

Community Pharmacy Lancashire & South Cumbria (CPLSC)

Minutes of Meeting 14.07.2026 09:30 – 16:39

Stanley House Hotel, Mellor, BB2 7NP

Present (Board):

Ashab Patel (AP), Tahir Hussain (TH), Abid Malluk (AM), Richard Wood (RW), Khalid Khan (KK), Sarah Vaukins (SV), Simon Abbott (SA)

In attendance:

- | | |
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| • Mubasher Ali (MA) | Chief Executive |
| • Michael Ball (MB) | Vice Chair |
| • Ben Fell (BF) | Independent Treasurer |

Chaired By:

- | | |
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| • Ali Dalal (AD) | CPLSC Chair |
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Guests:

- | | |
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| • Fin McCaul (FM) | CPE Regional Representative (Teams) |
| • Dr John Miles (AL) | LSCICB |
| • Richard Brown (RB) | VirtualOutcomes (Teams) |
| • Abdullah Siddiqi (AS) | Rapix Connect (Teams) |
| • John Horton (JH) | Camurus (Sponsor) regional lead NW and Wales |
| • Dan Curtis (DC) | Camurus (Sponsor) pathway development manager UK and Ireland |
| • Zahir Patel (ZP) | contractor representative. |

Apologies for absence:

Georgina Barber (GB), Roger Balshaw (RB), Julie Lonsdale (JL), Andrew White (AW)

Absent no apologies:

None noted

1. Welcome and Introductions

MA Comment from contractor MJ Moore patient abuse concerns. Upcoming meeting highlighted with Clive Dunn.

AD led welcome and introductions.

ZP (Imaan Healthcare contractor observer).

2. Apologies and Declarations of Interest

MA – highlighted apologies

AP taken over nelson health centre pharmacy.

3. Matters Arising

None Noted

4. Confirmation of previous CPLSC draft minutes

AM approved and KK seconded

5. Sponsor – Camurus

MA Highlighted the usual sponsorship criteria in that the sponsor had no influence on the planned agenda, items for discussion or any products being discussed

DC Overview of long acting LAIB (Long-Acting Injectable Buprenorphine).

Touch on models of care, real world evidence, support Camarus can provide to support access to treatment in local area. Varying levels of uptake across UK. 6% uptake across England, stark difference compared to Scotland and Wales. 20% marker target. Highlighted the importance of Community pharmacy's role.

JH Initially rolled out in community drug and alcohol services. Still a lot of disparity across NW.

Local services coming to capacity and struggling to manage capacity. Highlighted community pharmacy medication assisted treatment support over many years and continue to support.

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Overview of LAIB and that lipid base, natural fats, sub cut. Flexible dose weekly and monthly options also covered. Toxic supply of drugs in country and drug related deaths across board and LAIB mode allows a consistent release compared to other models. No cold chain. Camurus can provide support resources needed to help provide service. etc.

CPLSC have supported with conversations and national steering principles. University of South Wales have supported an independent report. Health economic cost modelling also undertaken.

AM cat c, clawback, little revenue are we taking money away from standard services? How to we make sure community pharmacy is remaining viable? With claw back, could be at net 0.

MA next session will cover this question.

BF Is rationale of weekly/ monthly to do with care and safeguarding?

JH Yes but is also less sedative than methadone. Start weekly then build up to monthly.

6. Medication Assistance Treatment Current and Future

MA requested DC and JH to remain for this part of the meeting for their expertise on the discussions and previous disclaimer was again noted.

MA Gave an overview of our current landscape and future proofing community pharmacy options on medication assisted treatments.

A wider discussion and review of core local council positions and options took place with partnership potential

DC Gave an overview of the national framework and principles

JH Blackpool current service overview shared and community pharmacy options to release capacity

MB What is in the framework?

DC Purpose of framework is to provide consistency in delivery across the board. Guideline around requirements for storage, training, what is needed to provide, broad overview of service for local commissioning.

FM Clinical standards and elements will be covered

DC Community pharmacies already doing this across a few locations Scotland and West Midlands

MB why wouldn't community pharmacies prescribe?

DC they could, community pharmacy has opportunity to lead in this sector and models could adapt and change to suit this.

SV Pharmacist best placed when comes to reducing doses.

AP have we had discussion with ministers?

MA not until framework received. Questions will be raised so all details need to be ready before taking to table.

DC shared the cost comparison of current models with long-acting injectable

MA we also supported the socioeconomic study

10:22 Camarus JH/ DC left.

7. Rapix Connect Update

AS joined via teams

MA led introductions.

SV gave an overview on the benefits and time savings of Rapix Connect for a vast population sized practice at Lancaster Medical Practice. Very simple click of a button to message out to several pharmacies and two-way communications less reliant on single individuals.

AS Spoken to Bay medical who are considering taking on Rapix due to how well it is working. Aiming to get other PCNs on board in Lancaster. Continue to work closely with CPLSC and local pharmacies for onboarding.

AP how many hours per week?

SV Use it daily. Just put business case together for funding married to colleague time savings

AS Rapix is an instant messaging platform between GP and CP (Community Pharmacy). Helping to tackle national and local shortages. Problem solving for time lost calling around, treatment delays, held on phone lines and features such as instant messaging and out of stock alerts work great.

AS Data as of 13/07/2026 300 medication searches, 583 responses from local pharmacies. Based on 15 minutes per call, 75 hours of time saved for Lancaster medical practice. Pharmacies respond on average within 26 mins some as little as 1.6 seconds and well within the day expectations.

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Bigger picture 75hrs GP time recovered and 62.5 community pharmacy hours.

Network wide 880 GP drug requests and 1927 pharmacy responses.

AS Potential EMIS integration ongoing

AS Attended community pharmacy and GP conference and had interest and specifically wanted to highlight the joint CPLSC case study with SV and MA.

MA stats are amazing. Thanks to Sarah and team as well. Response time incredible.

SV Also tells us when things are out of stock as well as what can order in. practice know that if something is completely out of stock can prescribe alternative.

MA echoing added value and benefits.

MA Big thanks to all contractors involved.

SA Lancaster was pilot so was for free. Going to Morecambe Bay, how much would the system cost them?

AS All surgeries get 3months free trial, then convert to paid contract. Depends on list size, starts at £49 per month, then rises by £10 for every 10, 000 patients.

SV Worried that cost would be a barrier but has worked with AS to get costing model right to ensure beneficial for everyone and off sets admin and Meds Ops teams times.

RW Do pharmacies see other responses?

SV Yes, you know what's coming back to you. Receive all replies.

MA Allows clear and concise messaging route.

RW Palliative care service. Palliative care nurses ask about stock on WhatsApp system could work for teams like this.

MA do have tier 1 and tier 2 across ICB

SA Perhaps one to take away and think about rolling out to wider teams.

10:49 AS left.

8. LSC Chief Pharmacist / Integration and Workforce Lead Update

MA Unfortunately JL sent apologies reasonably early. Andrew then sent apologies but allowed for email communication for any queries.

Queries sent:

- Latest developments of meds optimisation team impact.
- Clarification when may get an invite to discuss letter around stopping all third-party ordering and any relevant follow up and agreed timeline on implementation
- Understanding ahead of meeting that all patient groups will be included and digital ordering implications

No response before meeting.

MA JL is continuing with IP pathfinder and continue efforts in localised placed based role whilst also working on workforce. Also includes future IP modelling including agreements with CPE. JL has sadly announced that she will be leaving ICB within next few months, potentially November.

BREAK COMMENCED 11:20

SESSION RECOMMENCED 11:31

9. VirtualOutcomes

RB joined via Team 11:32.

Introductions.

Overview of VO training materials pharmacy team, pharmacy contract, GP training PF, PCS, HCF. GP reports harder to gather as don't have a list like LPCs do have.

Challenging time with VO, not much has changed in contract. Previously PF caused increase in training. 186 course views over the past year.

Recent and upcoming independent prescribing, eps and patient nominations, GP training in relation to IP. Need to wait until all IP details are released and how affects PF but over next year developing modules to go alongside. MenB module released this week meant EPS module was delayed slightly to allow for priority. Looking at support for pharmacies in relation to the 4-hour training closure per month for pharmacies.

Annual total cost cs actual course views were shared including limited contractor usage.

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MA CPLSC board plan to review licence cost and contractor benefit and choice.

LW Team actively marketing through NLs, f2f conversations etc but uptake remains low despite marketing and feedback has been a multitude of platforms are now available through provider organisations as well as the well-attended and watched back interactive CPLSC webinars and local stakeholder sessions.

MA highlighted the old school and out-dated setup and slide shows.

RB Looking at possible improvements. Focussed more on 'what you need to do' than the look and feel of the platform. RB ongoing difficulty with same contractors using. Hard to balance making accessible to all but ensuring it is being used equally. Same proportion of contractors using training whether online or f2f no answer.

MA can we pay per module?

RB tried to keep cost as low as possible so haven't increased pricing model as flat fee for all contractor base across the LPC. Wouldn't be financially viable to reduce cost, would just have to charge more per course and have access to fewer courses.

11:52 RB left meeting.

MA shared CPLSC drill down into exact usage, cost per contractor and course, usage over the last year and last 8 weeks as well as listing of active contractors to allow a board debate

11:56 ZP asked to leave room for a closes board conversation.

12:05 ZP returned to meeting

10. CPE Regional Rep Update

The Committee received updates from FM, including discussions on the recent contract settlement, ongoing sector reform, governance changes, and future election arrangements. Members heard that CPE is focused on developing a more sustainable funding model, reducing barriers for contractors, supporting pharmacy transformation, and using contractor feedback, patient stories, and current supply issues to inform national negotiations and engagement with government.

Feedback was also shared from the recent CPE roadshow and workshop as well as the afternoon CPE Northwest LPCs session. While the evening event was poorly attended it provided useful insights into contract negotiations and future reform plans, concerns were raised about the CPE table support, felt limited balanced discussion and contribution allowed from CPE attendees. Following discussion, it was agreed that this feedback should be passed to CPE, with a reminder of the expectations and responsibilities associated with representing the sector at regional events.

Elections principles for 2027 were also covered.

FM then led regional roadshow workshop in line with CPE roadshows and took away the overall CPLSC board views for each workshop with a polling system being used to capture remaining priorities for reform.

11. Actions Log

CPLSC board reviewed via Dropbox and will be added to next meeting agenda.

12. Actions / Activities to note since last meeting

CPLSC board reviewed via Dropbox and will be added to next meeting agenda.

13. Office & Contractor Support Update

MA Contractor support calls DMS, PF supply, PF referrals, WhatsApp group updates, roadshow, MenB, Settlement, webinars and VOIP stats 479 calls inbound and outbound

NL and website stats shared and peaks noted covid 19 spring, PF supply update, funding settlement, services ready MenB. Contractor visit details and splits shared

Elements and splits of contractor/commissioner/stakeholder's support queries and requests shared.

LW Healthcare Development Manager general update and overview of previous projects for benefit of contractor observer. Pharmacy first uptake project showcased GP training stats pre and post training. Tied in marketing and plans to rerun leaflet drop. Good links with LSCICB place based lead Rachel Dean. Listen to contractors when they raise both positives and issues with practices during visits. Addition of GP and Nurse 'saved time' slides and impact. Contraception chronicles ran after national changes had settled. Largely contractors lack confidence. Clear improvement in LPC

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rankings from September 2025 to Feb 2026. Marketing, SM and NL push, contractor visits all played a huge role. Hypertension hustle project currently 3rd in rankings and maintaining, particularly great results with ABPM service. Webinar was well attended and all CPLSC webinars have also had good playback numbers dermatology over 100. New contractor connection project updated that out of 29, only a handful of new contractors to visit now that have opened over last year. Has allowed for open discussions and questions covering NHS and PH SLAs, Smart cards, services delivery and more. Gives opportunity to cover CPLSC function, get them signed up to NL, guide to website and showcase virtual outcomes. Next project in the pipeline was NMS but have realigned due to recent MenB announcements. All queries will go through office triage system to a senior member of CPLSC team to ensure appropriate advice given. Contractors can have face to face visits upon request for assistance with service. Outreach works ongoing with signposting to community pharmacy training offer being accepted by local council teams, charities and further to help drive improvements in Pharmacy First thresholds.

LUNCH 13:02 13:35

MA Shared latest PF threshold payments and indicated the ongoing concerns around monthly cash losses by the percentile not achieving thresholds at both £1k and £500. Officially going to progress with revised data set to formulate a heatmap for marketing. Discussions and agreements made on timelines and planning.

ZP if not in 500/1000 bracket it is likely because contractors are not doing it right. Very simple to convert OTC pathways into PF consultations.

AP It's that people don't have interest or capability to push and market the service.

BF Speaking as a contractor who hasn't hit threshold until recently all avenues of support would benefit and not always reliant on teams and local effort

SA often people are product led, as opposed to consultation led.

LW contractors still appear to be rejecting and not completing referrals leading to cash losses and practice completion rates.

MA Cyber resilience and reducing risk. Digital infrastructure and Informatic is a big risk, as we hold patient data. MA has set up meeting with Cyber Resilience Centre NW which is police led organisation to bring our forum and partnerships to a higher level and better offering for contractors. Free offer for any contractor and teams at any time. 43% business report cyber breaches. Fully funded cyber security services. Cyber security health check. Network vulnerability assessments. Risk mitigation, simplified compliance, expert resources and MA working on the support plan alongside the planned meeting with Clive Grunshaw Crime Commissioner.

14. Financial Accounts Update

BF Had another levy holiday in March and currently at 3.3 months holding so green but need to be mindful of ringfenced going down steadily. Excluded from contractor funds.

BF Levy hasn't changed for three years. Few changes due to CPE levy/ inflation etc. fully expect to absorb incoming costs. Should hopefully get through without increase again. Budgeting well so far this year.

MA overlap with marketing that was put on hold with delayed CPE announcements.

MA board meeting venue locations discussed to support the vast geographical spread for contractor sites and commissioner / stakeholder attendance.

14:02 Dr John Miles entered and AD shifted to Item 19

19. LSCICB Operating Model & PCBB – Director of Primary Care & Associate Director of Primary Care

JM explained that the ICB had intended to present a full operating model, but this has been delayed until August. In the meantime, the session aimed to provide an update on current developments, the likely direction of travel, and what these changes could mean for community pharmacy.

The presentation focused on three areas:

1. What has happened over the past 12 months?
2. What is happening now?
3. What does this mean for the future?

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A key theme was that the NHS is experiencing both uncertainty and opportunity, as national reforms begin to influence local Integrated Care Boards (ICBs). The overall ambition remains to improve access to care for patients, strengthen population health outcomes, and support providers.

Although the NHS 10Year Plan is now a year old, its three core principles remain unchanged, particularly the commitment to move more healthcare delivery into communities. However, there is still limited detail about how this will be implemented. Two important developments emerging from this agenda are:

- Integrated Health Organisations (IHOs) – a new NHS England contract model being piloted with trusts, designed to give them greater flexibility to commission and deliver services across a place-based footprint. There is still uncertainty around the implications, but IHOs are expected to take on some functions previously associated with Care Connections. Current thinking suggests alignment with existing hospital providers, though the model will continue to evolve over the next 6–12 months.
- Neighbourhood Health Services – the main focus of the discussion and the area most relevant to LPCs. The aim is to deliver more care closer to home, enable organisations to work together more effectively, and ensure patients receive seamless care regardless of where they access services. While contracts may eventually be held at neighbourhood level, potentially through IHOs, the arrangements remain unclear. The approach builds on previous structures such as PCNs but is intended to be broader and more integrated.

Locally, Blackburn with Darwen and South Cumbria are identified as neighbourhood areas, and there is an expectation that neighbourhood working will strengthen links with Health and Wellbeing Boards.

The ICB restructuring programme is ongoing and expected to be finalised by August, with implementation in the autumn. The process has been challenging internally, including a second round of voluntary redundancies and further delays to the restructuring timetable. Following discussions with Dr Claire Fuller, there is reassurance that community pharmacy will continue to have a recognised professional role within future structures.

Looking ahead, the direction of travel is towards a consistent ICB core offer across Lancashire and South Cumbria, combined with greater local flexibility ("hyper localisation") through neighbourhood structures. The ICB is expected to act primarily as a strategic commissioner, while local areas will have greater freedom to develop solutions that best meet the needs of their populations.

Within general practice, two new GP confederations have been established over the last year, ensuring every practice now belongs to a federation and has a stronger collective voice and representation.

For community pharmacy, an important consideration is how the national contract can support neighbourhood working. Key strengths that pharmacies can bring include:

- Pharmacy First
- Pharmacy Contraception Service (PCS)
- Hypertension Case Finding Service (HCS)
- Workforce development, particularly the expansion of Independent Prescribing (IP)

Future governance structures may include:

- Health and Wellbeing Boards with a population health focus.
- Neighbourhood Boards with a commissioning focus.
- A potential Primary Care Provider Board with a provider focus.

JM concluded by acknowledging the current lack of detail but expressed confidence that greater clarity on neighbourhood structures, commissioning arrangements, and operating models should be available in the autumn.

MA We understand complex arena for our vast footprint.

AM Knowhere near end point of delivery but are there certain areas that are being picked off in secondary care to go into neighbourhood environments?

JM Currently in process of redesigning integrated urgent care non urgent treatment centre. Assumption that many patients don't need to be in ED. Developing plans and models. Looking at how we can join in with CP offer. Example 111 10pm Sunday night, sore throat, don't need to be seen out of hours, instead signpost to CP. Opportunities like this work for all parties.

AM feels like there will be a conflict with GPs in terms of IP and what CP can offer instead of a GP. Just signposting JM there is capacity. What additional things can be moved around? Communications from NHSE is that will have autonomy to make these kinds of decisions but in practice how is it commissioned, delivered, maintain relations within

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primary care. Hopeful that it will work. Reason for change is demand is now unsustainable so doing nothing isn't an option.

KK Had similar conversations when ICBs came into fruition. Were told in deficit and no money. Where are we now?

JM System is in better financial state than 12m ago but still in deficit. Chief exec spoke at GP forum to unpick. 5.7billion healthcare budget, how can we use it wisely internally. Won't be more money but better ways of using it. Sense of left shift moving from hospital to community. Still trying to find a way to safely invest in new environment while disinvesting in old environment.

MA GP federated model how does it link in with LMC role?

JM All about relationships. LMCs have statutory role to represent GP practice, role of federations/ confeds is an and, not an or. LMC play important NHS reorientation role similar to yourselves. Need to keep dialogue ongoing, have sense of respectful relationships, recognising skills and what fits into each bodies remit. Will be a degree of friction regardless but is scope for both.

JM left 14:35.

MA LCC Health and wellbeing board evening discussion meeting update given. Potential Huge structural change happening in county council. Good news projected a seat for CP. Challenged Primary care narrative for all four pillars and not just referencing GP practices. Discussed email around proposed GP practice seats and disproportionate.

15. HR Sub Group & CPLSC Closed Board Session

Closed session commenced LW and ZP left room for closed session.

CPLSC board covered areas including, HR matters, financial planning, confidential negotiations review, LSCICB collaboration and stats, confidential contractor updates, CPAF updates, NHS services delivery and PPV.

15:00 Break

15:15 Closed Session recommenced

16. MarketEntry

RW no recent applications for direct board review other than ongoing notifications as received

MA Strict market entry review process outlined for benefit of contractor observer.

17. Governance & Scrutiny Sub Group Update

MA AGM and election dates outlined with critical dates and key actions

CPLSC Annual accounts 2526 approved today for AGM papers release

Independent vacancy update shared and CPLSC board now awaiting imminent elections

SA is the concept of LPC staying the same, given closures and is it proportionate

MA elections process will involve a CPE release of contractors list by the agreed set date from which we will complete our usual proportional validations and subsequent seats in line with the constitution.

18. PR & Social Media Update

CPLSC SM activity continuing to showcase the best of our contractors and shine a light on collaboration and building for the future

Instagram, issues with meta and malicious impact has meant a holding on that channel and a possible revalidation and reconnect as a new account.

MA shared latest posts and views on NHS Confed associations, contractor sites as well as the dual recognition and of projects at the GP and Community Pharmacy conference.

MA also mentioned the CPNBS being pushed by Baba Akomolafe and after catching up with him at the conference it was that each LPC can choose whether they wish to be part of it and any practice can use it. Two big flaws were that we already have a fully funded integrated solution through Optum and Local Services Button so this will be duplication for practice teams and more so it means unfunded work for all minor illnesses and the many others around gateway which means more cash loss and additional workload.

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20. Services SG update – including CCPF Workshop

MA provided updates on several ongoing workstreams. Flu vaccination service arrangements continue to progress, with providers preparing for delivery and demonstrating flexibility to meet local demand. Updates were also shared regarding service negotiations and support for new providers. An update was provided on the Varenicline PGD programme, with business proposals submitted and currently awaiting approval. Discussions around workforce development and funding arrangements are ongoing. Progress was also reported on the Minor Illness training programme, which is being developed in response to Board priorities. Training will focus on key clinical skills and will be delivered across two locations to improve accessibility for contractors. Efforts have been made to secure favourable funding arrangements and minimise costs to participants. Sessions are provisionally planned for September and November, with final dates to be confirmed by MA. Additional details also shared on the revised marketing plan post CPE announcements.

16:06 ZP left meeting due to contractor confidential data session and thanked for participation.

MA led a Pharmacy First Data Workshop

A detailed workshop was undertaken by Board members, who split into groups to review the minimal referral datasets as received via LCICB, identify key trends, and consider recommendations for CPLSC teams moving forward.

Discussions focused on understanding the factors contributing to high performance, identifying opportunities to share good practice across the network, and exploring ways to support contractors with lower completion rates. Members also considered the value of undertaking deeper analysis of referral conversion rates, rejected referrals, GP referral activity, and patient list size data to better understand variations in performance and better understand noncompliance to SLA standards.

The workshop highlighted the importance of targeted engagement with both pharmacies and GP practices to identify learning opportunities, address potential barriers to referral completion, and encourage greater utilisation of Community Pharmacy PF services where appropriate.

MA also reported that work has been undertaken with PharmOutcomes to improve reporting functionality, enabling contractors to more easily access and review details of rejected referrals through the Services tab, supporting local performance monitoring and quality improvement.

21. Resources to provide NQPs in Community Pharmacy Workshop

This was deferred to the next meeting but noted the support provided by SV and the release of information

22. LPC Chairs meeting London

This was deferred to the next meeting and AD will circulate via email for board review.

23. North West LPCs meeting update

Covered in earlier sessions as part of the CPE North West meeting update

24. CPE Bundle Audit Results

Variance reviewed for month as received

25. AOB

No AOB noted

CLOSE 16:39