commissioners can activate the extension without going through the re-procurement process, but this is on the condition that the provider has met contractual obligations, and that the service needs remain.

The purpose of this paper is to support the GM PCCC committee to make an informed decision regarding all options available for the future of the 4 practices.

1.2 Outcome of Locality PCCC

Include:

- Locality PCCC reviewed full due diligence and options (16th January 2026).
- Locality PCCC **approved Option 3 – extend existing contracts**.
- Locality PCCC supported progressing to GM-level governance: GM PCCC → STAR → GM Finance Board.
- No concerns identified that prevent progression.

2.0 Summary

This paper presents the outcome of the due diligence review and full options appraisal for the four APMS contracts held by Hope Citadel CIC across Heywood, Middleton and Rochdale (HMR). The contracts, originally awarded on a 10+5-year basis, are approaching the end of their initial term in March 2027. The HMR Locality Primary Care Commissioning Committee has completed a comprehensive assessment of quality, access, performance, community impact, financial sustainability, workforce resilience, and strategic alignment. The locality concluded that Option 3 – extension of the existing APMS contracts**,** provides the strongest continuity, stability and value for the local and GM system.

The review confirms that all four practices demonstrate strong performance (CQC ratings Good/Outstanding, high QOF delivery, robust quality assurance) and operate a modern general practice model aligned with NHS England priorities. Hope Citadel's community-centred approach is well established, mitigating inequalities in areas of high deprivation and maintaining trusted relationships with vulnerable groups. Workforce models are multi-disciplinary and stable, with evidence of innovation and continuous improvement.

Alternative options—list dispersal or competitive procurement—carry significant risks, including destabilising two PCNs, loss of continuity for ~20,000 patients, worsening inequalities, and exposure to market failure due to limited provider interest. Financial assessment shows the extension is affordable, maintains value for money within the

national GP funding envelope, and avoids the considerable mobilisation costs associated with procurement.

3.0 The locality therefore recommends contract extension, noting alignment with GM's strategic aims of continuity, reducing inequalities, and maintaining a resilient primary care system. GM PCCC is asked to endorse the locality decision**,** approve progression through STAR and GM Finance Board, and support meeting the June 2026 extension-notice deadline. The comprehensive APMS Due Diligence Report (Appendix 1) sets out the full assessment of quality, performance, access, workforce, financial sustainability and strategic alignment. Members are asked to note the detailed evidence within the appendix when considering the recommendations within this summary paper

Appendices

Appendix 1 - A full due-diligence report containing the detailed analysis, evidence base and full options appraisal is included for members' reference. The main report provides a high-level summary of findings to support the recommendation to extend the APMS contracts.

APMS Contract Due Diligence V2.docx

NHS
Greater Manchester

Community Pharmacy Independent Prescriber Pathfinder Programme Evaluation

April 2026

Part of Greater Manchester Integrated Care Partnership

GM Primary Care Commissioning Committee

DATE

Required information	Details
Title of report	Community Pharmacy Independent Prescriber (IP) Pathfinder Programme Evaluation
Author	Ruby Aidoo, Project manager, IP Pathfinder Programme Northwest Region
Presented by	Alison Scowcroft, Community Pharmacy Integration and Commissioning Portfolio Lead
Contact for further information	Alison.scowcroft@nhs.net
Executive summary	A local evaluation of the Community Pharmacy Independent Prescriber Pathfinder Programme at Northwest level which reviews strategic and system context, clinical delivery and safety, impact on access, demand and equity, enablers for success, constraints and risks for scaling up and an overall assessment of the success of the programme.
The benefits that the population of Greater Manchester will experience.	Patients who visited 10 pathfinder site pharmacies received 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. In addition, 64% of GM community pharmacies are in areas of GM with the highest levels of deprivation (IMD 1-3). 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).
The decision to be made and/or input sought	The evaluation is for information only. Learnings from the evaluation will be utilised to inform the rollout and scaling of this service which is contingent on the outcomes of the contractual negotiations currently underway between DHSC, NHSE and CPE for the 2026/27 Community Pharmacy Contractual Framework.
How this supports the delivery of the strategy and mitigates the BAF risks	Independent prescribing in community pharmacy 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.
Key milestones	• 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. • Potential small-scale extension planning underway as presented to PCCC in March 2026.

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	PCCC April 2026 PC Blueprint Implementation Group (BIG) TBC CEGC TBC

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 accessiblity of report

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

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

NHS Greater Manchester

Community Pharmacy Independent Prescriber Pathfinder Programme Northwest Evaluation Report

February 2025 – March 2026

Service Delivery and Impact of the Independent Prescriber Pathfinder Programme in the Northwest

Author:
Ruby Aidoo, Project Manager, Northwest
March 2026

Contents Page

Executive Summary

The Community Pharmacy Independent Prescribing (CPIP) Pathfinder Programme's strategic aim was to establish a framework for the future commissioning of NHS community pharmacy clinical services incorporating independent prescribing for patients in primary care.. The programme forms part of a wider national transformation in pharmacy practice, with all newly qualified pharmacists expected to register as Independent Prescribers from 2026. The Pathfinder aimed to understand the operational, clinical, digital, and governance requirements needed to support future commissioning of community pharmacy prescribing services.

The programme was delivered across 24 community pharmacy sites in Greater Manchester, Cheshire and Merseyside, and Lancashire and South Cumbria between February 2025 and March 2026. Three clinical service models were tested: Minor Illness, Respiratory Care (including asthma and COPD optimisation), and Hypertension and Lipid Management in Greater Manchester. Mobilisation was supported by a structured governance framework to ensure safe clinical practice, regulatory compliance, and system integration.

Overall, the programme demonstrated strong patient engagement and positive clinical outcomes. Between February 2025 and February 2026, 9,634 patients accessed the Minor Illness service, with 68% receiving a prescribed medicine. The Respiratory pathway delivered 417 consultations, with 54% resulting in prescribing. Escalation rates were low across all pathways, indicating that pharmacists were able to manage most cases safely within community pharmacy. Patient experience was highly positive: of 422 patients who provided feedback, 96% reported that the service met their needs, and 78% said it prevented them from visiting their GP or another healthcare service.

The evaluation identified several areas of success. Strong collaboration between Integrated Care Boards (ICBs), pharmacy contractors, and clinical mentors enabled effective mobilisation and supported safe delivery. Pharmacists reported increased confidence in their prescribing practice, and the programme demonstrated that community pharmacy can provide timely, accessible clinical care that improves patient experience and reduces pressure on general practice.

However, the pilot also highlighted operational challenges that must be addressed for future scale-up. Workforce capacity pressures affected service delivery in some sites, and variation in site readiness influenced the pace of implementation. GP engagement was inconsistent, limiting referral activity in several areas. Digital infrastructure was fragmented, requiring Independent Prescribers to navigate multiple non-interoperable systems, which increased workload and reduced efficiency. Early awareness of the service among patients and healthcare professionals also varied, affecting utilisation.

Despite these challenges, the Pathfinder provides strong evidence that community pharmacy prescribing services can be delivered safely and effectively when supported by appropriate governance, training, and digital integration. The findings demonstrate that the model improves access to care, enhances patient experience, and creates additional capacity within general practice by shifting appropriate clinical workload into community pharmacy.

To support future service development and any potential national rollout, the evaluation recommends strengthening integration with primary care referral pathways and establishing standardised governance arrangements ahead of mobilisation. Investment in workforce development, digital interoperability, and sustainable funding models will also be essential. Clear transition planning will be required to ensure that the benefits demonstrated through the Pathfinder can be maintained and scaled across the Northwest.

2. Programme Overview

2.1 Introduction and Strategic Context

The Community Pharmacy Independent Prescribing (CPIP) Pathfinder Programme was implemented to establish a framework for future commissioning of NHS community pharmacy clinical services incorporating independent prescribing. This work aligns with a national shift in pharmacy education and practice. From September 2026, all newly qualified pharmacists will register as Independent Prescribers following completion of an integrated five-year training pathway. This represents a significant change from previous requirements, where pharmacists needed two years of post-registration experience before undertaking prescribing training.
Embedding prescribing competencies earlier in pharmacists' careers creates opportunities for community pharmacy to take on a more clinically focused role within primary care, supporting improved access and helping to manage demand across the wider NHS.

2.2 Programme Aims and Objectives

The Pathfinder programme aimed to test how expanded clinical capabilities—specifically pharmacist independent prescribing—could be embedded within community pharmacy. Its purpose was to inform the future commissioning framework for NHS community pharmacy clinical services by testing delivery models, defining governance, reimbursement and digital requirements, and shaping assurance processes for professional and clinical standards.
The programme also sought to identify the professional development needs of community pharmacists, support workforce planning across primary care, inform the post-2019–2024 CPCF clinical strategy, and clarify ICB responsibilities for commissioning services involving independent prescribing. Local and national evaluation captured patient experience and the perspectives of community pharmacy, general practice, community services, and secondary care to support the development of safe, effective prescribing services that improve access and help manage demand across the NHS.

2.3 Programme Delivery at a Glance

The Pathfinder programme was delivered across 24 community pharmacy sites in the Northwest of England, involving both independent contractors and pharmacy chains. A total of 48 Independent Prescribers participated in the programme. Delivery took place between February 2025 and March 2026 across three Integrated Care Board regions, testing three clinical service models and generating valuable insights into the operational, clinical, and digital enablers required for future implementation.

Feature	**Details**
Total Delivery Sites	24 Community Pharmacies (Pathfinder Sites)
Total Regional Independent Prescribers (IPs)	Greater Manchester (24 IPs), Cheshire & Merseyside (11 IPs), Lancashire & South Cumbria (13 IPs)
Regional Footprint	Greater Manchester (10 pathfinder sites), Cheshire & Merseyside (7 pathfinder sites), Lancashire & South Cumbria (7 pathfinder sites)
Pilot Duration	February 2025 – March 2026
Funding Model	National funding from February 2025 to March 2026
Clinical Models	Minor Illness, Respiratory, and Hypertension

2.4 Clinical Delivery Models

The Pathfinder programme tested three distinct prescribing models to understand the scope of clinical services that could be safely and effectively delivered by community pharmacist prescribers. Each model explored different aspects of clinical practice, patient need, and system integration.

Minor Illness Clinical Model

The Minor Illness pathway built on the foundations of the existing Pharmacy First service. Independent Prescribers assessed patients presenting with a range of minor conditions and were able to prescribe medicines where clinically appropriate, extending care beyond standardised treatment protocols. This model demonstrated how pharmacist prescribers can provide timely access to treatment and reduce demand on general practice and urgent care services.

Respiratory Clinical Model

The Respiratory pathway focused on supporting patients with asthma and chronic obstructive pulmonary disease (COPD). Pharmacists delivered medicines optimisation, including inhaler technique reviews, adherence support, and prescribing where appropriate. The pathway also contributed to environmental sustainability by supporting the transition to greener inhalers when clinically suitable. This model highlighted the potential for community pharmacy to play a greater role in long-term condition management.

Hypertension and Lipid Management Clinical Model

Delivered in Greater Manchester, the Hypertension and Lipid Management pathway focused on both primary and secondary prevention of cardiovascular disease. Independent Prescribers were able to initiate or optimise antihypertensive and lipid-lowering therapies in line with clinical guidelines. This model demonstrated how community pharmacy can support earlier identification, intervention, and ongoing management of cardiovascular risk.

2.5 Programme Mobilisation and Governance

2.5.1 Site Selection and Programme Mobilisation

Mobilising the Pathfinder programme required extensive preparatory work across the three Integrated Care Boards (ICBs) to ensure participating pharmacies were ready to deliver independent prescribing services safely and consistently. Entry into the programme followed a structured regional Expression of Interest (EoI) process, with final approval confirmed through ICB governance routes. Pharmacies were assessed against criteria designed to confirm their clinical capability, workforce capacity, and organisational readiness. Key considerations included:

Demonstrated experience in delivering clinical services

Availability of a qualified Independent Prescriber

Sufficient workforce capacity and organisational support

Consultation facilities meeting NHS privacy and safety standards

Alignment with local primary care priorities and integrated care models

While the EoI process provided a useful high-level assessment, a more detailed assurance process was required during mobilisation to prepare sites for go-live. The Project Manager and ICB Leads worked closely with each pharmacy to review documentation, coordinate governance approvals, support digital system access, and ensure all clinical and operational safeguards were in place.

Mobilisation proved more complex and time-intensive than anticipated. Sustained coordination was required between regional leads, national programme teams, and pharmacy contractors. Delays in CLEO Solo testing across the region further extended timelines. Despite these challenges, the mobilisation phase was essential in ensuring that prescribing services were introduced safely and in line with regulatory and clinical governance requirements.

2.5.2 Governance and Assurance Arrangements

Given the introduction of prescribing activity within community pharmacy, a comprehensive governance and assurance framework was developed collaboratively by the three ICBs prior to service launch. This framework covered both operational readiness and clinical safety, ensuring that all participating sites met the necessary regulatory, technical, and professional standards.

Operational and Technical Governance

Operational readiness checks were undertaken to confirm that pharmacies were technically and legally able to deliver prescribing services. This required significant coordination between project managers, ICB teams, national programme leads, and pharmacy contractors. Key requirements included:

Compliance with national clinical risk management standards (DCB0160 and DCB0129)

Completion of Data Protection Impact Assessments (DPIAs)

Verification of business continuity and operational resilience arrangements

Confirmation of suitable consultation facilities and premises readiness

Administrative checks of prescriber registration and Smartcard access

Technical configuration and readiness of the prescribing platform

Completion of Standard Operating Procedures and site-specific risk assessments

These processes involved extensive documentation and, in some cases, multiple iterations before sites were approved for go-live.

Clinical Governance and Patient Safety

Alongside operational checks, clinical governance oversight was established to ensure safe prescribing practice, including site Standard Operating Procedures (SOPs) and risk assessments specific to Independent Prescribing activities. Independent Prescribers were required to define the scope of their practice through submission of a P Formulary, outlining the conditions and medicines within their competence.

Additional safeguards included:

Clear supervision and mentorship arrangements

Alignment with local clinical governance processes

Documentation of consultations and prescribing activity via PharmOutcomes

Participation in clinical audit processes, including antimicrobial stewardship monitoring

These measures ensured that prescribing activity remained within defined professional boundaries and that clinical decisions could be appropriately monitored, reviewed, and assured.

2.6 Digital Infrastructure and Interoperability

The Pathfinder programme relied on CLEO Solo, a nationally approved stand-alone prescribing system, as the mandated platform for generating prescriptions and recording prescribing activity. CLEO Solo enabled Independent Prescribers to issue prescriptions within a secure digital environment. PharmOutcomes, which was used alongside CLEO Solo, supported the documentation of consultation records and structured post event messages (including pertinent clinical information and any actions required by the practice) to GP practices following patient encounters. CLEO also provided GP Connect 'Access Record' functionality for prescribers who did not have access to local shared care records, ensuring they could view essential patient information to support safe prescribing. In addition, many pharmacists were able to access their local shared care record systems, allowing them to review relevant patient history prior to prescribing.

Despite these strengths, the digital infrastructure underpinning the programme remained fragmented. Systems were not fully interoperable across primary care, resulting in largely one-directional communication from community pharmacy to general practice, with limited ability for pharmacists to receive follow-up information or updates from GP systems. This lack of integration created operational challenges. In several sites, prescribers were required to use multiple screens and switch between systems during consultations, which was time-consuming, reduced efficiency, and detracted from the overall patient experience. Addressing digital interoperability will be essential for any future expansion of community pharmacy prescribing services.

2.7 Programme Status and Future Considerations

The Pathfinder programme concludes in March 2026 due to limited national and local funding. While the service became operationally embedded within several participating pharmacies, the transition to programme closure presented challenges for maintaining continuity of care. Significant effort had been invested by regional teams, project managers, and pharmacy contractors to establish the service and build clinical capability within community pharmacy settings.

This evaluation therefore considers not only the outcomes achieved during the Pathfinder but also the wider implications of programme closure—particularly its impact on patient access to care and the potential re-emergence of pressures on general practice that the service had helped to alleviate.

3. Evaluation Methodology

3.1 Evaluation Design and Data Sources

A mixed-methods approach was used to evaluate how the Pathfinder programme operated in practice and the outcomes it achieved. Quantitative service activity data was combined with qualitative patient feedback to provide a balanced assessment of delivery, clinical impact, and patient experience.

Two primary data sources informed the evaluation:

PharmOutcomes: used by Independent Prescribers to record consultations and prescribing activity

Patient feedback surveys: collected via Microsoft Forms and paper surveys for digitally excluded patients

Together, these sources provided insight into service activity, prescribing patterns, and patient perceptions.

3.2 Learning-Focused Programme Approach

As a Pathfinder initiative, the evaluation was designed to support learning and service development rather than assess performance against fixed targets. The focus was on understanding how the service functioned in real-world settings and identifying insights to inform future rollout.

The programme tested pharmacist prescribing across three clinical pathways: Minor Illness, Respiratory Care, and Hypertension Management. Patients accessed the services through a range of routes depending on the pathway:

Minor Illness: GP Pharmacy First referrals, walk-ins, self-referrals, NHS 111, other community pharmacies, and GP out-of-hours services

Respiratory: GP referrals, walk-ins, proactive identification by the pharmacist, and review of pharmacy records for optimisation opportunities

Hypertension: GP referrals, referrals from in-house pharmacy services (e.g., blood pressure checks), follow-up appointments, and referrals from other community pharmacies

This flexible recruitment model reflected how services could operate in routine practice.

3.3 Operational Context and Regional Variation

Variation in activity levels across the three regions reflected differences in operational context rather than differences in service quality. Greater Manchester had more participating sites than Cheshire and Merseyside or Lancashire and South Cumbria, contributing to a higher overall number of consultations. However, strong activity was observed at site level across all regions. Several pharmacies delivered particularly high consultation volumes due to effective local relationships and delivery approaches, demonstrating that performance was not solely driven by the number of participating sites.

Key factors influencing activity levels included:

Integration with local GP practices: stronger relationships supported smoother referral pathways

Prescriber experience and confidence: influenced how proactively patients were identified and managed

Workforce capacity: staffing pressures affected the time available for consultations

These contextual factors are important when interpreting programme activity data.

3.4 Data Processing and Analysis

Clinical activity data was exported from PharmOutcomes and analysed using Microsoft Excel. Pivot tables were used to generate summary dashboards for each region. Both total activity volumes and percentage-based measures were analysed to enable comparison across ICBs while accounting for differences in the number of participating sites.

Patient feedback was collected through Microsoft Forms and paper surveys. The survey included rating-scale questions and open-text responses, enabling the evaluation to capture both measurable satisfaction and richer qualitative insights.

3.5 Information Governance and Data Protection

All data used in the evaluation was anonymised prior to analysis to protect patient confidentiality. No patient-identifiable information was included. The evaluation was conducted in line with General Data Protection Regulation (GDPR) requirements and followed the Data Protection Impact Assessment (DPIA) established at programme outset.

4. Outcomes of the IP Pathfinder Programme

4.1 Clinical Model Prescribing Outcomes

The impact of the pathfinder programme across the Northwest was very positive as patients engaged well with the service.

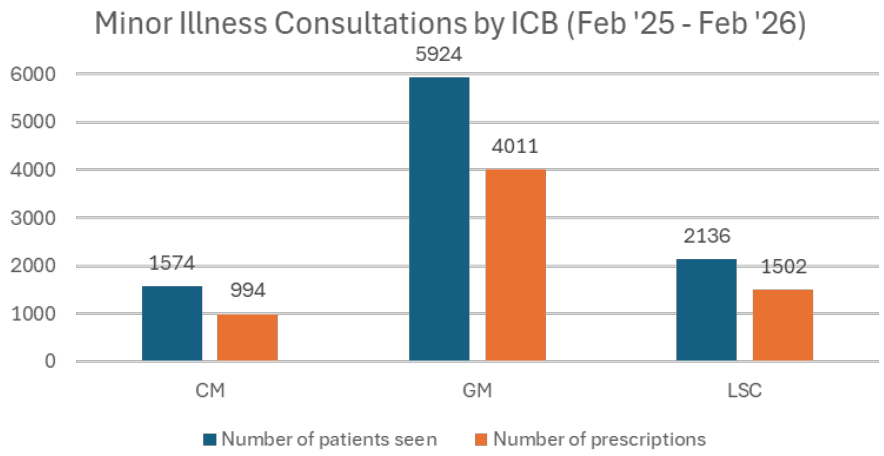

Figure 1- Number of minor illness patients seen, and number of medicines prescribed across the Northwest between February 2025 to February 2026.

Greater Manchester was the first area to launch the Independent Prescribing service for Minor Illness in February 2025, with a small number of early-adopter sites beginning activity ahead of the other regions. Lancashire and South Cumbria and Cheshire and Merseyside followed shortly after, going live in April 2025. Across the Northwest, a total of 9,634 minor illness patients accessed the service during the programme period, with 68% receiving a prescribed medicine.

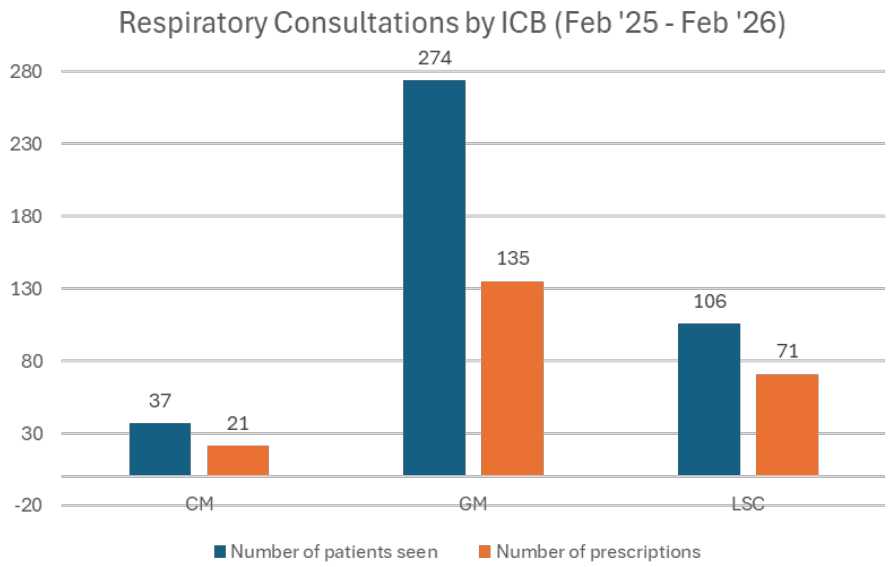

Figure 2 – Number of respiratory patients seen and number of medicines prescribed across the northwest

The Respiratory service went live shortly after the Minor Illness pathway; however, patient engagement developed more slowly and varied across the region. Unlike Minor Illness, sites found it more challenging to proactively identify suitable respiratory patients, and the more complex nature of these consultations meant that stronger GP engagement was essential to support referrals.

As a result, activity increased later in 2025 and was less consistent across sites. In total, 417 patients accessed the Respiratory service, with 54% receiving a prescribed medicine.

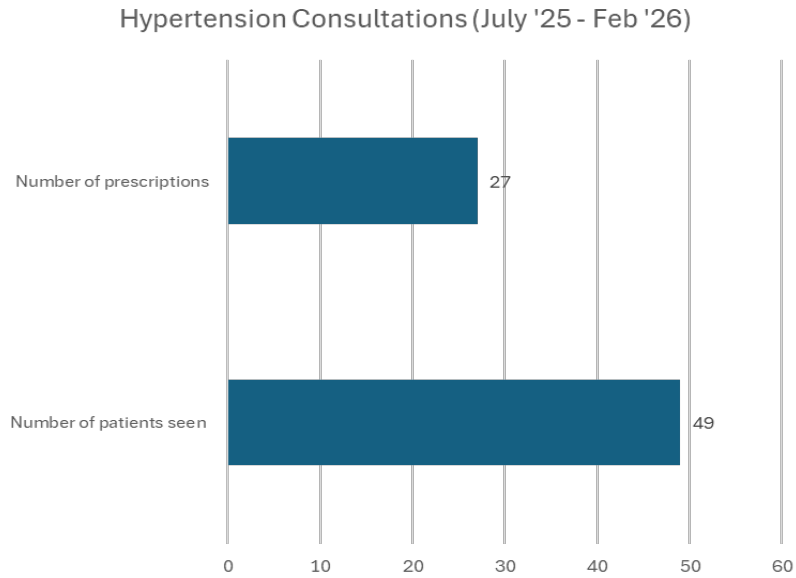

Figure 3 – Number of hypertension patients seen and number medicines prescribed between July 2025 and February 2026 (Greater Manchester only).

The Hypertension service, delivered only in Greater Manchester, went live in July 2025 following final approval from senior clinical leadership in GM. Activity developed more slowly than in the other pathways due to the more complex nature of the clinical model and the requirement for community pharmacies to access pathology results to support safe prescribing for hypertension and lipid

management. These factors contributed to lower and more variable activity levels compared with the Minor Illness and Respiratory pathways. 49 patients were seen in total and 55% of patients received prescribed medicines.

4.1.1 Escalation Rates Across the Programme

Escalation rates remained extremely low across all three clinical pathways, demonstrating that Independent Prescribers were able to manage most presentations safely within the community pharmacy setting.

Minor Illness: Fewer than 1% of consultations required escalation between February 2025 and February 2026.

Respiratory: Only 0.17% of consultations were escalated during the same period, reflecting strong clinical management despite the greater complexity of respiratory presentations.

Hypertension: Between July 2025 and February 2026, just 2% of consultations required escalation to other healthcare services.

These consistently low escalation rates indicate that pharmacists were able to assess, diagnose, and treat patients effectively within their defined scope of practice. They also highlight the robustness of the governance framework and the appropriateness of the clinical pathways selected for delivery within community pharmacy.

4.1.2 Index of Multiple Deprivation (IMD) Profile of Service Users

Analysis of IMD data shows that the service reached a high proportion of patients living in areas of greatest deprivation. Across the three ICBs, 64% of all patients who accessed the service between February 2025 and February 2026 were from the most deprived areas. This indicates that the Pathfinder programme was accessed by populations who often experience the greatest barriers to timely primary care.

The age ranges of patients was broad, with individuals ranging from infants to older adults (0–90 years) engaging with the service. This demonstrates that the Minor Illness pathway was utilised by a wide demographic and met a diverse range of patient needs.

4.1.3 Patient Access to Service

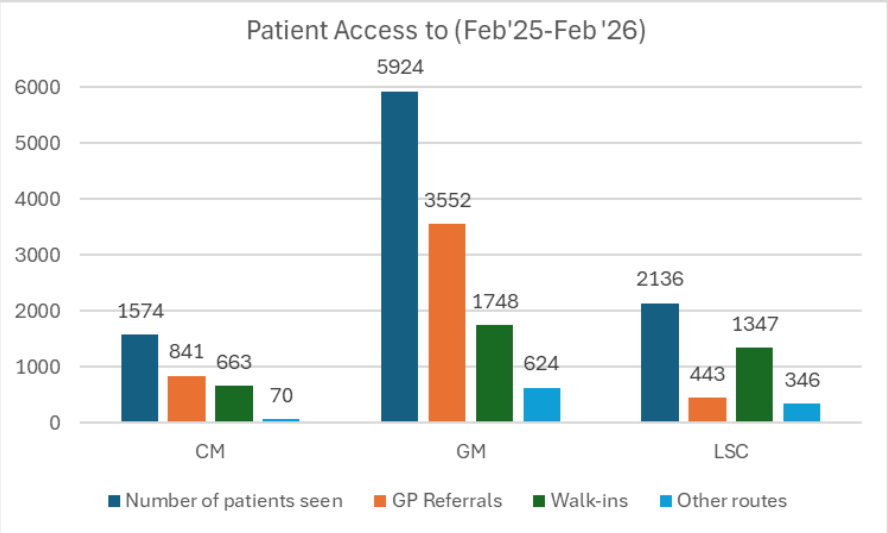

Figure 4 – Patient access to service across the region

This graph shows how patients accessed the service across the three ICBs between February 2025 and February 2026.

For each area, the chart shows the total number of patients seen and the distribution of referral routes, including GP referrals, walk-ins, and other sources such as NHS 111 or referrals from other pharmacies.

Across Greater Manchester and Cheshire and Merseyside, GP referrals formed the largest proportion of patient access, reflecting strong engagement from general practice and well-established local relationships. In contrast, Lancashire and South Cumbria recorded a higher proportion of walk-in patients, indicating strong patient awareness and direct engagement with the service. These differences do not suggest that some sites performed better than others; rather, they highlight the influence of local system dynamics on how patients entered the service.

Where strong pre-existing relationships with GP practices were in place, referral activity was naturally higher. Several Pathfinder sites worked proactively to build these relationships, with support from ICB leads and clinical mentors, but engagement varied, and in some areas GP referral pathways were slower to develop. Similarly, Independent Prescribers invested considerable effort in identifying eligible walk-in patients and raising awareness of the service. However, some patients preferred to continue their care with their GP, which influenced walk-in volumes.

Overall, the variation in patient access reflects the complexities of GP engagement and patient awareness rather than differences in clinical competence or service quality. These findings reinforce the importance of strong local system relationships in shaping how patients access community pharmacy prescribing services.

4.2 Patient and GP Experience & Feedback

Patients across the Northwest provided feedback through a digital survey platform. The National Team supplied the core question set and a QR code to support easy access to the survey. Each ICB Lead worked with their communications team and the project manager to finalise the feedback form, which was then shared with all Pathfinder sites. Sites were responsible for encouraging patients to complete the survey following their consultation.

To ensure the survey was accessible to all patients, paper copies of the feedback form were also made available for individuals who were unable to use the QR code. Independent Prescribers collected this feedback and shared it with their ICB Lead, who worked with the project manager to input the responses into the online system. This approach ensured that patient views were captured consistently across all sites, regardless of digital access.

A total of 422 patients across the three ICBs provided feedback on their experience of the service:

Cheshire and Merseyside: 60 responses

Greater Manchester: 104 responses

Lancashire and South Cumbria: 258 responses

Feedback was overwhelmingly positive. 96% of patients reported that the service met their needs, and 93% stated they were very likely to use the service again. Importantly, 78% indicated that the consultation prevented them from needing to visit their GP, demonstrating the service's potential to reduce pressure on primary care.

Overall satisfaction was extremely high, with 98% of patients saying they would recommend the service to others.

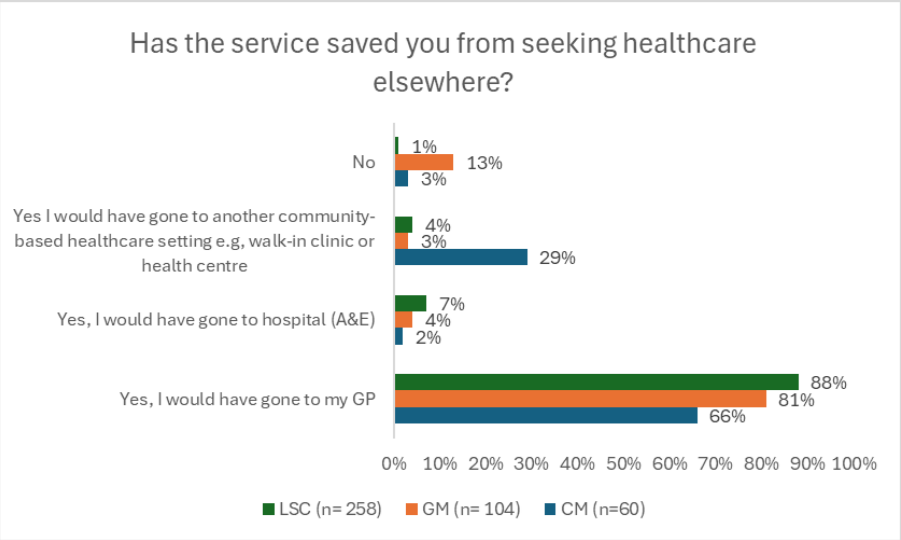

Figure 5 – Patients were asked whether the service saved them from seeking healthcare elsewhere.

Across the three ICBs, the proportion of patients reporting that the service prevented them from seeking care from their GP was consistently high. This reinforces the extent to which the service met patient needs and demonstrates the wider system impact, particularly in terms of repurposing GP practice time. These findings highlight the important contribution that community pharmacy prescribing can make in improving access while alleviating pressure on general practice.

Patient comments consistently highlighted the accessibility, professionalism and reassurance provided by Independent Prescribers. Patients valued being seen quickly, receiving timely treatment, and avoiding the need to attend GP or urgent care services. Many also expressed strong confidence in the clinical expertise of the pharmacists and appreciated the personalised support they received.

Illustrative patient comments included:

"I was able to see someone straight away and get the treatment I needed."

"Excellent service and saves time waiting in A&E or GP."

“I have used the service multiple times for issues that didn’t require a GP appointment and received a quicker, better service.”

“The pharmacist was very professional and updated my inhaler—excellent customer service.”

“The consultation put my mind at rest when I was worried it might be something more serious.”

“I have complete trust in the practitioner—very approachable and always helpful.”

These comments reinforce the strong levels of satisfaction reported through the survey data and demonstrate the value patients placed on accessing timely, high-quality care within community pharmacy.

In addition to the strong patient feedback, perspectives from general practice further reinforce the value of the Pathfinder services. One GP described the extended service delivered by their local community pharmacy as “an integral part of how we deliver primary care,” noting that hundreds of patients were managed “safely, promptly, and appropriately without requiring a GP appointment.” They highlighted the significant operational benefits for practices, explaining that the ability to rely on a funded prescribing pharmacist had enabled them to redesign how clinical capacity was used, allowing GPs to focus on patients with more complex or higher-risk needs. The GP emphasised that even within its pilot phase, the service had already moved beyond the impact typically expected of a pilot and was providing “critical operational capacity” within the local primary care system. This feedback aligns closely with patient experience data and demonstrates the wider system-level value of community pharmacy prescribing.

Overall, the feedback gathered across the three ICBs demonstrates exceptionally high levels of satisfaction with the Pathfinder prescribing services. Patients consistently valued the accessibility, timeliness, and professionalism of the consultations, and many reported that the service provided a convenient alternative to GP or urgent care appointments. The positive responses, combined with strong indications that the service met patient needs and reduced demand on general practice, highlight the important contribution that community pharmacy prescribing can make to improving patient experience and supporting wider system pressures.

4.3 Case Studies: Managing Complex Patient Needs in Community Pharmacy

The following case studies illustrate how independent prescribing within the Pathfinder programme enabled community pharmacists to manage complex presentations, provide timely interventions, and prevent avoidable GP or hospital activity. Together, they demonstrate the breadth of clinical impact achievable when prescribing capability is embedded within community pharmacy.

4.3.1 Clinical Case Example – Integrated Management of Acute and Long-Term Conditions (Lancashire & South Cumbria)

This case demonstrates how independent prescribing enabled a patient with multiple vulnerabilities

to receive coordinated, person-centred care within a single community pharmacy setting.

Patient Context

A 41-year-old female presented as a walk-in patient after being unable to secure a GP appointment. She had learning difficulties, behavioural challenges, and a history of sexual abuse, requiring a trauma-informed and sensitive approach to assessment.

Clinical Pathway

The patient initially accessed the Pharmacy First service for a sore throat. During the consultation, the pharmacist identified signs requiring further assessment and escalated the case to the Independent Prescribing (IP) service. A detailed clinical examination, including chest auscultation, identified features consistent with a bacterial chest infection, and appropriate treatment was prescribed.

During follow-up, the prescriber identified acute otitis media, which was also treated within the pharmacy. Elevated blood pressure readings prompted referral into the Hypertension Case Finding Service for ambulatory blood pressure monitoring (ABPM).

Outcomes

The pharmacist adapted their consultation approach to ensure the patient felt safe and supported, demonstrating the value of trauma-informed care. Multiple conditions were managed within the pharmacy, avoiding several GP appointments during a period of high demand. The patient reported improved symptoms and increased confidence engaging with healthcare services.

4.3.2 Clinical Case Example – Early Identification of Suspected Squamous Cell Carcinoma (Greater Manchester)

This case highlights how independent prescribing enabled early recognition of a potentially serious condition and facilitated rapid referral into specialist care.

Patient Context

A patient presented to the IP Pathfinder service at Timperley Pharmacy with a lesion on the external ear that had been present for several weeks. The lesion had increased in size and intermittently bled, although the patient reported no pain and felt otherwise well.

Clinical Pathway

Clinical examination revealed a 3–4 cm erythematous lesion on the pinna with irregular borders, surface ulceration, and features highly suggestive of cutaneous malignancy, particularly squamous cell carcinoma (SCC). The lesion showed rapid growth, friability, and crusting—key red-flag indicators.

The pharmacist conducted a comprehensive consultation, including history of onset, lesion evolution, bleeding episodes, occupational and sun-exposure history, and risk factors for non-melanoma skin cancer. A full examination of the lesion and surrounding tissue was completed.

Recognising the urgency, the pharmacist made a same-day referral to the GP surgery via direct telephone communication, ensuring the patient was prioritised for assessment.

Outcomes

Several weeks later, the patient returned to the pharmacy to confirm that they had been scheduled for excisional management and had received a confirmed diagnosis of squamous cell carcinoma. The patient thanked the pharmacist for their prompt assessment and urgent referral, which enabled timely specialist intervention.

This case demonstrates the critical role community pharmacist prescribers can play in early cancer detection and rapid escalation of care.

4.3.3 Key Learning from the Case Studies

Across both examples, several important insights emerge for the future development of pharmacist prescribing services:

Independent prescribing enables pharmacists to manage more complex presentations, including acute infections, long-term condition risks, and potential malignancies, reducing the need for GP appointments when appropriate governance and clinical expertise are in place.

Integrated use of multiple pharmacy services, such as Pharmacy First, Independent Prescribing, and Hypertension Case Finding, allows patient needs to be addressed holistically within a single care setting.

Community pharmacy provides an accessible and supportive environment, particularly for vulnerable patients or those who struggle to access traditional primary care routes.

Pharmacists can play a vital role in early identification of serious conditions, including suspected cancers, when equipped with the right training, clinical pathways, and escalation routes.

Together, these case studies demonstrate how pharmacist prescribing services can improve access to care, support continuity of treatment, and reduce pressure on general practice by safely managing appropriate cases within community pharmacy.

5. Evaluation Findings

5.1 Key Factors Supporting Programme Delivery

Several factors contributed to the successful mobilisation and early delivery of the Independent Prescribing Pathfinder programme.

Collaborative Working Across System Partners

The programme relied on strong collaboration between Integrated Care Boards, community pharmacy contractors, Local Pharmaceutical Committees, the Northwest Deputy Regional Chief Pharmacist, training providers, and regional teams. This partnership approach enabled effective mobilisation, supported consistent implementation across the three ICBs, and created opportunities to share learning as the programme progressed. Regular communication between partners helped resolve operational issues quickly and supported the development of aligned delivery approaches.

Robust Governance and Assurance Arrangements

Introducing prescribing activity into community pharmacy required comprehensive governance structures. Standard operating procedures, risk assessments, data protection documentation, and site readiness assessments were developed to ensure safe and compliant service delivery. These

arrangements helped ensure that prescribing activity aligned with NHS clinical guidance and GPhC standards, providing a strong foundation for safe practice.

Development Opportunities for Pharmacist Prescribers

The Pathfinder created a supportive environment for pharmacists to apply their Independent Prescribing qualification in real-world practice. Access to clinical supervision, peer support, and structured learning opportunities helped prescribers build confidence in clinical decision-making and in managing more complex consultations. ICBs collaborated with CPPE to deliver targeted training sessions to strengthen foundational clinical knowledge, and Community of Practice meetings provided ongoing peer learning and case discussion. Independent Prescribers consistently reported that this structured support was instrumental in developing their prescribing capability.

5.2 Implementation Challenges

While the programme delivered many positive outcomes, several challenges emerged during implementation.

Workforce Capacity Within Community Pharmacy

Community pharmacies operate within busy, high-demand environments. Balancing dispensing activity, existing services, and the additional responsibilities associated with prescribing consultations created operational pressures for some teams. Workforce capacity and skill mix were therefore key factors influencing how frequently consultations could be delivered and how easily services could be embedded.

Variation in Site Readiness

Although readiness assessments were conducted prior to programme entry, pharmacies varied in their infrastructure, workforce capacity, and experience delivering clinical services. Some sites required additional support during early implementation before they were able to deliver the service consistently.

Patient Awareness and Referral Pathways

In the early stages, awareness of the service among patients and healthcare professionals was limited. Referral pathways from general practice and other services developed gradually as confidence grew. Over time, GP confidence in community pharmacy prescribing increased, but strengthening awareness and communication remains an important area for future development.

5.3 Operational Barriers Identified

Feedback from pharmacists and regional leads highlighted several operational barriers that would need to be addressed to sustain and expand prescribing services in community pharmacy.

Engagement with General Practice

Engagement with general practice varied across the region. Where strong relationships existed, referral pathways and collaboration were effective. In other areas, limited engagement made it more challenging to establish referral routes or create opportunities for joint working. This variation influenced activity levels and the ease with which services could be embedded.

Local Context and Clinical Pathway Relevance

Local system priorities influenced which clinical pathways were most relevant. In some areas, existing GP-led initiatives had already addressed certain clinical needs, reducing demand for specific pathways within the Pathfinder. This suggests that future commissioning models may benefit from greater flexibility to tailor clinical pathways to local population needs.

Digital Infrastructure and Interoperability

The programme relied on multiple digital platforms for prescribing, documentation, and communication. While these systems enabled service delivery, the lack of interoperability created additional administrative steps and limited the ability to share information seamlessly with general practice. Participants highlighted that improved access to integrated patient records and structured consultation templates would support more efficient service delivery and strengthen clinical governance.

5.4 Lessons Learned

Several important lessons emerged from the Pathfinder programme that should inform future service development and national planning.

Integrated and Reliable Digital Infrastructure

The programme highlighted the need for fully integrated digital systems to support efficient prescribing workflows. Pharmacists frequently had to switch between multiple non-integrated platforms, and system outages or access issues (e.g., CLEO, GMCR, shared care records) created delays and disrupted consultations. As noted in the lessons learned, *"Pharmacists had to switch between multiple non-integrated systems, creating administrative burden"* and *"Cleo system outages occasionally disrupted prescribing activity."* Future prescribing services will require a single, reliable digital infrastructure with clear technical support and escalation pathways to minimise disruption and improve efficiency.

Strengthening GP Engagement and Referral Pathways

Sites with strong pre-existing relationships with general practice saw higher referral activity, while many pharmacies reported low or inconsistent referrals due to limited GP awareness or confidence in the programme. As captured in the lessons learned, *"Sites with strong pre-existing relationships… saw higher referral activity"* and *"Many pharmacies reported low or no referrals from GP practices."* Embedding structured GP engagement, communication, and education early in programme design will be essential to establishing consistent referral pathways.

Clear Governance and Standardised Processes

Complex governance processes and variation in local interpretation created delays and confusion, particularly around clinical supervision roles and service scope. The lessons learned note that *"Governance processes across systems were complex and time-consuming."* Future rollouts would benefit from simplified, standardised governance frameworks and templates developed at national or regional level to reduce duplication and streamline mobilisation.

Consistent Training Expectations and Competency Frameworks

Pharmacists valued clinical training and funded development time, but inconsistent or changing training requirements caused frustration. As noted, *"Some prescribers felt there was no clear baseline competency framework."* A clear, stable competency framework—supported by practical clinical skills training—will be essential for future prescribing services.

Sustainable Funding and Workforce Models

While sessional funding supported workforce capacity, the model did not always align with activity levels and created administrative burden. The lessons learned highlight that *"the sessional funding model sometimes resulted in low activity despite high sessional claims."* Future funding approaches should balance workforce support with incentives for activity, while simplifying claims processes to improve sustainability.

Improved Data Access and Monitoring

Inconsistent access to prescribing and activity data limited programme oversight. As stated, *"The sharing of prescribing data was not consistent… Without access to PharmOutcomes, there would have been limited visibility."* Clear, routine data-sharing processes are needed to support monitoring, governance, and evaluation.

5.5 Future Considerations: Scalability and Sustainability

The Pathfinder programme demonstrates that pharmacist prescribing services can be delivered safely and effectively within community pharmacy settings. Community pharmacies are highly accessible healthcare locations and already play an important role in managing minor conditions and supporting medicines optimisation. The programme shows that pharmacists can extend this role through independent prescribing when appropriate governance, training, and operational arrangements are in place.

However, the future scalability of the model will depend on several factors, including workforce capacity within community pharmacy, the availability of ongoing clinical supervision and training, appropriate remuneration, sustainable commissioning arrangements, and stronger integration with wider primary care services. Addressing these factors will be essential if pharmacist prescribing services are to be expanded and embedded more widely within the primary care system.

6. Recommendations

The Pathfinder programme has provided valuable insight into how independent prescribing services can be delivered within community pharmacy settings. The following recommendations reflect learning from programme delivery and feedback from participating pharmacies, clinical leads, and regional teams. They are intended to inform future development and potential expansion of pharmacist prescribing services.

6.1 Strengthening Integration with Primary Care

Successful delivery of the programme was closely linked to the strength of collaboration between community pharmacies and local primary care services. Future service development should focus on strengthening these relationships and establishing clearer referral pathways between community pharmacy, general practice, and urgent care services. More formal collaboration arrangements between pharmacies and Primary Care Networks (PCNs) may support shared understanding of

clinical pathways and improve patient flow.

Earlier engagement with general practice teams during service design may also help increase awareness of pharmacist prescribing services and encourage greater use of community pharmacy as a referral destination.

6.2 Supporting Local Flexibility in Clinical Pathways

Experience from the Pathfinder programme suggests that local population needs and existing service provision vary significantly between areas. Future commissioning approaches may therefore benefit from allowing greater flexibility in the clinical pathways delivered through pharmacist prescribing services. Rather than focusing on a single clinical condition, commissioners may wish to allow pharmacies to deliver a small range of pathways aligned to local health priorities. Consideration to prescribers' expanding scope of practice would need to be made in such flexible models.

This approach would help ensure that prescribing services address unmet need and maximise clinical value. Consideration may also be required for how prescribing services support temporary residents or visitors in areas with significant seasonal population changes, particularly where community pharmacy may represent the most accessible point of care.

6.3 Workforce Development and Clinical Confidence

The programme demonstrated the importance of structured support for pharmacists transitioning into prescribing roles. Future implementation should incorporate formal clinical development opportunities, including mentorship and peer learning within primary care settings. These activities can help build prescribing confidence, strengthen professional relationships, and support consistent clinical practice.

As the prescribing workforce grows, newly registered Independent Prescribers may require different types and levels of support compared with those who participated in the Pathfinder.

Ongoing access to employer-provided clinical supervision and professional development will remain critical to sustaining safe, high-quality prescribing services as the model expands.

6.4 Digital Infrastructure and Clinical Systems

Digital infrastructure was identified as a key area for improvement. Pharmacists currently operate across several separate digital platforms when delivering prescribing services. While these systems enabled service delivery, they also created additional administrative workload and limited the ability to share information seamlessly with other parts of the health system.

Future service development would benefit from improved integration between community pharmacy systems and general practice records, including extending the same standard consultation software available to medical prescribers to Independent Prescribers in community pharmacy. Access to structured consultation templates and integrated patient record systems may help improve efficiency, support clinical governance, and ensure greater consistency in documentation.

6.5 Sustainability and Future Commissioning

The Pathfinder programme demonstrated that community pharmacy has the potential to safely and

effectively deliver prescribing services that improve patient access to care. However, sustaining and expanding these services will require clear commissioning arrangements and long-term funding models. Resource within ICBs to support expansion, rollout, and ongoing oversight of prescribing in community pharmacy will also need to be in place.

Establishing sustainable pathways for service continuation will help ensure that the workforce capability developed during the pilot is retained and that patients continue to benefit from improved access to prescribing services. Careful transition planning will be essential when moving from pilot programmes to routine service delivery to avoid disruption for patients and participating pharmacies.

Overall, the Pathfinder programme demonstrated strong engagement, high-quality delivery, and meaningful progress in independent prescribing practice. Many Independent Prescribers grew significantly in confidence and capability, contributing to positive outcomes for patients and valuable learning for the system. The commitment shown by participating sites, clinical mentors, and ICB leads has been central to the programme's success. It is hoped that the national team will draw on these insights to inform the development of future prescribing services in 2026/27 and beyond.

References

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